

PPO VALUE

SUMMARY OF BENEFITS

Tufts Health Plan's preferred provider organization (PPO) plan covers preventive and medically necessary health care services and supplies.

As a PPO member:

- You are not required to choose a primary care physician.
- You can seek covered health care services from almost any licensed provider in or out of the Tufts Health Plan network.
- No referrals are needed.
- You can choose between two levels of coverage:
 - **Coverage at the in-network level of benefits**, a higher level of benefits, when you receive care from a provider in the Tufts Health Plan network. You pay a copayment when you receive covered health care services at the in-network level of benefits..
 - **Coverage at the out-of-network level of benefits**, when you receive care from a provider who is not in the Tufts Health Plan network. When you receive care at the out-of-network level of benefits, you pay a deductible and then

coinsurance until you reach your out-of-pocket maximum. Once you reach your out-of-pocket maximum, you are covered in full up to the reasonable charge for all out-of-network covered services for the remainder of the calendar year. You may also be responsible for paying any difference between what the plan covers and what the out-of-network provider has charged for a service. You must submit a claim form for each covered service you receive.

- A deductible is the amount you must first pay out-of-pocket before any coverage is available at the out-of-network level of benefits.
- Coinsurance is a percentage of the covered medical costs you are responsible for paying at the out-of-network level of benefits. You must pay coinsurance for these services until you reach the plan's out-of-pocket maximum.
- The deductible and out-of-pocket maximum for this plan are listed on this benefit summary.

Any emergency medical care you may need is covered at the in-network level of benefits.

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

Deductible and Out-of-pocket Maximums	Individual	Family
Deductible (per calendar year)	\$500	\$1,000
Out-of-pocket maximum	\$2,500	\$5,000
Day surgery copayment maximum	\$1,000	N/A
Inpatient copayment maximum	\$1,000	N/A

Prescription Drug Coverage (For up to a 30-day supply at a participating retail pharmacy)	
Tier 1	\$10
Tier 2	\$25
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)	In-Network	Out-of-network (after deductible)
Most Provider Office Visits	\$15 per visit	Plan covers 80%
Routine Physical Exams (including most preventive screenings)	\$15 per visit	Plan covers 80%
Well-Child Care	\$15 per visit	Plan covers 80%
OB/GYN Visits	\$15 per visit	Plan covers 80%
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	Plan covers 80%
Routine Eye Exams (1 visit every 24 months)	\$15 per visit	Plan covers 80%
Nutritional Counseling (When medically necessary)	\$15 per visit	Plan covers 80%
Preventive Immunizations	Covered in full	Plan covers 80%
Preventive Pap Smears and Mammograms	Covered in full	Plan covers 80%
Non-preventive Immunizations	Covered in full	Plan covers 80%
Non-routine Pap Smears and Mammograms	Covered in full	Plan covers 80%
Allergy Injections	\$5 per visit	Plan covers 80%
Diagnostic Procedures	Covered in full	Plan covers 80%
Diagnostic Imaging - General Imaging (such as x-rays and ultrasounds)	Covered in full	Plan covers 80%
Diagnostic Imaging - High-Tech Imaging (MRIs, CT/CAT Scans, PET Scans & Nuclear Medicine)	Covered in full	Plan covers 80%
Diagnostic Lab Tests	Covered in full	Plan covers 80%
Speech and Short-term Physical/Occupational Therapy	\$15 per visit	Plan covers 80%
Spinal Manipulation (12 visits per calendar year)	\$15 per visit	Plan covers 80%
Day Surgery	\$250 per admission	Plan covers 80%

Inpatient Hospital Care (Semi-private room, unless private room is medically necessary)		
All Hospital Services (Acute Care) and Maternity Care	\$250 per admission	Plan covers 80%
Skilled Nursing in Skilled Nursing Facility (up to 100 days per calendar year)	Covered in full	Plan covers 80%
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	Plan covers 80%
Inpatient Care (Services provided at a designated facility for up to 60 days per calendar year)	\$250 per admission	Plan covers 80%
Substance Abuse**		
Outpatient Care (Alcohol and drug treatment, detoxification) (Up to \$500 per calendar year for treatment)	\$15 per visit	Plan covers 80%
Inpatient Care (Services provided at a designated facility for up to 30 days per calendar year)	\$250 per admission	Plan covers 80%
Other Health Services		
Durable Medical Equipment (\$1,500 calendar year maximum)	Covered in full	Plan covers 80%
Ambulance Service	Covered in full	Plan covers 80%
Hospice Care	Covered in full	Plan covers 80%
Home Health Care	Covered in full	Plan covers 80%

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. or Total Health Plan, Inc., both Tufts Health Plan companies.

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.