TUFTS Health Plan

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). 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, see https://www.tuftshealthplan.com or call 866-352-9114. 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 866-352-9114 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$250 individual/$500 family out-of-network medical deductible; per calendar year.	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. In-network preventive care, primary care, specialist care, diagnostic test, high tech imaging, emergency room, surgical day care, inpatient surgery services are covered before you meet your 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?	$2,500 individual/$5,000 family for in-network medical and pharmacy expenses; $2,500 individual/$5,000 family out-of-network medical expenses; per calendar year.	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-billed 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 www.tuftshealthplan.com/berklee, "Find a doctor, hospital…" or call 866-352-9114 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.

		What You Will Pay		
Common Medical Event	**Services You May Need**	**In-network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information (limits apply per calendar year)**
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit; deductible does not apply	20% coinsurance	None
	Specialist visit	$25 copay/visit; deductible does not apply	20% coinsurance	Prior authorization may be required.
	Preventive care/ screening/ immunization	No charge; deductible does not apply	20% coinsurance	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)	No charge; deductible does not apply	20% coinsurance	Prior authorization may be required.
	Imaging (CT/PET scans, MRIs)	$75 copay/visit; deductible does not apply	20% coinsurance	Prior authorization is required. Maximum of two copayments per year regardless of diagnosis.
If you need drugs to treat your illness or condition	Low Cost Generic Drugs	$5 copay/fill (retail); $10 copay/fill (mail order); deductible does not apply	Reimbursable at in network level	Retail cost share is for up to a 30-day supply; mail order cost share is for up to a 90-day supply. Some drugs require prior authorization to be covered. Some drugs have quantity limitations.
	High Cost Generic Drugs	$20 copay/fill (retail); $40 copay/fill (mail order); deductible does not apply		
	Preferred Brand Drugs	$30 copay/fill (retail); $60 copay/fill (mail order); deductible does not apply		
More information about prescription drug coverage is available by calling OptumRx at 855-546-3439 or at www.tuftshealthplan.com/berklee **This is a Massachusetts Large Group Plan**	Non-Preferred Brand Drugs	$50 copay/fill (retail); $150 copay/fill (mail order); deductible does not apply	Not covered	Some drugs require prior authorization to be covered. Some drugs have quantity limitations. Some specialty drugs may also be covered under your medical benefit.

		What You Will Pay		
Common Medical Event	**Services You May Need**	**In-network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information (limits apply per calendar year)**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge; deductible does not apply	20% coinsurance	Some surgeries require prior authorization in order to be covered.
	Physician/surgeon fees	No charge; deductible does not apply	20% coinsurance	
If you need immediate medical attention	Emergency room care	$100 copay/visit; deductible does not apply		Cost share waived if admitted.
	Emergency medical transportation	No charge; deductible does not apply		Some emergency transportation requires prior authorization to be covered
	Urgent care	$25 copay/visit; deductible does not apply		Services with out-of-network providers in MA, RI and NH are covered subject to deductible and coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge; deductible does not apply	20% coinsurance	Some hospitalizations require prior authorization to be covered.
	Physician/surgeon fees	No charge; deductible does not apply	20% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit; deductible does not apply	20% coinsurance	Prior authorization may be required.
	Inpatient services	No charge; deductible does not apply	20% coinsurance	
If you are pregnant	Office Visits	$25 copay/visit; deductible does not apply	20% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge; deductible does not apply	20% coinsurance	
	Childbirth/delivery facility services	No charge; deductible does not apply	20% coinsurance	

		What You Will Pay		
Common Medical Event	**Services You May Need**	**In-network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information (limits apply per calendar year)**
If you need help recovering or have other special health needs	Home health care	No charge; deductible does not apply	20% coinsurance	Prior authorization is required.
	Rehabilitation services	$25 copay/visit; deductible does not apply	20% coinsurance	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.
	Habilitation services	$25 copay/visit; deductible does not apply	20% coinsurance	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.
	Skilled nursing care	No charge; deductible does not apply	20% coinsurance	Limited to 100 days per year. Prior authorization is required.
	Durable medical equipment	20% coinsurance; deductible does not apply	20% coinsurance	Prior authorization may be required.
	Hospice services	No charge; deductible does not apply	20% coinsurance	Prior authorization is required.
If your child needs dental or eye care	Children's eye exam	$25 copay/visit; deductible does not apply	20% coinsurance	Limited to one visit every 12 months with an EyeMed vision care provider.
	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 • Bariatric surgery • Chiropractic care (spinal manipulation)	• Hearing Aids (children and adults) • Infertility treatment	• Routine eye care (Adult) • Weight loss programs

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 866-352-9114. 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

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 866-352-9114.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 866-352-9114.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 866-352-9114.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 866-352-9114.

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	$0
Specialist copayment	$25
Hospital (facility) copayment	$0
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	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$10**

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	$0
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	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$10
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,030**

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	$0
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	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$350**

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 866-352-9114.

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: 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
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.

Arabic للحصول على خدمة الترجمة المجانية باللغة العربية، يرجى الاتصال على الرقم المدون بالجزء العلوي من الصفحة رقم 1

Chinese 若需免費的中文版本，請撥打第 1 頁頂端的電話號碼。

French Pour demander une traduction gratuite en français, composez le numéro indiqué en haut de la page 1.

German Um eine kostenlose deutsche Übersetzung zu erhalten, rufen Sie bitte die Telefonnummer oben auf Seite 1 an.

Greek Για δωρεάν μετάφραση στα Ελληνικά, καλέστε τον αριθμό που αναγράφεται στην κορυφή της σελίδας 1.

Haitian Creole Pou jwenn tradiksyon gratis nan lang Kreyòl Ayisyen, rele nimewo ki sou kat ID ou.

Indonesian Untuk terjemahan tanpa biaya dalam Bahasa Indonesia, hubungi nomor di bagian atas halaman 1.

Italian Per la traduzione in italiano senza costi aggiuntivi, è possibile chiamare il numero indicato nella parte superiore di pagina 1.

Japanese 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。

Khmer **សម្រាប់សេវាបកប្រែដោយឥតគិតថ្លៃជាភាសាខ្មែរសូមទូរស័ព្ទទៅកាន់លេខដែលនៅផ្នែកខាងលើនៃទំព័រទី1។**

Kirundi Urondera gusigurirwa ururimi ku buntu mu Kirundi, telefone inomero yanditse ku ntago ya paji ya 1.

Korean 한국어 무료 통역을 원하시면, 1 페이지 맨 위에 번호로 전화 하십시오.

Laotian ສໍາລັບການແປພາສາລາວທີ່ບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີໂທທີ່ຢູ່ດ້ານເທິງຂອງໜ້າທີ 1.

Navajo Doo bąąh ilíní da Diné k'ehjí álnéehgo, hodiilnih béésh bee haní'é binumber díí naaltsoos bikáá' wódahdi.

Nepali नेपालीमा नि:शुल्क अनुवादन गर्नको लागि, शीर्ष पृष्ठ 1 को नम्बरमा फोन गर्नुहोस्।

Persian برای ترجمه رایگان به فارسی، به شماره تلفن مندرج در بالای صفحه 1 زنگ بزنی د

Polish Aby uzyskać bezpłatne tłumaczenie w języku polskim, należy zadzwonić na numer zamieszczony u góry strony 1.

Portuguese Para tradução grátis para português, ligue para o número no topo da página 1.

Russian Для получения услуг бесплатного перевода на русский язык позвоните по номеру, указанному сверху на стр. 1.

Serbo-Croatian Za besplatan prevod na srpskohrvatski, pozovite broj na vrhu strane 1.

Spanish Por servicio de traducción gratuito en español, llame al número indicado en la parte superior de la página 1.

Tagalog Para sa walang bayad na pagsasalin sa Tagalog, tawagan ang numero na nasa itaas ng unang pahina.

Vietnamese Để có bản dịch tiếng Việt không phải trả phí, gọi theo số trên đầu trang 1.

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