



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 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 www.tuftshealthplan.com/doc-links-lg or by calling 800-462-0224.

| Important Questions | Answers | Why this Matters: |
|---|---|--|
| What is the overall deductible? | \$0 | See the chart starting on page 2 for your costs for services this plan covers. |
| Are there other deductibles for specific services? | Yes, \$100 person/\$200 family pharmacy deductible per calendar year | You must pay all of the costs for these services up to specific deductible amount before this plan begins to pay for these services. |
| Is there an out-of-pocket limit on my expenses? | Yes, \$2,000 person/\$4,000 family for medical and pharmacy 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 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 . |
| 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 <i>specific</i> covered services, such as office visits. |
| Does this plan use a network of providers? | Yes. For a list of participating providers, see www.tuftshealthplan.com , "find a doctor", select "Choice Copay" from the select a plan dropdown list, or call 800-462-0224. | If you use a participating doctor or other health care providers , this plan will pay some or all of the costs for covered services. Be aware, your participating doctor or hospital may use a non-participating provider for some services. Plans use the term in-network, preferred, or participating for providers in their network . 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? | Yes | This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist . |
| 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 800-462-0224 or visit us at www.tuftshealthplan.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary.

You can view the Glossary at www.tuftshealthplan.com or call 800-462-0224 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 a non-participating **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-participating 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 a participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions (limits apply per calendar year) |
|---|--|-----------------------------------|----------------------------|---|
| | | Participating Provider | Non-participating Provider | |
| 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 | \$30 copay/visit | Not covered | ----- none ----- |
| | Other practitioner office visit | \$30 copay/visit for chiropractor | Not covered | Spinal manipulations limited to 12 visits per year. |
| | Preventive care/screening/immunization | No charge | Not covered | ----- none ----- |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge | Not covered | ----- none ----- |
| | Imaging (CT/PET scans, MRIs) | \$75 copay/visit | Not covered | ----- none ----- |

| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions (limits apply per calendar year) |
|---|---|--|----------------------------|---|
| | | Participating Provider | Non-participating Provider | |
| If you need drugs to treat your illness or condition | Tier 1 - Generic drugs | \$10 copay/prescription (retail); \$20 copay/prescription (mail order); after deductible | Not covered | 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. |
| | Tier 2 - Preferred brand and some generic drugs | \$30 copay/prescription (retail); \$60 copay/prescription (mail order); after deductible | | |
| | Tier 3 - Non-preferred brand drugs | \$50 copay/prescription (retail); \$100 copay/prescription (mail order); after deductible | | |
| More Information about <u>prescription drug coverage</u> is available at www.tuftshealthplan.com This is a Massachusetts Large Group Plan | 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. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$250 copay/visit | Not covered | Some surgeries require prior authorization in order to be covered. |
| | Physician/surgeon fees | No charge | Not covered | |

| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions (limits apply per calendar year) |
|---|--|---|----------------------------|---|
| | | Participating Provider | Non-participating Provider | |
| If you need immediate medical attention | Emergency room services | \$100 copay/visit | | Copay waived if admitted. |
| | Emergency medical transportation | No charge | | Some emergency transportation requires prior authorization to be covered |
| | Urgent care | \$20 copay/visit for PCP \$30 copay/visit for specialist | | Services with non-participating providers are only covered out of the service area. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$500 copay/admission | Not covered | Some hospitalizations require prior authorization to be covered. |
| | Physician/surgeon fee | No charge | Not covered | |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | \$20 copay/visit | Not covered | Prior authorization may be required. |
| | Mental/Behavioral health inpatient services | \$500 copay/admission | Not covered | Prior authorization may be required. |

| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions (limits apply per calendar year) |
|---|--|--|----------------------------|---|
| | | Participating Provider | Non-participating Provider | |
| If you have mental health, behavioral health, or substance abuse needs | Substance use disorder outpatient services | \$20 copay/visit | Not covered | Prior authorization may be required. |
| | Substance use disorder inpatient services | \$500 copay/admission | Not covered | Prior authorization may be required. |
| If you are pregnant | Prenatal and postnatal care | No charge for routine outpatient office visits | Not covered | ----- none ----- |
| | Delivery and all inpatient services | \$500 copay/admission | Not covered | ----- none ----- |
| If you need help recovering or have other special health needs | Home health care | No charge | Not covered | Prior authorization is required. |
| | Rehabilitation services | \$30 copay/visit | Not covered | Short-term physical and occupational therapy limited to 30 visits for each type of service per year. Prior authorization may be required. |
| | Habilitation services | \$30 copay/visit | Not covered | Short-term physical and occupational therapy limited to 30 visits for each type of service per year. Prior authorization may be required. |
| | Skilled nursing care | No charge | Not covered | Limited to 100 days per year. Prior authorization is required. |

| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions (limits apply per calendar year) |
|---|---------------------------|------------------------|----------------------------|---|
| | | Participating Provider | Non-participating Provider | |
| If you need help recovering or have other special health needs | Durable medical equipment | 30% coinsurance | Not covered | Prior authorization may be required. |
| | Hospice service | No charge | Not covered | Prior authorization is required. |
| If your child needs dental or eye care | Eye exam | \$20 copay/visit | Not covered | Limited to one visit every 24 months with an EyeMed vision care provider. |
| | Glasses | Not covered | Not covered | Discounts may apply 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.
- 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)
- 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 and other requirements may apply.

- Bariatric surgery
- Chiropractic care (spinal manipulation)
- Hearing Aids (age 21 or younger only)
- Infertility treatment
- Routine eye care (Adult)

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 800-462-0224. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.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 800-462-0224. 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.

Other contact information: Department of Labor’s Employee Benefits Security Administration, 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform

Consumer Assistance Resource

If you need help, the consumer assistance programs in Massachusetts or Rhode Island can help you file your appeal.

Massachusetts

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

Rhode Island

Contact: Rhode Island Department of Business Regulation
1511 Pontiac Avenue, Bldg. 69-2
Cranston, RI 02920
(401) 462-9520
www.dbr.state.ri.us and www.ohic.ri.gov

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 800-462-0224.

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): Dinek'ehgo 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:

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.

Having a baby (normal delivery)

- Amount owed to providers: **\$7,540**
- Plan pays: **\$6,990**
- Patient pays: **\$550**

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 | \$50 |
| Copays | \$500 |
| Coinsurance | \$0 |
| Limits or exclusions | \$0 |
| Total | \$550 |

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

- Amount owed to providers: **\$5,400**
- Plan pays: **\$3,790**
- Patient pays: **\$1,610**

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 | \$100 |
| Copays | \$1,400 |
| Coinsurance | \$30 |
| Limits or exclusions | \$80 |
| Total | \$1,610 |

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 participating **providers**. If the patient had received care from non-participating **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 800-462-0224 or visit us at www.tuftshealthplan.com.

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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: 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.

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 ສຳລັບການແປບັນພາສາລາວທີ່ບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີໂທທີ່ຢູ່ດ້ານເທິງຂອງໜ້າທີ 1.

Navajo Doo bą́ąh ilíní da Diné k’ehjí álnéehgo, hodiilnih béésh bee haní’é binumber díí naaltsoos bikáá’ wódałhdi.

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.

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

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