



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 800-463-8080. 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 800-463-8080 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                                                                               | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$1,500 individual/\$3,000 family in- <a href="#">network</a> medical <a href="#">deductible</a> ; \$3,000 individual/\$6,000 family out-of- <a href="#">network</a> medical <a href="#">deductible</a> ; per plan year                                                               | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                                                                             |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. In-network <a href="#">preventive care</a> services are covered before you meet your <a href="#">deductibles</a> .                                                                                                                                                               | This <a href="#">plan</a> covers some items and <a href="#">services</a> even if you haven't yet met the annual <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this plan covers certain <a href="#">preventive services</a> without cost-sharing and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                                                 |
| Are there other <a href="#">deductibles</a> for specific services?              | Yes. \$50/Individual out-of-network pediatric dental <a href="#">deductible</a> .                                                                                                                                                                                                     | You must pay all of the costs for these <a href="#">services</a> up to the specific <a href="#">deductible</a> amount before this plan begins to pay for these <a href="#">services</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$8,700 individual/\$17,400 family in- <a href="#">network</a> medical, pharmacy and pediatric dental expenses; \$17,400 individual/\$34,800 family out-of- <a href="#">network</a> medical and pediatric dental expenses; per plan year                                              | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered <a href="#">services</a> . If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limit</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                                              |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this plan does not cover.                                                                                                                                                                         | Even though you pay these expenses they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="https://www.tuftshealthplan.com">https://www.tuftshealthplan.com</a> , "Find a Doctor or Hospital" and select PPO plan name (or Cigna PPO if you are on or considering an out-of-area plan), or call 800-463-8080 for a list of <a href="#">network providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some <a href="#">services</a> (such as lab work). Check with your <a href="#">provider</a> before you get <a href="#">services</a> . |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.                                                                                                                                                                                                                                                                                   | You can see the <a href="#">specialist</a> 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.

| Common Medical Event                                                                                                                                                                                                                                                           | Services You May Need                                   | What You Will Pay                                                                                                                                                                                                                                                                                                                                                                                                         |                                                    | Limitations, Exceptions, & Other Important Information<br>(limits apply per plan year)                                                                                                                                        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                |                                                         | In-network Provider<br>(You will pay the least)                                                                                                                                                                                                                                                                                                                                                                           | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                               |
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                                                                                                                                                         | Primary Care visit to treat an injury or illness        | \$40 <a href="#">copay</a> /visit                                                                                                                                                                                                                                                                                                                                                                                         | 20% <a href="#">coinsurance</a>                    | None.                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                                                                                | <a href="#">Specialist</a> visit                        | \$40 <a href="#">copay</a> /visit                                                                                                                                                                                                                                                                                                                                                                                         | 20% <a href="#">coinsurance</a>                    | <a href="#">Prior authorization</a> may be required.                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                | <a href="#">Preventive care/screening</a> /immunization | No charge; <a href="#">deductible</a> does not apply                                                                                                                                                                                                                                                                                                                                                                      | 20% <a href="#">coinsurance</a>                    | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for. |
| If you have a test                                                                                                                                                                                                                                                             | <a href="#">Diagnostic test</a> (x-ray, blood work)     | General imaging - \$75 <a href="#">copay</a> /visit<br>Lab tests - \$35 <a href="#">copay</a> /visit                                                                                                                                                                                                                                                                                                                      | 20% <a href="#">coinsurance</a>                    | <a href="#">Prior authorization</a> may be required.                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                | Imaging (CT/PET scans, MRIs)                            | \$200 <a href="#">copay</a> /visit                                                                                                                                                                                                                                                                                                                                                                                        | 20% <a href="#">coinsurance</a>                    | <a href="#">Prior authorization</a> is required.                                                                                                                                                                              |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.tuftshealthplan.com">www.tuftshealthplan.com</a> by selecting Massachusetts Individual and Small Group Drug List | Tier 1 - Generic drugs                                  | \$5 <a href="#">copay</a> /fill for low cost generic drugs (retail), <a href="#">deductible</a> does not apply;<br>\$10 <a href="#">copay</a> /fill for low cost generic drugs (mail order), <a href="#">deductible</a> does not apply;<br>\$35 <a href="#">copay</a> /fill; <a href="#">deductible</a> does not apply (retail); \$70 <a href="#">copay</a> /fill; <a href="#">deductible</a> does not apply (mail order) | Reimbursable at in <a href="#">network</a> 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 <a href="#">prior authorization</a> to be covered. Some drugs have quantity limitations.               |
|                                                                                                                                                                                                                                                                                | Tier 2 - Preferred Drugs                                | \$65 <a href="#">copay</a> /fill; <a href="#">deductible</a> does not apply (retail); \$130 <a href="#">copay</a> /fill; <a href="#">deductible</a> does not apply (mail order)                                                                                                                                                                                                                                           | Reimbursable at in <a href="#">network</a> level   |                                                                                                                                                                                                                               |

| Common Medical Event                    | Services You May Need                            | What You Will Pay                                                                                                                                                                                                                                                                                                                                                                                  |                                                    | Limitations, Exceptions, & Other Important Information<br>(limits apply per plan year)                                                                                                                                                                            |
|-----------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                         |                                                  | In-network Provider<br>(You will pay the least)                                                                                                                                                                                                                                                                                                                                                    | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                   |
|                                         | Tier 3 - Non Preferred Drugs                     | \$100 <a href="#">copay</a> /fill; <a href="#">deductible</a> does not apply (retail); \$300 <a href="#">copay</a> /fill; <a href="#">deductible</a> does not apply (mail order)                                                                                                                                                                                                                   | Reimbursable at in <a href="#">network</a> level   | Limited to a 30-day supply. Must be obtained at a designated specialty pharmacy. Some drugs require <a href="#">prior authorization</a> to be covered. Some drugs have quantity limitations. Some specialty drugs may also be covered under your medical benefit. |
|                                         | <a href="#">Specialty drugs</a>                  | Tier 1 - \$35 <a href="#">copay</a> /fill; <a href="#">deductible</a> does not apply (retail)<br>Tier 2 - \$65 <a href="#">copay</a> /fill; <a href="#">deductible</a> does not apply (retail)<br>Tier 3 - \$100 <a href="#">copay</a> /fill; <a href="#">deductible</a> does not apply (retail)<br>Tier 4 - \$160 <a href="#">copay</a> /fill; <a href="#">deductible</a> does not apply (retail) | Not covered                                        |                                                                                                                                                                                                                                                                   |
| If you have outpatient surgery          | Facility fee (e.g., ambulatory surgery center)   | \$200 <a href="#">copay</a> /visit                                                                                                                                                                                                                                                                                                                                                                 | 20% <a href="#">coinsurance</a>                    | Some surgeries require <a href="#">prior authorization</a> in order to be covered.                                                                                                                                                                                |
|                                         | Physician/surgeon fees                           | No charge                                                                                                                                                                                                                                                                                                                                                                                          | 20% <a href="#">coinsurance</a>                    |                                                                                                                                                                                                                                                                   |
| If you need immediate medical attention | <a href="#">Emergency room care</a>              | \$300 <a href="#">copay</a> /visit                                                                                                                                                                                                                                                                                                                                                                 |                                                    | Cost share waived if admitted.                                                                                                                                                                                                                                    |
|                                         | <a href="#">Emergency medical transportation</a> | \$50 <a href="#">copay</a> /trip                                                                                                                                                                                                                                                                                                                                                                   |                                                    | Some emergency transportation requires <a href="#">prior authorization</a> to be covered.                                                                                                                                                                         |
|                                         | <a href="#">Urgent care</a>                      | Urgent care center - \$40 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply<br>PCP - \$40 <a href="#">copay</a> /visit<br>Specialist - \$40 <a href="#">copay</a> /visit                                                                                                                                                                                                     |                                                    | Cost share will vary based on type of <a href="#">provider</a> seen and place of service. Services with out-of-network providers in MA, RI and NH are covered subject to <a href="#">deductible</a> and <a href="#">coinsurance</a> .                             |
| If you have a hospital stay             | Facility fee (e.g., hospital room)               | \$250 <a href="#">copay</a> /admission                                                                                                                                                                                                                                                                                                                                                             | 20% <a href="#">coinsurance</a>                    | Some <a href="#">hospitalizations</a> require <a href="#">prior authorization</a> to be covered.                                                                                                                                                                  |
|                                         | Physician/surgeon fees                           | No charge                                                                                                                                                                                                                                                                                                                                                                                          | 20% <a href="#">coinsurance</a>                    |                                                                                                                                                                                                                                                                   |

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                                    |                                                    | Limitations, Exceptions, & Other Important Information<br>(limits apply per plan year)                                                                                                                                                                                                                             |
|---------------------------------------------------------------------------|-------------------------------------------|------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | In-network Provider<br>(You will pay the least)      | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                    |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | \$40 <a href="#">copay</a> /visit                    | 20% <a href="#">coinsurance</a>                    | <a href="#">Prior authorization</a> may be required.                                                                                                                                                                                                                                                               |
|                                                                           | Inpatient services                        | \$250 <a href="#">copay</a> /admission               | 20% <a href="#">coinsurance</a>                    | <a href="#">Prior authorization</a> may be required.                                                                                                                                                                                                                                                               |
| If you are pregnant                                                       | Office visits                             | \$40 <a href="#">copay</a> /visit                    | 20% <a href="#">coinsurance</a>                    | Cost sharing does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|                                                                           | Childbirth/delivery professional services | No charge                                            | 20% <a href="#">coinsurance</a>                    |                                                                                                                                                                                                                                                                                                                    |
|                                                                           | Childbirth/delivery facility services     | \$250 <a href="#">copay</a> /admission               | 20% <a href="#">coinsurance</a>                    |                                                                                                                                                                                                                                                                                                                    |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>          | No charge                                            | 20% <a href="#">coinsurance</a>                    | <a href="#">Prior authorization</a> is required.                                                                                                                                                                                                                                                                   |
|                                                                           | <a href="#">Rehabilitation services</a>   | \$40 <a href="#">copay</a> /visit                    | 20% <a href="#">coinsurance</a>                    | Short-term physical and occupational therapy limited to 30 visits for each type of service per year. No set limit on speech therapy. <a href="#">Prior authorization</a> may be required.                                                                                                                          |
|                                                                           | <a href="#">Habilitation services</a>     | \$40 <a href="#">copay</a> /visit                    | 20% <a href="#">coinsurance</a>                    | Short-term physical and occupational therapy limited to 30 visits for each type of service per year. No set limit on speech therapy. <a href="#">Prior authorization</a> may be required.                                                                                                                          |
|                                                                           | <a href="#">Skilled nursing care</a>      | No charge                                            | 20% <a href="#">coinsurance</a>                    | Limited to 100 days per year. <a href="#">Prior authorization</a> is required.                                                                                                                                                                                                                                     |
|                                                                           | <a href="#">Durable medical equipment</a> | 30% <a href="#">coinsurance</a>                      | 30% <a href="#">coinsurance</a>                    | <a href="#">Prior authorization</a> may be required.                                                                                                                                                                                                                                                               |
|                                                                           | <a href="#">Hospice services</a>          | No charge                                            | 20% <a href="#">coinsurance</a>                    | <a href="#">Prior authorization</a> is required.                                                                                                                                                                                                                                                                   |
| If your child needs dental or eye care                                    | Children's eye exam                       | No charge; <a href="#">deductible</a> does not apply | 20% <a href="#">coinsurance</a>                    | Limited to one visit every 12 months with an EyeMed vision care provider.                                                                                                                                                                                                                                          |
|                                                                           | Children's glasses                        | No charge; <a href="#">deductible</a> does not apply | 20% <a href="#">coinsurance</a>                    | Limited to one pair of glasses every 12 months through EyeMed Vision Care. Limited collection of frames.                                                                                                                                                                                                           |



| Common Medical Event | Services You May Need      | What You Will Pay                            |                                                 | Limitations, Exceptions, & Other Important Information (limits apply per plan year)                                                                                                                                                       |
|----------------------|----------------------------|----------------------------------------------|-------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                      |                            | In-network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) |                                                                                                                                                                                                                                           |
|                      | Children's dental check-up | Covered through Delta Dental of MA           | Covered through Delta Dental of MA              | 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](http://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 800-463-8080. 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 800-463-8080.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-463-8080.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 800-463-8080.

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 800-463-8080.

*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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$40    |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$250   |
| ■ Other plan <a href="#">coinsurance</a>                        | 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                |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$1,500 |
| <a href="#">Copayments</a>  | \$300   |
| <a href="#">Coinsurance</a> | \$0     |
| What isn't covered          |         |
| Limits or exclusions        | \$0     |
| The total Peg would pay is  | \$1,800 |

### Managing Joe's type 2 Diabetes

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$40    |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$250   |
| ■ Other plan <a href="#">coinsurance</a>                        | 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                |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$1,500 |
| <a href="#">Copayments</a>  | \$1,000 |
| <a href="#">Coinsurance</a> | \$0     |
| What isn't covered          |         |
| Limits or exclusions        | \$20    |
| The total Joe would pay is  | \$2,520 |

### Mia's Simple Fracture

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$40    |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$250   |
| ■ Other plan <a href="#">coinsurance</a>                        | 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                |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$1,500 |
| <a href="#">Copayments</a>  | \$500   |
| <a href="#">Coinsurance</a> | \$70    |
| What isn't covered          |         |
| Limits or exclusions        | \$0     |
| The total Mia would pay is  | \$2,070 |

**This is a Massachusetts Small Group and Individual Silver 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).



# 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 inaccuracies 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](http://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](mailto: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](http://tuftshealthplan.com) |

800.462.0224

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

**Arabic** للحصول على خدمة الترجمة المجانية باللغة العربية، يرجى الاتصال على الرقم المدون على 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)** សម្រាប់សេវាកម្មប្រដោយឥតគិតថ្លៃជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខដែលមាននៅលើកាតសម្គាល់សមាជិករបស់អ្នក។

**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 bááłh ilíní da Diné k'ehjí álnéehgo, hodiilnih béesh bee hani'é bee née ho'díłzingo nantinígíí bikáá'.

**Persian** . بزنید زنگ تان شناسائی کارت در مندرج تلفن شماره به فارسی رایگان ترجمه برای .

**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.

**tagalog** 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.