

HMO SELECT 20

A LIMITED NETWORK PLAN

SUMMARY OF BENEFITS

With Tufts Health Plan's HMO (health maintenance organization) Select plan, a limited provider network plan, you enjoy quality coverage for your health care needs. The 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.

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

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

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 (per calendar year)	Individual/Family
Inpatient and day surgery copayment maximum	\$2,400 individual/\$4,800 family
Out-of-pocket maximum (includes inpatient and day surgery maximum, and ER copays)	\$5,000 individual/\$10,000 family

Prescription Drug Coverage (For up to a 30-day supply at a participating retail pharmacy)

Prescriptions are covered with copays after a \$100 Individual/\$200 family calendar year deductible.

Tier 1	\$15
Tier 2	\$30
Tier 3	\$50

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, spinal manipulation, routine eye exams, or mammograms)

	PCP	Specialist
Non-routine Office Visits (including PCP and specialist consultations, and urgent care)	\$20 per visit	\$35 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.)	\$20 per visit	\$20 per visit
Routine Eye Exams with an EyeMed Vision Care provider (1 visit every 24 months)	\$20 per visit	\$20 per visit
Nutritional Counseling (When medically necessary)	\$20 per visit	\$35 per visit
Allergy Injections	\$5 per visit	
Speech Therapy (when medically necessary)	\$20 per visit	\$35 per visit
Short-term Physical and Occupational Therapy (30 visits for each type of service per plan year)	\$20 per visit	\$35 per visit
Spinal Manipulation (12 visits per calendar year)	\$20 per visit	\$35 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 admission	
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 & Nuclear Cardiology)	\$150 per visit	
Diagnostic Lab Tests	Covered in full	
Day Surgery	\$600 per admission	

Inpatient Hospital Care (semiprivate room, unless private room is medically necessary)

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

Emergency Care

In Emergency Room (copay waived if admitted) \$200 per visit

Mental Health and Substance Abuse

Outpatient Care (up to 24 visits per plan year except as described below) \$20 per visit

Inpatient Care (Services provided at a designated facility for up to 60 days per plan year except as described below) \$600 per admission

Other Health Services

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 • 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.