

Covered Services	Tufts Value HMO (6)	Tufts Premium HMO	Tufts PPO	
			In-Network Benefit	Out-of-Network (after deductible) (1)
Outpatient Care Routine Physicals Doctor Office Visits	\$20 / visit \$20 / visit	\$15 / visit \$15 / visit	\$20 / visit \$20 / visit	20% coinsurance 20% coinsurance
Hospitalization Room & Board (3) Physician/Surgeon Services	\$250 / admission Covered in full Covered in full	Covered in full Covered in full	Covered in full Covered in full	20% coinsurance (7) 20% coinsurance
Day Surgery	\$100 / surgery	Covered in full	Covered in full	20% coinsurance
Maternity Prenatal/Postnatal Care Hospitalization	\$20 / visit \$250 / admission	\$15 / visit Covered in full	\$20 / visit Covered in full	20% coinsurance 20% coinsurance
Out of Pocket Maximum	\$1,000 for single (6) \$2,000 for family	None	None	\$1,000 for single (1) \$3,000 for family
Mental Health & Substance Abuse Inpatient – Non-Biological (3) <ul style="list-style-type: none"> Mental Health Substance Abuse 	\$250 / admission, up to 60 days per calendar year (4) \$250 / admission, up to 30 days per calendar year (4)	Covered in full, up to 60 days per calendar year (4) Covered in full, up to 30 days per calendar year (4)	Covered in full, up to 60 days per calendar year (4) Covered in full, up to 30 days per calendar year (4)	20% coinsurance 20% coinsurance
Outpatient – Non-Biological <ul style="list-style-type: none"> Mental Health Substance Abuse 	\$20 / visit, up to 24 visits per calendar year \$20 / visit, up to \$500 per calendar year	\$15 / visit, up to 24 visits per calendar year \$15 / visit, up to \$500 per calendar year	\$20 / visit, up to 24 visits per calendar year \$20 / visit, up to \$500 per calendar year	20% coinsurance 20% coinsurance
Physical Therapy <i>(short-term physical, occupational and speech therapy)</i>	\$20 / visit	\$15 / visit	\$20 / visit	20% coinsurance
Emergency Care (2)(5)	\$75 / visit	\$75 / visit	\$75 / visit	\$75 / visit
Chiropractic Care	None	None	\$20 / visit, up to 12 visits per calendar year	Plan covers 80%, up to 12 visits/ calendar year
Prescription Drugs <i>(up to a 30 day supply)</i>	\$15, Tier I \$25, Tier II \$40, Tier III	\$10, Tier I \$15, Tier II \$30, Tier III	\$10, Tier I \$20, Tier II \$35, Tier III	20% coinsurance
Mail Order Rx Drugs <i>(up to a 90 day supply)</i>	\$30, Tier I \$50, Tier II \$80, Tier III	\$20, Tier I \$30, Tier II \$60, Tier III	\$20, Tier I \$40, Tier II \$70, Tier III	Not Covered

Note: The above is intended as a brief overview of covered services only. Please refer to the Evidence of Coverage booklet (HMO's) or the Certificate of Insurance (PPO) for more detailed benefit information.

Terms and Conditions

- All covered Out-of-Network PPO benefits are paid at 80% after satisfying \$200 deductible for single plans and a \$600 deductible for family plans. The PPO out of pocket maximum on out of network services is \$1,000 individual / \$3,000 family per calendar year, which does not include the deductible.
- Waived if immediately admitted to the hospital. If admitted, Inpatient copayment would apply on Value HMO.
- A semi-private room is provided unless a private room is medically necessary.
- Treatment must be at a designated Tufts Health Plan facility.
- If you receive outpatient Emergency care at an emergency facility, you or someone acting on your behalf should call your PCP (HMO) or Tufts HP within 48 hours after receiving care. You are encouraged to contact your Primary Care Physician so your PCP can provide or arrange for any follow-up care that you may need.
- The HMO Value plan includes an out of pocket maximum of \$1,000 for an individual and \$2,000 for a family per calendar year. Only the inpatient copayment and day surgery copayment add up to this maximum.
- If you receive inpatient services which are not provided by a Network Provider, you must pre-register these services. If you do not Pre-register, you will be subject to a Pre-registration Penalty. Please refer to the Certificate of Insurance for additional information.