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 800-462-0224. 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?	$1,000 individual/$2,000 family medical deductible; per plan year	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. Preventive care, primary care, specialist care, emergency room care imaging, services are covered before you meet your deductibles.	This plan covers some items and services even if you haven't yet met the annual 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$7,000 individual/$14,000 family medical, pharmacy and pediatric dental expenses; per plan year	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 limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan does not 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 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.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information (limits apply per plan year)
		Participating Provider (You will pay the least)	Non-participating Provider (You will pay the most)	
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	Not covered	None.
	Specialist visit	$45 copay/visit; deductible does not apply	Not covered	Prior authorization may be required.
	Preventive care/screening/immunization	No charge; deductible does not apply	Not covered	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)	General imaging - $50 copay/visit Lab tests - $45 copay/visit	Not covered	Prior authorization may be required.
	Imaging (CT/PET scans, MRIs)	$250 copay/visit	Not covered	Prior authorization is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.tuftshealthplan.com** by selecting Massachusetts Individual and Small Group Drug List	Tier 1 - Generic drugs	$5 copay/fill for low cost generic drugs (retail), deductible does not apply; $10 copay/fill for low cost generic drugs (mail order), deductible does not apply; $25 copay/fill; deductible does not apply (retail);$50 copay/fill; deductible does not apply (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 Drugs	$60 copay/fill; deductible does not apply (retail);$120 copay/fill; deductible does not apply (mail order)	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information (limits apply per plan year)
		Participating Provider (You will pay the least)	Non-participating Provider (You will pay the most)	
	Tier 3 - Non Preferred Drugs	$90 copay/fill; deductible does not apply (retail);$270 copay/fill; deductible does not apply (mail order)	Not Covered	
	Specialty drugs	Tier 1 - $25 copay/fill; deductible does not apply (retail) Tier 2 - $60 copay/fill; deductible does not apply (retail) Tier 3 - $90 copay/fill; deductible does not apply (retail) Tier 4 - $160 copay/fill; deductible does not apply (retail)	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)	$300 copay/visit	Not covered	Some surgeries require prior authorization in order to be covered.
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	Emergency room care	$300 copay/visit; deductible does not apply		Cost share waived if admitted.
	Emergency medical transportation	$50 copay/trip		Some emergency transportation requires prior authorization to be covered.
	Urgent care	Urgent care center - $40 copay/visit; deductible does not apply PCP - $25 copay/visit; deductible does not apply Specialist - $45 copay/visit; deductible does not apply		Cost share will vary based on type of provider seen and place of service. Services with non-participating providers are only covered out of service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/admission	Not covered	Some hospitalizations require prior authorization 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 (limits apply per plan year)
		Participating Provider (You will pay the least)	Non-participating Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit; deductible does not apply	Not covered	Prior authorization may be required.
	Inpatient services	$250 copay/admission	Not covered	Prior authorization may be required.
If you are pregnant	Office visits	$25 copay/visit; deductible does not apply	Not covered	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	Not covered	
	Childbirth/delivery facility services	$250 copay/admission	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Prior authorization is required.
	Rehabilitation services	$40 copay/visit; deductible does not apply	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.
	Habilitation services	$40 copay/visit; deductible does not apply	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.
	Skilled nursing care	No charge	Not covered	Limited to 100 days per year. Prior authorization is required.
	Durable medical equipment	30% coinsurance	Not covered	Prior authorization may be required.
	Hospice services	No charge	Not covered	Prior authorization is required.
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply	Not covered	Limited to one visit every 12 months with an EyeMed vision care provider.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information (limits apply per plan year)
		Participating Provider (You will pay the least)	Non-participating Provider (You will pay the most)	
	Children's glasses	No charge; deductible does not apply	Not covered	Limited to one pair of glasses every 12 months through EyeMed Vision Care. Limited collection of frames.
	Children's dental check-up	Covered through Delta Dental of MA	Not Covered	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.)

- Cosmetic Surgery
- Non-emergency care when travelling outside the U.S.
- 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)
- Dental care (Adult)
- Private-duty nursing
- Long-term care/custodial care
- Routine foot care

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

- Acupuncture
- Hearing aids
- Weight Loss Programs
- Bariatric Surgery
- Infertility Treatment
- Chiropractic Care (spinal manipulation)
- 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 Health Policy Commission, Office of Patient Protection, Two Boylston St., 6th Fl., Boston MA 02116, (800)-436-7757 (phone), HPC-OPP@state.ma.us . 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 www.HealthCare.gov or call 1-800-318-2596. If you are a Massachusetts resident, contact the Massachusetts Health Connector at Marketplace, visit 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. Health Policy Commission, Office of Patient Protection, Two Boylston St., 6th Fl., Boston MA 02116, (800)-436-7757 (phone), HPC-OPP@state.ma.us. 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.hcfama.org.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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, kwiijigo holne' 800-462-0224.

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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	**$1,000**
Specialist copayment	**$45**
Hospital (facility) copayment	**$250**
Other 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	$1,000
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,400
The total Peg would pay is	**$2,700**

Managing Joe's type 2 Diabetes

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

The plan's overall deductible	**$1,000**
Specialist copayment	**$45**
Hospital (facility) copayment	**$250**
Other 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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,120**

Mia's Simple Fracture

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

The plan's overall deductible	**$1,000**
Specialist copayment	**$45**
Hospital (facility) copayment	**$250**
Other 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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$600
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,660**

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

ADDENDUM

This is a Massachusetts Small Group and Individual Gold 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.

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 full and equal access to covered services under the federal *Americans with Disabilities Act of 1990* and Section 504 of the federal *Rehabilitation Act of 1973*. This includes 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 any of the above services, have questions regarding any provider directory information, or would like to report an inaccuracy or network access issue, please contact Tufts Health Plan Member Services at 800.462.0024.

To report provider directory inaccuracies electronically, please visit **https://tuftshealthplan.com/find-a-doctor** and select your plan. Search or select the Provider whose information you believe needs updating and click *"Tell us if something needs to change"*. Please note that if you have complaints regarding provider directory inaccura- cies or provider network access issues, you also have the right at any time to contact the Commonwealth of Massachusetts Division of Insurance at (877) 563-4467, Option 2 or **www.mass.gov/doi**.

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 — 800.439.2370 or 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**. tuftshealthplan.com |

800.462.0224

For no cost translation in English, call the number on your ID card.

Arabic للحصول عل خدمة ال رتجمة المجانية باللغة العربية، يرج االتصال عل الرقم المدون عل بطاقة الهوية الخاصة بك .

Chinese 若需免費的中文版本，請撥打ID卡上的電話號碼。

French Pour demander une traduction gratuite en français, composez le numéro indiqué sur votre carte d'identité.

German Um eine kostenlose deutsche Übersetzung zu erhalten, rufen Sie bitte die Telefonnummer auf Ihrer Ausweiskarte an.

Greek Για δωρεάν μετάφραση στα Ελληνικά, καλέστε τον αριθμό που αναγράφεται στην αναγνωριστική κάρτα σας.

Haitian Creole Pou jwenn tradiksyon gratis nan lang kreyòl ayisyen, rele nimewo ki sou kat ID ou a.

Italian Per richiedere la traduzione in italiano senza costi aggiuntivi, chiamare il numero indicato sulla carta di identità.

Khmer (Cambodian) សម្រាប់សេវាបកប្រែដោយឥតគិតថ្លៃជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់សមាជិករបស់អ្នក។

Japanese 日本語の無料翻訳については**ID**カードに書いてある番号に電話してください。

Korean 한국어로 무료 통번역을 원하시면, ID 카드에 있는 번호로 연락하십시오.

Laotian ສຳລັບການແປພາສາເປັນພາສາລາວທີ່ບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີທີ່ຢູ່ເທິງບັດປະຈຳຕົວຂອງທ່ານ.

Navajo Doo bą́ą́h ilíní da Diné k'ehjí álnéehgo, hodiilnih béésh bee hani'é bee néé ho'dílzingo nantinígíí bikáá'.

Persian .برای ترجمه رایگانن به فاریس شماره تلفن مندرج در کارت شناسا ئ تان زنگ بزنید .

Polish Aby uzyskać bezpłatne tłumaczenie w języku polskim, należy zadzwonić na numer znajdujący się na Pana/i dowodzie tożsamości.

Portuguese Para tradução grátis para o português, ligue para o número no seu cartão de identificação.

Russian Для получения услуг бесплатного перевода на русский язык позвоните по номеру, указанному на идентификационной карточке.

Spanish Para servicios de traducción gratuitos en español, llame al número que aparece en su tarjeta de miembro.

agalog Para sa walang bayad na pagsasalin sa Tagalog, tawagan ang numero na nasa inyong ID card.

Vietnamese Để có bản dịch tiếng Việt không phải trả phí, gọi theo số trên thẻ căn cước của bạn.