



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). 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.

**TUFTS**Health Plan: **DIRECT SILVER 2500 WITH COINSURANCE**

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 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 deductible ?	\$2,500/individual \$5,000/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 and some outpatient visits (including mental health/behavioral health/substance use disorder) do not apply towards 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 ?	\$7,350/individual \$14,700/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 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 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 ?	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 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 .
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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 provider's office or clinic	Primary care visit to treat an injury or illness	\$30/visit. Deductible does not apply.	Not covered	
	Specialist visit	\$50/visit	Not covered	Deductible applies first. May require prior authorization for certain specialists.
	Preventive care/screening/immunization	No charge. Deductible 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	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	Deductible applies first.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	Deductible applies first. 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)	\$35/retail supply \$70/mail-order supply	Not covered	Deductible applies first. 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% coinsurance/retail or mail-order supply	Not covered	
	Non-preferred brand drugs (Tier 3)	50% coinsurance/retail or mail-order supply	Not covered	
	Specialty drugs	50% coinsurance/prescription	Not covered	Deductible 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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Deductible applies first. Covered at an in-network outpatient facility or hospital. May require prior authorization.
	Physician/surgeon fees	20% 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	\$650/visit	\$650/visit	<u>Deductible</u> applies first. Notification required within 48 hours, if admitted. <u>Copayment</u> waived, if admitted.
	Emergency medical transportation	No charge	No charge	<u>Deductible</u> applies first. Emergency transport only; nonemergency transport covered with prior authorization
	Urgent care	\$30/visit (PCP) \$50/visit (specialist) \$50/visit (UCC)	\$50/visit (UCC)	<u>Urgent care</u> within the service area is covered without prior authorization at in-network <u>Urgent Care</u> Centers (UCC)/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.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	<u>Deductible</u> applies first.
	Physician/surgeon fees	30% coinsurance	Not covered	Nonemergency/elective covered inpatient procedures or services may require prior authorization at least 5 business days before admission.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30/visit. <u>Deductible</u> does not apply.	Not covered	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	30% coinsurance	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.
If you are pregnant	Office visits	\$30/visit (PCP) \$50/visit (specialist)	Not covered	<u>Deductible</u> may apply for non-preventive services.

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)	
	Childbirth/delivery professional services	30% coinsurance	Not covered	<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 facility services	30% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	<u>Deductible</u> applies first. Requires prior authorization if services are daily or for longer than 6 months
	Rehabilitation services	\$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.
	Habilitation services	\$50/visit	Not covered	<u>Deductible</u> applies first. 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 in outpatient setting after initial evaluation. Prior authorization required in inpatient setting.
	Skilled nursing care	30% coinsurance	Not covered	<u>Deductible</u> applies first. Maximum of 100 calendar days total per benefit year. Requires prior authorization.
	Durable medical equipment	30% coinsurance	Not covered	<u>Deductible</u> applies first. May require prior authorization. (See list at tuftshealthplan.com.) Some services may not require cost share, such as one breast pump per birth. 20% Co-insurance after deductible applies to arm and leg prosthetics.
	Hospice services	No charge	Not covered	<u>Deductible</u> applies first. Requires 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)	
If your child needs dental or eye care	Children's eye exam	\$30/visit. <u>Deductible</u> 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. <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
- Dental care (adult)
- Long-term care (custodial)
- 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
- 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: 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
- 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, 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 plan's overall deductible	\$2,500
■ Specialist copayment	\$50
■ 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,500
Copayments	\$50
Coinsurance	\$2,300
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$4,850

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$2,500
■ Specialist copayment	\$50
■ 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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$2,500
Copayments	\$500
Coinsurance	\$1,800
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$4,860

Mia's Simple Fracture

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

■ The plan's overall deductible	\$2,500
■ Specialist copayment	\$50
■ 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
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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
The total Mia would pay is	\$1,900

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

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 | **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**.