



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.

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.



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 800-870-9488 (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/> 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 medical deductible	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> , primary care, <u>specialist</u> care services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. \$100 individual/\$200 family for <u>prescription drug coverage</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	\$5,000 individual/\$10,000 family for medical and pharmacy expenses.	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.
What is not included in the out-of-pocket limit?	<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> .
Will you pay less if you use a network provider?	Yes. See tuftshealthplan.com/gic , "Find a doctor, hospital..." or call 800-870-9488 (TDD: 711) 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.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copayment and coinsurance costs shown in this chart apply both before and 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
		In-network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	None
	<u>Specialist</u> visit	Tier 1 - \$30 <u>copay</u> /visit Tier 2 - \$60 <u>copay</u> /visit Tier 3 - \$90 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	Prior authorization may be required.
	<u>Preventive care/ screening/ immunization</u>	No charge; <u>deductible</u> does not apply	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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	Prior authorization may be required.
	Imaging (CT/PET scans, MRIs)	\$100 <u>copay</u> /test	Not covered	Prior authorization is required.
If you need drugs to treat your illness or condition	Tier 1 - Generic drugs	\$10 <u>copay</u> /prescription (retail); \$25 <u>copay</u> /prescription (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. A 90-day supply of maintenance medications may be obtained at a CVS pharmacy for the applicable mail order <u>copay</u> . 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 <u>copay</u> plus the cost difference between the generic and brand name drug.
	Tier 2 - Preferred brand and some generic drugs	\$30 <u>copay</u> /prescription (retail); \$75 <u>copay</u> /prescription (mail order)		
	Tier 3 - Non-preferred brand drugs	\$65 <u>copay</u> /prescription (retail); \$165 <u>copay</u> /prescription (mail order)		
	<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.

More information about prescription drug coverage is available at tuftshealthplan.com/gic
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		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
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 <u>copay</u> /visit	Not covered	Some surgeries require prior authorization in order to be covered. Limit of 4 <u>copays</u> , per member, per <u>plan</u> year maximum.
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> /visit		<u>Copay</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>	Free-standing <u>Urgent Care</u> Center - \$20 <u>copay</u> /visit PCP - \$20 <u>copay</u> /visit Tier 1 <u>specialist</u> - \$30 <u>copay</u> visit Tier 2 <u>specialist</u> - \$60 <u>copay</u> /visit Tier 3 <u>specialist</u> - \$90 <u>copay</u> visit; <u>deductible</u> does not apply		Services with <u>out-of-network providers</u> are only covered outside of the Spirit service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	Tier 1 - \$300 <u>copay</u> /admission Tier 2 - \$700 <u>copay</u> /admission	Not covered	Some <u>hospitalizations</u> require prior authorization to be covered. Limit of one <u>copay</u> , per member, per quarter.
	Physician/surgeon fees	No charge	Not covered	
If you need mental health, behavioral health, or substance abuse services <i>Benefits provided by Beacon Health Options</i> More information is available at beaconhealthoptions.com/gic Phone: 855-750-8980 (TTY: 711)	Outpatient services	Individual/family therapy:\$20 <u>copay</u> /visit; <u>deductible</u> does not apply Group therapy, medication management and telehealth services: \$15 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	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 <u>providers</u> . For treatment with non-DPH licensed <u>providers</u> , 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 authorization is not required. Limit of one inpatient <u>copay</u> , per member, per quarter.
	Inpatient services	\$200 <u>copay</u> /admission; <u>deductible</u> does not apply	Not covered	

		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
If you are pregnant	Office Visits	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	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	Tier 1 - \$300 <u>copay</u> /admission Tier 2 - \$700 <u>copay</u> /admission	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	Not covered	Prior authorization is required.
	<u>Rehabilitation services</u>	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	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>	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	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>	20% <u>coinsurance</u>	Not covered	Limited to 45 days per year. Prior authorization is required.
	<u>Durable medical equipment</u>	No charge	Not covered	Prior authorization may be required.
	<u>Hospice services</u>	No charge	Not covered	Prior authorization is required.
If your child needs dental or eye care	Children's eye exam	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	Limited to one visit every 24 months with an EyeMed vision care <u>provider</u> .
	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.)

- 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>. 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 800-870-9488. 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>. 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>.

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 (中文): 如果需要中文的帮助, 请拨打这个号码 800-870-9488.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo 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)

■ The plan's overall <u>deductible</u>	\$500
■ Tier 1 <u>Specialist copayment</u>	\$30
■ Tier 1 Hospital (facility) <u>copayment</u>	\$300
■ <u>Plan coinsurance</u>	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
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In this example, Peg 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

Managing Joe's type 2 Diabetes

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

■ The plan's overall <u>deductible</u>	\$500
■ Tier 1 <u>Specialist copayment</u>	\$30
■ Tier 1 Hospital (facility) <u>copayment</u>	\$300
■ <u>Plan coinsurance</u>	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
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In this example, Joe would pay:

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

Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$500
■ Tier 1 <u>Specialist copayment</u>	\$30
■ Tier 1 Hospital (facility) <u>copayment</u>	\$300
■ <u>Plan coinsurance</u>	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
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In this example, Mia would pay:

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: 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.

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.
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	សម្រាប់សេវាកម្រិតដោយឥតគិតថ្លៃជាភាសាខ្មែរសូមទូរស័ព្ទទៅកាន់លេខដែលនៅផ្នែកខាងលើនៃទំព័រទី 1។
Korean	한국어 무료 통역을 원하시면, 1 페이지 맨 위에 번호로 전화 하십시오.
Laotian	ສຳລັບການແປບັນພາສາລາວທີ່ບໍ່ໄດ້ສະແດງໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີໂທທີ່ຢູ່ດ້ານເທິງຂອງໜ້າທີ 1.
Navajo	Doo bą́ąh ilíní da Diné k’ehjí álnéehgo, hodiilnih béésh bee haní’é binumber díí naaltsoos bikáá’ wódahti.
Persian	برای ترجمه رایگان به فارسی، به شماره تلفن مندرج در بالای صفحه 1 زنگ بزنید
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.
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 1.
Vietnamese	Để có bản dịch tiếng Việt không phải trả phí, gọi theo số trên đầu trang 1.

