

TUFTS HEALTH PLAN IS THE RIGHT CHOICE

A national leader in quality

At Tufts Health Plan, no one does more to keep you healthy—that's why we're always looking for new ways to better meet your needs.

Plan design flexibility

With a wide range of plan designs and options, Tufts Health Plan can help you find the right plan that fits both your budget and your personal needs.

State-of-the-art health management programs

Our health management programs include support for members at all stages of health—from those who are relatively healthy to those with serious illnesses—all designed to enhance health and improve quality of life.

Easy access to information

At tuftshealthplan.com, you can find a physician and look up your claims, benefits, and prescription history, 24 hours a day.

Member Discounts

We offer a wide range of discounts on health products, treatments, and services—including massage therapy, Weight Watchers®, and even health and wellness products.

Worldwide coverage for urgent care and emergencies

Wherever you go in the world, our 24-hour a day, 7-day a week emergency coverage goes with you.

Decision-support tools to help you become more educated about your health care

These tools include a hospital comparison tool and an online health encyclopedia complete with a symptom checker.

Superior customer service

Our service is delivered by a team of highly trained and committed Member Specialists.

*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).

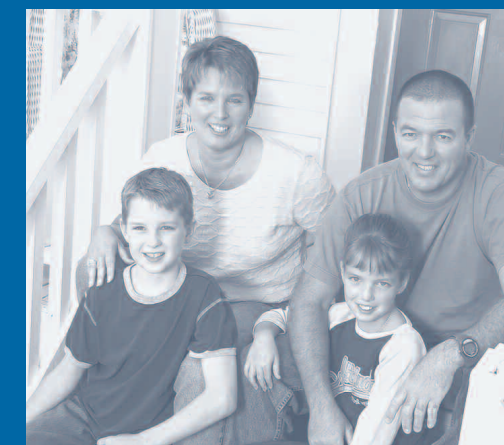
This health plan meets Minimum Creditable Coverage standards that are effective January 1, 2009, as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards. This disclosure is for minimum 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.

STANDARD AND SELECT NETWORK PRODUCTS FROM TUFTS HEALTH PLAN

2010 PLAN OPTIONS

The Select Network provides members a limited choice of doctors and hospitals in Massachusetts to help reduce the cost of coverage. Please note that the Select Network plans have a limited service area that excludes residents of Berkshire, Dukes, Franklin, Hampden, Hampshire, and Nantucket counties.

The Standard Network plans provide members with a choice of more than 22,000 participating doctors and 80 hospitals. The Standard Network plans are available for Massachusetts residents only. Residents of Martha's Vineyard and Nantucket are only eligible for the Standard Network PPO offerings.



Member Services
1-800-957-6596
tuftshealthplan.com/enrollnow

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COVERED SERVICES		Standard Network Products					Select Network Products				
		All Tufts Health Plan participating providers included.					Select Network providers only. Find participating providers at www.tuftshealthplan.com .				
		HMO BASIC 25	ADVANTAGE HMO 1000	ADVANTAGE HMO SAVER (HSA Qualified Plan)	ADVANTAGE PPO 1000		HMO SELECT 15 ¹	HMO SELECT 20 ¹	ADVANTAGE HMO SELECT 750 ¹	ADVANTAGE HMO SELECT 2000	
					In-network	Out-of-network after deductible					
DEDUCTIBLE	Individual Deductible (calendar year)	\$0	\$1,000	\$2,500	\$1,000		\$0	\$0	\$750	\$2,000	
	Family Deductible (calendar year)	\$0	\$2,000	\$5,000	\$2,000		\$0	\$0	\$1,500	\$4,000	
OUT-OF-POCKET MAXIMUM (Select Network Plans ²)	Individual Maximum (calendar year)	N/A	N/A	\$4,375 ³	\$4,000 ⁴		N/A	\$5,000	\$5,000	\$5,000	
	Family Maximum (calendar year)	N/A	N/A	\$8,750 ³	\$8,000 ⁴		N/A	\$10,000	\$10,000	\$10,000	
OUTPATIENT MEDICAL CARE (PCP/Specialist)	Doctor's Office Visits	\$25 per visit	\$20 per visit	Covered in full after deductible	\$20 per visit	Plan covers 80%	\$15 per visit	\$20 per visit	\$15 per visit	\$40 per visit	
	Specialist Care, Consultations	\$25 per visit	\$20 per visit	Covered in full after deductible	\$20 per visit	Plan covers 80%	\$25 per visit	\$35 per visit	\$25 per visit	\$60 per visit	
	Routine Physical Exams, OB/GYN Care, Well-Child Care	\$25 per visit	\$20 per visit	\$25 per visit	\$20 per visit	Plan covers 80%	\$15 per visit	\$20 per visit	\$15 per visit	\$40 per visit	
	Preventive Screenings, Pap Smears, and Mammograms	Covered in full	Covered in full	\$25 per visit	\$20 per visit	Plan covers 80%	Covered in full	Covered in full	Covered in full	Covered in full	
	Routine Prenatal and Postnatal Care	\$25 per visit	\$20 per visit	\$25 per visit	\$20 per visit	Plan covers 80%	\$15 per visit	\$20 per visit	\$15 per visit	\$40 per visit	
	Preventive Immunizations	Covered in full	Covered in full	Covered in full	\$20 per visit	Plan covers 80%	Covered in full	Covered in full	Covered in full	Covered in full	
	Annual Routine Eye Exams (once every 24 months)	\$25 per visit	\$20 per visit	\$25 per visit	\$20 per visit	Plan covers 80%	\$15 per visit	\$20 per visit	\$15 per visit	\$40 per visit	
	Speech Therapy (no visit limit); Short-term Physical Therapy (30 visits per calendar year); Short-term Occupational Therapy (30 visits per calendar year)	\$25 per visit	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	Plan covers 80%	\$15 per visit	\$35 per visit	Covered in full after deductible	Covered in full after deductible	
	Diagnostic X-Rays and Lab Tests	Covered in full	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	Plan covers 80%	Covered in full	Covered in full	Covered in full after deductible	Covered in full after deductible	
	Spinal Manipulation (Chiropractic) (12 visits/calendar year)	\$25 per visit	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	Plan covers 80%	\$25 per visit	\$35 per visit	Covered in full after deductible	No coverage	
INPATIENT HOSPITAL CARE AND DAY SURGERY	Day Surgery	\$600 per admission ⁵	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	Plan covers 80%	\$100 per admission ⁶	\$600 per admission ⁵	Covered in full after deductible	Covered in full after deductible	
	All Hospital Services (acute care) and Maternity Care	\$600 per admission ⁵	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	Plan covers 80%	\$100 per admission ⁶	\$600 per admission ⁵	Covered in full after deductible	Covered in full after deductible	
	Diagnostic CT/MRI/MRA/PET Scan	\$100 per visit	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	Plan covers 80%	\$100 per visit	\$100 per visit	Covered in full after deductible	Covered in full after deductible	
	Skilled Nursing in a Skilled Nursing Facility (100 calendar days/year)	Covered in full	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	Plan covers 80%	Covered in full	Covered in full	Covered in full after deductible	Covered in full after deductible	
MENTAL HEALTH (Non-Biologically Based)	Outpatient Care (24 visits/calendar year)	\$25 per visit	\$20 per visit	Covered in full after deductible	\$20 per visit	Plan covers 80%	\$15 per visit	\$20 per visit	\$15 per visit	\$40 per visit	
	Inpatient Care (60 days/calendar year)	\$600 per admission ⁵	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	Plan covers 80%	\$100 per admission	\$600 per admission ⁵	Covered in full after deductible	Covered in full after deductible	
SUBSTANCE ABUSE ⁷	Outpatient Care	\$25 per visit	\$20 per visit	Covered in full after deductible	\$20 per visit	Plan covers 80%	\$15 per visit	\$20 per visit	\$15 per visit	\$40 per visit	
	Inpatient Care	\$600 per admission ⁵	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	Plan covers 80%	\$100 per admission	\$600 per admission ⁵	Covered in full after deductible	Covered in full after deductible	
EMERGENCY CARE ⁸	In Doctor's Office	\$25 per visit	\$20 per visit	Covered in full after deductible	\$20 per visit	Plan covers 80%	\$15 per visit	\$20 per visit	\$15 per visit	\$40 per visit	
	In Emergency Room	\$75 per visit	\$100 per visit	Covered in full after deductible	\$100 per visit		\$75 per visit	\$150 per visit	\$200 per visit	\$200 per visit	
WELLNESS PROGRAMS	Tufts Health Plan Network Fitness Facility Memberships	\$150 fitness rebate, 20% off membership, no joining fee					\$150 fitness rebate, 20% off membership, no joining fee				
	GlobalFit Network Fitness Facility Memberships	Up to 60% off membership fees					Up to 60% off membership fees				
	Curves	50% off joining fee, earn a free month					50% off joining fee, earn a free month				
	Weight Watchers	No joining fee, \$10 off Deluxe At-Home Kit, \$10 off online program					No joining fee, \$10 off Deluxe At-Home Kit, \$10 off online program				
	Alternative Medicine: Acupuncture & Massage Therapy	25% off treatments and massage therapy from participating providers					25% off treatments and massage therapy from participating providers				
OTHER SERVICES	Durable Medical Equipment (\$1,500 calendar year maximum)	Covered in full	Covered in full	Covered in full after deductible \$1,500 plan year maximum	Covered in full	Plan covers 80%	Covered in full	Covered in full	Covered in full	Covered in full	
	Ambulance (when medically necessary)	Covered in full	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	Plan covers 80%	Covered in full	Covered in full	Covered in full after deductible	Covered in full after deductible	
PRESCRIPTION DRUG COVERAGE ⁹	Copayments	\$15/\$30/\$50	\$15/\$30/\$50	\$10/\$30/\$45 after deductible	\$15/\$30/\$50		\$10/\$25/\$45	\$10/\$25/\$45	\$10/\$30/\$45	\$20/\$50/\$75	
	Deductible (calendar year)	\$0	\$0	\$2,500/\$5,000 (plan year deductible)	\$0		\$0	\$100/\$200	\$250/\$500	\$250/\$500	
	Formulary	Standard	Standard	Standard	Standard		Generic-focused formulary and mandatory mail order for maintenance medications				

¹Select provider network, with a limited service area that excludes Berkshire, Dukes, Franklin, Hampden, Hampshire, and Nantucket counties.

²The out-of-pocket maximum includes the member's annual medical deductible, all emergency room copayments, and any copayments for inpatient care or surgery.

³Includes deductibles and copayments.

⁴Applies to out-of-pocket network care only.

⁵Inpatient/day surgery out-of-pocket maximum of \$2,400 individual/\$4,800 family applies.

⁶Inpatient/day surgery out-of-pocket maximum of \$400 individual/\$800 family applies.

⁷Due to changes in Massachusetts law, effective for renewals on and after July 1, 2009, there is no longer a visit or day limit for treatment of substance abuse disorders.

⁸Emergency room copayment is waived if the member is admitted to the hospital.

⁹Pharmacy benefit for all versions of HMO Select and Advantage HMO Select will include mandatory mail order for maintenance medications.

 All health plans in the above chart meet Minimum Creditable Coverage standards and satisfy the individual mandate that you have health insurance.*

This chart provides benefit highlights for general comparison purposes only. There are also services that the plans do not cover. Please see a Summary of Benefits for more information or refer to your Evidence of Coverage for complete information. Copies are available by calling a member services specialist at 1-800-957-6596 or on our Web site at tuftshealthplan.com/enrollnow.