ADVANTAGE EPO
SUMMARY OF BENEFITS

TUFTS Health Plan
No one does more to keep you healthy.

With Tufts Health Plan Advantage EPO, health care services may be covered subject to the plan's deductible or coinsurance, covered with a copayment, or covered in full. The deductible is the amount you must first pay out of pocket before many services are covered. The deductible is calculated each plan year. Once you meet the deductible, the plan covers in full services that are subject to the deductible for the remainder of the plan year.

As an Advantage EPO member:

- You must choose a primary care provider (PCP) from the Tufts Health Plan network of providers.
- In most cases, your network PCP must provide or authorize (provide a referral for) your care.
- You do not need a referral for emergency care.

How services are covered with Advantage EPO

In general, the Advantage EPO plan covers preventive and medically necessary health care services and supplies when they are provided or authorized by your network PCP. Services may be:

- **Covered subject to the plan's deductible:** Certain covered services—usually those used to diagnose, treat, or monitor health conditions (for example, an MRI)—are subject to the plan's deductible. Note: Services subject to the plan's deductible may also be performed during or in conjunction with preventive services (for example, during an office visit). The individual and family deductibles for this plan are listed below.
- **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 deductible. Generally, preventive services are the services your provider provides to help you stay healthy. Preventive services are needed at all ages. 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.
- **Covered subject to coinsurance:** You pay coinsurance for durable medical equipment. Coinsurance is a percentage of the covered medical costs you are responsible for paying.

Out-of-pocket Maximum: Your deductible, coinsurance, and copayments accumulate toward your out-of-pocket maximum. Once you reach your out-of-pocket maximum, you are covered in full for services subject to deductible, coinsurance, and copayments. Pharmacy copayments are excluded from the out-of-pocket maximum.

Please note that this is a summary of benefits only. For more detailed benefit information, please refer to this plan's member benefit document.

✓ This health plan meets Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance.

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**
Tier 1	$10	$20
Tier 2	$25	$50
Tier 3	$50	$110

Deductible and Out-of-Pocket Maximums (per plan year)	**Individual**	**Family**
Deductible	$250	$750
Out-of-pocket Maximum (includes deductible and copayments)	$2,000	$4,000

Outpatient Medical Care (No PCP referral is necessary for OB/GYN visits, spinal manipulation, routine eye exams, or mammograms)	**PCP**	**Specialist**
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	
Non-routine Office Visits (including PCP and specialist consultations)	$20 per visit	$35 per visit
Preventive Immunizations	Covered in full	
Non-preventive Immunizations	Covered in full after deductible	
Preventive Pap Smears and Mammograms	Covered in full	
Non-preventive Pap Smears and Mammograms	Covered in full after deductible	
Colonoscopy (without surgical intervention)	Covered in full	
Colonoscopy (with surgical intervention)	$150 per visit, then covered in full after deductible	
Outpatient Maternity Care (initial copay only)	$20 per visit	$20 per visit
OB/GYN Visits	$20 per visit	$20 per visit
Well-Child Care	Covered in full	
Routine eye exams with an EyeMed Vision Care provider (1 visit per Plan year)	$20 per visit	$20 per visit
Nutritional Counseling (When medically necessary)	$20 per visit	$35 per visit
Allergy Injections	Covered in full after deductible	

Speech Therapy (no visit limit); Short-term Physical Therapy (30 visits per plan year); Short-term Occupational Therapy (30 visits per plan year)	Covered in full after deductible	
Spinal Manipulation (12 visits per plan year)	Covered in full after deductible	
Diagnostic Procedures	Covered in full after deductible	
Diagnostic Imaging - General Imaging (such as X-rays and ultrasounds)	Covered in full after deductible	
Diagnostic Imaging - High-Tech Imaging (MRIs, CT/CAT Scans, PET Scans, and Nuclear Cardiology)	$100 per visit, then covered in full after deductible	
Diagnostic Lab Tests	Covered in full after deductible	
Day Surgery	$150 per visit, then covered in full after deductible	
Inpatient Hospital Care (Semi-private room, unless private room is medically necessary)		
All Hospital Services (Acute Care) and Maternity Care	$500 per visit, then covered in full after deductible	
Skilled Nursing in Skilled Nursing Facility (up to 100 days per plan year)	Covered in full after deductible	
Emergency Care	**PCP**	**Specialist**
In Provider's Office	$20 per visit	$35 per visit
In Emergency Room	$100 per visit, then covered in full after deductible	
Mental Health		
Outpatient Care	$20 per visit	
Inpatient Care (Services provided at a designated facility)	$500 per visit, then covered in full after deductible	
Substance Abuse		
Outpatient Care (Alcohol and drug treatment, detoxification)	$20 per visit	
Inpatient Care (Services provided at a designated facility)	$500 per visit, then covered in full after deductible	
Other Health Services		
Durable Medical Equipment	Covered in full after deductible	
Ambulance Service	Covered in full	
Hospice Care	Covered in full after deductible	
Home Health Care	Covered in full after deductible	

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 • Foot orthotics, except therapeutic/molded shoes for an individual with severe diabetic foot disease • Assisted reproductive technology (e.g. IVF) procedures for non-Massachusetts residents • 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) • Hearing aids.

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 1-800-462-0224.

Offered by Tufts Associated Health Maintenance Organization, Inc.

Massachusetts Requirement to Purchase Health Insurance: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector Web site (www.mahealthconnector.org).

This health plan meets Minimum Creditable Coverage standards that are effective January 1, 2009 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards. This disclosure is for minimum creditable coverage standards that are effective January 1, 2009. Because these standards may change, review your health plan material each year to determine whether your plan meets the latest standards. If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its Web site at www.mass.gov/doi.