

SELECT NETWORK PRODUCTS FROM TUFTS HEALTH PLAN

Select Network providers only. Find participating providers at www.tuftshealthplan.com.

COVERED SERVICES	HMO SELECT 20 ¹	ADVANTAGE HMO SELECT 750 ¹	ADVANTAGE HMO SELECT 2000 ¹
DEDUCTIBLE			
Individual Deductible (calendar year)	\$0	\$750	\$2,000
Family Deductible (calendar year)	\$0	\$1,500	\$4,000
ANNUAL BENEFIT LIMIT			
Individual Limit (calendar year)	Unlimited	Unlimited	Unlimited
Family Limit (calendar year)	Unlimited	Unlimited	Unlimited
OUT-OF-POCKET MAXIMUM (Select Network Plans²)			
Individual Maximum (calendar year)	\$5,000	\$5,000	\$5,000
Family Maximum (calendar year)	\$10,000	\$10,000	\$10,000
OUTPATIENT MEDICAL CARE (PCP/Specialist)			
Doctor's Office Visits	\$20 per visit	\$15 per visit	\$35 per visit
Specialist Care, Consultations	\$35 per visit	\$25 per visit	\$50 per visit
Routine Physical Exams, OB/GYN Care, Well-Child Care	\$20 per visit	\$15 per visit	\$35 per visit
Preventative screenings, Pap smears, mammograms, and immunizations	Covered in full	Covered in full	Covered in full
Prenatal and Postnatal Care	\$20 per visit	\$15 per visit	\$35 per visit
Annual Routine Eye Exams	\$20 per visit	\$15 per visit	\$35 per visit
Speech and Physical/Occupational Therapy	\$35 per visit	Covered in full after deductible	Covered in full after deductible
Diagnostic X-Rays, and lab tests	Covered in full	Covered in full after deductible	Covered in full after deductible
Spinal Manipulation (Chiropractic) (12 visits/calendar year)	\$35 per visit	Covered in full after deductible	No coverage
INPATIENT HOSPITAL CARE AND DAY SURGERY			
Day Surgery	\$500 per surgery ³	Covered in full after deductible	Covered in full after deductible
Acute Care for Illness/ Injury/ Maternity Services	\$500 per admission ³	Covered in full after deductible	Covered in full after deductible
Physician's Care While Hospitalized	Covered in full	Covered in full after deductible	Covered in full after deductible
Surgery/Surgeon's Care While Hospitalized	Covered in full	Covered in full after deductible	Covered in full after deductible
Newborn Care in Hospital	Covered in full	Covered in full after deductible	Covered in full after deductible
Anesthesia While Hospitalized	Covered in full	Covered in full after deductible	Covered in full after deductible
Medications While Hospitalized	Covered in full	Covered in full after deductible	Covered in full after deductible
Nursing Care While Hospitalized	Covered in full	Covered in full after deductible	Covered in full after deductible
X-Ray/Lab Services While Hospitalized	Covered in full	Covered in full after deductible	Covered in full after deductible
Intensive/Coronary Care While Hospitalized	Covered in full	Covered in full after deductible	Covered in full after deductible
Radiation Therapy While Hospitalized	Covered in full	Covered in full after deductible	Covered in full after deductible
Skilled Nursing in a Skilled Nursing Facility (100 calendar days/year)	Covered in full	Covered in full after deductible	Covered in full after deductible
MENTAL HEALTH (Non-Biologically Based)			
Outpatient Care (24 visits/calendar year)	\$20 per visit	\$15 per visit	\$35 per visit
Inpatient Care (60 days/calendar year)	\$500 per admission ³	Covered in full after deductible	Covered in full after deductible

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SUBSTANCE ABUSE			
Outpatient Care (Tufts Health Plan pays \$500/calendar year)	\$20 per visit	\$15 per visit	\$35 per visit
Inpatient Care (30 days/calendar year)	\$500 per admission ³	Covered in full after deductible	Covered in full after deductible
EMERGENCY CARE			
In Doctor's Office	\$20 per visit	\$15 per visit	\$35 per visit
In Emergency Room	\$150 per visit	\$200 per visit	\$200 per visit
WELLNESS PROGRAMS			
Tufts Health Plan Network Fitness Facility Memberships	20% off membership, No joining fee	20% off membership, No joining fee	20% off membership, No joining fee
GlobalFit Network Fitness Facility Memberships	Up to 60% off membership fees	Up to 60% off membership fees	Up to 60% off membership fees
Curves	50% off joining fee, Earn a free month	50% off joining fee, Earn a free month	50% off joining fee, Earn a free month
Weight Watchers	No joining fee, \$10 off Deluxe At-Home Kit, \$10 off online program	No joining fee, \$10 off Deluxe At-Home Kit, \$10 off online program	No joining fee, \$10 off Deluxe At-Home Kit, \$10 off online program
Alternative Medicine: Acupuncture & Massage Therapy	25% off treatments and massage therapy	25% off treatments and massage therapy	25% off treatments and massage therapy
OTHER SERVICES			
Durable Medical Equipment (\$1,500 calendar year maximum)	Covered in full	Covered in full	Covered in full
Ambulance (when medically necessary)	Covered in full	Covered in full after deductible	Covered in full after deductible
PRESCRIPTION DRUG COVERAGE^{4, 5}			
Copayments	\$10/\$25/\$45	\$10/\$30/\$45	\$20/\$50/\$75
Deductible (calendar year)	\$0	\$0	\$250/\$500
Benefit Limit (calendar year)	Unlimited	Unlimited	Unlimited
Formulary	Generic-focused/Mandatory mail order for maintenance medications	Generic-focused/Mandatory mail order for maintenance medications	Generic-focused/Mandatory mail order for maintenance medications

This chart provides benefit highlights for general comparison purposes only. There are also services that the plans do not cover. Please see a Summary of Benefits for more information or refer to your Evidence of Coverage for complete information.

¹Select provider network, with a limited service area that excludes Berkshire, Dukes, Franklin, Hampden, Hampshire, and Nantucket Counties.

²The out-of-pocket maximum includes the member's annual medical deductible, all emergency room copayments, and any copayments for inpatient care or surgery.

³Inpatient/day surgery out-of-pocket maximum of \$2,000 individual/\$4,000 family applies.

⁴Emergency room copayment is waived if the member is admitted to the hospital.

⁵Pharmacy benefit for all versions of HMO Select and Advantage HMO Select will include mandatory mail order for maintenance medications.