

# PPO PREMIUM SUMMARY OF BENEFITS

Tufts Health Plan's preferred provider organization (PPO) plan covers preventive and medically necessary health care services and supplies.

As a PPO member:

- You are not required to choose a primary care physician.
- 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 can choose between two levels of coverage:
  - **Coverage at the in-network level of benefits**, a higher level of benefits, when you receive care from a provider in the Tufts Health Plan network. You pay a copayment when you receive covered health care services at the in-network level of benefits.
  - **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. When you receive care at the out-of-network level of benefits, you pay a deductible and then

coinsurance until you reach your out-of-pocket maximum. Once you reach your out-of-pocket maximum, you are covered in full up to the reasonable charge for all out-of-network 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 the out-of-network provider charges for a service. You may need to submit a claim form for each covered service you receive.

- A deductible is the amount you must first pay out-of-pocket before any coverage is available at the out-of-network level of benefits.
- Coinsurance is a percentage of the covered medical costs you are responsible for paying at the out-of-network level of benefits. You must pay coinsurance for these services until you reach the plan's out-of-pocket maximum.
- The deductible and out-of-pocket maximum for this plan are listed on this benefit summary.

Any emergency medical care you may need is covered at the in-network level of benefits.

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	\$25	\$50
Tier 3	\$45	\$90

Deductible and Out-of-pocket Maximums (per plan year)	Individual	Family
Deductible (applies to out-of-network care only)	\$250	\$500
Out-of-pocket maximum (includes deductible and coinsurance)	\$1,250	\$2,500

Outpatient Medical Care	In-Network	Out-of-network (after deductible)
Most Provider Office Visits	\$10 per visit	Plan covers 80%
Routine Physical Exams (including most preventive screenings)	\$10 per visit	Plan covers 80%
Well-Child Care	\$10 per visit	Plan covers 80%
OB/GYN Visits	\$10 per visit	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.)	\$10 per visit	Plan covers 80%
Routine Eye Exams (1 visit every 24 months)	\$10 per visit	Plan covers 80%
Nutritional Counseling (When medically necessary)	\$10 per visit	Plan covers 80%
Preventive Immunizations	Covered in full	Plan covers 80%
Preventive Pap Smears and Mammograms	Covered in full	Plan covers 80%
Non-preventive Immunizations	Covered in full	Plan covers 80%
Non-routine Pap Smears and Mammograms	Covered in full	Plan covers 80%
Allergy Injections	\$5 per visit	Plan covers 80%
Diagnostic Procedures	Covered in full	Plan covers 80%
Diagnostic Imaging - General Imaging (such as X-rays and ultrasounds)	Covered in full	Plan covers 80%
Diagnostic Imaging - High-Tech Imaging (MRIs, CT/CAT Scans, PET Scans, and Nuclear Cardiology)	Covered in full	Plan covers 80%
Diagnostic Lab Tests	Covered in full	Plan covers 80%
Speech and Short-term Physical/Occupational Therapy (30 visits for each service type per plan year)	\$10 per visit	Plan covers 80%
Spinal Manipulation (12 visits per plan year)	\$10 per visit	Plan covers 80%
Day Surgery	Covered in full	Plan covers 80%

<b>Inpatient Hospital Care</b> (Semi-private room, unless private room is medically necessary)	<b>In-Network</b>	<b>Out-of-network (after deductible)</b>
All Hospital Services (Acute Care) and Maternity Care	Covered in full	Plan covers 80%
Skilled Nursing in Skilled Nursing Facility (up to 100 days per plan year)	Covered in full	Plan covers 80%
<b>Emergency Care</b>		
In Doctor's Office		\$10 per visit
In Emergency Room		\$50 per visit
<b>Mental Health</b>	<b>In-Network</b>	<b>Out-of-network (after deductible)</b>
Outpatient Care (up to 30 visits per plan year)	\$10 per visit	Plan covers 80%
Inpatient Care	Covered in full	Plan covers 80%
<b>Substance Abuse</b>	<b>In-Network</b>	<b>Out-of-network (after deductible)</b>
Outpatient Care (Alcohol and drug treatment, detoxification) (Up to 30 hours per plan year)	\$10 per visit	Plan covers 80%
Inpatient Care	Covered in full	Plan covers 80%
<b>Other Health Services</b>	<b>In-Network</b>	<b>Out-of-network (after deductible)</b>
Durable Medical Equipment (\$1,500 plan year maximum)	Covered in full	Plan covers 80%
Ambulance Service	Covered in full	Plan covers 80%
Hospice Care	Covered in full	Plan covers 80%
Home Health Care	Covered in full	Plan covers 80%

### **Great Savings While You Get Healthy**

In addition to your covered benefits, we offer great savings on a wide variety of healthy products, services, and treatments—from fitness club memberships to acupuncture and massage therapy to wellness programs. You save while you're taking care of your health. That's a real win-win! To learn more, visit [www.tuftshealthplan.com](http://www.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 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 Insurance Company or Tufts Benefit Administrators, Inc., both Tufts Health Plan companies.