Your Choice

DESCRIPTION

The Your Choice plan design allows employer groups to offer a variable cost-sharing structure for physician and other professional visits, inpatient admissions, and surgical day facility costs. Your Choice two and three tier plan options are available as HMO, EPO, POS, or PPO options. The HMO, POS and EPO Your Choice options require a member to choose a PCP who is responsible for managing or providing the member’s care.

Hospitals, Primary Care Providers (PCPs), and specialists are grouped into three tiers based on cost and quality measures. This grouping is at the provider organization level.

Members’ cost-sharing is based on the tier of the provider from whom they receive care. These tiers are based on a combination of nationally accepted quality measures and measures of cost efficiency, contracted rates for each service and total medical expense, which encompass efficiency in managing a member’s total care.

TIER PLACEMENT FOR YOUR CHOICE THREE-TIER PLAN DESIGN

For members of employer groups electing the three-tier Your Choice benefit design, provider organizations will be placed in tiers as follows:

- Tier 1 represents the most cost-efficient, quality providers, and offers members the lowest cost-share. It includes access to a broad range of physician groups, community hospitals, and several tertiary hospitals.
- Tier 2 represents quality providers that are not as cost-efficient as Tier 1 and result in higher member cost-sharing.
- Tier 3 represents providers that either do not meet the quality threshold and/or do not meet the threshold for cost efficiency and result in the highest member cost-sharing.

Note: Independent (i.e., not affiliated with a provider organization) PCPs’ and specialists’ tiers may vary. Tier designation can be verified by using one of our electronic services options.

TIER PLACEMENT FOR TWO-TIER YOUR CHOICE PLAN DESIGN

For members of employer groups electing the two-tier Your Choice benefit design, provider organizations will be placed in tiers as follows:

- Tier 1 represents providers designated as Tier 1 or Tier 2 (the lowest and intermediate cost sharing levels, respectively) for the three-tier benefit design, and all contracting mental health providers, including provider organization-affiliated psychiatrists.
- Tier 2 represents providers designated as Tier 3 (the highest cost sharing level) for the three-tier design.

Some services on the Your Choice plan design are not tiered. These include, but are not limited to:

- Chiropractic care
- Durable medical equipment
- Inpatient rehabilitation
- Skilled nursing care
- Routine eye care
- Emergency Department (ER) services in an ER setting
- Mental health and substance abuse services

COVERAGE

The plan option covers appropriately authorized, medically necessary covered services at 100% minus the applicable copayment, deductible and/or coinsurance. Copayments, deductibles, and coinsurance responsibilities vary by employer group plan design and can be verified by using one of our electronic services options.

AUTHORIZATION

For HMO and EPO Your Choice members, specialty care must be authorized by the PCP with either an electronic or written referral to be covered. For POS Your Choice members, specialty care must be authorized by the PCP to be covered at the authorized level of benefits. In the rare instance that it is necessary for a Your Choice member to be treated by a provider outside of the Tufts Health Plan network, a paper referral form must be completed and signed by the PCP and the Physician Reviewer associated with the PCP’s provider organization.

1 Member cost-sharing may apply.
Prior to submitting a referral request to a Physician Reviewer, the PCP should confirm that a specialist in the Tufts Health Plan network could not provide a comparable level of care. Referrals that require physician reviewer approval should be sent directly to the attention of the provider organization Physician Reviewer before being sent to Tufts Health Plan.

The Physician Reviewer is responsible for reviewing referrals issued to specialty care providers who are not affiliated with Tufts Health Plan or for out-of-area specialty care services. The Physician Reviewer will either approve and sign the referral form or offer an appropriate in-plan provider option. If the member is referred for specialty care to a provider out of the Tufts Health Plan network, the referral must also be authorized by the PCP’s Physician Reviewer in order to be covered.

POS Your Choice members can choose to use the unauthorized level of their benefits by seeking specialty care outside of the Tufts Health Plan network without a referral, and are then responsible for deductible and coinsurance.

PPO Your Choice members are not required to obtain a referral from their PCP for specialty care.

**Preregistration** is required for all inpatient admissions prior to rendering services.

**Prior authorization** by Tufts Health Plan’s Precertification Department is required for certain procedures and services. For a complete description of Tufts Health Plans authorization and notification requirements, refer to the [Authorization Payment Policy](#).

### MENTAL HEALTH/SUBSTANCE ABUSE
Mental health and substance abuse services are authorized by Tufts Health Plan’s Mental Health department and can be obtained by using one of our self service options or by contacting the Mental Health department at 888-766-9818.

**Outpatient**
For information about mental health and substance abuse services (MH/SA), refer to the [Outpatient Mental Health and Substance Abuse Payment Policy](#).

**Inpatient**
For information about Mental Health and Substance Abuse, refer to the [Inpatient and Intermediate Mental Health and Substance Abuse Payment Policy](#).