ADVANTAGE PPO SUMMARY OF BENEFITS

TUFTS Health Plan
No one does more to keep you healthy.

With Tufts Health Plan's Advantage PPO (preferred provider organization) plan, you enjoy quality coverage for your health care needs. 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. Services are covered at two levels of benefits: the in-network level of benefits and the out-of-network level of benefits.

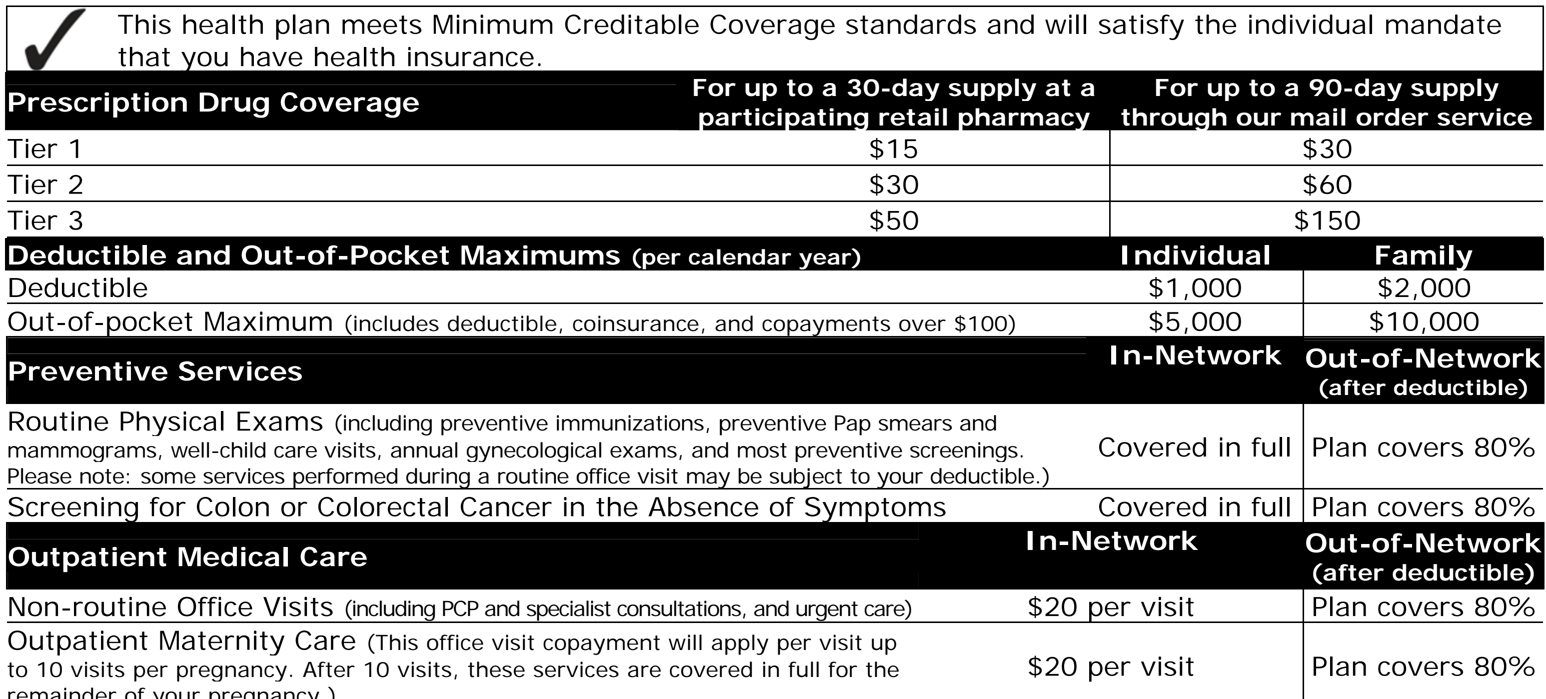
As an Advantage PPO member:

- You do not have to choose a primary care provider (PCP).
- You can seek covered services from most licensed providers in or out of the Tufts Health Plan network.
- No referrals are needed.
- Any emergency medical care you may need is covered at the in-network level of benefits.

How services are covered with Advantage PPO
The Advantage PPO plan covers preventive and medically needed health care services and supplies in the following ways:

- **In-network benefits—**Apply when you receive care from a provider in the Tufts Health Plan network. Services may be covered subject to the plan's deductible, covered with a copay, covered in full, or subject to coinsurance.
  - **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-network benefits—**Apply 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. A deductible is the amount of money you have to pay out of your own pocket before many services are covered. You must then pay coinsurance for these services until you reach the plan's out-of-pocket maximum. Once you reach your limit, you are covered in full for all eligible out-of-network covered services for the rest of the year. You may also have to pay the difference between what the plan covers and what the out-of-network provider charges for a service. You may need to submit a claim form for each covered service you receive. The deductible and out-of-pocket maximum for this plan are listed on this benefit summary.

Please note that this is a summary of benefits only. For complete benefit information, please refer to your member benefit document.



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

Prescription Drug Coverage	For up to a 30-day supply at a participating retail pharmacy	For up to a 90-day supply through our mail order service
Tier 1	$15	$30
Tier 2	$30	$60
Tier 3	$50	$150

Deductible and Out-of-Pocket Maximums (per calendar year)	Individual	Family
Deductible	$1,000	$2,000
Out-of-pocket Maximum (includes deductible, coinsurance, and copayments over $100)	$5,000	$10,000

Preventive Services	In-Network	Out-of-Network (after deductible)
Routine Physical Exams (including preventive immunizations, preventive Pap smears and mammograms, well-child care visits, annual gynecological exams, and most preventive screenings. Please note: some services performed during a routine office visit may be subject to your deductible.)	Covered in full	Plan covers 80%
Screening for Colon or Colorectal Cancer in the Absence of Symptoms	Covered in full	Plan covers 80%

Outpatient Medical Care	In-Network	Out-of-Network (after deductible)
Non-routine Office Visits (including PCP and specialist consultations, and urgent care)	$20 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.)	$20 per visit	Plan covers 80%

Service	In-Network	Out-of-Network
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	$20 per visit	Plan covers 80%
Nutritional Counseling (when medically necessary)	$20 per visit	Plan covers 80%
Allergy Injections	Covered in full after deductible	Plan covers 80%
Speech Therapy (when medically necessary)	Covered in full after deductible	Plan covers 80%
Short-term Physical and Occupational Therapy (30 visits for each type of service per calendar year)	Covered in full after deductible	Plan covers 80%
Spinal Manipulation (12 visits per calendar year)	Covered in full after deductible	Plan covers 80%
Non-preventive Pap Smears and Mammograms	Covered in full after deductible	Plan covers 80%
Colonoscopies Generally Associated With Symptoms (Including Family History of Cancer)	Covered in full after deductible	Plan covers 80%
Diagnostic Procedures	Covered in full after deductible	Plan covers 80%
Diagnostic Imaging - General Imaging (such as X-rays and ultrasounds)	Covered in full after deductible	Plan covers 80%
Diagnostic Imaging - High-Tech Imaging (MRIs, CT/CAT Scans, PET Scans, and Nuclear Cardiology)	Covered in full after deductible	Plan covers 80%
Diagnostic Lab Tests	Covered in full after deductible	Plan covers 80%
Day Surgery	Covered in full after deductible	Plan covers 80%
Inpatient Hospital Care (semiprivate room, unless private room is medically necessary)	**In-Network**	**Out-of-Network (after deductible)**
All Hospital Services — Acute Care and Maternity Care	Covered in full after deductible	Plan covers 80%
Skilled Nursing in Skilled Nursing Facility (up to 100 days per calendar year)	Covered in full after deductible	Plan covers 80%
Emergency Care		
In Emergency Room	Covered in full after deductible	
Mental Health and Substance Abuse	**In-Network**	**Out-of-Network (after deductible)**
Outpatient Care (up to 24 visits per calendar year except as described below)	$20 per visit	Plan covers 80%
Inpatient Care (Services for up to 60 days per calendar year except as described below)	Covered in full after deductible	Plan covers 80%
Other Health Services	**In-Network**	**Out-of-Network (after deductible)**
Durable Medical Equipment	Plan covers 70%	Plan covers 70%
Ambulance Service	Covered in full after deductible	Plan covers 80%
Hospice Care	Covered in full after deductible	Plan covers 80%
Home Health Care	Covered in full after deductible	Plan covers 80%

*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 is a summary only. Please refer to your plan's member benefit document for more detailed information. If there is a difference between the information in this benefit summary and your member benefit document, member benefit document is legally binding. If you have additional questions, please call a Member Specialist at 1-800-462-0224.

Offered by Tufts Insurance Company or Tufts Benefit Administrators, 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 Web site (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 Web site at www.mass.gov/doi.