

ADVANTAGE HMO

SUMMARY OF BENEFITS

With Tufts Health Plan Advantage HMO, health care services may be covered subject to the plan's deductible or coinsurance, 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.

In addition, Advantage HMO is compatible with health reimbursement arrangements (HRAs), which are designed specifically to help with an individual's health care expenses.

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:** You pay the applicable copayment at the time you receive covered health care services. With this plan, preventive services are covered in full and are not subject to the deductible. Generally, preventive services are the services your provider provides to help you stay healthy. Preventive services are needed at all ages. They might be office visits for routine physicals 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.
- **Covered subject to coinsurance:** You pay coinsurance for durable medical equipment. Coinsurance is a percentage of the covered medical costs you are responsible for paying.

Out-of-pocket Maximum: Your deductible and coinsurance accumulate toward your out-of-pocket maximum. Once you reach your out-of-pocket maximum, you are covered in full for services subject to deductible and coinsurance.

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 and Out-of-pocket Maximums (per plan year)	Individual	Family
Deductible	\$500	\$1,000
Out-of-pocket Maximum (includes deductible and coinsurance)	\$1,500	\$3,000

Outpatient Medical Care (No PCP referral is necessary for OB/GYN visits, spinal manipulation, routine eye exams, or mammograms)	PCP	Specialist
Routine Physical Exams (including most preventive screenings. Please note: some services performed during a routine office visit may be subject to your deductible.)	Covered in full	
Non-routine Office Visits (including PCP and specialist consultations)	\$20 per visit	\$30 per visit
Preventive Immunizations	Covered in full	
Non-preventive Immunizations	Covered in full after deductible	
Preventive Pap Smears and Mammograms	Covered in full	
Non-preventive Pap Smears and Mammograms	Covered in full after deductible	
Colonoscopy (without surgical intervention)	Covered in full	
Colonoscopy (with surgical intervention)	Covered in full after deductible	
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
OB/GYN Visits	\$20 per visit	\$20 per visit
Well-Child Care	Covered in full	
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	\$30 per visit
Allergy Injections	Covered in full after deductible	
Speech and Short-term Physical/Occupational Therapy (30 visits for each service type per plan year)	Covered in full after deductible	
Spinal Manipulation (12 visits per plan year)	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	
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	Plan covers 70%	
Ambulance Service	Covered in full after deductible	
Hospice Care	Covered in full after deductible	
Home Health Care	Covered in full after deductible	

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 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 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 or Urgent care while traveling, 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 Specialist at 1-800-682-8059.

Offered by Tufts Associated Health Maintenance Organization, Inc.