

# HMO BASIC 25 – OPTION 2

## SUMMARY OF BENEFITS

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 physician (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. There are annual maximums on the number or amount of copayments you pay for day surgery and inpatient care. Please check this benefit summary for more information.

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

- 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
- Emergency care in an emergency room or a physician's office
- Mammography screening, when obtained from a provider in the Tufts Health Plan network
- One routine eye exam every 24 months, when provided by a network physician, if your plan offers this benefit

 This health plan meets Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance.

| <b>Prescription Drug Coverage</b>  | <b>For up to a 30-day supply at a participating retail pharmacy</b> | <b>For up to a 90-day supply through our mail order service</b> |
|--|---|---|
| Prescriptions are covered at copays after a \$250 individual/\$500 family calendar year deductible.  |   |   |
| Tier 1   | \$20  | \$40  |
| Tier 2   | \$75  | \$150   |
| Tier 3   | \$100   | \$200   |
| <b>Out-of-Pocket Maximums (per calendar year)</b>  | <b>Individual</b>   | <b>Family</b>   |
| Inpatient and day surgery out-of-pocket maximums   | \$2,400   | \$4,800   |
| <b>Outpatient Medical Care</b> (No PCP referral is necessary for OB/GYN visits, spinal manipulation, routine eye exams, or mammograms)   |   |   |
| Most Provider Office Visits  | \$25 per visit  |   |
| Routine Physical Exams (including most preventive screenings)  | \$25 per visit  |   |
| Well-Child Care  | \$25 per visit  |   |
| OB/GYN Visits  | \$25 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.) | \$25 per visit  |   |
| Routine Eye Exams (1 visit every 24 months)  | \$25 per visit  |   |
| Nutritional Counseling (When medically necessary)  | \$25 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)   | \$100 per visit   |   |
| Diagnostic Lab Tests   | Covered in full   |   |
| Speech and Short-term Physical/Occupational Therapy  | \$25 per visit  |   |
| Spinal Manipulation (12 visits per calendar year)  | \$25 per visit  |   |
| Day Surgery  | \$600 per admission   |   |

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| <b>Inpatient Hospital Care</b> (Semi-private room, unless private room is medically necessary)             |                     |
| All Hospital Services (Acute Care) and Maternity Care  | \$600 per admission |
| Skilled Nursing in Skilled Nursing Facility (up to 100 days per calendar year)                             | Covered in full     |
| <b>Emergency Care</b>  |                     |
| In Doctor's Office   | \$25 per visit      |
| In Emergency Room  | \$75 per visit      |
| <b>Mental Health*</b>  |                     |
| Outpatient Care (up to 24 visits per calendar year)  | \$25 per visit      |
| Inpatient Care (Services provided at a designated facility for up to 60 days per calendar year)            | \$600 per admission |
| <b>Substance Abuse**</b>   |                     |
| Outpatient Care (Alcohol and drug treatment, detoxification) (Up to \$500 per calendar year for treatment) | \$25 per visit      |
| Inpatient Care (Services provided at a designated facility for up to 30 days per calendar year)            | \$600 per admission |
| <b>Other Health Services</b>   |                     |
| Durable Medical Equipment (\$1,500 calendar 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 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.

\*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 Tufts Health Plan member benefit document 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 Tufts Health Plan member benefit document 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, 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 • 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 • 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) • Hearing aids.

**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 1-800-462-0224.**

Offered by Tufts Associated Health Maintenance Organization, Inc.

Massachusetts Requirement to Purchase Health Insurance: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector Web site ([www.mahealthconnector.org](http://www.mahealthconnector.org)).

This health plan meets Minimum Creditable Coverage standards that are effective January 1, 2009 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards. This disclosure is for minimum creditable coverage standards that are effective January 1, 2009. Because these standards may change, review your health plan material each year to determine whether your plan meets the latest standards. If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its Web site at [www.mass.gov/doi](http://www.mass.gov/doi).