HMO PREMIUM SUMMARY OF BENEFITS

TUFTS Health Plan
No one does more to keep you healthy.

With Tufts Health Plan's HMO (health maintenance organization) plan, you enjoy quality coverage for your health care needs.

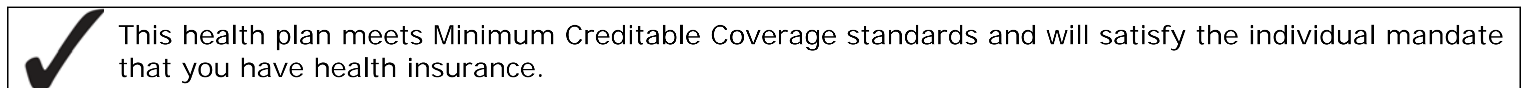
In general, preventive and medically necessary health care services and supplies are covered when they are provided or authorized by your network primary care provider (PCP).

As an HMO member:

- You must choose a PCP from the Tufts Health Plan network of providers.
- In most cases, your PCP must provide or authorize (provide a referral for) your care.
- You pay the applicable copayment at the time you receive covered health care services.
- You pay coinsurance for durable medical equipment. Coinsurance is a percentage of the covered medical costs you are responsible for paying.

HMO members do not need a PCP referral for certain types of covered services, including:

- Emergency care in an emergency room or a provider's office
- Maternity care and medically necessary evaluations and related health care services for acute/emergency gynecologic conditions, when these services are provided by an obstetrician, gynecologist, certified nurse midwife, or family practitioner in the Tufts Health Plan network
- Routine gynecologic exams and any medically necessary OB/GYN follow-up care resulting from that exam, when obtained from a provider in the Tufts Health Plan network
- Mammography screening, when obtained from a provider in the Tufts Health Plan network



This health plan meets Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance.

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
Tier 1	$10	$10
Tier 2	$20	$20
Tier 3	$35	$35

Outpatient Medical Care (No PCP referral is necessary for OB/GYN visits, spinal manipulation, routine eye exams, or mammograms)	
Routine Physical Exams (including most preventive screenings)	Covered in full
Non-routine Office Visits (including PCP and specialist consultations)	$5 per visit
Preventive Immunizations	Covered in full
Non-preventive Immunizations	Covered in full
Preventive Pap Smears and Mammograms	Covered in full
Non-preventive Pap Smears and Mammograms	Covered in full
Colonoscopy (without surgical intervention)	Covered in full
Colonoscopy (with surgical intervention)	Covered in full
Outpatient Maternity Care (This office visit copayment will apply per visit up to 10 visits per pregnancy. After 10 visits, these services are covered in full for the remainder of your pregnancy.)	$5 per visit
OB/GYN Visits	$5 per visit
Well-Child Care	Covered in full
Routine eye exams with an EyeMed Vision Care provider (1 visit every 12 months)	$5 per visit
Pediatric dental for children under 12 (one visit every 6 months)	
Nutritional Counseling (When medically necessary)	$5 per visit
Allergy Injections	$5 per visit
Speech Therapy (no visit limit); Short-term Physical Therapy (60 visits per plan year); Short-term Occupational Therapy (60 visits per plan year)	$5 per visit
Spinal Manipulation (20 visits per plan year)	$5 per visit
Diagnostic Procedures	Covered in full
Diagnostic Imaging - General Imaging (such as X-rays and ultrasounds)	Covered in full
Diagnostic Imaging - High-Tech Imaging (MRIs, CT/CAT Scans, PET Scans, and Nuclear Cardiology)	Covered in full
Diagnostic Lab Tests	Covered in full

Day Surgery	Covered in full
Inpatient Hospital Care (Semi-private room, unless private room is medically necessary)	
All Hospital Services (Acute Care) and Maternity Care	Covered in full
Skilled Nursing in Skilled Nursing Facility (up to 100 days per plan year)	Covered in full
Emergency Care	
In Provider's Office	$5 per visit
In Emergency Room	$25 per visit
Mental Health	
Outpatient Care	$5 per visit
Inpatient Care (Services provided at a designated facility)	Covered in full
Substance Abuse	
Outpatient Care (Alcohol and drug treatment, detoxification)	$5 per visit
Inpatient Care (Services provided at a designated facility)	Covered in full
Other Health Services	
Durable Medical Equipment	Plan covers 70%
Ambulance Service	Covered in full
Hospice Care	Covered in full
Home Health Care	Covered in full

There are some services that the plan does not cover. These include, but are not limited to: A service or supply not described as a covered service in your Tufts Health Plan member benefit document • Exams required by a third party, such as your employer, an insurance company, school, or court • Cosmetic surgery or any other cosmetic procedure, except certain reconstructive procedures described in your Tufts Health Plan member benefit document • Experimental or investigational drugs, services, and procedures • Eyeglasses or contact lenses, except as described in your Tufts Health Plan member benefit document • Blood, blood donor fees, blood storage fees, blood substitutes, blood banking, cord blood banking, or blood products, except as described in your Tufts Health Plan member benefit document • Drugs for use outside of a hospital, except as described in your Tufts Health Plan member benefit document • Personal comfort items • Custodial care • A service furnished to someone other than the member • Routine foot care, except as described in your Tufts Health Plan member benefit document • Charges incurred for stays in a covered facility beyond the discharge hour • Care for conditions that state or local law requires to be treated in a public facility • Medical or surgical procedures for sexual reassignment and reversal of voluntary sterilization • Foot orthotics, except therapeutic/molded shoes for an individual with severe diabetic foot disease • Assisted reproductive technology (e.g. IVF) procedures for non-Massachusetts residents • Spinal manipulation services for members age 12 and under • Except for Emergency care or Urgent care while traveling, a service, supply or medication that is obtained outside of the 50 United States • Private duty nursing (block or non-intermittent nursing) • Hearing aids.

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 a Member Specialist at 1-800-462-0224.

Offered by Tufts Associated Health Maintenance Organization, Inc.

Massachusetts Requirement to Purchase Health Insurance: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector Web site (www.mahealthconnector.org).

This health plan meets Minimum Creditable Coverage standards that are effective January 1, 2009 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards. This disclosure is for minimum creditable coverage standards that are effective January 1, 2009. Because these standards may change, review your health plan material each year to determine whether your plan meets the latest standards. If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its Web site at www.mass.gov/doi.