



**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](http://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](http://www.mass.gov/doi).



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, see <https://www.tuftshealthplan.com> or call 800-462-0224. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 800-462-0224 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable	This plan does not have a deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	\$2,000 individual/\$4,000 family for medical expenses; \$3,000 individual/\$6,000 family for pharmacy expenses.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
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.
Will you pay less if you use a network provider?	Yes. See <a href="https://www.tuftshealthplan.com">https://www.tuftshealthplan.com</a> , "Find a doctor, hospital..." or call 800-462-0224 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you 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 a referral before you see the specialist.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-participating Provider (You will pay the most)	
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit	Not covered	None
	<u>Specialist</u> visit	\$35 <u>copay</u> /visit	Not covered	Prior authorization may be required.
	<u>Preventive care/ screening/ immunization</u>	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	Prior authorization may be required.
	Imaging (CT/PET scans, MRIs)	\$100 <u>copay</u> /visit	Not covered	Prior authorization is required.
If you need drugs to treat your illness or condition	Tier 1 - Generic drugs	\$10 <u>copay</u> /fill (retail); \$20 <u>copay</u> /fill (mail order)	Not covered	Retail <u>cost share</u> is for up to a 30-day supply; mail order <u>cost share</u> 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 <u>copay</u> /fill (retail); \$50 <u>copay</u> /fill (mail order)		
	Tier 3 - Non-preferred brand drugs	\$50 <u>copay</u> /fill (retail); \$110 <u>copay</u> /fill (mail order)		
More information about <u>prescription drug coverage</u> is available at <a href="http://www.tuftshealthplan.com">www.tuftshealthplan.com</a> <b>This is a Massachusetts Large Group Plan</b>	<u>Specialty drugs</u>	Limited to a 30-day supply with appropriate tier <u>copay</u> (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 <u>specialty drugs</u> may also be covered under your medical benefit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 <u>copay</u> /visit	Not covered	Some surgeries require prior authorization in order to be covered.
	Physician/surgeon fees	No charge	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-participating Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> /visit		<u>Cost share</u> waived if admitted.
	<u>Emergency medical transportation</u>	No charge		Some <u>emergency transportation</u> requires prior authorization to be covered
	<u>Urgent care</u>	<u>Urgent Care Center</u> (non-hospital) - \$35 <u>copay</u> /visit PCP - \$20 <u>copay</u> /visit Specialist - \$35 <u>copay</u> /visit		Services with <u>non-participating providers</u> are only covered out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 <u>copay</u> /admission	Not covered	Some <u>hospitalizations</u> require prior authorization to be covered.
	Physician/surgeon fees	No charge	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copay</u> /visit	Not covered	Prior authorization may be required.
	Inpatient services	\$500 <u>copay</u> /admission	Not covered	
If you are pregnant	Office Visits	\$20 <u>copay</u> /visit	Not covered	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	\$500 <u>copay</u> /admission	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-participating Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	Not covered	Prior authorization is required.
	<u>Rehabilitation services</u>	\$35 <u>copay</u> /visit	Not covered	Short-term physical and occupational therapy limited to 30 visits for each type of service per year. No set limit on speech therapy. Prior authorization may be required.
	<u>Habilitation services</u>	\$35 <u>copay</u> /visit	Not covered	Short-term physical and occupational therapy limited to 30 visits for each type of service per year. No set limit on speech therapy. Prior authorization may be required.
	<u>Skilled nursing care</u>	No charge	Not covered	Limited to 100 days per year. Prior authorization is required.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	Not covered	Prior authorization may be required.
	<u>Hospice services</u>	No charge	Not covered	Prior authorization is required.
If your child needs dental or eye care	Children's eye exam	\$20 <u>copay</u> /visit	Not covered	Limited to one visit every 12 months with an EyeMed vision care <u>provider</u> .
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

#### Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any 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)
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

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

**Your Rights to Continue Coverage:**

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/healthreform>. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit <https://www.HealthCare.gov> or call 1-800-318-2596. If you are a Massachusetts resident, contact the Massachusetts Health Connector at <https://www.mahealthconnector.org>.

**Your Grievance and Appeals Rights:**

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, 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 or contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/healthreform>. Additionally, a consumer assistance program can help you file your appeal. Contact: MA: Health Care for All, One Federal Street, Boston, MA 02110, 1-800-272-4232, <https://www.massconsumerassistance.org>.

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**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, kwijigo 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:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$35
■ <u>Hospital (facility) copayment</u>	\$500
■ <u>Plan coinsurance</u>	0%

**This EXAMPLE event includes services like:**

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$0

*What isn't covered*

Limits or exclusions	\$0
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<b>The total Peg would pay is</b>	<b>\$500</b>
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### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$35
■ <u>Hospital (facility) copayment</u>	\$500
■ <u>Plan coinsurance</u>	0%

**This EXAMPLE event includes services like:**

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,300</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,500
Coinsurance	\$20

*What isn't covered*

Limits or exclusions	\$50
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<b>The total Joe would pay is</b>	<b>\$1,570</b>
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### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$35
■ <u>Hospital (facility) copayment</u>	\$500
■ <u>Plan coinsurance</u>	0%

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$400
Coinsurance	\$50

*What isn't covered*

Limits or exclusions	\$0
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<b>The total Mia would pay is</b>	<b>\$450</b>
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The plan would be responsible for the other costs of these EXAMPLE covered services.