TUFTS Health Plan

This is a Massachusetts Small Group and Individual Gold Plan

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

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). This health plan meets Minimum Creditable Coverage standards that are effective January 1, 2010 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, 2010. 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.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.tuftshealthplan.com/doc-links-sg or by calling 800-462-0224.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$500 person/$1,000 family in-network medical deductible per coverage period; $2,000 person/$4,000 family out-of-network medical deductible per coverage period	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	Yes, $50/person out-of-network pediatric dental deductible for specific services	You must pay all of the costs for these services up to specific **deductible** amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes, $7,000 person/$14,000 family for in-network medical, pharmacy, and pediatric dental expenses; $14,000 person/$28,000 family out-of-network medical expenses	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out–of–pocket limit.**
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.tuftshealthplan.com, "find a doctor", select "Advantage HMO and PPO and Saver" from the select a plan dropdown list, or call 800-462-0224.	If you use an in-network doctor or other health care **providers**, this plan will pay some or all of the costs for covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays for different types of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed later in this summary. See your policy or plan document for additional information about **excluded services.**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use an in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

		Your cost if you use a		
Common Medical Event	**Services You May Need**	**In-network Provider**	**Out-of-network Provider**	**Limitations & Exceptions (limits apply per coverage period)**
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/visit	20% coinsurance after deductible	———— none ————
	Specialist visit	$35 copay/visit	20% coinsurance after deductible	———— none ————
	Other practitioner office visit	$35 copay/visit for chiropractor	20% coinsurance after deductible	Spinal manipulations unlimited visits per year.
	Preventive care/screening/immunization	No charge	20% coinsurance after deductible	———— none ————
If you have a test	Diagnostic test (x-ray, blood work)	General imaging - $75 copay/visit after deductible Lab tests - Deductible	General imaging - 20% coinsurance after deductible Lab tests - 20% coinsurance after deductible	———— none ————
	Imaging (CT/PET scans, MRIs)	$250 copay/visit	20% coinsurance after deductible	———— none ————

		Your cost if you use a		
Common Medical Event	**Services You May Need**	**In-network Provider**	**Out-of-network Provider**	**Limitations & Exceptions (limits apply per coverage period)**
If you need drugs to treat your illness or condition	Tier 1 - Generic drugs	$25 copay/prescription (retail); $50 copay/prescription (mail order)	Reimbursable at in-network level	Retail cost share is for up to a 30-day supply; mail order cost share is for up to a 90-day supply. Some drugs require prior authorization to be covered. Some drugs have quantity limitations.
	Tier 2 - Preferred brand and some generic drugs	$65 copay/prescription (retail); $130 copay/prescription (mail order)		
	Tier 3 - Non-preferred brand drugs	$90 copay/prescription (retail); $270 copay/prescription (mail order)		
More Information about prescription drug coverage is available at www.tuftshealthplan.com **by selecting the Massachusetts Individual and Small Group Drug List**	Specialty drugs	Tier 1 - $25 copay/prescription Tier 2 - $65 copay/prescription Tier 3 - $90 copay/prescription Tier 4 - $150 copay/prescription	Not covered	Limited to a 30-day supply. Must be obtained at a designated specialty pharmacy. Some drugs require prior authorization to be covered. Some drugs have quantity limitations. Some specialty drugs may also be covered under your medical benefit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay/visit after deductible	20% coinsurance after deductible	Some surgeries require prior authorization in order to be covered.
	Physician/surgeon fees	Deductible	20% coinsurance after deductible	

		Your cost if you use a		
Common Medical Event	**Services You May Need**	**In-network Provider**	**Out-of-network Provider**	**Limitations & Exceptions (limits apply per coverage period)**
If you need immediate medical attention	Emergency room services	$250 copay/visit		Copay waived if admitted.
	Emergency medical transportation	$50 copay/trip after deductible		Some emergency transportation requires prior authorization to be covered
	Urgent care	$35 copay/visit for PCP $35 copay/visit for specialist		Services with out-of-network providers inside the service area are covered subject to deductible and coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 copay/admission after deductible	20% coinsurance after deductible	Some hospitalizations require prior authorization to be covered.
	Physician/surgeon fee	Deductible	20% coinsurance after deductible	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 copay/visit	20% coinsurance after deductible	Prior authorization may be required.
	Mental/Behavioral health inpatient services	$300 copay/admission after deductible	20% coinsurance after deductible	Prior authorization may be required.

		Your cost if you use a		
Common Medical Event	**Services You May Need**	**In-network Provider**	**Out-of-network Provider**	**Limitations & Exceptions (limits apply per coverage period)**
If you have mental health, behavioral health, or substance abuse needs	Substance use disorder outpatient services	$35 copay/visit	20% coinsurance after deductible	Prior authorization may be required.
	Substance use disorder inpatient services	$300 copay/admission after deductible	20% coinsurance after deductible	Prior authorization may be required.
If you are pregnant	Prenatal and postnatal care	No charge for routine outpatient office visits	20% coinsurance after deductible	———— none ————
	Delivery and all inpatient services	$300 copay/admission after deductible	20% coinsurance after deductible	———— none ————
If you need help recovering or have other special health needs	Home health care	Deductible	20% coinsurance after deductible	Prior authorization is required.
	Rehabilitation services	$35 copay/visit	20% coinsurance after deductible	Short-term physical and occupational therapy limited to 30 visits for each type of service per year. Prior authorization may be required.
	Habilitation services	$35 copay/visit	20% coinsurance after deductible	Short-term physical and occupational therapy limited to 30 visits for each type of service per year. Prior authorization may be required.
	Skilled nursing care	Deductible	20% coinsurance after deductible	Limited to 100 days per year. Prior authorization is required.

		Your cost if you use a		
Common Medical Event	**Services You May Need**	**In-network Provider**	**Out-of-network Provider**	**Limitations & Exceptions (limits apply per coverage period)**
If you need help recovering or have other special health needs	Durable medical equipment	30% coinsurance after deductible	30% coinsurance after deductible	Prior authorization may be required.
	Hospice service	Deductible	20% coinsurance after deductible	Prior authorization is required.
If your child needs dental or eye care	Eye exam	$35 copay/visit	20% coinsurance after deductible	Limited to one visit every 12 months with an EyeMed vision care provider.
	Glasses	No charge	20% coinsurance after deductible	Limited to one pair of glasses every 12 months through EyeMed Vision Care. Limited collection of frames.
	Dental check-up	Covered through Delta Dental of MA	Covered through Delta Dental of MA	Coverage includes preventative and diagnostic services (e.g. x-rays and periodic oral exams), basic covered services (e.g. extractions), major restorative services and medically necessary orthodontia. Covered for children under age 19.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for details on these exclusions and for a list of other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Long-term care/custodial care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Treatment that is experimental or investigational, for educational or developmental purposes, or does not meet Tufts Health Plan Medical Necessity Guidelines (with limited exceptions specified in your plan document)

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.) Please note: certain coverage limits and other requirements may apply.

- Bariatric surgery
- Chiropractic care (spinal manipulation)
- Hearing Aids (age 21 or younger only)
- Infertility treatment
- Routine eye care (Adult)
- Weight loss programs

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 800-462-0224. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Tufts Health Plan Member Services at 800-462-0224. Or you may write to us at Tufts Health Plan, Appeals and Grievances Department, 705 Mt. Auburn St., P.O. Box 9193, Watertown, MA 02471-9193.

Other contact information: Department of Labor's Employee Benefits Security Administration, 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform

Consumer Assistance Resource
If you need help, the consumer assistance programs in Massachusetts or Rhode Island can help you file your appeal.

Massachusetts	Rhode Island
Contact: Health Care for All	Contact: Rhode Island Department of Business Regulation
30 Winter Street, Suite 1004	1511 Pontiac Avenue, Bldg. 69-2
Boston, MA 02108	Cranston, RI 02920
(800) 272-4232	(401) 462-9520
http://www.hcfama.org/helpline	www.dbr.state.ri.us and www.ohic.ri.gov

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 800-462-0224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-462-0224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 800-462-0224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-462-0224.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays: $6,640**
- **Patient pays: $900**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$400
Coinsurance	$0
Limits or exclusions	$0
Total	**$900**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays: $2,520**
- **Patient pays: $2,880**

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5400**

Patient pays:

Deductibles	$200
Copays	$2,600
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,880**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from participating **providers**. If the patient had received care from non-participating **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

ADDENDUM

DISCRIMINATION IS AGAINST THE LAW

Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Tufts Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Tufts Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Tufts Health Plan at 800-462-0224.

If you believe that Tufts Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Tufts Health Plan, Attention:

Civil Rights Coordinator Legal Dept.
705 Mt. Auburn St. Watertown, MA 02472
Phone: 888-880-8699 ext. 48000, [TTY number — 800-439-2370 ext. 711]
Fax: 617-972-9048, Email: OCRCoordinator@tufts-health.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Tufts Health Plan Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

For no cost translation in English, call the number on the top of page 1.

Arabic للحصول على خدمة الترجمة المجانية باللغة العربية، يرجى الاتصال على الرقم المدون بالجزء العلوي من الصفحة رقم 1

Chinese 若需免費的中文版本，請撥打第 1 頁頂端的電話號碼。

French Pour demander une traduction gratuite en français, composez le numéro indiqué en haut de la page 1.

German Um eine kostenlose deutsche Übersetzung zu erhalten, rufen Sie bitte die Telefonnummer oben auf Seite 1 an.

Greek Για δωρεάν μετάφραση στα Ελληνικά, καλέστε τον αριθμό που αναγράφεται στην κορυφή της σελίδας 1.

Haitian Creole Pou jwenn tradiksyon gratis nan lang Kreyòl Ayisyen, rele nimewo ki sou kat ID ou.

Italian Per la traduzione in italiano senza costi aggiuntivi, è possibile chiamare il numero indicato nella parte superiore di pagina 1.

Japanese 日本語の無料翻訳については 1 ページ目の一番上にある番号に電話してください。

Khmer **សម្រាប់សេវាបកប្រែដោយឥតគិតថ្លៃជាភាសាខ្មែរសូមទូរស័ព្ទទៅកាន់លេខដែលនៅផ្នែកខាងលើនៃទំព័រទី 1។**

Korean 한국어 무료 통역을 원하시면, 1 페이지 맨 위에 번호로 전화 하십시오.

Laotian ສໍາລັບການແປເປັນພາສາລາວທີ່ບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີໂທທີ່ຢູ່ດ້ານເທິງຂອງໜ້າທີ 1.

Navajo Doo bą́ąh ilíní da Diné k'ehjí álnéehgo, hodiilnih béésh bee haní'é binumber díí naaltsoos bikáá' wódahdi.

Persian **برای ترجمه رایگان به فارسی، به شماره تلفن مندرج در بالای صفحه 1 زنگ بزنی د**

Polish Aby uzyskać bezpłatne tłumaczenie w języku polskim, należy zadzwonić na numer zamieszczony u góry strony 1.

Portuguese Para tradução grátis para português, ligue para o número no topo da página 1.

Russian Для получения услуг бесплатного перевода на русский язык позвоните по номеру, указанному сверху на стр. 1.

Spanish Por servicio de traducción gratuito en español, llame al número indicado en la parte superior de la página 1.

Tagalog Para sa walang bayad na pagsasalin sa Tagalog, tawagan ang numero na nasa itaas ng unang pahina.

Vietnamese Để có bản dịch tiếng Việt không phải trả phí, gọi theo số trên đầu trang 1.

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