

HMO BASIC

SUMMARY OF BENEFITS

With Tufts Health Plan's HMO (health maintenance organization) plan, you enjoy comprehensive coverage for your health care needs, while your out-of-pocket costs are kept to a minimum.

In general, preventive and medically necessary health care services and supplies are covered when they are provided or authorized by your network primary care physician (PCP).

As an HMO member:

- You must choose a PCP from the Tufts Health Plan network of providers.
- In most cases, your PCP must provide or authorize (provide a referral for) your care.
- You pay the applicable copayment at the time you receive covered health care services. There are annual maximums on the number or amount of copayments you pay for day surgery and inpatient care. Please check this benefit summary for more information.

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

- Maternity care and medically necessary evaluations and related health care services for acute/emergency gynecologic conditions, when these services are provided by an obstetrician, gynecologist, certified nurse midwife, or family practitioner in the Tufts Health Plan network
- Routine gynecologic exams and any medically necessary OB/GYN follow-up care resulting from that exam, when obtained from a provider in the Tufts Health Plan network
- Emergency care in an emergency room or a physician's office
- Mammography screening, when obtained from a provider in the Tufts Health Plan network
- One routine eye exam every 24 months, when provided by a network physician, if your plan offers this benefit

Out-of-Pocket Maximums	Individual/Family
Inpatient and day surgery out-of-pocket maximums (per plan year)	\$4,000/\$8,000
Prescription Drug Coverage (For up to a 30-day supply at a participating retail pharmacy)	
Tier 1	\$10
Tier 2	\$25
Tier 3	\$45

Members can save up to 33% off a three-month supply of most maintenance medications through our mail order service.

When your prescriber prescribes a brand-name drug that has a generic equivalent, you will receive the generic drug and pay the applicable copayment. However, if your prescriber requests that you receive a covered brand-name drug only, you will pay the copayment for the generic drug plus the difference between the cost of the generic drug and the cost of the covered brand-name drug.

Outpatient Medical Care (No PCP referral is necessary for OB/GYN visits, spinal manipulation, routine eye exams, or mammograms)	
Most Provider Office Visits	\$50 per visit
Routine Physical Exams (including most preventive screenings)	\$50 per visit
Well-Child Care	\$50 per visit
OB/GYN Visits	\$50 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.)	\$50 per visit
Routine Eye Exams (1 visit every 24 months)	\$50 per visit
Nutritional Counseling (When medically necessary)	\$50 per visit
Preventive Immunizations	Covered in full
Preventive Pap Smears and Mammograms	Covered in full
Non-preventive Immunizations	Covered in full
Non-routine Pap Smears and Mammograms	Covered in full
Allergy Injections	\$5 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 & Nuclear Medicine)	\$100 per visit
Diagnostic Lab Tests	Covered in full
Speech and Short-term Physical/Occupational Therapy	\$50 per visit
Spinal Manipulation (12 visits per plan year)	\$50 per visit
Day Surgery	\$1,000 per admission

Inpatient Hospital Care (Semi-private room, unless private room is medically necessary)	
All Hospital Services (Acute Care) and Maternity Care	\$1,000 per admission
Skilled Nursing in Skilled Nursing Facility (up to 100 days per plan year)	Covered in full
Emergency Care	
In Emergency Room	\$200 per visit
In Doctor's Office	\$50 per visit
Mental Health*	
Outpatient Care (up to 24 visits per plan year)	\$50 per visit
Inpatient Care (Services provided at a designated facility for up to 60 days per plan year)	\$1,000 per admission
Substance Abuse**	
Outpatient Care (Alcohol and drug treatment, detoxification) (Up to \$500 per plan year for treatment)	\$50 per visit
Inpatient Care (Services provided at a designated facility for up to 30 days per plan year)	\$1,000 per admission
Other Health Services	
Durable Medical Equipment (\$1,500 plan year maximum)	Covered in full
Ambulance Service	Covered in full
Hospice Care	Covered in full
Home Health Care	Covered in full

Health and Wellness Programs and Member Discounts

No one does more to keep you healthy than Tufts Health Plan. We offer discounts on a wide variety of healthy products, treatments, and services to help you save while taking care of your health. To learn more about the programs listed here and to find participating facilities, visit www.tuftshealthplan.com, or contact a member services specialist at 1-800-462-0224 who will be happy to help you.

- Acupuncture
- Appalachian Mountain Club
- Boys & Girls Club
- CATZ Kids Fitness Clubs
- Curves®
- Eyewear Discounts
- Fitness Clubs
- Fitness Together
- GlobalFit
- Home Instead Senior Care®
- Health and wellness programs through Healthyroads™
- Massage Therapy
- Nutritional Counseling
- Safety Helmet Discounts
- Tufts University Health & Nutrition Letter
- Weight Watchers®
- Wellness Programs

*Outpatient and inpatient mental health services are treated the same as any other medical condition when provided as required by law for the following: biologically-based mental disorders; certain mental, behavioral or emotional disorders for children under age 19; and rape-related mental or emotional disorders. See your Tufts Health Plan member benefit document for more information.

**Outpatient and inpatient substance abuse services are treated the same as mental health conditions when provided in conjunction with treatment of a mental disorder. Treatment for detoxification is not subject to substance abuse day and dollar limits listed in this document. 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, 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 • 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 hospital, except as covered under Prescription Drug Coverage • 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 to be treated in public facility • Medical or surgical procedures for sexual reassignment and reversal of voluntary sterilization • Foot orthotics, except therapeutic/molded shoes for an individual with severe diabetic foot disease • Assisted reproductive technology (e.g. IVF) procedures for non-Massachusetts residents.

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.