

Plan Year or Calendar Year Available for All Plans

Level	Office Visit Copay		ER Copay	Hospital Copay	Spinal Manipulation Coverage	High-Tech Imaging	Member Coinsurance	Medical Deductible Individual/Family	Annual Out-of-Pocket Maximum Individual/Family	Pharmacy Benefit Summary	Pricing Relativity
	Routine Physical Exam	Non-Routine Office Visit									
HMO											
Value 250	\$0	\$15	\$100	\$250	Yes	\$100	N/A	No	\$1,000/\$2,000	\$15/\$30/\$50 Mail: \$30/\$60/\$150	1 (baseline)
Value 350	\$0	\$15	\$100	\$350	Yes	\$100	N/A	No	\$1,400/\$2,800	\$250/\$500 Deductible then \$20/\$75/\$100 Mail: Deductible then \$40/\$150/\$300	-9.2%
Basic 20	\$0	\$20	\$125	\$250—Day Surgery \$500—Inpatient Care	Yes	\$150	N/A	No	\$2,000/\$4,000	\$15/\$30/\$50 Mail: \$30/\$60/\$150	-5%
Basic 25 ***	\$0	\$25	\$125	\$600	Yes	\$150	N/A	No	\$2,400/\$4,800	\$15/\$30/\$50 Mail: \$30/\$60/\$150	-9%
Basic 25 1000	\$0	\$25	\$150	\$250—Day Surgery \$1,000—Inpatient Care	Yes	\$150	N/A	No	\$1,000/\$2,000	\$15/\$30/\$50 Mail: \$30/\$60/\$150	-10.8%
Basic 35	\$0	\$35	\$150	\$750—Day Surgery \$1,000—Inpatient Care	Yes	\$150	N/A	No	\$4,000/\$8,000	\$100/\$200 Deductible then \$15/\$30/\$50 Mail: Deductible then \$30/\$60/\$150	-14.4%
Basic 50	\$0	\$50	\$250	\$1,000	Yes	\$150	N/A	No	\$4,000/\$8,000	\$250/\$500 Deductible then \$15/\$30/\$50 Mail: Deductible then \$30/\$60/\$150	-20%
Choice Copay	\$0	\$20—PCP \$40—Specialist	\$150	\$250—Community \$750—Tertiary	Yes	\$125	N/A	No	\$3,000/\$6,000	\$15/\$30/\$50 Mail: \$30/\$60/\$150	-9%
Advantage	\$0	\$20	Covered in full after Deductible	Covered in full after Deductible	Yes	Covered in full after Deductible	N/A	\$500/\$1,000	\$1,500/\$3,000	\$15/\$30/\$50 Mail: \$30/\$60/\$150	-16.4%
Advantage ***	\$0	\$20	Covered in full after Deductible	Covered in full after Deductible	Yes	Covered in full after Deductible	N/A	\$1,000/\$2,000	\$2,000/\$4,000	\$15/\$30/\$50 Mail: \$30/\$60/\$150	-21.5%
Advantage	\$0	\$20	Covered in full after Deductible	Covered in full after Deductible	Yes	Covered in full after Deductible	N/A	\$1,500/\$3,000	\$2,500/\$5,000	\$15/\$30/\$50 Mail: \$30/\$60/\$150	-24.2%
Advantage ***	\$0	\$20	Covered in full after Deductible	Covered in full after Deductible	Yes	Covered in full after Deductible	N/A	\$2,000/\$4,000	\$3,000/\$6,000	\$15/\$30/\$50 Mail: \$30/\$60/\$150	-26.5%
Advantage HMO 500 (90%)	\$0	\$20	Covered in full after Deductible	Deductible then 10% coinsurance	Yes	Deductible then 10% coinsurance	10%	\$500/\$1,000	\$2,500/\$5,000	\$15/\$30/\$50 Mail: \$30/\$60/\$150	-20.2%
Advantage HMO 1000 (80%)	\$0	\$20	Covered in full after Deductible	Deductible then 20% coinsurance	Yes	Deductible then 20% coinsurance	20%	\$1,000/\$2,000	\$4,000/\$8,000	\$15/\$30/\$50 Mail: \$30/\$60/\$150	-28.8%
Advantage HMO 2000 (80%)	\$0	\$20	Covered in full after Deductible	Deductible then 20% coinsurance	Yes	Deductible then 20% coinsurance	20%	\$2,000/\$4,000	\$5,000/\$10,000	\$15/\$30/\$50 Mail: \$30/\$60/\$150	-34.2%

HMO products offered by Tufts Associated Health Maintenance Organization, Inc. Pricing relativity as compared to HMO Value as the baseline measurement. Information is provided for illustrative purposes only; actual quotes may vary. This information is subject to change without notice.

***Plan is also available with a prescription deductible of \$250 individual/\$500 family and \$20/\$75/\$100 copayments. This chart provides benefit highlights for general comparison purposes only. There are also services that the plans do not cover. Please see a Summary of Benefits for more information or refer to your Evidence of Coverage for complete information.

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Level	Office Visit Copay		ER Copay	Hospital Copay		Spinal Manipulation Coverage	High-Tech Imaging	Member Coinsurance	Medical Deductible Individual/Family	Annual Out-of-Pocket Maximum Individual/Family	Pharmacy Benefit Summary	Pricing Relativity
	Routine Physical Exam	Non-Routine Office Visit		Surgical Day Care Copay	Inpatient Copay							
PPO												
Value	\$0	\$15	\$100	\$250 OOP Max \$1,000	\$250 OOP Max \$1,000	Yes	\$100	20% out-of-network	\$500/\$1,000 Deductible Out-of-network	\$2,500/\$5,000 Out-of-network	\$15/\$30/\$50 Mail: \$30/\$60/\$150	26%
Basic 20	\$0	\$20	\$125	\$250 OOP Max \$1,000	\$500 OOP Max \$2,000	Yes	\$150	20% out-of-network	\$750/\$1,500 Deductible Out-of-network	\$3,750/\$7,500 Out-of-network	\$15/\$30/\$50 Mail: \$30/\$60/\$150	19.6%
Basic 25	\$0	\$25	\$125	\$600 OOP Max \$2,400	\$600 OOP Max \$2,400	Yes	\$150	20% out-of-network	\$750/\$1,500 Deductible Out-of-network	\$3,750/\$7,500 Out-of-network	\$15/\$30/\$50 Mail: \$30/\$60/\$150	14%
Basic 35	\$0	\$35	\$150	\$750 OOP Max \$1,000	\$1,000 OOP Max \$4,000	Yes	\$150	20% out-of-network	\$1,250/\$2,500 Deductible Out-of-network	\$6,250/\$12,500 Out-of-network	\$100/\$200 Deductible then \$15/\$30/\$50 Mail: Deductible then \$30/\$60/\$150	6.5%
Basic 50	\$0	\$50	\$250	\$1,000 OOP Max \$4,000	\$1,000 OOP Max \$4,000	Yes	\$150	20% out-of-network	\$1,500/\$3,000 Deductible Out-of-network	\$7,500/\$15,000 Out-of-network	\$250/\$500 Deductible then \$15/\$30/\$50 Mail: Deductible then \$30/\$60/\$150	-0.7%
Advantage	\$0	\$20	Covered in full after Deductible	Covered in full after Deductible		Yes	Covered in full after Deductible	20% out-of-network	\$500/\$1,000 Deductible In- and Out-of-network	\$3,000/\$6,000 In- and out-of-network	\$15/\$30/\$50 Mail: \$30/\$60/\$150	8.7%
Advantage	\$0	\$20	Covered in full after Deductible	Covered in full after Deductible		Yes	Covered in full after Deductible	20% out-of-network	\$1,000/\$2,000 Deductible In- and Out-of-network	\$5,000/\$10,000 In- and out-of-network	\$15/\$30/\$50 Mail: \$30/\$60/\$150	1.9%
Advantage	\$0	\$20	Covered in full after Deductible	Covered in full after Deductible		Yes	Covered in full after Deductible	20% out-of-network	\$1,500/\$3,000 Deductible In- and Out-of-network	\$5,000/\$10,000 In- and out-of-network	\$15/\$30/\$50 Mail: \$30/\$60/\$150	-5%
Advantage	\$0	\$20	Covered in full after Deductible	Covered in full after Deductible		Yes	Covered in full after Deductible	20% out-of-network	\$2,000/\$4,000 Deductible In- and Out-of-network	\$5,000/\$10,000 In- and out-of-network	\$15/\$30/\$50 Mail: \$30/\$60/\$150	-8.8%
Advantage PPO 500 (90/70)	\$0	\$20	Covered in full after Deductible	Deductible then 10% coinsurance in-network		Yes	Deductible then 10% coinsurance in-network	10% in-network 30% out-of-network	\$500/\$1,000 Deductible In- and Out-of-network	\$5,000/\$10,000 In- and out-of-network	\$15/\$30/\$50 Mail: \$30/\$60/\$150	3.9%
Advantage PPO 1000 (80/60)	\$0	\$20	Covered in full after Deductible	Deductible then 20% coinsurance in-network		Yes	Deductible then 20% coinsurance in-network	20% in-network 40% out-of-network	\$1,000/\$2,000 Deductible In- and Out-of-network	\$5,000/\$10,000 In- and out-of-network	\$15/\$30/\$50 Mail: \$30/\$60/\$150	-7.7%
Advantage PPO 2000 (80/60)	\$0	\$20	Covered in full after Deductible	Deductible then 20% coinsurance in-network		Yes	Deductible then 20% coinsurance in-network	20% in-network 40% out-of-network	\$2,000/\$4,000 Deductible In- and Out-of-network	\$5,000/\$10,000 In- and out-of-network	\$15/\$30/\$50 Mail: \$30/\$60/\$150	-18.3%

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Pricing relativity as compared to HMO Value as the baseline measurement. Information is provided for illustrative purposes only; actual quotes may vary. This information is subject to change without notice.

This chart provides benefit highlights for general comparison purposes only. There are also services that the plans do not cover. Please see a Summary of Benefits for more information or refer to your Evidence of Coverage for complete information.

Plan Year or Calendar Year Available for All Plans

Tier	Office Visit Copay		ER Copay	Inpatient Hospital Copay	Day Surgery Center		High-Tech Imaging		Diagnostic Tests		Member Coinsurance	Medical Deductible Individual/Family (Plan Year)	Annual Out-of-Pocket Maximum Individual/Family	Pharmacy Retail Copays	Pricing Relativity		
	PCP	Specialist			Freestanding Outpatient Surgery Center	Hospital	Freestanding Imaging Center	Hospital or Other Provider	Any Non Hospital Provider	Outpatient Hospital							
YOUR CHOICE HMO — A Tiered Provider Network Option																	
Your Choice HMO 3-Tier Option 2																	
Tier 1	\$30	\$40	\$150	\$500	\$250	\$500	\$100	\$100	Covered in full	Covered in full	N/A	\$5,000/\$10,000		\$15*	-17%		
Tier 2	\$40	\$50	\$150	\$1,000		\$1,000		\$250		Covered in full	N/A			N/A		\$30	
Tier 3	\$60	\$75	\$150	\$1,500		\$1,500		\$450		Covered in full	N/A			N/A		\$50	
Your Choice HMO 3-Tier Option 3																	
Tier 1	\$15	\$25	\$100	\$150	\$150	\$150	\$50	\$50	Covered in full	Covered in full	N/A	\$5,000/\$10,000		\$15*	-22.2% without HRA		
Tier 2	\$25	\$35	\$100	Deductible then \$150		Deductible then \$150		Deductible then \$50		Deductible then covered in full	N/A			\$500/\$1,000		\$30	
Tier 3	\$45	\$50	\$100	Deductible then \$1,000		Deductible then \$1,000		Deductible then \$450		Deductible then covered in full	N/A			\$2,000/\$4,000		\$50	-19.3% with HRA
Your Choice HMO 3-Tier Option 6																	
Tier 1	\$25	\$35	\$150	\$350	\$350	\$350	\$150	\$150	Covered in full	Covered in full	N/A	\$5,000/\$10,000		\$15*	-25% without HRA		
Tier 2	\$35	\$50	\$150	Deductible then covered in full		Deductible then covered in full		Deductible then covered in full		Deductible then covered in full	N/A			\$750/\$1,500		\$30	
Tier 3	\$50	\$75	\$150	Deductible then \$1,000		Deductible then \$1,000		Deductible then \$450		Deductible then covered in full	N/A			\$2,000/\$4,000		\$50	-22.5% with HRA
Your Choice HMO 3-Tier Option 7																	
Tier 1	\$25	\$35	\$150	Deductible then 10% coinsurance	\$250	Deductible then 10% coinsurance	\$150	Deductible then 10% coinsurance	Covered in full	Deductible then 10% coinsurance	10%	\$500/\$1,000		\$15*	-26% without HRA		
Tier 2	\$35	\$50	\$150	Deductible then 20% coinsurance		Deductible then 20% coinsurance		Deductible then 20% coinsurance		Deductible then 20% coinsurance	20%			\$1,000/\$2,000		\$30	-23.3% with HRA
Tier 3	\$50	\$75	\$150	Deductible then 30% coinsurance		Deductible then 30% coinsurance		Deductible then 30% coinsurance		Deductible then 30% coinsurance	30%			\$2,000/\$4,000		\$50	

* Mail Order Pharmacy: 90-day supply is available at the 60-day supply copayment.

Massachusetts Small Group Plan Design Comparison

Plan Year or Calendar Year Available for All Plans

January 1, 2012

TUFTS  Health Plan

Tier	Office Visit Copay		ER Copay	Inpatient Hospital Copay	Day Surgery Center		High-Tech Imaging		Diagnostic Tests		Member Coinsurance	Medical Deductible Individual/Family (Plan Year)	Annual Out-of-Pocket Maximum Individual/Family	Pharmacy Retail Copays	Pricing Relativity
	PCP	Specialist			Freestanding Outpatient Surgery Center	Hospital	Freestanding Imaging Center	Hospital or Other Provider	Any Non Hospital Provider	Outpatient Hospital					
YOUR CHOICE HMO — A Tiered Provider Network Option															
Your Choice HMO 2-Tier Option 2															
Tier 1	\$20	\$35	\$150	Deductible then covered in full	\$250	Deductible then covered in full	\$150	Deductible then covered in full	Covered in full	Deductible then covered in full	N/A	\$500/\$1,000	\$5,000/\$10,000	\$15*	-22% without HRA
Tier 2	\$50	\$70	\$150	Deductible then \$1,000		Deductible then \$1,000		Deductible then \$450		Deductible then covered in full	N/A			\$30	-19.2% with HRA
Tier 3														\$50	
Your Choice HMO 2-Tier Option 4															
Tier 1	\$25	\$35	\$150	\$500	\$250	\$500	\$150	\$150	Covered in full	Covered in full	N/A	N/A	\$5,000/\$10,000	\$15*	-25.4% without HRA
Tier 2	\$50	\$75	\$150	Deductible then \$1,000		Deductible then \$1,000		Deductible then \$450		Deductible then covered in full	N/A			\$2,000/\$4,000	\$30
Tier 3														\$50	
Your Choice HMO 2-Tier Option 5															
Tier 1	\$25	\$40	\$150	Deductible then covered in full	\$250	Deductible then covered in full	\$150	Deductible then covered in full	Covered in full	Deductible then covered in full	N/A	\$1,000/\$2,000	\$5,000/\$10,000	\$15*	-25.5% without HRA
Tier 2	\$50	\$70	\$150	Deductible then \$1,000		Deductible then \$1,000		Deductible then \$450		Deductible then covered in full	N/A			\$30	-22.8% with HRA
Tier 3														\$50	
Your Choice HMO 2-Tier Option 7															
Tier 1	\$25	\$35	\$150	Deductible then 20% coinsurance	\$250	Deductible then 20% coinsurance	\$150	Deductible then 20% coinsurance	Covered in full	Deductible then 20% coinsurance	20%	\$2,000/\$4,000	\$5,000/\$10,000	\$15*	-31.1% without HRA
Tier 2	\$50	\$75	\$150	Deductible then 30% coinsurance		Deductible then 30% coinsurance		Deductible then 30% coinsurance		Deductible then 30% coinsurance	30%			\$30	-28.7% with HRA
Tier 3														\$50	

* Mail Order Pharmacy: 90-day supply is available at the 60-day supply copayment.

Plan Year or Calendar Year Available for All Plans

Tier	Office Visit Copay		ER Copay	Inpatient Hospital Copay	Day Surgery Center		High-Tech Imaging		Diagnostic Tests		Member Coinsurance	Medical Deductible Individual/Family (Plan Year)	Annual Out-of-Pocket Maximum Individual/Family	Pharmacy Retail Copays	Pricing Relativity	
	PCP	Specialist			Freestanding Outpatient Surgery Center	Hospital	Freestanding Imaging Center	Hospital or Other Provider	Any Non Hospital Provider	Outpatient Hospital						
YOUR CHOICE PPO — A Tiered Provider Network Option																
Your Choice PPO 3-Tier Option 2																
In-Network																
Tier 1	\$30	\$40	\$150	\$500	\$250	\$500	\$100	\$100	Covered in full	Covered in full	N/A	N/A	\$5,000/\$10,000	\$15*	-1.4%	
Tier 2	\$40	\$50	\$150	\$1,000		\$1,000				\$250	Covered in full	N/A		N/A		\$30
Tier 3	\$60	\$75	\$150	\$1,500		\$1,500				\$450	Covered in full	N/A		N/A		\$50
Out-of-Network																
	Deductible then coinsurance	Deductible then coinsurance	\$150	Deductible then coinsurance	Deductible then coinsurance	Deductible then coinsurance	Deductible then coinsurance	Deductible then coinsurance	20%	\$1,500/\$3,000	\$5,000/\$10,000	\$15/\$30/\$50*				
Your Choice PPO 2-Tier Option 5																
In-Network																
Tier 1	\$25	\$40	\$150	Deductible then covered in full	\$250	Deductible then covered in full	\$150	Deductible then covered in full	Covered in full	Deductible then covered in full	N/A	\$1,000/\$2,000	\$5,000/\$10,000	\$15*	-11.5% without HRA -8.3% with HRA	
Tier 2	\$50	\$70	\$150	Deductible then \$1,000		Deductible then \$1,000		Deductible then \$450		Deductible then covered in full	N/A			\$30		
Tier 3																\$50
Out-of-Network																
	Deductible then coinsurance	Deductible then coinsurance	\$150	Deductible then coinsurance	Deductible then coinsurance	Deductible then coinsurance	Deductible then coinsurance	Deductible then coinsurance	20%	\$1,000/\$2,000	\$5,000/\$10,000	\$15/\$30/\$50*				

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	Routine Physical Exam	Non-Routine Office Visit									
ADVANTAGE SAVER (HSA qualified plans that can be coupled with an HSA or HRA)											
Advantage HMO Saver	\$0	Covered in full after Deductible	Covered in full after Deductible	Covered in full after Deductible	Yes	Covered in full after Deductible	N/A	\$1,500/\$3,000	\$2,625/\$5,250	Deductible then \$15/\$30/\$50 Mail: Deductible then \$30/\$60/\$150	-27.7%
Advantage HMO Saver	\$0	Covered in full after Deductible	Covered in full after Deductible	Covered in full after Deductible	Yes	Covered in full after Deductible	N/A	\$2,000/\$4,000	\$3,500/\$7,000	Deductible then \$15/\$30/\$50 Mail: Deductible then \$30/\$60/\$150	-31.4%
Advantage HMO Saver	\$0	Covered in full after Deductible	Covered in full after Deductible	Covered in full after Deductible	Yes	Covered in full after Deductible	N/A	\$2,500/\$5,000	\$4,375/\$8,750	Deductible then \$15/\$30/\$50 Mail: Deductible then \$30/\$60/\$150	-34.4%
Advantage HMO Saver 2000 (80%)	\$0	Deductible then 20% coinsurance	Deductible then 20% coinsurance	Deductible then 20% coinsurance	Yes	Deductible then 20% coinsurance	20%	\$2,000/\$4,000	\$5,950/\$11,900	Deductible then \$15/\$30/\$50 Mail: Deductible then \$30/\$60/\$150	-39.7%
Advantage PPO Saver	\$0	Covered in full after Deductible	Covered in full after Deductible	Covered in full after Deductible	Yes	Covered in full after Deductible	20% out-of-network	\$1,500/\$3,000 In- and out-of-network	\$4,125/\$8,250 In- and out-of-network	Deductible then \$15/\$30/\$50 Mail: Deductible then \$30/\$60/\$150	-9.5%
Advantage PPO Saver	\$0	Covered in full after Deductible	Covered in full after Deductible	Covered in full after Deductible	Yes	Covered in full after Deductible	20% out-of-network	\$2,000/\$4,000 In- and out-of-network	\$5,500/\$11,000 In- and out-of-network	Deductible then \$15/\$30/\$50 Mail: Deductible then \$30/\$60/\$150	-15%
Advantage PPO Saver	\$0	Covered in full after Deductible	Covered in full after Deductible	Covered in full after Deductible	Yes	Covered in full after Deductible	20% out-of-network	\$2,500/\$5,000 In- and out-of-network	\$5,950/\$11,900 In- and out-of-network	Deductible then \$15/\$30/\$50 Mail: Deductible then \$30/\$60/\$150	-18.6%
Advantage PPO Saver 2000 (80%)	\$0	Deductible then 20% coinsurance in-network	Deductible then 20% coinsurance	Deductible then 20% coinsurance in-network	Yes	Deductible then 20% coinsurance in-network	20% in-network 40% out-of-network	\$2,000/\$4,000 In- and out-of-network	\$5,950/\$11,900 In- and out-of-network	Deductible then \$15/\$30/\$50 Mail: Deductible then \$30/\$60/\$150	-25.2%

PPO products offered by Tufts Associated Health Maintenance Organization, Inc., Tufts Insurance Company, or Tufts Benefit Administrators, Inc., all Tufts Health Plan companies.

PPO/Advantage products offered by Tufts Insurance Company, or Tufts Benefit Administrators, Inc., both Tufts Health Plan companies.

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	Routine Physical Exam	Non-Routine Office Visit									
SELECT NETWORK											
HMO Select 15	\$0	\$15—PCP \$25—Specialist	\$125	\$100	Yes	\$150	N/A	No	\$400/\$800	\$15/\$30/\$50 Mail: \$45/\$90/\$150	-6.5%
HMO Select 20	\$0	\$20—PCP \$35—Specialist	\$200	\$600	Yes	\$150	N/A	No	\$5,000/\$10,000	\$100/\$200 Deductible then \$15/\$30/\$50 Mail: \$45/\$90/\$150	-26.1%
Advantage HMO Select 750	\$0	\$15—PCP \$25—Specialist	Covered in full after Deductible	Covered in full after Deductible	Yes	Covered in full after Deductible	N/A	\$750/\$1,500	\$5,000/\$10,000	\$250/\$500 Deductible then \$15/\$30/\$50 Mail: \$45/\$90/\$150	-36%
Advantage HMO Select 2000	\$0	\$40—PCP \$60—Specialist	Covered in full after Deductible	Covered in full after Deductible	No	Covered in full after Deductible	N/A	\$2,000/\$4,000	\$5,000/\$10,000	\$250/\$500 Deductible then \$20/\$50/\$75 Mail: Deductible then \$60/\$150/\$225	-46.5%
STEWARD COMMUNITY CHOICE — Subject to approval from the Massachusetts Division of Insurance											
Copay Plan	\$0	\$15	\$150	\$250	Yes	\$100	N/A	No	\$1,000/\$2,000	\$15/\$30/\$50 Mail: \$30/\$60/\$150	-16.3%
Deductible Plan	\$0	\$20	Covered in full after Deductible	Covered in full after Deductible	Yes	Covered in full after Deductible	N/A	\$1,000/\$2,000	\$2,000/\$4,000	\$15/\$30/\$50 Mail: \$30/\$60/\$150	-34.3%

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All Select plans have a generic focused formulary. Mandatory mail order applies for all maintenance medications on Select Network plans.

HMO Select and Advantage HMO Select are not available to employers (small group coverage) located in the following Massachusetts counties: Berkshire, Dukes, Franklin, Hampden, Hampshire, and Nantucket. They offer a limited network of providers and are only available in Barnstable, Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties.

Mandatory mail order applies for all maintenance medications on Steward Community Choice Plans.

Steward Community Choice is a limited provider network product. The employer group must have a work site in the Steward Community Choice Service Area. Employees must reside or physically work in the Steward Community Choice Service Area in order to be eligible for the plan.

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