

# HMO BASIC SUMMARY OF BENEFITS

With Tufts Health Plan's HMO (health maintenance organization) plan, you enjoy quality coverage for your health care needs. Preventive and medically needed health care services and supplies are, for the most part, covered when they are given or referred by your network primary care provider (PCP).

**As an HMO member:**

- You must choose a PCP from the Tufts Health Plan network.
- In most cases, your PCP must give or refer your care.
- You pay a copay at the time you receive a covered service. This copay may vary depending on the type of services you receive. There are annual maximums, or yearly limits, to the amount of money you have to pay out of your own pocket for certain medical services. Please check this benefit summary for more details.
- You pay coinsurance for durable medical equipment. Coinsurance is the percentage of cost you must pay for some covered services.

HMO members do not need a PCP referral for certain types of covered services, including:

- Emergency care received in an emergency room
- Maternity care and other medically needed evaluations and related health care services for acute/emergency gynecologic conditions, when these services are given by an obstetrician, gynecologist, certified nurse midwife, or family practitioner in the Tufts Health Plan network
- Routine gynecologic exams and any medically needed OB/GYN follow-up care from those exams, when given by a provider in the Tufts Health Plan network
- Breast cancer screening, when given by a provider in the Tufts Health Plan network
- Routine eye exams
- Spinal manipulation

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](http://tuftshealthplan.com).

 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
Copayment Maximums (per calendar year)	Individual	Family
Inpatient and day surgery copayment maximums	\$2,400	\$4,800
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, spinal manipulation, routine eye exams, or mammograms)		
Non-routine Office Visits (including PCP and specialist consultations, and urgent care)		\$25 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
OB/GYN Visits		\$25 per visit
Well-Child Care		Covered in full
Routine eye exams with an EyeMed Vision Care provider (1 visit every 24 months)		\$25 per visit
Nutritional Counseling (when medically necessary)		\$25 per visit
Allergy Injections		\$5 per visit
Speech Therapy (when medically necessary)		\$25 per visit
Short-term Physical and Occupational Therapy (30 visits for each type of service per calendar year)		\$25 per visit
Spinal Manipulation (12 visits per calendar year)		\$25 per visit
Non-preventive Pap Smears and Mammograms		Covered in full
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	\$600 per visit
Diagnostic Procedures	Covered in full
Diagnostic Imaging - General Imaging (such as X-rays and ultrasounds)	Covered in full
Diagnostic Imaging - High-Tech Imaging (MRIs, CT/CAT Scans, PET Scans, and Nuclear Cardiology)	\$150 per visit
Diagnostic Lab Tests	Covered in full
Day Surgery	\$600 per admission
<b>Inpatient Hospital Care (semiprivate room, unless private room is medically necessary)</b>	
All Hospital Services — Acute Care and Maternity Care	\$600 per admission
Skilled Nursing in Skilled Nursing Facility (up to 100 days per calendar year)	Covered in full
<b>Emergency Care</b>	
In Emergency Room (copay waived if admitted)	\$125 per visit
<b>Mental Health and Substance Abuse</b>	
Outpatient Care (up to 24 visits per calendar year except as described below)	\$25 per visit
Inpatient Care (Services provided at a designated facility for up to 60 days per calendar year except as described below)	\$600 per admission
<b>Other Health Services</b>	
Durable Medical Equipment	Plan covers 70%
Ambulance Service	Covered in full
Hospice Care	Covered in full
Home Health Care	Covered in full

\*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 • Except for Emergency care and urgent care while traveling, a service, supply or medication that is obtained outside of the 50 United States.

**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 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 Web site ([www.mahealthconnector.org](http://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](http://www.mass.gov/doi).