




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 tuftshealthplan.com or by calling 888.257.1985.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0/individual, \$0/family	See the chart starting on page 2 for your other costs for services this plan covers.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes \$3,000 individual/\$6,000 family	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 <u>out-of-pocket limit</u> ?	Premiums, balance billing, and health care this plan doesn't cover	Even though you pay these expenses, they do not count towards your 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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. Visit tuftshealthplan.com or call 888.257.1985 to learn about our provider network.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of 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 different kinds of providers .
Do I need a referral to see a <u>specialist</u> ?	You may need a referral for certain specialty services. If your PCP needs to give you a referral for certain services, your member ID card will say "PCP Referral Required."	This plan will pay some or all of the costs to see a specialist for covered services, but only if you have the plan's permission before you see the specialist .
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

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Co-payments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- Co-insurance** 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 **co-insurance** payment of 30% would be \$300. 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 only covers our **in-network providers** by charging you lower **deductibles, co-payments, and co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 co-payment/visit	Not covered	————— none —————
	Specialist visit	\$40 co-payment/visit	Not covered	Some specialty services may require prior authorization
	Preventive care/screening/immunization	No charge	Not covered	————— none —————
If you have a test	Diagnostic test (X-ray, blood work)	\$0 co-payment/visit	Not covered	Covered if medically necessary
	Imaging (CT/PET scans, MRIs)	\$150 co-payment/visit	Not covered	Requires prior authorization
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at tuftshealthplan.com	Generic drugs	\$15/\$30 co-payment (retail/mail-order prescription)	Not covered	Covers up to a 30-day supply retail; up to a 90-day supply mail-order. May need prior authorization.
	Preferred brand drugs	\$30/\$60 co-payment (retail/mail-order prescription)	Not covered	
	Nonpreferred brand drugs	\$50/\$150 co-payment (retail/mail-order prescription)	Not covered	
	Specialty drugs	\$15/\$30/\$50 co-payment (generic/preferred brand/nonpreferred brand)	Not covered	May need prior authorization.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$500 co-payment/visit	Not covered	Covered if medically necessary, at in-network outpatient facility
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	Emergency room services	\$150 co-payment/visit		Notification required within 24 hours, if admitted. Co-payment waived, if admitted.
	Emergency medical transportation	No charge		Emergency transport only; nonemergency transport covered if medically necessary and with prior authorization
	Urgent care	\$25/\$40 co-payment/visit (PCP/specialist)		Requires prior authorization if not rendered by a licensed urgent care facility
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 co-payment/visit	Not covered	Electively scheduled inpatient medical care covered according to medical necessity and subject to prior authorization. Nonemergency admissions require submission of prior authorization five business days before admission. Urgent admissions require submission for authorization within one business day of the admission.
	Physician/surgeon fee	No charge	Not covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health outpatient services	\$25 co-payment	Not covered	After 12 outpatient therapy visits per benefit year, requires prior authorization
	Mental/behavioral health inpatient services	\$500 co-payment	Not covered	Inpatient mental health and/or substance abuse services covered according to medical necessity and subject to prior authorization
	Substance use disorder outpatient services	\$25 co-payment	Not covered	_____ none _____
	Substance use disorder inpatient services	\$500 co-payment	Not covered	_____ none _____

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	Providers must submit a Prenatal Registration Form to our medical management team
	Delivery and all inpatient services	\$500 co-payment/visit	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Requires prior authorization, if daily or longer than 6 months
	Outpatient rehabilitation services	\$40 co-payment	Not covered	Maximum of 60 days total combined physical and occupational therapy per member per benefit year. No limit on speech therapy. Prior authorization required for speech, physical, and occupational therapy. Prior authorization not required for initial evaluation.
	Habilitation services	\$40 co-payment	Not covered	Maximum of 60 days total combined physical and occupational therapy per member per benefit year. No limit on speech therapy. Prior authorization required for speech, physical, and occupational therapy. Prior authorization not required for initial evaluation.
	Skilled nursing care	\$500 co-payment/visit	Not covered	Maximum of 100 calendar days total per benefit year; requires prior authorization
	Inpatient rehabilitation services	\$500 co-payment/visit	Not covered	Maximum of 60 calendar days total per benefit year; requires prior authorization
	Durable medical equipment	20% co-insurance	Not covered	May require prior authorization (see list at tuftshealthplan.com)
	Hospice service	No charge	Not covered	Requires prior authorization
If your child needs	Eye exam	\$25 co-payment	Not covered	Coverage for routine eye exams for members 18

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dental or eye care	Glasses	Covered	Not covered	years and younger once every 12 months. For members over 18 years coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics. Eye glasses covered once every 12 months for members 18 years and younger.
	Dental checkup	No co-payment	Not covered	Covered for pediatric dental checkup for members 18 years and younger

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Hearing aids for members over age 21 • Long-term care 	<ul style="list-style-type: none"> • Nonemergency dental services for members over 18 years old • Nonemergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private-duty nursing • Vocational rehabilitation

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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.)

<ul style="list-style-type: none"> • Abortion services • Acupuncture to treat substance abuse • Bariatric surgery with prior authorization • Chiropractic care 	<ul style="list-style-type: none"> • Emergency dental care (adult) • Fitness reimbursement, up to three months • Infertility treatment with prior authorization 	<ul style="list-style-type: none"> • Routine eye care (adult), limitations may apply • Routine foot care for diabetics (adult) • Weight loss programs, covered for the first three months
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Your Rights to Continue Coverage

If you have Individual health insurance:

Federal and state laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You or your employer commit fraud or intentional misrepresentations of material fact
- The insurer stops offering services in the state
- You move outside the coverage area

For more information on your rights to continue coverage, contact Tufts Health Plan at **888.257.1985** (TTY: 888.391.5535). You may also contact your state insurance department at 877.563.4467 or mass.gov/doi.

If you have Group health coverage:

Federal and state laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- Your employer/sponsor changes insurance carrier
- Your employer cancels or does not renew your coverage
- Your employment/sponsorship terminates and you are not eligible to continue coverage under COBRA or state law

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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 **888.257.1985**
- U.S. Department of Labor's Employee Benefits Security Administration at **866.444.EBSA (3472)** or **dol.gov/ebsa/healthreform**
- Massachusetts Division of Insurance at **617.521.7777**

Language Access Services:

Para obtener asistencia en español, llame al **888.257.1985**.

We offer translation services in more than 200 languages. For assistance in another language, please call us at **888.257.1985**.

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.**

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

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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 \$7,040**
- **Patient pays \$500**

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	\$0
Co-payments	\$500
Co-insurance	\$0
Limits or exclusions	\$0
Total	\$500

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact **888.257.1985**.

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

- **Amount owed to providers: \$5,400**
- **Plan pays \$3,720**
- **Patient pays \$1,680**

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	\$5,400

Patient pays:

Deductibles	\$0
Co-payments	\$1,600
Co-insurance	\$0
Limits or exclusions	\$80
Total	\$1,680

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact **888.257.1985**.

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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 pre-existing 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 in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance 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 co-payments, deductibles, and co-insurance. 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.

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