

ADVANTAGE HMO SELECT 2000 A LIMITED NETWORK PLAN SUMMARY OF BENEFITS

With Tufts Health Plan's Advantage HMO (health maintenance organization) Select plan, a limited provider network plan, you enjoy quality coverage for your health care needs. The Advantage HMO Select plan provides access to a network that is smaller than Tufts Health Plan's standard network. In this plan, 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 clicking 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.

Health care services may be covered subject to the plan's deductible, coinsurance, covered with a copay, or covered in full. The deductible is the amount you need out of your own pocket before the health plan begins to pay for covered services.

As an Advantage HMO Select member:

- You must choose a PCP from the Tufts Health Plan Select Network, a limited provider network.
- In most cases, your Select Network PCP must give or refer your care.

How services are covered with Advantage HMO Select

The Advantage HMO Select plan covers preventive and medically needed health care services and supplies when they are given or referred by your network PCP. Services may be:

- **Covered subject to the plan's deductible:** Certain covered services—usually those used to diagnose, treat, or monitor health conditions (for example, an MRI)—are subject to the plan's deductible.


Note: Services subject to the plan's deductible may also be performed at the same time you are having a preventive office visit with your provider. Please see the chart below for information about your specific deductible.

- **Covered with a copay:** You pay a certain copay at the time you receive covered services, including non-routine office visits.
- **Covered in full:** This plan covers preventive services in full—they are not subject to the deductible or a copay. Preventive services, for the most part, are the services your provider offers to help you stay healthy. These are needed at all ages. They might be office visits for routine checkups for children and adults, tests (also called screenings) to measure your overall health or the health of certain parts of your body, measurements, immunizations (or shots) for children and adults, certain advice about health, or special tests at certain times in your life. Also, once you have met your plan's out-of-pocket maximum, or yearly limit, Tufts Health Plan pays for covered services for the rest of your plan's year.
- **Covered subject to coinsurance:** You pay coinsurance for durable medical equipment. Coinsurance is the percentage of cost you must pay for some covered services.

Out-of-pocket Maximum: Your deductible, coinsurance, and copays over \$100 (except pharmacy copays) go toward your out-of-pocket maximum, or yearly limit. Once you reach your yearly limit, you are covered in full for services subject to deductible, coinsurance, and copays over \$100 (except pharmacy copays).

Please note that this is a summary of benefits only. For complete benefit information, please refer to your member benefit document, available in your secure account at tuftshealthplan.com.

Limited Network: This plan provides access to a network that is smaller than Tufts Health Plan's standard network. In this plan, 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.

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

Out-of-pocket Maximums and Deductible		Individual/Family	
Out-of-pocket Maximum (applies to deductible, coinsurance and ER copays)		\$5,000/\$10,000	
Deductible (per calendar year)		\$2,000/\$4,000	
Prescription Drug Coverage (For up to a 30-day supply at a participating retail pharmacy)			
Prescriptions are covered with copays after a \$250 Individual/\$500 Family calendar year deductible.			
Tier 1		\$20	
Tier 2		\$50	
Tier 3		\$75	
This prescription drug benefit has a generic-focused formulary, meaning that most generic drugs are covered under Tier 1. Only select brand name drugs that have no generic equivalent are covered under Tiers 2 and 3. The drug formulary is subject to change without notice throughout the year. Medications included in the Special Designated Pharmacy program must be filled at the designated pharmacy. All other prescription medications may be filled at your retail pharmacy for up to one 30-day supply and one 30-day refill. Additional refills, as well as most maintenance medications, must be filled through the Caremark mail order pharmacy program.			
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	
Screening for Colon or Colorectal Cancer in the Absence of Symptoms		Covered in full	
Outpatient Medical Care (No PCP referral is necessary for OB/GYN visits, routine eye exams, or mammograms)			
		PCP	Specialist
Non-routine Office Visits (including PCP and specialist consultations, and urgent care)		Covered in full	
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.)		\$40 per visit	\$40 per visit
Routine Eye Exams with an EyeMed Vision Care provider (1 visit every 24 months)		\$40 per visit	\$40 per visit
Nutritional Counseling (When medically necessary)		\$40 per visit	\$60 per visit
Allergy Injections		Covered in full after deductible	
Speech Therapy (when medically necessary)		Covered in full after deductible	
Short-term Physical and Occupational Therapy (30 visits for each type of service per plan year)		Covered in full after deductible	
Spinal Manipulation		Not covered	
Preventive Pap Smears and Mammograms		Covered in full	
Non-preventive Pap Smears and Mammograms		Covered in full after deductible	
Colonoscopies Generally Associated With Symptoms (Including Family History of Cancer) - without surgical intervention		Covered in full	
Colonoscopies Generally Associated With Symptoms (Including Family History of Cancer) - with surgical intervention		Covered in full after deductible	
Diagnostic Procedures		Covered in full after deductible	
Diagnostic Imaging - General Imaging (such as x-rays and ultrasounds)		Covered in full after deductible	
Diagnostic Imaging - High-Tech Imaging (MRIs, CT/CAT Scans, PET Scans & Nuclear Cardiology)		Covered in full after deductible	
Diagnostic Lab Tests		Covered in full after deductible	
Day Surgery		Covered in full after deductible	
Inpatient Hospital Care (semiprivate room, unless private room is medically necessary)			
All Hospital Services — Acute Care and Maternity Care		Covered in full after deductible	
Skilled Nursing in Skilled Nursing Facility (up to 100 days per calendar year)		Covered in full after deductible	
Emergency Care			
In Emergency Room (copay waived if admitted)		Covered in full after deductible	
Mental Health and Substance Abuse			
Outpatient Care (up to 24 visits per plan year except as described below)		\$40 per visit	
Inpatient Care (Services provided at a designated facility for up to 60 days per plan year except as described below)		Covered in full after deductible	
Other Health Services			
Durable Medical Equipment		Plan covers 70%	
Ambulance Service		Covered in full after deductible	
Hospice Care		Covered in full after deductible	
Home Health Care		Covered in full after deductible	

*Outpatient 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.

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, a 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, except as described in your Tufts Health Plan member benefit document • 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 a hospital, except as described in your Tufts Health Plan member benefit document • 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 be treated in a public facility • Medical or surgical procedures for sexual reassignment and reversal of voluntary sterilization • Foot orthotics, except therapeutic or molded shoes for an individual with severe diabetic foot disease • Spinal manipulation services for members age 12 and under • Private-duty nursing (block or nonintermittent nursing) • Hearing aids • Assisted reproductive technology (e.g., IVF) procedures for non-Massachusetts residents.

**This plan is not available to Massachusetts residents residing in the following counties:
Berkshire, Dukes, Franklin, Hampden, Hampshire, and Nantucket.**

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, 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.