



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 ?	\$2,000 individual/\$4,000 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 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$6,500 individual/\$13,000 family for 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 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 ?	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.

		What You Will Pay		
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information (limits apply per <u>plan</u> year)
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	None
	<u>Specialist</u> visit	\$60 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	Prior authorization may be required.
	<u>Preventive care/ screening/</u> immunization	No charge; <u>deductible</u> does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	Not covered	Prior authorization may be required.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	Not covered	Prior authorization is required.

		What You Will Pay		
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information (limits apply per <u>plan</u> year)
If you need drugs to treat your illness or condition	Tier 1 - Generic drugs	\$35 <u>copay</u> /fill or \$5/fill for low cost generic drugs (retail); \$70 <u>copay</u> /fill or \$10/fill for low cost generic drugs (mail order); <u>deductible</u> does not apply	Not covered	Retail <u>cost share</u> is for up to a 30-day supply; mail order <u>cost share</u> is for up to a 90-day supply. Some drugs require prior authorization to be covered. Some drugs have quantity limitations.
	Tier 2 - Preferred brand and some generic drugs	\$75 <u>copay</u> /fill (retail); \$225 <u>copay</u> /fill (mail order); <u>deductible</u> does not apply		
	Tier 3 - Non-preferred brand drugs	\$100 <u>copay</u> /fill (retail); \$300 <u>copay</u> /fill (mail order); <u>deductible</u> does not apply		
	Tier 4 - <u>Specialty drugs</u> and some selected brand drugs	Tier 1-\$25 <u>copay</u> /fill; <u>deductible</u> does not apply Tier 2-\$45 <u>copay</u> /fill; <u>deductible</u> does not apply Tier 3-\$70 <u>copay</u> /fill; <u>deductible</u> does not apply Tier 4-25% <u>coinsurance</u> ; <u>deductible</u> does not apply; \$250 max/fill (retail); Tier 4 selected brand drugs - \$750 max/fill (mail order)	Not covered	Some Tier 4 drugs are selected brand drugs and eligible for a 90-day supply. <u>Specialty drugs</u> are limited to a 30-day supply and must be obtained at a designated specialty pharmacy. Some drugs require prior authorization to be covered. Some drugs have quantity limitations. Some <u>specialty drugs</u> may also be covered under your medical benefit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not covered	Some surgeries require prior authorization in order to be covered.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>		<u>Cost share</u> waived if admitted.
	<u>Emergency medical transportation</u>	\$50 <u>copay</u> /trip		Some <u>emergency transportation</u> requires prior authorization to be covered
	<u>Urgent care</u>	<u>Urgent Care</u> Center (non-hospital) - \$50 <u>copay</u> /visit; <u>deductible</u> does not apply PCP - \$30 <u>copay</u> /visit; <u>deductible</u> does not apply <u>Specialist</u> - \$60 <u>copay</u> /visit; <u>deductible</u> does not apply		<u>Cost share</u> will vary based on type of <u>provider</u> seen and place of service. Services with <u>non-participating providers</u> are only covered out of the service area.

		What You Will Pay		
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information (limits apply per <u>plan</u> year)
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Some hospitalizations require prior authorization to be covered.
	Physician/surgeon fees	20% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 copay /visit; deductible does not apply	Not covered	Prior authorization may be required.
	Inpatient services	20% coinsurance	Not covered	
If you are pregnant	Office Visits	\$30 copay /visit; deductible does not apply	Not covered	Cost sharing does not apply for 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	20% coinsurance	Not covered	
	Childbirth/delivery facility services	20% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Prior authorization is required.
	Rehabilitation services	No charge	Not covered	Short-term physical therapy limited to 30 visits, occupational therapy limited to 30 visits and speech therapy limited to 30 visits per year. Prior authorization may be required.
	Habilitation services	No charge	Not covered	Short-term physical therapy limited to 30 visits, occupational therapy limited to 30 visits and speech therapy limited to 30 visits per year. Prior authorization may be required.
	Skilled nursing care	20% coinsurance	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	20% coinsurance	Not covered	Prior authorization is required.

		What You Will Pay		
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information (limits apply per plan year)
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 .
	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 DentaQuest	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 .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) • Long-term care/custodial care 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine foot care 	<ul style="list-style-type: none"> • 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.)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery 	<ul style="list-style-type: none"> • Chiropractic care (spinal manipulation) • Hearing Aids (children and adults) 	<ul style="list-style-type: none"> • 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, 1 Wellness Way, P.O. Box 474, Canton, MA 02021-1166; 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

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 800-682-8059.

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, kwijigo holne' 800-682-8059.

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

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	\$2,000
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	20%
■ Plan coinsurance	20%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$30
Coinsurance	\$1,400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$3,430

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$2,000
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	20%
■ Plan coinsurance	20%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$2,200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,320

Mia's Simple Fracture

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

■ The plan's overall deductible	\$2,000
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	20%
■ Plan coinsurance	20%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$200
Coinsurance	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,210

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, sex, sexual orientation, or gender identity. Tufts Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

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 800-682-8059.

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.

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.

1 Wellness Way Canton, MA 02021-1166

Phone: 888.880.8699 ext. 48000, [TTY number — 800.439.2370 or 711]

Fax: 617.972.9048

Email: OCRCoordinator@point32health.org

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 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.

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。

Khmer (Cambodian) សម្រាប់សេវាបកប្រែដោយឥតគិតថ្លៃ ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់សមាជិករបស់អ្នក។

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

Laotian ສໍາລັບການແປພາສາເປັນພາສາລາວທີ່ບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີທີ່ຢູ່ເທິງບັດປະຈຳຕົວຂອງທ່ານ.

Navajo Doo báąłh ilíní da Diné k'ehjí álnéehgo, hodiilnih béesh bee haní'é bee née ho' dítzingo 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.

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