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/doc-links-sg or call 800-682-8059. 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 800-682-8059 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$250 individual/$500 family in-network medical deductible; $2,000 individual/$4,000 family out-of-network medical deductible.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care, primary care, specialist care, diagnostic test, emergency room services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $50/individual out-of-network pediatric dental deductible.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$2,000 individual/$4,000 family for in-network medical, pharmacy, and pediatric dental expenses; $6,000 individual/$12,000 family out-of-network medical 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 https://www.tuftshealthplan.com, "Find a doctor, hospital…" or call 800-682-8059 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?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

		What You Will Pay		
Common Medical Event	**Services You May Need**	**In-network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit; deductible does not apply	20% coinsurance	None
	Specialist visit	$25 copay/visit; deductible does not apply	20% coinsurance	Prior authorization may be required.
	Preventive care/ screening/ immunization	No charge; deductible does not apply	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge; deductible does not apply	20% coinsurance	Prior authorization may be required.
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	Prior authorization is required.
If you need drugs to treat your illness or condition	Tier 1 - Generic drugs	$25 copay/fill or $5/fill for low cost generic drugs (retail); $50 copay/fill or $10/fill for low cost generic drugs (mail order); deductible does not apply	Reimbursable at in network level	Retail cost share is for up to a 30-day supply; mail order cost share is for up to a 90-day supply. Some drugs require prior authorization to be covered. Some drugs have quantity limitations.
	Tier 2 - Preferred brand and some generic drugs	$35 copay/fill (retail); $105 copay/fill (mail order); deductible does not apply		
	Tier 3 - Non-preferred brand drugs	$65 copay/fill (retail); $195 copay/fill (mail order); deductible does not apply		
More information about prescription drug coverage is available at www.tuftshealthplan.com by selecting the Rhode Island Individual and Small Group Drug List	Specialty drugs	Tier 1-$25 copay/fill; deductible does not apply Tier 2-$35 copay/fill; deductible does not apply Tier 3-$65 copay/fill; deductible does not apply Tier 4-$100 copay/fill; deductible does not apply	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.

		What You Will Pay		
Common Medical Event	**Services You May Need**	**In-network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	Some surgeries require prior authorization in order to be covered.
	Physician/surgeon fees	No charge	20% coinsurance	
If you need immediate medical attention	Emergency room care	$100 copay/visit; deductible does not apply		Copay waived if admitted.
	Emergency medical transportation	$50 copay/trip		Some emergency transportation requires prior authorization to be covered
	Urgent care	Urgent Care Center (non-hospital) - $50 copay/visit; deductible does not apply PCP - $25 copay/visit; deductible does not apply Specialist - $25 copay/visit; deductible does not apply		Services with out-of-network providers inside the service area are covered subject to deductible and coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 copay/admission	20% coinsurance	Some hospitalizations require prior authorization to be covered.
	Physician/surgeon fees	No charge	20% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit; deductible does not apply	20% coinsurance	Prior authorization may be required.
	Inpatient services	$150 copay/admission	20% coinsurance	
If you are pregnant	Office Visits	$25 copay/visit; deductible does not apply	20% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	$150 copay/admission	20% coinsurance	

		What You Will Pay		
Common Medical Event	**Services You May Need**	**In-network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Prior authorization is required.
	Rehabilitation services	$40 copay/visit; deductible does not apply	20% coinsurance	Short-term physical therapy limited to 30 visits, occupational therapy limited to 30 visits and speech therapy limited to 30 visits for per year. Prior authorization may be required.
	Habilitation services	$40 copay/visit; deductible does not apply	20% coinsurance	Short-term physical therapy limited to 30 visits, occupational therapy limited to 30 visits and speech therapy limited to 30 visits for per year. Prior authorization may be required.
	Skilled nursing care	No charge	20% coinsurance	Limited to 100 days per year. Prior authorization is required.
	Durable medical equipment	30% coinsurance	30% coinsurance	Prior authorization may be required.
	Hospice services	No charge	20% coinsurance	Prior authorization is required.
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply	20% coinsurance	Limited to one visit every 12 months with an EyeMed vision care provider.
	Children's glasses	No charge; deductible does not apply	20% coinsurance	Limited to one pair of glasses every 12 months through EyeMed Vision Care. Limited collection of frames.
	Children's dental check-up	Covered through DentaQuest	Covered through DentaQuest	Coverage includes preventive and diagnostic services (e.g. x-rays and periodic oral exams), basic covered services (e.g. extractions), major restorative services and medically necessary orthodontia. Covered for children under age 19.

Excluded Services & Other Covered Services:

Services Your Plan 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
- Chiropractic care (spinal manipulation)
- Hearing Aids (children and adults)
- Infertility treatment
- Routine eye care (Adult)

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 and RIREACH, 1210 Pontiac Ave., Cranston, RI 02920, 855-747-3224, rireach@ripin.org. 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 800-682-8059. 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 ; or RIREACH, 1210 Pontiac Ave., Cranston, RI 02920, 855-747-3224, rireach@ripin.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 800-682-8059.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-682-8059.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 800-682-8059.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-682-8059.

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 plan's overall deductible	$250
Specialist copayment	$25
Hospital (facility) copayment	$150
Plan coinsurance	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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$450**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$250
Specialist copayment	$25
Hospital (facility) copayment	$150
Plan coinsurance	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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$70
Copayments	$1,900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,030**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$250
Specialist copayment	$25
Hospital (facility) copayment	$150
Plan coinsurance	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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$400
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$710**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

ADDENDUM

DISCRIMINATION IS AGAINST THE LAW

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

Tufts Health Plan:

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

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

If you need these services, contact Tufts Health Plan at 800-682-8059.

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

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

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

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

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

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

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

Chinese 若需免費的中文版本，請撥打第 1 頁頂端的電話號碼。

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

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

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

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

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

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

Khmer **សម្រាប់សេវាបកប្រែដោយឥតគិតថ្លៃជាភាសាខ្មែរសូមទូរស័ព្ទទៅកាន់លេខដែលនៅផ្នែកខាងលើនៃទំព័រទី1។**

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

Laotian ສໍາລັບການແປພາສາລາວທີ່ບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີໂທທີ່ຢູ່ດ້ານເທິງຂອງໜ້າທີ 1.

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

Persian **برای ترجمه رایگان به فارسی، به شماره تلفن مندرج در بالای صفحه1زنگ بزنی د**

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

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

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

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

Tagalog Para sa walang bayad na pagsasalin sa Tagalog, tawagan ang numero na nasa itaas ng unang pahina 1.

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