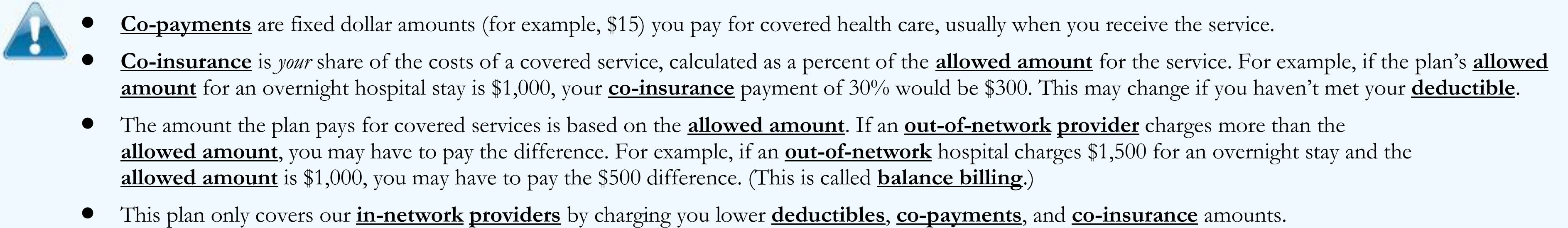
This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **Network-Health.org** or by calling **888-257-1985**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,000**/individual, **$4,000**/family	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 1). See the chart starting on page 2 for 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 for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes Medical: **$5,350** individual/**$10,700** family Pharmacy: **$1,000** individual/**$2,000** family	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, co-payments, and co-insurance for prescription drugs, balance-billing, and health care this plan doesn't cover	Even though you pay these expenses, they do not count towards your **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 Visit **Network-Health.org** or call **888-257-1985** to learn about our provider network.	If you use an **in-network** doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your **in-network** doctor or hospital may use an **out-of-network 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 different kinds of **providers**.
Do I need a referral to see a specialist?	No, as long as the **specialist** is a **preferred in-network** provider	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 on page 5. See your policy or plan document for additional information about **excluded services**.



- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** payment of 30% would be $300. 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 only covers our **in-network providers** by charging you lower **deductibles**, **co-payments**, and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an 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	$30 co-payment/visit	Not covered	——— none ———
	Specialist visit	$50 co-payment/visit	Not covered	Some specialty services may require prior authorization
	Preventive care/screening/immunization	No charge	Not covered	——— none ———
If you have a test	Diagnostic test (X-ray, blood work)	$75 co-payment/visit	Not covered	Covered if medically necessary
	Imaging (CT/PET scans, MRIs)	$400 co-payment/visit (after deductible)	Not covered	Requires prior authorization
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **Network-Health.org**	Generic drugs	$20/$40 co-payment (retail/mail-order prescription)	Not covered	Covers up to a 30-day supply retail; up to a 90-day supply mail-order
	Preferred brand drugs	$40/$80 co-payment (retail/mail-order prescription)	Not covered	Covers up to a 30-day supply retail; up to a 90-day supply mail-order
	Nonpreferred brand drugs	$70/$210 co-payment (retail/mail-order prescription)	Not covered	Covers up to a 30-day supply retail; up to a 90-day supply mail-order
	Specialty drugs	$20/$40/$70 co-payment (generic/preferred brand/nonpreferred brand)	Not covered	——— none ———

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$750 co-payment/visit (after deductible)	Not covered	Covered if medically necessary, at in-network outpatient facility
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	Emergency room services	$350 co-payment/visit (after deductible)	$350 co-payment/visit (after deductible)	Notification required within 24 hours, if admitted. Co-payment waived, if admitted.
	Emergency medical transportation	No charge	No charge	Emergency transport only; nonemergency transport covered if medically necessary and with prior authorization
	Urgent care	$30/$50 co-payment/visit (PCP/specialist)		Requires prior authorization if not rendered by a licensed urgent care facility
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,000 co-payment/visit (after deductible)	Not covered	Electively scheduled inpatient medical care covered according to medical necessity and subject to prior authorization. Nonemergency admissions require submission of prior authorization five business days before admission. Urgent admissions require submission for authorization within one business day of the admission.
	Physician/surgeon fee	No charge	Not covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health outpatient services	$30 co-payment	Not covered	After 12 outpatient therapy visits per benefit year, requires prior authorization
	Mental/behavioral health inpatient services	$1,000 co-payment (after deductible)	Not covered	Inpatient mental health and/or substance abuse services covered according to medical necessity and subject to prior authorization
	Substance use disorder outpatient services	$30 co-payment	Not covered	Requires prior authorization
	Substance use disorder inpatient services	$500 co-payment (after deductible)	Not covered	Requires prior authorization
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	Providers must submit a Prenatal Registration Form to our medical management team
	Delivery and all inpatient services	$1,000 co-payment/visit (after deductible)	Not covered	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Requires prior authorization
	Outpatient rehabilitation services: - Cardiac - Speech - Physical - Occupational	$50 co-payment	Not covered	Physical and occupational therapy limited to 90 days per condition per benefit year Prior authorization required for speech, physical, and occupational therapy Prior authorization not required for initial evaluation
	Habilitation services	Not covered	Not covered	——————— none ———————
	Skilled nursing care	$1,000 co-payment (after deductible)	Not covered	Maximum of 100 calendar days total per benefit year; requires prior authorization
	Inpatient rehabilitation services	$1,000 co-payment (after deductible)	Not covered	Maximum of 60 calendar days total per benefit year; requires prior authorization
	Durable medical equipment	20% co-insurance	Not covered	May require prior authorization (see list at Network-Health.org)
	Hospice service	No charge	Not covered	Requires prior authorization
If your child needs dental or eye care	Eye exam	No charge	No charge	Coverage for routine eye exams for members once every 12 months for diabetics, 24 months for nondiabetics, from in-network ophthalmologists or optometrists. Eyeglasses covered $80 every 24 months. Contact lenses, contact lens fittings, or any other services related to contact lenses not covered.
	Glasses	Up to $80 of basic frames/lenses covered every 24 months. Member pays for any additional services/extras.	Not covered	
	Dental checkup	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 other excluded services.)

• Cosmetic surgery • Hearing aids for members over age 21 • Long-term care	• Nonemergency dental services (excluding cleft palate/lip services for members under age 18) • Nonemergency care when traveling outside the U.S.	• Private-duty nursing • Vocational rehabilitation

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.)

• Acupuncture to treat substance abuse • Bariatric surgery with prior authorization • Chiropractic care, covered up to 12 visits per benefit year	• Emergency dental care (adult) • Fitness reimbursement, up to three months • Infertility treatment with prior authorization	• Routine eye care (adult), limitations may apply • Routine foot care for diabetics (adult) • Weight loss programs, covered for the first three months

Your Rights to Continue Coverage

If you have Individual health insurance:

Federal and state laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You or your employer commit fraud or intentional misrepresentations of material fact
- The insurer stops offering services in the state
- You move outside the coverage area

For more information on your rights to continue coverage, contact Tufts Health Plan – Network Health at **888-257-1985** (TTY: 888-391-5535). You may also contact your state insurance department at 877-563-4467 or mass.gov/doi.

If you have Group health coverage:

Federal and state laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- Your employer/sponsor changes insurance carrier
- Your employer cancels or does not renew your coverage
- Your employment/sponsorship terminates and you are not eligible to continue coverage under COBRA or state law

For more information on your rights to continue coverage, contact Tufts Health Plan – Network Health at **888-257-1985** (TTY: 888-391-5535). You may also contact your state insurance department at 877-563-4467 or mass.gov/doi.

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 – Network Health member services at **888-257-1985**
- U.S. Department of Labor's Employee Benefits Security Administration at **866-444-EBSA (3472)** or **dol.gov/ebsa/healthreform**
- Massachusetts Division of Insurance at **617-521-7777**

Language Access Services:

Para obtener asistencia en español, llame al **888-257-1985**.
We offer translation services in more than 200 languages. For assistance in another language, please call us at **888-257-1985**.

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** $5,270
- **Patient pays** $2,270

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	$2,000
Co-payments	$270
Co-insurance	
Limits or exclusions	$0
Total	**$2,270**

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact **888-257-1985**.

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,710
- **Patient pays** $2,690

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	$2,000
Co-payments	$430
Co-insurance	$260
Limits or exclusions	$0
Total	**$2,690**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact **888-257-1985**.

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 pre-existing 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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.

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