

ADVANTAGE PPO



SUMMARY OF BENEFITS

You can seek care from a network provider or one outside the network. If you choose an out-of-network provider, you will be responsible for a deductible, after which the plan pays a percentage of covered services up to the out-of-pocket maximum. Once you reach the out-of-pocket maximum, you are covered in full for the reasonable charge for all out-of-network covered services for the remainder of that calendar year. Your out-of-pocket maximums and deductibles are listed on the other side of this document.

Outpatient Medical Care	In Network	Out of Network (after deductible)
Most Provider Office Visits	\$20 per visit	Plan covers 80%
Routine Physical Exams (including most preventive screenings)	\$20 per visit	Plan covers 80%
Well-Child Care	\$20 per visit	Plan covers 80%
OB/GYN Care	\$20 per visit	Plan covers 80%
Prenatal and Postnatal Care*	\$20 per visit	Plan covers 80%
Injections and Immunizations	Covered in Full	Plan covers 80%
Pap Smears and Mammograms	Covered in Full	Plan covers 80%
Diagnostic Procedures	Covered in Full after deductible	Plan covers 80%
Colonoscopies, Sigmoidoscopies	Covered in Full after deductible	Plan covers 80%
Diagnostic Imaging	Covered in Full after deductible	Plan covers 80%
Diagnostic Lab Tests	Covered in Full after deductible	Plan covers 80%
Speech and Short-term Physical/Occupational Therapy	Covered in Full after deductible	Plan covers 80%
Annual Routine Eye Exams	\$20 per visit	Plan covers 80%
Spinal Manipulation (12 visits per calendar year)	Covered in Full after deductible	Plan covers 80%

Inpatient Hospital Care** and Day Surgery	In Network (after deductible)	Out of Network (after deductible)
Day Surgery	Covered in Full	Plan covers 80%
Hospital Services (Acute Care) and Maternity Care	Covered in Full	Plan covers 80%
Physician's Care while hospitalized	Covered in Full	Plan covers 80%
Surgery and Surgeon's Services while hospitalized	Covered in Full	Plan covers 80%
Newborn Care in hospital	Covered in Full	Plan covers 80%
Anesthesia while hospitalized	Covered in Full	Plan covers 80%
Medications while hospitalized	Covered in Full	Plan covers 80%
Nursing Care while hospitalized	Covered in Full	Plan covers 80%
Diagnostic Imaging and Lab Tests while hospitalized	Covered in Full	Plan covers 80%
Intensive Care/Coronary Care while hospitalized	Covered in Full	Plan covers 80%
Radiation Therapy while hospitalized	Covered in Full	Plan covers 80%
Skilled Nursing In Skilled Nursing Facility (up to 100 days per calendar year)	Covered in Full	Plan covers 80%

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

* 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. Preregistration required when not arranged by a network provider.

(OVER)

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Mental Health**	In Network	Out of Network (after deductible)
Outpatient Care (up to 24 visits per calendar year)	\$20 per visit	Plan covers 80%
Inpatient Care (services for up to 60 days per calendar year)	Covered in Full after deductible	Plan covers 80%

Substance Abuse***	In Network	Out of Network (after deductible)
Outpatient Care (Alcohol and drug treatment, and detoxification) (Plan pays up to \$500 per calendar year for treatment)	\$20 per visit	Plan covers 80%
Inpatient Care (services for up to 30 days per calendar year)	Covered in Full after deductible	Plan covers 80%

Emergency Care	In Network and Out of Network	
In Doctor's Office	\$20 per visit	
In Emergency Room	\$100 per visit	

Other Services	In Network	Out of Network (after deductible)
Durable Medical Equipment (\$1,500 calendar year maximum, then at out-of-network level)	Covered in Full	Plan covers 80%
Ambulance Service	Covered in Full after deductible	Plan covers 80%

Annual Deductible and Out-of-Pocket Maximums	Individual	Family
Deductible	\$1,000	\$2,000
Out-of-Pocket Maximum	\$4,000	\$8,000

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 member benefit document for more information.

*** Outpatient and inpatient substance abuse services are treated the same as any other mental health condition 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 member benefit document 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 member benefit document for more detailed information.

Copies are available by calling a member services coordinator at 800-462-0224

Offered by Tufts Insurance Company, a Tufts Health Plan company.