



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

**TUFTS**Health Plan: **DIRECT BRONZE 2750**

Amended as of 2/11/2019

Coverage for: Individual/Family | 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](http://tuftshealthplan.com) or call 888.257.1985 (TTY: 711). 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: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$2,750/individual \$5,500/family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this plan 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 deductible.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Preventive services and some prescription drug coverage do not apply toward the <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> 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?	No	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$7,900/individual \$15,800/family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</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> ?	Premiums, balance billing 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="http://tuftshealthplan.com">tuftshealthplan.com</a> or call 888.257.1985 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 <a href="#">plan's 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 <a href="#">provider's</a> 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 services (such as lab work). Check with your <a href="#">provider</a> before you get services.

Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes	If a PCP referral is needed, your member ID card will say “PCP Referral Required.” Please consult with your PCP to determine if the service you are seeking requires a referral. This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .
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 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$25/visit	Not covered	<a href="#">Deductible</a> applies first.
	<a href="#">Specialist</a> visit	\$50/visit	Not covered	<a href="#">Deductible</a> applies first. May require prior authorization for certain specialists.
	<a href="#">Preventive care/screening/immunization</a>	No charge. <a href="#">Deductible</a> does not apply.	Not covered	GYN exam limited to one exam per calendar year. 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.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$50/visit	Not covered	<a href="#">Deductible</a> applies first.
	Imaging (CT/PET scans, MRIs)	\$500/visit	Not covered	<a href="#">Deductible</a> applies first. Requires prior authorization
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="#">tuftshealthplan.com</a> .	Generic drugs (Tier 1)	\$25/retail supply \$50/mail-order supply. <a href="#">Deductible</a> does not apply.	Not covered	<a href="#">Deductible</a> applies first, except as noted otherwise. Up to a 90-day retail supply (with certain exceptions), up to a 90-day mail-order supply. Cost share may be waived for certain covered drugs. May require prior authorization.
	Preferred brand drugs (Tier 2)	\$50/retail supply \$100/mail-order supply	Not covered	
	Non-preferred brand drugs (Tier 3)	\$100/retail supply \$300/mail-order supply	Not covered	
	<a href="#">Specialty drugs</a>	\$100/prescription	Not covered	<a href="#">Deductible</a> applies first. Must be obtained from designated specialty pharmacy provider. Covers up to a 30-day supply. For certain Specialty drugs, a lower tier cost share may apply. May require prior authorization.

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)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$500/visit	Not covered	<u>Deductible</u> applies first. Covered at an in-network outpatient facility or hospital. May require prior authorization.
	Physician/surgeon fees	No charge	Not covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$250/visit	\$250/visit	<u>Deductible</u> applies first. Notification required within 48 hours, if admitted. <u>Copayment</u> waived, if admitted.
	<a href="#">Emergency medical transportation</a>	No charge	No charge	<u>Deductible</u> applies first. Emergency transport only; nonemergency transport covered with prior authorization
	<a href="#">Urgent care</a>	\$25/visit (PCP) \$50/visit (specialist) \$50/visit (UCC)	\$50/visit (UCC)	<u>Deductible</u> applies first. <u>Urgent care</u> within the service area is covered without prior authorization at in-network <u>Urgent Care Centers (UCC)</u> /clinics or with in-network providers only. Out-of-network UCC within the service area may require prior authorization for coverage. <u>Urgent care</u> outside the service area is covered without prior authorization. Cost share may vary depending on place of service.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$750/visit	Not covered	<u>Deductible</u> applies first. Nonemergency/elective covered inpatient procedures or services may require prior authorization at least 5 business days before admission.
	Physician/surgeon fees	No charge	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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25/visit	Not covered	<u>Deductible</u> applies first. Some services may require prior authorization. Prior authorization required after 12 outpatient psychotherapy visits. No prior authorization required to begin services for in-network substance use treatment.
	Inpatient services	\$750/visit	Not covered	<u>Deductible</u> applies first. Some services may require prior authorization. No prior authorization required to begin services for in-network substance use treatment.
<b>If you are pregnant</b>	Office visits	\$25/visit (PCP) \$50/visit (specialist)	Not covered	<u>Deductible</u> may apply for non-preventive services. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	\$750/visit	Not covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge	Not covered	<u>Deductible</u> applies first. Requires prior authorization if services are daily or for longer than 6 months.
	<a href="#">Rehabilitation services</a>	\$50/visit	Not covered	<u>Deductible</u> applies first. 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 in outpatient setting after initial evaluation. Prior authorization required in inpatient setting.
	<a href="#">Habilitation services</a>	\$50/visit	Not covered	<u>Deductible</u> applies first. Maximum of 60 visits total combined habilitative physical and occupational therapy

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)	
				per member per benefit year. No limit on speech therapy. May require prior authorization in outpatient setting after initial evaluation. Prior authorization required in inpatient setting.
	<a href="#">Skilled nursing care</a>	\$750/visit	Not covered	<u>Deductible</u> applies first. Maximum of 100 medically necessary calendar days total per benefit year. Requires prior authorization.
	<a href="#">Durable medical equipment</a>	20% coinsurance	Not covered	<u>Deductible</u> applies first. May require prior authorization. (See list at <a href="http://tuftshealthplan.com">tuftshealthplan.com</a> .) Some services may not require cost share, such as one breast pump per birth.
	<a href="#">Hospice services</a>	No charge	Not covered	<u>Deductible</u> applies first. Requires prior authorization
If your child needs dental or eye care	Children's eye exam	\$25/visit	Not covered	<u>Deductible</u> applies first. Coverage for routine eye exams for members 18 years and younger once every 12 months
	Children's glasses	No charge. <u>Deductible</u> 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	<u>Deductible</u> applies first. Covered 2 exams per year 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    | • Long-term care (custodial)                         | • Private-duty nursing |
| • Dental care (adult) | • Non-emergency care when traveling outside the U.S. |                        |

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

- |  |  |   |
|--|--|---|
| • Abortion services                          | • Chiropractic care  | • Routine eye care (adult)                        |
| • Acupuncture to treat substance abuse       | • Hearing aids (age 21 and younger, covered up to \$2,000 per ear every 36 months) | • Routine foot care for diabetics                 |
| • Bariatric surgery with prior authorization | • Infertility treatment with prior authorization                                   | • 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](http://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](http://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: 711).

**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: 711)
- U.S. Department of Labor's Employee Benefits Security Administration at 866.444.EBSA (3272) or [dol.gov/ebsa/healthreform](http://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): Dinekehgo shika at'ohwol ninisingo, kwijigo 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,750
■ <a href="#">Specialist</a> copayment	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$750

#### 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,750
Copayments	\$800
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$3,550</b>

### 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>	\$2,750
■ <a href="#">Specialist</a> copayment	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$750

#### 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$2,750
Copayments	\$1,800
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$4,610</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,750
■ <a href="#">Specialist</a> copayment	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$750

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,900
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>



# DISCRIMINATION IS AGAINST THE LAW



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

## **Tufts Health Plan:**

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Tufts Health Plan at **888.257.1985**.

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 Street

Watertown, MA 02472

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

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

Phone: 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) | **888.257.1985**

**Important plan information is enclosed.**

We can give you information in other formats, such as braille and large print, and also in different languages upon request.

For no-cost translation in English, call **888.257.1985**.

**Arabic** للحصول على خدمة الترجمة المجانية باللغة العربية، يرجى الاتصال على الرقم 888-257-1985

**Chinese** 若需免費的中文版本，請撥打 **888.257.1985**。

**French** Pour demander une traduction gratuite en français, composez le **888.257.1985**.

**German** Um eine kostenlose deutsche Übersetzung zu erhalten, rufen Sie bitte die folgende Telefonnummer an: **888.257.1985**.

**Greek** Για δωρεάν μετάφραση στα ελληνικά, καλέστε στο **888.257.1985**.

**Haitian Creole** Pou tradiksyon gratis nan Kreyòl Ayisyen, rele **888.257.1985**.

**Italian** Per la traduzione in italiano senza costi aggiuntivi, è possibile chiamare il numero **888.257.1985**.

**Japanese** 日本語の無料翻訳については **888.257.1985** に電話してください。

**Khmer (Cambodian)** សម្រាប់សេវាបកប្រែឥតគិតថ្លៃជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅលេខ **888.257.1985**។

**Korean** 한국어로 무료 통역을 원하시면, **888.257.1985** 로 전화하십시오.

**Laotian** ສໍາລັບການແປພາສາເປັນພາສາລາວທີ່ບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີ **888.257.1985**.

**Navajo** Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' **888.257.1985**.

**Persian** برای ترجمه رایگان به فارسی به شماره تلفن **888.257.1985** زنگ بزنید.

**Polish** Aby uzyskać bezpłatne tłumaczenie w języku polskim, należy zadzwonić na numer **888.257.1985**.

**Portuguese** Para tradução grátis para português, ligue para o número **888.257.1985**.

**Russian** Для получения услуг бесплатного перевода на русский язык позвоните по номеру **888.257.1985**.

**Spanish** Para servicio de traducción gratuito en español, llame al **888.257.1985**.

**Tagalog** Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **888.257.1985**.

**Vietnamese** Để có bản dịch tiếng Việt không phải trả phí, gọi theo số **888.257.1985**.