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?	**$2,000**/individual, **$4,000**/family	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 1). 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, $0 pharmacy deductible	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 out-of-pocket limit on my expenses?	Yes **$7,150** individual/**$14,300** 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 out-of-pocket limit?	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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	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 specialist?	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**.

- **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	$30 co-payment/visit	Not covered	——— none ———
	Specialist visit	$50 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)	$25 co-payment/visit (after deductible)	Not covered	Covered if medically necessary
	Imaging (CT/PET scans, MRIs)	$500 co-payment/visit (after deductible)	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	$20/$40 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 require prior authorization.
	Preferred brand drugs	$60/$120 co-payment (retail/ mail-order prescription)	Not covered	
	Nonpreferred brand drugs	$90/$270 co-payment (retail/ mail-order prescription)	Not covered	
	Specialty drugs	$20/$50/$75 co-payment (generic/preferred brand/ nonpreferred brand)	Not covered	May require prior authorization.

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)	$750 co-payment/visit (after deductible)	Not covered	Covered if medically necessary, at in-network outpatient facility
	Physician/surgeon fees	No charge (after deductible)	Not covered	
If you need immediate medical attention	Emergency room services	$700 co-payment/visit (after deductible)		Notification required within 24 hours, if admitted. Co-payment waived, if admitted.
	Emergency medical transportation	No charge (after deductible)		Emergency transport only; nonemergency transport covered if medically necessary and with prior authorization
	Urgent care	$30/$50 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)	$1,000 co-payment/visit (after deductible)	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 (after deductible)	Not covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health outpatient services	$30 co-payment	Not covered	After 12 outpatient therapy visits per benefit year, requires prior authorization
	Mental/behavioral health inpatient services	$1,000 co-payment (after deductible)	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	$30 co-payment	Not covered	——— none ———
	Substance use disorder inpatient services	$1,000 co-payment (after deductible)	Not covered	——— none ———

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	$1,000 co-payment/visit (after deductible)	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge (after deductible)	Not covered	Requires prior authorization, if daily or longer than 90 days
	Outpatient rehabilitation services	$50 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	$50 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	$1,000 co-payment (after deductible)	Not covered	Maximum of 100 calendar days total per benefit year; requires prior authorization
	Inpatient rehabilitation services	$1,000 co-payment (after deductible)	Not covered	Maximum of 60 calendar days total per benefit year; requires prior authorization
	Durable medical equipment	20% co-insurance (after deductible)	Not covered	May require prior authorization (see list at tuftshealthplan.com)
	Hospice service	No charge (after deductible)	Not covered	Requires prior authorization
If your child needs	Eye exam	$30 co-payment	Not covered	Coverage for routine eye exams for members 18

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 (after deductible)	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 excluded services.)

- Cosmetic surgery
- Hearing aids for members over age 21
- Long-term care
- Nonemergency dental services for members over 18 years old
- Nonemergency care when traveling outside the U.S.
- Private-duty nursing
- Vocational rehabilitation

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.)

- Abortion services
- Acupuncture to treat substance abuse
- Bariatric surgery with prior authorization
- Chiropractic care
- Emergency dental care (adult)
- Fitness reimbursement, up to three months
- Infertility treatment with prior authorization
- Routine eye care (adult), limitations may apply
- Routine foot care for diabetics (adult)
- Weight loss programs, covered for the first three months

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

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.

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.

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** $4,540
- **Patient pays** $3,000

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	$2,000
Co-payments	$1,000
Co-insurance	$0
Limits or exclusions	$0
Total	**$3,000**

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** $2,720
- **Patient pays** $2,680

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	$200
Co-payments	$2,400
Co-insurance	$0
Limits or exclusions	$80
Total	**$2,680**

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**.

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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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 888.257.1985.

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 Mount Auburn St.
Watertown, MA 02472
Phone: 888.880.8699 ext. 48000, [TTY number— 711 or 800.439.2370]
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
Phone: 800.368.1019, 800.537.7697 (TDD)

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

tuftshealthplan.com | 888.257.1985

For no-cost translation in English, call **888.257.1985**.

Arabic 888-257-1985 للحصول على خدمة الترجمة المجانية باللغة العربية، يرجى الاتصال على الرقم

Chinese 若需免費的中文版本，請撥打 **888.257.1985**。

French Pour demander une traduction gratuite en français, composez le **888.257.1985**.

German Um eine kostenlose deutsche Übersetzung zu erhalten, rufen Sie bitte die folgende Telefonnummer an: **888.257.1985**.

Greek Για δωρεάν μετάφραση στα ελληνικά, καλέστε στο **888.257.1985**.

Haitian Creole Pou tradiksyon gratis nan Kreyòl Ayisyen, rele **888.257.1985**.

Italian Per la traduzione in italiano senza costi aggiuntivi, è possibile chiamare il numero **888.257.1985**.

Japanese 日本語の無料翻訳については **888.257.1985** に電話してください。

Khmer (Cambodian) សម្រាប់សេវាបកប្រែដោយឥតគិតថ្លៃជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 888.257.1985។

Korean 한국어로 무료 통역을 원하시면, **888.257.1985** 로 전화하십시오.

Laotian ສໍາລັບການແປພາສາເປັນພາສາລາວທີ່ບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີ **888.257.1985**.

Navajo Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **888.257.1985**.

Persian برای ترجمه رایگان به فارسی به شماره تلفن 888.257.1985 زنگ بزنید.

Polish Aby uzyskać bezpłatne tłumaczenie w języku polskim, należy zadzwonić na numer **888.257.1985**.

Portuguese Para tradução grátis para português, ligue para o número **888.257.1985**.

Russian Для получения услуг бесплатного перевода на русский язык позвоните по номеру **888.257.1985**.

Spanish Para servicio de traducción gratuito en español, llame al **888.257.1985**.

Tagalog Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **888.257.1985**.

Vietnamese Để có bản dịch tiếng Việt không phải trả phí, gọi theo số **888.257.1985**.