Health Insurance Matrix 01/01/20- 12/31/20

Description	Tufts Health Plan HSA HMO	Tufts Health Plan HMO $1,000 Deductible	Tufts Health Plan HMO 20B	Tufts Health Plan PPO
Employee Contributions Family	Monthly : $160.00 Bi-Weekly : $73.85	Monthly : $370.31 Bi-Weekly : $170.91	Monthly : $545.43 Bi-Weekly : $251.74	Monthly : $933.44 Bi-Weekly : $430.82
Employee Contributions Individual	Monthly : $61.45 Bi-Weekly : $28.36	Monthly : $140.77 Bi-Weekly : $64.97	Monthly : $206.91 Bi-Weekly : $95.50	Monthly : $353.22 Bi-Weekly : $163.02
Office Visits	Primary Care Physician: $0 after deductible Specialist: $0 after deductible	Primary Care Physician: $25 Specialist: $25	Primary Care Physician: $25 Specialist: $25	In Network : $25 Out-of-Network : 20% co-insurance after deductible
Preventive care - including routine physical, gynecological, well child, school, camp, sports,	Covered in full	Covered in full	Covered in full	In Network : Covered in full Out-of-Network : 20% co-insurance after deductible
Routine OB-GYN Exams	$0 (one per calendar year) No PCP referral required	$0 (one per calendar year) No PCP referral required	$0 (one per calendar year) No PCP referral required	In Network : $0 Out-of-Network : 20% co-insurance after deductible (one per calendar year)
Pap Smears	Included as part of the physical exam	Included as part of the physical exam	Included as part of the physical exam	Included as part of the physical exam
Routine Colonoscopy	Covered in full (Unless physician performs surgery during the procedure)	Covered in full (Unless physician performs surgery during the procedure)	Covered in full (Unless physician performs surgery during the procedure)	In Network : Covered in full (Unless physician performs surgery during the procedure) Out-of-Network : 20% co-insurance after deductible
Chiropractic Services	Covered in full after deductible 20 visits per calendar year No referral required	$25 co-payment 20 visits per calendar year No referral required	$25 co-payment 20 visits per calendar year No referral required	In Network : $25 (20 visits) Out-of-Network : 20% co-insurance after deductible
Diagnostic Laboratory and X-Rays	Covered in full after deductible	Covered in full after deductible	Covered in full	In Network : Covered in full Out-of-Network : 20% co-insurance after deductible
High Tech Radiology - CT Scans, MRIs, and PET Scans	Covered in full after deductible	$75 co-payment (No Deductible) Only charged twice annually per member	$75 co-payment Only charged twice annually per member	In Network : $75 co-payment Out-of-Network : 20% co-insurance after deductible
Dependent Coverage	Dependents are covered through the end of the month in which the attain age 26, regardless of the dependent's financial dependency, student status, marital or employment status.	Dependents are covered through the end of the month in which the attain age 26, regardless of the dependent's financial dependency, student status, marital or employment status.	Dependents are covered through the end of the month in which the attain age 26, regardless of the dependent's financial dependency, student status, marital or employment status.	Dependents are covered through the end of the month in which the attain age 26, regardless of the dependent's financial dependency, student status, marital or employment status.

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Emergency Room Visits	Covered in full after deductible	$100 co-payment No deductible (waived if admitted or for observation)	$100 co-payment (waived if admitted or for observation)	$100 co-payment (waived if admitted or for observation stay)
Mental Health Counseling	Covered in full after deductible	$25 co-payment - Individual Therapy	$25 co-payment - Individual Therapy	In Network : $25 co-payment - Individual Therapy Out-of-Network : 20% co-insurance after deductible
Doctor Selection	HMO Network	HMO Network	HMO Network	In Network : CareLink Out-of-Network : All Others
Pre-Existing Condition	No restriction	No restriction	No restriction	No restriction
Out-of-Area Emergency Care	Seek treatment at the nearest appropriate health care facility	Seek treatment at the nearest appropriate health care facility	Seek treatment at the nearest appropriate health care facility	Seek treatment at the nearest appropriate health care facility
Non-Emergency Hospital Admission	Before you enter a facility for inpatient non-emergency medical care and non-maternity care, your network provider must obtain approval from the Plan in order for the care to be covered	Before you enter a facility for inpatient non-emergency medical care and non-maternity care, your network provider must obtain approval from the Plan in order for the care to be covered	Before you enter a facility for inpatient non-emergency medical care and non-maternity care, your network provider must obtain approval from the Plan in order for the care to be covered	Before you enter a facility for inpatient non-emergency medical care and non-maternity care, your network provider must obtain approval from the Plan in order for the care to be covered
Prescription Drugs Retail (Any participating pharmacy) Coverage through OptumRX (855-546-3439)	After deductible $15 - Tier 1 $30 - Tier 2 $50 - Tier 3	$15 - Tier 1 $30 - Tier 2 $50 - Tier 3	$15 - Tier 1 $30 - Tier 2 $50 - Tier 3	$15 - Tier 1 $30 - Tier 2 $50 - Tier 3
Prescription Drugs Mail Order - 90-Day Supply Coverage through OptumRX (855-546-3439)	After deductible $30 - Tier 1 $60 - Tier 2 $150 - Tier 3	$30 - Tier 1 $60 - Tier 2 $150 - Tier 3	$30 - Tier 1 $60 - Tier 2 $150 - Tier 3	$30 - Tier 1 $60 - Tier 2 $150 - Tier 3
Dental Care, Routine Exams, Cleaning	N/A	N/A	N/A	N/A

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Pediatric Preventive Dental Coverage for Dependent Children under age 12	Covered in Full (two visits per member, per year)	Covered in Full (two visits per member, per year)	Covered in Full (two visits per member, per year)	In Network : Covered in full Out-of-Network : Not Covered
Calendar Year Deductibles	For most services, you must meet a deductible before services are provided: $1,500 for an individual, or $3,000 for a family. If enrolled in a family contract the entire family deductible must be satisfied before Tufts Health Plan will begin to pay claims for any family member.	For some services, you must meet a deductible before services are provided: $1,000 for each member, or $2,000 for all family members covered under the same membership	N/A	In Network : N/A Out of Network : $500 for each member, or $1,000 for all family members covered under the same membership
Calendar Year Out-of-Pocket Maximum: includes all medical and prescription copayments, deductible and coinsurance.	$2,500 for each member, or $5,000 for all family members covered under the same membership	$5,000 for each member, or $10,000 for all family members covered under the same membership	$2,500 for each member, or $5,000 for all family members covered under the same membership	$2,500 for each member, or $5,000 for all family members covered under the same membership
Inpatient Hospital Services - Semi-Private Room	Yes	Yes	Yes	Yes
Inpatient Hospital Services - Private Room	When medically necessary	When medically necessary	When medically necessary	When medically necessary
Inpatient Hospital Care & Surgery	Covered in full after deductible	Covered in full after the deductible. $1,000 deductible for each member, or $2,000 for all family members covered under the same membership	$500 co-payment per admission	In Network : $500 co-payment Out-of-Network : 20% co-insurance after deductible

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Outpatient (Day) Surgery Hospital or Surgical Facility	Covered in full after deductible	Covered in full after deductible	$250 co-pay per visit	In Network: $250 co-payment Out-of-Network: 20% co-insurance after deductible
Outpatient (Day) Surgery Office Setting	Covered in full after deductible	Applicable Office Visit Copay Applies	Applicable Office Visit Copay Applies	In Network : Applicable Office Visit Copay Applies Out-of-Network : 20% co-insurance after deductible
Lifetime Maximum (Catastrophic Illness)	None	None	None	None
Optical--through EyeMed	Vision Exam - $25 One per calendar year, no PCP referral required 35% off the retail price of frames, as well as discounts on lenses and lens options with the purchase of a complete pair of eyeglasses 15% off the retail price, or 5% off the promotional price of LASIK and PRK laser vision correction	Vision Exam - $25 One per calendar year, no PCP referral required 35% off the retail price of frames, as well as discounts on lenses and lens options with the purchase of a complete pair of eyeglasses 15% off the retail price, or 5% off the promotional price of LASIK and PRK laser vision correction	Vision Exam - $25 One per calendar year, no PCP referral required 35% off the retail price of frames, as well as discounts on lenses and lens options with the purchase of a complete pair of eyeglasses 15% off the retail price, or 5% off the promotional price of LASIK and PRK laser vision correction	Vision Exam - $25 One per calendar year, no PCP referral required 35% off the retail price of frames, as well as discounts on lenses and lens options with the purchase of a complete pair of eyeglasses 15% off the retail price, or 5% off the promotional price of LASIK and PRK laser vision correction
Durable Medical Equipment	20% cost share after deductible	20% cost share	20% cost share	In Network: 20% cost share Out of network: 20% cost share after deductible
Diabetic Equipment	Therapeutic molded shoes and inserts, dosage gauges, injectors, lancet devices, voice synthesizers and visual magnifying aids - Subject to the applicable cost sharing under the durable medical equipment benefit. Blood glucose monitors, insulin pumps and supplies and infusion devices - 20% cost share after deductible. Insulin, insulin syringes, insulin pens with insulin, lancets, oral agents for controlling blood sugar, blood test strips, and glucose, ketone and urine test strips - Subject to the applicable prescription drug co-payment. These items are also available through DME providers and are covered in full after deductible	Therapeutic molded shoes and inserts, dosage gauges, injectors, lancet devices, voice synthesizers and visual magnifying aids - Covered in full after deductible Blood glucose monitors, insulin pumps and supplies and infusion devices - Subject to the applicable cost sharing under the durable medical equipment benefit. (No Deductible) Insulin, insulin syringes, insulin pens with insulin, lancets, oral agents for controlling blood sugar, blood test strips, and glucose, ketone and urine test strips - Subject to the applicable prescription drug co-payment. These items are also available through DME providers and are covered in full after deductible	Therapeutic molded shoes and inserts, dosage gauges, injectors, lancet devices, voice synthesizers and visual magnifying aids - Subject to the applicable cost sharing under the durable medical equipment benefit. Blood glucose monitors, insulin pumps and supplies and infusion devices - Subject to the applicable cost sharing under the durable medical equipment benefit (No deductible). Insulin, insulin syringes, insulin pens with insulin, lancets, oral agents for controlling blood sugar, blood test strips, and glucose, ketone and urine test strips - Subject to the applicable prescription drug co-payment. These items are also available through DME providers and are covered in full	Therapeutic molded shoes and inserts, dosage gauges, injectors, lancet devices, voice synthesizers and visual magnifying aids - Subject to the applicable cost sharing under the durable medical equipment benefit. Blood glucose monitors, insulin pumps and supplies and infusion devices - Subject to the applicable cost sharing under the durable medical equipment benefit Insulin, insulin syringes, insulin pens with insulin, lancets, oral agents for controlling blood sugar, blood test strips, and glucose, ketone and urine test strips - Subject to the applicable prescription drug co-payment. These items are also available through DME providers and are covered in full (In-Network) or 20% coinsurance (Out-of-Network)

Health Insurance Matrix 01/01/20- 12/31/20

Description	Tufts Health Plan HSA HMO	Tufts Health Plan HMO $1,000 Deductible	Tufts Health Plan HMO 20B	Tufts Health Plan PPO
Wellness Plans	Weight Loss Benefit: $150 per year per subscriber Fitness Benefit: $150 per year per subscriber Appalachian Mountain Club: 20% discount Mindfulness & Stress Management: 15% discount on cost of tuition for 8-week Programs at UMASS Massage: 25% discount off usual and customary or $15 per 15 minutes Acupuncture: 25% discount off usual and customary	Weight Loss Benefit: $150 per year per subscriber Fitness Benefit: $150 per year per subscriber Appalachian Mountain Club: 20% discount Mindfulness & Stress Management: 15% discount on cost of tuition for 8-week Programs at UMASS Massage: 25% discount off usual and customary or $15 per 15 minutes Acupuncture: 25% discount off usual and customary	Weight Loss Benefit: $150 per year per subscriber Fitness Benefit: $150 per year per subscriber Appalachian Mountain Club: 20% discount Mindfulness & Stress Management: 15% discount on cost of tuition for 8-week Programs at UMASS Massage: 25% discount off usual and customary or $15 per 15 minutes Acupuncture: 25% discount off usual and customary	Weight Loss Benefit: $150 per year per subscriber Fitness Benefit: $150 per year per subscriber Appalachian Mountain Club: 20% discount Mindfulness & Stress Management: 15% discount on cost of tuition for 8-week Programs at UMASS Massage: 25% discount off usual and customary or $15 per 15 minutes Acupuncture: 25% discount off usual and customary
Unique Features	On Line Tools: Mytuftshealthplan Member Portal, Empower Me, Choosehealthy.com Allergy Injections: Deductible applies Speech, Hearing, and Language Disorder Treatment: 100% after deductible - no limit Short Term Rehabilitation Therapy (Physical and Occupational): 100% after deductible - Covered up to 30 visits each per calendar year	On Line Tools: Mytuftshealthplan Member Portal, Empower Me, Choosehealthy.com Allergy Injections: $5 copay Speech, Hearing, and Language Disorder Treatment: 100% after deductible - no limit Short Term Rehabilitation Therapy (Physical and Occupational): 100% after deductible - Covered up to 30 visits each per calendar year	On Line Tools: Mytuftshealthplan Member Portal, Empower Me, Choosehealthy.com Allergy Injections: $5 copay Speech, Hearing, and Language Disorder Treatment: $25 copayment - no limit Short Term Rehabilitation Therapy (Physical and Occupational): $25 co-payment - Covered up to 30 visits each per calendar year	On Line Tools: Mytuftshealthplan Member Portal, Empower Me, Choosehealthy.com Allergy Injections: In-Network: $5 co-payment Out-of-Network: 20% coinsurance after deductible Speech, Hearing, and Language Disorder Treatment: In-Network: $25 copayment - no limit Out-of-Network: 20% coinsurance after deductible Short Term Rehabilitation Therapy (Physical and Occupational): In-Network: $25 co-payment - Covered up to 30 visits each per calendar year Out-of-Network: 20% coinsurance after deductible
Hospitals	100% of all MA, NH, and RI hospitals	100% of all MA, NH, and RI hospitals	100% of all MA, NH, and RI hospitals	National network of providers and hospitals

For a complete description of benefits, please refer to your plan certificate (booklet). In case of a discrepancy, the plan certificate will prevail.
Please refer to the summary plan description (SPD) for complete details on plan eligibility.