

HMO VALUE CHOICE COPAY SUMMARY OF BENEFITS

With Tufts Health Plan HMO (health maintenance organization) Choice Copayment plan, you enjoy comprehensive 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 physician (PCP). It also covers emergency medical care you may need, even when the care is not provided or authorized by your PCP.

As an HMO Choice Copayment member:

- You must choose a PCP from the Tufts Health Plan network of providers.
- In most cases, your network PCP must provide or authorize (provide a referral for) your care.

- You pay a copayment at the time you receive covered health care services.
This plan offers flexibility to choose between two copayment levels when you receive certain types of care:
- **Doctor visits:** The copayment for a specialist office visit may be higher than the copayment for a PCP visit.
- **Inpatient admissions at network hospitals:** The copayment for inpatient hospital admissions at a tertiary hospital is usually higher than the copayment for an inpatient admission at a community hospital.

A list of network hospitals and their copayments is included in your plan information. To review a list of community and tertiary hospitals in our network, please check our Provider Directory or Web site, www.tuftshealthplan.com

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

Out-of-Pocket Maximums	Individual/Family
Inpatient and day surgery out-of-pocket maximums (per calendar year)	\$2,000/\$4,000
Prescription Drug Coverage (For up to a 30-day supply at a participating retail pharmacy)	
Tier 1	\$10
Tier 2	\$30
Tier 3	\$45

Members can save up to 33% off a three-month supply of most maintenance medications through our mail order service.

Outpatient Medical Care (No PCP referral is necessary for OB/GYN visits, spinal manipulation, routine eye exams, or mammograms)	Primary Care Physician	Specialist
Most Provider Office Visits	\$15 per visit	\$25 per visit
Routine Physical Exams (including most preventive screenings)	\$15 per visit	\$25 per visit
Well-Child Care	\$15 per visit	\$25 per visit
OB/GYN Visits	\$15 per visit	\$15 per visit
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.)	\$15 per visit	\$15 per visit
Routine Eye Exams (1 visit every 24 months)	\$15 per visit	\$15 per visit
Nutritional Counseling (When medically necessary)	\$15 per visit	\$25 per visit
Preventive Immunizations	Covered in full	
Preventive Pap Smears and Mammograms	Covered in full	
Non-preventive Immunizations	Covered in full	
Non-routine Pap Smears and Mammograms	Covered in full	
Allergy Injections	\$5 per visit	\$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 & Nuclear Medicine)	\$75 per visit	
Diagnostic Lab Tests	Covered in full	
Speech and Short-term Physical/Occupational Therapy	\$15 per visit	\$25 per visit
Spinal Manipulation (12 visits per calendar year)	\$15 per visit	\$25 per visit
Day Surgery	Covered in full at a community hospital \$500 per admission to a tertiary hospital	

Inpatient Hospital Care (Semi-private room, unless private room is medically necessary)		
All Hospital Services (Acute Care) and Maternity Care	Covered in full at a community hospital \$500 per admission to a tertiary hospital	
Skilled Nursing in Skilled Nursing Facility (up to 100 days per calendar year)	Covered in full	

Emergency Care

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

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)	Covered in full

Substance Abuse**

Outpatient Care (Alcohol and drug treatment, 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)	Covered in full

Other Health Services

Durable Medical Equipment (\$1,500 calendar year maximum)	Covered in full
Ambulance Service	Covered in full
Hospice Care	Covered in full
Home Health Care	Covered in full

Health and Wellness Programs and Member Discounts

No one does more to keep you healthy than Tufts Health Plan. We offer discounts on a wide variety of healthy products, treatments, and services to help you save while taking care of your health. To learn more about the programs listed here and to find participating facilities, visit www.tuftshealthplan.com, or contact a member services specialist at 1-800-462-0224 who will be happy to help you.

- Acupuncture
- Appalachian Mountain Club
- Boys & Girls Club
- CATZ Kids Fitness Clubs
- Curves®
- Eyewear Discounts
- Fitness Clubs
- Fitness Together
- GlobalFit
- Home Instead Senior Care®
- Health and wellness programs through Healthyroads™
- Massage Therapy
- Nutritional Counseling
- Safety Helmet Discounts
- Tufts University Health & Nutrition Letter
- Weight Watchers®
- Wellness Programs

*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 Tufts Health Plan member benefit document 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 Tufts Health Plan 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 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 services 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 website (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 website at www.mass.gov/doi.