Advantage HMO Select 2000

Summary of Benefits

With Tufts Health Plan, you enjoy quality, comprehensive coverage for your health care needs. The following benefits apply when care is medically necessary and provided or authorized by your Tufts Health Plan primary care physician (PCP). Once you have met your deductible, Tufts Health Plan pays the full charge for authorized services that are subject to the deductible for the remainder of that calendar year. You do, however, continue to pay copayments for emergency care and outpatient medical care that is not subject to the deductible. This is a Tufts Health Plan HMO Select Network Option and offers a limited network of providers. It is available in Barnstable, Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties.

Outpatient Medical Care*	
Routine Physical Exams, including preventive screenings	$35 per visit
Specialist Consultations	$50 per visit
Well-Child Care	$35 per visit
OB/GYN visits	$35 per visit
Prenatal and Postnatal Care **	$35 per visit
Injections and Immunizations	Covered in Full
Mammograms and Pap Smears	Covered in Full
Allergy Shots	Covered in Full after deductible
Diagnostic Procedures	Covered in Full after deductible
Colonoscopies, Sigmoidoscopies	Covered in Full after deductible
Diagnostic Imaging	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
Annual Routine Eye Exams	$35 per visit
Spinal Manipulation	Not Covered

Inpatient Hospital Care*** and Day Surgery	
Day Surgery	Covered in Full after deductible
Hospital Services (Acute Care) and Maternity Care	Covered in Full after deductible
Physician's Care while hospitalized	Covered in Full after deductible
Surgery and Surgeon's Services while hospitalized	Covered in Full after deductible
Newborn Care in hospital	Covered in Full after deductible
Anesthesia while hospitalized	Covered in Full after deductible
Medications while hospitalized	Covered in Full after deductible
Nursing Care while hospitalized	Covered in Full after deductible
Diagnostic Imaging and Lab Tests while hospitalized	Covered in Full after deductible
Intensive Care/Coronary Care while hospitalized	Covered in Full after deductible
Radiation Therapy while hospitalized	Covered in Full after deductible
Skilled Nursing In Skilled Nursing Facility (up to 100 days per calendar year)	Covered in Full after deductible

Wellness Programs	
Membership at Network Fitness Facilities	Multiple discount options
Weight Watchers Weight Management Program	Discounted membership
Health Education (may require advance payment)	30% discount per program

Mental Health*	
Outpatient Care (up to 24 visits per calendar year)	$35 per visit
Inpatient Care (Services provided at a Designated Facility for up to 60 days per calendar year)	Covered in Full after deductible

* No PCP referral is necessary for OB/GYN visits, routine eye exams, or mammograms.

** 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.

*** Semi-private room, unless private room is medically necessary.

Advantage HMO Select 2000 - Summary of Benefits

Substance Abuse**	
Outpatient Care (Alcohol and drug treatment and detoxification) (Up to $500 per calendar year for treatment)	$35 per visit
Inpatient Care (Services provided at a Designated Facility for up to 30 days per calendar year)	Covered in Full after deductible

Emergency Care	
In Doctor's Office	$35 per visit
In Emergency Room	$200 per visit

Other Services	
Durable Medical Equipment ($1,500 calendar year maximum)	Covered in Full
Ambulance Service	Covered in Full after deductible

Prescription Drug Coverage (for up to a 30-day supply at a participating pharmacy)	
Tier 1	$20
Tier 2	$50
Tier 3	$75
Pharmacy Deductible	$250 ind./$500 fam.

This prescription drug benefit has a generic-focused formulary, meaning that most generic drugs are covered under Tier 1. Only select brand name drugs that have no generic equivalent are covered under Tiers 2 and 3. The drug formulary is subject to change without notice throughout the year. Medications included in the Special Designated Pharmacy program must be filled at the designated pharmacy. All other prescription medications may be filled at your retail pharmacy for up to one 30-day supply and one 30-day refill. Additional refills, as well as most maintenance medications, must be filled through the Caremark mail order pharmacy program.

Out-of-Pocket Maximums (applies to deductible and ER copays)	
Individual	$5,000
Family	$10,000

Deductible	Individual	Family
Deductible (per calendar year)	$2,000	$4,000

* 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 Evidence of Coverage 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 Evidence of Coverage 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 your Evidence of Coverage for more detailed information.
Copies are available by calling a member services coordinator at 800-462-0224.

Offered by Tufts Associated Health Maintenance Organization, Inc.