TUFTS Health Plan : *DIRECT GOLD 750 WITH COINSURANCE*

Coverage for: All Coverage Types | **Plan Type:** HMO

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, visit tuftshealthplan.com or call **888.257.1985** (TTY: 888.391.5535). 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 **888.257.1985** (TTY: 888.391.5535) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$750**/individual **$1,500**/family	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 services, most outpatient visits (including mental health/behavioral health/substance use disorder), generic drug coverage and urgent care do not apply toward the 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?	**$5,000**/individual **$10,000**/family	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 billing, 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 tuftshealthplan.com or call **888.257.1985** 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?	You may need a referral for certain specialty services. If your PCP needs to give you a referral for certain services, your member ID card will say "PCP Referral Required."	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
		Network Provider (You will pay the least)	Out-of-Network 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	$20/visit. Deductible does not apply.	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Some specialty services may require prior authorization.
	Specialist visit	$35/visit. Deductible does not apply.	Not covered	
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not covered	Covered if medically necessary
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	Requires prior authorization
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at tuftshealthplan.com.	Generic drugs (Tier 1)	$15/prescription (retail) $30/prescription (mail-order). Deductible does not apply.	Not covered	Covers up to a 30-day retail supply, up to a 90-day mail-order supply. May require prior authorization.
	Preferred brand drugs (Tier 2)	50% coinsurance (retail or mail-order)	Not covered	
	Non-preferred brand drugs (Tier 3)	50% coinsurance (retail or mail-order)	Not covered	
	Specialty drugs (Tier 3)	50% coinsurance (retail)	Not covered	Covers up to a 30-day supply. May require prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	Covered if medically necessary at an in-network outpatient facility or hospital. Some services may require prior authorization.
	Physician/surgeon fees	30% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	Notification required within 24 hours, if admitted. Co-payment waived, if admitted.
	Emergency medical transportation	No charge	No charge	Emergency transport only; nonemergency transport covered if medically necessary and with prior authorization.
	Urgent care	$20/visit (PCP) $35/visit (specialist) Deductible does not apply	Not covered	Urgent care covered with PCP or at in-network urgent care facilities. Urgent care centers at out-of-network hospitals are not covered.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	Electively scheduled inpatient medical care covered according to medical necessity and subject to prior authorization. Nonemergency admissions require submission of prior authorization 5 business days before admission. Urgent admissions require submission for authorization within 1 business day of the admission.
	Physician/surgeon fees	30% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20/visit. Deductible does not apply.	Not covered	Prior authorization required after 12 outpatient therapy visits per benefit year. In-network substance abuse services do not require prior authorization.
	Inpatient services	30% coinsurance	Not covered	
If you are pregnant	Office visits	$20/visit (PCP) $35/visit (specialist) Deductible does not apply	Not covered	Cost sharing does not apply for preventive services. Providers must submit a Prenatal Registration Form to our medical management team.
	Childbirth/delivery professional services	30% coinsurance	Not covered	
	Childbirth/delivery facility services	30% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Requires prior authorization if services are daily or for longer than 6 months.
	Rehabilitation services	$35/visit. Deductible does not apply.	Not covered	Maximum of 60 visits total combined rehabilitative physical and occupational therapy per member per benefit year. No limit on speech therapy. May require prior authorization for speech, physical, and occupational therapy after initial evaluation. Maximum of 60 calendar days total per benefit year for inpatient services. Requires prior authorization.
	Habilitation services	$35/visit. Deductible does not apply.	Not covered	Maximum of 60 visits total combined habilitative physical and occupational therapy per member per benefit year. No limit on speech therapy. May require prior authorization for speech, physical, and occupational therapy after initial evaluation. Maximum of 60 calendar days total per benefit year for inpatient services. Requires prior authorization.
	Skilled nursing care	30% coinsurance	Not covered	Maximum of 100 calendar days total per benefit year. Requires prior authorization.
	Durable medical equipment	30% coinsurance	Not covered	May require prior authorization. (See list at tuftshealthplan.com.)
	Hospice services	No charge	Not covered	Requires prior authorization
If your child needs dental or eye care	Children's eye exam	$20/visit. Deductible does not apply.	Not covered	Coverage for routine eye exams for members 18 years and younger once every 12 months
	Children's glasses	No charge. Deductible does not apply.	Not covered	Coverage for eye glasses for members 18 years and younger once every 12 months. Collection frames only.
	Children's dental check-up	No charge	Not covered	Covered for pediatric dental checkup for members 18 years and younger

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
- Dental care (adult) (except in cases of emergency)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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

- Abortion services
- Acupuncture to treat substance abuse
- Bariatric surgery with prior authorization
- Chiropractic care (may require prior authorization)
- Hearing aids (age 21 and younger, covered up to $2,000 per ear every 36 months)
- Infertility treatment with prior authorization
- Routine eye care (adult)
- Routine foot care for diabetics (adult)
- Weight-loss programs covered for first 3 months

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: Massachusetts Division of Insurance at 877.563.4467 or mass.gov/doi. 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. For more information on your rights to continue coverage, contact Tufts Health Plan at **888.257.1985** (TTY: 888.391.5535).

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 **888.257.1985** (TTY: 888.391.5535)
- U.S. Department of Labor's Employee Benefits Security Administration at 866.444.EBSA (3272) or dol.gov/ebsa/healthreform
- Massachusetts Division of Insurance at 617.521.7794

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

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

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

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 888.257.1985.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888.257.1985.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 888.257.1985.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 888.257.1985.

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	$750
Specialist copayment	$35
Hospital (facility) coinsurance	30%

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	$750
Copayments	$0
Coinsurance	$2,800
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,550**

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

The plan's overall deductible	$750
Specialist copayment	$35
Hospital (facility) coinsurance	30%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750
Copayments	$600
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,810**

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

The plan's overall deductible	$750
Specialist copayment	$35
Hospital (facility) coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,150**

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