2021 SUMMARY OF BENEFITS

TUFTS Health Plan

YOUR CHOICE HMO 1500

Deductible and Out-of-Pocket Maximums

Individual/Family	
Deductible (For both Tier 1 and Tier 2)	$1500/$3000
Out-of-Pocket Maximum (includes medical and pharmacy deductibles, coinsurance, and copayments)	$7000/$14000

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	$25 copay	$35 copay
Specialist Office Visits	$45 copay	$65 copay
Routine eye exams with an EyeMed Vision Care provider (1 visit every 24 months)	$25 copay	
Pediatric (Under age 19) Routine eye exams with an EyeMed Vision Care provider (1 visit every 12 months)	Covered in full	
Telehealth (Teladoc)	Covered in full	
Nutritional Counseling (when medically necessary)	PCP: $25/$35 copay Nutritionist/Dietician: $45 copay	
Allergy Injections	$5 copay	
Speech Therapy (when medically necessary)	$40 copay	
Short-term Physical and Occupational Therapy (30 visits for each type of service per plan year)	$40 copay	
Spinal Manipulation and Acupuncture	$25 copay	
Colonoscopies: Diagnostic - Without Surgical Intervention	Covered in full after deductible	Covered in full after deductible
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)	Deductible then $50 copay	Deductible then $125 copay
Diagnostic Imaging- High-Tech Imaging (MRIs, CT/CAT scans, PET scans, and nuclear cardiology)	Deductible then $150 copay	Deductible then $450 copay
Lab Tests (such as blood work)	Deductible then $25 copay	Deductible then $40 copay
Day Surgery	Deductible then $150 copay	Deductible then $1000 copay

Inpatient Hospital Care (semiprivate room, unless private room is medically necessary)		
All Hospital Services - Acute Care and Maternity Care	Deductible then $250 Copay	Deductible then $1000 Copay
Skilled Nursing in Skilled Nursing Facility (up to 100 days per plan year)	Covered in full after the deductible	
Emergency & Urgent Care		
In Emergency Room (copayment waived if admitted)	$300 copay	
Urgent Care	$40 copay	
Mental Health and Substance Abuse		
Outpatient Care	$25 copay	
Inpatient Care (services provided at a designated facility)	Deductible then $250 copay	
Other Health Services		
Durable Medical Equipment	Deductible then 30% coinsurance	
Emergency Ambulance Service	Deductible then $50 copay	
Hospice Care	Covered in full after deductible	
Home Health Care	Covered in full after deductible	

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	$25 copay	$50 copay
Tier 2	$60 copay	$120 copay
Tier 3	$90 copay	$270 copay
Tier 4	$160 copay	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.