



**This is a Massachusetts Large Group 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).



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> or call 800-462-0224. 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 800-462-0224 to request a copy.

Important Questions	Answers	Why this Matters:
<b>What is the overall <u>deductible</u>?</b>	\$0; per calendar year.	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Not Applicable	This <u>plan</u> does not have a <u>deductible</u> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	\$2,500 individual/\$5,000 family for medical and pharmacy expenses; per calendar year.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>balance-billed</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="https://www.tuftshealthplan.com/berklee">www.tuftshealthplan.com/berklee</a> , "Find a doctor, hospital..." or call 800-462-0224 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

		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 calendar year)
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit	Not covered	None
	<u>Specialist</u> visit	\$25 <u>copay</u> /visit	Not covered	Prior authorization may be required.
	<u>Preventive care/ screening/ immunization</u>	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	General imaging - \$75 <u>copay</u> /visit Lab tests - No charge	Not covered	Prior authorization may be required.
	Imaging (CT/PET scans, MRIs)	\$75 <u>copay</u> /visit	Not covered	Prior authorization is required. Maximum of two <u>copayments</u> per year regardless of diagnosis.
<b>If you need drugs to treat your illness or condition</b>	Tier 1 - Generic drugs	\$15 <u>copay</u> /fill (retail); \$30 <u>copay</u> /fill (mail order)	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	\$30 <u>copay</u> /fill (retail); \$60 <u>copay</u> /fill (mail order)		
	Tier 3 - Non-preferred brand drugs	\$50 <u>copay</u> /fill (retail); \$150 <u>copay</u> /fill (mail order)		
<p>More information about <u>prescription drug coverage</u> is available by calling OptumRx at 855-546-3437 or at <a href="http://www.tuftshealthplan.com/berklee">www.tuftshealthplan.com/berklee</a></p> <p><b>This is a Massachusetts Large Group Plan</b></p>	<u>Specialty drugs</u>	Limited to a 30-day supply with appropriate tier <u>copay</u> (see above) when purchased at a designated specialty pharmacy	Not covered	Limited to a 30-day supply. 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.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$250 <u>copay</u> /visit	Not covered	Some surgeries require prior authorization in order to be covered.
	Physician/surgeon fees	No charge	Not covered	

		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 calendar year)
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> /visit		<u>Cost share</u> waived if admitted.
	<u>Emergency medical transportation</u>	No charge		Some <u>emergency transportation</u> requires prior authorization to be covered
	<u>Urgent care</u>	\$25 <u>copay</u> /visit		Services with <u>non-participating providers</u> are only covered out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 <u>copay</u> /admission	Not covered	Some <u>hospitalizations</u> require prior authorization to be covered.
	Physician/surgeon fees	No charge	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> /visit	Not covered	Prior authorization may be required.
	Inpatient services	\$500 <u>copay</u> /admission	Not covered	
If you are pregnant	Office Visits	\$25 <u>copay</u> /visit	Not covered	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. 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	\$500 <u>copay</u> /admission	Not covered	

		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 calendar year)
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No charge	Not covered	Prior authorization is required.
	<u>Rehabilitation services</u>	\$25 <u>copay</u> /visit	Not covered	Short-term physical and occupational therapy limited to 30 visits for each type of service per year. No set limit on speech therapy. Prior authorization may be required.
	<u>Habilitation services</u>	\$25 <u>copay</u> /visit	Not covered	Short-term physical and occupational therapy limited to 30 visits for each type of service per year. No set limit on speech therapy. Prior authorization may be required.
	<u>Skilled nursing care</u>	No charge	Not covered	Limited to 100 days per year. Prior authorization is required.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	Prior authorization may be required.
	<u>Hospice services</u>	No charge	Not covered	Prior authorization is required.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$25 <u>copay</u> /visit	Not covered	Limited to one visit every 12 months with an EyeMed vision care <u>provider</u> .
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Covered through Delta Dental	Not covered	Coverage includes X-Rays (full mouth) once every 5 years. Bitewings, once every 6 months and periapicals as needed. Periodic oral exam, oral prophylaxis and fluoride treatment once every 6 months. Covered for children under age 12.

#### **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 care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- 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)

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

- |   |                                      |                            |
|---|--------------------------------------|----------------------------|
| • Acupuncture                             | • Hearing Aids (children and adults) | • Routine eye care (Adult) |
| • Bariatric surgery                       | • Infertility treatment              | • Weight loss programs     |
| • Chiropractic care (spinal manipulation) |                                      |                            |

**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>. 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 800-462-0224. Or you may write to us at Tufts Health Plan, Appeals and Grievances Department, 705 Mt. Auburn St., P.O. Box 9193, Watertown, MA 02471-9193 or contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/healthreform>. Additionally, a consumer assistance program can help you file your appeal. Contact: MA: Health Care for All, One Federal Street, Boston, MA 02110, 1-800-272-4232, <https://www.hcfama.org>.

**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 800-462-0224.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-462-0224.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 800-462-0224.

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 800-462-0224.

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

## 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	\$0
■ Specialist copayment	\$25
■ Hospital (facility) copayment	\$500
■ Plan coinsurance	0%

#### 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	\$0
Copayments	\$600
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$600</b>

### Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$25
■ Hospital (facility) copayment	\$500
■ Plan coinsurance	0%

#### 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	\$0
Copayments	\$1,800
Coinsurance	\$10
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,870</b>

### Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$25
■ Hospital (facility) copayment	\$500
■ Plan coinsurance	0%

#### 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	\$0
Copayments	\$400
Coinsurance	\$40
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$440</b>

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, 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 800-462-0224.

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 Mt. Auburn St. Watertown, MA 02472  
Phone: 888-880-8699 ext. 48000, [TTY number — 800-439-2370 ext. 711]  
Fax: 617-972-9048, Email: [OCRCordinator@tufts-health.com](mailto:OCRCordinator@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  
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>



**For no cost translation in English, call the number on the top of page 1.**

<b>Arabic</b>	للحصول على خدمة الترجمة المجانية باللغة العربية، يرجى الاتصال على الرقم المدون بالجزء العلوي من الصفحة رقم 1
<b>Chinese</b>	若需免費的中文版本，請撥打第 1 頁頂端的電話號碼。
<b>French</b>	Pour demander une traduction gratuite en français, composez le numéro indiqué en haut de la page 1.
<b>German</b>	Um eine kostenlose deutsche Übersetzung zu erhalten, rufen Sie bitte die Telefonnummer oben auf Seite 1 an.
<b>Greek</b>	Για δωρεάν μετάφραση στα Ελληνικά, καλέστε τον αριθμό που αναγράφεται στην κορυφή της σελίδας 1.
<b>Haitian Creole</b>	Pou jwenn tradiksyon gratis nan lang Kreyòl Ayisyen, rele nimewo ki sou kat ID ou.
<b>Italian</b>	Per la traduzione in italiano senza costi aggiuntivi, è possibile chiamare il numero indicato nella parte superiore di pagina 1.
<b>Japanese</b>	日本語の無料翻訳については 1 ページ目の一番上にある番号に電話してください。
<b>Khmer</b>	សម្រាប់សេវាកម្រិតដោយឥតគិតថ្លៃជាភាសាខ្មែរសូមទូរស័ព្ទទៅកាន់លេខដែលនៅផ្នែកខាងលើនៃទំព័រទី 1។
<b>Korean</b>	한국어 무료 통역을 원하시면, 1 페이지 맨 위에 번호로 전화 하십시오.
<b>Laotian</b>	ສຳລັບການແປບັນພາສາລາວທີ່ບໍ່ໄດ້ສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີໂທທີ່ຢູ່ດ້ານເທິງຂອງໜ້າທີ 1.
<b>Navajo</b>	Doo bą́ąh ilíní da Diné k’ehjí álnéehgo, hodiilnih béésh bee haní’é binumber díí naaltsoos bikáá’ wódahti.
<b>Persian</b>	برای ترجمه رایگان به فارسی، به شماره تلفن مندرج در بالای صفحه 1 زنگ بزنید
<b>Polish</b>	Aby uzyskać bezpłatne tłumaczenie w języku polskim, należy zadzwonić na numer zamieszczony u góry strony 1.
<b>Portuguese</b>	Para tradução grátis para português, ligue para o número no topo da página 1.
<b>Russian</b>	Для получения услуг бесплатного перевода на русский язык позвоните по номеру, указанному сверху на стр. 1.
<b>Spanish</b>	Por servicio de traducción gratuito en español, llame al número indicado en la parte superior de la página 1.
<b>Tagalog</b>	Para sa walang bayad na pagsasalin sa Tagalog, tawagan ang numero na nasa itaas ng unang pahina 1.
<b>Vietnamese</b>	Để có bản dịch tiếng Việt không phải trả phí, gọi theo số trên đầu trang 1.

