

ADVANTAGE PPO SAVER SUMMARY OF BENEFITS

With Tufts Health Plan Advantage PPO Saver, health care services may be covered subject to the plan's deductible, covered subject to coinsurance, covered with a copayment, or covered in full. Health care services are covered at two levels of benefits: the in-network level of benefits and the out-of-network level of benefits.

In addition, Advantage HMO Saver is fully compatible with health savings accounts (HSAs), which are designed specifically to help with individuals' future health care expenses. For a list of financial institutions that administer HSAs, please see your employer or our website.

As an Advantage PPO Saver member:

- You can seek covered health care services from most licensed providers in or out of the Tufts Health Plan network.
- No referrals are needed.
- You do not have to choose a primary care provider (PCP).

How services are covered with Advantage PPO Saver

In general, Advantage PPO Saver covers preventive and medically necessary health care services and supplies in the following ways:

- Coverage at the in-network level of benefits:** When you receive care from a provider in the Tufts Health Plan network, services are covered subject to the plan's deductible or coinsurance, covered with a copayment, or covered in full.
 - Covered subject to the plan's deductible:** All covered pharmacy services are subject to the plan deductible, as well as most covered medical services, generally those used to diagnose, treat, or monitor health conditions (for example, an MRI or nonroutine office visits to your primary care provider or a specialist). The deductible is the amount you must first pay out of pocket each plan year before many services are covered. Once you meet the deductible, services are covered in full or subject to coinsurance, which is a percentage of covered medical costs you are responsible for paying. You pay coinsurance until you reach the plan's out-of-pocket maximum, after which you are

covered in full for covered services for the remainder of the plan year. In addition, services subject to the plan's deductible may also be performed during or in conjunction with preventive services; for example, during an office visit.

Note: There is no individual deductible on a family plan. If you have two or more family members enrolled in the plan, and only one member receives services that are subject to the deductible in a plan year, that member alone must meet the full family deductible before services subject to the deductible are covered. The same calculation applies to the out-of-pocket maximum.

- Covered in full or with a copayment:** You pay the applicable copayment at the time you receive covered health care services. With this plan, preventive services are covered in full and are not subject to the plan's deductible. Generally, preventive services are the services your provider provides to help you stay healthy. They might be office visits for routine physicals for children and adults, tests (also called screenings) to evaluate your general health or the health of certain parts of your body, measurements, immunizations (or shots) for children and adults, certain advice about health, or special tests at certain times in your life.
- Coverage at the out-of-network level of benefits:** When you receive care from a provider who is not in the Tufts Health Plan network, services will be covered subject to the plan's deductible and then coinsurance. The deductible is the amount you must first pay out of pocket each plan year before many services are covered. You pay coinsurance until you reach the plan's out-of-pocket maximum, after which you are covered in full up to the reasonable charge for covered services for the remainder of the plan year. You may also be responsible for paying any difference between what the plan covers and what an out-of-network provider charges for a service.

The individual and family deductibles and out-of-pocket maximums for this plan are listed in this benefit summary. Please note that this is a summary of benefits only. For more detailed benefit information, please refer to this plan's member benefit document.

| Prescription Drug Coverage | For up to a 30-day supply at a participating retail pharmacy | For up to a 90-day supply through our mail order service |
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| Tier 1 | \$10 after deductible | \$20 after deductible |
| Tier 2 | \$30 after deductible | \$60 after deductible |
| Tier 3 | \$45 after deductible | \$90 after deductible |
| Deductible and Out-of-Pocket Maximums (per plan year) | | |
| | Individual plans | Family plans |
| Deductible | \$3,000 | \$6,000 |
| Out-of-pocket Maximum (includes deductible, coinsurance, and copays) | \$5,950 | \$11,900 |
| Outpatient Medical Care | | |
| | In Network | Out of Network (after deductible) |
| Routine Physical Exams (including most preventive screenings. Please note: some services performed during a routine office visit may be subject to your deductible.) | Covered in full | Plan covers 80% |
| Non-routine Office Visits (including PCP and specialist consultations) | Covered in full after deductible | Plan covers 80% |
| Routine Outpatient Maternity Care (This office visit copayment will apply per visit up to 10 visits per pregnancy. After 10 visits, these services are covered in full for the remainder of your pregnancy.) | \$25 per visit | Plan covers 80% |
| Non-Routine Outpatient Maternity Care | Covered in full after deductible | Plan covers 80% |
| Preventive Immunizations | Covered in full | Plan covers 80% |
| Non-preventive Immunizations | Covered in full after deductible | Plan covers 80% |
| Preventive Pap Smears and Mammograms | Covered in full | Plan covers 80% |
| Non-preventive Pap Smears and Mammograms | Covered in full after deductible | Plan covers 80% |
| Colonoscopy (without surgical intervention) | Covered in full | Plan covers 80% |
| Colonoscopy (with surgical intervention) | Covered in full | Plan covers 80% |
| Well-Child Care | Covered in full | Plan covers 80% |
| Routine eye exams (1 visit every 24 months)—you must use an EyeMed Vision Care provider to be covered at the in-network level of benefits | \$25 per visit | Plan covers 80% |

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| Nutritional Counseling (When medically necessary) | Covered in full after deductible | Plan covers 80% |
| Allergy Injections | Covered in full after deductible | Plan covers 80% |
| Speech and Short-term Physical/Occupational Therapy (30 visits for each service type per plan year) | Covered in full after deductible | Plan covers 80% |
| Spinal Manipulation (12 visits per plan year) | Covered in full after deductible | Plan covers 80% |
| Diagnostic Procedures | Covered in full after deductible | Plan covers 80% |
| Diagnostic Imaging - General Imaging (such as X-rays and ultrasounds) | Covered in full after deductible | Plan covers 80% |
| Diagnostic Imaging - High-Tech Imaging (MRIs, CT/CAT Scans, PET Scans & Nuclear Cardiology) | Covered in full after deductible | Plan covers 80% |
| Diagnostic Lab Tests | Covered in full after deductible | Plan covers 80% |
| Day Surgery | Covered in full after deductible | Plan covers 80% |
| Inpatient Hospital Care (Semi-private room, unless private room is medically necessary) | In Network | Out of Network (after deductible) |
| All Hospital Services (Acute Care) and Maternity Care | Covered in full after deductible | Plan covers 80% |
| Skilled Nursing in Skilled Nursing Facility (up to 100 days per plan year) | Covered in full after deductible | Plan covers 80% |
| Emergency Care | | |
| In Provider's Office | Covered in full after deductible | |
| In Emergency Room | Covered in full after deductible | |
| Mental Health | In Network | Out of Network (after deductible) |
| Outpatient Care (up to 30 visits per plan year) | Covered in full after deductible | Plan covers 80% |
| Inpatient Care | Covered in full after deductible | Plan covers 80% |
| Substance Abuse | In Network | Out of Network (after deductible) |
| Outpatient Care (Alcohol and drug treatment, detoxification) (Up to 30 hours per plan year) | Covered in full after deductible | Plan covers 80% |
| Inpatient Care | Covered in full after deductible | Plan covers 80% |
| Other Health Services | In Network | Out of Network (after deductible) |
| Durable Medical Equipment | 70% after deductible | Plan covers 70% |
| Ambulance Service | Covered in full after deductible | Plan covers 80% |
| Hospice Care | Covered in full after deductible | Plan covers 80% |
| Home Health Care | Covered in full after deductible | Plan covers 80% |

There are some services that the plan does not cover. These include, but are not limited to: A service or supply not described as a covered service in your Tufts Health Plan member benefit document • Exams required by a third party, such as your employer, an insurance company, school, or court • Cosmetic surgery or any other cosmetic procedure, except certain reconstructive procedures described in your Tufts Health Plan member benefit document • Experimental or investigational drugs, services, and procedures • Eyeglasses or contact lenses, except as described in your Tufts Health Plan member benefit document • Blood, blood donor fees, blood storage fees, blood substitutes, blood banking, cord blood banking, or blood products, except as described in your Tufts Health Plan member benefit document • Drugs for use outside of a hospital, except as described in your Tufts Health Plan member benefit document • Personal comfort items • Custodial care • A service furnished to someone other than the member • Routine foot care, except as described in your Tufts Health Plan member benefit document • Charges incurred for stays in a covered facility beyond the discharge hour • Care for conditions that state or local law requires to be treated in a public facility • Medical or surgical procedures for sexual reassignment and reversal of voluntary sterilization • Spinal manipulation services for members age 12 and under • Except for Emergency care or Urgent care while traveling, a service, supply or medication that is obtained outside of the 50 United States • Private duty nursing (block or non-intermittent nursing).

This is a summary only. Please refer to the member benefit document for a detailed explanation of your coverage. If there is a difference between the information in this benefit summary and your member benefit document, the terms of your member benefit document will govern. If you have additional questions, please call a Member Specialist at 1-800-682-8059.

Offered by Tufts Insurance Company or Tufts Benefit Administrators, Inc., both Tufts Health Plan companies.