

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

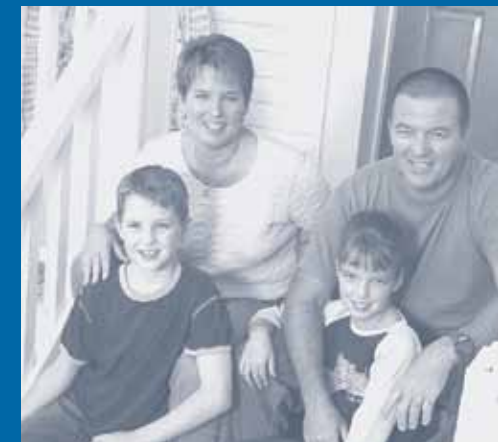
Our service is delivered by a team of highly trained and committed Member Specialists.

STANDARD AND SELECT NETWORK PRODUCTS FROM TUFTS HEALTH PLAN

2012 PLAN OPTIONS

Standard Network: The Standard Network plans provide members with a choice of more than 25,000 participating doctors and 90 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.

Limited Network: The Select Network plans provide access to a network that is smaller than Tufts Health Plan's standard network. In these plans, members have access to network benefits only from the providers in the Select Network. Please consult the Select Network provider directory by visiting the provider search tool at tuftshealthplan.com and click on Find a Doctor to determine the providers in the Select Limited Provider Network. If you need a paper copy of the provider directory, please contact member services. Please note that the Select Network plans have a limited service area that excludes residents of Berkshire, Dukes, Franklin, Hampden, Hampshire, and Nantucket counties.



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

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COVERED SERVICES		Standard Network Products					Select Network Products—Limited Provider Network Options			
		All Tufts Health Plan participating providers included.					Select Network providers only. Find participating providers at 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	Individual Maximum (calendar year)	N/A	\$2,000 ⁹	\$4,375 ³	\$5,000 ⁴		N/A	\$5,000	\$5,000 ²	\$5,000 ²
	Family Maximum (calendar year)	N/A	\$4,000 ⁹	\$8,750 ³	\$10,000 ⁴		N/A	\$10,000	\$10,000 ²	\$10,000 ²
PREVENTIVE SERVICES	Routine Physical Exams (including preventive immunizations, preventive Pap smears and mammograms, well-child care visits, annual gynecological exams, and most preventive screenings)	Covered in full	Covered in full	Covered in full	Covered in full	Plan covers 80%	Covered in full	Covered in full	Covered in full	Covered in full
	Screening for colon or colorectal cancer in the absence of symptoms	Covered in full	Covered in full	Covered in full	Covered in full	Plan covers 80%	Covered in full	Covered in full	Covered in full	Covered in full
OUTPATIENT MEDICAL CARE (PCP/Specialist)	Non-Routine Office Visits (including PCP and specialist consultations, and urgent care)	\$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
	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.)	\$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
	Routine Eye Exams (1 visit every 24 months. You must use an EyeMed Vision Care provider to be covered at the in-network level of benefits.)	\$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
	Colonoscopies Generally Associated with Symptoms (including family history of cancer) — without surgical intervention	Covered in full	Covered in full	Covered in full	Covered in full	Plan covers 80%	Covered in full	Covered in full	Covered in full	Covered in full
	Colonoscopies Generally Associated with Symptoms (including family history of cancer) — with surgical intervention	\$600 per visit	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	Plan covers 80%	\$100 per visit	\$600 per visit	Covered in full after deductible	Covered in full after deductible
	Diagnostic Imaging—General Imaging (such as X-rays and ultrasounds)	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
	Diagnostic Imaging — High-Tech Imaging (MRIs, CT/CAT Scans, PET Scans, and Nuclear Cardiology)	\$150 per visit	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	Plan covers 80%	\$150 per visit	\$150 per visit	Covered in full after deductible	Covered in full after deductible
	Spinal Manipulation (12 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%	\$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
	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 AND SUBSTANCE ABUSE	Outpatient Care (24 visits/calendar year except as described below)	\$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 except as described below)	\$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	In Emergency Room (copay waived if admitted)	\$125 per visit	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible		\$125 per visit	\$200 per visit	Covered in full after deductible	Covered in full after deductible
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			
	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	Plan covers 70%	Plan covers 70%	Plan covers 70% after deductible	Plan covers 70%	Plan covers 70%	Plan covers 70%	Plan covers 70%	Plan covers 70%	Plan covers 70%
	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 ⁸	Copayments - at a participating retail pharmacy	\$15/\$30/\$50	\$15/\$30/\$50	\$15/\$30/\$50 after deductible	\$15/\$30/\$50		\$15/\$30/\$50	\$15/\$30/\$50	\$15/\$30/\$50	\$20/\$50/\$75
	Copayments - through our mail order service	\$30/\$60/\$150	\$30/\$60/\$150	\$30/\$60/\$150 after deductible	\$30/\$60/\$150		\$45/\$90/\$150	\$45/\$90/\$150	\$45/\$90/\$150	\$60/\$150/\$225
	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			

**Note to Medicare beneficiaries only: This plan is not Medicare Part D creditable. If you don't enroll in a Medicare Part D plan, you may be subject to a Medicare part D premium penalty.

***Routine Outpatient Maternity Care

¹Select provider network, with a limited service area that excludes Berkshire, Dukes, Franklin, Hampden, Hampshire, and Nantucket counties. Please note that emergency room, inpatient, and day surgery copayments are included in the out-of-pocket maximum.

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

³Includes deductibles and copayments.

⁴Includes deductible, durable medical equipment coinsurance, and out-of-network coinsurance.

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.

⁷Outpatient and inpatient mental health services are treated the same as any other medical condition and are not subject to a benefit limit when provided as required by law for the following: biologically-based mental disorders, as defined by Massachusetts law (schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder; delirium and dementia; affective disorders; eating disorders; substance abuse disorders; autism; post-traumatic stress disorder; and any other mental disorders added by the Commissioners of the Department of Mental Health and the Division of Insurance); certain mental, behavioral or emotional disorders for children under age 19; and rape-related mental or emotional disorders. All other mental health services are subject to the benefit limit described above. See your Tufts Health Plan member benefit document for more information.

⁸Pharmacy benefit for all versions of HMO Select and Advantage HMO Select will include mandatory mail order for maintenance medications.

⁹Includes deductible and durable medical equipment coinsurance.

 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 Specialist at 800-957-6596 or on our website at tuftshealthplan.com/enrollnow.

*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).

These health plans meet 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.

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