2020 SUMMARY OF BENEFITS

TUFTS Health Plan

YOUR CHOICE HMO COPAY (65%)

Deductible and Out-of-Pocket Maximums

Individual/Family	Tier 1	Tier 2
Deductible (For both Tier 1 and Tier 2)	N/A	$4000/$8000
Out-of-Pocket Maximum (includes medical and pharmacy deductibles, coinsurance, and copayments)	$4000/$8000	$8150/$16300

Medical Benefits

Preventive Services		
Routine Physical Exams, including: • preventive immunizations • preventive Pap smears and mammograms • well-child care visits • annual gynecological exams • most preventive screenings • routine prenatal and postnatal exams	Covered in full	
Colonoscopies: Screenings (in the absence of symptoms or personal history)	Covered in full	
Outpatient Medical Care **(No PCP referral is necessary for OB/GYN visits, spinal manipulation, routine eye exams, or mammograms)**	**Tier 1**	**Tier 2**
Primary Care Office Visits	$30 copay	$65 copay
Specialist Office Visits	$30 copay	$65 copay
Routine eye exams with an EyeMed Vision Care provider (1 visit every 24 months)	$30 copay	
Pediatric (Under age 19) Routine eye exams with an EyeMed Vision Care provider (1 visit every 12 months)	Covered in full	
Telahealth (Teladoc)	Covered in full	
Nutritional Counseling (when medically necessary)	PCP: $30/$65 copay Nutritionist/Dietician: $30 copay	
Allergy Injections	$5 copay	
Speech Therapy (when medically necessary)	$30 copay	
Short-term Physical and Occupational Therapy (30 visits for each type of service per plan year)	$30 copay	
Spinal Manipulation and Acupuncture	$30 copay	
Colonoscopies: Diagnostic - Without Surgical Intervention	Covered in full	Deductible then 35% coinsurance
Colonoscopies: Diagnostic - With Surgical Intervention	See Day Surgery for cost share	See Day Surgery for cost share
Diagnostic Imaging – General Imaging (such as X-rays and ultrasounds)	$30 copay	Deductible then 35% coinsurance
Diagnostic Imaging- High-Tech Imaging (MRIs, CT/CAT scans, PET scans, and nuclear cardiology)	$100 copay	Deductible then 35% coinsurance
Lab Tests (such as blood work)	Covered in full	Deductible then 35% coinsurance
Day Surgery	Deductible then $500 copay	Deductible then 35% coinsurance

Inpatient Hospital Care (semiprivate room, unless private room is medically necessary)		
All Hospital Services - Acute Care and Maternity Care	$500 copay	Deductible then 35% coinsurance
Skilled Nursing in Skilled Nursing Facility (up to 100 days per plan year)	Covered in full	
Emergency & Urgent Care		
In Emergency Room (copayment waived if admitted)	$200 copay	
Urgent Care	$40 copay	
Mental Health and Substance Abuse		
Outpatient Care	$30 copay	
Inpatient Care (services provided at a designated facility)	$500 copay	Deductible then 35% coinsurance
Other Health Services		
Durable Medical Equipment	30% coinsurance	
Emergency Ambulance Service	$100 copay	
Hospice Care	Covered in full	
Home Health Care	Covered in full	

Prescription Drug Benefits

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
Low Cost Generics Program	$5 copay	$10 copay
Tier 1	$35 copay	$70 copay
Tier 2	$80 copay	$160 copay
Tier 3	$100 copay	$300 copay
Tier 4	$150 copay (Max of $250 per fill)	N/A

- This summary reflects benefits that are in compliance with the Affordable Care Act (ACA).
- 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 Member Services at 1-800-462-0224.