

ADVANTAGE PPO

SUMMARY OF BENEFITS

With Tufts Health Plan Advantage PPO, most health care services are covered subject to the plan's deductible or coinsurance, covered with a copayment, or covered in full. Services are covered at two levels of benefits: the in-network level of benefits and the out-of-network level of benefits.

As an Advantage PPO member:

- You can seek covered health care services from most licensed providers in or out of the Tufts Health Plan network.
- No referrals are needed.
- You do not have to choose a primary care provider (PCP).

How services are covered with Advantage PPO

In general, Advantage PPO covers preventive and medically necessary health care services and supplies in the following ways:

- Coverage at the in-network level of benefits:** When you receive care from a provider in the Tufts Health Plan network, services may be covered subject to the plan's deductible or coinsurance, covered with a copayment, or covered in full.
 - 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. The deductible is the amount you must first pay out of pocket each plan year before many services are covered. Once you meet the deductible, those services are covered in full for the remainder of the plan year. 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.

- 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 plan's 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, preventive immunizations (or shots) for children and adults, certain advice about health, or special tests at certain times in your life.
- Covered subject to coinsurance:** Coinsurance is a percentage of the covered medical costs you are responsible for paying. You pay coinsurance on durable medical equipment until you reach the plan's out-of-pocket maximum, after which you are covered in full.
- Coverage at the out-of-network level of benefits:** When you receive care from a provider who is not in the Tufts Health Plan network, services will be covered subject to the plan's deductible and then coinsurance. When you receive covered out-of-network services, you pay coinsurance until you reach the plan's out-of-pocket maximum, after which you are covered in full up to the reasonable charge for covered services for the remainder of the plan year. You may also be responsible for paying any difference between what the plan covers and what an out-of-network provider charges for a service.

The individual and family deductibles and out-of-pocket maximums for this plan are listed in this benefit summary. 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)	In-Network	Out-of-Network
Individual Deductible	\$500	\$500
Family Deductible	\$1,000	\$1,000
Individual Out-of-pocket Maximum (includes deductibles and coinsurance)	\$1,500	\$4,000
Family Out-of-pocket Maximum (includes deductibles and coinsurance)	\$3,000	\$8,000

Outpatient Medical Care	In-Network		Out-of-Network (after deductible)
	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		Plan covers 80%
Non-routine Office Visits (including PCP and specialist consultations)	\$20 per visit	\$30 per visit	Plan covers 80%
Preventive Immunizations	Covered in full		Plan covers 80%
Non-preventive Immunizations	Covered in full after deductible		Plan covers 80%
Preventive Pap Smears and Mammograms	Covered in full		Plan covers 80%
Non-preventive Pap Smears and Mammograms	Covered in full after deductible		Plan covers 80%
Colonoscopy (without surgical intervention)	Covered in full		Plan covers 80%
Colonoscopy (with surgical intervention)	Covered in full after deductible		Plan covers 80%
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	Plan covers 80%
OB/GYN Visits	\$20 per visit	\$20 per visit	Plan covers 80%
Well-Child Care	Covered in full		Plan covers 80%
Routine eye exams (1 visit every 24 months)—you must use an EyeMed Vision Care provider to be covered at the in-network level of benefits	\$20 per visit	\$20 per visit	Plan covers 80%

Nutritional Counseling (When medically necessary)	\$20 per visit \$30 per visit	Plan covers 80%
Allergy Injections	Covered in full after deductible	Plan covers 80%
Speech and Short-term Physical/Occupational Therapy (30 visits for each service type per plan year)	Covered in full after deductible	Plan covers 80%
Spinal Manipulation (12 visits per plan year)	Covered in full after deductible	Plan covers 80%
Diagnostic Procedures	Covered in full after deductible	Plan covers 80%
Diagnostic Imaging - General Imaging (such as X-rays and ultrasounds)	Covered in full after deductible	Plan covers 80%
Diagnostic Imaging - High-Tech Imaging (MRIs, CT/CAT Scans, PET Scans, and Nuclear Cardiology)	Covered in full after deductible	Plan covers 80%
Diagnostic Lab Tests	Covered in full after deductible	Plan covers 80%
Day Surgery	Covered in full after deductible	Plan covers 80%
Inpatient Hospital Care (Semi-private room, unless private room is medically necessary)	In-Network	Out-of-Network (after deductible)
All Hospital Services (Acute Care) and Maternity Care	Covered in full after deductible	Plan covers 80%
Skilled Nursing in Skilled Nursing Facility (up to 100 days per plan year)	Covered in full after deductible	Plan covers 80%
Emergency Care	PCP	Specialist
In Provider's Office	\$20 per visit	\$30 per visit
In Emergency Room	\$100 per visit	
Mental Health	In-Network	Out-of-Network (after deductible)
Outpatient Care (up to 30 visits per plan year)	\$30 per visit	Plan covers 80%
Inpatient Care	Covered in full after deductible	Plan covers 80%
Substance Abuse	In-Network	Out-of-Network (after deductible)
Outpatient Care (Alcohol and drug treatment, detoxification) (Up to 30 hours per plan year)	\$30 per visit	Plan covers 80%
Inpatient Care	Covered in full after deductible	Plan covers 80%
Other Health Services	In-Network	Out-of-Network (after deductible)
Durable Medical Equipment	Plan covers 70%	Plan covers 70%
Ambulance Service	Covered in full after deductible	Plan covers 80%
Hospice Care	Covered in full after deductible	Plan covers 80%
Home Health Care	Covered in full after deductible	Plan covers 80%

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 Insurance Company or Tufts Benefit Administrators, Inc., both Tufts Health Plan companies.