

ADVANTAGE HMO

SUMMARY OF BENEFITS

With Tufts Health Plan Advantage HMO, health care services may be covered subject to the plan's deductible, covered with a copayment, or covered in full. The deductible is the amount you must first pay out of pocket before many services are covered. The deductible is calculated each plan year. Once you meet the deductible, the plan covers in full services that are subject to the deductible for the remainder of the plan year.

As an Advantage HMO member:

- You must choose a primary care provider (PCP) from the Tufts Health Plan network of providers.
- In most cases, your network PCP must provide or authorize (provide a referral for) your care.
- You do not need a referral for emergency care.

How services are covered with Advantage HMO

In general, the Advantage HMO plan covers preventive and medically necessary health care services and supplies when they are provided or authorized 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 during or in conjunction with preventive services (for example, during an office visit). The individual and family deductibles for this plan are listed below.

- **Covered in full or with a copayment:** In most cases with this plan, preventive health care services are covered in full or with a copayment, and are not subject to the deductible. Generally, preventive health care services are the services your PCP provides to help you stay healthy. Preventive health services are needed at all ages. They might be office visits for preventive care for children and adults; tests (also called screenings) to evaluate your general 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. (Please visit tuftshealthplan.com/members to review the most recent Massachusetts Health Quality Partners preventive care recommendations for every age.)

Please note that this is a summary of benefits only. For more detailed benefit information, please refer to this plan's member benefit document.

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	\$10	\$20	
Tier 2	\$30	\$60	
Tier 3	\$45	\$90	
Deductible (per plan year)	Individual	Family	
Deductible	\$1,000	\$2,000	
Outpatient Medical Care (No PCP referral is necessary for OB/GYN visits, spinal manipulation, routine eye exams, or mammograms)	PCP		Specialist
Most Provider Office Visits	\$20 per visit	\$20 per visit	\$30 per visit
Routine Physical Exams (including most preventive screenings. Please note: some services performed during a routine office visit may be subject to your deductible.)	\$20 per visit	\$20 per visit	\$30 per visit
Well-Child Care	\$20 per visit	\$20 per visit	\$30 per visit
OB/GYN Visits	\$20 per visit	\$20 per visit	\$20 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	\$20 per visit
Routine Eye Exams (1 visit every 24 months)	\$20 per visit	\$20 per visit	\$20 per visit
Nutritional Counseling (When medically necessary)	\$20 per visit	\$20 per visit	\$30 per visit
Preventive Immunizations	Covered in full		
Preventive Pap Smears and Mammograms	Covered in full		
Non-preventive Immunizations	Covered in full after deductible		
Non-routine Pap Smears and Mammograms	Covered in full after deductible		
Allergy Injections	Covered in full after deductible		
Colonoscopy	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, and Nuclear Cardiology)	Covered in full after deductible		
Diagnostic Lab Tests	Covered in full after deductible		
Speech and Short-term Physical/Occupational Therapy	Covered in full after deductible		
Spinal Manipulation (12 visits per plan year)	Covered in full after deductible		
Day Surgery	Covered in full after deductible		

Inpatient Hospital Care (Semi-private 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 plan year)	Covered in full after deductible	
Emergency Care		
	PCP	Specialist
In Doctor's Office	\$20 per visit	\$30 per visit
In Emergency Room	\$100 per visit	
Mental Health		
Outpatient Care (up to 30 visits per plan year)	\$30 per visit	
Inpatient Care	Covered in full after deductible	
Substance Abuse		
Outpatient Care (Alcohol and drug treatment, detoxification) (Up to 30 hours per plan year for treatment)	\$30 per visit	
Inpatient Care	Covered in full after deductible	
Other Health Services		
Durable Medical Equipment (\$1,500 plan year maximum)	Covered in full	
Ambulance Service	Covered in full after deductible	
Hospice Care	Covered in full after deductible	
Home Health Care	Covered in full after deductible	

Great Savings While You Get Healthy

In addition to your covered benefits, we offer great savings on a wide variety of health products, services, and treatments—from fitness club memberships to acupuncture and massage therapy to wellness programs. You can save while you're taking care of your health. To learn more, visit tuftshealthplan.com and click on Discounts on the Members tab.

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, 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 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 a public facility • Medical or surgical procedures for sexual reassignment and reversal of voluntary sterilization • Spinal manipulation services for members age 12 and under • Except for Emergency care, a service, supply or medication that is obtained outside of the 50 United States • Private duty nursing (block or non-intermittent nursing).

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 1-800-682-8059.

Offered by Tufts Associated Health Maintenance Organization, Inc.