

This is a Massachusetts Large Group Plan



This health plan does not meet Minimum Creditable Coverage standards and will not satisfy the individual mandate that you have health insurance because:

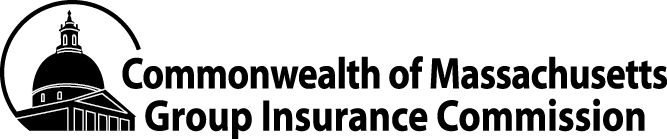
* A broad range of medical benefits, as defined by the Connector, are not covered.

## NOTE: Your total employer coverage meets Minimum Creditable Coverage Standards and does satisfy the insurance mandate.

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 website (www.mahealthconnector.org). This health plan, alone, does not meet Minimum Creditable Coverage standards that are effective January 1, 2010 as part of the Massachusetts Health Care Reform Law. If you purchase this plan only, you will not satisfy the statutory requirement that you have health insurance meeting these standards. If this health plan is offered to you through your place of employment, contact your employer or other plan sponsor to determine if it offers other health plan options that meet Minimum Creditable Coverage standards. Your employer or other plan sponsor also may offer supplemental plans you can add to this insured health plan in order to meet Minimum Creditable Coverage. If this health plan is offered to you through your place of employment and you want to learn about other health plan options available to individuals, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at [www.mass.gov/doi,](http://www.mass.gov/doi) or the Connector by calling

1-877-MA-ENROLL or visiting its website at [www.mahealthconnector.org.](http://www.mahealthconnector.org/) 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 website at [www.mass.gov/doi.](http://www.mass.gov/doi)

This plan includes the Tiered Provider Network called Navigator by Tufts Health Plan, or Navigator. In this plan members may pay different levels of copayments, coinsurance, and/or deductibles depending on their plan design and the tier of the provider delivering a covered service or supply. This plan may make changes to a provider’s benefit tier annually on July 1. Please consult the Navigator provider directory by visiting the provider search tool at tuftshealthplan.com and click on Find a Doctor to determine the tier of providers in the Navigator Tiered Provider Network. If you need a paper copy of the provider directory, please contact Member Services.

 Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services Coverage Period: 7/1/2017 – 6/30/2018 GIC Navigator POS Coverage for: Individual/Family | Plan Type: POS



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](http://www.tuftshealthplan.com/) or call 800-870-9488 (TDD: 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/](http://www.healthcare.gov/sbc-glossary/) or call 800-870-9488 to request a copy.

|  |  |  |
| --- | --- | --- |
| Important Questions | Answers | Why this Matters: |
| What is the overall deductible? | $500 individual/$1,000 family authorized; $500 individual/$1,000 family unauthorized medical deductible. | 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. Authorized preventive care, primary care, and specialist care 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/.](http://www.healthcare.gov/coverage/preventive-care-benefits/) |
| Are there other deductibles for specific services? | Yes. $100 individual/$200 family for prescription drug coverage. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| What is the out-of-pocket limit for this plan? | $5,000 individual/$10,000 family for authorized medical and pharmacy expenses; $5,000 individual/$10,000 family unauthorized medical expenses. | 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 famiily  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 tuftshealthpan.com/gic, “Find a doctor, hospital…” or call  800-870-9488 (TDD: 711) 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. | 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. |

030117063837-13355-POS-Navigator-2017-0

**1 of 7**



All copayment and coinsurance costs shown in this chart apply both before and after your deductible has been met, if a deductible applies.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | What You Will Pay | |  |
| Common Medical Event | Services You May Need | Authorized Provider (You will pay the least) | Unauthorized Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | Tier 1 - $10 copay/visit Tier 2 - $20 copay/visit Tier 3 - $40 copay/visit; deductible does not apply | 20% coinsurance | None |
| Specialist visit | Tier 1 - $30 copay/visit Tier 2 - $60 copay/visit Tier 3 - $90 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 you need are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge | 20% coinsurance | Prior authorization may be required. |
| Imaging (CT/PET scans, MRIs) | $100 copay/test | 20% coinsurance | Prior authorization is required. Limit of one copay per day. |
| If you need drugs to treat your illness or condition  More information about prescription drug coverage is available at tuftshealthpan.com/gic This is a Massachusetts Large Group Plan | Tier 1 - Generic drugs | $10 copay/prescription (retail);  $25 copay/prescription (mail order) | 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. A 90-day supply of maintenance medications may be obtained at a CVS pharmacy for the applicable mail order copay. If a drug has a generic equivalent, and you buy the brand name (even if your physician indicates no substitutions), you will pay the generic-level copay plus the cost difference between the generic and brand name drug. |
| Tier 2 - Preferred brand and some generic drugs | $30 copay/prescription (retail);  $75 copay/prescription (mail order) |
| Tier 3 - Non-preferred brand drugs | $65 copay/prescription (retail);  $165 copay/prescription (mail order) |
| Specialty drugs | Limited to a 30-day supply with appropriate tier copay (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 specialty drugs may also be covered under your medical benefit. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | What You Will Pay | |  |
| Common Medical Event | Services You May Need | Authorized Provider (You will pay the least) | Unauthorized Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | $250 copay/visit | 20% coinsurance | Some surgeries require prior authorization in order to be covered.  Limit of 4 copays, per member, per plan year maximum. |
| Physician/surgeon fees | No charge | 20% coinsurance |
| If you need immediate medical attention | Emergency room care | $100 copay/visit; deductible does not apply | | Copay waived if admitted. |
| Emergency medical transportation | No charge; deductible does not apply | | Some emergency transportation requires prior authorization to be covered |
| Urgent care | Free-standing Urgent Care Center - $20 copay/visit Tier 1 PCP - $10 copay/visit, specialist - $30 copay visit Tier 2 PCP - $20 copay/visit, specialist - $60 copay/visit  Tier 3 PCP - $40 copay/visit, specialist - $90 copay visit; deductible does not apply | | Services with unauthorized providers inside the service area are covered subject to deductible and coinsurance. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | Tier 1 - $275 copay/admission Tier 2 - $500 copay/admission Tier 3 - $1,500 copay/admission | 20% coinsurance | Some hospitalizations require prior authorization to be covered.  Maximum of one copay, per member, per quarter. |
| Physician/surgeon fees | No charge | 20% coinsurance |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | What You Will Pay | |  |
| Common Medical Event | Services You May Need | Authorized Provider (You will pay the least) | Unauthorized Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
| If you need mental health, behavioral health, or substance abuse services, (including individual/family therapy, group therapy, medication management and telehealth services)  *Benefits provided by Beacon Health Options*. More information is available at beaconhealthoptions.c om/gic  Phone: 855-750-8980 (TTY:711) | Outpatient services | $10 copay/visit; deductible does not apply | 20% coinsurance | Mental Health Services: Medical necessity review required for outpatient visits (individual/family) beyond 26. Treatment for Autism Spectrum Disorders is covered with prior authorization. Substance Use Disorder Services: Prior authorization is not required for treatment with Massachusetts Department of Public Health (DPH) licensed providers. For treatment with non-DPH licensed providers; medical necessity review required for outpatient visits (individual/family) beyond 26.  Mental Health Services: Services in a general hospital or psychiatric hospital. May require prior authorization.  Substance Use Disorder Services: Services in a general hospital or substance use disorder facility. Prior authorizations is required for out-of-network facilities that are outside of Massachusetts only.  Limit of one inpatient copay, per member, per quarter. |
| Inpatient services | $200 copay/admission; deductible does not apply | 20% coinsurance |
| If you are pregnant | Office Visits | Tier 1 - $10 copay/visit Tier 2 - $20 copay/visit Tier 3 - $40 copay/visit; deductible does not apply | 20% coinsurance | Cost sharing does not apply to certain 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 | 20% coinsurance |
| Childbirth/delivery facility services | Tier 1 - $275 copay/admission Tier 2 - $500 copay/admission Tier 3 - $1,500 copay/admission | 20% coinsurance |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | What You Will Pay | |  |
| Common Medical Event | Services You May Need | Authorized Provider (You will pay the least) | Unauthorized Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
| If you need help recovering or have other special health needs | Home health care | No charge | 20% coinsurance | Prior authorization is required. |
| Rehabilitation services | $20 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 | $20 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 | 50% coinsurance | 20% coinsurance | Limited to 45 days per year. Prior authorization is required. |
| Durable medical equipment | No charge | No charge | Prior authorization may be required. |
| Hospice services | No charge | 20% coinsurance | Prior authorization is required. |
| If your child needs dental or eye care | Children's eye exam | $20 copay/visit; deductible does not apply | 20% coinsurance | Limited to one visit every 24 months with an EyeMed vision care provider. |
| Children's glasses | Not covered | Not covered | None |
| Children's dental check-up | Not covered | Not covered | None |

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.)

* Acupuncture
* Cosmetic surgery
* Dental care (Adult)
* Long-term care/custodial care
* Non-emergency care when traveling outside the U.S.
* 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)
* Weight loss programs

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.) | | | | |
| * Abortion * Bariatric surgery * Chiropractic care (spinal manipulation) |    | Hearing Aids (children and adults) Infertility treatment |    | Private-duty nursing Routine eye care (Adult) |

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.](http://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](http://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.](http://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 800-870-9488. 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](http://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.massconsumerassistance.org.](http://www.massconsumerassistance.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 800-870-9488.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-870-9488. Chinese(୰ᩥ): ዴᯝ㟂せ୰ᩥⓗᖎຓ㸪実㊐ᡴ征୭ྕ䞩 800-870-9488.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-870-9488.

*––––––––––––––––––––––––––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)

Managing Joe’s type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

Mia’s Simple Fracture

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

Specialist office visits *(prenatal care)* Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests *(ultrasounds and blood work)* Specialist visit *(anesthesia)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| * The plan's overall deductible | $500 | * The plan's overall deductible | $500 | * The plan's overall deductible | $500 |
| * Tier 1 Specialist copayment | $30 | * Tier 1 Specialist copayment | $30 | * Tier 1 Specialist copayment | $30 |
| * Tier 1 Hospital (facility) copayment | $275 | * Tier 1 Hospital (facility) copayment | $275 | * Tier 1 Hospital (facility) copayment | $275 |
| * Plan coinsurance   This EXAMPLE event includes services like: | 0% | * Plan coinsurance   This EXAMPLE event includes services like: | 0% | * Plan coinsurance   This EXAMPLE event includes services like: | 0% |

Primary care physician office visits *(including disease education)*

Diagnostic tests *(blood work)*

Prescription drugs

Durable medical equipment *(glucose meter)*

Emergency room care *(including medical supplies)*

Diagnostic test *(x-ray)*

Durable medical equipment *(crutches)*

Rehabilitation services *(physical therapy)*

|  |  |
| --- | --- |
| Total Example Cost | $12,700 |

|  |  |
| --- | --- |
| Total Example Cost | $7,400 |

|  |  |
| --- | --- |
| Total Example Cost | $1,900 |

In this example, Peg would pay:

In this example, Joe would pay:

In this example, Mia would pay:

|  |  |
| --- | --- |
| *Cost Sharing* | |
| Deductibles | $500 |
| Copayments | $300 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Peg would pay is | $800 |

|  |  |
| --- | --- |
| *Cost Sharing* | |
| Deductibles | $300 |
| Copayments | $1,600 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| The total Joe would pay is | $1,960 |

|  |  |
| --- | --- |
| *Cost Sharing* | |
| Deductibles | $500 |
| Copayments | $300 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $800 |

Note: These numbers assume the patient does not participate in the plan’s wellness program. If you participate in the plan’s wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 800-870-9488.

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 800-870-9488.

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](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 800-368-1019, 800-537-7697 (TDD)

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

