

Advantage HMO 1000



SUMMARY OF BENEFITS

With Tufts Health Plan, you enjoy comprehensive coverage for your health care needs, while your out-of-pocket costs are kept to a minimum. The following benefits apply when care is medically necessary and provided or authorized by your Tufts Health Plan primary care physician (PCP). Once you have met your deductible, Tufts Health Plan pays the full charge for authorized services that are subject to the deductible for the remainder of that calendar year. You do, however, continue to pay copayments for emergency care and outpatient medical care that is not subject to the deductible.

| Outpatient Medical Care* | |
|---|----------------------------------|
| Most Provider Office Visits | \$20 per visit |
| Routine Physical Exams (including most preventive screenings) | \$20 per visit |
| Well-Child Care | \$20 per visit |
| OB/GYN visits | \$20 per visit |
| Prenatal and Postnatal Care ** | \$20 per visit |
| Injections and Immunizations | Covered in Full |
| Pap Smears and Mammograms | Covered in Full |
| Diagnostic Procedures | Covered in Full after deductible |
| Colonoscopies, Sigmoidoscopies | Covered in Full after deductible |
| Diagnostic Imaging | Covered in Full after deductible |
| Diagnostic Lab Tests | Covered in Full after deductible |
| Speech and Short-term Physical/Occupational Therapy | Covered in Full after deductible |
| Annual Routine Eye Exams | \$20 per visit |
| Spinal Manipulation (12 visits per calendar year) | Covered in Full after deductible |

| Inpatient Hospital Care*** and Day Surgery | |
|---|----------------------------------|
| Day Surgery | Covered in Full after deductible |
| Hospital Services (Acute Care) and Maternity Care | Covered in Full after deductible |
| Physician's Care while hospitalized | Covered in Full after deductible |
| Surgery and Surgeon's Services while hospitalized | Covered in Full after deductible |
| Newborn Care in hospital | Covered in Full after deductible |
| Anesthesia while hospitalized | Covered in Full after deductible |
| Medications while hospitalized | Covered in Full after deductible |
| Nursing Care while hospitalized | Covered in Full after deductible |
| Diagnostic Imaging and Lab Tests while hospitalized | Covered in Full after deductible |
| Intensive Care/Coronary Care while hospitalized | Covered in Full after deductible |
| Radiation Therapy while hospitalized | Covered in Full after deductible |
| Skilled Nursing In Skilled Nursing Facility (up to 100 days per calendar year) | Covered in Full after deductible |

| Wellness Programs | |
|--|---------------------------|
| Membership at Network Fitness Facilities | Multiple discount options |
| Weight Watchers Weight Management Program | Discounted membership |
| Health Education (may require advance payment) | 30% discount per program |

* No PCP referral is necessary for OB/GYN visits, spinal manipulation, routine eye exams, or mammograms.

** 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.

*** Semi-private room, unless private room is medically necessary.

(OVER)

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| Mental Health* | | |
|---|----------------------------------|---------|
| Outpatient Care (up to 24 visits per calendar year) | \$20 per visit | |
| Inpatient Care (Services provided at a Designated Facility for up to 60 days per calendar year) | Covered in Full after deductible | |
| Substance Abuse** | | |
| Outpatient Care (Alcohol and drug treatment, and, detoxification) (Up to \$500 per calendar year for treatment) | \$20 per visit | |
| Inpatient Care (Services provided at a Designated Facility for up to 30 days per calendar year) | Covered in Full after deductible | |
| Emergency Care | | |
| In Doctor's Office | \$20 per visit | |
| In Emergency Room | \$100 per visit | |
| Other Services | | |
| Durable Medical Equipment (\$1,500 calendar year maximum) | Covered in Full | |
| Ambulance Service | Covered in Full after deductible | |
| Deductible | | |
| Deductible (per calendar year) | Individual | Family |
| | \$1,000 | \$2,000 |
| Prescription Drug Coverage (for up to a 30-day supply at a participating retail pharmacy) | | |
| Prescriptions are covered at copays after a \$100 Individual/\$200 Family calendar year deductible. | | |
| Tier 1 | \$10 | |
| Tier 2 | \$30 | |
| Tier 3 | \$45 | |
| <i>Members can receive a three month supply for two copayments through our mail order service. Prescriptions filled through mail order are subject to the deductible.</i> | | |

* Outpatient and inpatient mental health services are treated the same as any other medical condition when provided as required by law for the following: biologically-based mental disorders; certain mental, behavioral or emotional disorders for children under age 19; and rape-related mental or emotional disorders. See your Evidence of Coverage for more information.

** Outpatient and inpatient substance abuse services are treated the same as mental health conditions when provided in conjunction with treatment of a mental disorder. Treatment for detoxification is not subject to substance abuse day and dollar limits listed in this document. See your Evidence of Coverage for more information.

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 • 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 hospital, except as covered under Prescription Drug Coverage • 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 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.

*This is a summary only. Please refer to your Evidence of Coverage for more detailed information.
Copies are available by calling a member services coordinator at 800-462-0224.*

Offered by Tufts Associated Health Maintenance Organization, Inc.