



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.



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 ?	\$2,000/individual \$4,000/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 , most outpatient visits (including mental health/behavioral health/substance use disorder), most prescription drug coverage, and urgent care 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 ?	\$8,550/individual \$17,100/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 does not 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 ?	No.	You can see the specialist 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
		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	\$25/visit. 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 care . Ask your provider if the services needed are preventive. Then check what your plan will pay for in your Tufts Health Direct Member Handbook "Benefits and Cost-sharing Summary" section.
	Specialist visit	\$50/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)	\$75/visit (x-ray) \$50/visit (blood work)	Not covered	Deductible applies first.
	Imaging (CT/PET scans, MRIs)	\$400/visit	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 www.tuftshealthplan.com	Generic drugs	\$25/retail supply \$50/mail-order supply. Deductible does not apply.	Not covered	Deductible applies first. Up to a 90-day retail supply (with certain exceptions), up to a 90-day mail-order supply. Cost sharing may be waived for certain covered prescription drugs . May require prior authorization.
	Preferred brand drugs	\$50/retail supply \$100/mail-order supply. Deductible does not apply.	Not covered	
	Non-preferred brand drugs	\$75/retail supply \$225/mail-order supply	Not covered	
	Specialty drugs	\$75/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 sharing 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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$500/visit	Not covered	<u>Deductible</u> applies first. May require prior authorization.
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	Emergency room care	\$300/visit	\$300/visit	<u>Deductible</u> applies first. Notification required within 48 hours, if admitted. Co-payment 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	\$25/visit (PCP/behavioral health provider) \$50/visit (Urgent Care Center) <u>Deductible</u> does not apply.	\$50/visit (UCC) <u>Deductible</u> does not apply.	In our <u>service area</u> , you must visit an <u>Urgent Care Center (UCC)</u> that is in our <u>network</u> to be covered for services. Outside of our <u>service area</u> , <u>emergency services</u> and free-standing <u>Urgent Care Centers (UCC)</u> are covered at <u>out-of-network provider</u> sites, including hospitals and clinics. <u>Cost sharing</u> may vary depending on place of service.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1,000/visit	Not covered	<u>Deductible</u> applies first. Nonemergency/elective covered inpatient procedures or services may require prior authorization and notification at least 5 business days before <u>hospitalization</u> . Emergency admissions (in or out-of-network) do not require prior authorization and are covered at the in-network level of benefits. Notification required within 48 hours of 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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25/visit. <u>Deductible</u> does not apply.	Not covered	Certain services require prior authorization. No prior authorization required for outpatient behavioral health therapy visits or to begin services for in-network substance use treatment.
	Inpatient services	\$1,000/visit	Not covered	<u>Deductible</u> applies first. No prior authorization required. Notification required within 48 hours of admission.
If you are pregnant	Office visits	\$25/visit (PCP) \$50/visit (<u>specialist</u>) <u>Deductible</u> does not apply for office visits.	Not covered	<u>Deductible</u> applies first for non-preventive services. <u>Cost sharing</u> does not apply for <u>preventive services</u> , including standard prenatal and postnatal care. 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	\$1,000/visit	Not covered	
If you need help recovering or have other special health needs	Home health care	\$5/visit	Not covered	<u>Deductible</u> applies first. Requires prior authorization, if services are daily or for longer than 6 months.
	Rehabilitation services	\$50/visit. <u>Deductible</u> 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 in outpatient setting after initial evaluation.
	Habilitation services	\$50/visit. <u>Deductible</u> 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 in outpatient setting after initial evaluation.

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	Skilled nursing care	\$1,000/visit	Not covered	<u>Deductible</u> applies first. Maximum of 100 calendar days total per benefit year. Requires prior authorization.
	Durable medical equipment	20% coinsurance	Not covered	<u>Deductible</u> applies first. May require prior authorization. (See list at tuftshealthplan.com). Some services may not require <u>cost sharing</u> , such as one breast pump per birth.
	Hospice services	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. <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 eyeglasses for members 18 years and younger once every 12 months. Collection frames only or \$150 allowance + 20% off expense beyond allowance.
	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 .)			
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (adult) 	<ul style="list-style-type: none"> • Long-term care (custodial) • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private-duty nursing 	

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"> • Abortion services • Acupuncture • Bariatric surgery with prior authorization 	<ul style="list-style-type: none"> • Chiropractic care • Hearing aids (age 21 and younger, covered up to \$2,000 per ear every 36 months) • Infertility treatment with prior authorization 	<ul style="list-style-type: none"> • Routine eye care (adult) • Routine foot care for diabetics • Weight-loss programs covered for 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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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 on how 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

[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 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): Dine'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.

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 plan's overall deductible	\$2,000
■ Specialist copayment	\$50
■ Hospital (facility) copayment	\$1000

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	\$1,000
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$3,000

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	\$50
■ Hospital (facility) copayment	\$1000

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	\$1,700
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,820

Mia's Simple Fracture

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

■ The plan's overall deductible	\$2,000
■ Specialist copayment	\$50
■ Hospital (facility) copayment	\$1000

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	\$400
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,400

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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 and 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**

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**.

Igbo Maka ntughari asusu n'Igbo na akwughị ugwo, kpọọ **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) សម្រាប់សេវាកម្រិតដោយឥតគិតថ្លៃ ជាភាសាខ្មែរ សូមទូរស័ព្ទទៅលេខ **888.257.1985**។

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

Kru Inyu yangua ndonõl ni Kru sèbèl **888.257.1985**.

Laotian ສໍາລັບການແປພາສາແບ້ພາສາລາວທີ່ບໍ່ໄດ້ລະຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາຕີ **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**.

Yorùbá Fún isé ògbùfò l'ófè ní Yorùbá, pe **888.257.1985**.