This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at tuftshealthplan.com/gic or by calling 800-870-9488.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$300/person, $900/family Doesn't apply to preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). The chart starting on page 2 shows how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs of services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. $5,000/person, $10,000/family for medical, pharmacy and behavioral health expenses.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket maximum?	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.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see tuftshealthplan.com/gic or call 800-870-9488.	If you use an in-network doctor or other health care **providers**, this plan will pay some or all of the costs for covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services (such as lab work). See the chart starting on page 2 for how this plan pays for different types of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed later in this summary. See your policy or plan document for additional information about **excluded services**.

Questions: Call 800-870-9488 or visit us at tuftshealthplan.com/gic.
If you aren't clear about any of the bolded and underlined terms used in this form, see the Glossary.
You can view the Glossary at tuftshealthplan.com/gic or call 800-870-9488 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible.**
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles, copayments** and **coinsurance** amounts.

		Your cost if you use an		
Common Medical Event	**Services You May Need**	**In-network Provider**	**Out-of-network Provider**	**Limitations & Exceptions**
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	Not covered	none
	Specialist visit	In MA: Tier 1 (Excellent) - $30 copay/visit Tier 2 (Good) - $60 copay/visit Tier 3 (Standard) - $90 copay/visit Outside MA, and all other specialists $60 copay/visit	Not covered	none
	Other practitioner office visit	Chiropractic care: $20 copay/visit	Not covered	Spinal manipulations limited to one evaluation and 20 visits per coverage period. Not covered for children age 12 and under.
	Preventive care/screening/immunization	No charge	Not covered	none

		Your cost if you use an		
Common Medical Event	**Services You May Need**	**In-network Provider**	**Out-of-network Provider**	**Limitations & Exceptions**
If you have a test	Diagnostic test (x-ray, blood work)	Deductible	Not covered	none
	Imaging (CT/PET scans, MRIs)	$100 copay/day, then deductible	Not covered	Maximum 1 copay per day.
If you need drugs to treat your illness or condition **More Information about prescription drug coverage is available at tuftshealthplan.com/gic**	Tier 1 - Generic drugs	$10 copay/prescription (retail); $25 copay/prescription (mail order or CVS/pharmacy)	Not covered	Retail copay is for up to a 30-day supply. Mail order copay is for up to a 90-day supply; a 90-day supply of maintenance medications can also be obtained at a local CVS Pharmacy for the applicable mail order copay. When you fill a prescription for a brand name drug that has a generic equivalent, you will be responsible for the generic-level copay plus the cost difference between the generic and the brand name. This is true even when the prescribing physician indicates no substitutions. Some drugs require prior authorization to be covered. Some drugs are subject to quantity limitations, step therapy, and other provisions.
	Tier 2 - Preferred brand and some generic drugs	$30 copay/prescription (retail); $75 copay/prescription (mail order or CVS/pharmacy)		
	Tier 3 - Non-preferred brand drugs	$65 copay/prescription (retail); $165 copay/prescription (mail order or CVS/pharmacy)		

		Your cost if you use an		
Common Medical Event	**Services You May Need**	**In-network Provider**	**Out-of-network Provider**	**Limitations & Exceptions**
	Specialty drugs	Limited to a 30-day supply with appropriate tier copay (see above) when provided by a designated specialty pharmacy	Not covered	Limited to a 30-day supply. Some drugs require prior authorization to be covered. Some drugs are subject to quantity limitations and other provisions. Some specialty drugs may also be covered under your medical benefit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay/visit, then deductible	Not covered	Maximum of four copays per coverage period. Some surgeries require prior authorization in order to be covered.
	Physician/surgeon fees (e.g., ambulatory surgery center)	Deductible	Not covered	none
If you need immediate medical attention	Emergency room services	$100 copay/visit, then deductible		Copay waived if admitted.
	Emergency medical transportation	Deductible		Some emergency transportation requires prior authorization to be covered.

		Your cost if you use an		
Common Medical Event	**Services You May Need**	**In-network Provider**	**Out-of-network Provider**	**Limitations & Exceptions**
	Urgent care	$20 copay/visit		For urgent care at a free-standing urgent care center or limited service medical clinic only. Urgent care services at other sites are covered as primary care or specialist visits. 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)	$300/Tier 1 hospital, $700/Tier 2 hospital; then deductible	Not covered	Maximum of one copay per member per quarter. You must obtain prior authorization for some hospitalizations to be covered.
	Physician/surgeon fee	Deductible	Not covered	none

		Your cost if you use an		
Common Medical Event	**Services You May Need**	**In-network Provider**	**Out-of-network Provider**	**Limitations & Exceptions**
If you have mental health, behavioral health, or substance abuse needs ***Benefits provided by Beacon Health Options*** **Additional information can be found at: beaconhealthoptions.com/gic** **Ph: 855-750-8980** **TTY: 866-727-9441** **These services are subject to the plan out-of-pocket maximum detailed on page 1.**	Mental health outpatient services	Individual and family therapy: $20 copay/visit Group therapy and medication management: $15 copay/visit	Not covered	Up to 26 outpatient visits (individual/family) without prior authorization. Medical necessity review required for visits beyond 26. Treatment for Autism Spectrum Disorders is covered with prior authorization.
	Mental health inpatient services	$200 copay per coverage period quarter	Not covered	May require prior authorization. Maximum of one inpatient copay per quarter.
	Substance use disorder outpatient services	Individual and family therapy: $20 copay/visit Group therapy and medication management: $15 copay/visit	Not covered	Prior authorization is not required for treatment with Massachusetts Department of Public Health (DPH) licensed providers. For treatment with non-DPH licensed providers, up to 26 outpatient visits (individual/family) are allowed without prior authorization. Medical necessity review required for visits beyond 26.

		Your cost if you use an		
Common Medical Event	**Services You May Need**	**In-network Provider**	**Out-of-network Provider**	**Limitations & Exceptions**
	Substance use disorder inpatient services	$200 copay per coverage period quarter	Not covered	Prior authorization is not required for facilities licensed by the Massachusetts DPH. Maximum of one inpatient copay per quarter.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	———— none ————
	Delivery and all inpatient services	$275/Tier 1 hospital, $500/Tier 2 hospital copay per admission; then deductible	Not covered	
If you need help recovering or have other special health needs	Home health care	Deductible	Not covered	Prior authorization is required.
	Rehabilitation services	$20 copay/visit	Not covered	Short-term physical and occupational therapy limited to 30 visits for each type of service per coverage period. Prior authorization may be required.
	Habilitation services	No charge	Not covered	Early intervention services are covered for children up to their third birthday.
	Skilled nursing care	20% coinsurance after deductible	Not covered	Limited to 45 days per coverage period. Prior authorization is required.

		Your cost if you use an		
Common Medical Event	**Services You May Need**	**In-network Provider**	**Out-of-network Provider**	**Limitations & Exceptions**
	Durable medical equipment	Deductible	Not covered	Prior authorization may be required.
	Hospice service	Deductible	Not covered	Prior authorization is required.

		Your cost if you use an		
Common Medical Event	**Services You May Need**	**In-network Provider**	**Out-of-network Provider**	**Limitations & Exceptions**
If your child needs dental or eye care	Eye exam	$20 copay/visit	Not covered	Limited to one exam every 24 months with an EyeMed vision care provider.
	Glasses	Not covered	Not covered	Discounts may be available through EyeMed Vision Care.
	Dental check-up	Not covered	Not covered	———— none ————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for details on these exclusions and for a list of 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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.) Please note: certain coverage limits may apply.

- Bariatric surgery
- Chiropractic care (spinal manipulation)
- Hearing aids
- Infertility treatment
- Routine eye care (Adult) – same schedule as child eye exam

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 800-870-9488. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 866-444-3272 or dol.gov/ebsa, or the U.S. Department of Health and Human Services at 877-267-2323 x61565 or cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can 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.

Other contact information: Department of Labor's Employee Benefits Security Administration, 866-444-EBSA (3272) or dol.gov/ebsa/healthreform

Consumer Assistance Resource
If you need help, the consumer assistance program in Massachusetts can help you file your appeal.

Massachusetts
Contact: Health Care for All
30 Winter Street, Suite 1004
Boston, MA 02108
(800) 272-4232
hcfama.org/helpline

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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, 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:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

NOTE: These numbers assume the patient has not met any part of his/her coverage period deductible and is using in-network Tier 1 physicians and hospitals. If you go out-of-network, or see a Tier 2 or Tier 3 provider, your costs will be higher.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $6,890**
- **Patient pays $650**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$300
Copays	$350
Coinsurance	$0
Limits or exclusions	$0
Total	**$650**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays $3,720**
- **Patient pays $1,680**

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$200
Copays	$1,400
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,680**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call **800-870-9488** or visit us at **tuftshealthplan.com/gic.**
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