HMO PREMIUM SUMMARY OF BENEFITS

TUFTS Health Plan
No one does more to keep you healthy.

With Tufts Health Plan's HMO (health maintenance organization) plan, you enjoy comprehensive coverage for your health care needs, while your out-of-pocket costs are kept to a minimum.

In general, preventive and medically necessary health care services and supplies are covered when they are provided or authorized by your network primary care provider (PCP).

As an HMO member:

- **You must choose a PCP from the Tufts Health Plan network of providers.**
- **In most cases, your PCP must provide or authorize (provide a referral for) your care.**
- **You pay the applicable copayment at the time you receive covered health care services.**

HMO members do not need a PCP referral for certain types of covered services, such as:

- **Emergency care in an emergency room or a physician's office**
- **Maternity care and medically necessary evaluations and related health care services for acute/emergency gynecologic conditions, when these services are provided by an obstetrician, gynecologist, certified nurse midwife, or family practitioner in the Tufts Health Plan network**
- **Routine gynecologic exams and any medically necessary OB/GYN follow-up care resulting from that exam, when obtained from a provider in the Tufts Health Plan network**
- **Mammography screening, when obtained from a provider in the Tufts Health Plan network**

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
Outpatient Medical Care (No PCP referral is necessary for OB/GYN visits, spinal manipulation, routine eye exams, or mammograms)		
Most Provider Office Visits		$10 per visit
Routine Physical Exams (including most preventive screenings)		$10 per visit
Well-Child Care		$10 per visit
OB/GYN Visits		$10 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.)		$10 per visit
Routine Eye Exams (1 visit every 24 months)		$10 per visit
Nutritional Counseling (When medically necessary)		$10 per visit
Preventive Immunizations		Covered in full
Preventive Pap Smears and Mammograms		Covered in full
Non-preventive Immunizations		Covered in full
Non-routine Pap Smears and Mammograms		Covered in full
Allergy Injections		$5 per visit
Diagnostic Procedures		Covered in full
Diagnostic Imaging - General Imaging (such as X-rays and ultrasounds)		Covered in full
Diagnostic Imaging - High-Tech Imaging (MRIs, CT/CAT Scans, PET Scans, and Nuclear Cardiology)		Covered in full
Diagnostic Lab Tests		Covered in full
Speech and Short-term Physical/Occupational Therapy		$10 per visit
Spinal Manipulation (12 visits per plan year)		$10 per visit
Day Surgery		Covered in full
Inpatient Hospital Care (Semi-private room, unless private room is medically necessary)		
All Hospital Services (Acute Care) and Maternity Care		Covered in full
Skilled Nursing in Skilled Nursing Facility (up to 100 days per plan year)		Covered in full
Emergency Care		
In Doctor's Office		$10 per visit
In Emergency Room		$50 per visit

Mental Health	
Outpatient Care (up to 30 visits per plan year)	$10 per visit
Inpatient Care	Covered in full
Substance Abuse	
Outpatient Care (Alcohol and drug treatment, detoxification) (Up to 30 hours per plan year)	$10 per visit
Inpatient Care	Covered in full
Other Health Services	
Durable Medical Equipment ($1,500 plan year maximum)	Covered in full
Ambulance Service	Covered in full
Hospice Care	Covered in full
Home Health Care	Covered in full

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.