TUFTS Health Plan

This is a Massachusetts Large Group 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-lg or by calling 800-462-0224.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$750 person/$1,500 family 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?	No, there are no other specific deductibles.	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, $1,500 person/$3,000 family for medical and pharmacy 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 participating 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 a participating doctor or other health care **providers**, this plan will pay some or all of the costs for covered services. Be aware, your participating doctor or hospital may use a non-participating **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?	Yes	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 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 a non-participating **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-participating 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 a participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

		Your cost if you use a		
Common Medical Event	**Services You May Need**	**Participating Provider**	**Non-participating 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	$20 copay/visit	Not covered	———— none ————
	Specialist visit	$30 copay/visit	Not covered	———— none ————
	Other practitioner office visit	Deductible for chiropractor	Not covered	Spinal manipulations limited to 12 visits per year.
	Preventive care/screening/immunization	No charge	Not covered	———— none ————
If you have a test	Diagnostic test (x-ray, blood work)	Deductible	Not covered	———— none ————
	Imaging (CT/PET scans, MRIs)	Deductible	Not covered	———— none ————

		Your cost if you use a		
Common Medical Event	**Services You May Need**	**Participating Provider**	**Non-participating Provider**	**Limitations & Exceptions (limits apply per coverage period)**
If you need drugs to treat your illness or condition	Tier 1 - Generic drugs	$15 copay/prescription (retail); $30 copay/prescription (mail order)	Not covered	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	$35 copay/prescription (retail); $70 copay/prescription (mail order)		
	Tier 3 - Non-preferred brand drugs	$60 copay/prescription (retail); $120 copay/prescription (mail order)		
More Information about prescription drug coverage is available at www.tuftshealthplan.com **This is a Massachusetts Large Group Plan**	Specialty drugs	Limited to a 30-day supply with appropriate tier copay (see above) when purchased at a designated specialty pharmacy	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)	Deductible	Not covered	Some surgeries require prior authorization in order to be covered.
	Physician/surgeon fees	Deductible	Not covered	

		Your cost if you use a		
Common Medical Event	**Services You May Need**	**Participating Provider**	**Non-participating Provider**	**Limitations & Exceptions (limits apply per coverage period)**
If you need immediate medical attention	Emergency room services	$100 copay/visit		Copay waived if admitted.
	Emergency medical transportation	Deductible		Some emergency transportation requires prior authorization to be covered
	Urgent care	$20 copay/visit for PCP $30 copay/visit for specialist		Services with non-participating providers are only covered out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible	Not covered	Some hospitalizations require prior authorization to be covered.
	Physician/surgeon fee	Deductible	Not covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay/visit	Not covered	Prior authorization may be required.
	Mental/Behavioral health inpatient services	Deductible	Not covered	Prior authorization may be required.

		Your cost if you use a		
Common Medical Event	**Services You May Need**	**Participating Provider**	**Non-participating Provider**	**Limitations & Exceptions (limits apply per coverage period)**
If you have mental health, behavioral health, or substance abuse needs	Substance use disorder outpatient services	$20 copay/visit	Not covered	Prior authorization may be required.
	Substance use disorder inpatient services	Deductible	Not covered	Prior authorization may be required.
If you are pregnant	Prenatal and postnatal care	No charge for routine outpatient office visits	Not covered	———— none ————
	Delivery and all inpatient services	Deductible	Not covered	———— none ————
If you need help recovering or have other special health needs	Home health care	Deductible	Not covered	Prior authorization may be required.
	Rehabilitation services	Deductible	Not covered	Short-term physical and occupational therapy limited to 30 visits for each type of service per year. Prior authorization may be required.
	Habilitation services	Deductible	Not covered	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	Not covered	Limited to 100 days per year. Prior authorization is required.

		Your cost if you use a		
Common Medical Event	**Services You May Need**	**Participating Provider**	**Non-participating Provider**	**Limitations & Exceptions (limits apply per coverage period)**
If you need help recovering or have other special health needs	Durable medical equipment	30% coinsurance	Not covered	Prior authorization may be required.
	Hospice service	Deductible	Not covered	Prior authorization may be required.
If your child needs dental or eye care	Eye exam	$20 copay/visit	Not covered	Limited to one visit every 24 months with an EyeMed vision care provider.
	Glasses	Not covered	Not covered	Discounts may apply through EyeMed Vision Care.
	Dental check-up	Not covered	Not covered	———— none ————

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) - same schedule as child eye exam
- 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: $6,750**
- **Patient pays: $790**

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	$750
Copays	$40
Coinsurance	$0
Limits or exclusions	$0
Total	**$790**

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

- **Amount owed to providers: $5,400**
- **Plan pays: $3,890**
- **Patient pays: $1,510**

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	$100
Copays	$1,300
Coinsurance	$30
Limits or exclusions	$80
Total	**$1,510**

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.

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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-lg or by calling 800-462-0224.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$3,000 person/$6,000 family medical and pharmacy 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?	No, there are no other specific deductibles.	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, $6,350 person/$12,700 family for medical and pharmacy 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 participating 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 a participating doctor or other health care **providers**, this plan will pay some or all of the costs for covered services. Be aware, your participating doctor or hospital may use a non-participating **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?	Yes	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 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 a non-participating **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-participating 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 a participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

		Your cost if you use a		
Common Medical Event	**Services You May Need**	**Participating Provider**	**Non-participating 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% coinsurance after deductible	Not covered	———— none ————
	Specialist visit	35% coinsurance after deductible	Not covered	———— none ————
	Other practitioner office visit	35% coinsurance after deductible for chiropractor	Not covered	Spinal manipulations limited to 12 visits per year.
	Preventive care/screening/immunization	No charge	Not covered	———— none ————
If you have a test	Diagnostic test (x-ray, blood work)	35% coinsurance after deductible	Not covered	———— none ————
	Imaging (CT/PET scans, MRIs)	35% coinsurance after deductible	Not covered	———— none ————

		Your cost if you use a		
Common Medical Event	**Services You May Need**	**Participating Provider**	**Non-participating Provider**	**Limitations & Exceptions (limits apply per coverage period)**
If you need drugs to treat your illness or condition	Tier 1 - Generic drugs	$15 copay/prescription (retail); $30 copay/prescription (mail order); after deductible	Not covered	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	$25 copay/prescription (retail); $50 copay/prescription (mail order); after deductible		
	Tier 3 - Non-preferred brand drugs	$40 copay/prescription (retail); $80 copay/prescription (mail order); after deductible		
More Information about prescription drug coverage is available at www.tuftshealthplan.com **This is a Massachusetts Large Group Plan**	Specialty drugs	Limited to a 30-day supply with appropriate tier copay (see above) when purchased at a designated specialty pharmacy	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)	35% coinsurance after deductible	Not covered	Some surgeries require prior authorization in order to be covered.
	Physician/surgeon fees	35% coinsurance after deductible	Not covered	

		Your cost if you use a		
Common Medical Event	**Services You May Need**	**Participating Provider**	**Non-participating Provider**	**Limitations & Exceptions (limits apply per coverage period)**
If you need immediate medical attention	Emergency room services	35% coinsurance after deductible		———— none ————
	Emergency medical transportation	35% coinsurance after deductible		Some emergency transportation requires prior authorization to be covered
	Urgent care	35% coinsurance after deductible		Services with non-participating providers are only covered out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	35% coinsurance after deductible	Not covered	Some hospitalizations require prior authorization to be covered.
	Physician/surgeon fee	35% coinsurance after deductible	Not covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	35% coinsurance after deductible	Not covered	Prior authorization may be required.
	Mental/Behavioral health inpatient services	35% coinsurance after deductible	Not covered	Prior authorization may be required.

		Your cost if you use a		
Common Medical Event	**Services You May Need**	**Participating Provider**	**Non-participating 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% coinsurance after deductible	Not covered	Prior authorization may be required.
	Substance use disorder inpatient services	35% coinsurance after deductible	Not covered	Prior authorization may be required.
If you are pregnant	Prenatal and postnatal care	No charge for routine outpatient office visits	Not covered	———— none ————
	Delivery and all inpatient services	35% coinsurance after deductible	Not covered	———— none ————
If you need help recovering or have other special health needs	Home health care	35% coinsurance after deductible	Not covered	Prior authorization may be required.
	Rehabilitation services	35% coinsurance after deductible	Not covered	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% coinsurance after deductible	Not covered	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	35% coinsurance after deductible	Not covered	Limited to 100 days per year. Prior authorization is required.

		Your cost if you use a		
Common Medical Event	**Services You May Need**	**Participating Provider**	**Non-participating 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	Not covered	Prior authorization may be required.
	Hospice service	35% coinsurance after deductible	Not covered	Prior authorization may be required.
If your child needs dental or eye care	Eye exam	$25 copay/visit	Not covered	Limited to one visit every 24 months with an EyeMed vision care provider.
	Glasses	Not covered	Not covered	Discounts may apply through EyeMed Vision Care.
	Dental check-up	Not covered	Not covered	———— none ————

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) - same schedule as child eye exam
- 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: $3,800**
- **Patient pays: $3,740**

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	$3,000
Copays	$40
Coinsurance	$700
Limits or exclusions	$0
Total	**$3,740**

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

- **Amount owed to providers: $5,400**
- **Plan pays: $1,620**
- **Patient pays: $3,780**

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	$3,000
Copays	$600
Coinsurance	$100
Limits or exclusions	$80
Total	**$3,780**

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.

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TUFTS Health Plan

This is a Massachusetts Large Group 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-lg or by calling 800-462-0224.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No, there are no other specific deductibles.	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, $6,350 person/$12,700 family for medical and pharmacy 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 participating providers, see www.tuftshealthplan.com, "find a doctor", select "HMO, POS, PPO, and EPO Basic, Value and Premium Plans" from the select a plan dropdown list, or call 800-462-0224.	If you use a participating doctor or other health care **providers**, this plan will pay some or all of the costs for covered services. Be aware, your participating doctor or hospital may use a non-participating **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?	Yes	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 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 a non-participating **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-participating 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 a participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

		Your cost if you use a		
Common Medical Event	**Services You May Need**	**Participating Provider**	**Non-participating 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	$15 copay/visit	Not covered	———— none ————
	Specialist visit	$25 copay/visit	Not covered	———— none ————
	Other practitioner office visit	$25 copay/visit for chiropractor	Not covered	Spinal manipulations limited to 12 visits per year.
	Preventive care/screening/immunization	No charge	Not covered	———— none ————
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	———— none ————
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	———— none ————

		Your cost if you use a		
Common Medical Event	**Services You May Need**	**Participating Provider**	**Non-participating Provider**	**Limitations & Exceptions (limits apply per coverage period)**
If you need drugs to treat your illness or condition	Tier 1 - Generic drugs	$10 copay/prescription (retail); $20 copay/prescription (mail order)	Not covered	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	$30 copay/prescription (retail); $60 copay/prescription (mail order)		
	Tier 3 - Non-preferred brand drugs	$50 copay/prescription (retail); $100 copay/prescription (mail order)		
More Information about prescription drug coverage is available at www.tuftshealthplan.com **This is a Massachusetts Large Group Plan**	Specialty drugs	Limited to a 30-day supply with appropriate tier copay (see above) when purchased at a designated specialty pharmacy	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)	$350 copay/visit	Not covered	Some surgeries require prior authorization in order to be covered.
	Physician/surgeon fees	No charge	Not covered	

		Your cost if you use a		
Common Medical Event	**Services You May Need**	**Participating Provider**	**Non-participating Provider**	**Limitations & Exceptions (limits apply per coverage period)**
If you need immediate medical attention	Emergency room services	$100 copay/visit		Copay waived if admitted.
	Emergency medical transportation	No charge		Some emergency transportation requires prior authorization to be covered
	Urgent care	$15 copay/visit for PCP $25 copay/visit for specialist		Services with non-participating providers are only covered out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	$350 copay/admission	Not covered	Some hospitalizations require prior authorization to be covered.
	Physician/surgeon fee	No charge	Not covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 copay/visit	Not covered	Prior authorization may be required.
	Mental/Behavioral health inpatient services	$350 copay/admission	Not covered	Prior authorization may be required.

		Your cost if you use a		
Common Medical Event	**Services You May Need**	**Participating Provider**	**Non-participating Provider**	**Limitations & Exceptions (limits apply per coverage period)**
If you have mental health, behavioral health, or substance abuse needs	Substance use disorder outpatient services	$15 copay/visit	Not covered	Prior authorization may be required.
	Substance use disorder inpatient services	$350 copay/admission	Not covered	Prior authorization may be required.
If you are pregnant	Prenatal and postnatal care	No charge for routine outpatient office visits	Not covered	———— none ————
	Delivery and all inpatient services	$350 copay/admission	Not covered	———— none ————
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Prior authorization may be required.
	Rehabilitation services	$25 copay/visit	Not covered	Short-term physical and occupational therapy limited to 30 visits for each type of service per year. Prior authorization may be required.
	Habilitation services	$25 copay/visit	Not covered	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	No charge	Not covered	Limited to 100 days per year. Prior authorization is required.

		Your cost if you use a		
Common Medical Event	**Services You May Need**	**Participating Provider**	**Non-participating Provider**	**Limitations & Exceptions (limits apply per coverage period)**
If you need help recovering or have other special health needs	Durable medical equipment	30% coinsurance	Not covered	Prior authorization may be required.
	Hospice service	No charge	Not covered	Prior authorization may be required.
If your child needs dental or eye care	Eye exam	$15 copay/visit	Not covered	Limited to one visit every 24 months with an EyeMed vision care provider.
	Glasses	Not covered	Not covered	Discounts may apply through EyeMed Vision Care.
	Dental check-up	Not covered	Not covered	———— none ————

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) - same schedule as child eye exam
- 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.**

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(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays: $7,140**
- **Patient pays: $400**

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
Copays	$400
Coinsurance	$0
Limits or exclusions	$0
Total	**$400**

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

- **Amount owed to providers: $5,400**
- **Plan pays: $3,990**
- **Patient pays: $1,410**

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	$0
Copays	$1,300
Coinsurance	$30
Limits or exclusions	$80
Total	**$1,410**

Questions and answers about the Coverage Examples:

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