HMO Value - Without Prescription

TUFTS Health Plan

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). Your annual out-of-pocket maximums for day surgery and inpatient admissions are listed on the back of this benefit summary.

Outpatient Medical Care*	
Most Provider Office Visits	$15 per visit
Routine Physical Exams (including most preventive screenings)	$15 per visit
Well-Child Care	$15 per visit
OB/GYN visits	$15 per visit
Prenatal and Postnatal Care **	$15 per visit
Injections and Immunizations	Covered in Full
Pap Smears and Mammograms	Covered in Full
Diagnostic Procedures (Certain procedures may be subject to a day surgery copayment)	Covered in Full
Diagnostic Imaging	Covered in Full
Diagnostic Lab Tests	Covered in Full
Speech and Short-term Physical/Occupational Therapy	$15 per visit
Annual Routine Eye Exams	$15 per visit
Spinal Manipulation (12 visits per calendar year)	$15 per visit
Allergy Shot	$5 per visit

Inpatient Hospital Care*** and Day Surgery	
Day Surgery	$350 per admission
Hospital Services (Acute Care) and Maternity Care	$350 per admission
Physician's Care while hospitalized	Covered in Full
Surgery and Surgeon's Services while hospitalized	Covered in Full
Newborn Care in hospital	Covered in Full
Anesthesia while hospitalized	Covered in Full
Medications while hospitalized	Covered in Full
Nursing Care while hospitalized	Covered in Full
Diagnostic Imaging and Lab Tests while hospitalized	Covered in Full
Intensive Care/Coronary Care while hospitalized	Covered in Full
Radiation Therapy while hospitalized	Covered in Full
Skilled Nursing In Skilled Nursing Facility (up to 100 days per calendar year)	Covered in Full

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)

HMO Value Without Prescription - Summary of Benefits

Mental Health*	
Outpatient Care (up to 24 visits per calendar year)	$15 per visit
Inpatient Care (Services provided at a Designated Facility for up to 60 days per calendar year)	$350 per admission

Substance Abuse**	
Outpatient Care (Alcohol and drug treatment, and, detoxification) (Up to $500 per calendar year for treatment)	$15 per visit
Inpatient Care (Services provided at a Designated Facility for up to 30 days per calendar year)	$350 per admission

Emergency Care	
In Doctor's Office	$15 per visit
In Emergency Room	$50 per visit

Other Services	
Durable Medical Equipment ($1,500 calendar year maximum)	Covered in Full
Ambulance Service	Covered in Full

Annual Inpatient and Day Surgery Out-of-Pocket Maximums	
Individual	$1,400
Family	$2,800

* 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.