TUFTS Health Plan

a Point32Health company

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
DIRECT SILVER 2000

Coverage Period: 1/1/2027 to 12/31/2027
Coverage for: Individual/Family | Plan Type: HMO

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, visit www.tuftshealthplan.com or call 888-257-1985 (TTY: 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 888-257-1985 (TTY:711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,000**/individual or **$4,000**/family	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. Preventive services, most outpatient visits, some prescription drug coverage, and urgent care do not apply toward the 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?	**$12,000** individual / **$24,000** family	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 billing 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 or call 888-257-1985 (TTY: 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.

Important Questions	Answers	Why This Matters:
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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit. Deductible does not apply.	Not covered	
	Specialist visit	$60 copay/visit. Deductible does not apply.	Not covered	
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	Not covered	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 in your *Tufts Health Direct Member Handbook* "Benefits and Cost-sharing Summary" section.
If you have a test	Diagnostic test (x-ray, blood work)	$60 copay/visit (x-ray) $50 copay/visit (blood work)	Not covered	
	Imaging (CT/PET scans, MRIs)	$350 copay/visit	Not covered	Requires prior authorization
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.tuftshealthplan.com	Generic drugs	$30 copay/retail supply $60 copay/mail-order supply. Deductible does not apply.	Not covered	Up to a 30-day retail supply (with certain exceptions), up to a 90-day mail-order supply. Cost sharing may be waived for certain covered prescription drugs. May require prior authorization.
	Preferred brand drugs	$60 copay/retail supply $120 copay/mail-order supply	Not covered	
	Non-preferred brand drugs	$90 copay/retail supply $270 copay/mail-order supply	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs	$90 copay/prescription	Not covered	Must be obtained from designated specialty pharmacy provider. Covers up to a 30-day supply. May require prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500 copay/visit	Not covered	May require prior authorization
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	Emergency room care	$500 copay/visit	$500 copay/visit	Copayment waived, if admitted.
	Emergency medical transportation	No charge	No charge	Emergency transport only; nonemergency transport may be covered with prior authorization.
	Urgent care	$30 copay/visit (PCP/behavioral health provider) $60 copay/visit (UCC). Deductible does not apply.	$60 copay/visit (UCC). Deductible does not apply.	Outside of our service area, free-standing Urgent Care Centers (UCC) are covered at out-of-network provider sites, including hospitals and clinics. Cost sharing may vary depending on place of service.
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,000 copay/visit	Not covered	No Prior Authorization required for Inpatient admissions from the Emergency room.
	Physician/surgeon fees	No charge	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/visit. Deductible does not apply.	Not covered	Certain services require prior authorization. No visit limits and no prior authorization required for outpatient behavioral health therapy visits or substance use treatment.
	Inpatient services	$1,000 copay/visit	Not covered	No prior authorization required for admission.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	$30 copay/visit (PCP) $60 copay/visit (specialist). Deductible does not apply.	Not covered	Cost sharing does not apply for preventive services, including standard prenatal and postnatal care. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound) and may require cost sharing.
	Childbirth/delivery professional services	No charge.	Not covered	
	Childbirth/delivery facility services	$1,000 copay/visit	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Requires prior authorization.
	Rehabilitation services	$60 copay/visit. Deductible does not apply.	Not covered	Maximum of 60 visits total combined rehabilitative physical and occupational therapy per member per plan year. No limit on speech therapy. May require prior authorization in outpatient setting after initial evaluation.
	Habilitation services	$60 copay/visit. Deductible does not apply.	Not covered	Maximum of 60 visits total combined habilitative physical and occupational therapy per member per plan year. No limit on speech therapy. May require prior authorization in outpatient setting after initial evaluation.
	Skilled nursing care	$1,000 copay/visit	Not covered	Maximum of 100 calendar days total per member per plan year. Requires prior authorization.
	Durable medical equipment	20% coinsurance	Not covered	May require prior authorization. Some services may not require cost sharing, such as one breast pump per birth.
	Hospice services	No charge	Not covered	Requires prior authorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$60 copay/visit. Deductible does not apply.	Not covered	Coverage for routine eye exams for members under 19 years of age once every 12 months.
	Children's glasses	20% coinsurance	Not covered	Coverage for eyeglasses for members under 19 years of age once every 12 months. Collection frames only or $150 allowance + 20% off expense beyond allowance.
	Children's dental check-up	No charge. Deductible does not apply.	Not covered	Covered 2 exams per year for pediatric dental checkup for members under 19 years of age.

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)
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Services that are not Medically Necessary

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Bariatric surgery with prior authorization
- Chiropractic care
- Hearing aids (age 21 and younger, covered up to $2,000 per ear every 36 months)
- Infertility treatment with prior authorization
- Routine eye care (adult)
- Routine foot care for diabetics
- Weight loss programs covered for 3 months

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: the Massachusetts Division of Insurance Consumer Service Section at 1-877-563-4467; the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa; and the Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 www.HealthCare.gov or call 1-800-318- 2596. For more information on your rights to continue coverage, contact Tufts Health Plan at **888-257-1985** (TTY: 711).

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 on how 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 **888-257-1985** (TTY: 711)
- U.S. Department of Labor's Employee Benefits Security Administration at 866.444.EBSA (3272) or dol.gov/ebsa/healthreform
- Massachusetts Division of Insurance at 617.521.7794

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 888-257-1985.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-257-1985.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 888-257-1985.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 888-257-1985.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

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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	**$2,000**
Specialist copayment	**$60**
Hospital (facility) copayment	**$1,000**
Other copayment	**$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	$2,000
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,000**

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

The plan's overall deductible	**$2,000**
Specialist copayment	**$60**
Hospital (facility) copayment	**$1,000**
Other copayment	**$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	$2,000
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,320**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$2,000**
Specialist copayment	**$60**
Hospital (facility) copayment	**$1,000**
Other copayment	**$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	$2,000
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,400**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Language Assistance Services

Español (Spanish) ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 888.257.1985 (TTY: 711).

Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 888.257.1985 (TTY: 711).

Kreyòl Ayisyen (French Creole) ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 888.257.1985 (TTY: 711).

繁體中文 (Traditional Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 888.257.1985 (TTY: 711).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu quí vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quí vị miễn phí. Gọi số 888.257.1985 (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 888.257.1985 (телетайп: 711).

العربية (Arabic)
إنتباه: إذا أنت تتكلم اللُغةِ **العربية** ، خَدَمات اَلمُساعَدة اَللُغَوية مُتَوفرة لك مَجانا. **إتصل على** 888.257.1985 (TTY: 711)

ខ្មែរ (Cambodian) ប្រសុំជូនដំណឹង៖ បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 888.257.1985 (TTY: 711).។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 888.257.1985 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 888.257.1985 (TTY: 711).

한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 888.257.1985 (TTY: 711). 번으로 전화해 주십시오.

ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 888.257.1985 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 888.257.1985 (TTY: 711).

हिंदी (Hindi) ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्त में उपलब्ध है. जानकारी के लिये फोन करे. 888.257.1985 (TTY: 711).

ગુજરાતી (Gujarati) ધ્યાન આપો : જો તમે ગુજરાતી બોલતા હો તો આપને માટે ભાષાકીય સહાય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 888.257.1985 (TTY: 711).

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 888.257.1985 (TTY: 711).

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 888.257.1985 (TTY: 711).

DISCRIMINATION IS AGAINST THE LAW

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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, sex, sexual orientation, or gender identity.

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 and information written in other languages

If you need these services, contact Tufts Health Plan at **888.257.1985**.

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.
1 Wellness Way
Canton, MA 02021-1166
Phone: 888.880.8699 ext. 48000, [TTY number— 800.439.2370 or 711]
Fax: 617.972.9048
Email: OCRCoordinator@point32health.org

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
Phone: 800.368.1019, 800.537.7697 (TDD)

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

tuftshealthplan.com | **888.257.1985**