2023

Tufts Health Direct

Member Handbook

This health plan meets **Minimum Creditable Coverage** standards and will satisfy the individual mandate that you have health insurance. Please see page 13 for additional information.

Effective Date: January 1, 2023

Form Number: EOC-DIRECT-003 Ed. 1-2023

TUFTS Health Plan

a Point32Health company

ACCREDITED NCQA HEALTH PLAN ACCREDITED

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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, 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— 711 or 800.439.2370]
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**

For no-cost translation in English, call **888.257.1985**.

Arabic .888.257.1985 للحصول على خدمة الترجمة المجانية باللغة العربية، يرجى الاتصال على الرقم

Chinese 若需免費的中文版本，請撥打 **888.257.1985**。

French Pour demander une traduction gratuite en français, composez le **888.257.1985**.

German Um eine kostenlose deutsche Übersetzung zu erhalten, rufen Sie bitte die folgende Telefonnummer an: **888.257.1985**.

Greek Για δωρεάν μετάφραση στα ελληνικά, καλέστε στο **888.257.1985**.

Haitian Creole Pou tradiksyon gratis nan Kreyòl Ayisyen, rele **888.257.1985**.

Igbo Maka ntụgharị asụsụ n'Igbo na akwụghị ụgwọ, kpọọ **888.257.1985**.

Italian Per la traduzione in italiano senza costi aggiuntivi, è possibile chiamare il numero **888.257.1985**.

Japanese 日本語の無料翻訳については **888.257.1985** に電話してください。

Khmer (Cambodian) សម្រាប់សេវាបកប្រែដោយឥតគិតថ្លៃ ជាភាសាខ្មែរ សូមទូរស័ព្ទទៅលេខ 888.257.1985។

Korean 한국어로 무료 통역을 원하시면, **888.257.1985** 로 전화하십시오.

Kru Inyu yangua ndonõl ni Kru sébèl **888.257.1985**.

Laotian ສໍາລັບການແປພາສາເປັນພາສາລາວທີ່ບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີ **888.257.1985**.

Navajo Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **888.257.1985**.

Persian برای ترجمه رایگان به فارسی به شماره تلفن888.257.1985 زنگ بزنید.

Polish Aby uzyskać bezpłatne tłumaczenie w języku polskim, należy zadzwonić na numer **888.257.1985**.

Portuguese Para tradução grátis para português, ligue para o número **888.257.1985**.

Russian Для получения услуг бесплатного перевода на русский язык позвоните по номеру **888.257.1985**.

Spanish Para servicio de traducción gratuito en español, llame al **888.257.1985**.

Tagalog Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **888.257.1985**.

Vietnamese Để có bản dịch tiếng Việt không phải trả phí, gọi theo số **888.257.1985**.

Yorùbá Fún isẹ́ ògbùfọ̀ l'ọ́fẹ̀ ní Yorùbá, pe **888.257.1985**.

Table of Contents

Introduction

This Handbook is full of information about how your health plan benefits work. If you want to know how to get care when you need it, what services are covered or whom to talk to when you have a question, you will find the answers here.

This page includes important information to keep handy.

Contact us

888.257.1985, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays

TTY: 711 (for people with partial or total hearing loss)

Web: tuftshealthplan.com/memberlogin

Mail: Tufts Health Plan, P.O. Box 524, Canton, MA 02021

Language translation

We have bilingual staff available, and we offer translation services in 200 languages. All translation services are free to Members. For no-cost translation in English, call **888.257.1985**.

Arabic 888.257.1985 للحصول على خدمة الترجمة المجانية باللغة العربية، يرجى التصال على الرقم.

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Vietnamese Để có bản dịch tiếng Việt không phải trả phí, gọi theo số 888.257.1985.

Call us

- **If you move or change your phone number**
  Do not risk losing your health benefits because we cannot find you. If you move, whether you are enrolled through the Health Connector or an Enrollment Administrator (for example, HSA Insurance), you must call the applicable exchange or administrator and Tufts Health Plan to tell us your new address and phone number. You should also put the last names of all Tufts Health Direct Members in your household on your mailbox. The post office may not deliver mail from the Health Connector, your Enrollment Administrator, or us to someone whose name is not listed on the mailbox.

If you move, call the Health Connector's customer service center at 877.623.6765 (TTY: 877.623.7773), Monday through Friday, from 8 a.m. to 6 p.m. or your Enrollment Administrator's (HSA Insurance) customer service center at 781.228.2222 (toll-free: 877.777.4414), and Tufts Health Plan at **888.257.1985**, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays, to update your contact information.

Also, tell the Health Connector about any changes in your income, family size, employment status or disability status or if you have additional health insurance.

- **To find out if other household members are eligible for an affordable health plan**
  If other people in your home may be eligible for an affordable health plan, we can help! Call us at 888.257.1985. They can also call the Health Connector's customer service center at 877.623.6765 (TTY: 877.623.7773), Monday through Friday, from 8 a.m. to 6 p.m.
- **If you want to change your Primary Care Provider (PCP)**
  You can switch your PCP for any reason by calling us at **888.257.1985** or by visiting us at tuftshealthplan.com/memberlogin.

IN AN EMERGENCY, GET CARE RIGHT AWAY

Take immediate action if you believe that you are in a life-threatening Emergency situation.

- For medical or Behavioral Health (mental health and/or substance use) Emergencies, call 911 or go to the nearest Emergency room right away.
- Bring your Tufts Health Direct Member ID Card with you.
- Tell your PCP and, if applicable, your Behavioral Health Provider within 48 hours of an Emergency to get any necessary follow-up care.
- For Urgent, non-emergent care, see below.

Prior Authorization is not required for any Emergency care, including ambulance transportation.

IN AN URGENT CARE SITUATION

Call your PCP or Behavioral Health (mental health and/or substance use) Provider.

If you need Urgent Care for a problem that is serious but does not put your life in danger or risk permanent damage to your health, call your PCP or Behavioral Health Provider. Your PCP or Behavioral Health Provider can usually address these health problems. You can contact any of your Providers' offices or a Covering Provider 24 hours a day, seven days a week.

The Behavioral Health Help Line is a 24/7 clinical hotline staffed by trained behavioral health providers and peer coaches who offer clinical assessment, treatment referrals, and crisis triage services. The Help Line is available in more than 200 languages, 24/7, 365 days a year. Call or Text: 833-773-2445 or Web Chat: masshelpline.com.

If you are in the Service Area, you may also visit an In-network Free-standing Urgent Care Center (UCC) or MinuteClinic® (a Limited Service Medical Clinic) for your Urgent Care needs. For more information, see Urgent Care page 20.

Member Services hours

If you want to talk to a Member Services Representative who can answer your questions, call us at **888.257.1985**, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays.

24/7 NurseLine

For general health information and support, call our 24/7 NurseLine at 888.MY.RN.LINE (888.697.6546) (TTY: 800.942.1859), 24 hours a day, seven days a week.

Visit us on the web!

Visit us at tuftshealthplan.com/memberlogin to:

- Find a PCP, Specialist or health center near you in our Tufts Health Direct Network.
- Find a Behavioral Health Provider near you in our Tufts Health Direct Network. If you need assistance locating a Provider or finding information about your Behavioral Health/substance use disorder benefits, please contact us at 888.257.1985.
- Sign up for the secure Member portal, and:
- Change your address or phone number.
- Choose or change your PCP.
- Use the secure messaging center to send us information and questions.
- Get answers to your questions.
- Download the forms to get your Tufts Health Direct EXTRAS.
- Get important information on:
- Our Quality Management and Improvement Program
- Our Utilization Management Program
- How we use information that your Providers give us in order to decide what services you may need (Utilization Review)
- How you can file a Grievance or an Appeal
- How you have the right to request an External Review if we deny an Appeal, as well as your other rights and responsibilities
- How we may collect, use, protect, and disclose your Protected Health Information (PHI), and your rights concerning your PHI

Treatment Cost Estimator

Tufts Health Plan offers a cost transparency estimator tool to help Members estimate the cost of Covered Services. In order to access this tool, you must register at tuftshealthplan.com/memberlogin.

Once you have registered, enter the Member portal to access the tool. Examples of information you can find by using the treatment cost estimator include:

- The estimated or maximum allowed cost for a proposed admission, procedure or service
- The estimated amount you will be responsible for paying for admissions, procedures or services that are Covered Services (including Facility Fees and Cost-Sharing Amounts), based on information available to Tufts Health Plan at the time the request is made.

The cost estimates generated by the tool are binding to the extent required by Massachusetts law. The actual amount you may be responsible for paying may vary due to unforeseen services that arise out of the proposed admission, procedure or service.

If you have any questions, please call us at **888.257.1985**. Members with partial or total hearing loss should call our TTY line at 711 for assistance.

Fraud, Waste, and Abuse

You may have concerns about being billed for services you never received or that your insurance information has been stolen or used by someone else. To report potential health care Fraud or abuse or if you have questions, please call us at 800.462.0224 or email THPP_Claims_Fraud_and_Abuse@point32health.org.

See Glossary at the end of this Handbook to learn more. You can also call our anonymous hotline anytime at 877.824.7123 or send an anonymous letter to us at:

Tufts Health Plan
Attn: Fraud and Abuse
1 Wellness Way
Canton, MA 02021

Your Concerns

If you need to call about a concern or file an Appeal, contact a Member Services Representative at **888.257.1985**. To submit your Appeal or Grievance in writing, send your letter to:

Tufts Health Plan
Attn: Appeals and Grievances
1 Wellness Way
Canton, MA 02021
Fax: 857.304.6321

DISCRIMINATION IS AGAINST THE LAW

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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, and other format)
- 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 **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, sex, sexual orientation, or gender identity you can file a Grievance with:

Tufts Health Plan
Attention: Civil Rights Coordinator, Legal Dept.
1 Wellness Way
Canton, MA 02021
Phone: 888.880.8699 ext. 48000 (TTY 711 or 800.439.2370)
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 1-800-368-1019, TDD: 1-800-537-7697.

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
Phone: 800.368.1019 (TTY 800.537.7697)

Complaint forms are available at:

- http://www.hhs.gov/ocr/office/file/index.html.
- tuftshealthplan.com/memberlogin
- tuftshealthplan.com
- 888.257.1985

Welcome

You deserve great care. We want you to get the most out of your Tufts Health Direct membership.

To bring you the best value in health care, we work with a high-quality Network of doctors, Hospitals, and other Providers across Massachusetts. We serve Tufts Health Direct Members in all or parts of the following counties: Barnstable, Berkshire, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester. For a complete listing of our Providers or to see a map of our Service Area, please visit tuftshealthplan.com/memberlogin.

To help you understand what you need to know about your health plan, we have capitalized important words and terms throughout this Member Handbook. You can find definitions for each in the Glossary at the end of this Handbook.

This plan is offered by Tufts Health Public Plans, Inc. Tufts Health Public Plans, Inc. is licensed as a health maintenance organization in Massachusetts and does business under the name Tufts Health Plan.

Translation and Other Formats

Call us at **888.257.1985**, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays, if you:

- Have questions

- Need this document orally translated
- Need someone to read this or other printed information to you
- Want to learn more about any of our benefits or Covered Services

We have bilingual staff available. And we offer translation services in 200 languages. All translation services are free to Members.

Your Tufts Health Direct Evidence of Coverage

This *Member Handbook* (including the Benefit and Cost-Sharing Summary for each Plan Level at the end of this Handbook), your Formulary, and any amendments we may send you, make up your Evidence of Coverage.

These documents are a contract between you and Tufts Health Plan. By causing your membership application to be submitted to Tufts Health Direct, you applied for coverage from Tufts Health Plan. You also agreed to all the terms and conditions of Tufts Health Direct that we set forth, and to the terms and conditions in this Handbook.

This Handbook explains your rights, benefits, and responsibilities as a Tufts Health Direct Member.

It also explains our responsibilities to you. If there are any major plan changes, we will mail you a letter 60 Days before the changes go into effect.

Minimum creditable coverage and mandatory health insurance requirement

Massachusetts law requires that Massachusetts Residents 18 years old and older must have health coverage that meets the minimum creditable coverage standards that the Health Connector sets, unless waived by the Health Connector for affordability or individual hardship. For more information, call the Health Connector at 877.623.6765 (TTY: 877.623.7773) or visit the Health Connector's website at MAhealthconnector.org.

This health plan meets minimum creditable coverage standards as part of the Massachusetts health care reform law and minimum essential coverage standards under the federal Affordable Care Act. If you enroll in this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

Health Care Costs

Premiums

A Premium is a monthly bill for your Tufts Health Direct benefits. If you have an individual plan, you must pay your Premium every month by the due date stated on the bill in order for your health benefits to continue. Please follow the payment directions on your bill when paying your Premiums. If you have questions about your Premium, please call the number listed on your bill.

If you are part of a Group, please note that your employer pays your Premium, and we will send an annual notice about the Premium that must be paid.

If an individual or Group is late (delinquent) in paying required Premiums, we may terminate coverage, which would include stopping payment of Claims until we get the full Premium payment.

In addition to the Premium, you may have to pay for cost sharing. Cost sharing is what you pay for specific health care benefits (e.g., office visits, X-rays and prescriptions). Coinsurance, copayments

and deductibles are all examples of cost sharing and are explained in more detail below.

Federal Premium Tax Credit and ConnectorCare Plans

You might be eligible for a Federal Premium Tax Credit if your household income is up to 400% of the Federal Poverty Level (FPL). The Department of Health and Human Services sets the FPL. If you are eligible for a Tax Credit, the United States government will pay part of your Tufts Health Direct Premiums directly to Tufts Health Plan. Alternatively, you can claim the Credit when you file your tax return for the year.

We have low-cost plans available through the Health Connector, including plans with subsidies (ConnectorCare and/or advanced Premium Tax Credits) for those who qualify.

You might also be eligible for a lower-cost ConnectorCare Plan if your household income is up to 300% of the FPL. If you are eligible, the Commonwealth of Massachusetts will pay part of your Tufts Health Direct Premiums directly to Tufts Health Plan. This would be in addition to any tax credits you might qualify for, further decreasing your share of the Premium cost.

The Health Connector can help you find out if you are eligible for a ConnectorCare Plan and/or Federal Premium Tax Credit and, if so, how much the Credit would be.

Cost-Sharing

Coinsurance

Coinsurance is a set percentage of the total allowed amount that you must pay for certain Covered Services. After you have met any Deductible you may have, you will be responsible for that set percentage. Tufts Health Plan will be responsible for the rest of the cost. You may be required to pay the Coinsurance on the date of service. If your Plan Level requires Coinsurance, the Coinsurance percentages are listed in your Benefit and Cost-Sharing Summary.

Note: Coinsurance you paid for Covered Services you got before the start of a Benefit Year is not counted toward your Out-of-pocket Maximum for your current Benefit Year. At the start of each new Benefit Year, your accumulation will begin at zero and you will start building again to your annual Out-of-pocket Maximum for the new Benefit Year.

Copayments

Copayments are set dollar amounts that are due from you when you get care or a service or when billed by a Provider. You are responsible for paying all of the Copayments listed in your Plan Level's Benefit and Cost-Sharing Summary starting after the Glossary. Preventive Services do not have any Copayments. But you will need to pay a Copayment for most Covered Services, such as doctors' visits, pharmacy services, advanced imaging (MRIs, PET, CT scans), Emergency room visits, and care you get in the Hospital. If you do not pay the Copayment at the time of your visit, you will still owe the money to the Provider. The Provider may use a legal method to collect the money from you. Tufts Health Plan is not responsible for paying the Provider the Copayment that you owe.

American Indians and Alaskan Natives do not need to pay Copayments or Coinsurance for services received through the Indian Health Service. American Indians and Alaskan Natives who make less than 300% of the FPL never pay Copayments and Coinsurance, regardless of where a service is received.

Deductibles

You may have an annual Deductible. The Deductible is the amount you pay for certain Covered Services in a Benefit Year before Tufts Health Plan will begin to pay for those Covered Services. Your Benefit and Cost-Sharing Summary will show if you have any Deductible amounts. You may have a medical Deductible and a separate pharmacy Deductible or a combined pharmacy and medical Deductible, depending on your plan. Once you meet your annual Deductible, you may still have to pay Copayments and Coinsurance. Please see your Benefit and Cost-Sharing Summary for information specific to your Plan Level. If your plan has a Deductible, it will have one of the following types of

Deductibles:

- Individual Deductible: An individual Deductible will apply when you have individual coverage. Once you have met the individual Deductible amount, you will have no additional Deductible Member Cost Sharing for Covered Services for the remainder of the Benefit Year. An individual Deductible may also apply if you have family coverage that includes a family Deductible with an embedded individual Deductible. Please see additional information on family coverage Deductible below.
- Family Deductible: A family Deductible will apply when you have family coverage. If you have family coverage, the Deductible may be met by all Members of the family combined. For example, a family of four would meet a $4,000 family Deductible if one covered family Member incurs $3,000 in covered medical expenses and another covered family Member incurs $1,000 in covered medical expenses during the Benefit Year. At that point, the family Deductible would also be met for the entire family for that Benefit Year.

Not all services apply toward a Deductible. For some services, you are only responsible for a Copayment or Coinsurance. For other services, you are responsible for Copayment or Coinsurance after you meet your annual Deductible. Other services are covered with no charge at all.

The following do not apply to the Deductible:

- Premiums
- Any payments you make for non-Covered Services.
- Payments you made for Covered Services you got before the start of the current Benefit Year. At the start of each new Benefit Year, your Deductible accumulation resets at zero, and you start building again toward your Deductible for the new Benefit Year.

Out-of-pocket Maximum

Your Tufts Health Direct Plan has an Out-of-pocket Maximum. This is the maximum amount of Cost-Sharing you have to pay in a Benefit Year for Covered Services.

The Out-of-pocket Maximum is made up of Deductibles, Copayments, and Coinsurance.

However, it does not include:

- Premiums
- Any amount you pay to an Out-of-network Provider in excess of the allowed amount for Covered Services paid by the plan to that Out-of-network Provider
- Costs for non-Covered Services

Once you meet your Out-of-pocket Maximum, you no longer pay Deductibles, Copayments or Coinsurance for the rest of that Benefit Year.

- Individual Out-of-pocket Maximum: The maximum amount of Cost-Sharing an individual has to pay in a Benefit Year for Covered Services.
- **Note:** Under a family plan, any combination of enrolled Members in a family can contribute toward meeting the Family Out-of-Pocket Maximum. Once the Family Out-of-Pocket Maximum is met during a Benefit Year, we begin to pay for Covered Services for all enrolled Members in a family under the terms of this *Member Handbo*ok. If any enrolled Member in a family meets the Individual Out-of-Pocket Maximum before the Family Out-of- Pocket Maximum is met, then: (1) that Member has met his/her Out-of-Pocket Maximum requirement; and (2) we will begin to pay for his/her Covered Services, subject to the terms of this *Member Handbook*.

Note: Deductibles, Copayments, and Coinsurance you paid before the start of a Benefit Year are not counted toward your Out-of-pocket Maximum for your current Benefit Year. At the start of each new Benefit Year, your accumulation will begin at zero and you will start building again toward your annual

Out-of-pocket Maximum for the new Benefit Year.

Benefit Year

The Benefit Year is the consecutive 12-month period during which:

- Health plan benefits are purchased and administered
- Deductibles, Copayments, Coinsurance, and Out-of-pocket Maximums are calculated
- Most benefit limits apply

Note: In some cases, described in the following paragraphs, your first Benefit Year will not be a full 12 months.

For individual Subscribers:

- If you enrolled during an annual open enrollment period, your Benefit Year begins on your Effective Coverage Date and continues until December 31. (This means your first Benefit Year may not be a full 12 months if you enroll on a date after January 1st.)
- If you enrolled due to a qualifying event at any other time of the year, your first Benefit Year begins on your Effective Coverage Date and continues until December 31. (This means your first Benefit Year is not a full 12 months.) See page 33 for more information.

For Subscribers enrolled through a Group Contract: Your Benefit Year begins on the Group Effective Date (always the first of a calendar month) and continues for 12 months from that date. (For example, if the Group Effective Date is April 1, your Benefit Year runs from April 1 to March 31.)

If you are a new employee who became a Subscriber after the Group Effective Date, your Benefit Year ends on the same date the Benefit Year ends for all Subscribers in your Group. That means that your first Benefit Year will not be a full 12 months.

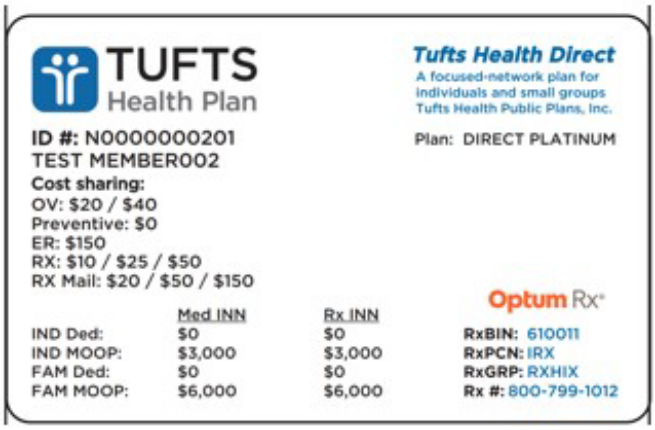
For new Dependents who are added during a Benefit Year (e.g., a new baby, Adoptive Child or new Spouse): The new Dependent's Benefit Year begins on his or her Effective Coverage Date and ends on the same date the Subscriber's Benefit Year ends.

Important Information About Your Cost-Sharing Amounts
In accordance with the Affordable Care Act (ACA), Preventive Care services—including women's Preventive Health Care services, Preventive Care visits, certain prescription medications, and certain over-the-counter medications when prescribed by a licensed Provider and dispensed at a pharmacy pursuant to a prescription—are covered in full. For more information on what services are covered in full, please see: https://www.tuftshealthplan.com/documents/providers/payment-policies/preventive-services. If you have any questions about whether specific services are considered preventive under the ACA, please call Member Services.

Getting the care you need

Your Member ID Card

Always carry your Tufts Health Direct Member ID Card with you. It has important information about you and your benefits that Providers and pharmacists need. Each person in your family with Tufts Health Direct will get a Tufts Health Direct Member ID Card. You should show your ID card every time you request health services. If you do not show your ID card, the Provider may not bill us for Covered Services, and you may be responsible for the cost of the service.



Your PCP Manages your care

As a Tufts Health Direct Member, you must have a Primary Care Provider (PCP) who is in our Tufts Health Direct Network. Your PCP is the Provider you should call for any non-Emergency health care that you need. You will get the same Medically Necessary Covered Services whether you choose a Nurse Practitioner, a Physician Assistant or a doctor as your PCP, as long as the services s/he offers fall under the scope of the Provider's license. To choose a Tufts Health Direct PCP and to find out where the PCP's office is located, please use the Find a Doctor or Hospital tool at tuftshealthplan.com, tuftshealthplan.com/memberlogin or call us at **888.257.1985**.

You can call your PCP's office 24 hours a Day, seven Days a week. If your PCP is not available, your PCP's office will direct you to somebody else who can help you. If you have problems contacting your PCP or if you have any questions, please call our Member Services Team at **888.257.1985**.

Here is what your PCP can do for you:

- Arrange necessary tests, laboratory procedures or Hospital visits
- Give you regular checkups and health screenings, including Behavioral Health (mental health and/or substance use) screenings
- Help you get Behavioral Health (mental health and/or substance use) services, when necessary
- Keep your medical records
- Make sure you get the health care you need
- Provide information on Covered Services that require Prior Authorization before you get treatment
- Refer you to Specialists, if needed
- Write prescriptions, when necessary

PCP assignment

It is important that you have a PCP in order to take full advantage of all your benefits. When you enroll, we will choose a PCP for you near to where you live and tell you your PCP's name when we send you your ID Card. You may change your PCP at any time. Just choose a different PCP in the Tufts Health Direct Network at tuftshealthplan.com/memberlogin or by calling us at **888.257.1985.** For help locating an In-network PCP, visit tuftshealthplan.com/directproviders.

Specialists

Sometimes you may need to visit a Specialist, such as a cardiologist, dermatologist or ophthalmologist. Tufts Health Direct also covers pediatric specialty care, including mental health care, by In-network pediatric Specialists. You can visit most Specialists without Prior Authorization as long as the Specialist is In-network.

To find a Tufts Health Direct Specialist, talk to your PCP. You can also call us at **888.257.1985** or visit tuftshealthplan.com/memberlogin to search for a Specialist. If you don't have a member portal account, go to tuftshealthplan.com/directproviders to search for a Tufts Health Direct In-network Providers. You should discuss your need for a Specialist with your PCP first, and then call the Specialist to make an appointment.

If you choose to get services outside of our Network, we will not cover the services. If you choose to get the services anyway, the Specialist will bill you, and you will be responsible for paying for the full cost of the care.

For more information about which services require Prior Authorization, please see your Plan Level's Benefit and Cost-Sharing Summary section in this *Member Handbook*.

Second opinions

Tufts Health Direct Members can get a second opinion from a different In-network Provider about a medical or Behavioral Health condition or a proposed treatment and care plan. Tufts Health Direct does not require Prior Authorization to get a second opinion from an In-network Provider about a medical or Behavioral Health issue or concern. If no second opinion is available inside the Network, a second opinion outside of the Network may be available and is subject to Prior Authorization. You can see the most up-to-date list of our In-network Providers at tuftshealthplan.com/memberlogin. If you don't have a member portal account, go to tuftshealthplan.com/directproviders to search for a Tufts Health Direct In-network Providers. Please call us at **888.257.1985** for help or for more information about picking a Provider to see for the second opinion.

Emergency care

For medical and Behavioral Health (mental health and/or substance use) Emergencies, call 911 or go to the nearest Emergency facility right away.

Prior Authorization is never required for Emergency services, which are available In-network or Out-of-network. Bring your Tufts Health Direct Member ID Card with you. You are covered for Emergency care 24 hours a Day, seven Days a week, wherever you are, even when you are traveling. We also cover Emergency-related ambulance transportation. A Provider will examine and treat your Emergency health needs before sending you home or moving you to another Hospital, if necessary. Continued services with an Out-of-network Provider after the Emergency condition has been treated or stabilized may not be covered if we determine, in coordination with your Providers, that it is safe to transport you to a Network facility and it is appropriate and cost-effective to transport you.

Members may also access Mobile Crisis Intervention services at a Community Behavioral Health Centers (CBHC) without prior authorization. These services provide short term, mobile, on-site, face-to-face therapeutic response for Members experiencing a Behavioral Health crisis for the purpose of

identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger. This service is provided 24 hours a day, 7 days a week.

If you are admitted as an Inpatient after receiving Emergency care, you or someone acting for you must call Tufts Health Plan or your Primary Care Provider (PCP) or, if applicable, your Behavioral Health Provider, within 48 hours after receiving care. In-Network providers will be responsible for notifying Tufts Health Plan on your behalf. If the Emergency room where you were seen or your PCP notifies us, you do not need to tell us. You are encouraged to contact your PCP or, if applicable, your Behavioral Health Provider so your PCP can provide or arrange for any follow-up care that you may need.

From an Emergency room, you may be admitted for Observation, which is an Outpatient Level of Care, or admitted Inpatient. Cost-Share will vary depending on the level of admission.

Urgent Care

Call your PCP or Behavioral Health Provider if you need Urgent Care. You can contact any of your Providers' offices 24 hours a Day, seven Days a week. Provider offices have Covering Providers who work after hours. A Covering Provider is the Provider named by your PCP to provide or authorize services in your PCP's absence.

If needed, make an appointment to visit your Provider. If your condition becomes an Emergency before your PCP or Behavioral Health Provider sees you, call 911 or go to the nearest Emergency room.

In our Service Area, there are Free-standing Urgent Care Centers (UCC) you may go to that are Tufts Health Direct In-network Providers. When going to a UCC, you should also try to contact your PCP. You must visit a UCC in our Service Area who is in our Network in order to be covered for services. To find UCCs in our Provider Network, go to tuftshealthplan.com/memberlogin and use our Find a Doctor or Hospital tool. If you don't have a member portal account go to tuftshealthplan.com/directproviders to search for a Tufts Health Direct In-network Provider. In our Service Area, if you obtain services at an Out-of-network UCC or at a UCC in an Out-of-network Hospital, you will not be covered.

Notes:

- Outside of our Service Area, Free-standing Urgent Care Centers (UCC) are covered at Out-of-network Provider sites, including Hospitals and clinics.
- If you are in the Service Area, you may also visit an In-network Free-standing Urgent Care Center (UCC) or MinuteClinic® (a Limited Service Medical Clinic) for your Urgent Care needs.

Follow these guidelines for receiving Urgent Care

Place of Service	Tufts Health Direct Provider	Non-Tufts Health Direct Provider Inside of Service Area	Non-Tufts Health Direct Provider Outside of Service Area
Limited Service Medical Clinic (MinuteClinic ®) or Free-Standing Urgent Care Center	You are covered for Urgent Care.	Not covered.	You are covered for Urgent Care.
Emergency Room	You are covered for Urgent Care.	You are covered for Urgent Care.	You are covered for Urgent Care.
Primary Care Provider's (PCP's) office	You are covered for Urgent Care.	Not applicable and not covered. You must have an In-network PCP.	Not applicable and not covered. You must have an In-network PCP.

Place of Service	Tufts Health Direct Provider	Non-Tufts Health Direct Provider Inside of Service Area	Non-Tufts Health Direct Provider Outside of Service Area
Provider's office (non-PCP) or Hospital-based walk-in clinic	You are covered for Urgent Care.	Not covered.	You are covered for Urgent Care.
Behavioral Health/Substance Use Disorder Provider's office	You are covered for Urgent Care.	Not covered.	You are covered for Urgent Care.

Hospital services

If you need Hospital services for non-emergency care, please contact your PCP, who will coordinate your care.

Getting care after office hours

Talk to your PCP to find out how to get care after normal business hours. Some PCPs have longer office hours. If you need Urgent Care after regular business hours, call your PCP's office. PCPs have Covering Providers who work after hours. If you have any problems seeing your PCP or any other Provider, please call us at **888.257.1985**, Monday - Friday, 8am to 5pm.

As a Tufts Health Direct member, you have access to a registered nurse any time of day through our 24/7 NurseLine at 888.MY.RN.LINE (888.697.6546) (TTY: 800.942.1859), 24 hours a day, seven days a week.

Getting care away from home (outside of the Service Area)

If you are outside Tufts Health Direct's Service Area, including out of the country, we will cover only Emergency care and Urgent Care. Continued services after the Emergency or Urgent condition has been treated or stabilized may not be covered if we determine, in coordination with your Providers, that it is safe for you to return to the Service Area. Transportation back to the Service Area after stabilization may not be a covered medical benefit.

We will not cover:

- Tests or treatment that your PCP asked for but that you decided to get outside of the Service Area
- Routine or follow-up care that can wait until you return to the Service Area, such as physical exams, flu shots, removal of stitches, Behavioral Health (mental health and/or substance use) counseling, and therapies such as Physical Therapy
- Care that you knew you were going to get before you left the Service Area, such as elective surgery
- Most follow-up care after a hospitalization, including Rehabilitation services outside of the Service Area
- Delivery or problems with pregnancy at any time after the onset of the 36th week of pregnancy or within 4 weeks of the due date of pregnancy, or being told by your Provider that you are at risk for early delivery.

When you get care outside Tufts Health Direct's Service Area, the Provider might ask you to pay for that care at the time of service.

If you are asked to pay for Emergency care or Urgent Care that you get outside of our Service Area, you should show your Tufts Health Direct Member ID Card. The Provider should not ask you to pay. If you do pay for any of these services, you may ask us to pay you back. You will be responsible for paying the applicable In-network Cost-Share under your Plan.

You or your representative or a contracted Provider must call Tufts Health Plan within 48 hours after Emergency care is received. If you are admitted as an Inpatient, you or someone acting for you must call your PCP or Tufts Health Plan within 48 hours. You may receive a bill for these services. Please call Member Services at **888.257.1985** for more information about what to do if you receive a bill.

Note: You may get a bill for Copayments, Coinsurance, and/or a Deductible for some Covered Services if you obtained Authorized services from an Out-of-network Provider. If you get a bill, call us at **888.257.1985**.

Getting information about Tufts Health Direct Providers

For the most up-to-date information about Providers (doctors and other professionals who contract with us to provide health care), visit us at tuftshealthplan.com/memberlogin and use the Find a Doctor or Hospital tool to find a Tufts Health Direct In-network Provider. If you don't have a member portal account go to tuftshealthplan.com/directproviders to search for a Tufts Health Direct In-network Provider. To request a hard copy of the *Provider Directory*, to request information from our online *Provider Directory* or to get information about a Provider, call our Member Services Team at **888.257.1985**.

Our online Find a Doctor or Hospital tool lists the following types of Tufts Health Direct Providers:

- Behavioral Health (mental health and/or substance use treatment) Providers
- Primary Care Providers (PCPs)
- Primary Care sites
- Specialists
- Hospitals

In our online *Provider Directory*, you can find important information such as a Provider's address, phone number, hours of operation, handicap accessibility, and languages spoken.

Our online *Provider Directory* also lists all Tufts Health Direct pharmacies, facilities, ancillary Providers, Hospital Emergency services, and Durable Medical Equipment suppliers. You can find this information at tuftshealthplan.com and tuftshealthplan.com/memberlogin.

For help finding an In-network Provider, call us at **888.257.1985** and follow the appropriate prompts. Our Member Services Team can help you find a Provider who is appropriate for your age, condition, and type of treatment.

Utilization Management

The Utilization Management (UM) program's purpose is to manage health care costs by reviewing whether certain medical services, supplies, and drugs are Medically Necessary. We also review whether they are being given in the most clinically appropriate and cost-effective manner. We base all UM decisions on how appropriate the care is and your coverage. We do not reward Providers, UM clinical staff or consultants for denying care. We do not offer Network Providers, UM clinical staff or consultants money or financial incentives that could discourage them from making a certain service available to you.

Utilization Review, Medical Necessity Guidelines, and review guidelines

Utilization Review, Medical Necessity Guidelines, and review guidelines are used to determine if services requested are Medically Necessary as defined by Health Care Services that are consistent with generally accepted principles of professional medical practice. These guidelines are updated periodically and are available at tuftshealthplan.com/medicalnecessityguidelines.

Tufts Health Plan may perform UM prospectively, concurrently, or retrospectively for selected inpatient and outpatient health care services to determine whether services are medically necessary as defined in the Member's Evidence of Coverage (EOC):

- Prospective UM helps determine whether a proposed treatment is medically necessary before the treatment begins. This is called Prior Authorization.
- Concurrent UM monitors treatment as it occurs and determines when the treatment is no longer medically necessary. This is called Concurrent Review.
- Retrospective UM evaluates care received by members after the care has been provided to determine whether services were medically necessary. This is called Retrospective Review.

For status or outcome of Utilization Review decisions, please call us at **888.257.1985**, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays or log on to your secure Member portal. When deciding what services are best for your health care needs, we apply consistent and objective guidelines to our decision making. Local practicing Providers help us create Medical Necessity Guidelines. We also use standards that national accreditation organizations develop. We review these guidelines annually or more often as new drugs, treatments, and technologies become generally accepted.

If you have questions about UM or want more information on how we determine the care we approve, please call us at **888.257.1985**, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays. Our staff is available to discuss Utilization issues during these business hours, as well as to respond to voicemails and faxes. If you leave a voicemail or send a fax during nonbusiness hours, we will respond the next business day.

Prior Authorization

Your Primary Care Provider (PCP) will work with your other Providers to make sure you get the care you need. For certain services, your PCP or Behavioral Health Provider will need to ask us for Prior Authorization before sending you to get those services. Please see your Plan Level's Benefit and Cost-Sharing Summary section in this *Member Handbook* for the most up-to-date list of services that require Prior Authorization consistent with Tufts Health Plan's Medical Necessity Guidelines in effect at the time the services or supplies are provided. This information is also available to you at tuftshealthplan.com, tuftshealthplan.com/memberlogin or by calling the Member Services Team at **888.257.1985**.

Your PCP knows when and how to ask us for Prior Authorization if it is required. When your PCP asks for the Prior Authorization, we will determine if the service is Medically Necessary and if we have a qualified In-network Provider who can provide the service.

If the service is Medically Necessary and we do not have an In-network Provider who can treat your health condition, we may approve and cover services from an Out-of-network Provider for you. You will be responsible for any Cost-Share as if the Provider were In-network. **You are required to obtain Prior Authorization from Tufts Health Plan before you can receive coverage for services with Out-of- network Providers, even if the service is not listed in the Benefit and Cost-Sharing Summary as requiring Prior Authorization in-network. All non-emergent or non-urgent Out-of-network services require Prior Authorization.** Please visit us at tuftshealthplan.com or

tuftshealthplan.com/memberlogin for the most up-to-date list of our In-network Providers. You are responsible for ensuring that Prior Authorization for Out-of-network services has been obtained except in emergency situations as noted above. If Prior Authorization is not granted before you see an Out-of-network Provider, coverage will be denied, and you will be responsible for payment.

Your PCP, Specialist or Behavioral Health Specialist must ask us for and get Prior Authorization before you can see an Out-of-network Provider. You may ask your PCP or Behavioral Health Specialist to ask for the Prior Authorization.

You may be authorized to see an Out-of-network Provider in the following circumstances:

- When a participating In-network Provider is unavailable because of distance
- When a delay in seeing a participating In-network Provider, other than a Member-related delay, would result in interrupted access to Medically Necessary services
- If there is not a participating In-network Provider with the qualifications and expertise that you need to get and stay better

If you become a Tufts Health Plan Member by changing from another health plan and a Provider who does not contract with us is treating you already, we will review that treatment, and we may let that Provider continue to treat you. For more information, please see the Continuity of Care section on page 25. Remember, you must get Prior Authorization from us to see that Out-of-network Provider during and after the transition period.

Request for Prior Authorization

Medical and Behavioral Health Services Requests

Prior Authorization and notification are required no later than five business days prior to any elective medical procedure that requires an Inpatient stay. In-Network providers will be responsible for obtaining authorization and notifying Tufts Health Plan on your behalf.

For expedited requests requiring prior authorization, we will make a decision as soon as possible taking into account exigent circumstances and always within 2 working days of receipt of all necessary information, but no later than 72 hours of receipt of the request. When a provider submits a prior authorization request, the provider will indicate if the request is expedited.

"Exigent circumstances" exist when a member is suffering from a health condition that may seriously jeopardize his or her life, health, or ability to regain maximum function.

For standard requests requiring prior authorization, we will make a decision within 2 working days of receipt of all necessary information, but no later than 15 days from receipt of the request.

"Necessary information" for expedited and standard requests includes, but is not limited to, the results of any face-to-face clinical evaluation, consults, second opinion, labs, imaging, and/or previous therapies.

We will let your requesting Provider know of our decision within 24 hours when a decision has been made. We will let you know in writing within one business day if we deny the request and within two business days if we approve the request.

Pharmacy (Drug) Requests

We will make a decision within two business days from the date we receive the request for standard Prior Authorization requests and within 48 hours for urgent Prior Authorization requests. Exigent Non-Covered Prior Authorization reviews are completed within 24 hours from the date we receive the Exigent request. Exigent circumstances exist when a Member:

- Is suffering from a health condition that may seriously jeopardize his or her life, health or ability to regain maximum function; or
- Is undergoing a current course of treatment using a non-Formulary drug.

We will let your Provider requesting drug coverage know within 24 hours of our decision. We will let you know in writing within 24 hours of our decision if we deny or approve the Authorization.

Remember: If we do not approve you to see a Provider or have a procedure that requires Prior Authorization, we will not pay for those visits or services.

Prior Authorization approvals and denials

If we approve payment coverage for a service, we will clearly tell you and your Provider which services we agree to cover. The Provider providing the service must have a Prior Authorization letter from us before giving you care in order to be reimbursed. If you need more care than we approved, your Provider will have to ask us to approve coverage for more services. If we approve the request for more services, we will send you and your Provider an Authorization letter.

If we do not approve payment for any of the services requested, we will send you, your Provider or your Personal Representative a denial or Adverse Determination letter. We will also send a notice if we decide to reduce, delay or stop covering services that we have previously approved.

The Adverse Determination letter we send will include a clinical explanation for our decision and will:

- Discuss your symptoms or condition, diagnosis, and the specific reasons why the evidence your Provider sent us fails to meet the relevant medical review criteria
- Identify specific information we used
- Reference and include applicable Medical Necessity Guidelines used in the decision-making process
- Specify alternative treatment options that we cover, if appropriate
- Tell you how to ask for an Appeal, including an Expedited Internal Appeal

If you disagree with any of these decisions, you can request a Standard Internal Appeal. For details on requesting a Standard Internal Appeal, please see "How to resolve concerns", page 72.

Concurrent review

When you are a Hospital patient or are undergoing a continuous course of treatment, we will review your situation to ensure throughout the duration of your treatment that the right care is given in the right place at the right Level of Care.

We make these concurrent review decisions within 24 hours of getting all the necessary information from your Provider. "Necessary information" includes, but is not limited to, the results of any face-to-face clinical evaluation, consults, second opinion, labs, and imaging, and/or previous therapies. We will inform your Provider in that time period and we will mail you and fax your Provider a written confirmation within 24 hours of receipt of request.

Notification to the Member and to the Provider will include:

- The date of admission or start of services
- The number of extended Days or the next review date
- The new total number of Days or services we have approved

If we deny payment Authorization for a longer stay or more services, we will mail you and fax your Provider confirmation of this Adverse Determination within 24 hours of receipt of the request. You can keep getting the service at no cost to you until we notify you of our concurrent review decision.

You or your Provider may appeal the decision before or after you are discharged. For information on the Appeals process, please see page 73.

Experimental and/or investigational drugs and procedures

As new technologies come up, we have a way to consider whether to cover new (experimental and/or investigational or investigative) procedures, including clinical trials. Before we decide to cover new procedures, equipment, and prescription drugs, we look at how safe they are and how well these treatments work. Our Health Care Services team, led by our Chief Medical Officer, makes all decisions on whether to cover experimental and/or investigational procedures. If you have questions about our pharmacy program or benefits, please call us at **888.257.1985**.

Reconsideration of an Adverse Determination

If your Prior Authorization request or concurrent review for coverage for services was denied, the Provider treating you can ask us to reconsider our decision. The Reconsideration process will occur within one business day after we get the request. A clinical peer reviewer will conduct the Reconsideration and talk to your Provider.

If your provider has requested a reconsideration and we do not change our decision, you, your Provider or your Personal Representative may use the Appeals process described starting on page 73. You do not have to ask us to reconsider an Adverse Determination before requesting a Standard Internal Appeal or Expedited Internal Appeal.

Continuity of Care

We support Continuity of Care for new and current Members.

New Members

If you are a new Tufts Health Direct Member, we will help you smoothly transition any covered care you are currently getting to one of our In-network Providers. To ensure Continuity of Care, we may be able to cover some health services, including Behavioral Health (mental health and/or substance use) services, from a Provider who is not part of our Network for a limited period of time. For example, we will cover:

- Ongoing covered treatment or management of chronic or acute medical conditions (such as heart disease, or kidney disease) for up to 30 Days from your date of enrollment, including previously approved services or Covered Services
- Ongoing care for up to 30 Days from your date of enrollment if the Provider is your PCP

In specific circumstances, we offer longer Continuity of Care after Prior Authorization is obtained. For example, we will cover:

- Care you get from your current OB/GYN if you are at least three months pregnant (meaning you are starting your fourth month or second trimester, based on your expected due date): You can keep seeing your current OB/GYN until you have the baby and a follow-up checkup within the first six weeks after delivery.
- Care from your Provider if you are terminally ill and in active treatment

Current Members

If your Provider is disenrolled from Tufts Health Plan for reasons other than quality or fraud, you may continue to see your Provider (including your PCP) for the following continuing care conditions for up to 90 days from the date we notify you of your Provider's termination, unless otherwise indicated below:

- If you are receiving treatment for a Serious or Complex Condition.

- If you are pregnant, you may continue to receive care from your Provider through your first postpartum visit.
- If you are an Inpatient.
- If you are scheduled to undergo urgent or emergent surgery, including postoperative.
- If you are terminally ill (having a life expectancy of 6 months or less), you may continue to see your Provider as long as necessary.

Note: Serious and Complex Condition means:

- An acute illness or condition that requires specialized medical treatment to avoid possibility of death or permanent harm; or
- A chronic illness or condition that (i) is life-threatening, degenerative, potentially disabling, or congenital; and (ii) requires specialized medical care over a prolonged period of time.

If your PCP disenrolls, we will provide you notice at least 30 days in advance. If the disenrollment is for reasons other than quality or fraud and you do not meet the conditions described above, you may continue to see your PCP for up to 30 days after the disenrollment.

To choose a new PCP, call our Member Services Team. A Member Services Representative will help you to select one. You can also see the online Provider Directory, which is available on our website to choose a PCP.

Conditions for coverage of Continuity of Care

Services provided by a disenrolled Provider or an Out-of-network Provider as described in this Continuity of Care section are covered only when you or your Provider obtain Prior Authorization from us for the continued services, when the services would otherwise be covered under this Member Handbook, and when the Provider agrees to:

- Accept payment from us at the rates we pay In-network Providers
- Accept such payment as payment in full and not charge you any more than you would have paid in Cost-Sharing if the Provider were an In-network Provider
- Comply with our quality standards
- Comply with our policies and procedures, including for Prior Authorization and providing Covered Services pursuant to a treatment plan we approve, if any
- Give us necessary medical information related to the care provided

Eligibility, enrollment, renewal, and disenrollment

The Health Connector or the Enrollment Administrator determines eligibility for Tufts Health Direct Subscribers and their Dependents. Subscribers and their Dependents must meet these requirements to be enrolled in Tufts Health Direct. Eligible individuals include Massachusetts Residents who live in our Service Area with the exception of members on ConnectorCare plans. ConnectorCare Members can only enroll in select zip codes within Franklin County (01002, 01039, 01054, 01070, 01093, 01096, 01247, 01350, 01355, 01364, 01366, 01367, 01378). For all other plans, Members are eligible to enroll in all of Franklin County.

Please contact the Health Connector for more information about eligibility if you are applying for assistance to pay for your health insurance coverage. We and the Health Connector may require reasonable verification of eligibility from time to time.

If you meet the applicable eligibility requirements, we will accept you into Tufts Health Direct. You may stay enrolled in Tufts Health Direct for as long as you keep meeting the eligibility requirements and your Premium is paid. When we get notice of your enrollment from the Health Connector or Enrollment Administrator, we will send you a Member ID Card and more information about your Plan.

Acceptance into our Plan is never based on your:

- Age
- Claims experience
- Duration of coverage
- Ethnicity or race
- Gender
- Health condition, actual or expected
- Income
- Medical condition
- Occupation
- Physical or mental condition
- Physical or mental disability
- Pre-existing conditions
- Previous status as a Member
- Religion
- Sexual orientation

We do not use the results of genetic testing when making decisions about enrollment, eligibility, renewal, payment or coverage of Health Care Services.

Once you are enrolled in our plan, we will pay for Covered Services that are given to you on or after your Effective Coverage Date. (There are no Waiting Periods or pre-existing condition limitations or exclusions.) We will not pay for any services you received before your Effective Coverage Date with our plan.

Dependent eligibility

The following individuals are eligible for enrollment as a Dependent of the Subscriber:

- A legal Spouse of a Subscriber, according to the law of the state in which the Subscriber resides
- A divorced Spouse of a Subscriber is eligible to remain covered in accordance with Massachusetts law
- The Subscriber's civil union partner according to the law of the state in which the Subscriber lives
- Children who are recognized under a qualified medical Child-support order as having the right to enroll for coverage under the plan
- A Child of a Subscriber or Subscriber's legal Spouse, until the last day of the month the child turns age twenty-six (26), defined as:
    - A biological child; or
    - A stepchild; or

    - A legally adopted Child or Child placed for adoption with the Subscriber or Subscriber's legal Spouse, according to the law of the state in which the Subscriber resides. The date of placement in the home for the purpose of adoption is the Effective Date of the Child's coverage; or, if the Child has been living in the home as a foster Child for whom the beneficiary has received foster care payments, the Effective Date is the date of the filing of the petition to adopt.
- A child for whom the Subscriber or Subscriber's legal Spouse is the court appointed legal guardian
    - Documentation must be provided that includes a court document signed by a judge indicating the Child's name, the appointed legal guardian(s), the temporary or permanent designation, the Effective Date, and, if temporary legal guardianship, the termination date.
- A Dependent Child of an enrolled Child;
- A Disabled Dependent of a Subscriber or the Subscriber's Spouse is eligible for coverage.

Divorce or separation

In the event of a divorce or legal separation, the person who was the Spouse of the Subscriber before the divorce or legal separation will remain eligible for coverage in this plan under the Subscriber's Group Contract whether or not the judgment was entered before the Effective Date of the Group Contract. This coverage requires no further Premium other than the normal cost of covering a current Spouse. In instances of remarriage, there may be an additional cost. The former Spouse remains eligible for this coverage only until one of the following happens:

- The Subscriber is no longer required by the judgment to provide health insurance for the former Spouse.
- The Subscriber or former Spouse remarries. However, if the Subscriber remarries, and the judgment so provides, the former Spouse may keep coverage under the plan in accordance with Massachusetts law.
- The Subscriber disenrolls from the plan.

Newborn and Adoptive Children—eligibility, enrollment, and coverage

A newborn infant of a Member is eligible for coverage under the plan from the moment of birth as required by Massachusetts law.

- The Subscriber must properly enroll the newborn in the plan within 60 Days of the newborn's birth for the newborn to be covered from birth. Otherwise, the Subscriber must wait until the next open enrollment period to enroll the Child.
- The Subscriber must enroll an Adoptive Child within 60 Days after the date of filing a petition to adopt the Child or the date the Child is placed with the Subscriber for the purpose of adoption. Otherwise, the Subscriber must wait until the next open enrollment period to enroll an Adoptive Child.
- If payment of a specific Premium is required to provide coverage for a Child, the policy or contract may require that both the notification of birth of a newly born Child or of filing of a petition to adopt a foster Child or of placement of a Child for purposes of adoption and the payment of the required Premium be furnished to the insurer.

- The Subscriber must choose a Primary Care Provider (PCP) for a newborn or Adoptive Child within 48 hours after the newborn's birth or after the date of adoption or placement for adoption. This PCP can manage the Child's care from the time of birth or adoption.
- The Subscriber must contact the Health Connector or their Enrollment Administrator for further information about enrollment of a newborn or an Adoptive Child.

Employee eligibility

An employee is eligible to enroll in Tufts Health Direct through an employer Group if s/he:

- Is employed by a qualified contributing Massachusetts employer
- Meets all employer eligibility requirements
- Resides or works within the Tufts Health Direct Service Area

Change in eligibility status

It is your responsibility to tell the Health Connector or your Enrollment Administrator of all changes that may affect your or your Dependents' eligibility under your Plan or the amount of Premium you pay for coverage under your plan. Notification must occur **within 60 Days** of the event. Changes that affect your eligibility or your Dependents' eligibility include the following:

- A Member or Dependent dies
- One of your Dependents marries
- You have an address change
- You have a baby or adopt a Child
- You have a change in marital status
- You have a job or income change
- You or a Dependent no longer meets the Plan's eligibility requirements
- You move out of our Service Area

Note: Changes in Dependents covered by the plan and/or household income changes may result in a change to the Plan type you are eligible for and the Premium that an individual or Group must pay. Changes could also affect the amount of federal or state subsidies or tax credits you can get.

Tufts Health Plan and the Health Connector or your Enrollment Administrator need your current address and phone number so we can send you important information about benefits and services. To report eligibility, address or phone number changes, please call:

- The Health Connector customer service center at 877.623.6765 (TTY: 877.623.7773), Monday through Friday, from 8 a.m. to 6 p.m.
- Us at 888.257.1985, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays
- Enrollment Administrator (HSA Insurance) customer service center at 781.228.2222 (toll-free: 877.777.4414), Monday through Friday, from 8:30 a.m. to 5 p.m.

No Waiting Period or pre-existing condition limitations

There are no Waiting Periods or pre-existing condition limitations in our plan. All Covered Services are available to you as of your Effective Coverage Date. If your membership begins while you are hospitalized, coverage starts on the day membership is effective.

Effective Coverage Date

The Effective Coverage Date is the date you become a Member of Tufts Health Direct and are eligible to get Covered Services from Tufts Health Direct Providers. The Health Connector and the Enrollment Administrator set Effective Coverage Dates for new individual Subscribers and Dependents in accordance with state and federal law. Please contact the Health Connector for more information. Your coverage will start at 12:01 a.m. on the first Day of the month your enrollment in Tufts Health Direct begins. Individuals who do not meet the requirements to enroll outside of the annual open enrollment period may seek an enrollment waiver. A waiver permits enrollment outside of the open enrollment period. Contact the Health Connector or the MA Office of Patient Protection for more information about enrollment waivers.

For Subscribers enrolled through a Group Contract: You will have a Group Effective Date (always the first of a calendar month). If your Group does not meet the participation rules, you may have to apply as individuals during open enrollment or with a qualifying event.

Renewing your coverage

Individual/family Tufts Health Direct Subscribers

Individual coverage will renew on January 1 of each calendar year. An individual who enrolls in or renews current coverage with an Effective Date of February 1 or later will have a short Benefit Year. All individuals will renew membership during the open enrollment period (November 1 – January 31). Monthly Premiums are based on your Effective Coverage Date.

We do not have to renew the Health Benefit Plan of an eligible person if s/he:

- Has not paid the required Premiums
- Has committed Fraud or misrepresented whether s/he qualifies for the plan or misrepresented information needed to determine eligibility for a health plan or for specific health benefits
- Has failed to comply with our provisions, the Member contract or the Subscriber agreement, including but not limited to an individual, employee or Dependent moving outside of our Service Area
- Fails, at the time of renewal, to meet eligibility rules, provided that we collect enough information to make such a determination and make such information available to the Health Connector, when appropriate, upon request
- Has failed to comply with our reasonable request for information in an application for coverage

Group Plan participants

Employer Groups renew membership 12 months after their Effective Coverage Date and every 12 months thereafter. Employee coverage renews 12 months after the employer Group's Effective Coverage Date, regardless of the employee's Effective Coverage Date. Monthly Premiums are based on the employer Group's Effective Coverage Date.

You must notify us of any changes that affect you or your Dependents' eligibility. Examples of these changes are:

- Address changes
- Birth, adoption, changes in marital status, or death
- Changes in an enrolled Dependent's status as a Child or Disabled Dependent
- Moving out of the Service Area, or
- Temporarily residing out of the Service Area for more than 90 consecutive Days

- Your remarriage or the remarriage of your former Spouse, when the former Spouse is an enrolled Dependent under your Family Coverage

If a participating employer changes any of the above items, we, the Health Connector or Enrollment Administrator must revalidate the company at the time of the Group's renewal. The Health Connector or Enrollment Administrator may ask for documentation to validate the information provided by the participating employer at renewal.

We, the Health Connector or Enrollment Administrator may not renew an employer's plan if the employer does not meet the eligibility or participation requirements at the time of renewal or if the employer:

- Has not paid its Premiums
- Has committed Fraud or misrepresented its employees' eligibility for the plan
- Has misrepresented information needed to determine the Group's size, participation rate or Premium rate
- Failed to comply with the Plan's requirements, including but not limited to the employer or its employee(s) moving outside of the Plan's Service Area
- Failed to comply with our or the Health Connector's reasonable request for information needed to verify the application for coverage
- Is not actively engaged in business
- Failed to satisfy the definition of an Eligible Small Business

Plan nonrenewal

We must provide at least 60 Days' prior notice to an eligible individual or Eligible Small Business of our intention not to renew its Health Benefit Plan. We will include the specific reason(s) for the nonrenewal in accordance with our filed criteria. We must provide at least 90 Days' prior notice to affected eligible individuals or Eligible Small Businesses of our intention to stop offering a particular type of health plan.

Disenrollment

If you are an individual Member who has been disenrolled from Tufts Health Direct, we will provide coverage for Covered Services for you through 11:59 p.m. on the last Day of the month your enrollment ends. If you are a Group Member, please check with your employer to confirm whether coverage will end on your final day of employment or on the final day of the month.

Your enrollment in our plan can be ended if:

- An individual or a Group chooses to end coverage by notifying us or the Health Connector.
- You are an individual or Group Member who has not paid the required Premium for 60 Days from the first Day of the coverage month for which the Premium was due (individuals enrolled in subsidized coverage will have 90 Days from the first Day of the coverage month for which the Premium was due.).
- You commit an act of physical or verbal abuse unrelated to your physical or mental condition that poses a threat to any Provider, any other Member or to the plan or a plan employee.
- You commit an act of intentional misrepresentation or Fraud related to coverage, obtaining Health Care Services or payment for such services (e.g., obtaining or trying to obtain benefits under this Member Handbook for a person who is not a Member, submitting a false request for reimbursement or misrepresenting your eligibility for enrollment in our plan): Termination may be retroactive to your Effective Date, the date of the Fraud or misrepresentation or another date determined by us.

- You fail to comply with our rules under this Member Handbook: For Groups, this may mean that the Group failed to meet requirements related to Group Premium contributions or that the Group is not actively engaged in business.
- You fail to meet the Health Connector's or our eligibility requirements, such as moving out of the Service Area.

Note: We will never request to end services for a Member due to a negative change in his or her health or because of the Member's use of medical services, diminished mental capacity or uncooperative behavior resulting from his or her special needs.

Effective date of termination

We, the Health Connector or Enrollment Administrator will notify you of the date your coverage under the Plan ends. If we, the Health Connector or Enrollment Administrator terminate your coverage because you did not pay your Premiums, the Health Connector or Enrollment Administrator will notify you at least 30 Days before termination. The time frames for termination depend on how you pay your Premiums:

- If you are an individual enrolled in unsubsidized coverage or a Member in a small Group and you have not paid your Premium for two months, we, the Health Connector or Enrollment Administrator will terminate your coverage on the Day after the payment due date. Your coverage end date is the last Day of the month for which you made full payment. Your termination is retroactive. For example, if you made your last payment for coverage on January 1 but did not pay your Premium for February or March, we, the Health Connector or Enrollment Administrator would terminate your coverage on April 1, effective January 31.
- If you are an individual enrolled in a ConnectorCare Plan or receiving a Federal Premium Tax Credit and you have not paid your Premium for three months, the Health Connector will terminate your coverage on the Day after the payment due date. Your coverage end date is the last Day of the first month for which you owed but did not make a payment. Your termination is retroactive with a 30-Day grace period. For example, if you made your last payment for coverage January 1 but did not pay your Premium for February, March or April, the Health Connector would terminate your coverage on May 1, effective February 28.

Benefits after termination

We will not pay for services, supplies or drugs* you get after your coverage ends, even if:

- You were receiving Inpatient or Outpatient care before your coverage ended
- You had a medical condition (known or unknown), such as pregnancy, that requires medical care after your coverage ends

* Requests for reimbursement for drugs must be submitted within one year from the date of service.

Health plan changes

We, the Health Connector or your Enrollment Administrator will give you information about the yearly Tufts Health Direct open enrollment period. All current Tufts Health Direct Members can change plans for any reason during the open enrollment period.

Outside of the open enrollment period, all Members can change their health plan enrollment or coverage type (individual to family) for the following reasons (called "qualifying events"):

- Marriage
- Divorce, legal separation or annulment
- Birth, adoption or placement for adoption of a Child

- Dependent Spouse required to cover a Child by court order
- Death of a Spouse or Dependent
- Covered Dependent reaches the age limit for coverage, making him or her ineligible for coverage
- You, your Spouse or eligible Dependent moves outside of your health Plan's Service Area
- You, your Spouse or eligible Dependent becomes a U.S. citizen/national, a qualified immigrant or a lawfully present immigrant
- You, your Spouse or eligible Dependent is an Indian, as defined by Section 4 of the Indian Self-Determination and Education Assistance Act: See Indian Self-Determination and Education Assistance Act, 25 U.S.C. §450b(d), https://uscode.house.gov/view.xhtml?path=/prelim@title25/chapter46&edition=prelim
- Such individual may enroll in or change from one plan to another one time per month
- You, your Spouse or eligible Dependent is newly determined eligible for a Federal Premium Tax Credit or there is a change in eligibility for a ConnectorCare Plan
- Other exceptional circumstances: There may be additional qualifying events offered by your employer. Please contact Tufts Health Plan and call our Member Services Team at **888.257.1985**. Please refer to the Health Connector for a complete list.

The qualifying event must be reported to the Health Connector or your Enrollment Administrator within 60 Days of the event. Changes to health plan enrollment or coverage type will be effective as of the qualifying event date.

Continuing coverage for Group Members

Continuation of Group coverage under federal law (COBRA)

Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), group Members may be eligible to keep coverage under the Group Contract if:

- You were enrolled in a group that has 20 or more eligible employees
- You experience a qualifying event that would cause you to lose coverage under your group
- You elect coverage as provided under COBRA

Below is a brief summary of COBRA continuation coverage:

- **Qualifying events:** Qualifying events that may entitle you to COBRA continued coverage are as follows:
    - Termination of the Subscriber's employment (for reasons other than gross misconduct)
    - Reduction in the Subscriber's work hours
    - The Subscriber's divorce or legal separation
    - Death of the Subscriber
    - The Subscriber's entitlement to Medicare
    - Loss of status as an eligible Dependent
- **Period of continued coverage under COBRA:** The period of continued group coverage begins with the date of your qualifying event. The length of this continued group coverage will be between 18 and 36 months, depending on the qualifying event. COBRA coverage will end at

the end of the maximum period of coverage, being 18 months (unless extended due to disability or other reason). However, coverage may end earlier if:

  - The Premium is not paid on time
  - Your group ceases to maintain any Group Plan
  - The group terminates its Group Contract with us or the Health Connector (in which case your coverage may continue under another health plan)
  - There are other reasons, such as the end of disability, or becoming eligible for or obtaining other coverage

- **Cost of coverage**: In most cases, you are responsible for payment of 102% of the cost of coverage.
- **Continued coverage for disabled Subscribers:** At the time of the Subscriber's termination of employment or reduction in work hours (or within 60 Days of the qualifying event under federal law), if a Subscriber or his or her eligible Dependent is determined to be disabled under Title II or Title XVI of the Social Security Act, continued group coverage will be available for up to 29 months from the date of the qualifying event. The Premium cost for the extra 11 months may be up to 150% of the Premium rate.
- **Enrollment:** To enroll, you must complete an election form and return it to your group. The form must be returned within 60 Days from your date of termination of group coverage or your notification (by your group) of eligibility, whichever is later. If you do not return the completed form, it will be considered a waiver. This means you will not be allowed to keep coverage in this Plan under a Group Contract.
- **Qualified beneficiaries** are eligible for federal COBRA continuation coverage, in most cases, for a period of 18 or 36 months from the date of the qualifying event, depending on the type of qualifying event. Generally, COBRA coverage is available for a maximum of 18 months for qualifying events due to employment termination or reduction of work hours. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a qualified beneficiary to receive a maximum of 36 months of COBRA continuation coverage. For more information, see the "Duration of Coverage" table below.

FEDERAL COBRA - DURATION OF COVERAGE		
Qualifying Event(s)	**Qualified Beneficiaries**	**Maximum Period of Coverage**
Termination of Subscriber's employment for any reason other than gross misconduct Reduction in the Subscriber's work hours	Subscriber, Spouse, and Dependent Children	18 months*
Subscriber's divorce, legal separation, entitlement to Medicare, or death	Spouse and Dependent Children	36 months
Subscriber's or Spouse's enrolled Dependent ceases to be a Dependent	Dependent Child	36 months
*__**Important Note:**__ If a qualified beneficiary is determined under the federal Social Security Act to have been disabled within the first 60 Days of federal COBRA continuation coverage for these qualifying events, then that qualified beneficiary and all of the qualified beneficiaries in his or her family may be able to extend COBRA coverage for up to an additional 11 months. You may be responsible for payment of up to 150% of the cost of COBRA coverage for this additional period of up to 11 months.		

When coverage ends
Federal COBRA continuation coverage will end at the end of the maximum period of coverage. However, coverage may end earlier if:

- Coverage costs are not paid on a timely basis.
- Your Group ceases to maintain any group health Plan.
- After the COBRA election, the qualified beneficiary obtains coverage with another employer group health Plan that does not contain any exclusion or pre-existing condition of such beneficiary. However, if other group health coverage is obtained prior to the COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election.
- After the COBRA election, the qualified beneficiary becomes entitled to federal Medicare benefits. However, if Medicare is obtained prior to COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election.

For more information about COBRA, contact your Group or the Health Connector.

Continuation of Group coverage under Massachusetts law

How to qualify for coverage

A Member's Group coverage under the Group Contract may end because the member experiences a qualifying event. A qualifying event is defined as:

- The Subscriber's death;
- Termination of the Subscriber's employment for any reason other than gross misconduct;
- Reduction in the Subscriber's work hours;
- The Subscriber's divorce or legal separation;
- The Subscriber's entitlement to Medicare; or
- The Subscriber's or Spouse's enrolled Dependent ceases to be a Dependent Child.

If a Member experiences a qualifying event, s/he may be eligible to continue Group coverage as a Subscriber or an enrolled Dependent under Massachusetts continuation coverage as described below.

Note: Continuation provisions apply to same-sex Spouses. Contact your employer for more information.

When coverage begins
Massachusetts continuation coverage is effective on the date following the day Group coverage ends, in most cases.

When coverage ends
Massachusetts continuation coverage would end, in most cases, 18 or 36 months from the date of the Qualifying Event, depending on the type of Qualifying Event.

Payment of Premium
In most cases, you are responsible for payment of 102% of the Group Premium for Massachusetts continuation coverage.

Rules for Massachusetts continuation
Under a Massachusetts law similar to COBRA, you may be eligible to continue coverage after Group coverage ends if: you were enrolled in Tufts Health Direct Plan through a Massachusetts Group which has 2-19 eligible employees; and you experience a qualifying event which would cause you to lose coverage under your Group; and you elect this continuation coverage by following the procedure described below.

A Member who is eligible for Massachusetts continuation of coverage (a "qualified beneficiary") must be given an election period of 60 Days to choose whether to elect Massachusetts continuation of coverage. This period is measured from the later of the date the qualified beneficiary's coverage under the Group Contract ends, or the date the Group provides the qualified beneficiary with an election notice. To elect this coverage, you must complete a Massachusetts continuation of coverage election form and return it to your Group with the 60-Day period. Contact your Group for more information.

Coverage under an Individual Contract
When your coverage under federal COBRA continuation or Massachusetts continuation ends, you and your enrolled Dependents may be eligible to apply for coverage under an Individual Contract. See "Coverage under an Individual Contract" at the end of this chapter for more information.

Plant Closing

Description of continuation available under a Group Contract
Under Massachusetts law, Subscribers whose employment is terminated due to a state-certified plant closing or covered partial closing may be eligible, along with their enrolled Dependents, for continuation of coverage for a period of 90 Days. The Group is responsible for notifying Subscribers of their eligibility. Call your Group or Member Services for more information.

Note: Continuation provisions apply to same-sex Spouses. Contact your employer for more information.

Coverage under an individual contract: If your Group coverage ends, you may be eligible to enroll in coverage under an individual contract offered through the Health Connector or directly through us. Please be aware that coverage under an individual contract may differ from coverage under a Group Contract. For more information, call the Health Connector at 877.623.6765 (TTY: 877.623.7773) or call our Member Services Team at **888.257.1985**.

Covered Services

We cover Medically Necessary Covered Services listed in this Handbook that are provided by In-network Providers (except Emergency services, which you can get anywhere). You will not be responsible for paying more than the amount required for services received at an In-network facility, even if some of the Medically Necessary Covered Benefits are performed by Out-of-network Provider(s), unless you have a reasonable opportunity to choose to have the service performed by an In-network Provider. If a service or service category is not specifically listed as covered, then it is not covered under this agreement. (See also "Services not covered" on page 65.)

If a proposed admission, procedure or Covered Service that is Medically Necessary is not available In-network, we will cover the pre-approved Out-of-network admission, procedure or service, and you will not be responsible for paying more than the amount that would be required for a similar admission, procedure or service offered In-network.

The following "Services we cover" section lists services we cover for Tufts Health Direct Members. In addition, your cost for Covered Services for each of the Plan Levels is listed in the section Benefit and Cost-Sharing Summaries starting after the Glossary. Check the Summary for your Plan Level and for a list of services covered and Prior Authorization requirements for Tufts Health Direct Members. If you have any questions, call us at **888.257.1985**, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays. We can give you more information about any of these Covered Services.

Services are covered only if they are Medically Necessary. Medically Necessary services are services that we determine are consistent with generally accepted principles of medical practice. This means that they are the least intensive and most cost-effective available, and are:

- The most appropriate available supply or service for you based on potential benefits and harm to you

- Known to be effective in improving health outcomes based on scientific evidence, professional standards, and expert opinion

In addition to any limitations in the Benefit and Cost-Sharing Summaries, we may limit or require Prior Authorization for Covered Services on the basis of Medical Necessity.

When you require Prior Authorization for a Behavioral Health service, a Licensed Mental Health Professional will make the determination about whether the service is Medically Necessary. We will not apply treatment limitations or Cost-Sharing to Behavioral Health services that we do not apply to medical services.

Services we cover

Note: Some or all of the following services may require Prior Authorization. Out-of-network services require Prior Authorization. Covered Services must be consistent with Tufts Health Plan's Medical Necessity Guidelines in effect at the time the services or supplies are provided. Please see our Medical Necessity Guidelines at tuftshealthplan.com/medicalnecessityguidelines.

Covered medical benefits

Abortion services

We cover surgical or medication-based abortion and abortion-related care from a Tufts Health Direct Provider without Prior Authorization.

The following abortion-related services are covered when they are provided in conjunction with an abortion procedure:

- Pre-abortion evaluation and examination
- Pre-operative counseling
- Ultrasounds
- Laboratory services, including pregnancy testing, blood type, and Rh factor
- Rh (D) immune globulin (human)
- Anesthesia (general or local)
- Post-abortion care
- Follow-up
- Advice on contraception or referral to family planning services

Note: Care related to a pregnancy or miscarriage is not covered under this benefit.

Acupuncture

We cover acupuncture visits by In-network acupuncturists. There is no visit limit for this Covered Service.

Allergy testing and treatment

We cover medically necessary allergy testing and allergy immunotherapy (allergy injections) by In-network providers. Coverage limits apply.

Bariatric surgery

We cover certain Medically Necessary inpatient and outpatient bariatric procedures. Bariatric surgery and procedures require Prior Authorization.

Chemotherapy and Radiation Oncology Services

We cover medically necessary chemotherapy and radiation oncology services by In-network providers for the treatment of cancer. Some services require prior authorization.

Chiropractic care
We cover spinal manipulation, therapeutic exercise and electrical muscle stimulation for Members by In-network chiropractors.

Cleft palate/cleft lip
We cover medical, dental, oral, and facial surgery by In-network Providers for Members under the age of 18 with a cleft palate and/or cleft lip. This includes:

- Surgical management and follow-up care by oral and plastic surgeons
- Orthodontic treatment and management
- Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy, Speech Therapy, audiology, and nutrition services, if prescribed by the treating physician or surgeon, and the physician or surgeon certifies that the services are Medically Necessary.

Services for the treatment of cleft palate and cleft lip may require prior authorization.

Clinical trials
Tufts Health Plan will provide coverage for routine patient care services when a Member is enrolled in a qualified clinical trial, both Outpatient and Inpatient. Coverage will be under the terms and conditions provided for under Massachusetts and federal law. We cover the following services:

- Routine Patient care services provided by a qualified clinical trial conducted to prevent, detect or treat cancer or another life-threatening disease or condition (to the extent required by Massachusetts and federal law). These patient care services are covered and reimbursed to the same extent if the patient did not receive care in a qualified clinical trial.
- Prior Authorization is not required for coverage of routine patient care services associated with clinical trials. Please refer to the appropriate Medical Necessity Guideline at https://tuftshealthplan.com/documents/providers/guidelines/medical-necessity-guidelines/clinical-trials-routine-costs.

Community health center visits and office visits
We cover community health center and office visits to Tufts Health Direct Providers for Primary Care or for specialty services. We must give Prior Authorization for office visits to all Out-of-network Providers.

Dental care (Pediatric only)
Pediatric dental care services for Members under 19 years of age are covered through Delta Dental. Dental care includes Medically Necessary Preventive and restorative and basic and major restorative services. Orthodontia is covered when Medically Necessary and with Prior Authorization. Please call Delta Dental at 800.872.0500 or visit https://deltadentalma.com/epo-find-a-dentist for more information.

Note: For these pediatric services, "under 19 years of age" means the last Day of the month in which a Member turns 19 years old.

Diabetes treatment
We cover the following services for Members with diabetes if they are Medically Necessary to diagnose or treat insulin-dependent, insulin-using, non-insulin-dependent or gestational diabetes:

- Diabetes Outpatient self-management training and educational services. This includes medical nutrition therapy. An In-network Provider who is a certified diabetes Provider must provide these services.
- Podiatry services to treat podiatric conditions for Members diagnosed with diabetes, such as diagnostic lab tests and X-rays, surgery and necessary postoperative care, routine foot care

(such as trimming of corns, nails or other hygienic care), and other Medically Necessary foot care by In-network Providers at In-network locations.

- Diabetes lab tests, such as glycosylated hemoglobin (or HbA1c) tests, urinary protein/microalbumin, and lipid profiles.
- Insulin pumps and insulin pump supplies, voice synthesizers (with Prior Authorization), and visual magnifying aids when Medically Necessary for home use for the legally blind.
- Therapeutic and molded shoes and shoe inserts for a Member with severe diabetic foot disease: An In-network Podiatrist or other qualified doctor must prescribe shoes/shoe inserts, and an In-network Podiatrist, orthotist, prosthetist or pedorthist must furnish them.
- Prescribed diabetes medications: Insulin, insulin pens, insulin needles and syringes; lancets; blood glucose, urine glucose, and ketone monitoring strips; oral diabetes medications that influence blood sugar levels, and contiguous blood glucose monitors (CGMs) and related CGM supplies. Some of these products may require Prior Authorization. Our Formulary shows covered medications and diabetes supplies.

Dialysis

We cover Medically Necessary dialysis services. Prior Authorization is required if the dialysis is being performed by an Out-of-network Provider.

Durable Medical Equipment (DME)

We cover certain DME. Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs. Prior Authorization is required for some DME. Examples of the DME benefit include but are not limited to:

Hearing aids

We cover Medically Necessary hearing aids for Members age 21 and younger. This includes the cost of one hearing aid per hearing-impaired ear, up to $2,000 per ear every 36 months. This includes both the amount Tufts Health Direct pays and the applicable Member Cost-Share as listed in the Plan's Benefit and Cost-Sharing Summary. Additional coverage is provided for related services including hearing aid evaluations, the fitting and adjustment of hearing aids, and supplies, including ear molds.

Medical supplies

We cover prescribed, Medically Necessary disposable medical supplies used to treat a specific medical condition, up to the limits documented in your Benefit and Cost-Sharing Summary. Examples of covered medical supplies include ostomy, tracheostomy, and catheter supplies. These medical supplies must be obtained from a vendor who has an agreement with Tufts Health Direct Plan to provide such supplies.

Orthotics

We provide coverage for nondental braces and other mechanical or molded devices when Medically Necessary, excluding oral devices.

We cover shoe inserts without Prior Authorization only for Members with diabetes.

Oxygen and respiratory therapy equipment services

We cover oxygen and respiratory therapy equipment with Prior Authorization, such as:

- Ambulatory liquid oxygen systems and refills
- Aspirators
- Compressor-driven nebulizers
- Intermittent positive pressure breathers
- Oxygen, oxygen gas, oxygen-generating devices, and oxygen-therapy equipment rental

Prosthetic Devices

We cover the cost (including repairs) of breast prostheses and prosthetic arms and legs. Coverage is

provided for the most appropriate Medically Necessary model that adequately meets the Member's needs. (Prior Authorization is required.)

Notes:

- Coverage is provided for the most appropriate Medically Necessary model that adequately meets the Member's needs.
- Breast prostheses require Prior Authorization, except when provided in connection with a mastectomy.

Scalp hair prostheses or wigs
We cover scalp hair prostheses made specifically for an individual, or a wig when needed for hair loss suffered as a result of the treatment for any form of cancer or leukemia or a certain pathological condition such as alopecia areata, alopecia totalis, or alopecia medicamentosa, or permanent loss of scalp hair due to injury. No benefits are provided for wigs when hair loss is due to: male pattern baldness; female pattern baldness; or natural or premature aging.

Early intervention services

We cover early intervention services provided by a Provider who is a certified early intervention Specialist. These services must be part of an early intervention program meeting the standards of the Department of Public Health. This benefit is only for Members from birth up to age three (3) who meet set criteria. There are no charges, Copayments, Deductibles or Coinsurance for these services when part of an Early Intervention Program. Benefit limits applicable to Rehabilitation services do not apply to Early Intervention services. Early intervention services include the following:

- Nursing care
- Occupational Therapy
- Physical Therapy
- Psychological counseling
- Speech Therapy

Emergency/non-Emergency transportation

We cover ground ambulance and sea and air transportation services in an Emergency without Prior Authorization. We may cover non-Emergency ground ambulance transportation with Prior Authorization. We do not cover transportation to and from medical appointments. We do not cover the use of chair cars.

Family-planning Services

We cover Family-planning Services from an In-network physician (PCP, obstetrician or gynecologist), Nurse Practitioner, Physician Assistant or certified nurse midwife. These services include:

- Birth control counseling
- Diagnostic tests
- Medical consults
- Pregnancy testing
- Prescription and nonprescription contraceptives that have been approved by the U.S. Food and Drug Administration, when given to you by an In-network Provider during an office visit. Our Formulary includes covered prescription contraceptives. Nonprescription contraceptives include, for example, IUDs, implantable contraceptives, and cervical caps. For a complete list of nonprescription contraceptives, please see the Preventive Services list at https://tuftshealthplan.com/documents/providers/payment-policies/preventive-services.

- Routine medical exams

See the "Preventive Health Care Services" section for additional information.

Fitness center reimbursement

We cover three (3) months of fitness center fees after you have been a Tufts Health Direct Member for four (4) months. The reimbursement excludes initiation fees. See the Benefit and Cost-Sharing Summary for your Plan Level at the end of this *Member Handbook* for more details.

If you are an individual plan Subscriber requesting this reimbursement, you may submit a reimbursement form, with itemized receipts attached, once per Benefit Year. We will reimburse individual level fitness center membership fees only. The reimbursement will be paid to the individual plan Subscriber.

If you are a family plan Subscriber requesting this reimbursement, you may submit a reimbursement form, with itemized receipts attached, once per family per Benefit Year. Only the Subscriber may request this reimbursement on behalf of the family or individuals on the family plan.

We will reimburse once per Benefit Year for individual- or family-level fitness center membership fees. The reimbursement will be paid to the family plan Subscriber.

Call us at **888.257.1985**, and we will send you a reimbursement form to complete. You can also get the form at https://tuftshealthplan.com/member/tufts-health-direct-plans/forms-documents/forms-documents.

Note: This reimbursement covers membership fees of a standard fitness center. A standard fitness center offers cardio and strength-training machines and other programs for improved physical fitness. This reimbursement does not include luxury fitness centers, country clubs, social clubs, tennis clubs, gymnastics centers, pilates or yoga studios, martial arts centers, aerobic-only or pool-only centers, personal trainers, sports coaches, or the purchase of personal or at-home exercise machines.

Gender-affirming services

We cover Medically Necessary gender-affirming services including reconstruction surgeries, hair removal and speech therapy. Prior Authorization is required.

Habilitative and Rehabilitative Services (Physical, Occupational, and Speech Therapies)

Physical and Occupational Therapies

Therapies are covered In-network for evaluation and restorative short-term treatments that you need to attain your highest level of independent functioning. Care is provided in the timeliest manner possible and when we determine that the therapy will result in significant, sustained, and measurable improvement of your condition. We require Prior Authorization for Rehabilitative Therapy services after the initial evaluation and 11 visits. Rehabilitative Physical and Occupational Therapies are covered for up to 60 visits combined per Member per Benefit Year. In addition, we require Prior Authorization for Habilitative Services after the initial evaluation and 11 visits. Habilitative Physical and Occupational Therapies are covered for up to 60 visits combined per Member per Benefit Year. These Limits do not apply when services are furnished to treat autism spectrum disorders.

Cardiac Rehabilitation

We cover specialized cardiac Rehabilitation services.

Speech, hearing, and language disorders

We cover the diagnosis and treatment of speech, hearing, and language disorders when you get services from a registered, licensed speech-language pathologist, audiologist or therapist as part of a formal treatment plan for speech loss or impairment. We cover these services in a Hospital, clinic or private office. We require Prior Authorization after 30 covered visits. All Providers and locations of services must be In-network.

Home health care

We cover certain home health services provided by an In-network home health agency in your home, as long as your home is not a Hospital or Skilled Nursing or Rehabilitation institution. You must be homebound* to receive home Health Care Services.

The services also must be part of a Provider-approved home health services plan. Prior Authorization is required for all home care services and disciplines. Covered Services include:

- Durable Medical Equipment (DME)
- Part-time or intermittent Skilled Nursing care
- Physical, Occupational, and Speech Therapies
- Part-time or intermittent home health aide services
- Medical/psychiatric social work services
- Nutritional consults

***Note:** To be considered homebound, you do not have to be bedridden. However, your condition should be such that there exists a normal inability to leave the home and, consequently, leaving the home would require a considerable and taxing effort. If you leave the home, you may be considered homebound if the absences from the home are infrequent or for periods of relatively short duration or to receive medical treatment. Please note that this homebound requirement does not apply to Covered Services for palliative care under this benefit.

Hospice

We cover hospice and palliative care for terminally ill Members ("terminally ill" means having a life expectancy of six months or less, as certified by an In-network Provider) who agree with their Providers not to go on with a curative treatment program. Prior Authorization is required. The services must be the equivalent of hospice services provided by a Medicare-certified hospice Provider regulated by the Massachusetts Department of Public Health. We cover a package of services, such as:

- Biological supplies
- Counseling (e.g., bereavement, dietary, spiritual)
- Bereavement counseling includes services for the Member's family for up to one year following the Member's death
- Drugs
- Homemaker/home health aide services
- Institutional care services
- Medical and social services
- Medical supplies
- Nursing
- Physical, Occupational, and Speech-language Therapies
- Provider care
- Short-term Inpatient care services

Hospice care services are defined as a coordinated licensed program of services provided to a terminally ill Member. Such services can be provided:

- In a home setting;

- On a short-term Inpatient basis, for the control of pain and management of acute and severe clinical problems which cannot, for medical reasons, be managed in a home setting

The 100-Day limit for care at a Skilled Nursing Facility and a Rehabilitation Hospital described on your Plan Level's Benefit and Cost-Sharing Summary does not apply to hospice services.

Immunizations and Vaccinations

We cover routine Preventive immunizations and other Medically Necessary immunizations. See additional information in the Preventive Health Care Services section.

Infertility services

We cover the diagnosis and treatment of infertility. In-network Providers must provide services in accordance with Massachusetts law. "Infertility" is defined as the condition of an individual who is unable to conceive or produce conception during a period of either:

- One year if the female is age 35 or younger
- Six months if the female is over the age of 35

Note: Attempts at conception to satisfy the diagnosis of Infertility may be done naturally or through artificial insemination.

Qualification: If a person conceives but is unable to carry that pregnancy to live birth, the period of time she tried to conceive before achieving that pregnancy is included in the calculation of the one-year or six-month period, as applicable.

Infertility services are Covered Services only for Members who are diagnosed with infertility and:

- Who meet our Medical Necessity Guidelines for coverage of infertility services which are based on the Member's medical history, diagnostic testing, and medical evaluations
- Who meet the eligibility requirements of In-network Providers of infertility services

To the extent that donor-related costs are not covered by the donor's health insurance or other health coverage and the Member is in active infertility treatment, Covered Services include the procurement and processing of donor eggs, sperm or inseminated eggs or the banking of donor sperm or embryos.

We cover the following Medically Necessary infertility services that may require Prior Authorization:

- The following services and supplies provided in connection with an infertility evaluation and/or treatment:
    - Artificial insemination (intracervical or intrauterine) when done with non-donor (partner) sperm
    - Diagnostic tests and procedures
    - Procurement, processing, and long-term (longer than 90 Days) banking of sperm when associated with active infertility treatment
- The following procedures with Prior Authorization in accordance with our clinical review criteria:
    - Artificial insemination (intracervical or intrauterine) when done with donor sperm* and/or gonadotropins
    - Procurement and processing of eggs or inseminated eggs and banking of embryos when associated with active infertility treatment
- The following "assisted reproductive technology" (ART) procedures** with Prior Authorization in accordance with our clinical review criteria:
    - Donor oocyte (DO)
    - Frozen embryo transfer (FET)

- Gamete intrafallopian transfer (GIFT)
- Intracytoplasmic sperm injection (ICSI) for the treatment of male factor infertility
- In vitro fertilization and embryo transfer (IVF-ET)
- Zygote intrafallopian transfer (ZIFT)

- Preimplantation Genetic Diagnosis (PGD) testing with IVF is covered when either of the partners is a known carrier for certain genetic disorders. In addition to the Infertility Services provided in connection with Massachusetts law (as described above), PGD testing with IVF may be covered for Members who do not have a diagnosis of infertility in certain circumstances when the fetus would be at risk for an inherited genetic disorder associated with severe disability and/or premature death. Prior Authorization by an Authorized Reviewer is required. For more information, please call Member Services and see the Medical Necessity Guideline for "Preimplantation Genetic Diagnosis" on our web site at https://tuftshealthplan.com/documents/providers/guidelines/medical-necessity-guidelines/pre-gen-diag.

* Donor sperm is covered only when the partner has a male factor infertility diagnosis or when donor sperm is being used as an alternative to PGD when a couple meets the criteria for PGD.

**ART procedures include diagnostic evaluation, testing, ovarian stimulation, egg retrieval, procurement and processing of sperm and eggs or inseminated eggs, transfer of embryos, and banking of extra embryos when associated with active infertility treatment, as applicable.

Under your prescription drug benefit: Oral and injectable drug therapies used in the treatment of covered infertility services are covered when you have been approved for covered infertility treatment and when obtained from an In-network specialty pharmacy. Our Formulary includes covered drug therapies.

Related infertility services exclusions:

- Any experimental infertility procedure as defined by applicable Massachusetts regulation
- Infertility services for any Member who does not live in Massachusetts
- Reversal of voluntary sterilization
- Gestational carrier
    - The costs of gestational carrier, which means all costs incurred by a fertile female to achieve a pregnancy as a gestational carrier for an infertile Member. These costs include, but are not limited to: (1) use of donor egg and a gestational carrier; (2) costs for drugs necessary to achieve implantation in a gestational carrier, embryo transfer, and cryo-preservation of embryos; and (3) costs for maternity care if the gestational carrier is not a Member.
    - A gestational carrier is a person who carries and delivers a Child for another either through artificial insemination or surgical implantation of an embryo.
    - A gestational carrier is a surrogate with no biological connection to the embryo/Child.

Inpatient medical care

We cover 24-hour Inpatient Medically Necessary medical services delivered in a licensed In-network Hospital setting. Inpatient admissions for elective procedures may require Prior Authorization. Prior Authorization is never required for Emergency services, which are available In- or Out-of-network. From an Emergency room, you may be admitted for Observation. You should call us within 48 hours of your Emergency admission.

Rehabilitation Hospital
We cover daily Medically Necessary rehabilitative services provided in an Inpatient setting for a maximum of 60 Days per Member per Benefit Year at an In-network Inpatient Rehabilitation Hospital or Chronic Disease Hospital. Prior Authorization is required.

Skilled Nursing Facility
We cover daily Medically Necessary Skilled Nursing care in an Inpatient setting for a maximum of 100 Days per Member per Benefit Year at an In-network Skilled Nursing Facility. Prior Authorization is required.

Inpatient Surgery

Organ transplant
We cover human organ transplants, including bone marrow transplants, with Prior Authorization. Members must meet the criteria set by the Massachusetts Department of Public Health. Transplants must be non-experimental surgical procedures provided by an In-network Provider. Coverage includes cadaver donor costs and living donor costs if not covered by the donor's own coverage. We do not cover donor charges for Members who donate organs to non-Members or recipients of transplants who are not Tufts Health Direct Members. We do not cover personal searches for solid organs or stem cell donation outside of the organ bank.

Reconstructive procedures, mastectomy surgeries, and surgeries to treat functional deformity or impairment
Coverage is provided for the cost of:

- Services required to relieve pain or to restore a bodily function that is impaired as a result of a congenital defect (including treatment of cleft lip or cleft palate for Children under the age of 18, as required under Massachusetts law**), birth abnormality, traumatic injury or covered surgical procedure (must be approved by an Authorized Reviewer)
- The following services in connection with mastectomy:
    - Reconstruction of the breast affected by the mastectomy
    - Surgery and reconstruction of the other breast to produce a symmetrical appearance
    - Prostheses* and treatment of physical complications of all stages of mastectomy (including lymphedema)
    - Removal of a breast implant is covered when any one of the following conditions exists:
    - The implant was placed post-mastectomy
    - There is documented rupture of a silicone implant
    - There is documented evidence of auto-immune disease or infection

* Breast prostheses are covered as described under "Prosthetic Devices" in the Durable Medical Equipment section.

**Prior Authorization by an Authorized Reviewer is not required for the treatment of cleft lip or cleft palate for Children under the age of 18.

Important: No coverage is provided for the removal of ruptured or intact saline breast implants or intact silicone breast implants except as specified above.

Note: Cosmetic surgery is not covered.

Maternity care

Inpatient

We cover:

- Hospital and delivery services for the mother at an In-network Facility (home birth is not a covered benefit). The mother's Inpatient stay is covered at the facility where she delivered for at least:
    - 48 hours following a vaginal delivery
    - 96 hours following a Caesarean delivery

Note: Decisions to reduce the mother and Child's Inpatient stay are made only by the attending obstetrician, pediatrician or certified nurse midwife, and mother (and not by the Plan).

- Routine nursery charges and well-newborn care for a healthy newborn. This includes:
    - Pediatric care
    - Routine circumcision by a Provider
    - Newborn hearing screening tests performed by an In-network Provider before the newborn Child (an infant under three months of age) is discharged from the Hospital or as provided by regulations of the Massachusetts Department of Public Health
- Covered Services will include one home visit by a registered nurse, physician or certified nurse midwife and additional home visits, when Medically Necessary and provided by a licensed health care Provider. Covered Services will also include, but not be limited to, parent education, assistance, and training in breast or bottle feeding and the performance of any necessary, and appropriate clinical tests. These Covered Services will be available to a mother and her newborn Child regardless of whether or not there is an early discharge (Hospital discharge less than 48 hours following a vaginal delivery or 96 hours following a Caesarean delivery).

Note: Care that could have been foreseen before leaving the Service Area is not covered. This includes, but is not limited to, deliveries outside the Service Area within one month of the due date, including postpartum care, and care provided to the newborn Child.

There is no coverage outside of the Service Area for delivery or problems with pregnancy at any time after the onset of the 36th week of pregnancy or within 4 weeks of the due date of pregnancy, or being told by your Provider that you are at risk for early delivery. Delivery is covered at the In-network facilities only. Home birth is not covered by Tufts Health Direct.

Outpatient

We cover the following Outpatient maternity services:

- Breastfeeding classes, breast pumps and related supplies.
- Childbirth classes: For information about this benefit, including coverage and available Providers, please contact Member Services.
- Postpartum exams and tests: Routine Outpatient postpartum care for the mother: This includes lactation consultations from a trained In-network Provider.
- Prenatal exams and tests: Routine Outpatient prenatal care, such as evaluation and progress screening, physical exams, and recording of weight, and blood pressure monitoring.

Medical benefit drugs

We cover Medically Necessary, practitioner-administered, FDA-approved drugs and biologicals and the associated administration services. Prior authorization may be required.

Medical formulas

We cover medical formulas and low protein foods to treat certain conditions. This coverage includes:

- Special medical formulas that are approved by the Massachusetts Department of Public Health and are medically necessary for you to treat one of the listed conditions: homocystinuria; maple syrup urine disease; phenylketonuria; propionic acidemia; methylmalonic acidemia; or tyrosinemia.
- Enteral formulas that you need to use at home and are medically necessary for you to treat malabsorption caused by one of the listed conditions: Crohn's disease; chronic intestinal pseudo-obstruction; gastroesophageal reflux; gastrointestinal motility; ulcerative colitis; or inherited diseases of amino acids and organic acids.
- Food products that are modified to be low protein and are medically necessary for you to treat inherited diseases of amino acids and organic acids. (You may buy these food products directly from a distributor.)

Please see our Medical Necessity Guidelines at https://tuftshealthplan.com/documents/providers/guidelines/medical-necessity-guidelines/oral-formula-massachusetts-products-m.

Nutritional counseling

We cover nutritional counseling. Prior Authorization may be required. This includes nutrition-related diagnostic, therapeutic, and counseling services furnished by a registered dietician or nutrition professional for the purpose of disease management. Nutritional counseling includes an initial assessment of nutritional status followed by planned visits for dietary interventions to treat medical illness.

Outpatient laboratory, radiology imaging, and other diagnostic tests

We cover In-network Outpatient laboratory, radiology imaging, and other diagnostic tests. You must have Prior Authorization to have lab work, X-rays or other diagnostic tests done as an Outpatient at a Hospital or free-standing laboratory facility that is Out-of-network. Without Prior Authorization, if you get these services outside the Network, you may be responsible for paying the full cost of care, even if referred for these tests by an In-network or Covering Provider. Not all Providers are aware of which facilities are In-network, and some may direct you to an Out-of- network facility. If you have questions, please call **888.257.1985** or visit tuftshealthplan.com/directproviders to search for an In-network laboratory or facility.

Laboratory services

We cover In-network laboratory services that your Provider orders to diagnose, treat, and prevent disease, and to maintain your health.

Laboratory tests must be ordered by a Physician, Physician Assistant, or Advanced Practice Registered Nurse. The lab tests must also be performed at a licensed laboratory.

Certain laboratory tests may require Prior Authorization, such as genetic testing and others..

Please note that certain laboratory tests associated with routine Preventive Care are covered in full when billed in accordance with our Preventive Services Policy. An example of this is the colorectal cancer screening test Cologuard. For additional information on this policy, please see our website at https://tuftshealthplan.com/documents/providers/payment-policies/preventive-services.

If a laboratory test is not billed according to this policy, it will be subject to the Cost-Share for "Laboratory Outpatient and Professional Services " specified in the Benefit and Cost-Sharing Summary in Appendix B. Please note that these laboratory tests include but are not limited to: blood tests; urinalysis; throat cultures; glycosylated hemoglobin (A1c) tests; genetic testing; and urinary protein/microalbumin and lipid profiles.

Imaging services (Radiology)
We cover radiology imaging services by In-network Providers, such as:

- Mammograms
- MRIs
- PET and CT scans
- X-rays

Some of these—MRIs, MRAs, CT scans, Outpatient nuclear cardiology, and PET—require Prior Authorization. Please see the Benefit and Cost-Sharing Summary for your Plan Level at the end of this *Member Handbook* for more details. Or, call us at **888.257.1985** for more information.

Other diagnostic tests
Other diagnostic tests may be covered, including EKGs, testing for allergies, and sleep studies. Prior Authorization may be required.

Outpatient Surgery
We cover surgical procedures and anesthesia services related to covered surgery performed in an In-network Outpatient surgical center or In-network Hospital operating room. Some procedures require Prior Authorization. Refer to the Benefit and Cost-Sharing Summary for your Tufts Health Direct Plan type for Outpatient Surgery facility and professional fee Cost-Sharing.

Pain Management
In compliance with Massachusetts law, Tufts Health Plan offers coverage for services and medications for pain management that are alternatives to opioids. Services include, but are not limited to:

- Acupuncture
- Nutrition counseling
- Physical Therapy
- Spinal manipulation, and Chiropractic medicine

To find a Provider for these services, please see our website. Click on Find a Doctor or Hospital tool to start your search. You may also call Member Services for help in finding a Provider.

Please note that Prior Authorization for these services may be required. Please see your Plan's Benefit and Cost-Sharing Summary to determine if these services require Prior Authorization.

Medications for pain management that are alternatives to opioids include, but are not limited to:

- Cyclooyxgenase-2 (Cox-2) inhibitors, such as celecoxib
- Non-steroidal anti-inflammatory agents, such as ibuprofen

For information about medication alternatives to opioids, please call us at **888.257.1985**.

Podiatry
We cover Medically Necessary nonroutine podiatry services for Members when a licensed In-network Podiatrist performs the service. We cover routine foot care only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot.

Preventive Health Care Services
We cover Preventive Health Care Services without Cost-Share to the extent required by the Affordable Care Act. The Preventive Health Care Services listed below are the most common. For a complete and up-to-date list of covered Preventive Health Care Services, please see our Preventive Services list at tuftshealthplan.com/documents/providers/payment-policies/preventive-services.

Note: Any follow-up care determined to be Medically Necessary as a result of a routine physical exam may be subject to Cost-Share.

For Children

- Hereditary and metabolic screening at birth
- Immunizations, tuberculin tests, hematocrit, hemoglobin, blood lead screening or other appropriate blood tests, and urinalysis as recommended by a Provider
- Newborn hearing screening test before discharge from the Hospital or birthing center
- Newborn care for properly enrolled newborns and Adoptive Children, such as medically diagnosed congenital defects and birth abnormalities or premature birth
- Physical exam, history, measurements, sensory screening, neuropsychiatric evaluation, and developmental screening, and assessment at the following intervals:
    - Six times during the Child's first year after birth
    - Three times during the second year of life (age 1 to age 2)
    - Annually from age 2 through age 5 (until age 6)
- Routine physical exams and Developmental/Behavioral Health screenings for Children age 6 and older, including vision and auditory screening

For adults

- Nutritional counseling and health education
- Routine medical exams (once per Benefit Year) and related routine lab tests and X-rays
- Recommended routine Preventive immunizations
- Routine Preventive screening tests and procedures (e.g., screening colonoscopies in the absence of symptoms, with or without surgical intervention)

For women, including pregnant women

- Baseline mammograms for women between the ages of 35 and 40, and routine annual screening mammograms once per Benefit Year for women age 40 and older
- Laboratory tests associated with routine maternity care
- Voluntary sterilization procedures
- Breastfeeding services, breast pumps and related supplies
- Lactation counseling and support from a trained In-network Provider
- Prescription drug and nonprescription contraceptives listed on our Formulary, as described earlier in the Family-planning Services section
- Prenatal care
- Routine gynecological exam. Depending on the result of your previous pap smear a yearly pap smear is included once per Benefit Year. You must see an In-network Provider (PCP, obstetrician or gynecologist), Nurse Practitioner or certified nurse midwife.

Some testing or lab screening ordered by a Provider during a Preventive examination may not qualify as Preventive Services. That additional diagnostic testing and lab screening may be subject to Cost-Share.

Smoking Cessation Counseling Services

Smoking / Tobacco Cessation Counseling Services covered by Tufts Health Direct include individual, group, and telephonic smoking cessation counseling services provided in accordance with current

guidelines established by the United States Department of Health and Human Services, and which meet the requirements of the Affordable Care Act.

Tufts Health Direct also provides coverage for prescription smoking cessation agents and generic over-the-counter smoking cessation agents when prescribed by your PCP. See also "Health and Wellness Support" "Help with quitting smoking" on page 67.

Telehealth

We cover Medically Necessary, Covered Services from In-Network Providers that are appropriate to be provided via telephone, video or other technology. Common examples include, but are not limited to, seeing your PCP or Behavioral Health provider through a video portal provided by the Provider. See the Telehealth definition in the Glossary for additional examples.

Vision care

We cover routine eye exams for Members 19 years of age or older once every 24 months. Members under 19 years of age* are covered for routine eye exams every 12 months. You must receive routine eye examinations from a Provider in the EyeMed Vision Care Select Network in order to obtain coverage for these services. Call EyeMed at **866.504.5908** or visit https://eyedoclocator.eyemedvisioncare.com/ tuftsac/en/ for the names of EyeMed Providers.

For all Plan Levels, Members with diabetes are eligible for and are strongly encouraged to get routine vision exams every 12 months.

Eyeglasses are covered for Members under 19 years of age.* See the Benefit and Cost-Sharing Summary for more details on vision coverage.

***Note:** "under 19 years of age" means the last Day of the month in which a Member turns 19 years old.

Important Information about Providers: Call EyeMed at **866.504.5908** or visit https://eyedoclocator.eyemedvisioncare.com/tuftsac/en/ for the names of EyeMed Select Providers.

Weight loss program reimbursement

You can request a reimbursement for three months of membership fees for a qualified weight loss program.

A qualified weight loss program is a hospital-based or a non-hospital-based weight loss program that focuses on weight loss by modifying eating and physical activity habits and that requires participation in behavioral/lifestyle counseling with nutritionists, registered dieticians, exercise physiologists or other certified health professionals in multiple sessions throughout enrollment in the program. Program delivery and counseling may be in-person, over the phone, or online.

No reimbursement will be provided for any fees or costs you pay for:

- weight loss programs that do not include sessions with a health professional to support progress toward your weight loss goals;
- individual nutrition counseling sessions;
- one-time initiation fees;
- pre-packaged meals;
- books; videos; scales; or
- other weight loss related items or supplies.

You must be a Tufts Health Direct Member for three months and participate in a qualified weight loss program for at least three consecutive months. Each Member on a family plan can request a weight loss program reimbursement once per Benefit Year.

Call us at **888.257.1985**, and we will send you a reimbursement form to complete. You can also get the form at https://tuftshealthplan.com/member/tufts-health-direct-plans/forms-documents/forms-documents and https://tuftshealthplan.com/memberlogin.

Covered Behavioral Health (mental health and/or substance use) services

Certain services in this category may require Prior Authorization. All out-of-network non-emergency services require Prior Authorization. No prior authorization is required for emergency services.

Outpatient Behavioral Health (mental health and/or substance use treatment) services

We cover Medically Necessary Behavioral Health services with Licensed Mental Health Professionals. These services may be provided in a face-to-face encounter or via telehealth in:

- A licensed Hospital
- A mental health or substance use clinic licensed by the Massachusetts Department of Public Health
- A public community mental health center
- A Community Behavioral Health Center (CBHC)
- An office of a Licensed Mental Health Professional
- Home-based services by a licensed professional acting within the scope of his or her license

Biologically based and non-biologically based Outpatient services are provided without annual, lifetime or visit/unit/Day limits. Outpatient Behavioral Health services include:

- Annual mental health wellness examination performed by a Licensed Mental Health Professional or by a PCP during a routine physical exam. A mental health wellness examination is a screening or assessment that seeks to identify any behavioral or mental health needs and appropriate resources for treatment.
- Applied Behavior Analysis (ABA). Prior Authorization is required.
- Community crisis counseling
- Diagnostic evaluation
- Electroconvulsive therapy
- Family and case consultation
- Individual, group, and family counseling
- Medication management services/visits
- Narcotic treatment services
- Neuropsychological assessment and psychological testing. Prior Authorization is required.
- Psychiatric collaborative care by an evidence-based, integrated behavioral health service delivery method in which a primary care team provides structured care management to a Member. A primary care team includes a PCP and a care manager working in collaboration with a psychiatric consultant that provides regular consultations to the team to review the Member's clinical status and care and to make recommendations. Please note that not all PCP offices provide this service.
- Recovery coaches and peer specialists if part of a licensed behavioral health treatment program, such as a licensed mental health clinic, substance use disorder clinic, or outpatient

hospital clinic and under supervision of a licensed clinician, such as a licensed social worker, registered nurse, or clinical psychologist

We do not require Prior Authorization for visits with In-network Providers when treatment is for Outpatient Behavioral Health therapy or substance use disorder Outpatient services. Please see our Medical Necessity Guidelines at tuftshealthplan.com/medicalnecessityguidelines.

Intermediate Behavioral Health services

We cover Medically Necessary intermediate services for Behavioral Health disorders. Intermediate services are a range of services more intensive than Outpatient services and less intensive than Inpatient Services. Intermediate services do not have any annual, lifetime or visit/unit/Day limits. Examples include:

- Acute residential treatment, such as community-based acute treatment (this is not a substance-use-specific service)
- Clinically managed detoxification services
- Community Crisis Stabilization (CCS)
- Adult and Youth Mobile Crisis Intervention (AMCI and YMCI)
- Day treatment programs
- Intensive Outpatient programs
- In-home therapy services, such as family stabilization team services
- Level 3 community-based detoxification services
- Partial Hospital programs

Services may require Prior Authorization or notification to the plan. Notification to the plan is required within 1 day of beginning treatment and clinical review is conducted on a concurrent basis to determine Medical Necessity. Please see our Medical Necessity Guidelines at tuftshealthplan.com/medicalnecessityguidelines.

Inpatient Behavioral Health (mental health and/or substance use) services

We cover Medically Necessary 24-hour clinical intervention services at In-network facilities and with In-network Providers for Behavioral Health diagnoses delivered in:

- A facility under the direction and supervision of the Department of Mental Health
- A licensed Hospital
- A private mental health Hospital licensed by the Department of Mental Health
- A substance use facility licensed by the Massachusetts Department of Public Health

We cover In-network Inpatient treatment without Prior Authorization. Notification to the plan is required within 48 hours of admission and clinical review is conducted on a concurrent basis to determine Medical Necessity. Biologically based and non-biologically based Inpatient Services are provided on a nondiscriminatory basis.

Inpatient and intermediate services for Child-adolescent Behavioral Health disorders

In addition to the Outpatient, Inpatient, and intermediate Behavioral Health and substance use disorder services listed above, the following services are available to Children and adolescents until age 19, and to their parents and/or appropriate caregiver, when Medically Necessary. Services include the following, and they are covered, and require Prior Authorization, except as designated below. Services may be provided by an appropriate health care professional under the supervision of a Licensed Mental Health Professional:

Intensive community-based acute treatment (ICBAT) provides the same services as CBAT (see below) for Children and adolescents, but of higher intensity, including:

- More frequent psychiatric and psychopharmacological evaluation and treatment
- More intensive staffing and service delivery

ICBAT programs have the capability to admit children and adolescents with more acute symptoms than those admitted to CBAT. ICBAT programs are able to treat Children and adolescents with clinical presentations similar to those referred to Inpatient mental health services, but who are able to be cared for safely in an unlocked setting. Children and adolescents may be admitted to an ICBAT directly from the community as an alternative to Inpatient hospitalization.

ICBAT is not used as a step-down placement following discharge from a locked, 24-hour setting.

These services do not require Prior Authorization for admission. Notification to the plan is required on the first business day following admission and clinical review is conducted on a concurrent basis to determine Medical Necessity.

Community-based acute treatment (CBAT)—Mental health services provided in a staff-secure setting on a 24-hour basis with sufficient clinical staffing to ensure safety for the Child or adolescent, while providing intensive therapeutic services including, but not limited to:

- Case management
- Daily medication monitoring
- Discharge planning
- Family assessment and consultation
- Individual, group, and family therapy
- Nursing assessment
- Psychiatric assessment
- Psychological testing, as needed
- Specialling (as needed)

These services may be used as an alternative to or transition from Inpatient Services.

These services do not require Prior Authorization for admission. Notification to the plan is required on the first business day following admission and clinical review is conducted on a concurrent basis to determine Medical Necessity.

Youth Mobile crisis intervention – A short-term, mobile, on-site, face-to-face therapeutic response service that is available 24 hours a day, 7 days a week to a Child experiencing a Behavioral Health crisis. Mobile crisis intervention is used to:

- Identify, assess, treat, and stabilize a situation
- Reduce the immediate risk of danger to the Child or others
- Make linkages to all Medically Necessary Behavioral Health services and supports and the appropriate level of care

The intervention shall be consistent with the Child's risk management or safety plan, if any. Mobile crisis intervention includes a crisis assessment and crisis planning, which may result in the development or update of a crisis safety plan. Mobile crisis intervention does not require Prior Authorization.

In-home behavioral services – A combination of Medically Necessary behavior management therapy and behavior management monitoring. These services shall be available, when indicated, where the Child resides, including in the Child's home, a foster home, a therapeutic foster home or another community setting. In-home behavioral services include:

- Behavior management monitoring – Monitoring of a Child's behavior, the implementation of a behavior plan and reinforcing implementation of a behavior plan by the Child's parent or other caregiver
- Behavior management therapy – Therapy that addresses challenging behaviors that interfere with a Child's successful functioning. Behavior management therapy shall include:
    - A functional behavioral assessment and Observation of the youth in the home and/or community setting
    - Development of a behavior plan
    - Supervision and coordination of interventions to address specific behavioral objectives or performance, including the development of a crisis-response strategy

Behavior management therapy may include short-term counseling and assistance.

In-home therapy services—Medically Necessary therapeutic clinical intervention or ongoing training, as well as therapeutic support. The intervention or support shall be provided where the Child resides, including in the Child's home, a foster home, a therapeutic foster home or another community setting. Covered Services include:

- Therapeutic clinical intervention: These services include a structured and consistent therapeutic relationship between a licensed clinician and a Child and the Child's family to treat the Child's Behavioral Health needs. This may include improvement of the family's ability to provide effective support for the Child and promote healthy functioning of the Child within the family; the development of a treatment plan; and the use of established psychotherapeutic techniques, working with family members to enhance problem solving, limit setting, communication, emotional support or other family or individual functions.
- Ongoing therapeutic training and support: These services include those that support implementation of a treatment plan that involve therapeutic interventions that teach the Child to understand, direct, interpret, and manage and control feelings and emotional responses to situations, and assist the family in supporting the Child and addressing the Child's emotional and Behavioral Health needs.

Intensive care coordination (ICC) – A collaborative service that provides targeted case management services to Children and adolescents with a serious emotional disturbance, including individuals with co-occurring conditions, in order to meet the comprehensive medical, Behavioral Health, and psychosocial needs of an individual and the individual's family, while promoting quality, cost-effective outcomes. This service includes:

- An assessment
- The development of an individualized care plan
- Assignments to appropriate levels of care
- Monitoring of goals
- Coordinating with other services and social supports and with state agencies, as indicated

The service shall be based on a system of care philosophy. The individualized care plan shall be tailored to meet the needs of the individual. The service shall include both face- to-face and telephonic meetings, as indicated and as clinically appropriate. ICC is delivered in office, home or other settings, as clinically appropriate. Intensive care coordination does require Prior Authorization. You or your Provider must notify Tufts Health Plan within 3 Days of your initial visit by calling Tufts Health Plan at **888.257.1985**.

Family support and training*—Medically Necessary services provided to a parent or other caregiver of a Child to improve the capacity of the parent(s) or caregiver(s) to improve or resolve the Child's

emotional or behavioral needs. This benefit is provided where the Child resides, which may include the Child's home, a foster home, a therapeutic foster home, or another community setting.
Family support and training addresses one or more goals on the youth's Behavioral Health treatment plan and may include:

- Educating parent(s)/caregiver(s) about the youth's Behavioral Health needs and resiliency factors
- Teaching parent(s)/caregiver(s) how to navigate services on behalf of the Child
- Identifying formal and informal services and supports in their communities, including parent support and self-help groups

Therapeutic mentoring services*—Medically Necessary services provided to a Child, designed to support age-appropriate social functioning or to improve deficits in the Child's age-appropriate social functioning resulting from a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis. Therapeutic mentoring is a skill-building service addressing one or more goals on the youth's Behavioral Health treatment plan.
This benefit includes:

- Supporting, coaching, and training the Child in age-appropriate behaviors
- Interpersonal communication, problem solving, conflict resolution
- Relating appropriately to other Children and adolescents and to adults

Such services are provided, when indicated, where the Child resides, which may include the Child's home, a foster home, a therapeutic foster home, or another community setting to enable the youth to practice desired skills in appropriate settings.

* Prior Authorization will not be required for initial visits for these services; however, the Member must be approved by Tufts Health Direct Plan to receive services through a clinical hub Provider (i.e., a Provider for Outpatient therapy, in-home therapy, or intensive care coordination). The clinical hub Provider serves as the Primary Behavioral Health Care Provider for the youth and will coordinate with other service Providers to meet the Child's clinical needs.

For more information about the services available under this benefit, please call the Tufts Health Direct Plan Behavioral Health Department at 800.208.9565. You may also see the Medical Necessity Guidelines on our website at the following links:

- **Intensive Care Coordination**
  https://tuftshealthplan.com/documents/providers/guidelines/medical-necessity-guidelines/icc
- **In-Home Behavioral Services**
  https://tuftshealthplan.com/documents/providers/guidelines/medical-necessity-guidelines/ihbs
- **In-Home Therapy**
  https://tuftshealthplan.com/documents/providers/guidelines/medical-necessity-guidelines/iht
- **Mobile Crisis Intervention**
  https://tuftshealthplan.com/documents/providers/guidelines/medical-necessity-guidelines/mci
- **Family Support and Training**
  https://tuftshealthplan.com/documents/providers/guidelines/medical-necessity-guidelines/fs-t
- **Therapeutic Mentoring Services**
  https://tuftshealthplan.com/documents/providers/guidelines/medical-necessity-guidelines/tm

For more information about the services available under this benefit, please call us at **888.257.1985**. You may also see the Medical Necessity Guidelines on our website at tuftshealthplan.com and tuftshealthplan.com/medicalnecessityguidlines.

Additional Behavioral Health (mental health and/or substance use) services

We cover Medically Necessary Outpatient, Intermediate, and Inpatient Behavioral Health services to diagnose and treat mental disorders. These include:

- Biologically based mental disorders, such as schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia, panic disorder, obsessive-compulsive disorder, delirium and dementia, affective disorders, eating disorders, post-traumatic stress disorder, substance use disorders, autism, and other psychotic disorders or biologically based mental disorders
- Autism spectrum disorder (ASD) services: We provide coverage for ASD in accordance with Massachusetts law without annual, lifetime or visit/unit/Day limits. Prior Authorization may be required.
    - ASD includes any of the pervasive developmental disorders (as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders), such as autistic disorder, Asperger's disorder, and pervasive developmental disorders not otherwise specified.
    - Diagnosis of ASD includes: Medically Necessary assessments, evaluations (such as neuropsychological evaluations), genetic testing or other tests to diagnose whether a Member has an ASD.
    - Treatment for ASD includes: Habilitative or rehabilitative care (such as applied behavioral analysis*), pharmacy care (under the pharmacy benefit), psychiatric care (direct or consultative services provided by a licensed psychiatrist), psychological care (direct or consultative services provided by a licensed psychologist), and therapeutic care (services provided by licensed or certified speech therapists, occupational therapists, physical therapists or social workers): Benefit limits applicable to the Rehabilitation and Habilitation Therapies benefit do not apply to therapeutic care services provided to Members with ASD. Services must be rendered by In-network Autism Services Providers (Providers who treat ASDs). These include Board-Certified Behavior Analysts,** psychiatrists, psychologists, pharmacies, and licensed or certified speech therapists, occupational therapists, physical therapists, and social workers.
- Rape-related mental or emotional disorders for victims of rape or victims of an assault with intent to commit rape are covered.
- All other non-biologically based mental disorders.

Note: These services may require Prior Authorization. When treatment is for substance use disorder, we do not require Prior Authorization for visits with In-network Providers. Please see our Medical Necessity Guidelines at tuftshealthplan.com/medicalnecessityguidelines.

*Defined as the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences to produce socially significant improvement in human behavior. This includes the use of direct Observation, measurement, and functional analysis of the relationship between environment and behavior.

**Defined as a behavioral analyst credentialed by the Behavior Analyst Certification Board as a Board-Certified Behavior Analyst.

Mental health parity law

Tufts Health Plan complies with Massachusetts and federal laws on mental health parity. This means, among other things, that Copayments, Coinsurance, Deductibles, and/or unit of service limits (e.g., Hospital Days, Outpatient visits) are not greater for Behavioral Health or substance use disorders than those required for medical/surgical services, and office visit Copayments are not greater than those

required for Primary Care visits.

Covered medications and pharmacy

Pharmacy program

We aim to provide high-quality, cost-effective options for drug therapy. We work with your Providers and pharmacists to make sure we cover the most important and useful drugs for a variety of conditions and diseases.

Our pharmacy program does not cover all drugs and prescriptions. Some drugs or products must meet certain Medical Necessity Guidelines before we can cover them. Your Provider must ask us for Prior Authorization before we will cover these drugs.

Prior Authorization drug program

We restrict the coverage of certain drug products that have a narrow indication for usage, may have safety concerns, and/or are extremely expensive, requiring the prescribing Provider to obtain Prior Authorization from us for such drugs. Our Formulary states whether a drug requires Prior Authorization.

If we do not approve the request for Prior Authorization, you or your Personal Representative can appeal the decision. For more information, please see the section "How to resolve concerns" starting on page 72. If you want more information about our pharmacy program, visit https://tuftshealthplan.com/member/tufts-health-direct-plans/pharmacy/pharmacy or call us at **888.257.1985**.

Formulary

We use a Formulary, also known as the Preferred Drug List, as our list of covered drugs. The Formulary applies only to drugs you get at retail, mail-order, and specialty pharmacies. The Formulary does not apply to drugs you get if you are in the Hospital. For the most current Formulary information, please visit https://tuftshealthplan.com/member/tufts-health-direct-plans/pharmacy/pharmacy or https://tuftshealthplan.com/member/employer-individual-or-family-plans/plans-benefits/pharmacy-benefit/pharmacy-formularies or call us at **888.257.1985**.

Step-therapy program

Step therapy is a type of Prior Authorization program (usually automated) that uses a stepwise approach, requiring the use of the most therapeutically appropriate and cost-effective agents first before other medications may be covered. Members must first try one or more medications on a lower step to treat a certain medical condition before a medication on a higher step is covered for that condition. If your Provider advises that the medications on lower step(s) is not right for your health condition and that the medication on higher step is Medically Necessary, your Provider can submit a request for approval. If we do not approve it, you or your Personal Representative can appeal the decision.

Quantity limits

To make sure the drugs you take are safe and that you are getting the right amount, we may limit how much you can get at one time. Your Provider can ask us for approval if you need more than we cover. One of our clinicians will review the request. We will cover the drug according to our Medical Necessity Guidelines if there is a medical reason you need this particular amount.

If you fill a lesser quantity than is prescribed of a Schedule II opioid controlled substance and then decide to fill the remainder of the original prescription at the same pharmacy within 30 Days of the original prescription date, no additional Copayment or other Cost-Sharing will be applied.

Medication Synchronization (Med Sync)

This program permits and applies a prorated daily Cost-Sharing rate to covered maintenance prescription drugs that are:

- Dispensed by a Tufts Health Plan Network pharmacy
- In a quantity less than a thirty (30) Days' supply

- Used for the management or treatment of a chronic, long-term condition

Limitation: Medication synchronization is limited to one per Benefit Year per maintenance prescription drug.

Excluded prescription drugs: Prescription drugs excluded from this program include, but are not limited to, controlled substances, pain medications, and antibiotics.

Specialty pharmacy program

We have designated specialty pharmacies that specialize in providing medications used to treat certain conditions and are staffed with clinicians to provide support services for Members. Some medications must be obtained at a specialty pharmacy. Medications may be added to this program from time to time. Designated specialty pharmacies can dispense up to a 30-Day supply of medication at one time, and the supply is delivered directly to the Member's home via mail. This is NOT part of the mail-order pharmacy Benefit. Extended-Day supplies and Copayment savings do not apply to these designated specialty drugs.

Generic drugs

Generic drugs have the same active ingredients and work the same as brand-name drugs. When generic drugs are available, we may not cover the brand-name drug without granting approval. If you and your Provider feel that a generic drug is not right for your health condition and that the brand-name drug is Medically Necessary, your Provider can ask for Prior Authorization. One of our clinicians will then review the request.

90–Day Prescription Drug Benefit at a Pharmacy

You may purchase up to a 90–day supply of maintenance medications from a participating pharmacy. Although most maintenance medications are available for a 90–day supply, we may limit drugs for clinical reasons or to prevent potential waste. In addition, drugs included in the Specialty Pharmacy Program, discussed above, are not available for a 90–day supply.

New-to-market drugs

We review new drugs for safety and effectiveness before we add them to our Formulary. A Provider who feels a new-to-market drug is Medically Necessary for you before we have reviewed it can submit a request for approval. One of our clinicians will review this request. If we approve the request, we will cover the drug according to our Medical Necessity Guidelines. If we do not approve it, you or your Personal Representative can appeal the decision.

Covered prescription drugs and supplies

In addition to the covered prescription drugs and supplies listed in the Formulary, we may cover:

- Off-label use of U.S. Food and Drug Administration (FDA) approved prescription drugs for the treatment of cancer or HIV/AIDS that have not been approved by the FDA for that indication. We also cover any Medically Necessary services associated with giving these drugs. These drugs must be recognized for such treatment in one of the standard reference compendia, in the medical literature or by the Massachusetts Commissioner of Insurance.
- Oral and injectable drug therapies used in the treatment of covered infertility services only when you have been approved for covered infertility treatment (see the section "Infertility services" starting on page 43.)
- Compounded medications: (1) If the Member is under the age of 18, (2) the active ingredients are listed in the Prescription Drug List and (3) one or more agents within the compound is FDA approved and requires a prescription. Compounded medications are covered for Members over the age of 18 when determined to be Medically Necessary. Compounding kits that are not FDA-approved and include prescription ingredients that are readily available may not be covered. To confirm whether the specific medication or kit is covered under this plan, please call Member Services.

Included in the Formulary are:

- Hormone replacement therapy (HRT) for perimenopausal and postmenopausal individuals
- Hypodermic syringes or needles when Medically Necessary

In compliance with Massachusetts law, opioid medications listed as Schedule II or Schedule III controlled substances will be filled at a lesser quantity than prescribed if the Member requests it. If the Member requests the lesser quantity, no additional cost or penalty will be enforced on the Member. If the Member fills a lesser quantity than is prescribed of a Schedule II opioid controlled substance, and then decides to fill the remainder of the original prescription at the same pharmacy within 30 Days of the original prescription date, no additional Copayment or other Cost-Sharing will be applied. Please see Appendix C, "Schedule II and III Opioid Medications", for a list of these medications.

Non-Formulary drugs

There are thousands of drugs listed on the Tufts Health Plan covered drug list. In fact, most drugs are covered. There are however, select drugs that Tufts Health Plan does not include on the formulary. In many cases, these drugs are not on the Tufts Health Plan formulary because there are safe, comparably effective, and cost-effective alternatives available. Our goal is to keep pharmacy benefits as affordable as possible. If your doctor feels that one of the non-formulary drugs is needed, your doctor can submit a request for coverage under the Formulary Exception Process.

Note: Drug approved through the Formulary Exception Process may be subject to the highest Cost Sharing Amount.

Exclusions

We do not cover:

- Any drug products used exclusively for cosmetic purposes
- Experimental drugs, which are those that cannot be marketed lawfully without the approval of the FDA and such approval has not been granted at the time of their use or proposed use or such approval has been withdrawn
- Prescription drugs that are not approved by the FDA (This does not include off-label uses of FDA approved drugs where use is recognized by established research documentation.)
- Immunization agents: These may be provided under Preventive Health Care earlier in this chapter. Other select vaccines may be accessible at the pharmacy at no Cost-Share and covered under the medical benefit.
- Medical supplies*
- Mifepristone (Mifeprex)*
- Prescription and over-the-counter homeopathic medications
- Drugs that by law do not require a prescription (unless listed as covered in the "Covered medications and pharmacy" section) or listed on the Formulary as covered
- Vitamins and dietary supplements (except prescription prenatal vitamins, vitamins as required by the Affordable Care Act, fluoride for Children, and supplements for the treatment of mitochondrial disease)
- Topical and oral fluorides for adults
- Medications for the treatment of idiopathic short stature
- Non-drug products, such as therapeutic or other prosthetic devices, appliances, supports or other non-medical products. These may be provided as described earlier in this section.
- Prescriptions written by Providers who do not participate in the Tufts Health Direct Network, except in cases of Prior Authorization or Emergency care

- Prescriptions filled at pharmacies other than Tufts Health Plan-designated pharmacies, except for Emergency care
- Prescriptions filled through an internet pharmacy that is not a verified internet pharmacy practice site certified by the National Association of Boards of Pharmacy
- Prescription medications once the same active ingredient or a modified version of an active ingredient that is therapeutically equivalent to a covered prescription medication that becomes available over the counter: in this case, the specific medication may not be covered, and the entire class of prescription medications may also not be covered.
- Prescription medications when co-packaged with non-prescription products

* Certain drugs may be covered as a non-pharmacy benefit, e.g., infused or injected drugs, which are covered under your medical Benefits.

* Medications packaged for institutional use will be excluded from the pharmacy benefit coverage unless otherwise noted on the formulary.

Exception Requests

An exception request may be submitted for the following pharmacy programs: Prior Authorization, Step Therapy Prior Authorization, Quantity Limitations, New-to-market, or Non-Formulary drugs.

Exception requests are reviewed on a case-by-case basis. Your Provider will be asked to provide medical reasons and any other important information about why you need an exception. We will determine if a request is consistent with our Medical Necessity Guidelines. Please see the definition of Medical Necessity in Appendix A Glossary Terms and Definitions on page 95 for an explanation of how we develop our guidelines.

We will notify you and your Provider about our decision:

- If the request for a Non-covered Drug is approved, the medication will be covered on the highest Tier (e.g., Tier-3 on a 3-Tier Formulary).
- If the request for coverage of a Formulary drug under another program is approved, the medication will be covered with the Tier Cost-Sharing Amount applicable to that drug's current tier on the Formulary.
- If the request is denied, you and your Provider have the right to appeal.

Your appeal can be submitted in one of the following ways:

- By phone, call a Member Services Representative.
- By fax, send it to us at 617-972-9509.
- By mail, submit your appeal in writing to:

  Tufts Health Plan
  Attn: Appeals and Grievances Department
  1 Wellness Way
  Canton, MA 02021

Please see "How to resolve concerns" for information regarding Member Appeals, including Expedited Appeals.

You may have questions about your Prescription Drug Benefit. You may want to know the Tier of a particular drug. You might like to know if your medication is part of a Pharmacy Management Program. For these issues, check our website at https://tuftshealthplan.com/member/tufts-health-direct-plans/pharmacy/pharmacy or you can also call a Member Services Representative.

The Tufts Health Plan website has a list of covered drugs with their Tiers. The Formulary is updated regularly so please review the website for the most current information.

IMPORTANT NOTE: There may be limited circumstances when we may change a drug's Tier which can happen at any time throughout the year. For example, a brand drug's patent may expire. In this case, we may change the drug's status by either (a) moving the brand drug from Tier-2 to Tier-3 or (b) no longer covering the brand drug when a generic alternative becomes available. In such cases, we will make the generic available at the same Tier (i.e., Tier-2) or a lower Tier (i.e., Tier-1).

If you get a bill for a Covered Service

Certain services you receive from non-Tufts Health Plan Providers may be reimbursable. Some examples include:

- Emergency ambulance transportation
- Emergency rooms specialists; and
- Radiologists, pathologists, and anesthesiologists who work at In-network Hospitals.

In these situations, you will not be responsible to pay the non-Tufts Health Plan Provider more than your In-network Cost Share amount for Covered Services. Before paying the bill, contact the Member Services at **888.257.1985**

If you do pay the bill, you must send the following information to the Tufts Health Plan Member Reimbursement Area:

- a completed, signed Member Reimbursement Medical Claim Form which can be obtained from the Tufts Health Plan website or by contacting Member Services; and
- the documents listed on the Member Reimbursement Medical Claim Form that are required for proof of service and payment.

The address for the Member Reimbursement Medical Claims Department is listed on the Member Reimbursement Medical Claims Form.

Please note: You must contact Tufts Health Plan regarding your bill(s) or send your bill(s) to Tufts Health Plan within twelve months from the date of service. If you do not, the bill cannot be considered for payment.

Most completed reimbursement requests are processed within 30 days. Incomplete requests and requests for services rendered outside of the United States may take longer.

Reimbursements will be sent to the Subscriber at the address Tufts Health Plan has on file.

For more information, call Member Services at **888.257.1985**.

You may also receive a bill for Covered prescription drugs.

Note: Requests for reimbursement for drugs must be submitted within one year of the date of service.

Services not covered

Services, supplies or medications we do not cover include, but are not limited to, the following:

- Massage therapy
- Cosmetic (meaning to change or improve appearance) services and procedures, unless required to restore bodily function or correct a functional physical impairment after an accidental injury, prior surgical procedure or congenital/birth defect.
- Custodial Care which includes:

- Care provided primarily to assist in the activities of daily living, such as bathing, dressing, eating, and maintaining personal hygiene and safety;
- Care, other than behavioral health care, provided primarily for maintaining the Member's or anyone else's safety, when no other aspects of treatment require an acute hospital level of care;
- Services that could be provided by people without professional skills or training; or
- Routine maintenance of colostomies, ileostomies, and urinary catheters; or
- Adult and pediatric day care.

- Some types of Durable Medical Equipment (This list is not all-inclusive.):
  - Elevators, ramps, and home modifications
  - "Back-up" equipment
  - Whirlpool equipment used for soothing/comfort
  - Heating or cooling pads, caps or devices, hot water bottles, and paraffin bath units
  - Hospital-type beds requiring installation in a home
  - Hygienic equipment that does not serve a primary medical purpose
  - Nonmedical equipment otherwise available to Members that does not serve a primary medical purpose
  - Bed lifters that are not primarily medical
  - Non-Hospital beds and mattresses
  - Hospital-type beds in full, queen, and king sizes
  - Cushions, pads and pillows, except when Medically Necessary and we give Prior Authorization
  - Pulse tachometers
  - Externally powered exoskeleton assistive devices and orthoses
  - Air conditioners, dehumidifiers, HEPA filters and other filters, and portable nebulizers
  - Articles of special clothing, mattress and pillow covers, including hypo-allergenic versions
  - Bath and toilet aids, including but not limited to, tub seats/benches/stools, raised toilet seats, commodes, and rails
  - Bed-related items, including bed trays, bed pans, bed rails, over-the-bed tables, and bed wedges
  - Car seats
  - Car/van modifications
  - Comfort or convenience devices
  - Cooling devices
  - Dentures
  - Ear plugs
  - Emergency response systems (e.g., LifeAlert)

- Exercise equipment and saunas
- Externally powered exoskeleton assistive devices and orthoses
- Fixtures to real property: Examples are ceiling lifts, elevators, ramps, stair lifts, or stair climbers
- Heat and cold therapy devices, including but not limited to, hot packs, cold packs, and water pumps with or without compression wrap
- Heating pads, hot water bottles, and paraffin bath units
- Home blood pressure monitors and cuffs
- Hot tubs, jacuzzis, swimming pools, or whirlpools
- Mattresses, except for mattresses used in conjunction with a hospital bed and ordered by a Provider. Commercially available standard mattresses not used primarily to treat an illness or injury (e.g., Tempur-Pedic® and Posturepedic® mattresses), even if used in conjunction with a hospital bed, are not covered
- Certain wearable devices (e.g., smartwatches, bracelets, patches) used for physiological monitoring and fitness tracking (e.g., Fitbit, Biostamp, Embrace, Smartwatch, Smartmonitor smartwatch, Garmin Vivofit 4, Garmin Vivosmart 3, Samsung Galaxy Fit)
- Incontinence supplies/Absorbent products
- Educational testing and evaluations
- Exams required or ordered by a third party (e.g., physical, psychiatric and psychological examinations or testing ordered by a third party, such as an employer, court or school)

- A drug, device, medical treatment or procedure (collectively "treatment") that is experimental or investigational treatment. This exclusion does not apply to the following services which meet the requirements of Massachusetts and federal law:
  - Long-term antibiotic treatment of chronic Lyme disease
  - Bone marrow transplants for breast cancer
  - Patient care services provided as part of a qualified clinical trial conducted to prevent, detect or treat cancer or other life-threatening diseases or conditions
  - Off-label uses of prescription drugs for the treatment of cancer or HIV/AIDs

Note: If the treatment is experimental or investigative, we will not pay for any related treatments that are provided to the Member for the purpose of furnishing the experimental or investigative treatment.

- We do not cover the cost of services (including tuition-based programs) that offer educational, vocational, recreational or personal development activities, including but not limited to therapeutic schools, camps, wilderness or ranch programs, sports or performance enhancement programs, spas/resorts, leadership or behavioral coaching or Outward Bound.
- We will provide coverage for Medically Necessary Outpatient or intermediate Behavioral Health services provided by Licensed Mental Health Professionals while the Member is in a tuition-based program, subject to plan rules including any Network requirements or Cost- Share.
- Routine podiatry/foot care, except as noted in the Podiatry Benefit on page 49
- Private duty nursing (block or non-intermittent nursing)
- Hearing aids for Members more than 21 years old (see Benefit and Cost-Sharing Summary for more information)
- Laser eyesight correction or any other eye surgery to treat a condition that another treatment besides surgery can correct

- Biofeedback, except for the treatment of urinary incontinence; neuromuscular stimulators, and related supplies
- Services from Out-of-network Providers, unless we give Prior Authorization (except Emergency services, which never require Prior Authorization)
- Personal comfort items, such as air conditioners, air purifiers, chair lifts, dehumidifiers, radios, telephones, and televisions
- Reversal of voluntary sterilization
- A Provider's charge for shipping and handling or copying of records
- Medications, devices, treatments, and procedures that have not been demonstrated to be medically effective
- Routine care, including routine prenatal care, when you are outside of our Service Area
- Services of a chair car
- Costs associated with home births; and/or cost associated with services provided by a doula
- Wheelchair trays
- Services for which there would be no charge in the absence of insurance
- Special equipment needed for sports or job purposes
- Any non-Emergency dental services for Members 19 years or older
- A service or supply that is not covered by or at the direction of a Tufts Health Direct Provider, except for Emergency services
- Replacement of Durable Medical Equipment or prosthetics due to loss, intentional damage or negligence
- With respect to Child-adolescent mental health intermediate care and Outpatient services, the following programs:
    - Programs in which the patient has a pre-defined duration of care without Tufts Health Direct Plan's ability to conduct concurrent determinations of continued Medical Necessity for an individual
    - Programs that only provide meetings or activities that are not based on individualized treatment planning
    - Programs that focus solely on improvement in interpersonal or other skills rather than services directed toward symptom reduction and functional recovery related to specific mental health disorders
- Any service, supply, or medication that is not Medically Necessary
- Any service, supply, or medication that is not a Covered Service.
- Services for which we did not give required Prior Authorization

Tufts Health Direct EXTRAS

To help you become and stay your healthiest, we reward you with Tufts Health Direct EXTRAS discounts and perks. See the following table for details about EXTRAS and how to get them. You must be a current, eligible Tufts Health Direct Member to get the EXTRAS we give our Members. However, some restrictions may apply, and we reserve the right to change or stop giving an EXTRA at any time.

EXTRAS	What It Is	How to Get It
$25 diabetes checkup supermarket gift card	If you have diabetes, we want to help you manage it. We will give you a $25 supermarket gift card for completing five routine diabetes checkups: • An eye exam • Two blood sugar (HbA1c) tests • A protein test • A blood cholesterol test	• Call us at **888.257.1985** and ask to speak to a member of our staff. We will send you a form with a list of screenings to complete in a calendar year, or download it from https://tuftshealthplan.com/documents/members/forms/direct-extras-reward-form. Getting these screenings will help you manage your diabetes. You can also get the form at https://tuftshealthplan.com/DirectExtras. • Visit your *PCP*, complete the tests, and fill out the form. • Make a copy of the form to keep for yourself. • Mail the completed form to: **Tufts Health Plan** **Attn: Claims Department** **P.O. Box 524** **Canton, MA 02021** • Watch your mail for your $25 supermarket gift card that should come in six to eight weeks. **Note:** You must be a Tufts Health Plan Member when you get the five screenings and when we process your form. You can get one $25 supermarket gift card every 12 months for completing the five screenings.

EXTRAS	What It Is	How to Get It
Fitness band or $25 supermarket gift card for completing your yearly checkup	If you get a yearly checkup, we will send you a fitness band that will help you track daily steps, calories, sleep monitoring, and more, or a $25 supermarket gift card.	• Call us at 888.257.1985 and ask to speak to a member of our staff. We will send you a form to complete. You can also download the form at https://tuftshealth plan.com/documents/members/forms/direct-extras-reward-form. • Visit your PCP, complete your yearly checkup, and fill out the form. • Make a copy of the form to keep for yourself. • Mail the completed form to: **Tufts Health Plan** **Attn: Claims Department** **P.O. Box 524** **Canton, MA 02021** **Note:** You must be a Tufts Health Plan Member when you get your yearly checkup and when we process your form. You can get one fitness band for completing your yearly checkup, you may get one $25 supermarket gift card all other years.
Car and booster seats gift cards	Members who are 28 or more weeks pregnant or Members who are 8 years old or younger are eligible to get a $50 department store gift card to use to buy a convertible car seat (for kids 5–40 pounds and 19–43 inches tall). Also, one year later, as long as your Child is a Tufts Health Plan Member, you can get a $25 department store gift card to use to buy a booster car seat (for kids 30–100 pounds and 43–57 inches tall).	• Call us at **888.257.1985** and ask to speak to a member of our staff. We will send you a form to complete. You can also get the form at https://tuftshealthplan.com/DirectExtras • Car seat reimbursement form: https://tuftshealthplan.com/documents/members/forms/direct-extras-car-seat-form • Visit your PCP, complete the tests, and fill out the form. • Fill out the form and make a copy for yourself. • Mail the completed form to: **Tufts Health Plan** **Attn: Claims Department** **P.O. Box 524** **Canton, MA 02021** Watch your mail for your gift card that should arrive in six to eight weeks.

Care Management

We provide Care Management services to help keep you well and improve your health. We accept and screen all referrals for our Care Management programs. Our Care Management services may include helping you make appointments, providing you with health information, and coordinating your care with your Provider(s). Care Management includes:

- Health and wellness support
- Integrated Care Management, which includes medical Care Management for Members with complex care needs, integrated clinical management (ICM), Behavioral Health, and Community Health Management
- Transition of care

Care Management does not replace the care you get from your Primary Care Provider (PCP) or other Providers, but it helps support it. Please remember to schedule regular and ongoing visits with your Providers.

Our care managers work with your Providers to coordinate your care and make sure you get the care you need when you need it. Call us at **888.257.1985** to talk to our Care Management team, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays.

Health and wellness support

Maternal and Child Health Program

We work closely with you and your Providers to make sure you get ongoing prenatal care if you are pregnant. We can also help coordinate care you may need after you deliver. For information about the benefits and services we offer pregnant Tufts Health Direct Members, see page 46.

24/7 NurseLine

We have a NurseLine for help with health questions, 24 hours a day, seven days a week. When you call our 24/7 NurseLine at 888.MY.RN.LINE (888.697.6546) (TTY: 800.942.1859), you can talk with a caring and supportive licensed health care professional at no cost. Our 24/7 NurseLine staff members do not give medical advice and are not a replacement for your Providers.

Help with quitting smoking

Tufts Health Direct Members can get medications from their doctor and counseling from the Massachusetts Tobacco Cessation and Prevention Program to help quit smoking. This benefit is covered in full. For more information about quitting smoking, talk to your PCP. See also Smoking Cessation Counseling Services on page 50.

Integrated Care Management

When appropriate, our Behavioral Health, medical, and Community Health Workers work closely with you and each other to coordinate the care you need. We call this an Integrated Care Management model. It is designed to make sure you get the best care and results possible.

Integrated Care Management can help if you have complex and/or specific needs and conditions, such as:

- A mental health and/or substance abuse issue
- A physical disability
- A special health condition, such as a high-risk pregnancy, cancer or HIV/AIDS

Our team will work with you to:

- Address your needs including medical, Behavioral Health, social, and financial concerns
- Answer your questions

- Develop a plan to get you feeling better
- Monitor your health

Behavioral Health (mental health and/or substance use) Care Services

We have different levels of Behavioral Health services, based on what type and how many services you need and/or any medical condition you may have. You can find a list of these services (including Inpatient, Outpatient, substance use disorder, and diversionary services) in the Benefit and Cost-Sharing Summary at the end of this Handbook. You can find a list of Behavioral Health Providers who can provide these services at tuftshealthplan.com, tuftshealthplan.com/memberlogin or you may call us at **888.257.1985**.

Tufts Health Plan's Behavioral Health clinicians are licensed clinicians who can help you by:

- Giving you information about community-based services
- Monitoring your treatment
- Participating with your health care team on discharge planning
- Reviewing your need for ongoing care

Together, we can help make sure you get the best care. We want to:

- Continue to improve your health and your family's health
- Coordinate your care among your Providers and, with your consent, make sure that your PCP and Behavioral Health Providers share relevant information regarding diagnoses, medication and/or treatment
- Involve you in your treatment planning and recovery
- Make sure your care continues smoothly if you change Providers or plans
- Make sure you have timely and easy access to the appropriate level of Behavioral Health care

Anytime you are having a Behavioral Health Emergency, call 911 or go to the nearest Emergency room. For a complete list of Emergency rooms throughout the state, please visit us at tuftshealthplan.com, tuftshealthplan.com/memberlogin or call us at **888.257.1985**.

Transition of Care

When you leave a 24-hour care facility, such as an acute-care Hospital or Skilled Nursing Facility, our care team will help you with your transition of care needs (the care you need to help you keep getting better). Our care team will work with ancillary Providers to make sure you get the services you need when you need them. Ancillary Providers include a Visiting Nurse Association or other home care agency and Durable Medical Equipment Providers.

The transition plan or transition of care plan includes:

- Coordinating your care needs with your Providers, such as making timely follow-up appointments
- Reviewing your medications
- Developing a plan to help you get the services you need
- Providing you with educational information about your condition, your medication, managing your disease, and what you can expect
- Providing you with individual and Integrated Care Management

Your Provider can ask us to provide you with transition of care services by visiting tuftshealthplan.com, tuftshealthplan.com/memberlogin or calling us at **888.257.1985**.

Complex Care Management

Our Complex Care Management program is for Members with hard-to-manage, unstable, and/or fragile, long-lasting medical and/or Behavioral Health conditions. Members in these programs have the support of a team of dedicated health care professionals who can help them get and stay healthy. They can also help to identify, reduce or remove social barriers to appropriate care.

Members with the following conditions may benefit from our Complex Care Management services:

- AIDS or other immune system diseases
- Bipolar disorder
- Cancer
- Certain neurological diseases
- High-risk pregnancy and newborn Children
- Intensive-care needs
- Major depressive disorder
- Multiple health conditions that are hard to manage
- Organ transplantation
- Pediatric care needs
- Schizophrenia
- Serious heart or lung disease
- Severe disability or impairment
- Severe traumatic injury
- Substance use disorders

Our Care Managers can work with you to help you with specific conditions such as:

Asthma

Our Care Managers can give you information and tools to help you understand asthma and its causes, triggers, and symptoms. Working with your Provider, we can help you avoid trips to the Emergency room.

A visiting nurse, with Prior Authorization from us, can also order for you supplies such as anti- allergen covers for a mattress and pillows can also help with additional asthma education. If you have asthma or think you have asthma, please contact us today at **888.257.1985**.

Diabetes

Care Managers are available to help you manage type 1, type 2, and gestational diabetes. We may send you helpful information, such as information about why certain tests are important and how you can better manage diabetes. We may also call to remind you about yearly lab work and PCP appointments.

Visiting Nurse Association services are available to help you get any needed ongoing medical care and diabetes education as necessary if you are homebound. For more information, please call us at **888.257.1985**.

Chronic Obstructive Pulmonary Disease

Our doctors, nurses, and other health care professionals want to help our Members who live with chronic obstructive pulmonary disease (COPD) stay healthy. We may send you helpful information, such as reminders about certain tests that are important to help you stay as healthy as you can.

If you meet home care criteria, you may receive in-home COPD education from a visiting nurse. For more information, please call us at **888.257.1985**.

Heart Failure

Our Care Managers can work with you to help you manage heart failure. We will speak with you about your understanding of the disease, how you and your doctors are working together to manage your heart failure, and work to identify ways to improve or maintain good health. We can send you educational materials or direct you to web resources for helpful information. For more information, please call us at **888.257.1985**.

Behavioral Health (mental health and/or substance use) Care Management (CM)

Behavioral Health CM is offered to our members who:

- Request support after being newly diagnosed with a mental health or substance use condition.
- Have a Behavioral Health condition that they are finding hard to manage.
- Have been admitted for a Behavioral Health condition, especially when there have been multiple admissions.
- Have not accessed or cannot access community-based services
- Experience a catastrophic event
- Have needs or cultural issues that require multiple agencies to coordinate service delivery

Call us at **888.257.1985** if you want more information or have questions about Behavioral Health ICM and how we determine the care we approve.

Community Health

Our Community Health Workers' team can help you with more than health care issues. Community Health Workers are here to support you with anything in your life that could affect your health, including getting health care. Community Health Workers can help you:

- Access Behavioral Health resources
- Access community services in conjunction with services we provide
- Ask for benefits, such as Supplemental Security Income (SSI) and Social Security and Disability Insurance (SSDI)
- Find Emergency shelter
- Find school-based services
- Get information about programs that help pay for utilities (electricity or heat)
- Locate disability support groups
- Find community resources that are available to you as a Tufts Health Plan Member
- Find health maintenance programs
- Find preventive Care services
- Help connect you to our programs that help you with any medical needs or conditions
- Help you find a doctor
- Make sure you know what benefits you can get
- Support you in getting help with food, transportation, and/or housing

We will look at your situation and will then refer you to another member of our Care Management team, if we think it is necessary.

Call us at **888.257.1985** if you want more information or if you have questions about the clinical community outreach program.

Quality Management

We are committed to seeing that you get high-quality health care in the right place, at the right time, with the best possible results.

Our Quality Management and Improvement Program Description (QMIPD), produced annually, is:

- An overview of our Quality Management and improvement methods and measures
- A high-level overview of our care and disease management programs and activities
- A summary of our patient safety-focused work

The QMIPD includes:

- A description of our Quality Management programs, resources devoted to the programs, program structure, and its governing body
- Both medical and Behavioral Health (mental health and/or substance use) care aspects of our quality program
- A discussion of our yearly Member survey that evaluates your satisfaction with access to:
    - Ancillary Services, such as lab tests
    - Durable Medical Equipment
    - Hospitalization services
    - Specialist services
    - Other Covered Services
- Objectives for serving our culturally and linguistically diverse membership and Members with complex health needs

We are committed to the improvement of Culturally and Linguistically Appropriate Services (CLAS) and to reducing disparities in health care. The U.S. Department of Health and Human Services defines cultural competence as the ability to:

- Understand the social, linguistic, moral, intellectual, and behavioral characteristics of a community or population
- Translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations

Tufts Health Plan’s unwavering commitment to providing affordable, high-quality health care coverage to members is reflected in our NCQA rating—we are among the top health plans in the country based on quality and member satisfaction.

Tufts Health Plan has been NCQA accredited since 1994. From 1999-2019, its HMO/POS products achieved “Excellent” accreditation status from NCQA, which is the highest possible achievement for consumer protection, quality improvement, and clinical effectiveness. Tufts Health Plan's PPO product has been accredited since 2006 and held “Excellent” accreditation status during that time.

As of 2020, NCQA updated its scoring methodology and will no longer issue “Excellent” accreditation. Instead, the highest score a plan will receive is “Accredited.” As a result, the HMO/POS and PPO products are now “Accredited.”

The effective date for the present accreditation expires in 2024. Tufts Health Plan's next NCQA Commercial accreditation review is in 2024. Tufts Health Plan's last NCQA Commercial accreditation review was in 2021.

If you have a concern about the quality of care you get from a Network Provider or the services we provide, please contact us at **888.257.1985**, Monday through Friday, 8 a.m. to 5 p.m., excluding holidays.

How to resolve concerns

Inquiries

An Inquiry is any question or request that you may have about how we work. As a Tufts Health Plan Member, you have the right to make an Inquiry at any time. We will resolve your Inquiries immediately or, at the latest, within three business days of the day we receive it. We will let you know the resolution the day we resolve your Inquiry.

Grievances

If you are dissatisfied with something Tufts Health Plan has done or not done, you have the right to file a Grievance. This means you can tell us why you are dissatisfied, and we will look into the situation, and resolve it. (If you are dissatisfied with an Adverse Determination or any denial based on your benefits, you may file an Appeal; see the next section.)

You may file a Grievance at any time after the action or inaction that is of concern to you. You may file a Grievance for any reason, such as:

- If you are dissatisfied with the quality of care or services you receive
- If one of your Providers or one of our employees is rude to you
- If you believe one of your Providers or one of our employees did not respect your rights
- If you disagree with our decision to extend the time frame for making an Authorization or a Standard Internal Appeal or Expedited Internal Appeal decision
- If you disagree with our decision not to expedite a Standard Internal Appeal request

Your Personal Representative, if you identify one, can file a Grievance for you. You can appoint a Personal Representative by sending us a signed Tufts Health Plan Personal Representative Form. You can get a Form at tuftshealthplan.com, tuftshealthplan.com/memberlogin or by calling our Member Services Team at **888.257.1985**, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays.

If we do not receive your signed Tufts Health Direct Personal Representative Form within 30 Days of someone other than you filing a Grievance on your behalf, we will dismiss the Grievance.

How to file a Grievance

You or your Personal Representative may file a Grievance in the following ways:

Telephone—Call us at **888.257.1985**, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays.

TTY/TTD—People with hearing loss can call our TTY line at 711, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays.

Mail—mail a Grievance to:

Tufts Health Plan
Attn: Appeals and Grievances
1 Wellness Way
Canton, MA 02021
Email—Email a Grievance via the "Contact us" section of our website at tuftshealthplan.com and tuftshealthplan.com/memberlogin.

Fax—Fax a Grievance to us at 617.972.9509.

In person — Visit our office at 1 Wellness Way (Canton, Mass.), Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays.

Secure online member portal — Log into your secure online portal at https://members.tufts-health.com/thp/portal/members/login to file a Grievance electronically.

Once you file a Grievance, we will:

- Tell you or your Personal Representative that we got your Grievance by sending you a written notice
- Provide you or your Personal Representative a written response to your Grievance by certified or registered mail within 30 days of the date the Grievance was received, which will include the information we considered and will explain our decision
- Provide interpreter services, if necessary

Appeals

As a Tufts Health Direct Member, you, your Provider or your Personal Representative all have the right to request a Standard Internal Appeal if you disagree with any denial based on your benefits or Adverse Determination (i.e., a denial based on Medical Necessity).

How to request a Standard Internal Appeal
You or your Personal Representative may request a Standard Internal Appeal within 180 Days of a denial or Adverse Determination in the following ways:

Telephone—Call us at **888.257.1985**, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays.

TTY/TTD—People with hearing loss can call 711, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays.

Mail—Mail a request for a Standard Internal Appeal, along with a copy of any relevant notices and any additional information about the Standard Internal Appeal, to:

Tufts Health Plan
Attn: Appeals and Grievances
1 Wellness Way
Canton, MA 02021
Email—Request a Standard Internal Appeal by email via the "Contact us" section of our website at tuftshealthplan.com and tuftshealthplan.com/memberlogin.

Fax—Request a Standard Internal Appeal by faxing us at 857-304-6321.

In person—Visit our office at 1 Wellness Way (Canton, Mass), Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays.

Secure online member portal Log into your secure online portal at https://members.tufts-health.com/thp/portal/members/login to file an Appeal electronically.

Although you have **180 Days** to request a Standard Internal Appeal, we encourage you to act as soon as possible.

We will let you know we got your Standard Internal Appeal request by sending you a written notice **within 48 hours** of receiving your written or verbal Appeal.

Other people who can request a Standard Internal Appeal for you

Your Personal Representative can request a Standard Internal Appeal for you. You need to tell us in writing if your Personal Representative will request a Standard Internal Appeal for you.

You can appoint a Personal Representative by sending us a signed Tufts Health Plan Personal Representative Form. You can get a Form by calling our Member Services Team at **888.257.1985**. You can also find this form at tuftshealthplan.com and tuftshealthplan.com/memberlogin.

Note: If someone tries to request a Standard Internal Appeal for you and you did not already send us a Personal Representative Form for that person, we will tell you in writing that a request has been made and will send you a copy of the Personal Representative Form to sign and return to us. We will not take further action until we get the signed Personal Representative Form. If you do not send the Form, we will dismiss the request, unless it is an Expedited Internal Appeal requested by a Provider.

Continuation of services during the Appeal process
If your Appeal concerns the termination of ongoing coverage or treatment, the disputed coverage shall remain in effect at our expense through the completion of the Internal Appeal Process. This will happen as long as you request or your Personal Representative requests the Standard or Expedited Internal Appeal in a timely manner. You will still need to pay your portion of Cost-Sharing, as indicated in your Benefit and Cost-Sharing Summary. Only those services that were originally authorized by us and that were not terminated pursuant to a specific time or episode- related exclusion will continue to be covered.

Standard Internal Appeal time frames
We will review and make a decision about your Standard Internal Appeal request within 30 Days from the date we receive your request. We may ask to extend the time frame if we need more information. We will call to discuss the extension and send an extension letter. The extra time will not be more than 30 Days from the date we discuss an extension.

Any Appeal, including an Expedited Internal Appeal not properly acted on by Tufts Health Plan within the time limits specified will be decided in your favor.

Reviewing medical records as part of the Standard Internal Appeal
You may send us written comments, documents or other information relating to your Standard Internal Appeal. You have the right to review your case file, which includes information such as medical records and other documents and records we considered during the Appeal process.

Expedited Internal Appeal
You or your Personal Representative may request an Expedited (fast) Internal Appeal of an Adverse Determination (i.e., a denial based on Medical Necessity) if you or your Provider think that our standard time frame of 30 Days:

- Could seriously harm your life, health or ability to get back to maximum function
- Will cause you severe pain that cannot be adequately managed without the requested service

If either you or your Provider believes your Appeal request meets the criteria noted above, your Provider and you or your Personal Representative may request an Expedited Internal Appeal from us orally, in writing or in person, rather than requesting a Standard Internal Appeal. If the request is not made by a Provider, it will be reviewed by a Tufts Health Plan Physician Reviewer MD to determine if the criteria for an Expedited Appeal have been met. You or your Personal Representative will be notified of the decision of your appeal within 72 hours after the review is initiated. You or your Personal Representative may also request an Expedited External Review from the Office of Patient Protection (OPP) at the same time you request an Expedited Internal Appeal. If the request is placed by the Provider, the case is processed as an expedited request and not reviewed to see if it meets

expedited criteria. For more information, please see the sections on Expedited External Reviews, starting on page 76.

There are situations in which we may review a Standard Internal Appeal in a fast manner, and each situation has a certain time requirement in which we must decide the Standard Internal Appeal:

- If you are a patient in a Hospital, we must issue a decision before you are discharged from the Hospital.
- If a Provider tells us in writing that a delay in getting the requested service or supply would result in risk of substantial harm to you, Tufts Health Plan will reverse the decision within forty-eight (48) hours after the review is initiated pending outcome of the Expedited Appeal decision..
- If you are requesting Durable Medical Equipment, we will issue a decision within 48 hours or in less time when the Provider specifies a reasonable time.
- If you are terminally ill, a decision will be made by us within five business days of the receipt of the Appeal.

Important note about prescription drugs:
If your Provider feels it is Medically Necessary for you to take medications that are not on the Formulary or are restricted under any of the Tufts Health Plan pharmacy management programs, s/he may submit a request for coverage. We will review the request and provide you with notification of our coverage determination within 72 hours after receiving the request. We will approve the request if it meets our guidelines for coverage. For more information, you can call Member Services, or visit https://tuftshealthplan.com/member/tufts-health-direct-plans/pharmacy/pharmacy

Note regarding prescription drugs: You or your prescribing Provider may request an expedited exception process for a prescription drug based on exigent circumstances. We will notify you and your prescribing Provider of our determination no later than 24 hours after receiving such a request. Exigent circumstances exist when a Member:

- Is suffering from a health condition that may seriously jeopardize his or her life, health or ability to regain maximum function; or
- Is undergoing a current course of treatment using a non-Formulary drug

Written notice of Appeal decisions
We will tell you our Appeal decisions in writing:

- For Standard Internal Appeals, we will send you a decision letter via certified or registered mail within thirty (30) calendar days of the date the Appeal was received.
- For Expedited Internal Appeals, we will send you a decision letter via certified or registered mail within two (2) business days of the decision

For Adverse Determinations, this notice will include a clinical explanation for the decision and will:

- Give specific information upon which we based an Adverse Determination
- Discuss your symptoms or condition, diagnosis, and the specific reasons why the evidence submitted does not meet the relevant medical review criteria
- Specify alternative treatment options we cover
- Reference and include applicable clinical review criteria
- Let you or your Personal Representative know your options to further appeal our decision, such as procedures for requesting an External Review and an Expedited External Review

External Review process

If you get a Final Adverse Determination from us (i.e., a decision that you failed to meet the requirements for coverage based on Medical Necessity), you have the opportunity to request an

External Review from the Office of Patient Protection (OPP). You can ask for an Expedited Internal Appeal and an Expedited External Appeal at the same time. You or your Personal Representative are responsible for starting the External Review process. We will enclose an External Review Form anytime we issue a Final Adverse Determination. To start the review, send the required Form to the OPP at this address within four months of getting our Final Adverse Determination:

Health Policy Commission Office of Patient Protection
50 Milk Street
Eighth Floor
Boston, MA 02109

If you have been getting a Covered Service and we end coverage of the service, the disputed coverage will continue at our expense through the end of the Appeal process. This will happen as long as you request an External Review before the end of the second business day of getting your Final Adverse Determination. You will still need to pay your portion of Cost-Sharing, as indicated in your Benefit and Cost-Sharing Summary. If the External Review Agency decides you should keep getting the service because there could be substantial harm to you if the service ends, we will keep covering the service until the External Review is decided, no matter what the final External Review decision.

The OPP will screen all requests for External Reviews to see if they:

- Meet the requirements of the External Review
- Do not involve a service or benefit we specify in this Member Handbook as excluded from coverage
- Result from our issuing a Final Adverse Determination (You will not need a Final Adverse Determination from us if we fail to act within the timelines for the Standard Internal Appeal or if you filed for an Expedited External Review from the OPP and an Expedited Internal Appeal from us at the same time.)

Note: Payment disputes are not eligible for external review, except when the appeal is filed to determine if surprise billing protections are applicable.

The OPP will screen your request for an External Review within five business days of receiving the request. Once your case is deemed eligible for External Review, the OPP will submit it to the External Review Agency. The External Review Agency will then send you a written decision.

Expedited External Reviews
You may request an Expedited External Review if your Provider tells the OPP in writing that a delay in providing the care would result in a serious threat to your health. The OPP will screen your review within 72 hours of receiving the request from us. Expedited External Reviews are resolved within four business days from when the External Review Agency gets the referral from the OPP. You may request an Expedited External Review at the same time you request an Expedited Internal Appeal from Tufts Health Plan.

When your External Review involves a decision by us to end a previously approved service
If the External Review involves ending ongoing coverage of services, you may apply to the OPP to keep getting the services during the External Review. You need to make the request before the end of the second business day after you get our Final Adverse Determination. If the External Review Agency decides you should keep receiving the service because there could be substantial harm to you if the service ends, we will keep covering the service until the External Review is decided, no matter what the final External Review decision is.

How to contact the Office of Patient Protection (OPP)
If you have questions about your rights as a Member or questions about the External Review process, you can contact the OPP at 800.436.7757 or by fax at 617.624.46 or visit the OPP's website: https://www.mass.gov/orgs/office-of-patient-protection.

You may also contact the OPP by email at HPC-OPP@state.ma.us or by mail at:

Health Policy Commission
Office of Patient Protection
50 Milk Street
Eighth Floor
Boston, MA 02109

Limitation on Actions

You cannot file a lawsuit against Tufts Health Plan for failing to pay or arrange for covered services unless you have completed the Tufts Health Plan appeals and any applicable external review processes and file the lawsuit within two years from initial denial of benefits. Going through the appeals and applicable external review process does not extend the time limit for filing a lawsuit beyond two years after the date you were first denied coverage. However, if you choose to pursue available external review by the Office of Patient Protection, the days from the date your request is received by the Office of Patient Protection until the date you receive the response are not counted toward the two-year limit.

Questions or concerns

If you have questions or concerns about the Grievance and/or Appeal process, please call our Member Services Team at **888.257.1985**, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays.

Your rights and responsibilities

Your Member rights

As a Tufts Health Plan Member, you have the right to:

- Be treated with respect and dignity, regardless of your race, ethnicity, creed, religious beliefs, sexual orientation or source of payment for care.
- Get Medically Necessary treatment including Emergency care.
- Get information about us and our services, Primary Care Providers (PCPs), Specialists, other
- Providers, and your rights and responsibilities.
- Have a candid discussion of appropriate or Medically Necessary treatment options for your condition(s), regardless of cost or benefit coverage.
- Work with your PCP, Specialists, and other Providers to make decisions about your health care.
- Accept or refuse medical or surgical treatment.
- Call your PCP's and/or Behavioral Health (mental health and/or substance use) Provider's office 24 hours a day, seven days a week.
- Expect that your health care records are private, and that we abide by all laws regarding confidentiality of patient records and personal information in recognition of your right to privacy.
- Get a second opinion for proposed treatments and care.
- File a Grievance to express dissatisfaction with us, your Providers or the quality of care or services you get.
- Appeal a denial or Adverse Determination we make for your care or services.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline or retaliation.

- Ask for more information or explanation of anything included in this Member Handbook, either orally or in writing.
- Ask for a duplicate copy of this Member Handbook at any time.
- Get written notice of any significant and final changes to our Provider Network, including but not limited to PCP, Specialist, Hospital, and facility terminations that affect you.
- Ask for and get copies of your medical records, and ask that we amend or correct the records, if necessary.
- Get the services we cover (see page 37).
- Make recommendations about our Member rights and responsibilities policy.
- Ask for and get this Member Handbook and other Tufts Health Plan information translated into your preferred language.

Your Member responsibilities

As a Tufts Health Plan Member, you have the responsibility to:

- Treat all Providers with respect and dignity.
- Keep appointments, be on time or call if you will be late or need to cancel an appointment.
- Give us, your Primary Care Provider (PCP), Specialists, and other Providers complete and correct information about your medical history, medicine you take, and other matters about your health.
- Ask for more information from your PCP and other Providers if you do not understand what they tell you.
- Participate with your PCP, Specialists, and other Providers to understand and help develop plans and goals to improve your health.
- Follow plans and instructions for care that you have agreed to with your Providers.
- Understand that refusing treatment may have serious effects on your health.
- Contact your PCP or Behavioral Health Provider within 48 hours after you visit the Emergency room, for follow-up care.
- Change your PCP or Behavioral Health Provider if you are not happy with your current care.
- Voice your concerns and complaints clearly.
- Tell us if you have access to any other insurance.
- Tell us if you suspect potential Fraud and/or abuse.
- Tell us about any PCP changes.
- Tell us and the Health Connector about any address or phone.
- Tell us if you are pregnant.

More information available to you

You can learn about your rights and responsibilities with Tufts Health Plan by calling us at **888.257.1985** (TTY: 711), Monday through Friday, 8 a.m. to 5 p.m., excluding holidays.

You can also get information about us from:

- The Massachusetts Board of Registration in Medicine https://www.mass.gov/orgs/board-of-registration-in-medicine, which may be able to give you information about Providers licensed to practice in Massachusetts
- The Office of Patient Protection (OPP), which can also give you information about your rights as a managed care Member and about the External Review process
- A list of sources of independently published information assessing Members' satisfaction and evaluating the quality of Health Care Services we offer
- The percentage of Premium revenue we spend for Health Care Services for our Members during the most recent year for which information is available
- A summary report on Appeals, such as the number of Appeals filed, the number of Appeals approved internally, the number of Appeals denied internally, and the number of Appeals withdrawn before resolution

Protecting your benefits

Help reduce health care Fraud and abuse. Examples of Fraud or abuse include:

- Receiving bills for Health Care Services you never got
- Individuals loaning their health insurance ID Card to others for the purpose of getting Health Care Services or prescription drugs
- Being asked to provide false or misleading health care information
- Individuals reselling supplies or equipment provided to them as Covered Services

To report potential health care Fraud and abuse or if you have questions, please call us at **888.257.1985**, Monday through Friday, 8 a.m. to 5 p.m., or email THPP_Claims_Fraud_and_Abuse@point32health.org. We do not need your name or Member information. You can also call our anonymous hotline anytime at 800.826.6762 or send an anonymous letter to us at:

Tufts Health Plan
Attn: Fraud and Abuse
Privacy Officer
1 Wellness Way
Canton, MA 02021

When you have more insurance

You must tell us if you have any other health insurance coverage in addition to Tufts Health Direct. You must also let us know when there are any changes to your other insurance coverage. The types of other insurance you might have include:

- Coverage from an employer's Group health insurance for employees or retirees, either for yourself or your Spouse
- Coverage under a nongroup insurance contract
- Coverage under Workers' Compensation because of a job-related illness or injury
- Coverage from Medicare or other public insurance
- Coverage for an accident wherein no-fault insurance or liability insurance is involved
- Coverage you have through Veterans Benefits Administration
- "Continuation coverage" that you have, such as through COBRA: COBRA is a law that requires employers with 20 or more employees to let employees and their Dependents keep their Group

health coverage for a time after they leave their Group Plan under certain conditions. See the section Continuing Coverage for Group Members starting on page 33 for more information.

Coordination of Benefits

You may have benefits under other plans for hospital, medical, dental or other health care expenses. We have a Coordination of Benefits (COB) program that prevents duplication of payment for the same Health Care Services. We will coordinate benefits payable for Covered Services with benefits payable by other plans, consistent with Massachusetts law, 211 CMR 38.00 et seq. Through this Coordination of Benefits, your Tufts Health Direct Plan may cover a Covered Service. In other situations, such as for care we do not cover, another insurer may cover the service for you. As permitted under Massachusetts law, 211 CMR 38.00 et seq, we will coordinate benefits for prescription drug Claims pursuant to our secondary payer allowed amount in all cases.

We will coordinate benefits by determining which plan has to pay first when you make a Claim, and which plan has to pay second. We determine the order of benefits using the first applicable rule set forth in 211 CMR 38, and we pay or provide benefits pursuant to the rules set forth in 211 CMR.

These regulations are available on the Massachusetts state website, mass.gov/code-of-massachusetts-regulations-cmr.

If you have additional health insurance, please call us at **888.257.1985**, Monday through Friday, 8 a.m. to 5 p.m., to find out how payment will be handled.

Subrogation

Tufts Health Direct's right of Subrogation

You may have a legal right to recover some or all of the costs of your health care from someone else (a "Third Party"). "Third Party" means any person or company that is, could be or is claimed to be responsible for the costs of injuries or illness to you. This includes such costs to any Dependent covered under this plan.

Tufts Health Direct may cover health care costs for which a Third Party is responsible. In this case, we may require that Third Party to repay us the full cost of all such benefits provided by this plan. Our rights of recovery apply to any recoveries made by you or on your behalf from any source.

This includes, but is not limited to:

- Payments made by a Third Party;
- Payments made by any insurance company on behalf of the Third Party;
- Any payments or rewards under an uninsured or underinsured motorist coverage policy;
- Any disability award or settlement;
- No-fault, personal injury protection ("PIP") or medical payments coverage ("MedPay") under any automobile policy to the extent permissible by law;
- Premises' or homeowners' medical payments coverage;
- Premises' or homeowners' insurance coverage; and
- Any other payments from a source intended to compensate you for Third Party injuries.

We have the right to recover those costs in your name. We can do this with or without your consent, directly from that person or company. Our right has priority, except as otherwise provided by law. We can recover against the total amount of any recovery, regardless of whether:

- All or part of the recovery is for medical expenses; or

- The recovery is less than the amount needed to reimburse you fully for the illness or injury.

Tufts Health Direct's right of reimbursement

This provision applies in addition to the rights described above. You may recover money by suit, settlement or otherwise. If this happens, you are required to reimburse us for the cost of Health Care Services, supplies, medications, and expenses for which we paid or will pay. This right of reimbursement attaches when we have provided health care benefits for expenses for which a Third

Party is responsible, and you have recovered any amounts from any sources. This includes, but is not limited to:

- Payments made by a Third Party;
- Payments made by any insurance company on behalf of the Third Party;
- Any payments or awards under an uninsured or underinsured motorist coverage policy;
- Any disability award or settlement;
- No-fault PIP or MedPay under any automobile policy to the extent permissible by law;
- Premises' or homeowners' medical payments coverage;
- Premises' or homeowners' insurance coverage; and
- Any other payments from a source intended to compensate you and for which a Third Party is responsible.

We have the right to be reimbursed up to the amount of any payment received by you to the extent permissible by law, regardless of whether (a) all or part of the payment to you was designated, allocated or characterized as payment for medical expenses; or (b) the payment is for an amount less than that necessary to compensate you fully for the illness or injury.

Member cooperation

You further agree:

- To notify Tufts Health Direct promptly and in writing when notice is given to any Third Party or representative of a Third Party of the intention to investigate or pursue a Claim to recover damages or obtain compensation;
- To cooperate with us and provide us with requested information;
- To do whatever is necessary to secure our rights of Subrogation and reimbursement under this plan;
- To assign us any benefits you may be entitled to receive from a Third Party. Your assignment is up to the cost of Health Care Services and supplies and expenses that we paid or will pay for your illness or injury;
- To give us a first priority lien on any recovery, settlement or judgment or other source of compensation which may be had by any Third Party. You agree to do this to the extent of the full cost of all benefits associated with Third Party responsibility;
- To do nothing to prejudice our rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by this plan;
- To serve as a constructive trustee for the benefit of this plan over any settlement or recovery funds received as a result of Third Party responsibility;
- That we may recover the full cost of all benefits provided by this plan without regard to any
- Claim of fault on your part, whether by comparative negligence or otherwise;
- That no court costs or attorney fees may be deducted from our recovery;

- That we are not required to pay or contribute to paying court costs or attorney's fees for the
- Attorney hired by you to pursue your Claim or lawsuit against any Third Party; and
- That in the event you or your representative fail to cooperate with Tufts Health Direct, you shall be responsible for all benefits provided by this plan in addition to costs and attorney's fees incurred by Tufts Health Direct in obtaining repayment.

Workers' Compensation

Employers provide Workers' Compensation insurance for their employees to protect them in case of work-related illness or injury.

If you have a work-related illness or injury, you and your employer must ensure that all medical Claims related to the illness or injury are billed to your employer's Workers' Compensation insurer. We will not provide coverage for any injury or illness for which it is determined that the Member is entitled to benefits pursuant to any Workers' Compensation statute or equivalent employer liability or indemnification law (whether or not the employer has obtained Workers' Compensation coverage as required by law).

If we pay for the costs of Health Care Services or medications for any work-related illness or injury, we have the right to recover those costs from you, the person or company legally obligated to pay for such services or from the Provider. If your Provider bills services or medications to us for any work-related illness or injury, Members should please call **Member Services: 888.257.1985.**

Constructive Trust

By accepting benefits from Tufts Health Direct (whether the payment of such benefits is made to you directly or made on your behalf, for example, to a Provider), you hereby agree that if you receive any payment from any responsible party as a result of an injury, illness or condition, you will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to Tufts Health Direct.

Subrogation Agent

We may contract with a third party to administer Subrogation recoveries. In such case, that subcontractor will act as our agent.

Motor vehicle accidents and/or work-related injury/illness

If you are in a motor vehicle accident, regardless of fault, you may be entitled to medical benefits under your own or another individual's automobile coverage. These benefits are known as Personal Injury Protection (PIP) and Medical Payments (MedPay) benefits. PIP benefits under the automobile policy pay first, up to $2,000 in medical and funeral expenses. After PIP benefits are exhausted, our coverage becomes primary. If we pay for medical services connected to your motor vehicle accident before PIP benefits have been exhausted, we may recover the cost of those benefits as described above. MedPay is always secondary to our coverage. You must send us any explanation of payment or denial letters from an auto insurance carrier for us to consider paying a Claim that your Provider sends to us. In the case of a work-related injury or illness, the Workers' Compensation carrier will be responsible for those expenses first. You must send us any explanation of payment or denial letters from the Workers' Compensation carrier for us to consider paying a Claim that your Provider sends us.

Other Provisions

Use and Disclosure of Medical Information

Tufts Health Plan mails a separate Notice of Privacy Practice to all Subscribers to explain how we use and disclose your medical information. If you have questions or would like another copy of our Notice of Privacy Practices, pleases call a Member Representative. Information is also available on our website at www.tuftshealthplan.com and tuftshealthplan.com/memberlogin.

Relationships between Tufts Health Plan and Providers

Tufts Health Plan and Providers

We arrange Health Care Services. We do not provide Health Care Services. We have agreements with Providers practicing in their own private offices throughout the Service Area. These Providers are independent. They are not Tufts Health Plan employees, agents or representatives. Providers are not authorized to:

- Change this Evidence of Coverage; or
- Assume or create any obligation for Tufts Health Plan

We are not liable for acts, omissions, representations or other conduct of any Provider.

Circumstances Beyond Tufts Health Plan's Reasonable Control

Tufts Health Plan shall not be responsible for a failure or delay in arranging for the provision of services in cases of circumstances beyond our reasonable control. Such circumstances include but are not limited to: Major disaster, epidemic, strike, war, riot, and civil insurrection. In such circumstances, we will make a good faith effort to arrange for the provision of services. In doing so, we will take into account the impact of the event and the availability of Network Providers.

Appendix A: Glossary

An **Adoptive Child** is a Child deemed adopted as of the date s/he is legally adopted by the Subscriber or placed for adoption with the Subscriber, where "placed for adoption" means that the Subscriber has assumed a legal obligation for the partial or total support of a Child in anticipation of adoption. If the legal obligation ends, the Child is no longer considered to be placed for adoption. As required by state law, a foster Child is considered an Adoptive Child as of the date that a petition to adopt was filed. See also Dependent.

An **Advance Directive** is a legal document, sometimes called a living will, with written instructions that you create to manage your care if you are no longer capable of making decisions about your own health care. A living will gives instructions to the survivors, in the event of death. A health care proxy or a durable power of attorney for health care lets you choose someone specifically to make decisions for you if you become ill or incapacitated.

An **Adverse Determination** is a decision, based on a review of information you provide to us or our designated Utilization Review organization, to deny, reduce, modify or end an admission, continued Inpatient stay, experimental/investigational service or any other services, for failing to meet the requirements for coverage, based on Medical Necessity, appropriateness of health care setting, and level of care or effectiveness.

The **Affordable Care Act (ACA)** is the federal health reform legislation that became effective in 2010. The goal of the ACA is to extend health insurance coverage to millions of uninsured Americans to help lower health care costs and to make sure people can get insurance coverage even if they have pre-existing conditions.

Ancillary Services are tests, procedures, imaging, and support services (such as lab tests and radiology services) that you get in a health care setting which help your Provider diagnose and/or treat your condition.

Appeal—see Standard Internal Appeal or Expedited Internal Appeal.

Authorization—see Prior Authorization.

Behavioral Health (mental health and/or substance use) services include visits, consultations, counseling, screenings, and assessments for mental health and/or substance use, as well as Inpatient, Outpatient, detoxification, and diversionary services.

The Benefit and Cost-Sharing Summary is the section included at the end of this *Member Handbook* to provide a general description of your Tufts Health Direct Plan Level's Covered Services. It lists benefits, Copayment and Coinsurance amounts, if any, and any limits on the benefits your policy covers.

A **Benefit Year** is the consecutive 12-month period during which health plan benefits are purchased and administered; Deductibles, Coinsurance, and Out-of-pocket Maximums are calculated; and most benefit limits apply. **Note:** In some cases, your first Benefit Year will not be a full 12 months.

A **Board-Certified Behavior Analyst (BCBA)** meets the qualifications of the Behavior Analyst Certification Board (BACB) by achieving a master's degree, training, experience, and other requirements. A BCBA professional conducts behavioral assessments, designs and supervises behavior analytic interventions, and develops and implements assessment and interventions for Members with diagnoses of autism spectrum disorders. BCBAs may supervise the work of Board-Certified Assistant Behavior Analysts and other Paraprofessionals who implement behavior analytic interventions.

Care Management is how we regularly evaluate, coordinate, and help you with your medical, Behavioral Health (mental health and/or substance use), and/or Community Health Management needs. Through Care Management, we do our best to make sure you can: Access high-quality, cost-effective, and appropriate care; get information about disease prevention and wellness; and help you

get and stay healthy.

A **Certified Nurse Anesthetist** is certified by the Board of Registration in Nursing to provide anesthesia services within the scope of Massachusetts law.

A **Child** is one of the following individuals, until the last Day of the month in which his/her 26th birthday occurs:

- The Subscriber or Spouse's natural Child, step-Child or Adoptive Child
- The Dependent Child of an enrolled Child
- A Subcriber or Spouse's Disabled Dependent who is currently disabled and remains financially dependent on the Subscriber
- A Child for whom the Subscriber or Spouse is the court-appointed legal guardian
- A Child is an Adoptive Child as of the date s/he is legally adopted by the Subscriber or placed for adoption with the Subscriber, where "placed for adoption" means that the Subscriber has assumed a legal obligation for the partial or total support of a Child in anticipation of adoption
- If the legal obligation ends, the Child is no longer considered to be placed for adoption (as required by state law, a foster Child is considered an Adoptive Child as of the date that a petition to adopt was filed)

A **Claim** is a bill your Provider sends us to ask us to pay for services you get.

Coinsurance is an amount, stated as a percentage, that you must pay for certain Covered Services.

A **Copayment** is a fixed amount you may have to pay for a covered pharmacy or medical service.

A **ConnectorCare Plan** is a subsidized non-Group Plan available only to Members with a household income of 0%–300% of the Federal Poverty Level. Members must apply for and purchase a ConnectorCare Plan through the Health Connector.

Continuity of Care is how we make sure you keep getting the care you need when your doctor is no longer in our Network or when you first become a Member and you are getting care from another doctor who is not in our Network.

Coordination of Benefits is how we get money from other sources to pay for your health care needs when you have coverage from more than one insurer.

Cost-Sharing Amount is the cost you pay for certain Covered Services. This amount may consist of Deductibles, Copayments, and/or Coinsurance. Also called Cost-Share.

Covered Services are the services and supplies Tufts Health Direct covers. The Benefit and Cost-Sharing Summary we include in this *Member Handbook* includes all of your Covered Services and supplies.

A **Covering Provider** is the Provider named by your PCP to provide or authorize services in your PCP's absence, e.g., after hours. A Covering Provider is a Provider who can help you when your PCP is not available.

Custodial Care includes:

- Care provided primarily to assist in the activities of daily living, such as bathing, dressing, eating, and maintaining personal hygiene and safety;
- Care, other than behavioral health care, provided primarily for maintaining the Member's or anyone else's safety, when no other aspects of treatment require an acute hospital level of care;
- Services that could be provided by people without professional skills or training; or
- Routine maintenance of colostomies, ileostomies, and urinary catheters; or

- Adult and pediatric day care.

Note: Custodial Care is not covered by Tufts Health Plan.

Day means a calendar day, unless "business day" is specified.

Day Surgery is any surgical procedure(s) provided to a Member at a facility licensed by the state to perform surgery. The Member must be expected to depart the same Day or in some instances within twenty-four hours. Also called Ambulatory Surgery or Surgical Day Care. Day Surgery is Outpatient discharged within 24-hour same-Day in Hospital, Free-standing Facility, or ambulatory care unit, while Outpatient Surgery in a Provider's office.

The **Deductible** is the amount you pay for certain Covered Services in a Benefit Year before we will begin to pay for those Covered Services.

The **Department of Health and Human Services** is the United States department in charge of all federal programs dealing with health and welfare.

Dependent The Subscriber's Spouse, Child or Disabled Dependent.

Disabled Dependent The Subscriber's Child who:

- Is currently physically or mentally disabled and
- Remains financially dependent on the Subscriber due to disability.

Durable Medical Equipment (DME) includes devices or instruments of a durable nature that can withstand repeated use, are reasonable and necessary to sustain a minimum threshold of independent daily living, are made primarily to serve a medical purpose, are not useful to a person in the absence of illness or injury, and are appropriate for use in the home.

Effective Coverage Date means the date on which you become a Member of Tufts Health Direct and are eligible to get Covered Services from Tufts Health Direct Providers.

An **Eligible Small Business** or **Group** is an employer or other legal entity with which Tufts Health Plan has an agreement to provide Group coverage. An employer Group subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended, is the ERISA plan sponsor. If you are covered under a Group Contract, the Group is your agent and is not Tufts Health Plan's agent.

An **Emergency** is a medical or Behavioral Health (mental health and/or substance use) condition with such serious symptoms, including such severe pain, that a person with an average knowledge of health and medicine could realistically expect that not getting medical attention right away would result in the health of the Member (or in the case of a pregnant individual, the health of the individual and/or her unborn Child) being put in serious danger; this danger could include serious damage to bodily function or a serious problem with any body organ or part. In the case of a pregnant individual who is having contractions, it would be an Emergency if there is not enough time to safely transfer to another Hospital before delivery or if that transfer could be harmful to the health of the individual or her unborn Child.

Some examples of illnesses or medical conditions requiring Emergency care are severe pain, a broken leg, loss of consciousness, vomiting blood, chest pain, difficulty breathing, uncontrollable urges to harm self or others or any medical condition that is quickly getting much worse.

An **Enrollment Administrator** is a benefits marketplace that is not part of the state health insurance exchange. Tufts Health Direct is offered through the Enrollment Administrator, HSA Insurance.

Essential Health Benefits are the minimum Health Care Services that health plans must cover, according to the Affordable Care Act. Essential Health Benefits include: Emergency services, hospitalization, maternity and newborn care, Behavioral Health (mental health and/or substance use) services, including Behavioral Health treatment, prescription drugs, rehabilitative and Habilitative Services and devices, laboratory services, Preventive and wellness services, and chronic disease

management, and pediatric services including oral and vision care.

Evidence of Coverage (EOC), also referred to as the *Member Handbook* or Handbook, means this document and any future amendments. This includes the Benefit and Cost-Sharing Summary for each Plan Level at the end of this Handbook, your Formulary, and any amendments we may send you.

An **Expedited External Review** is a request for a quick resolution to an External Review involving immediate and urgently needed services. You may request an Expedited External Review at the same time you request an Expedited Internal Appeal from Tufts Health Plan.

An **Expedited Internal Appeal** is an oral or written request for a fast review of an Adverse Determination when your life, health or ability to attain, maintain or regain maximum function will be at risk if we follow our standard time frames when reviewing your request. We will review Expedited Internal Appeals and make a decision about a request within 72 hours.

Experimental and/or investigative or investigational – A service, supply, treatment, procedure, device or medication (collectively "treatment") is considered Experimental and/or Investigative or Investigational, and therefore not Medically Necessary if any of the following apply:

- The drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished or to be furnished;
- The treatment or the "informed consent" form used with the treatment, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function or federal law requires such review or approval;
- Reliable scientific evidence shows that the treatment is: The subject of ongoing Phase I or Phase II clinical trials; is the research, experimental study or investigative arm of ongoing Phase III clinical trials; or is otherwise under study to determine its safety, efficacy, toxicity, maximum tolerated dose or its efficacy as compared with a standard means of treatment or diagnosis;
- Evaluation by an independent health technology assessment organization has determined that the treatment is not proven safe;
- Even if approved for lawful marketing by the U.S. Food and Drug Administration, reliable scientific evidence does not support that the treatment is effective in improving health outcomes or that appropriate patient selection has not been determined;
- The peer-reviewed published literature regarding the treatment is predominantly non-randomized, historically controlled, case controlled or cohort studies; or there are few or no well-designed, randomized, controlled trials; or
- There is no scientific or clinical evidence that the treatment is at least as beneficial as any established, evidence-based alternatives.

This definition is fully explained in the corresponding Medical Necessity Guidelines.

An **External Review** is a request for an External Review Agency to review Tufts Health Plan's final Standard Internal Appeal decision.

An **External Review Agency** is an accredited company under contract with the Office of Patient Protection and separate from Tufts Health Plan that looks at decisions made by Tufts Health Plan about a Member's coverage. Providers who work at the designated External Review Agency review all appropriate medical records according to objective, evidence-based medical standards to make a final decision about a Member's Final Adverse Determination.

Facility Fee refers to a fee that clinics or Hospitals may charge to cover the costs of maintaining those facilities. For certain Outpatient services, you may be billed both a Facility Fee and a separate physician fee for a single episode of care if the services are provided in a Hospital setting or Free-standing facility.

Family-planning Services include birth control methods, exams, counseling, education, pregnancy testing, follow-up health care, and some lab tests.

The **Federal Poverty Level** is set each year by the Department of Health and Human Services. The Federal Poverty Level is the lowest amount of total income an individual or family needs for food, clothing, transportation, shelter, and other necessities.

A **Federal Premium Tax Credit** is a way that the United States government can help you pay your Premiums if your household income is less than or equal to 400% of the Federal Poverty Level. To qualify for a Federal Premium Tax Credit, you must apply for and purchase your insurance through the Health Connector.

A **Final Adverse Determination** is an Adverse Determination made after you have exhausted all remedies available through Tufts Health Plan's formal Appeal process.

A **Formulary** is a listing of drugs that are considered preferred therapy for Members within the pharmacy benefit of a managed health plan. See list at https://tuftshealthplan.com/member/tufts-health-direct-plans/pharmacy/pharmacy.

Fraud is when a person knowingly makes or permits another person to make a false statement in order to get services or items or receive a payment s/he does not have a right to receive.

Examples of Fraud include Members submitting false or misleading information on a membership application form, making a false request for reimbursement, failing to notify the Tufts Health Direct of changes (such as residency) that affect the Member's eligibility or lending their Tufts Health Direct Member ID Card to another person so s/he can get Health Care or pharmacy Services.

A **Free-standing Urgent Care Center** is a medical facility that provides treatment for Urgent Care services (see definition of Urgent Care). A Free-standing Urgent Care Center primarily treats patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an Emergency room. A Free-standing Urgent Care Center offers an alternative to certain Emergency room visits for a Member who is not able to visit his or her Primary Care Provider or health care Provider in the time frame that is felt to be warranted by the condition or symptoms. A Free-standing Urgent Care Center does not provide Emergency care and is not appropriate for people who have life-threatening conditions. Members experiencing these conditions should go to an Emergency room. Free-standing Urgent Care Centers are not part of a Hospital or Hospital system and are not MinuteClinic® (a Limited Service Medical Clinic). To find a Free-standing Urgent Care Center in our Network, please click on "Find a Doctor" on the Tufts Health Plan website.

A **Grievance** is any expression of dissatisfaction by you or Personal Representative, if you identify one, about any action or inaction by Tufts Health Plan other than an Adverse Determination.

Reasons to file Grievances may include, but are not limited to, the quality of care or services provided, rudeness on the part of a Provider or employee of Tufts Health Plan, failure to respect your rights, a disagreement you may have with our decision not to approve a request to speed up a Standard Internal Appeal, a disagreement with our request to extend the time frame for resolving an Authorization decision or an Appeal, and the retroactive ending of coverage due to Fraud.

A **Group Contract** is the agreement between Tufts Health Plan and the Group under which we agree to provide Group coverage and the Group agrees to pay a Premium to us on your behalf. The Group Contract includes this *Member Handbook*, also called Evidence of Coverage.

A **Group Plan** is the plan of an employer or other legal entity with which Tufts Health Plan has an agreement to provide Group coverage. An employer Group subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended, is the ERISA plan sponsor. If you are covered under a Group Plan, the Group is your agent and is not Tufts Health Plan's agent.

Habilitative Services are Health Care Services provided in accordance with the federal Affordable Care Act (ACA) in order for a person to attain, maintain or prevent deterioration of a life skill or

function never learned or acquired due to a disabling condition. These services may include Physical and Occupational Therapy, and Speech-language pathology services in various Inpatient and Outpatient settings.

The **Handbook** is the same as our *Member Handbook* and Evidence of Coverage (EOC).

A **Health Benefit Plan** is an individual or Group health maintenance contract issued by a health maintenance organization.

Health Care Services are services for the diagnosis, prevention, treatment, cure or relief of a physical, behavioral, substance use disorder or mental health condition, illness, injury or disease.

The **Health Connector** is an independent state agency that helps eligible Massachusetts Residents find affordable health care coverage. The Health Connector is the designated health insurance exchange for Massachusetts. The Health Connector reviews health plans offered by private insurance companies and approves plans that meet service and cost standards. The Health Connector also helps Residents and employers choose the plan that best meets their needs.

A **Health Savings Account (HSA)** is a type of savings account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses. By using untaxed dollars in a Health Savings Account (HSA) to pay for deductibles, copayments, coinsurance, and some other expenses, you may be able to lower your overall health care costs. HSA funds generally may not be used to pay premiums. While you can use the funds in an HSA at any time to pay for qualified medical expenses, you may contribute to an HSA only if you have a High Deductible Health Plan (HDHP).

A **High Deductible Health Plan (HDHP)** is subject to IRS rules requiring that a minimum Deductible be satisfied before the health plan provides coverage for non-Preventive Care. For additional information on the rules governing HDHP plans, please refer to https://www.irs.gov/publications/p969.

A **Hospital** is any licensed facility that provides medical and surgical care for patients who have acute illnesses or injuries, and that the American Hospital Association (AHA) lists as a Hospital or that The Joint Commission accredits.

HSA Insurance is an Enrollment Administrator that offers Tufts Health Direct products in a benefits marketplace that is not part of the state health insurance exchange.

A Tufts Health Direct Member **Identification Card (ID Card)** is the Card that identifies you as a Member of Tufts Health Direct. Your Member ID Card includes your name and your Member Identification number. It must be shown to Providers before you get services.

In-network describes a Provider who Tufts Health Direct contracts to provide Covered Services to Members.

Inpatient Services are services that need at least one overnight stay in a Hospital setting. This generally applies to services you get in licensed facilities, such as Hospitals and Skilled Nursing Facilities.

An **Inquiry** is any question or request you have for us.

A **Licensed Mental Health Professional** is a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed certified social worker, a licensed mental health counselor, a licensed supervised mental health counselor, a licensed psychiatric nurse mental health clinical specialist, a licensed psychiatric mental health nurse practitioner, a licensed physician assistant who practices in the area of psychiatry, a licensed alcohol and drug counselor I, as defined in Massachusetts General Law chapter 111J, section 1, or a licensed marriage and family therapist within the lawful scope of practice for such therapist.

Limited Service Medical Clinic is walk-in medical clinic licensed to provide limited services, generally based in a retail store. Care is provided by a Nurse Practitioner or Physician Assistant. For example, MinuteClinic® (a Limited Service Medical Clinic) offers an alternative to certain Emergency room visits for a Member who requires less emergent care or who is not able to visit his or her Primary Care Provider in the time frame that is felt to be warranted by the Member's condition or symptoms. Some

examples of common illnesses a Limited Service Medical Clinic can treat include strep throat or eye, ear, sinus or bronchial infections. The services provided by a Limited Service Medical Clinic are only available to patients of ages 24 months or older. A Limited Service Medical Clinic does not provide Emergency or wound care or treatment for injuries. It is not appropriate for people who need x-rays or stitches or who have life-threatening conditions.

Members experiencing these conditions should go to an Emergency room.

Medically Necessary and **Medical Necessity** describe services that are, within reason, intended to prevent, diagnose, stop the worsening of, improve, correct or cure conditions that endanger your life, cause suffering or pain, cause physical deformity or malfunction, may cause or worsen a disability or that could result in making you very sick. Medically Necessary services are consistent with generally accepted principles of professional medical practice as determined by whether the service is 1) the most appropriate available supply or level of service for the Member in question, considering potential benefits and harms to the individual; 2) known to be effective based on scientific evidence, professional standards, and expert opinion in improving health outcomes; or 3) not in widespread use, as based on scientific evidence.

Our Medical Necessity Guidelines are available on our website at https://tuftshealthplan.com/provider/resource-center.

- Click on "Please select a Division" and then on "Tufts Health Public Plans"
- Click on the category you are looking for, such as "Behavioral Health" or "Guidelines"
- Resource documents in these categories are listed alphabetically

If you prefer, call Member Services at **888.257.1985** (TTY: 711) Monday through Friday, from 8 to 5 p.m., excluding holidays.

A **Member** is a person enrolled in Tufts Health Plan Direct under an individual or Group Plan. Also referred to as "you."

Your Member Handbook is this document. It details Covered Services you get with Tufts Health Direct. It is our agreement with you, and includes any riders, amendments or other documents that add to the details of Covered Services. It is also called Evidence of Coverage or Handbook.

Member Services Team is the team at Tufts Health Plan who handle all of your questions about policies, procedures, requests, and concerns. You can reach our Member Services Team at **888.257.1985**. For those with partial or total hearing loss, you can reach our Member Services Team at our TTY line: 711. We are available Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays.

Network refers to the collective group of health care Providers who have contracted with Tufts Health Public Plans, Inc., to provide Covered Services.

Network Provider refers to a Provider or Hospital that has an agreement with either Tufts Health Plan directly or with a Provider Network with which we have a contract to provide Covered Services to Members. Network Providers are located throughout the Service Area, also called the Service Area. See also In-network Provider.

Non-network Provider refers to a Provider or Hospital that does not have an agreement with Tufts Health Plan either directly or with a Provider Network with which we have a contract. See also Out-of-network Provider.

Our **Notice of Privacy Practices** tells you about how we may use and disclose your Protected Health Information (PHI). We send you our Notice of Privacy Practices upon enrollment.

Our 24/7 **NurseLine** is our helpline for health questions, 24 hours a day, seven days a week. When you call our NurseLine at 888-MY-RN-LINE (888.697.6546), you can talk with a caring and supportive health care professional at any hour and at no cost. 24/7 NurseLine staff members can give you

information and support on health care issues such as symptoms, diagnoses, and test results, as well as treatments, tests, and procedures your Provider has ordered. 24/7 NurseLine staff members do not give medical advice or replace your Provider.

A **Nurse Practitioner** is a registered nurse who holds authorization in advanced nursing practice as a Nurse Practitioner under Massachusetts law.

Observation is the use of Hospital services to treat and/or evaluate a condition that should result in either a discharge within 48 hours or a verified diagnosis and concurrent treatment plan. At times, an Observation stay may be followed by an Inpatient admission to treat a diagnosis revealed during the period of Observation.

Occupational Therapy helps people gain the knowledge, skills, and attitude necessary to perform the activities of daily life.

An **Out-of-network Provider** is a Provider, including Hospitals, that we do not contract with to provide Covered Services to Members.

Out-of-pocket Maximum (MOOP) is the maximum amount of Cost-Sharing you are required to pay in a Benefit Year for Covered Services. All Tufts Health Direct plans have an Out-of-pocket Maximum.

Outpatient Medical Care refers to the services provided in a Provider's office, a Day Surgery or ambulatory care unit, an Emergency room, Outpatient clinic or other location. Outpatient Services include all services that are not Inpatient Services.

A **Paraprofessional,** as it pertains to the treatment of autism and autism spectrum disorders, is an individual who performs applied behavior analysis (ABA) services under the supervision of a Board-Certified Behavior Analyst (BCBA).

A **Personal Representative** is someone you approve in writing to act on behalf regarding a specific Grievance, Appeal or External Review by the Massachusetts Office of Patient Protection (OPP). If you are unable to pick a Personal Representative, your Provider, a guardian, conservator or holder of a power of attorney may be your Personal Representative. You can give your Personal Representative a standing authorization to act on your behalf if you make this request in writing. This standing authorization will remain in effect until you revoke it. If you are a minor, and you are able by law to consent to a medical procedure, you may appeal our denial of the medical procedure without parental or guardian consent. In that case, you can also pick a Personal Representative without parental or guardian consent.

Physical Therapy refers to the treatment of disease, injury or disability by physical and mechanical means, such as massage, regulated exercise or water, light, heat or electrical therapy.

A **Physician Assistant** is a health care Provider licensed to practice medicine with physician supervision.

Plan Level refers to the kind of Cost-Sharing your specific Tufts Health Direct Plan has. There are four Plan Levels (some of the levels have sub-levels):

- Platinum plans: Highest monthly Premiums but low out-of-pocket costs
- Gold plans: High monthly Premiums but low out-of-pocket costs
- Silver plans: Moderate monthly Premiums and moderate out-of-pocket costs
- Bronze plans: Lower monthly Premiums but higher out-of-pocket costs

Your Member ID Card will show your specific Tufts Health Direct Plan Level.

A **Podiatrist** is a Specialist who provides medical and surgical foot care services within the scope of practice of a licensed Podiatrist under Massachusetts law.

Premium is the monthly financial contribution that Tufts Health Direct Members pay for coverage.

Preventive Care includes a variety of services for adults and Children, such as annual physicals,

blood pressure screenings, immunizations, behavioral assessments for Children, and many other services to help keep Members from getting sick. Preventive Care services must be covered without Cost-Sharing under the Affordable Care Act.

Primary Care is the arrangement of coordinated, comprehensive medical services you get during a first visit with a Provider and at any later time. Primary Care involves an initial medical history intake, medical diagnosis, and treatment, Behavioral Health (mental health and/or substance use) screenings, communication of information about illness prevention, health maintenance, and Prior Authorizations.

A **Primary Care Provider** (PCP) is the individual Provider or team you select or to whom we assign you, from the Provider Directory to provide general medical care for common health care problems. This Provider has an agreement with Tufts Health Plan to provide Primary Care and to coordinate, arrange, and authorize the provision of Covered Services. A PCP prescribes or otherwise provides or proposes Health Care Services. All medical care starts with the PCP and s/he refers to Medically Necessary Specialists as needed. PCPs who are doctors must practice one of the following specialties: Family practice, internal medicine, general practice, adolescent and pediatric medicine, or obstetrics/gynecology. PCPs must be board-certified or eligible for board certification in their specialty. You may also choose a licensed Nurse Practitioner or a licensed Physician Assistant as your PCP if the Nurse Practitioner or Physician Assistant is a Provider in our Network. PCPs for people with disabilities, including people with HIV/AIDS, may include practitioners in other specialties.

Prior Authorization is a process that determines if you need a specific Health Care Service or where you can get or receive a specific Health Care Service and/or if a specific Health Care Service can be provided by an Out-of-Network Provider. Tufts Health Plan must approve coverage for certain types of services and Providers before payment can be made to you or to the Provider for the service or visit with the Provider. We take into account the benefit, any Benefit Limits, the Provider's Network status, your unique health conditions, Medical Necessity and other factors when we make our decision. We make coverage decisions using these Guidelines, along with the Member's Evidence of Coverage (EOC), and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Protected Health Information (PHI) is any information (oral, written or electronic) about your past, present or future physical or mental health or condition or about your health care or payment for your health care. PHI includes any individually identifiable health information, which includes any health information that a person could use to identify you.

A **Provider** is an appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity who has an agreement with Tufts Health Plan or its subcontractor, to deliver the Covered Services under this contract.

The online **Provider Directory** lists Tufts Health Direct's contracted health care facilities and professionals, including all PCPs, Specialists listed by specialty, Hospitals, Emergency rooms and Emergency Services Program Providers, pharmacies, Ancillary Services, and Behavioral Health (mental health and/or substance use) services. You can call us at **888.257.1985** to get a printed *Provider Directory*, free of charge. The *Provider Directory* is also available at tuftshealthplan.com and tuftshealthplan.com/memberlogin through our Find a Doctor or Hospital tool.

Quality Management is the process we use to monitor and improve the quality of care our Members get.

Reasonable Charge is the lesser of the amount charged or the amount that we determine to be reasonable, based upon nationally accepted means and amounts of Claims payment. Nationally accepted means and amounts of Claims payment include but are not limited to: Medicare fee schedules and allowed amounts, CMS medical coding policies, AMA CPT coding guidelines, nationally recognized academy and society coding, and clinical guidelines.

A **Reconsideration of a Standard Internal Appeal** is a request by you or your Personal Representative, if you identify one, for us to review our Standard Internal Appeal decision a second

time. We will review and make a decision about a Reconsideration of a Standard Internal Appeal request within 30 Days of the date we receive the request.

A **Rehabilitation Hospital** is a facility licensed to provide therapeutic services to help patients restore function after an illness or injury. These facilities provide Occupational, Physical, and Speech Therapy and Skilled Nursing care services.

A **Resident** is a person living in Massachusetts. Confinement in a nursing home, Hospital or other institution is not by itself sufficient to qualify a person as a Resident.

Service Area is the geographical area within which Tufts Health Plan has developed a Network of Providers for Tufts Health Direct plans to provide adequate access to Covered Services and is approved by the Health Connector and/or the Division of Insurance to enroll Members. The Service Area is all of

Massachusetts EXCEPT Dukes and Nantucket Counties. **Note:** For ConnectorCare plans, Members can only enroll in select zip codes within Franklin County (01002, 01039, 01054, 01070, 01093, 01096, 01247, 01350, 01355, 01364, 01366, 01367, 01378). For all other plans, Members are eligible to enroll in all of Franklin County.

A **Skilled Nursing Facility** is a licensed Inpatient facility that provides Skilled Nursing to Members who do not require or no longer require the services of an acute care Hospital.

A **Specialist** is a doctor who is trained to provide specialty medical services. Examples include cardiologists, obstetricians, and dermatologists or for Behavioral Health (mental health and/or substance use) services, a psychologist, psychiatrist or social worker.

Speech Therapy refers to the evaluation and treatment of speech, language, voice, hearing and fluency disorders.

Spouse refers to the Subscriber's legal Spouse, according to the law of the state in which you reside, and includes a divorced Spouse as required by Massachusetts law. Spouse also includes the spousal equivalent of the Subscriber who is registered as a domestic partner, civil union partner or other similar legally recognized partner of the Subscriber who resides in a state or municipal jurisdiction that provides such legal recognition/spousal equivalent rights.

A **Standard Internal Appeal** is an oral or written request for Tufts Health Plan to review any Adverse Determination. We will review and make a decision about a Standard Internal Appeal request within 30 Days of the date we get the request.

Subrogation is the procedure under which Tufts Health Plan can recover the full or partial cost of benefits paid from a third person ("Third Party") or entity, such as an insurer.

A **Subscriber** is the person who enrolls in Tufts Health Direct on behalf of himself or herself and any Dependents and in whose name the Premium is paid in accordance with either a Group Contract or an individual contract (as applicable). For an individual contract, a Subscriber must live in Massachusetts. For a Group Contract, a Subscriber is an employee of a Group.

Telehealth is the use of synchronous or asynchronous audio, video, electronic media or other telecommunications technology, including, but not limited to: (i) interactive audio-video technology; (ii) remote patient monitoring devices; (iii) audio-only telephone; and (iv) online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating or monitoring of a patient's physical health, oral health, mental health or substance use disorder condition.

Tufts Health Plan in this Handbook refers to Tufts Health Direct.

Tufts Health Direct means Tufts Health Public Plans, Inc., a Massachusetts corporation. Tufts Health Direct is licensed by Massachusetts as a health maintenance organization (HMO). Also referred to as "we," "us", "our", and "Tufts Health Plan".

Urgent Care is care provided when your health is not in serious danger, but you need immediate medical attention for an unforeseen illness or injury. Examples of illnesses or injuries in which Urgent Care might be needed are a broken or dislocated toe, a cut that needs stitches but is not actively

bleeding, sudden extreme anxiety or symptoms of a urinary tract infection.

Note: Care that is rendered after the urgent condition has been treated and stabilized and the Member is safe for transport is not considered Urgent Care.

Utilization Management Tufts Health Plan has a Utilization Management program. This is employed to evaluate whether health care services provided to Members are: (1) Medically Necessary; and (2) provided in the most appropriate and efficient manner. UM is our constant process of reviewing and evaluating the care you get to make sure that it is appropriate and what you need.

Utilization Review is our process of reviewing information from doctors and other clinicians to help us decide what services you need to get better or stay healthy. Our formal review methods help us monitor the use of—or evaluate the clinical necessity, appropriateness or efficiency of— Covered Services, procedures or settings. The review methods may include but are not limited to ambulatory review, prospective review, second opinion, certification, concurrent review, Care Management, discharge planning or retrospective review.

A **Waiting Period** is a specified period immediately following the Effective Date of an eligible Member's coverage under a health plan during which the plan does not pay for some or all medical expenses. There is no Waiting Period for Tufts Health Direct coverage.

Workers' Compensation is insurance coverage employers maintain under state and federal law to cover employees' injuries and illnesses under certain conditions.

Your Health Form is a series of questions we ask Members so that we can get their most up-to- date health information.

Appendix B: Schedule of Benefits & Benefit and Cost-Sharing Summary

Direct ConnectorCare I

Benefit and Cost-Sharing Summary

This Benefit and Cost-Sharing Summary gives you information about your Tufts Health Direct Covered Services and costs you may have to pay. Make sure you review the services you are eligible for under the Benefit and Cost-Sharing Summary for your specific Plan Level. To see which Tufts Health Direct Plan Level you have, check your Tufts Health Plan Member ID Card.

Your Tufts Health Direct Plan may also have a Deductible. A Deductible is the amount you pay for certain Covered Services in a Benefit Year before your Tufts Health Direct Plan will begin to pay for those Covered Services. You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document.

This Summary gives you a general understanding of your benefits. If you want more information about your benefits and capitalized terms, see your *Tufts Health Direct Member Handbook*.

You must go to Providers (doctors, Hospitals, and other health care professionals) who are part of the Tufts Health Direct Provider Network to get services. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal. Services are only covered with In-network Providers, except for Emergency care and out of the Service Area Urgent Care.

Out-of-network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. [Service Area is all of Massachusetts EXCEPT Dukes and Nantucket Counties.]

Always check for the most up-to-date In-network Provider information. If you have questions about your Tufts Health Direct benefits or you need help locating an In-network Provider, call us at **888.257.1985** (TTY: 711).

ANNUAL DEDUCTIBLE	
Individual	$0
Family	$0
ANNUAL OUT-OF-POCKET MAXIMUM	
Individual	$0 (medical) | $250 (pharmacy)
Family	$0 (medical) | $500 (pharmacy)

Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The family Deductible and Out-of-pocket Maximum on this Plan have embedded individual Deductibles and Out-of-pocket Maximums, meaning the individual Deductible and Out-of-pocket Maximum above applies to each individual member of the family. This ensures that no single Member on a family Plan will ever have to satisfy the full family Deductible or Out-of-pocket Maximum on their own. Once any combination of family members meets the family Deductible and/or Out-of-pocket Maximum, the entire family is considered to have met the Deductible and/or Out-of-pocket Maximum.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Emergency Room Care	No charge	Notification required within 48 hours, if admitted to the Hospital. Copayment waived, if admitted.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Abortion Services	No charge	
Acupuncture	No charge	
Allergy testing	No charge	Covered for up to 200 allergy tests per benefit year when administered by an In-Network provider. No prior authorization required.
Allergy treatments (Injections)	No charge	Allergy immunotherapy covered as part of the pharmacy prescription benefit may require prior authorization and have separate pharmacy Cost-Sharing responsibility.
Ambulance	No charge	Emergency transport covered without Prior Authorization; non-Emergency ambulance transport may be covered with Prior Authorization.
Autism Spectrum Disorder		
Applied Behavioral Analysis (ABA)	No charge	Requires Prior Authorization. Includes assessments, evaluations, testing, and treatment; covered in home, Outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst for treatment of Autism Spectrum Disorder.
Habilitative and Rehabilitative Services (Physical, Occupational, Speech Therapy)	No charge	Physical, occupational, and speech therapy benefit limitations do not apply.
Breastfeeding Services	No charge	Includes lactation consultants.
Breast Pumps	No charge	Covered for the purchase of a manual or electric pump or the rental of a hospital-grade pump when deemed appropriate by the ordering provider in accordance with the Preventive Services Policy. Limit of one pump per pregnancy. No Prior Authorization required. Prescription required. Pump must be obtained from contracting DME provider. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related DME Cost-Sharing may apply.
Cardiac Rehabilitation	No charge	
Chemotherapy Administration	No charge	
Chiropractic Care	No charge	

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Cleft Palate/Cleft Lip Care	No charge Additional cost-sharing may apply based on place of service.	Covered for Members under the age of 18. Includes medical, dental, oral, and facial surgery, follow-up, and related services.
Clinical Trials (Qualified)	Based on place of service	Routine patient care services covered for Members in a qualified clinical trial pursuant to state and federal mandates.
Dental, Accidental	Based on place of service	Coverage for services related to teeth is limited to the emergency treatment of accidental injury to sound, natural and permanent teeth when caused by a source external to the mouth.
Dental Care (Pediatric Only), Non-Emergency (Delta Dental)		
Type I Services: Preventive & Diagnostic	No charge	Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age. Medically Necessary orthodontia requires Prior Authorization. Members are eligible for pediatric services until the last day of the month in which they turn 19 years old. More information about pediatric dental is available in the Covered Services section of the *Tufts Health Direct Member Handbook*. Please call Delta Dental at 800.872.0500 for more information.
Type II Services: Basic Covered Services	No charge	
Type III Services: Major Restorative Services	No charge	
Type IV Services: Orthodontia (only as Medically Necessary)	No charge	
Diabetes Education		
Primary Care Provider Non-Preventive office visit	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit Cost-Sharing may apply. No charge for the Good Measures program available to Direct Members.
Specialist	No charge	
Diagnostic Testing (including sleep studies outside of an Inpatient setting)	Related office visit or Inpatient Copayment/Cost-Share may be required	Sleep studies require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, Cost-Sharing may apply based on type and place of service.
Dialysis Services	No charge	
Disease Management Programs • Asthma • Diabetes • Chronic Obstructive Pulmonary Disease (COPD) • Congestive-Heart Failure	No charge	If you have any of these conditions, please contact us at **888.257.1985** to discuss our disease management programs.

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Durable Medical Equipment (DME) • Medical Supplies • Orthotics • Oxygen and respiratory therapy equipment • Prosthetics • Wigs	No charge	Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs. Prior Authorization is required for certain services, including prosthetic orthotics (see list at https://tuftshealthplan.com/documents/providers/guides/thpp-dme-pa-quick-reference-guide).
Early Intervention Services	No charge	Covered for Members up to age 3; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention Specialist.
Eye Care (Vision Care) Visits		
Routine Visit	No charge	Pediatric services for members under 19 years of age: Coverage for routine eye exams once every 12 months; Eyeglasses covered once every 12 months Collection frames only or $150 allowance + 20% off expense beyond allowance. Members are eligible for pediatric services until the last day of the month in which they turn 19 years old. Adult Services for Members 19 years of age or older: Coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics. You must receive routine eye examinations from a Provider in the EyeMed Vision Care Select Network in order to obtain coverage for these services. Call EyeMed at 866.504.5908 for the names of EyeMed Select Providers.
Eye Care (Vision Care) Non-Routine Visit	No charge	For non-routine vision services, please visit tuftshealthplan.com/find-a-doctor.
Family-planning Services		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit or lab Cost-Sharing may apply.
Non-Preventive	Related office visit or lab Cost-Sharing may apply	
Fitness Center Reimbursement	Covered for 3 months	Covered for 3 months of membership at a standard fitness center; excludes initiation fees. This benefit is available to Members once every Benefit Year after being a Member for 4 months. See the *Tufts Health Direct Member Handbook* for more information on limitations. Must complete a Fitness Center Reimbursement form.

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Habilitative Services (Physical, Occupational, Speech Therapy)	No charge	Maximum of 60 visits total combined Habilitative Physical and Occupational Therapy per Member per Benefit Year. No limit on Speech Therapy. Physical Therapy and Occupational Therapy require a Prior Authorization after initial evaluation and 11 visits. Speech Therapy requires Prior Authorization after visit 30.
Hearing Aids	No charge	Covered for Members 21 and younger. This includes the cost of one hearing aid per hearing-impaired ear up to $2,000 per ear every 36 months. This includes both the amount Tufts Health Direct pays and the applicable Member Cost-Share as listed in this document. Related services and supplies do not count toward the $2,000 limit.
Home Health Care	No charge	Prior Authorization is required for all home care services and disciplines
Hospice	No charge	Requires Prior Authorization
Imaging Services (Radiology)		
Preventive	No charge	Advanced imaging services require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit or lab Cost-Sharing may apply.
X-ray Services and Diagnostic	No charge	
Advanced: MRI, CT, PET	No charge	
Individual therapy/Counseling	No charge	No visit limits and no Prior Authorization required for Outpatient Behavioral Health therapy visits or substance use treatment.
Infertility Treatment	Cost-share varies based on type of service	Requires Prior Authorization. Medically necessary services may include Inpatient Medical Care, Outpatient Surgery, Laboratory Services, Imaging (x-ray/diagnostic), Office Visits (Specialist), Medical Drugs and/or Prescription Drugs.
Inpatient Medical Care		
Facility fee (includes room and board for maternity/surgery/radiology imaging services and lab work)	No charge	No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission. Elective admissions require Prior Authorization and notification 5 business days before admission. Sleep studies may require Prior Authorization.
Professional fee	No charge	
Inpatient Mental Health and/or Substance Use	No charge	No Prior Authorization required for admission. Notification to the Plan is required within 48 hours of the Inpatient admission.
Intensive community based acute treatment (ICBAT) for Children and adolescents	No charge	No Prior Authorization required for admission. Notification to the Plan is required within 48 hours of the Inpatient admission.

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Intermediate care, including Behavioral Health services for children and adolescents	No charge	Prior Authorization is only required for certain Behavioral Health services for children and adolescents. Please see the "Covered Services" section of the *Tufts Health Direct Member Handbook* for more information about these services.
Laboratory Outpatient and Professional Services		
Preventive Labs	No charge	Includes blood tests, urinalysis, Pap smears, and throat cultures to maintain health and to test, diagnose, treat, and prevent disease. Laboratory must be In-network. Genetic testing may require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related lab Cost-Sharing may apply.
Non-Preventive Labs	No charge	
Medical Benefit drugs	No charge	Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit. Prior authorization may be required.
Medication-Assisted Treatment (MAT) services	No charge	Certain medication may require Prior Authorization.
Mental Health Wellness Exam	No charge	Annual mental health wellness examination performed by a Licensed Mental Health Professional Please Note: Your annual mental health wellness examination may also be provided by a PCP during your annual routine physical exam.
Methadone treatment (dosing, counseling, labs)	No charge	
MinuteClinic®	No charge	A walk-in clinic accessible at select CVS locations.
Nutritional counseling		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related Cost-Sharing may apply.
Non-Preventive	No charge	
Office Visits		
Primary Care Provider Preventive Care/screening/immunization /vaccine	No charge	Includes community health center visits
Primary Care Provider Non-Preventive office visit	No charge	Includes community health center visits
Specialist	No charge	Includes community health center visits
Organ Transplant (including bone marrow transplants)	See "Inpatient Medical Care"	Requires Prior Authorization.

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Outpatient Surgery (Outpatient Hospital/ambulatory surgery centers)		
Professional/Surgeon Services	No charge	Prior Authorization required for certain services. Please call us at **888.257.1985** for mor information.
Surgery services and Facility Fee	No charge	
Pharmacy		
Retail drugs (up to 30-Day supply)		
• Tier 1 (primarily generic focused)	$1.00 Copayment	See Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost-Share. Refer to Formulary for a complete list.
• Tier 2 (includes some non-preferred generics and preferred brands)	$3.65 Copayment	
• Tier 3 (includes high-cost generics, and non-preferred brands and specialty)	$3.65 Copayment	
Mail-order drugs (up to 90-Day supply)		
• Tier 1 (Generic)	$2.00 Copayment	See Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost-Share. Refer to Formulary for a complete list.
• Tier 2 (Preferred Brands)	$7.30 Copayment	
• Tier 3 (Non-preferred Brands and Specialty)	$7.30 Copayment	
Podiatry	No charge	Non-routine podiatry services covered when medically necessary. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot.
Prenatal care		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related Cost-Sharing may apply.
Non-Preventive	Related office visit or lab Cost-Sharing may apply	
Radiation Therapy	No charge	May require Prior Authorization
Reconstructive Surgery and Procedures	See "Outpatient Surgery"	Please see the "Covered Services" section of the *Tufts Health Direct Member Handbook* for limitations. May require Prior Authorization.
Rehabilitation Hospital or Chronic Disease Hospital	No charge	Maximum of 60 Days total per Member per Benefit Year. May require Prior Authorization.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Rehabilitative Services (Physical, Occupational, Speech Therapy)	No charge	Maximum of 60 visits total combined Rehabilitative Physical and Occupational Therapy per Member per Benefit Year. No limit on Speech Therapy. Physical Therapy and Occupational Therapy require a Prior Authorization after initial evaluation and 11 visits. Speech Therapy requires Prior Authorization after visit 30.
Skilled Nursing Facility	No charge	Maximum of 100 Days total per Member per Benefit Year. Prior Authorization required.
Substance Use		
Substance Use Treatment Programs	Related Outpatient or Inpatient Cost-Sharing may apply	Please see the "Covered Behavioral Health (mental health and/or substance use) services" section of the *Tufts Health Direct Member Handbook* for more information about these services.
Recovery Coaches and Peer Specialist	No charge	Must be part of a licensed behavioral health treatment program, such as a licensed mental health clinic, substance use disorder clinic, or outpatient hospital clinic and under supervision of a licensed clinician, such as a licensed social worker, registered nurse, or clinical psychologist
Telehealth	Related Outpatient Medical Care Cost-Sharing may apply	Please ask your Providers' office for information on telehealth availability and access.
Urgent Care	No charge	You must visit a UCC in our Service Area [(all of Massachusetts EXCEPT Dukes and Nantucket Counties)] that is in our Network to be covered for services. In our Service Area, if you obtain services at an Out-of-network UCC or at a UCC in an Out-of-network Hospital, you will not be covered. Outside of our Service Area, Free-standing Urgent Care Centers (UCC) are covered at Out-of-network Provider sites, including Hospitals and clinics. Cost-Share may vary depending on place of service.
Weight Loss Programs	No charge for 3 months of membership fees for a qualified program	You must be a Tufts Health Direct Member for three months and participate in a qualified weight loss program for at least three consecutive months. Each Member on a family Plan can request a weight loss program reimbursement once per Benefit Year. Must complete a Weight Loss Programs reimbursement form. See the *Tufts Health Direct Member Handbook* for more information on limitations.

Services not covered

See the section "Services not covered" in the *Tufts Health Direct Member Handbook* for the list of services not covered.

Direct ConnectorCare II

Benefit and Cost-Sharing Summary

This Benefit and Cost-Sharing Summary gives you information about your Tufts Health Direct Covered Services and costs you may have to pay. Make sure you review the services you are eligible for under the Benefit and Cost-Sharing Summary for your specific Plan Level. To see which Tufts Health Direct Plan Level you have, check your Tufts Health Plan Member ID Card.

Your Tufts Health Direct Plan may also have a Deductible. A Deductible is the amount you pay for certain Covered Services in a Benefit Year before your Tufts Health Direct Plan will begin to pay for those Covered Services. You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document.

This Summary gives you a general understanding of your benefits. If you want more information about your benefits and capitalized terms, see your *Tufts Health Direct Member Handbook*.

You must go to Providers (doctors, Hospitals, and other health care professionals) who are part of the Tufts Health Direct Provider Network to get services. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal. Services are only covered with In-network Providers, except for Emergency care and out of the Service Area Urgent Care.

Out-of-network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. [Service Area is all of Massachusetts EXCEPT Dukes and Nantucket Counties.]

Always check for the most up-to-date In-network Provider information. If you have questions about your Tufts Health Direct benefits or you need help locating an In-network Provider, call us at **888.257.1985** (TTY: 711).

ANNUAL DEDUCTIBLE	
Individual	$0
Family	$0
ANNUAL OUT-OF-POCKET MAXIMUM	
Individual	$750 (medical) | $500 (pharmacy)
Family	$1,500 (medical) | $1,000 (pharmacy)

Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The family Deductible and Out-of-pocket Maximum on this Plan have embedded individual Deductibles and Out-of-pocket Maximums, meaning the individual Deductible and Out-of-pocket Maximum above applies to each individual member of the family. This ensures that no single Member on a family Plan will ever have to satisfy the full family Deductible or Out-of-pocket Maximum on their own. Once any combination of family members meets the family Deductible and/or Out-of-pocket Maximum, the entire family is considered to have met the Deductible and/or Out-of-pocket Maximum.

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Emergency Room Care	$50 Copayment per visit	Notification required within 48 hours, if admitted to the Hospital. Copayment waived, if admitted.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Abortion Services	No charge”	
Acupuncture	$18 Copayment per visit	
Allergy testing	$18 Copayment per visit	Covered for up to 200 allergy tests per benefit year when administered by an In-Network provider. No prior authorization required.
Allergy treatments (Injections)	$5 Copayment per visit	Allergy immunotherapy covered as part of the pharmacy prescription benefit may require prior authorization and have separate pharmacy Cost-Sharing responsibility.
Ambulance	No charge	Emergency transport covered without Prior Authorization; non-Emergency ambulance transport may be covered with Prior Authorization.
Autism Spectrum Disorder		
Applied Behavioral Analysis (ABA)	No charge	Requires Prior Authorization. Includes assessments, evaluations, testing, and treatment; covered in home, Outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst for treatment of Autism Spectrum Disorder.
Habilitative and Rehabilitative Services (Physical, Occupational, Speech Therapy)	$10 Copayment per visit	Physical, occupational, and speech therapy benefit limitations do not apply.
Breastfeeding Services	No charge	Includes lactation consultants.
Breast Pumps	No charge	Covered for the purchase of a manual or electric pump or the rental of a hospital-grade pump when deemed appropriate by the ordering provider in accordance with the Preventive Services Policy. Limit of one pump per pregnancy. No Prior Authorization required. Prescription required. Pump must be obtained from contracting DME provider. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related DME Cost-Sharing may apply.
Cardiac Rehabilitation	$10 Copayment per visit	
Chemotherapy Administration	No charge	
Chiropractic Care	$18 Copayment per visit	

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Cleft Palate/Cleft Lip Care	No charge Additional cost-sharing may apply based on place of service.	Covered for Members under the age of 18. Includes medical, dental, oral, and facial surgery, follow-up, and related services.
Clinical Trials (Qualified)	Based on place of service	Routine patient care services covered for Members in a qualified clinical trial pursuant to state and federal mandates.
Dental, Accidental	Based on place of service	Coverage for services related to teeth is limited to the emergency treatment of accidental injury to sound, natural and permanent teeth when caused by a source external to the mouth.
Dental Care (Pediatric Only), Non-Emergency (Delta Dental)		
Type I Services: Preventive & Diagnostic	No charge	Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age. Medically Necessary orthodontia requires Prior Authorization. Members are eligible for pediatric services until the last day of the month in which they turn 19 years old. More information about pediatric dental is available in the Covered Services section of the *Tufts Health Direct Member Handbook*. Please call Delta Dental at 800.872.0500 for more information.
Type II Services: Basic Covered Services	No charge	
Type III Services: Major Restorative Services	No charge	
Type IV Services: Orthodontia (only as Medically Necessary)	No charge	
Diabetes Education		
Primary Care Provider Non-Preventive office visit	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit Cost-Sharing may apply. No charge for the Good Measures program available to Direct Members.
Specialist	$18 Copayment per visit	
Diagnostic Testing (including sleep studies outside of an Inpatient setting)	Related office visit or Inpatient Copayment/Cost-Share may be required	Sleep studies require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, Cost-Sharing may apply based on type and place of service.
Dialysis Services	No charge	
Disease Management Programs • Asthma • Diabetes • Chronic Obstructive Pulmonary Disease (COPD) • Congestive-Heart Failure	No charge	If you have any of these conditions, please contact us at **888.257.1985** to discuss our disease management programs.

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Durable Medical Equipment (DME) • Medical Supplies • Orthotics • Oxygen and respiratory therapy equipment • Prosthetics • Wigs	No charge	Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs. Prior Authorization is required for certain services, including prosthetic orthotics (see list at https://tuftshealthplan.com/documents/providers/guides/thpp-dme-pa-quick-reference-guide).
Early Intervention Services	No charge	Covered for Members up to age 3; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention Specialist.
Eye Care (Vision Care) Visits		
Routine Visit	$10 Copayment per visit	Pediatric services for members under 19 years of age: Coverage for routine eye exams once every 12 months; Eyeglasses covered once every 12 months Collection frames only or $150 allowance + 20% off expense beyond allowance. Members are eligible for pediatric services until the last day of the month in which they turn 19 years old. Adult Services for Members 19 years of age or older: Coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics. You must receive routine eye examinations from a Provider in the EyeMed Vision Care Select Network in order to obtain coverage for these services. Call EyeMed at 866.504.5908 for the names of EyeMed Select Providers.
Eye Care (Vision Care) Non-Routine Visit	$18 Copayment per visit	For non-routine vision services, please visit tuftshealthplan.com/find-a-doctor.
Family-planning Services		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit or lab Cost-Sharing may apply.
Non-Preventive	Related office visit or lab Cost-Sharing may apply	
Fitness Center Reimbursement	Covered for 3 months	Covered for 3 months of membership at a standard fitness center; excludes initiation fees. This benefit is available to Members once every Benefit Year after being a Member for 4 months. See the *Tufts Health Direct Member Handbook* for more information on limitations. Must complete a Fitness Center Reimbursement form.

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Habilitative Services (Physical, Occupational, Speech Therapy)	$10 Copayment per visit	Maximum of 60 visits total combined Habilitative Physical and Occupational Therapy per Member per Benefit Year. No limit on Speech Therapy. Physical Therapy and Occupational Therapy require a Prior Authorization after initial evaluation and 11 visits. Speech Therapy requires Prior Authorization after visit 30.
Hearing Aids	No charge	Covered for Members 21 and younger. This includes the cost of one hearing aid per hearing-impaired ear up to $2,000 per ear every 36 months. This includes both the amount Tufts Health Direct pays and the applicable Member Cost-Share as listed in this document. Related services and supplies do not count toward the $2,000 limit.
Home Health Care	No charge	Prior Authorization is required for all home care services and disciplines
Hospice	No charge	Requires Prior Authorization
Imaging Services (Radiology)		
Preventive	No charge	Advanced imaging services require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit or lab Cost-Sharing may apply.
X-ray Services and Diagnostic	No charge	
Advanced: MRI, CT, PET	$30 Copayment	
Individual therapy/Counseling	No charge	No visit limits and no Prior Authorization required for Outpatient Behavioral Health therapy visits or substance use treatment.
Infertility Treatment	Cost-share varies based on type of service	Requires Prior Authorization. Medically necessary services may include Inpatient Medical Care, Outpatient Surgery, Laboratory Services, Imaging (x-ray/diagnostic), Office Visits (Specialist), Medical Drugs and/or Prescription Drugs.
Inpatient Medical Care		
Facility fee (includes room and board for maternity/surgery/radiology imaging services and lab work)	$50 Copayment per stay	No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission. Elective admissions require Prior Authorization and notification 5 business days before admission. Sleep studies may require Prior Authorization.
Professional fee	No charge	
Inpatient Mental Health and/or Substance Use	$50 Copayment per stay	No Prior Authorization required for admission. Notification to the Plan is required within 48 hours of the Inpatient admission.
Intensive community based acute treatment (ICBAT) for Children and adolescents	No charge	No Prior Authorization required for admission. Notification to the Plan is required within 48 hours of the Inpatient admission.

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Intermediate care, including Behavioral Health services for children and adolescents	No charge	Prior Authorization is only required for certain Behavioral Health services for children and adolescents. Please see the "Covered Services" section of the *Tufts Health Direct Member Handbook* for more information about these services.
Laboratory Outpatient and Professional Services		
Preventive Labs	No charge	Includes blood tests, urinalysis, Pap smears, and throat cultures to maintain health and to test, diagnose, treat, and prevent disease. Laboratory must be In-network. Genetic testing may require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related lab Cost-Sharing may apply.
Non-Preventive Labs	No charge	
Medical Benefit drugs	No charge	Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit. Prior authorization may be required.
Medication-Assisted Treatment (MAT) services	No charge	Certain medication may require Prior Authorization.
Mental Health Wellness Exam	No charge	Annual mental health wellness examination performed by a Licensed Mental Health Professional Please Note: Your annual mental health wellness examination may also be provided by a PCP during your annual routine physical exam.
Methadone treatment (dosing, counseling, labs)	No charge	
MinuteClinic®	No charge	A walk-in clinic accessible at select CVS locations.
Nutritional counseling		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related Cost-Sharing may apply.
Non-Preventive	$18 Copayment per visit	
Office Visits		
Primary Care Provider Preventive Care/screening/immunization /vaccine	No charge	Includes community health center visits
Primary Care Provider Non-Preventive office visit	No charge	Includes community health center visits
Specialist	$18 Copayment per visit	Includes community health center visits
Organ Transplant (including bone marrow transplants)	See "Inpatient Medical Care"	Requires Prior Authorization.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Outpatient Surgery (Outpatient Hospital/ambulatory surgery centers)		
Professional/Surgeon Services	No charge	Prior Authorization required for certain services. Please call us at **888.257.1985** for mor information.
Surgery services and Facility Fee	$50 Copayment per visit	
Pharmacy		
Retail drugs (up to 30-Day supply)		
• Tier 1 (primarily generic focused)	$10 Copayment	See Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost-Share. Refer to Formulary for a complete list.
• Tier 2 (includes some non-preferred generics and preferred brands)	$20 Copayment	
• Tier 3 (includes high-cost generics, and non-preferred brands and specialty)	$40 Copayment	
Mail-order drugs (up to 90-Day supply)		
• Tier 1 (Generic)	$20 Copayment	See Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost-Share. Refer to Formulary for a complete list.
• Tier 2 (Preferred Brands)	$40 Copayment	
• Tier 3 (Non-preferred Brands and Specialty)	$80 Copayment	
Podiatry	$18 Copayment per visit	Non-routine podiatry services covered when medically necessary. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot.
Prenatal care		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related Cost-Sharing may apply.
Non-Preventive	Related office visit or lab Cost-Sharing may apply	
Radiation Therapy	No charge	May require Prior Authorization
Reconstructive Surgery and Procedures	See "Outpatient Surgery"	Please see the "Covered Services" section of the *Tufts Health Direct Member Handbook* for limitations. May require Prior Authorization.
Rehabilitation Hospital or Chronic Disease Hospital	$50 Copayment per stay	Maximum of 60 Days total per Member per Benefit Year. May require Prior Authorization.

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Rehabilitative Services (Physical, Occupational, Speech Therapy)	$10 Copayment per visit	Maximum of 60 visits total combined Rehabilitative Physical and Occupational Therapy per Member per Benefit Year. No limit on Speech Therapy. Physical Therapy and Occupational Therapy require a Prior Authorization after initial evaluation and 11 visits. Speech Therapy requires Prior Authorization after visit 30.
Skilled Nursing Facility	No charge	Maximum of 100 Days total per Member per Benefit Year. Prior Authorization required.
Substance Use		
Substance Use Treatment Programs	Related Outpatient or Inpatient Cost-Sharing may apply	Please see the "Covered Behavioral Health (mental health and/or substance use) services" section of the *Tufts Health Direct Member Handbook* for more information about these services.
Recovery Coaches and Peer Specialist	No charge	Must be part of a licensed behavioral health treatment program, such as a licensed mental health clinic, substance use disorder clinic, or outpatient hospital clinic and under supervision of a licensed clinician, such as a licensed social worker, registered nurse, or clinical psychologist
Telehealth	Related Outpatient Medical Care Cost-Sharing may apply	Please ask your Providers' office for information on telehealth availability and access.
Urgent Care	$18 Copayment per visit	You must visit a UCC in our Service Area [(all of Massachusetts EXCEPT Dukes and Nantucket Counties)] that is in our Network to be covered for services. In our Service Area, if you obtain services at an Out-of-network UCC or at a UCC in an Out-of-network Hospital, you will not be covered. Outside of our Service Area, Free-standing Urgent Care Centers (UCC) are covered at Out-of-network Provider sites, including Hospitals and clinics. Cost-Share may vary depending on place of service.
Weight Loss Programs	No charge for 3 months of membership fees for a qualified program	You must be a Tufts Health Direct Member for three months and participate in a qualified weight loss program for at least three consecutive months. Each Member on a family Plan can request a weight loss program reimbursement once per Benefit Year. Must complete a Weight Loss Programs reimbursement form. See the *Tufts Health Direct Member Handbook* for more information on limitations.

Services not covered

See the section "Services not covered" in the *Tufts Health Direct Member Handbook* for the list of services not covered.

Direct ConnectorCare III

Benefit and Cost-Sharing Summary

This Benefit and Cost-Sharing Summary gives you information about your Tufts Health Direct Covered Services and costs you may have to pay. Make sure you review the services you are eligible for under the Benefit and Cost-Sharing Summary for your specific Plan Level. To see which Tufts Health Direct Plan Level you have, check your Tufts Health Plan Member ID Card.

Your Tufts Health Direct Plan may also have a Deductible. A Deductible is the amount you pay for certain Covered Services in a Benefit Year before your Tufts Health Direct Plan will begin to pay for those Covered Services. You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document.

This Summary gives you a general understanding of your benefits. If you want more information about your benefits and capitalized terms, see your *Tufts Health Direct Member Handbook*.

You must go to Providers (doctors, Hospitals, and other health care professionals) who are part of the Tufts Health Direct Provider Network to get services. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal. Services are only covered with In-network Providers, except for Emergency care and out of the Service Area Urgent Care.

Out-of-network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. [Service Area is all of Massachusetts EXCEPT Dukes and Nantucket Counties.]

Always check for the most up-to-date In-network Provider information. If you have questions about your Tufts Health Direct benefits or you need help locating an In-network Provider, call us at **888.257.1985** (TTY: 711).

ANNUAL DEDUCTIBLE	
Individual	$0
Family	$0
ANNUAL OUT-OF-POCKET MAXIMUM	
Individual	$1,500 (medical) | $750 (pharmacy)
Family	$3,000 (medical) | $1,500 (pharmacy)

Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The family Deductible and Out-of-pocket Maximum on this Plan have embedded individual Deductibles and Out-of-pocket Maximums, meaning the individual Deductible and Out-of-pocket Maximum above applies to each individual member of the family. This ensures that no single Member on a family Plan will ever have to satisfy the full family Deductible or Out-of-pocket Maximum on their own. Once any combination of family members meets the family Deductible and/or Out-of-pocket Maximum, the entire family is considered to have met the Deductible and/or Out-of-pocket Maximum.

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Emergency Room Care	$100 Copayment per visit	Notification required within 48 hours, if admitted to the Hospital. Copayment waived, if admitted.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Abortion Services	No charge	
Acupuncture	$22 Copayment per visit	
Allergy testing	$22 Copayment per visit	Covered for up to 200 allergy tests per benefit year when administered by an In-Network provider. No prior authorization required.
Allergy treatments (Injections)	$7 Copayment per visit	Allergy immunotherapy covered as part of the pharmacy prescription benefit may require prior authorization and have separate pharmacy Cost-Sharing responsibility.
Ambulance	No charge	Emergency transport covered without Prior Authorization; non-Emergency ambulance transport may be covered with Prior Authorization.
Autism Spectrum Disorder		
Applied Behavioral Analysis (ABA)	No charge	Requires Prior Authorization. Includes assessments, evaluations, testing, and treatment; covered in home, Outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst for treatment of Autism Spectrum Disorder.
Habilitative and Rehabilitative Services (Physical, Occupational, Speech Therapy)	$20 Copayment per visit	Physical, occupational, and speech therapy benefit limitations do not apply.
Breastfeeding Services	No charge	Includes lactation consultants.
Breast Pumps	No charge	Covered for the purchase of a manual or electric pump or the rental of a hospital-grade pump when deemed appropriate by the ordering provider in accordance with the Preventive Services Policy. Limit of one pump per pregnancy. No Prior Authorization required. Prescription required. Pump must be obtained from contracting DME provider. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related DME Cost-Sharing may apply.
Cardiac Rehabilitation	$20 Copayment per visit	
Chemotherapy Administration	No charge	
Chiropractic Care	$22 Copayment per visit	

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Cleft Palate/Cleft Lip Care	No charge Additional cost-sharing may apply based on place of service.	Covered for Members under the age of 18. Includes medical, dental, oral, and facial surgery, follow-up, and related services.
Clinical Trials (Qualified)	Based on place of service	Routine patient care services covered for Members in a qualified clinical trial pursuant to state and federal mandates.
Dental, Accidental	Based on place of service	Coverage for services related to teeth is limited to the emergency treatment of accidental injury to sound, natural and permanent teeth when caused by a source external to the mouth.
Dental Care (Pediatric Only), Non-Emergency (Delta Dental)		
Type I Services: Preventive & Diagnostic	No charge	Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age. Medically Necessary orthodontia requires Prior Authorization. Members are eligible for pediatric services until the last day of the month in which they turn 19 years old. More information about pediatric dental is available in the Covered Services section of the *Tufts Health Direct Member Handbook*. Please call Delta Dental at 800.872.0500 for more information.
Type II Services: Basic Covered Services	No charge	
Type III Services: Major Restorative Services	No charge	
Type IV Services: Orthodontia (only as Medically Necessary)	No charge	
Diabetes Education		
Primary Care Provider Non-Preventive office visit	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit Cost-Sharing may apply. No charge for the Good Measures program available to Direct Members.
Specialist	$22 Copayment per visit	
Diagnostic Testing (including sleep studies outside of an Inpatient setting)	Related office visit or Inpatient Copayment/Cost-Share may be required	Sleep studies require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, Cost-Sharing may apply based on type and place of service.
Dialysis Services	No charge	
Disease Management Programs • Asthma • Diabetes • Chronic Obstructive Pulmonary Disease (COPD) • Congestive-Heart Failure	No charge	If you have any of these conditions, please contact us at **888.257.1985** to discuss our disease management programs.

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Durable Medical Equipment (DME) • Medical Supplies • Orthotics • Oxygen and respiratory therapy equipment • Prosthetics • Wigs	No charge	Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs. Prior Authorization is required for certain services, including prosthetic orthotics (see list at https://tuftshealthplan.com/documents/providers/guides/thpp-dme-pa-quick-reference-guide).
Early Intervention Services	No charge	Covered for Members up to age 3; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention Specialist.
Eye Care (Vision Care) Visits		
Routine Visit	$15 Copayment per visit	Pediatric services for members under 19 years of age: Coverage for routine eye exams once every 12 months; Eyeglasses covered once every 12 months Collection frames only or $150 allowance + 20% off expense beyond allowance. Members are eligible for pediatric services until the last day of the month in which they turn 19 years old. Adult Services for Members 19 years of age or older: Coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics. You must receive routine eye examinations from a Provider in the EyeMed Vision Care Select Network in order to obtain coverage for these services. Call EyeMed at 866.504.5908 for the names of EyeMed Select Providers.
Eye Care (Vision Care) Non-Routine Visit	$22 Copayment per visit	For non-routine vision services, please visit tuftshealthplan.com/find-a-doctor.
Family-planning Services		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit or lab Cost-Sharing may apply.
Non-Preventive	Related office visit or lab Cost-Sharing may apply	
Fitness Center Reimbursement	Covered for 3 months	Covered for 3 months of membership at a standard fitness center; excludes initiation fees. This benefit is available to Members once every Benefit Year after being a Member for 4 months. See the *Tufts Health Direct Member Handbook* for more information on limitations. Must complete a Fitness Center Reimbursement form.

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Habilitative Services (Physical, Occupational, Speech Therapy)	$20 Copayment per visit	Maximum of 60 visits total combined Habilitative Physical and Occupational Therapy per Member per Benefit Year. No limit on Speech Therapy. Physical Therapy and Occupational Therapy require a Prior Authorization after initial evaluation and 11 visits. Speech Therapy requires Prior Authorization after visit 30.
Hearing Aids	No charge	Covered for Members 21 and younger. This includes the cost of one hearing aid per hearing-impaired ear up to $2,000 per ear every 36 months. This includes both the amount Tufts Health Direct pays and the applicable Member Cost-Share as listed in this document. Related services and supplies do not count toward the $2,000 limit.
Home Health Care	No charge	Prior Authorization is required for all home care services and disciplines
Hospice	No charge	Requires Prior Authorization
Imaging Services (Radiology)		
Preventive	No charge	Advanced imaging services require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit or lab Cost-Sharing may apply.
X-ray Services and Diagnostic	No charge	
Advanced: MRI, CT, PET	$60 Copayment	
Individual therapy/Counseling	No charge	No visit limits and no Prior Authorization required for Outpatient Behavioral Health therapy visits or substance use treatment.
Infertility Treatment	Cost-share varies based on type of service	Requires Prior Authorization. Medically necessary services may include Inpatient Medical Care, Outpatient Surgery, Laboratory Services, Imaging (x-ray/diagnostic), Office Visits (Specialist), Medical Drugs and/or Prescription Drugs.
Inpatient Medical Care		
Facility fee (includes room and board for maternity/surgery/radiology imaging services and lab work)	$250 Copayment per stay	No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission. Elective admissions require Prior Authorization and notification 5 business days before admission. Sleep studies may require Prior Authorization.
Professional fee	No charge	
Inpatient Mental Health and/or Substance Use	$250 Copayment per stay	No Prior Authorization required for admission. Notification to the Plan is required within 48 hours of the Inpatient admission.
Intensive community based acute treatment (ICBAT) for Children and adolescents	No charge	No Prior Authorization required for admission. Notification to the Plan is required within 48 hours of the Inpatient admission.

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Intermediate care, including Behavioral Health services for children and adolescents	No charge	Prior Authorization is only required for certain Behavioral Health services for children and adolescents. Please see the "Covered Services" section of the *Tufts Health Direct Member Handbook* for more information about these services.
Laboratory Outpatient and Professional Services		
Preventive Labs	No charge	Includes blood tests, urinalysis, Pap smears, and throat cultures to maintain health and to test, diagnose, treat, and prevent disease. Laboratory must be In-network. Genetic testing may require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related lab Cost-Sharing may apply.
Non-Preventive Labs	No charge	
Medical Benefit drugs	No charge	Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit. Prior authorization may be required.
Mental Health Wellness Exam	No charge	Annual mental health wellness examination performed by a Licensed Mental Health Professional Please Note: Your annual mental health wellness examination may also be provided by a PCP during your annual routine physical exam.
Medication-Assisted Treatment (MAT) services	No charge	Certain medication may require Prior Authorization.
Methadone treatment (dosing, counseling, labs)	No charge	
MinuteClinic®	No charge	A walk-in clinic accessible at select CVS locations.
Nutritional counseling		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related Cost-Sharing may apply.
Non-Preventive	$22 Copayment per visit	
Office Visits		
Primary Care Provider Preventive Care/screening/immunization /vaccine	No charge	Includes community health center visits
Primary Care Provider Non-Preventive office visit	No charge	Includes community health center visits
Specialist	$22 Copayment per visit	Includes community health center visits
Organ Transplant (including bone marrow transplants)	See "Inpatient Medical Care"	Requires Prior Authorization.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Outpatient Surgery (Outpatient Hospital/ambulatory surgery centers)		
Professional/Surgeon Services	No charge	Prior Authorization required for certain services. Please call us at **888.257.1985** for mor information.
Surgery services and Facility Fee	$125 Copayment per visit	
Pharmacy		
Retail drugs (up to 30-Day supply)		
• Tier 1 (primarily generic focused)	$12.50 Copayment	See Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost-Share. Refer to Formulary for a complete list.
• Tier 2 (includes some non-preferred generics and preferred brands)	$25 Copayment	
• Tier 3 (includes high-cost generics, and non-preferred brands and specialty)	$50 Copayment	
Mail-order drugs (up to 90-Day supply)		
• Tier 1 (Generic)	$25 Copayment	See Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost-Share. Refer to Formulary for a complete list.
• Tier 2 (Preferred Brands)	$50 Copayment	
• Tier 3 (Non-preferred Brands and Specialty)	$100 Copayment	
Podiatry	$22 Copayment per visit	Non-routine podiatry services covered when medically necessary. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot.
Prenatal care		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related Cost-Sharing may apply.
Non-Preventive	Related office visit or lab Cost-Sharing may apply	
Radiation Therapy	No charge	May require Prior Authorization
Reconstructive Surgery and Procedures	See "Outpatient Surgery"	Please see the "Covered Services" section of the *Tufts Health Direct Member Handbook* for limitations. May require Prior Authorization.
Rehabilitation Hospital or Chronic Disease Hospital	$250 Copayment per stay	Maximum of 60 Days total per Member per Benefit Year. May require Prior Authorization.

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Rehabilitative Services (Physical, Occupational, Speech Therapy)	$20 Copayment per visit	Maximum of 60 visits total combined Rehabilitative Physical and Occupational Therapy per Member per Benefit Year. No limit on Speech Therapy. Physical Therapy and Occupational Therapy require a Prior Authorization after initial evaluation and 11 visits. Speech Therapy requires Prior Authorization after visit 30.
Skilled Nursing Facility	No charge	Maximum of 100 Days total per Member per Benefit Year. Prior Authorization required.
Substance Use		
Substance Use Treatment Programs	Related Outpatient or Inpatient Cost-Sharing may apply	Please see the "Covered Behavioral Health (mental health and/or substance use) services" section of the *Tufts Health Direct Member Handbook* for more information about these services.
Recovery Coaches and Peer Specialist	No charge	Must be part of a licensed behavioral health treatment program, such as a licensed mental health clinic, substance use disorder clinic, or outpatient hospital clinic and under supervision of a licensed clinician, such as a licensed social worker, registered nurse, or clinical psychologist
Telehealth	Related Outpatient Medical Care Cost-Sharing may apply	Please ask your Providers' office for information on telehealth availability and access.
Urgent Care	$22 Copayment per visit	You must visit a UCC in our Service Area [(all of Massachusetts EXCEPT Dukes and Nantucket Counties)] that is in our Network to be covered for services. In our Service Area, if you obtain services at an Out-of-network UCC or at a UCC in an Out-of-network Hospital, you will not be covered. Outside of our Service Area, Free-standing Urgent Care Centers (UCC) are covered at Out-of-network Provider sites, including Hospitals and clinics. Cost-Share may vary depending on place of service.
Weight Loss Programs	No charge for 3 months of membership fees for a qualified program	You must be a Tufts Health Direct Member for three months and participate in a qualified weight loss program for at least three consecutive months. Each Member on a family Plan can request a weight loss program reimbursement once per Benefit Year. Must complete a Weight Loss Programs reimbursement form. See the *Tufts Health Direct Member Handbook* for more information on limitations.

Services not covered

See the section "Services not covered" in the *Tufts Health Direct Member Handbook* for the list of services not covered.

Direct Platinum

Benefit and Cost-Sharing Summary

This Benefit and Cost-Sharing Summary gives you information about your Tufts Health Direct Covered Services and costs you may have to pay. Make sure you review the services you are eligible for under the Benefit and Cost-Sharing Summary for your specific Plan Level. To see which Tufts Health Direct Plan Level you have, check your Tufts Health Plan Member ID Card.

Your Tufts Health Direct Plan may also have a Deductible. A Deductible is the amount you pay for certain Covered Services in a Benefit Year before your Tufts Health Direct Plan will begin to pay for those Covered Services. You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document.

This Summary gives you a general understanding of your benefits. If you want more information about your benefits and capitalized terms, see your *Tufts Health Direct Member Handbook*.

You must go to Providers (doctors, Hospitals, and other health care professionals) who are part of the Tufts Health Direct Provider Network to get services. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal. Services are only covered with In-network Providers, except for Emergency care and out of the Service Area Urgent Care.

Out-of-network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. [Service Area is all of Massachusetts EXCEPT Dukes and Nantucket Counties.]

Always check for the most up-to-date In-network Provider information. If you have questions about your Tufts Health Direct benefits or you need help locating an In-network Provider, call us at **888.257.1985** (TTY: 711).

ANNUAL DEDUCTIBLE	
Individual	$0
Family	$0
ANNUAL OUT-OF-POCKET MAXIMUM	
Individual	$3,000
Family	$6,000

Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The family Deductible and Out-of-pocket Maximum on this Plan have embedded individual Deductibles and Out-of-pocket Maximums, meaning the individual Deductible and Out-of-pocket Maximum above applies to each individual member of the family. This ensures that no single Member on a family Plan will ever have to satisfy the full family Deductible or Out-of-pocket Maximum on their own. Once any combination of family members meets the family Deductible and/or Out-of-pocket Maximum, the entire family is considered to have met the Deductible and/or Out-of-pocket Maximum.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Emergency Room Care	$150 Copayment per visit	Notification required within 48 hours, if admitted to the Hospital. Copayment waived, if admitted.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Abortion Services	No charge	
Acupuncture	$40 Copayment per visit	
Allergy testing	$40 Copayment per visit	Covered for up to 200 allergy tests per benefit year when administered by an In-Network provider. No prior authorization required.
Allergy treatments (Injections)	$10 Copayment per visit	Allergy immunotherapy covered as part of the pharmacy prescription benefit may require prior authorization and have separate pharmacy Cost-Sharing responsibility.
Ambulance	No charge	Emergency transport covered without Prior Authorization; non-Emergency ambulance transport may be covered with Prior Authorization.
Autism Spectrum Disorder		
Applied Behavioral Analysis (ABA)	$20 Copayment per visit	Requires Prior Authorization. Includes assessments, evaluations, testing, and treatment; covered in home, Outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst for treatment of Autism Spectrum Disorder.
Habilitative and Rehabilitative Services (Physical, Occupational, Speech Therapy)	$40 Copayment per visit	Physical, occupational, and speech therapy benefit limitations do not apply.
Breastfeeding Services	No charge	Includes lactation consultants.
Breast Pumps	20% Coinsurance	Covered for the purchase of a manual or electric pump or the rental of a hospital-grade pump when deemed appropriate by the ordering provider in accordance with the Preventive Services Policy. Limit of one pump per pregnancy. No Prior Authorization required. Prescription required. Pump must be obtained from contracting DME provider. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related DME Cost-Sharing may apply.
Cardiac Rehabilitation	$40 Copayment per visit	
Chemotherapy Administration	No charge	
Chiropractic Care	$40 Copayment per visit	

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Cleft Palate/Cleft Lip Care	No charge Additional cost-sharing may apply based on place of service.	Covered for Members under the age of 18. Includes medical, dental, oral, and facial surgery, follow-up, and related services.
Clinical Trials (Qualified)	Based on place of service	Routine patient care services covered for Members in a qualified clinical trial pursuant to state and federal mandates.
Dental, Accidental	Based on place of service	Coverage for services related to teeth is limited to the emergency treatment of accidental injury to sound, natural and permanent teeth when caused by a source external to the mouth.
Dental Care (Pediatric Only), Non-Emergency (Delta Dental)		
Type I Services: Preventive & Diagnostic	No charge	Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age. Medically Necessary orthodontia requires Prior Authorization. Members are eligible for pediatric services until the last day of the month in which they turn 19 years old. More information about pediatric dental is available in the Covered Services section of the *Tufts Health Direct Member Handbook*. Please call Delta Dental at 800.872.0500 for more information.
Type II Services: Basic Covered Services	25% Coinsurance	
Type III Services: Major Restorative Services	50% Coinsurance	
Type IV Services: Orthodontia (only as Medically Necessary)	50% Coinsurance	
Diabetes Education		
Primary Care Provider Non-Preventive office visit	$20 Copayment per visit	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit Cost-Sharing may apply. No charge for the Good Measures program available to Direct Members.
Specialist	$40 Copayment per visit	
Diagnostic Testing (including sleep studies outside of an Inpatient setting)	Related office visit or Inpatient Copayment/Cost-Share may be required	Sleep studies require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, Cost-Sharing may apply based on type and place of service.
Dialysis Services	No charge	
Disease Management Programs • Asthma • Diabetes • Chronic Obstructive Pulmonary Disease (COPD) • Congestive-Heart Failure	No charge	If you have any of these conditions, please contact us at **888.257.1985** to discuss our disease management programs.

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Durable Medical Equipment (DME) • Medical Supplies • Orthotics • Oxygen and respiratory therapy equipment • Prosthetics • Wigs	20% Coinsurance	Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs. Prior Authorization is required for certain services, including prosthetic orthotics (see list at https://tuftshealthplan.com/documents/providers/guides/thpp-dme-pa-quick-reference-guide).
Early Intervention Services	No charge	Covered for Members up to age 3; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention Specialist.
Eye Care (Vision Care) Visits		
Routine Visit	$20 Copayment per visit	Pediatric services for members under 19 years of age: Coverage for routine eye exams once every 12 months; Eyeglasses covered once every 12 months Collection frames only or $150 allowance + 20% off expense beyond allowance. Members are eligible for pediatric services until the last day of the month in which they turn 19 years old. Adult Services for Members 19 years of age or older: Coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics. You must receive routine eye examinations from a Provider in the EyeMed Vision Care Select Network in order to obtain coverage for these services. Call EyeMed at 866.504.5908 for the names of EyeMed Select Providers.
Eye Care (Vision Care) Non-Routine Visit	$40 Copayment per visit	For non-routine vision services, please visit tuftshealthplan.com/find-a-doctor.
Family-planning Services		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit or lab Cost-Sharing may apply.
Non-Preventive	Related office visit or lab Cost-Sharing may apply	
Fitness Center Reimbursement	Covered for 3 months	Covered for 3 months of membership at a standard fitness center; excludes initiation fees. This benefit is available to Members once every Benefit Year after being a Member for 4 months. See the *Tufts Health Direct Member Handbook* for more information on limitations. Must complete a Fitness Center Reimbursement form.

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Habilitative Services (Physical, Occupational, Speech Therapy)	$40 Copayment per visit	Maximum of 60 visits total combined Habilitative Physical and Occupational Therapy per Member per Benefit Year. No limit on Speech Therapy. Physical Therapy and Occupational Therapy require a Prior Authorization after initial evaluation and 11 visits. Speech Therapy requires Prior Authorization after visit 30.
Hearing Aids	20% Coinsurance	Covered for Members 21 and younger. This includes the cost of one hearing aid per hearing-impaired ear up to $2,000 per ear every 36 months. This includes both the amount Tufts Health Direct pays and the applicable Member Cost-Share as listed in this document. Related services and supplies do not count toward the $2,000 limit.
Home Health Care	No charge	Prior Authorization is required for all home care services and disciplines
Hospice	No charge	Requires Prior Authorization
Imaging Services (Radiology)		
Preventive	No charge	Advanced imaging services require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit or lab Cost-Sharing may apply.
X-ray Services and Diagnostic	No charge	
Advanced: MRI, CT, PET	$150 Copayment	
Individual therapy/Counseling	$20 Copayment per visit	No visit limits and no Prior Authorization required for Outpatient Behavioral Health therapy visits or substance use treatment.
Infertility Treatment	Cost-share varies based on type of service	Requires Prior Authorization. Medically necessary services may include Inpatient Medical Care, Outpatient Surgery, Laboratory Services, Imaging (x-ray/diagnostic), Office Visits (Specialist), Medical Drugs and/or Prescription Drugs.
Inpatient Medical Care		
Facility fee (includes room and board for maternity/surgery/radiology imaging services and lab work)	$500 Copayment per stay	No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission. Elective admissions require Prior Authorization and notification 5 business days before admission. Sleep studies may require Prior Authorization.
Professional fee	No charge	
Inpatient Mental Health and/or Substance Use	$500 Copayment per stay	No Prior Authorization required for admission. Notification to the Plan is required within 48 hours of the Inpatient admission.
Intensive community based acute treatment (ICBAT) for Children and adolescents	No charge	No Prior Authorization required for admission. Notification to the Plan is required within 48 hours of the Inpatient admission.

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Intermediate care, including Behavioral Health services for children and adolescents	No charge	Prior Authorization is only required for certain Behavioral Health services for children and adolescents. Please see the "Covered Services" section of the *Tufts Health Direct Member Handbook* for more information about these services.
Laboratory Outpatient and Professional Services		
Preventive Labs	No charge	Includes blood tests, urinalysis, Pap smears, and throat cultures to maintain health and to test, diagnose, treat, and prevent disease. Laboratory must be In-network. Genetic testing may require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related lab Cost-Sharing may apply.
Non-Preventive Labs	No charge	
Medical Benefit drugs	No charge	Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit. Prior authorization may be required.
Medication-Assisted Treatment (MAT) services	No charge	Certain medication may require Prior Authorization.
Mental Health Wellness Exam	No charge	Annual mental health wellness examination performed by a Licensed Mental Health Professional Please Note: Your annual mental health wellness examination may also be provided by a PCP during your annual routine physical exam.
Methadone treatment (dosing, counseling, labs)	No charge	
MinuteClinic®	$20 Copayment per visit	A walk-in clinic accessible at select CVS locations.
Nutritional counseling		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related Cost-Sharing may apply.
Non-Preventive	$40 Copayment per visit	
Office Visits		
Primary Care Provider Preventive Care/screening/immunization /vaccine	No charge	Includes community health center visits
Primary Care Provider Non-Preventive office visit	$20 Copayment per visit	Includes community health center visits
Specialist	$40 Copayment per visit	Includes community health center visits
Organ Transplant (including bone marrow transplants)	See "Inpatient Medical Care"	Requires Prior Authorization.

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Outpatient Surgery (Outpatient Hospital/ambulatory surgery centers)		
Professional/Surgeon Services	No charge	Prior Authorization required for certain services. Please call us at **888.257.1985** for mor information.
Surgery services and Facility Fee	$250 Copayment per visit	
Pharmacy		
Retail drugs (up to 30-Day supply)		
• Tier 1 (primarily generic focused)	$10 Copayment	See Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost-Share. Refer to Formulary for a complete list.
• Tier 2 (includes some non-preferred generics and preferred brands)	$25 Copayment	
• Tier 3 (includes high-cost generics, and non-preferred brands and specialty)	$50 Copayment	
Mail-order drugs (up to 90-Day supply)		
• Tier 1 (Generic)	$20 Copayment	See Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost-Share. Refer to Formulary for a complete list.
• Tier 2 (Preferred Brands)	$50 Copayment	
• Tier 3 (Non-preferred Brands and Specialty)	$150 Copayment	
Podiatry	$40 Copayment per visit	Non-routine podiatry services covered when medically necessary. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot.
Prenatal care		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related Cost-Sharing may apply.
Non-Preventive	Related office visit or lab Cost-Sharing may apply	
Radiation Therapy	No charge	May require Prior Authorization
Reconstructive Surgery and Procedures	See "Outpatient Surgery"	Please see the "Covered Services" section of the *Tufts Health Direct Member Handbook* for limitations. May require Prior Authorization.
Rehabilitation Hospital or Chronic Disease Hospital	$500 Copayment per stay	Maximum of 60 Days total per Member per Benefit Year. May require Prior Authorization.

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Rehabilitative Services (Physical, Occupational, Speech Therapy)	$40 Copayment per visit	Maximum of 60 visits total combined Rehabilitative Physical and Occupational Therapy per Member per Benefit Year. No limit on Speech Therapy. Physical Therapy and Occupational Therapy require a Prior Authorization after initial evaluation and 11 visits. Speech Therapy requires Prior Authorization after visit 30.
Skilled Nursing Facility	$500 Copayment per stay	Maximum of 100 Days total per Member per Benefit Year. Prior Authorization required.
Substance Use		
Substance Use Treatment Programs	Related Outpatient or Inpatient Cost-Sharing may apply	Please see the "Covered Behavioral Health (mental health and/or substance use) services" section of the *Tufts Health Direct Member Handbook* for more information about these services.
Recovery Coaches and Peer Specialist	No charge	Must be part of a licensed behavioral health treatment program, such as a licensed mental health clinic, substance use disorder clinic, or outpatient hospital clinic and under supervision of a licensed clinician, such as a licensed social worker, registered nurse, or clinical psychologist
Telehealth	Related Outpatient Medical Care Cost-Sharing may apply	Please ask your Providers' office for information on telehealth availability and access.
Urgent Care	$40 Copayment per visit	You must visit a UCC in our Service Area [(all of Massachusetts EXCEPT Dukes and Nantucket Counties)] that is in our Network to be covered for services. In our Service Area, if you obtain services at an Out-of-network UCC or at a UCC in an Out-of-network Hospital, you will not be covered. Outside of our Service Area, Free-standing Urgent Care Centers (UCC) are covered at Out-of-network Provider sites, including Hospitals and clinics. Cost-Share may vary depending on place of service.
Weight Loss Programs	No charge for 3 months of membership fees for a qualified program	You must be a Tufts Health Direct Member for three months and participate in a qualified weight loss program for at least three consecutive months. Each Member on a family Plan can request a weight loss program reimbursement once per Benefit Year. Must complete a Weight Loss Programs reimbursement form. See the *Tufts Health Direct Member Handbook* for more information on limitations.

Services not covered

See the section "Services not covered" in the *Tufts Health Direct Member Handbook* for the list of services not covered.

Direct Gold

Benefit and Cost-Sharing Summary

This Benefit and Cost-Sharing Summary gives you information about your Tufts Health Direct Covered Services and costs you may have to pay. Make sure you review the services you are eligible for under the Benefit and Cost-Sharing Summary for your specific Plan Level. To see which Tufts Health Direct Plan Level you have, check your Tufts Health Plan Member ID Card.

Your Tufts Health Direct Plan may also have a Deductible. A Deductible is the amount you pay for certain Covered Services in a Benefit Year before your Tufts Health Direct Plan will begin to pay for those Covered Services. You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document.

This Summary gives you a general understanding of your benefits. If you want more information about your benefits and capitalized terms, see your *Tufts Health Direct Member Handbook*.

You must go to Providers (doctors, Hospitals, and other health care professionals) who are part of the Tufts Health Direct Provider Network to get services. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal. Services are only covered with In-network Providers, except for Emergency care and out of the Service Area Urgent Care.

Out-of-network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. [Service Area is all of Massachusetts EXCEPT Dukes and Nantucket Counties.]

Always check for the most up-to-date In-network Provider information. If you have questions about your Tufts Health Direct benefits or you need help locating an In-network Provider, call us at **888.257.1985** (TTY: 711).

ANNUAL DEDUCTIBLE	
Individual	$0
Family	$0
ANNUAL OUT-OF-POCKET MAXIMUM	
Individual	$5,000
Family	$10,000

Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The family Deductible and Out-of-pocket Maximum on this Plan have embedded individual Deductibles and Out-of-pocket Maximums, meaning the individual Deductible and Out-of-pocket Maximum above applies to each individual member of the family. This ensures that no single Member on a family Plan will ever have to satisfy the full family Deductible or Out-of-pocket Maximum on their own. Once any combination of family members meets the family Deductible and/or Out-of-pocket Maximum, the entire family is considered to have met the Deductible and/or Out-of-pocket Maximum.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Emergency Room Care	$350 Copayment per visit	Notification required within 48 hours, if admitted to the Hospital. Copayment waived, if admitted.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Abortion Services	No charge	
Acupuncture	$55 Copayment per visit	
Allergy testing	$55 Copayment per visit	Covered for up to 200 allergy tests per benefit year when administered by an In-Network provider. No prior authorization required.
Allergy treatments (Injections)	$10 Copayment per visit	Allergy immunotherapy covered as part of the pharmacy prescription benefit may require prior authorization and have separate pharmacy Cost-Sharing responsibility.
Ambulance	No charge	Emergency transport covered without Prior Authorization; non-Emergency ambulance transport may be covered with Prior Authorization.
Autism Spectrum Disorder		
Applied Behavioral Analysis (ABA)	$30 Copayment per visit	Requires Prior Authorization. Includes assessments, evaluations, testing, and treatment; covered in home, Outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst for treatment of Autism Spectrum Disorder.
Habilitative and Rehabilitative Services (Physical, Occupational, Speech Therapy)	$55 Copayment per visit	Physical, occupational, and speech therapy benefit limitations do not apply.
Breastfeeding Services	No charge	Includes lactation consultants.
Breast Pumps	20% Coinsurance	Covered for the purchase of a manual or electric pump or the rental of a hospital-grade pump when deemed appropriate by the ordering provider in accordance with the Preventive Services Policy. Limit of one pump per pregnancy. No Prior Authorization required. Prescription required. Pump must be obtained from contracting DME provider. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related DME Cost-Sharing may apply.
Cardiac Rehabilitation	$55 Copayment per visit	
Chemotherapy Administration	No charge	
Chiropractic Care	$55 Copayment per visit	

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Cleft Palate/Cleft Lip Care	No charge Additional cost-sharing may apply based on place of service.	Covered for Members under the age of 18. Includes medical, dental, oral, and facial surgery, follow-up, and related services.
Clinical Trials (Qualified)	Based on place of service	Routine patient care services covered for Members in a qualified clinical trial pursuant to state and federal mandates.
Dental, Accidental	Based on place of service	Coverage for services related to teeth is limited to the emergency treatment of accidental injury to sound, natural and permanent teeth when caused by a source external to the mouth.
Dental Care (Pediatric Only), Non-Emergency (Delta Dental)		
Type I Services: Preventive & Diagnostic	No charge	Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age. Medically Necessary orthodontia requires Prior Authorization. Members are eligible for pediatric services until the last day of the month in which they turn 19 years old. More information about pediatric dental is available in the Covered Services section of the *Tufts Health Direct Member Handbook*. Please call Delta Dental at 800.872.0500 for more information.
Type II Services: Basic Covered Services	25% Coinsurance	
Type III Services: Major Restorative Services	50% Coinsurance	
Type IV Services: Orthodontia (only as Medically Necessary)	50% Coinsurance	
Diabetes Education		
Primary Care Provider Non-Preventive office visit	$30 Copayment per visit	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit Cost-Sharing may apply. No charge for the Good Measures program available to Direct Members.
Specialist	$55 Copayment per visit	
Diagnostic Testing (including sleep studies outside of an Inpatient setting)	Related office visit or Inpatient Copayment/Cost-Share may be required	Sleep studies require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, Cost-Sharing may apply based on type and place of service.
Dialysis Services	No charge	
Disease Management Programs • Asthma • Diabetes • Chronic Obstructive Pulmonary Disease (COPD) • Congestive-Heart Failure	No charge	If you have any of these conditions, please contact us at **888.257.1985** to discuss our disease management programs.

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Durable Medical Equipment (DME) • Medical Supplies • Orthotics • Oxygen and respiratory therapy equipment • Prosthetics • Wigs	20% Coinsurance	Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs. Prior Authorization is required for certain services, including prosthetic orthotics (see list at https://tuftshealthplan.com/documents/providers/guides/thpp-dme-pa-quick-reference-guide).
Early Intervention Services	No charge	Covered for Members up to age 3; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention Specialist.
Eye Care (Vision Care) Visits		
Routine Visit	$30 Copayment per visit	Pediatric services for members under 19 years of age: Coverage for routine eye exams once every 12 months; Eyeglasses covered once every 12 months Collection frames only or $150 allowance + 20% off expense beyond allowance. Members are eligible for pediatric services until the last day of the month in which they turn 19 years old. Adult Services for Members 19 years of age or older: Coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics. You must receive routine eye examinations from a Provider in the EyeMed Vision Care Select Network in order to obtain coverage for these services. Call EyeMed at 866.504.5908 for the names of EyeMed Select Providers.
Eye Care (Vision Care) Non-Routine Visit	$55 Copayment per visit	For non-routine vision services, please visit tuftshealthplan.com/find-a-doctor.
Family-planning Services		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit or lab Cost-Sharing may apply.
Non-Preventive	Related office visit or lab Cost-Sharing may apply	
Fitness Center Reimbursement	Covered for 3 months	Covered for 3 months of membership at a standard fitness center; excludes initiation fees. This benefit is available to Members once every Benefit Year after being a Member for 4 months. See the *Tufts Health Direct Member Handbook* for more information on limitations. Must complete a Fitness Center Reimbursement form.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Habilitative Services (Physical, Occupational, Speech Therapy)	$55 Copayment per visit	Maximum of 60 visits total combined Habilitative Physical and Occupational Therapy per Member per Benefit Year. No limit on Speech Therapy. Physical Therapy and Occupational Therapy require a Prior Authorization after initial evaluation and 11 visits. Speech Therapy requires Prior Authorization after visit 30.
Hearing Aids	20% Coinsurance	Covered for Members 21 and younger. This includes the cost of one hearing aid per hearing-impaired ear up to $2,000 per ear every 36 months. This includes both the amount Tufts Health Direct pays and the applicable Member Cost-Share as listed in this document. Related services and supplies do not count toward the $2,000 limit.
Home Health Care	No charge	Prior Authorization is required for all home care services and disciplines
Hospice	No charge	Requires Prior Authorization
Imaging Services (Radiology)		
Preventive	No charge	Advanced imaging services require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit or lab Cost-Sharing may apply.
X-ray Services and Diagnostic	$75 Copayment	
Advanced: MRI, CT, PET	$250 Copayment	
Individual therapy/Counseling	$30 Copayment per visit	No visit limits and no Prior Authorization required for Outpatient Behavioral Health therapy visits or substance use treatment.
Infertility Treatment	Cost-share varies based on type of service	Requires Prior Authorization. Medically necessary services may include Inpatient Medical Care, Outpatient Surgery, Laboratory Services, Imaging (x-ray/diagnostic), Office Visits (Specialist), Medical Drugs and/or Prescription Drugs.
Inpatient Medical Care		
Facility fee (includes room and board for maternity/surgery/radiology imaging services and lab work)	$750 Copayment per stay	No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission. Elective admissions require Prior Authorization and notification 5 business days before admission. Sleep studies may require Prior Authorization.
Professional fee	No charge	
Inpatient Mental Health and/or Substance Use	$750 Copayment per stay	No Prior Authorization required for admission. Notification to the Plan is required within 48 hours of the Inpatient admission.
Intensive community based acute treatment (ICBAT) for Children and adolescents	No charge	No Prior Authorization required for admission. Notification to the Plan is required within 48 hours of the Inpatient admission.

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Intermediate care, including Behavioral Health services for children and adolescents	No charge	Prior Authorization is only required for certain Behavioral Health services for children and adolescents. Please see the "Covered Services" section of the *Tufts Health Direct Member Handbook* for more information about these services.
Laboratory Outpatient and Professional Services		
Preventive Labs	No charge	Includes blood tests, urinalysis, Pap smears, and throat cultures to maintain health and to test, diagnose, treat, and prevent disease. Laboratory must be In-network. Genetic testing may require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related lab Cost-Sharing may apply.
Non-Preventive Labs	$25 Copayment	
Medical Benefit drugs	No charge	Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit. Prior authorization may be required.
Medication-Assisted Treatment (MAT) services	No charge	Certain medication may require Prior Authorization.
Mental Health Wellness Exam	No charge	Annual mental health wellness examination performed by a Licensed Mental Health Professional Please Note: Your annual mental health wellness examination may also be provided by a PCP during your annual routine physical exam.
Methadone treatment (dosing, counseling, labs)	No charge	
MinuteClinic®	$30 Copayment per visit	A walk-in clinic accessible at select CVS locations.
Nutritional counseling		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related Cost-Sharing may apply.
Non-Preventive	$55 Copayment per visit	
Office Visits		
Primary Care Provider Preventive Care/screening/immunization /vaccine	No charge	Includes community health center visits
Primary Care Provider Non-Preventive office visit	$30 Copayment per visit	Includes community health center visits
Specialist	$55 Copayment per visit	Includes community health center visits
Organ Transplant (including bone marrow transplants)	See "Inpatient Medical Care"	Requires Prior Authorization.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Outpatient Surgery (Outpatient Hospital/ambulatory surgery centers)		
Professional/Surgeon Services	No charge	Prior Authorization required for certain services. Please call us at **888.257.1985** for mor information.
Surgery services and Facility Fee	$500 Copayment per visit	
Pharmacy		
Retail drugs (up to 30-Day supply)		
• Tier 1 (primarily generic focused)	$30 Copayment	See Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost-Share. Refer to Formulary for a complete list.
• Tier 2 (includes some non-preferred generics and preferred brands)	$60 Copayment	
• Tier 3 (includes high-cost generics, and non-preferred brands and specialty)	$90 Copayment	
Mail-order drugs (up to 90-Day supply)		
• Tier 1 (Generic)	$60 Copayment	See Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost-Share. Refer to Formulary for a complete list.
• Tier 2 (Preferred Brands)	$120 Copayment	
• Tier 3 (Non-preferred Brands and Specialty)	$270 Copayment	
Podiatry	$55 Copayment per visit	Non-routine podiatry services covered when medically necessary. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot.
Prenatal care		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related Cost-Sharing may apply.
Non-Preventive	Related office visit or lab Cost-Sharing may apply	
Radiation Therapy	No charge	May require Prior Authorization
Reconstructive Surgery and Procedures	See "Outpatient Surgery"	Please see the "Covered Services" section of the *Tufts Health Direct Member Handbook* for limitations. May require Prior Authorization.
Rehabilitation Hospital or Chronic Disease Hospital	$750 Copayment per stay	Maximum of 60 Days total per Member per Benefit Year. May require Prior Authorization.

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Rehabilitative Services (Physical, Occupational, Speech Therapy)	$55 Copayment per visit	Maximum of 60 visits total combined Rehabilitative Physical and Occupational Therapy per Member per Benefit Year. No limit on Speech Therapy. Physical Therapy and Occupational Therapy require a Prior Authorization after initial evaluation and 11 visits. Speech Therapy requires Prior Authorization after visit 30.
Skilled Nursing Facility	$750 Copayment per stay	Maximum of 100 Days total per Member per Benefit Year. Prior Authorization required.
Substance Use		
Substance Use Treatment Programs	Related Outpatient or Inpatient Cost-Sharing may apply	Please see the "Covered Behavioral Health (mental health and/or substance use) services" section of the *Tufts Health Direct Member Handbook* for more information about these services.
Recovery Coaches and Peer Specialist	No charge	Must be part of a licensed behavioral health treatment program, such as a licensed mental health clinic, substance use disorder clinic, or outpatient hospital clinic and under supervision of a licensed clinician, such as a licensed social worker, registered nurse, or clinical psychologist
Telehealth	Related Outpatient Medical Care Cost-Sharing may apply	Please ask your Providers' office for information on telehealth availability and access.
Urgent Care	$55 Copayment per visit	You must visit a UCC in our Service Area [(all of Massachusetts EXCEPT Dukes and Nantucket Counties)] that is in our Network to be covered for services. In our Service Area, if you obtain services at an Out-of-network UCC or at a UCC in an Out-of-network Hospital, you will not be covered. Outside of our Service Area, Free-standing Urgent Care Centers (UCC) are covered at Out-of-network Provider sites, including Hospitals and clinics. Cost-Share may vary depending on place of service.
Weight Loss Programs	No charge for 3 months of membership fees for a qualified program	You must be a Tufts Health Direct Member for three months and participate in a qualified weight loss program for at least three consecutive months. Each Member on a family Plan can request a weight loss program reimbursement once per Benefit Year. Must complete a Weight Loss Programs reimbursement form. See the *Tufts Health Direct Member Handbook* for more information on limitations.

Services not covered

See the section "Services not covered" in the *Tufts Health Direct Member Handbook* for the list of services not covered.

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Benefit and Cost-Sharing Summary

This Benefit and Cost-Sharing Summary gives you information about your Tufts Health Direct Covered Services and costs you may have to pay. Make sure you review the services you are eligible for under the Benefit and Cost-Sharing Summary for your specific Plan Level. To see which Tufts Health Direct Plan Level you have, check your Tufts Health Plan Member ID Card.

Your Tufts Health Direct Plan may also have a Deductible. A Deductible is the amount you pay for certain Covered Services in a Benefit Year before your Tufts Health Direct Plan will begin to pay for those Covered Services. You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document.

This Summary gives you a general understanding of your benefits. If you want more information about your benefits and capitalized terms, see your *Tufts Health Direct Member Handbook*.

You must go to Providers (doctors, Hospitals, and other health care professionals) who are part of the Tufts Health Direct Provider Network to get services. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal. Services are only covered with In-network Providers, except for Emergency care and out of the Service Area Urgent Care.

Out-of-network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. [Service Area is all of Massachusetts EXCEPT Dukes and Nantucket Counties.]

Always check for the most up-to-date In-network Provider information. If you have questions about your Tufts Health Direct benefits or you need help locating an In-network Provider, call us at **888.257.1985** (TTY: 711).

ANNUAL DEDUCTIBLE	
Individual	$1,600 (medical) | $180 (pharmacy)
Family	$3,200 (medical) | $360 (pharmacy)
ANNUAL OUT-OF-POCKET MAXIMUM	
Individual	$6,000
Family	$12,000

Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The family Deductible and Out-of-pocket Maximum on this Plan have embedded individual Deductibles and Out-of-pocket Maximums, meaning the individual Deductible and Out-of-pocket Maximum above applies to each individual member of the family. This ensures that no single Member on a family Plan will ever have to satisfy the full family Deductible or Out-of-pocket Maximum on their own. Once any combination of family members meets the family Deductible and/or Out-of-pocket Maximum, the entire family is considered to have met the Deductible and/or Out-of-pocket Maximum.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Emergency Room Care	$400 Copayment per visit after Deductible	Notification required within 48 hours, if admitted to the Hospital. Copayment waived, if admitted.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Abortion Services	No charge	
Acupuncture	$55 Copayment per visit	
Allergy testing	$55 Copayment per visit	Covered for up to 200 allergy tests per benefit year when administered by an In-Network provider. No prior authorization required.
Allergy treatments (Injections)	$10 Copayment per visit after Deductible	Allergy immunotherapy covered as part of the pharmacy prescription benefit may require prior authorization and have separate pharmacy Cost-Sharing responsibility.
Ambulance	No charge after Deductible	Emergency transport covered without Prior Authorization; non-Emergency ambulance transport may be covered with Prior Authorization.
Autism Spectrum Disorder		
Applied Behavioral Analysis (ABA)	$35 Copayment per visit	Requires Prior Authorization. Includes assessments, evaluations, testing, and treatment; covered in home, Outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst for treatment of Autism Spectrum Disorder.
Habilitative and Rehabilitative Services (Physical, Occupational, Speech Therapy)	$55 Copayment per visit	Physical, occupational, and speech therapy benefit limitations do not apply.
Breastfeeding Services	No charge	Includes lactation consultants.
Breast Pumps	20% Coinsurance after Deductible	Covered for the purchase of a manual or electric pump or the rental of a hospital-grade pump when deemed appropriate by the ordering provider in accordance with the Preventive Services Policy. Limit of one pump per pregnancy. No Prior Authorization required. Prescription required. Pump must be obtained from contracting DME provider. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related DME Cost-Sharing may apply.
Cardiac Rehabilitation	$55 Copayment per visit	
Chemotherapy Administration	No charge after Deductible	
Chiropractic Care	$55 Copayment per visit	

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Cleft Palate/Cleft Lip Care	No charge after Deductible Additional cost-sharing may apply based on place of service.	Covered for Members under the age of 18. Includes medical, dental, oral, and facial surgery, follow-up, and related services.
Clinical Trials (Qualified)	Based on place of service	Routine patient care services covered for Members in a qualified clinical trial pursuant to state and federal mandates.
Dental, Accidental	Based on place of service	Coverage for services related to teeth is limited to the emergency treatment of accidental injury to sound, natural and permanent teeth when caused by a source external to the mouth.
Dental Care (Pediatric Only), Non-Emergency (Delta Dental)		
Type I Services: Preventive & Diagnostic	No charge after Deductible	Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age. Medically Necessary orthodontia requires Prior Authorization. Members are eligible for pediatric services until the last day of the month in which they turn 19 years old. More information about pediatric dental is available in the Covered Services section of the *Tufts Health Direct Member Handbook*. Please call Delta Dental at 800.872.0500 for more information.
Type II Services: Basic Covered Services	25% Coinsurance after Deductible	
Type III Services: Major Restorative Services	50% Coinsurance after Deductible	
Type IV Services: Orthodontia (only as Medically Necessary)	50% Coinsurance after Deductible	
Diabetes Education		
Primary Care Provider Non-Preventive office visit	$35 Copayment per visit	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit Cost-Sharing may apply. No charge for the Good Measures program available to Direct Members.
Specialist	$55 Copayment per visit	
Diagnostic Testing (including sleep studies outside of an Inpatient setting)	Related office visit or Inpatient Copayment/Cost-Share may be required	Sleep studies require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, Cost-Sharing may apply based on type and place of service.
Dialysis Services	No charge after Deductible	
Disease Management Programs • Asthma • Diabetes • Chronic Obstructive Pulmonary Disease (COPD) • Congestive-Heart Failure	No charge	If you have any of these conditions, please contact us at **888.257.1985** to discuss our disease management programs.

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Durable Medical Equipment (DME) • Medical Supplies • Orthotics • Oxygen and respiratory therapy equipment • Prosthetics • Wigs	20% Coinsurance after Deductible	Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs. Prior Authorization is required for certain services, including prosthetic orthotics (see list at https://tuftshealthplan.com/documents/providers/guides/thpp-dme-pa-quick-reference-guide).
Early Intervention Services	No charge	Covered for Members up to age 3; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention Specialist.
Eye Care (Vision Care) Visits		
Routine Visit	$35 Copayment per visit	Pediatric services for members under 19 years of age: Coverage for routine eye exams once every 12 months; Eyeglasses covered once every 12 months Collection frames only or $150 allowance + 20% off expense beyond allowance. Members are eligible for pediatric services until the last day of the month in which they turn 19 years old. Adult Services for Members 19 years of age or older: Coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics. You must receive routine eye examinations from a Provider in the EyeMed Vision Care Select Network in order to obtain coverage for these services. Call EyeMed at 866.504.5908 for the names of EyeMed Select Providers.
Eye Care (Vision Care) Non-Routine Visit	$55 Copayment per visit	For non-routine vision services, please visit tuftshealthplan.com/find-a-doctor.
Family-planning Services		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit or lab Cost-Sharing may apply.
Non-Preventive	Related office visit or lab Cost-Sharing may apply	
Fitness Center Reimbursement	Covered for 3 months	Covered for 3 months of membership at a standard fitness center; excludes initiation fees. This benefit is available to Members once every Benefit Year after being a Member for 4 months. See the *Tufts Health Direct Member Handbook* for more information on limitations. Must complete a Fitness Center Reimbursement form.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Habilitative Services (Physical, Occupational, Speech Therapy)	$55 Copayment per visit	Maximum of 60 visits total combined Habilitative Physical and Occupational Therapy per Member per Benefit Year. No limit on Speech Therapy. Physical Therapy and Occupational Therapy require a Prior Authorization after initial evaluation and 11 visits. Speech Therapy requires Prior Authorization after visit 30.
Hearing Aids	20% Coinsurance after Deductible	Covered for Members 21 and younger. This includes the cost of one hearing aid per hearing-impaired ear up to $2,000 per ear every 36 months. This includes both the amount Tufts Health Direct pays and the applicable Member Cost-Share as listed in this document. Related services and supplies do not count toward the $2,000 limit.
Home Health Care	No charge after Deductible	Prior Authorization is required for all home care services and disciplines
Hospice	No charge after Deductible	Requires Prior Authorization
Imaging Services (Radiology)		
Preventive	No charge	Advanced imaging services require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit or lab Cost-Sharing may apply.
X-ray Services and Diagnostic	$75 Copayment after Deductible	
Advanced: MRI, CT, PET	$300 Copayment after Deductible	
Individual therapy/Counseling	$35 Copayment per visit	No visit limits and no Prior Authorization required for Outpatient Behavioral Health therapy visits or substance use treatment.
Infertility Treatment	Cost-share varies based on type of service	Requires Prior Authorization. Medically necessary services may include Inpatient Medical Care, Outpatient Surgery, Laboratory Services, Imaging (x-ray/diagnostic), Office Visits (Specialist), Medical Drugs and/or Prescription Drugs.
Inpatient Medical Care		
Facility fee (includes room and board for maternity/surgery/radiology imaging services and lab work)	$750 Copayment per stay after Deductible	No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission. Elective admissions require Prior Authorization and notification 5 business days before admission. Sleep studies may require Prior Authorization.
Professional fee	No charge after Deductible	
Inpatient Mental Health and/or Substance Use	$750 Copayment per stay after Deductible	No Prior Authorization required for admission. Notification to the Plan is required within 48 hours of the Inpatient admission.
Intensive community based acute treatment (ICBAT) for Children and adolescents	No charge	No Prior Authorization required for admission. Notification to the Plan is required within 48 hours of the Inpatient admission.

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Intermediate care, including Behavioral Health services for children and adolescents	No charge	Prior Authorization is only required for certain Behavioral Health services for children and adolescents. Please see the "Covered Services" section of the *Tufts Health Direct Member Handbook* for more information about these services.
Laboratory Outpatient and Professional Services		
Preventive Labs	No charge	Includes blood tests, urinalysis, Pap smears, and throat cultures to maintain health and to test, diagnose, treat, and prevent disease. Laboratory must be In-network. Genetic testing may require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related lab Cost-Sharing may apply.
Non-Preventive Labs	$50 Copayment after Deductible	
Medical Benefit drugs	No charge after Deductible	Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit. Prior authorization may be required.
Medication-Assisted Treatment (MAT) services	No charge	Certain medication may require Prior Authorization.
Mental Health Wellness Exam	No charge	Annual mental health wellness examination performed by a Licensed Mental Health Professional Please Note: Your annual mental health wellness examination may also be provided by a PCP during your annual routine physical exam.
Methadone treatment (dosing, counseling, labs)	No charge	
MinuteClinic®	$35 Copayment per visit	A walk-in clinic accessible at select CVS locations.
Nutritional counseling		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related Cost-Sharing may apply.
Non-Preventive	$55 Copayment per visit	
Office Visits		
Primary Care Provider Preventive Care/screening/immunization /vaccine	No charge	Includes community health center visits
Primary Care Provider Non-Preventive office visit	$35 Copayment per visit	Includes community health center visits
Specialist	$55 Copayment per visit	Includes community health center visits
Organ Transplant (including bone marrow transplants)	See "Inpatient Medical Care"	Requires Prior Authorization.

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Outpatient Surgery (Outpatient Hospital/ambulatory surgery centers)		
Professional/Surgeon Services	No charge after Deductible	Prior Authorization required for certain services. Please call us at **888.257.1985** for mor information.
Surgery services and Facility Fee	$500 Copayment per visit after Deductible	
Pharmacy		
Retail drugs (up to 30-Day supply)		
• Tier 1 (primarily generic focused)	$25 Copayment	See Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost-Share. Refer to Formulary for a complete list.
• Tier 2 (includes some non-preferred generics and preferred brands)	$50 Copayment after Deductible	
• Tier 3 (includes high-cost generics, and non-preferred brands and specialty)	$125 Copayment after Deductible	
Mail-order drugs (up to 90-Day supply)		
• Tier 1 (Generic)	$50 Copayment	See Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost-Share. Refer to Formulary for a complete list.
• Tier 2 (Preferred Brands)	$100 Copayment after Deductible	
• Tier 3 (Non-preferred Brands and Specialty)	$375 Copayment after Deductible	
Podiatry	$55 Copayment per visit	Non-routine podiatry services covered when medically necessary. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot.
Prenatal care		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related Cost-Sharing may apply.
Non-Preventive	Related office visit or lab Cost-Sharing may apply	
Radiation Therapy	No charge after Deductible	May require Prior Authorization
Reconstructive Surgery and Procedures	See "Outpatient Surgery"	Please see the "Covered Services" section of the *Tufts Health Direct Member Handbook* for limitations. May require Prior Authorization.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Rehabilitation Hospital or Chronic Disease Hospital	$750 Copayment per stay after Deductible	Maximum of 60 Days total per Member per Benefit Year. May require Prior Authorization.
Rehabilitative Services (Physical, Occupational, Speech Therapy)	$55 Copayment per visit	Maximum of 60 visits total combined Rehabilitative Physical and Occupational Therapy per Member per Benefit Year. No limit on Speech Therapy. Physical Therapy and Occupational Therapy require a Prior Authorization after initial evaluation and 11 visits. Speech Therapy requires Prior Authorization after visit 30.
Skilled Nursing Facility	$750 Copayment per stay after Deductible	Maximum of 100 Days total per Member per Benefit Year. Prior Authorization required.
Substance Use		
Substance Use Treatment Programs	Related Outpatient or Inpatient Cost-Sharing may apply	Please see the "Covered Behavioral Health (mental health and/or substance use) services" section of the *Tufts Health Direct Member Handbook* for more information about these services.
Recovery Coaches and Peer Specialist	No charge	Must be part of a licensed behavioral health treatment program, such as a licensed mental health clinic, substance use disorder clinic, or outpatient hospital clinic and under supervision of a licensed clinician, such as a licensed social worker, registered nurse, or clinical psychologist
Telehealth	Related Outpatient Medical Care Cost-Sharing may apply	Please ask your Providers' office for information on telehealth availability and access.
Urgent Care	$55 Copayment per visit	You must visit a UCC in our Service Area [(all of Massachusetts EXCEPT Dukes and Nantucket Counties)] that is in our Network to be covered for services. In our Service Area, if you obtain services at an Out-of-network UCC or at a UCC in an Out-of-network Hospital, you will not be covered. Outside of our Service Area, Free-standing Urgent Care Centers (UCC) are covered at Out-of-network Provider sites, including Hospitals and clinics. Cost-Share may vary depending on place of service.
Weight Loss Programs	No charge for 3 months of membership fees for a qualified program	You must be a Tufts Health Direct Member for three months and participate in a qualified weight loss program for at least three consecutive months. Each Member on a family Plan can request a weight loss program reimbursement once per Benefit Year. Must complete a Weight Loss Programs reimbursement form. See the *Tufts Health Direct Member Handbook* for more information on limitations.

Services not covered

See the section "Services not covered" in the *Tufts Health Direct Member Handbook* for the list of services not covered.

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Benefit and Cost-Sharing Summary

This Benefit and Cost-Sharing Summary gives you information about your Tufts Health Direct Covered Services and costs you may have to pay. Make sure you review the services you are eligible for under the Benefit and Cost-Sharing Summary for your specific Plan Level. To see which Tufts Health Direct Plan Level you have, check your Tufts Health Plan Member ID Card.

Your Tufts Health Direct Plan may also have a Deductible. A Deductible is the amount you pay for certain Covered Services in a Benefit Year before your Tufts Health Direct Plan will begin to pay for those Covered Services. You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document.

This Summary gives you a general understanding of your benefits. If you want more information about your benefits and capitalized terms, see your *Tufts Health Direct Member Handbook*.

You must go to Providers (doctors, Hospitals, and other health care professionals) who are part of the Tufts Health Direct Provider Network to get services. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal. Services are only covered with In-network Providers, except for Emergency care and out of the Service Area Urgent Care.

Out-of-network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. [Service Area is all of Massachusetts EXCEPT Dukes and Nantucket Counties.]

Always check for the most up-to-date In-network Provider information. If you have questions about your Tufts Health Direct benefits or you need help locating an In-network Provider, call us at **888.257.1985** (TTY: 711).

ANNUAL DEDUCTIBLE	
Individual	$2,000
Family	$4,000
ANNUAL OUT-OF-POCKET MAXIMUM	
Individual	$9,100
Family	$18,200

Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The family Deductible and Out-of-pocket Maximum on this Plan have embedded individual Deductibles and Out-of-pocket Maximums, meaning the individual Deductible and Out-of-pocket Maximum above applies to each individual member of the family. This ensures that no single Member on a family Plan will ever have to satisfy the full family Deductible or Out-of-pocket Maximum on their own. Once any combination of family members meets the family Deductible and/or Out-of-pocket Maximum, the entire family is considered to have met the Deductible and/or Out-of-pocket Maximum.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Emergency Room Care	$350 Copayment per visit after Deductible	Notification required within 48 hours, if admitted to the Hospital. Copayment waived, if admitted.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Abortion Services	No charge	
Acupuncture	$60 Copayment per visit	
Allergy testing	$60 Copayment per visit	Covered for up to 200 allergy tests per benefit year when administered by an In-Network provider. No prior authorization required.
Allergy treatments (Injections)	$10 Copayment per visit after Deductible	Allergy immunotherapy covered as part of the pharmacy prescription benefit may require prior authorization and have separate pharmacy Cost-Sharing responsibility.
Ambulance	No charge after Deductible	Emergency transport covered without Prior Authorization; non-Emergency ambulance transport may be covered with Prior Authorization.
Autism Spectrum Disorder		
Applied Behavioral Analysis (ABA)	$30 Copayment per visit	Requires Prior Authorization. Includes assessments, evaluations, testing, and treatment; covered in home, Outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst for treatment of Autism Spectrum Disorder.
Habilitative and Rehabilitative Services (Physical, Occupational, Speech Therapy)	$60 Copayment per visit	Physical, occupational, and speech therapy benefit limitations do not apply.
Breastfeeding Services	No charge	Includes lactation consultants.
Breast Pumps	20% Coinsurance after Deductible	Covered for the purchase of a manual or electric pump or the rental of a hospital-grade pump when deemed appropriate by the ordering provider in accordance with the Preventive Services Policy. Limit of one pump per pregnancy. No Prior Authorization required. Prescription required. Pump must be obtained from contracting DME provider. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related DME Cost-Sharing may apply.
Cardiac Rehabilitation	$60 Copayment per visit	
Chemotherapy Administration	No charge after Deductible	
Chiropractic Care	$60 Copayment per visit	

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Cleft Palate/Cleft Lip Care	No charge after Deductible Additional cost-sharing may apply based on place of service.	Covered for Members under the age of 18. Includes medical, dental, oral, and facial surgery, follow-up, and related services.
Clinical Trials (Qualified)	Based on place of service	Routine patient care services covered for Members in a qualified clinical trial pursuant to state and federal mandates.
Dental, Accidental	Based on place of service	Coverage for services related to teeth is limited to the emergency treatment of accidental injury to sound, natural and permanent teeth when caused by a source external to the mouth.
Dental Care (Pediatric Only), Non-Emergency (Delta Dental)		
Type I Services: Preventive & Diagnostic	No charge after Deductible	Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age. Medically Necessary orthodontia requires Prior Authorization. Members are eligible for pediatric services until the last day of the month in which they turn 19 years old. More information about pediatric dental is available in the Covered Services section of the *Tufts Health Direct Member Handbook*. Please call Delta Dental at 800.872.0500 for more information.
Type II Services: Basic Covered Services	25% Coinsurance after Deductible	
Type III Services: Major Restorative Services	50% Coinsurance after Deductible	
Type IV Services: Orthodontia (only as Medically Necessary)	50% Coinsurance after Deductible	
Diabetes Education		
Primary Care Provider Non-Preventive office visit	$30 Copayment per visit	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit Cost-Sharing may apply. No charge for the Good Measures program available to Direct Members.
Specialist	$60 Copayment per visit	
Diagnostic Testing (including sleep studies outside of an Inpatient setting)	Related office visit or Inpatient Copayment/Cost-Share may be required	Sleep studies require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, Cost-Sharing may apply based on type and place of service.
Dialysis Services	No charge after Deductible	

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Disease Management Programs • Asthma • Diabetes • Chronic Obstructive Pulmonary Disease (COPD) • Congestive-Heart Failure	No charge	If you have any of these conditions, please contact us at **888.257.1985** to discuss our disease management programs.
Durable Medical Equipment (DME) • Medical Supplies • Orthotics • Oxygen and respiratory therapy equipment • Prosthetics • Wigs	20% Coinsurance after Deductible	Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs. Prior Authorization is required for certain services, including prosthetic orthotics (see list at https://tuftshealthplan.com/documents/providers/guides/thpp-dme-pa-quick-reference-guide).
Early Intervention Services	No charge	Covered for Members up to age 3; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention Specialist.
Eye Care (Vision Care) Visits		
Routine Visit	$30 Copayment per visit	Pediatric services for members under 19 years of age: Coverage for routine eye exams once every 12 months; Eyeglasses covered once every 12 months Collection frames only or $150 allowance + 20% off expense beyond allowance. Members are eligible for pediatric services until the last day of the month in which they turn 19 years old. Adult Services for Members 19 years of age or older: Coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics. You must receive routine eye examinations from a Provider in the EyeMed Vision Care Select Network in order to obtain coverage for these services. Call EyeMed at 866.504.5908 for the names of EyeMed Select Providers.
Eye Care (Vision Care) Non-Routine Visit	$60 Copayment per visit	For non-routine vision services, please visit tuftshealthplan.com/find-a-doctor.
Family-planning Services		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit or lab Cost-Sharing may apply.
Non-Preventive	Related office visit or lab Cost-Sharing may apply	

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Fitness Center Reimbursement	Covered for 3 months	Covered for 3 months of membership at a standard fitness center; excludes initiation fees. This benefit is available to Members once every Benefit Year after being a Member for 4 months. See the *Tufts Health Direct Member Handbook* for more information on limitations. Must complete a Fitness Center Reimbursement form.
Habilitative Services (Physical, Occupational, Speech Therapy)	$60 Copayment per visit	Maximum of 60 visits total combined Habilitative Physical and Occupational Therapy per Member per Benefit Year. No limit on Speech Therapy. Physical Therapy and Occupational Therapy require a Prior Authorization after initial evaluation and 11 visits. Speech Therapy requires Prior Authorization after visit 30.
Hearing Aids	20% Coinsurance after Deductible	Covered for Members 21 and younger. This includes the cost of one hearing aid per hearing-impaired ear up to $2,000 per ear every 36 months. This includes both the amount Tufts Health Direct pays and the applicable Member Cost-Share as listed in this document. Related services and supplies do not count toward the $2,000 limit.
Home Health Care	No charge after Deductible	Prior Authorization is required for all home care services and disciplines
Hospice	No charge after Deductible	Requires Prior Authorization
Imaging Services (Radiology)		
Preventive	No charge	Advanced imaging services require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit or lab Cost-Sharing may apply.
X-ray Services and Diagnostic	$75 Copayment after Deductible	
Advanced: MRI, CT, PET	$350 Copayment after Deductible	
Individual therapy/Counseling	$30 Copayment per visit	No visit limits and no Prior Authorization required for Outpatient Behavioral Health therapy visits or substance use treatment.
Infertility Treatment	Cost-share varies based on type of service	Requires Prior Authorization. Medically necessary services may include Inpatient Medical Care, Outpatient Surgery, Laboratory Services, Imaging (x-ray/diagnostic), Office Visits (Specialist), Medical Drugs and/or Prescription Drugs.
Inpatient Medical Care		
Facility fee (includes room and board for maternity/surgery/radiology imaging services and lab work)	$1,000 Copayment per stay after Deductible	No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission. Elective admissions require Prior Authorization and notification 5 business days before admission. Sleep studies may require Prior Authorization.
Professional fee	No charge after Deductible	

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Inpatient Mental Health and/or Substance Use	$1,000 Copayment per stay after Deductible	No Prior Authorization required for admission. Notification to the Plan is required within 48 hours of the Inpatient admission.
Intensive community based acute treatment (ICBAT) for Children and adolescents	No charge	No Prior Authorization required for admission. Notification to the Plan is required within 48 hours of the Inpatient admission.
Intermediate care, including Behavioral Health services for children and adolescents	No charge	Prior Authorization is only required for certain Behavioral Health services for children and adolescents. Please see the "Covered Services" section of the *Tufts Health Direct Member Handbook* for more information about these services.
Laboratory Outpatient and Professional Services		
Preventive Labs	No charge	Includes blood tests, urinalysis, Pap smears, and throat cultures to maintain health and to test, diagnose, treat, and prevent disease. Laboratory must be In-network. Genetic testing may require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related lab Cost-Sharing may apply.
Non-Preventive Labs	$50 Copayment after Deductible	
Medical Benefit drugs	No charge after Deductible	Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit. Prior authorization may be required.
Medication-Assisted Treatment (MAT) services	No charge	Certain medication may require Prior Authorization.
Mental Health Wellness Exam	No charge	Annual mental health wellness examination performed by a Licensed Mental Health Professional Please Note: Your annual mental health wellness examination may also be provided by a PCP during your annual routine physical exam.
Methadone treatment (dosing, counseling, labs)	No charge	
MinuteClinic®	$30 Copayment per visit	A walk-in clinic accessible at select CVS locations.
Nutritional counseling		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related Cost-Sharing may apply.
Non-Preventive	$60 Copayment per visit	

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Office Visits		
Primary Care Provider Preventive Care/screening/immunization /vaccine	No charge	Includes community health center visits
Primary Care Provider Non-Preventive office visit	$30 Copayment per visit	Includes community health center visits
Specialist	$60 Copayment per visit	Includes community health center visits
Organ Transplant (including bone marrow transplants)	See "Inpatient Medical Care"	Requires Prior Authorization.
Outpatient Surgery (Outpatient Hospital/ambulatory surgery centers)		
Professional/Surgeon Services	No charge after Deductible	Prior Authorization required for certain services. Please call us at **888.257.1985** for mor information.
Surgery services and Facility Fee	$500 Copayment per visit after Deductible	
Pharmacy		
Retail drugs (up to 30-Day supply)		
• Tier 1 (primarily generic focused)	$30 Copayment	See Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost-Share. Refer to Formulary for a complete list.
• Tier 2 (includes some non-preferred generics and preferred brands)	$60 Copayment after Deductible	
• Tier 3 (includes high-cost generics, and non-preferred brands and specialty)	$90 Copayment after Deductible	
Mail-order drugs (up to 90-Day supply)		
• Tier 1 (Generic)	$60 Copayment	See Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost-Share. Refer to Formulary for a complete list.
• Tier 2 (Preferred Brands)	$120 Copayment after Deductible	
• Tier 3 (Non-preferred Brands and Specialty)	$270 Copayment after Deductible	
Podiatry	$60 Copayment per visit	Non-routine podiatry services covered when medically necessary. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Prenatal care		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related Cost-Sharing may apply.
Non-Preventive	Related office visit or lab Cost-Sharing may apply	
Radiation Therapy	No charge after Deductible	May require Prior Authorization
Reconstructive Surgery and Procedures	See "Outpatient Surgery"	Please see the "Covered Services" section of the *Tufts Health Direct Member Handbook* for limitations. May require Prior Authorization.
Rehabilitation Hospital or Chronic Disease Hospital	$1,000 Copayment per stay after Deductible	Maximum of 60 Days total per Member per Benefit Year. May require Prior Authorization.
Rehabilitative Services (Physical, Occupational, Speech Therapy)	$60 Copayment per visit	Maximum of 60 visits total combined Rehabilitative Physical and Occupational Therapy per Member per Benefit Year. No limit on Speech Therapy. Physical Therapy and Occupational Therapy require a Prior Authorization after initial evaluation and 11 visits. Speech Therapy requires Prior Authorization after visit 30.
Skilled Nursing Facility	$1,000 Copayment per stay after Deductible	Maximum of 100 Days total per Member per Benefit Year. Prior Authorization required.
Substance Use		
Substance Use Treatment Programs	Related Outpatient or Inpatient Cost-Sharing may apply	Please see the "Covered Behavioral Health (mental health and/or substance use) services" section of the *Tufts Health Direct Member Handbook* for more information about these services.
Recovery Coaches and Peer Specialist	No charge	Must be part of a licensed behavioral health treatment program, such as a licensed mental health clinic, substance use disorder clinic, or outpatient hospital clinic and under supervision of a licensed clinician, such as a licensed social worker, registered nurse, or clinical psychologist
Telehealth	Related Outpatient Medical Care Cost-Sharing may apply	Please ask your Providers' office for information on telehealth availability and access.
Urgent Care	$60 Copayment per visit	You must visit a UCC in our Service Area [(all of Massachusetts EXCEPT Dukes and Nantucket Counties)] that is in our Network to be covered for services. In our Service Area, if you obtain services at an Out-of-network UCC or at a UCC in an Out-of-network Hospital, you will not be covered. Outside of our Service Area, Free-standing Urgent Care Centers (UCC) are covered at Out-of-network Provider sites, including Hospitals and clinics. Cost-Share may vary depending on place of service.

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Weight Loss Programs	No charge for 3 months of membership fees for a qualified program	You must be a Tufts Health Direct Member for three months and participate in a qualified weight loss program for at least three consecutive months. Each Member on a family Plan can request a weight loss program reimbursement once per Benefit Year. Must complete a Weight Loss Programs reimbursement form. See the *Tufts Health Direct Member Handbook* for more information on limitations.

Services not covered

See the section "Services not covered" in the *Tufts Health Direct Member Handbook* for the list of services not covered.

Direct Silver 2000 II

Benefit and Cost-Sharing Summary

This Benefit and Cost-Sharing Summary gives you information about your Tufts Health Direct Covered Services and costs you may have to pay. Make sure you review the services you are eligible for under the Benefit and Cost-Sharing Summary for your specific Plan Level. To see which Tufts Health Direct Plan Level you have, check your Tufts Health Plan Member ID Card.

Your Tufts Health Direct Plan may also have a Deductible. A Deductible is the amount you pay for certain Covered Services in a Benefit Year before your Tufts Health Direct Plan will begin to pay for those Covered Services. You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document.

This Summary gives you a general understanding of your benefits. If you want more information about your benefits and capitalized terms, see your *Tufts Health Direct Member Handbook*.

You must go to Providers (doctors, Hospitals, and other health care professionals) who are part of the Tufts Health Direct Provider Network to get services. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal. Services are only covered with In-network Providers, except for Emergency care and out of the Service Area Urgent Care.

Out-of-network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. [Service Area is all of Massachusetts EXCEPT Dukes and Nantucket Counties.]

Always check for the most up-to-date In-network Provider information. If you have questions about your Tufts Health Direct benefits or you need help locating an In-network Provider, call us at **888.257.1985** (TTY: 711).

ANNUAL DEDUCTIBLE	
Individual	$2,000
Family	$4,000
ANNUAL OUT-OF-POCKET MAXIMUM	
Individual	$9,100
Family	$18,200

Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The family Deductible and Out-of-pocket Maximum on this Plan have embedded individual Deductibles and Out-of-pocket Maximums, meaning the individual Deductible and Out-of-pocket Maximum above applies to each individual member of the family. This ensures that no single Member on a family Plan will ever have to satisfy the full family Deductible or Out-of-pocket Maximum on their own. Once any combination of family members meets the family Deductible and/or Out-of-pocket Maximum, the entire family is considered to have met the Deductible and/or Out-of-pocket Maximum.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Emergency Room Care	$350 Copayment per visit after Deductible	Notification required within 48 hours, if admitted to the Hospital. Copayment waived, if admitted.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Abortion Services	No charge	
Acupuncture	$60 Copayment per visit	
Allergy testing	$60 Copayment per visit	Covered for up to 200 allergy tests per benefit year when administered by an In-Network provider. No prior authorization required.
Allergy treatments (Injections)	$10 Copayment per visit after Deductible	Allergy immunotherapy covered as part of the pharmacy prescription benefit may require prior authorization and have separate pharmacy Cost-Sharing responsibility.
Ambulance	No charge after Deductible	Emergency transport covered without Prior Authorization; non-Emergency ambulance transport may be covered with Prior Authorization.
Autism Spectrum Disorder		
Applied Behavioral Analysis (ABA)	$30 Copayment per visit	Requires Prior Authorization. Includes assessments, evaluations, testing, and treatment; covered in home, Outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst for treatment of Autism Spectrum Disorder.
Habilitative and Rehabilitative Services (Physical, Occupational, Speech Therapy)	$60 Copayment per visit	Physical, occupational, and speech therapy benefit limitations do not apply.
Breastfeeding Services	No charge	Includes lactation consultants.
Breast Pumps	20% Coinsurance after Deductible	Covered for the purchase of a manual or electric pump or the rental of a hospital-grade pump when deemed appropriate by the ordering provider in accordance with the Preventive Services Policy. Limit of one pump per pregnancy. No Prior Authorization required. Prescription required. Pump must be obtained from contracting DME provider. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related DME Cost-Sharing may apply.
Cardiac Rehabilitation	$60 Copayment per visit	
Chemotherapy Administration	No charge after Deductible	
Chiropractic Care	$60 Copayment per visit	

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Cleft Palate/Cleft Lip Care	No charge after Deductible Additional cost-sharing may apply based on place of service.	Covered for Members under the age of 18. Includes medical, dental, oral, and facial surgery, follow-up, and related services.
Clinical Trials (Qualified)	Based on place of service	Routine patient care services covered for Members in a qualified clinical trial pursuant to state and federal mandates.
Dental, Accidental	Based on place of service	Coverage for services related to teeth is limited to the emergency treatment of accidental injury to sound, natural and permanent teeth when caused by a source external to the mouth.
Dental Care (Pediatric Only), Non-Emergency (Delta Dental)		
Type I Services: Preventive & Diagnostic	No charge after Deductible	Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age. Medically Necessary orthodontia requires Prior Authorization. Members are eligible for pediatric services until the last day of the month in which they turn 19 years old. More information about pediatric dental is available in the Covered Services section of the *Tufts Health Direct Member Handbook*. Please call Delta Dental at 800.872.0500 for more information.
Type II Services: Basic Covered Services	25% Coinsurance after Deductible	
Type III Services: Major Restorative Services	50% Coinsurance after Deductible	
Type IV Services: Orthodontia (only as Medically Necessary)	50% Coinsurance after Deductible	
Diabetes Education		
Primary Care Provider Non-Preventive office visit	$30 Copayment per visit	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit Cost-Sharing may apply. No charge for the Good Measures program available to Direct Members.
Specialist	$60 Copayment per visit	
Diagnostic Testing (including sleep studies outside of an Inpatient setting)	Related office visit or Inpatient Copayment/Cost-Share may be required	Sleep studies require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, Cost-Sharing may apply based on type and place of service.
Dialysis Services	No charge after Deductible	

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Disease Management Programs • Asthma • Diabetes • Chronic Obstructive Pulmonary Disease (COPD) • Congestive-Heart Failure	No charge	If you have any of these conditions, please contact us at **888.257.1985** to discuss our disease management programs.
Durable Medical Equipment (DME) • Medical Supplies • Orthotics • Oxygen and respiratory therapy equipment • Prosthetics • Wigs	20% Coinsurance after Deductible	Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs. Prior Authorization is required for certain services, including prosthetic orthotics (see list at https://tuftshealthplan.com/documents/providers/guides/thpp-dme-pa-quick-reference-guide).
Early Intervention Services	No charge	Covered for Members up to age 3; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention Specialist.
Eye Care (Vision Care) Visits		
Routine Visit	$30 Copayment per visit	Pediatric services for members under 19 years of age: Coverage for routine eye exams once every 12 months; Eyeglasses covered once every 12 months Collection frames only or $150 allowance + 20% off expense beyond allowance. Members are eligible for pediatric services until the last day of the month in which they turn 19 years old. Adult Services for Members 19 years of age or older: Coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics. You must receive routine eye examinations from a Provider in the EyeMed Vision Care Select Network in order to obtain coverage for these services. Call EyeMed at 866.504.5908 for the names of EyeMed Select Providers.
Eye Care (Vision Care) Non-Routine Visit	$60 Copayment per visit	For non-routine vision services, please visit tuftshealthplan.com/find-a-doctor.
Family-planning Services		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit or lab Cost-Sharing may apply.
Non-Preventive	Related office visit or lab Cost-Sharing may apply	

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Fitness Center Reimbursement	Covered for 3 months	Covered for 3 months of membership at a standard fitness center; excludes initiation fees. This benefit is available to Members once every Benefit Year after being a Member for 4 months. See the *Tufts Health Direct Member Handbook* for more information on limitations. Must complete a Fitness Center Reimbursement form.
Habilitative Services (Physical, Occupational, Speech Therapy)	$60 Copayment per visit	Maximum of 60 visits total combined Habilitative Physical and Occupational Therapy per Member per Benefit Year. No limit on Speech Therapy. Physical Therapy and Occupational Therapy require a Prior Authorization after initial evaluation and 11 visits. Speech Therapy requires Prior Authorization after visit 30.
Hearing Aids	20% Coinsurance after Deductible	Covered for Members 21 and younger. This includes the cost of one hearing aid per hearing-impaired ear up to $2,000 per ear every 36 months. This includes both the amount Tufts Health Direct pays and the applicable Member Cost-Share as listed in this document. Related services and supplies do not count toward the $2,000 limit.
Home Health Care	$5 Copayment per visit after Deductible	Prior Authorization is required for all home care services and disciplines
Hospice	No charge after Deductible	Requires Prior Authorization
Imaging Services (Radiology)		
Preventive	No charge	Advanced imaging services require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit or lab Cost-Sharing may apply.
X-ray Services and Diagnostic	$75 Copayment after Deductible	
Advanced: MRI, CT, PET	$350 Copayment after Deductible	
Individual therapy/Counseling	$30 Copayment per visit	No visit limits and no Prior Authorization required for Outpatient Behavioral Health therapy visits or substance use treatment.
Infertility Treatment	Cost-share varies based on type of service	Requires Prior Authorization. Medically necessary services may include Inpatient Medical Care, Outpatient Surgery, Laboratory Services, Imaging (x-ray/diagnostic), Office Visits (Specialist), Medical Drugs and/or Prescription Drugs.
Inpatient Medical Care		
Facility fee (includes room and board for maternity/surgery/radiology imaging services and lab work)	$1,000 Copayment per stay after Deductible	No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission. Elective admissions require Prior Authorization and notification 5 business days before admission. Sleep studies may require Prior Authorization.
Professional fee	No charge after Deductible	

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Inpatient Mental Health and/or Substance Use	$1,000 Copayment per stay after Deductible	No Prior Authorization required for admission. Notification to the Plan is required within 48 hours of the Inpatient admission.
Intensive community based acute treatment (ICBAT) for Children and adolescents	No charge	No Prior Authorization required for admission. Notification to the Plan is required within 48 hours of the Inpatient admission.
Intermediate care, including Behavioral Health services for children and adolescents	No charge	Prior Authorization is only required for certain Behavioral Health services for children and adolescents. Please see the "Covered Services" section of the *Tufts Health Direct Member Handbook* for more information about these services.
Laboratory Outpatient and Professional Services		
Preventive Labs	No charge	Includes blood tests, urinalysis, Pap smears, and throat cultures to maintain health and to test, diagnose, treat, and prevent disease. Laboratory must be In-network. Genetic testing may require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related lab Cost-Sharing may apply.
Non-Preventive Labs	$50 Copayment after Deductible	
Medical Benefit drugs	No charge after Deductible	Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit. Prior authorization may be required.
Medication-Assisted Treatment (MAT) services	No charge	Certain medication may require Prior Authorization.
Mental Health Wellness Exam	No charge	Annual mental health wellness examination performed by a Licensed Mental Health Professional Please Note: Your annual mental health wellness examination may also be provided by a PCP during your annual routine physical exam.
Methadone treatment (dosing, counseling, labs)	No charge	
MinuteClinic®	$30 Copayment per visit	A walk-in clinic accessible at select CVS locations.
Nutritional counseling		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related Cost-Sharing may apply.
Non-Preventive	$60 Copayment per visit	

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Office Visits		
Primary Care Provider Preventive Care/screening/immunization /vaccine	No charge	Includes community health center visits
Primary Care Provider Non-Preventive office visit	$30 Copayment per visit	Includes community health center visits
Specialist	$60 Copayment per visit	Includes community health center visits
Organ Transplant (including bone marrow transplants)	See "Inpatient Medical Care"	Requires Prior Authorization.
Outpatient Surgery (Outpatient Hospital/ambulatory surgery centers)		
Professional/Surgeon Services	No charge after Deductible	Prior Authorization required for certain services. Please call us at **888.257.1985** for mor information.
Surgery services and Facility Fee	$500 Copayment per visit after Deductible	
Pharmacy		
Retail drugs (up to 30-Day supply)		
• Tier 1 (primarily generic focused)	$30 Copayment	See Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost-Share. Refer to Formulary for a complete list.
• Tier 2 (includes some non-preferred generics and preferred brands)	$60 Copayment after Deductible	
• Tier 3 (includes high-cost generics, and non-preferred brands and specialty)	$90 Copayment after Deductible	
Mail-order drugs (up to 90-Day supply)		
• Tier 1 (Generic)	$60 Copayment	See Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost-Share. Refer to Formulary for a complete list.
• Tier 2 (Preferred Brands)	$120 Copayment after Deductible	
• Tier 3 (Non-preferred Brands and Specialty)	$270 Copayment after Deductible	
Podiatry	$60 Copayment per visit	Non-routine podiatry services covered when medically necessary. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Prenatal care		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related Cost-Sharing may apply.
Non-Preventive	Related office visit or lab Cost-Sharing may apply	
Radiation Therapy	No charge after Deductible	May require Prior Authorization
Reconstructive Surgery and Procedures	See "Outpatient Surgery"	Please see the "Covered Services" section of the *Tufts Health Direct Member Handbook* for limitations. May require Prior Authorization.
Rehabilitation Hospital or Chronic Disease Hospital	$1,000 Copayment per stay after Deductible	Maximum of 60 Days total per Member per Benefit Year. May require Prior Authorization.
Rehabilitative Services (Physical, Occupational, Speech Therapy)	$60 Copayment per visit	Maximum of 60 visits total combined Rehabilitative Physical and Occupational Therapy per Member per Benefit Year. No limit on Speech Therapy. Physical Therapy and Occupational Therapy require a Prior Authorization after initial evaluation and 11 visits. Speech Therapy requires Prior Authorization after visit 30.
Skilled Nursing Facility	$1,000 Copayment per stay after Deductible	Maximum of 100 Days total per Member per Benefit Year. Prior Authorization required.
Substance Use		
Substance Use Treatment Programs	Related Outpatient or Inpatient Cost-Sharing may apply	Please see the "Covered Behavioral Health (mental health and/or substance use) services" section of the *Tufts Health Direct Member Handbook* for more information about these services.
Recovery Coaches and Peer Specialist	No charge	Must be part of a licensed behavioral health treatment program, such as a licensed mental health clinic, substance use disorder clinic, or outpatient hospital clinic and under supervision of a licensed clinician, such as a licensed social worker, registered nurse, or clinical psychologist
Telehealth	Related Outpatient Medical Care Cost-Sharing may apply	Please ask your Providers' office for information on telehealth availability and access.
Urgent Care	$60 Copayment per visit	You must visit a UCC in our Service Area [(all of Massachusetts EXCEPT Dukes and Nantucket Counties)] that is in our Network to be covered for services. In our Service Area, if you obtain services at an Out-of-network UCC or at a UCC in an Out-of-network Hospital, you will not be covered. Outside of our Service Area, Free-standing Urgent Care Centers (UCC) are covered at Out-of-network Provider sites, including Hospitals and clinics. Cost-Share may vary depending on place of service.

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Weight Loss Programs	No charge for 3 months of membership fees for a qualified program	You must be a Tufts Health Direct Member for three months and participate in a qualified weight loss program for at least three consecutive months. Each Member on a family Plan can request a weight loss program reimbursement once per Benefit Year. Must complete a Weight Loss Programs reimbursement form. See the *Tufts Health Direct Member Handbook* for more information on limitations.

Services not covered

See the section "Services not covered" in the *Tufts Health Direct Member Handbook* for the list of services not covered.

Direct Silver 2000 HSA

Benefit and Cost-Sharing Summary

This Benefit and Cost-Sharing Summary gives you information about your Tufts Health Direct Covered Services and costs you may have to pay. Make sure you review the services you're eligible for under the Benefit and Cost-Sharing Summary for your specific Plan Level. To see which Tufts Health Direct Plan Level you have, check your Tufts Health Direct Plan Member ID Card.

This Summary gives you a general understanding of your benefits. If you want more information about your benefits and capitalized terms, see your *Tufts Health Direct Member Handbook*.

You must go to Providers (doctors, Hospitals, and other health care professionals) who are part of the Tufts Health Direct Provider Network to get services. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal. Services are only covered with In-network Providers, except for Emergency care and out of the Service Area Urgent Care.

Out-of-network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. Service Area is all of Massachusetts EXCEPT Dukes and Nantucket Counties.

Note: This Plan is a Health Savings Account (HSA)-compatible High Deductible Health Plan (HDHP) as defined by the Internal Revenue Service (IRS). High Deductible Health Plans are subject to IRS rules requiring that a minimum Deductible is satisfied before the health Plan provides coverage for Non-Preventive Care. The minimum Deductible dollar amount is adjusted each year to meet IRS requirements. For additional information on the rules governing HDHP Plans, please refer to https://www.irs.gov/publications/p969.

Your Tufts Health Direct Plan has a Deductible. A Deductible is the amount you must pay for certain Covered Services in a Benefit Year before your Tufts Health Direct Plan will begin to pay for those Covered Services. The Deductible applies to all Covered Services except as listed in the Benefit and Cost-Sharing Summary. The amount of the Deductible which applies to you and the enrolled members of your family (if applicable) each Benefit Year is:

ANNUAL DEDUCTIBLE	
Individual (Self-only plan)	$2,000
Family (two members or more)*	$4,000
ANNUAL OUT-OF-POCKET MAXIMUM	
Individual	$7,050
Family**	$14,100

Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum.

*On the Family Plan, there is no individual Deductible, meaning that all members of the family collectively work towards meeting the family Plan Deductible and it is possible for one individual on his or her own to satisfy the family Deductible.

**An individual Out-of-pocket Maximum is embedded on the family Plan, meaning the individual Out-of-pocket Maximum still applies to each individual member of the family. Once the family meets the family Out-of-pocket Maximum, the entire family is considered to have met the Out-of-pocket Maximum and no member of the family will have additional Cost-Share for Covered Services.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Emergency Room Care	$300 Copayment per visit after Deductible	Notification required within 48 hours, if admitted to the Hospital. Copayment waived, if admitted.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Abortion Services	No charge after Deductible	
Acupuncture	$60 Copayment per visit after Deductible	
Allergy testing	$60 Copayment per visit after Deductible	Covered for up to 200 allergy tests per benefit year when administered by an In-Network provider. No prior authorization required.
Allergy treatments (Injections)	$10 Copayment per visit after Deductible	Allergy immunotherapy covered as part of the pharmacy prescription benefit may require prior authorization and have separate pharmacy Cost-Sharing responsibility.
Ambulance	No charge after Deductible	Emergency transport covered without Prior Authorization; non-Emergency ambulance transport may be covered with Prior Authorization.
Autism Spectrum Disorder		
Applied Behavioral Analysis (ABA)	$30 Copayment per visit after Deductible	Requires Prior Authorization. Includes assessments, evaluations, testing, and treatment; covered in home, Outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst for treatment of Autism Spectrum Disorder.
Habilitative and Rehabilitative Services (Physical, Occupational, Speech Therapy)	$60 Copayment per visit after Deductible	Physical, occupational, and speech therapy benefit limitations do not apply.
Breastfeeding Services	No charge	Includes lactation consultants.
Breast Pumps	20% Coinsurance after Deductible	Covered for the purchase of a manual or electric pump or the rental of a hospital-grade pump when deemed appropriate by the ordering provider in accordance with the Preventive Services Policy. Limit of one pump per pregnancy. No Prior Authorization required. Prescription required. Pump must be obtained from contracting DME provider. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related DME Cost-Sharing may apply.
Cardiac Rehabilitation	$60 Copayment per visit after Deductible	
Chemotherapy Administration	No charge after Deductible	
Chiropractic Care	$60 Copayment per visit after Deductible	

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Cleft Palate/Cleft Lip Care	No charge after Deductible Additional cost-sharing may apply based on place of service.	Covered for Members under the age of 18. Includes medical, dental, oral, and facial surgery, follow-up, and related services.
Clinical Trials (Qualified)	Based on place of service	Routine patient care services covered for Members in a qualified clinical trial pursuant to state and federal mandates.
Dental, Accidental	Based on place of service	Coverage for services related to teeth is limited to the emergency treatment of accidental injury to sound, natural and permanent teeth when caused by a source external to the mouth.
Dental Care (Pediatric Only), Non-Emergency (Delta Dental)		
Type I Services: Preventive & Diagnostic	No charge after Deductible	Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age. Medically Necessary orthodontia requires Prior Authorization. Members are eligible for pediatric services until the last day of the month in which they turn 19 years old. More information about pediatric dental is available in the Covered Services section of the *Tufts Health Direct Member Handbook*. Please call Delta Dental at 800.872.0500 for more information.
Type II Services: Basic Covered Services	25% Coinsurance after Deductible	
Type III Services: Major Restorative Services	50% Coinsurance after Deductible	
Type IV Services: Orthodontia (only as Medically Necessary)	50% Coinsurance after Deductible	
Diabetes Education		
Primary Care Provider Non-Preventive office visit	$30 Copayment per visit after Deductible	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit Cost-Sharing may apply. No charge for the Good Measures program available to Direct Members.
Specialist	$60 Copayment per visit after Deductible	
Diagnostic Testing (including sleep studies outside of an Inpatient setting)	Related office visit or Inpatient Copayment/Cost-Share may be required	Sleep studies require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, Cost-Sharing may apply based on type and place of service.
Dialysis Services	No charge after Deductible	

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Disease Management Programs • Asthma • Diabetes • Chronic Obstructive Pulmonary Disease (COPD) • Congestive-Heart Failure	No charge	If you have any of these conditions, please contact us at **888.257.1985** to discuss our disease management programs.
Durable Medical Equipment (DME) • Medical Supplies • Orthotics • Oxygen and respiratory therapy equipment • Prosthetics • Wigs	20% Coinsurance after Deductible	Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs. Prior Authorization is required for certain services, including prosthetic orthotics (see list at https://tuftshealthplan.com/documents/providers/guides/thpp-dme-pa-quick-reference-guide).
Early Intervention Services	No charge	Covered for Members up to age 3; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention Specialist.
Eye Care (Vision Care) Visits		
Routine Visit	$30 Copayment per visit after Deductible	Pediatric services for members under 19 years of age: Coverage for routine eye exams once every 12 months; Eyeglasses covered once every 12 months Collection frames only or $150 allowance + 20% off expense beyond allowance. Members are eligible for pediatric services until the last day of the month in which they turn 19 years old. Adult Services for Members 19 years of age or older: Coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics. You must receive routine eye examinations from a Provider in the EyeMed Vision Care Select Network in order to obtain coverage for these services. Call EyeMed at 866.504.5908 for the names of EyeMed Select Providers.
Eye Care (Vision Care) Non-Routine Visit	$60 Copayment per visit after Deductible	For non-routine vision services, please visit tuftshealthplan.com/find-a-doctor.
Family-planning Services		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit or lab Cost-Sharing may apply.
Non-Preventive	Related office visit or lab Cost-Sharing may apply	

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Fitness Center Reimbursement	Covered for 3 months	Covered for 3 months of membership at a standard fitness center; excludes initiation fees. This benefit is available to Members once every Benefit Year after being a Member for 4 months. See the *Tufts Health Direct Member Handbook* for more information on limitations. Must complete a Fitness Center Reimbursement form.
Habilitative Services (Physical, Occupational, Speech Therapy)	$60 Copayment per visit after Deductible	Maximum of 60 visits total combined Habilitative Physical and Occupational Therapy per Member per Benefit Year. No limit on Speech Therapy. Physical Therapy and Occupational Therapy require a Prior Authorization after initial evaluation and 11 visits. Speech Therapy requires Prior Authorization after visit 30.
Hearing Aids	20% Coinsurance after Deductible	Covered for Members 21 and younger. This includes the cost of one hearing aid per hearing-impaired ear up to $2,000 per ear every 36 months. This includes both the amount Tufts Health Direct pays and the applicable Member Cost-Share as listed in this document. Related services and supplies do not count toward the $2,000 limit.
Home Health Care	No charge after Deductible	Prior Authorization is required for all home care services and disciplines
Hospice	No charge after Deductible	Requires Prior Authorization
Imaging Services (Radiology)		
Preventive	No charge	Advanced imaging services require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit or lab Cost-Sharing may apply.
X-ray Services and Diagnostic	$75 Copayment after Deductible	
Advanced: MRI, CT, PET	$500 Copayment after Deductible	
Individual therapy/Counseling	$30 Copayment per visit after Deductible	No visit limits and no Prior Authorization required for Outpatient Behavioral Health therapy visits or substance use treatment.
Infertility Treatment	Cost-share varies based on type of service	Requires Prior Authorization. Medically necessary services may include Inpatient Medical Care, Outpatient Surgery, Laboratory Services, Imaging (x-ray/diagnostic), Office Visits (Specialist), Medical Drugs and/or Prescription Drugs.
Inpatient Medical Care		
Facility fee (includes room and board for maternity/surgery/radiology imaging services and lab work)	$750 Copayment per stay after Deductible	No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission. Elective admissions require Prior Authorization and notification 5 business days before admission. Sleep studies may require Prior Authorization.
Professional fee	No charge after Deductible	

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Inpatient Mental Health and/or Substance Use	$750 Copayment per stay after Deductible	No Prior Authorization required for admission. Notification to the Plan is required within 48 hours of the Inpatient admission.
Intensive community based acute treatment (ICBAT) for Children and adolescents	No charge after Deductible	No Prior Authorization required for admission. Notification to the Plan is required within 48 hours of the Inpatient admission.
Intermediate care, including Behavioral Health services for children and adolescents	No charge after Deductible	Prior Authorization is only required for certain Behavioral Health services for children and adolescents. Please see the "Covered Services" section of the *Tufts Health Direct Member Handbook* for more information about these services.
Laboratory Outpatient and Professional Services		
Preventive Labs	No charge	Includes blood tests, urinalysis, Pap smears, and throat cultures to maintain health and to test, diagnose, treat, and prevent disease. Laboratory must be In-network. Genetic testing may require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related lab Cost-Sharing may apply.
Non-Preventive Labs	$60 Copayment after Deductible	
Medical Benefit drugs	No charge after Deductible	Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit. Prior authorization may be required.
Medication-Assisted Treatment (MAT) services	No charge after Deductible	Certain medication may require Prior Authorization.
Mental Health Wellness Exam	No charge after Deductible	Annual mental health wellness examination performed by a Licensed Mental Health Professional Please Note: Your annual mental health wellness examination may also be provided by a PCP during your annual routine physical exam.
Methadone treatment (dosing, counseling, labs)	No charge after Deductible	
MinuteClinic®	$30 Copayment per visit after Deductible	A walk-in clinic accessible at select CVS locations.
Nutritional counseling		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related Cost-Sharing may apply.
Non-Preventive	$60 Copayment per visit after Deductible	

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Office Visits		
Primary Care Provider Preventive Care/screening/immunization /vaccine	No charge	Includes community health center visits
Primary Care Provider Non-Preventive office visit	$30 Copayment per visit after Deductible	Includes community health center visits
Specialist	$60 Copayment per visit after Deductible	Includes community health center visits
Organ Transplant (including bone marrow transplants)	See "Inpatient Medical Care"	Requires Prior Authorization.
Outpatient Surgery (Outpatient Hospital/ambulatory surgery centers)		
Professional/Surgeon Services	No charge after Deductible	Prior Authorization required for certain services. Please call us at **888.257.1985** for mor information.
Surgery services and Facility Fee	$500 Copayment per visit after Deductible	
Pharmacy		
Retail drugs (up to 30-Day supply)		
• Tier 1 (primarily generic focused)	$30 Copayment after Deductible	See Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost-Share. Refer to Formulary for a complete list.
• Tier 2 (includes some non-preferred generics and preferred brands)	$60 Copayment after Deductible	
• Tier 3 (includes high-cost generics, and non-preferred brands and specialty)	$105 Copayment after Deductible	
Mail-order drugs (up to 90-Day supply)		
• Tier 1 (Generic)	$60 Copayment after Deductible	See Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost-Share. Refer to Formulary for a complete list.
• Tier 2 (Preferred Brands)	$120 Copayment after Deductible	
• Tier 3 (Non-preferred Brands and Specialty)	$315 Copayment after Deductible	
Podiatry	$60 Copayment per visit after Deductible	Non-routine podiatry services covered when medically necessary. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Prenatal care		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related Cost-Sharing may apply.
Non-Preventive	Related office visit or lab Cost-Sharing may apply	
Radiation Therapy	No charge after Deductible	May require Prior Authorization
Reconstructive Surgery and Procedures	See "Outpatient Surgery"	Please see the "Covered Services" section of the *Tufts Health Direct Member Handbook* for limitations. May require Prior Authorization.
Rehabilitation Hospital or Chronic Disease Hospital	$750 Copayment per stay after Deductible	Maximum of 60 Days total per Member per Benefit Year. May require Prior Authorization.
Rehabilitative Services (Physical, Occupational, Speech Therapy)	$60 Copayment per visit after Deductible	Maximum of 60 visits total combined Rehabilitative Physical and Occupational Therapy per Member per Benefit Year. No limit on Speech Therapy. Physical Therapy and Occupational Therapy require a Prior Authorization after initial evaluation and 11 visits. Speech Therapy requires Prior Authorization after visit 30.
Skilled Nursing Facility	$750 Copayment per stay after Deductible	Maximum of 100 Days total per Member per Benefit Year. Prior Authorization required.
Substance Use		
Substance Use Treatment Programs	Related Outpatient or Inpatient Cost-Sharing may apply	Please see the "Covered Behavioral Health (mental health and/or substance use) services" section of the *Tufts Health Direct Member Handbook* for more information about these services.
Recovery Coaches and Peer Specialist	No charge after Deductible	Must be part of a licensed behavioral health treatment program, such as a licensed mental health clinic, substance use disorder clinic, or outpatient hospital clinic and under supervision of a licensed clinician, such as a licensed social worker, registered nurse, or clinical psychologist
Telehealth	Related Outpatient Medical Care Cost-Sharing may apply	Please ask your Providers' office for information on telehealth availability and access.
Urgent Care	$60 Copayment per visit after Deductible	You must visit a UCC in our Service Area [(all of Massachusetts EXCEPT Dukes and Nantucket Counties)] that is in our Network to be covered for services. In our Service Area, if you obtain services at an Out-of-network UCC or at a UCC in an Out-of-network Hospital, you will not be covered. Outside of our Service Area, Free-standing Urgent Care Centers (UCC) are covered at Out-of-network Provider sites, including Hospitals and clinics. Cost-Share may vary depending on place of service.

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Weight Loss Programs	No charge for 3 months of membership fees for a qualified program	You must be a Tufts Health Direct Member for three months and participate in a qualified weight loss program for at least three consecutive months. Each Member on a family Plan can request a weight loss program reimbursement once per Benefit Year. Must complete a Weight Loss Programs reimbursement form. See the *Tufts Health Direct Member Handbook* for more information on limitations.

Services not covered

See the section "Services not covered" in the *Tufts Health Direct Member Handbook* for the list of services not covered.

Direct Bronze 2850

Benefit and Cost-Sharing Summary

This Benefit and Cost-Sharing Summary gives you information about your Tufts Health Direct Covered Services and costs you may have to pay. Make sure you review the services you are eligible for under the Benefit and Cost-Sharing Summary for your specific Plan Level. To see which Tufts Health Direct Plan Level you have, check your Tufts Health Plan Member ID Card.

Your Tufts Health Direct Plan may also have a Deductible. A Deductible is the amount you pay for certain Covered Services in a Benefit Year before your Tufts Health Direct Plan will begin to pay for those Covered Services. You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document.

This Summary gives you a general understanding of your benefits. If you want more information about your benefits and capitalized terms, see your *Tufts Health Direct Member Handbook*.

You must go to Providers (doctors, Hospitals, and other health care professionals) who are part of the Tufts Health Direct Provider Network to get services. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal. Services are only covered with In-network Providers, except for Emergency care and out of the Service Area Urgent Care.

Out-of-network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. [Service Area is all of Massachusetts EXCEPT Dukes and Nantucket Counties.]

Always check for the most up-to-date In-network Provider information. If you have questions about your Tufts Health Direct benefits or you need help locating an In-network Provider, call us at **888.257.1985** (TTY: 711).

ANNUAL DEDUCTIBLE	
Individual	$2,850
Family	$5,700
ANNUAL OUT-OF-POCKET MAXIMUM	
Individual	$9,100
Family	$18,200

Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The family Deductible and Out-of-pocket Maximum on this Plan have embedded individual Deductibles and Out-of-pocket Maximums, meaning the individual Deductible and Out-of-pocket Maximum above applies to each individual member of the family. This ensures that no single Member on a family Plan will ever have to satisfy the full family Deductible or Out-of-pocket Maximum on their own. Once any combination of family members meets the family Deductible and/or Out-of-pocket Maximum, the entire family is considered to have met the Deductible and/or Out-of-pocket Maximum.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Emergency Room Care	$400 Copayment per visit after Deductible	Notification required within 48 hours, if admitted to the Hospital. Copayment waived, if admitted.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Abortion Services	No charge	
Acupuncture	$65 Copayment per visit after Deductible	
Allergy testing	$65 Copayment per visit after Deductible	Covered for up to 200 allergy tests per benefit year when administered by an In-Network provider. No prior authorization required.
Allergy treatments (Injections)	$10 Copayment per visit after Deductible	Allergy immunotherapy covered as part of the pharmacy prescription benefit may require prior authorization and have separate pharmacy Cost-Sharing responsibility.
Ambulance	No charge after Deductible	Emergency transport covered without Prior Authorization; non-Emergency ambulance transport may be covered with Prior Authorization.
Autism Spectrum Disorder		
Applied Behavioral Analysis (ABA)	$30 Copayment per visit after Deductible	Requires Prior Authorization. Includes assessments, evaluations, testing, and treatment; covered in home, Outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst for treatment of Autism Spectrum Disorder.
Habilitative and Rehabilitative Services (Physical, Occupational, Speech Therapy)	$65 Copayment per visit after Deductible	Physical, occupational, and speech therapy benefit limitations do not apply.
Breastfeeding Services	No charge	Includes lactation consultants.
Breast Pumps	20% Coinsurance after Deductible	Covered for the purchase of a manual or electric pump or the rental of a hospital-grade pump when deemed appropriate by the ordering provider in accordance with the Preventive Services Policy. Limit of one pump per pregnancy. No Prior Authorization required. Prescription required. Pump must be obtained from contracting DME provider. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related DME Cost-Sharing may apply.
Cardiac Rehabilitation	$65 Copayment per visit after Deductible	
Chemotherapy Administration	No charge after Deductible	
Chiropractic Care	$65 Copayment per visit after Deductible	

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Cleft Palate/Cleft Lip Care	No charge after Deductible Additional cost-sharing may apply based on place of service.	Covered for Members under the age of 18. Includes medical, dental, oral, and facial surgery, follow-up, and related services.
Clinical Trials (Qualified)	Based on place of service	Routine patient care services covered for Members in a qualified clinical trial pursuant to state and federal mandates.
Dental, Accidental	Based on place of service	Coverage for services related to teeth is limited to the emergency treatment of accidental injury to sound, natural and permanent teeth when caused by a source external to the mouth.
Dental Care (Pediatric Only), Non-Emergency (Delta Dental)		
Type I Services: Preventive & Diagnostic	No charge after Deductible	Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age. Medically Necessary orthodontia requires Prior Authorization. Members are eligible for pediatric services until the last day of the month in which they turn 19 years old. More information about pediatric dental is available in the Covered Services section of the *Tufts Health Direct Member Handbook*. Please call Delta Dental at 800.872.0500 for more information.
Type II Services: Basic Covered Services	25% Coinsurance after Deductible	
Type III Services: Major Restorative Services	50% Coinsurance after Deductible	
Type IV Services: Orthodontia (only as Medically Necessary)	50% Coinsurance after Deductible	
Diabetes Education		
Primary Care Provider Non-Preventive office visit	$30 Copayment per visit after Deductible	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit Cost-Sharing may apply. No charge for the Good Measures program available to Direct Members.
Specialist	$65 Copayment per visit after Deductible	
Diagnostic Testing (including sleep studies outside of an Inpatient setting)	Related office visit or Inpatient Copayment/Cost-Share may be required	Sleep studies require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, Cost-Sharing may apply based on type and place of service.
Dialysis Services	No charge after Deductible	

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Disease Management Programs • Asthma • Diabetes • Chronic Obstructive Pulmonary Disease (COPD) • Congestive-Heart Failure	No charge	If you have any of these conditions, please contact us at **888.257.1985** to discuss our disease management programs.
Durable Medical Equipment (DME) • Medical Supplies • Orthotics • Oxygen and respiratory therapy equipment • Prosthetics • Wigs	20% Coinsurance after Deductible	Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs. Prior Authorization is required for certain services, including prosthetic orthotics (see list at https://tuftshealthplan.com/documents/providers/guides/thpp-dme-pa-quick-reference-guide).
Early Intervention Services	No charge	Covered for Members up to age 3; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention Specialist.
Eye Care (Vision Care) Visits		
Routine Visit	$30 Copayment per visit after Deductible	Pediatric services for members under 19 years of age: Coverage for routine eye exams once every 12 months; Eyeglasses covered once every 12 months Collection frames only or $150 allowance + 20% off expense beyond allowance. Members are eligible for pediatric services until the last day of the month in which they turn 19 years old. Adult Services for Members 19 years of age or older: Coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics. You must receive routine eye examinations from a Provider in the EyeMed Vision Care Select Network in order to obtain coverage for these services. Call EyeMed at 866.504.5908 for the names of EyeMed Select Providers.
Eye Care (Vision Care) Non-Routine Visit	$65 Copayment per visit after Deductible	For non-routine vision services, please visit tuftshealthplan.com/find-a-doctor.
Family-planning Services		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit or lab Cost-Sharing may apply.
Non-Preventive	Related office visit or lab Cost-Sharing may apply	

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Fitness Center Reimbursement	Covered for 3 months	Covered for 3 months of membership at a standard fitness center; excludes initiation fees. This benefit is available to Members once every Benefit Year after being a Member for 4 months. See the *Tufts Health Direct Member Handbook* for more information on limitations. Must complete a Fitness Center Reimbursement form.
Habilitative Services (Physical, Occupational, Speech Therapy)	$65 Copayment per visit after Deductible	Maximum of 60 visits total combined Habilitative Physical and Occupational Therapy per Member per Benefit Year. No limit on Speech Therapy. Physical Therapy and Occupational Therapy require a Prior Authorization after initial evaluation and 11 visits. Speech Therapy requires Prior Authorization after visit 30.
Hearing Aids	20% Coinsurance after Deductible	Covered for Members 21 and younger. This includes the cost of one hearing aid per hearing-impaired ear up to $2,000 per ear every 36 months. This includes both the amount Tufts Health Direct pays and the applicable Member Cost-Share as listed in this document. Related services and supplies do not count toward the $2,000 limit.
Home Health Care	No charge after Deductible	Prior Authorization is required for all home care services and disciplines
Hospice	No charge after Deductible	Requires Prior Authorization
Imaging Services (Radiology)		
Preventive	No charge	Advanced imaging services require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit or lab Cost-Sharing may apply.
X-ray Services and Diagnostic	$100 Copayment after Deductible	
Advanced: MRI, CT, PET	$350 Copayment after Deductible	
Individual therapy/Counseling	$30 Copayment per visit after Deductible	No visit limits and no Prior Authorization required for Outpatient Behavioral Health therapy visits or substance use treatment.
Infertility Treatment	Cost-share varies based on type of service	Requires Prior Authorization. Medically necessary services may include Inpatient Medical Care, Outpatient Surgery, Laboratory Services, Imaging (x-ray/diagnostic), Office Visits (Specialist), Medical Drugs and/or Prescription Drugs.
Inpatient Medical Care		
Facility fee (includes room and board for maternity/surgery/radiology imaging services and lab work)	$1,000 Copayment per stay after Deductible	No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission. Elective admissions require Prior Authorization and notification 5 business days before admission. Sleep studies may require Prior Authorization.
Professional fee	No charge after Deductible	

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Inpatient Mental Health and/or Substance Use	$1,000 Copayment per stay after Deductible	No Prior Authorization required for admission. Notification to the Plan is required within 48 hours of the Inpatient admission.
Intensive community based acute treatment (ICBAT) for Children and adolescents	No charge	No Prior Authorization required for admission. Notification to the Plan is required within 48 hours of the Inpatient admission.
Intermediate care, including Behavioral Health services for children and adolescents	No charge	Prior Authorization is only required for certain Behavioral Health services for children and adolescents. Please see the "Covered Services" section of the *Tufts Health Direct Member Handbook* for more information about these services.
Laboratory Outpatient and Professional Services		
Preventive Labs	No charge	Includes blood tests, urinalysis, Pap smears, and throat cultures to maintain health and to test, diagnose, treat, and prevent disease. Laboratory must be In-network. Genetic testing may require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related lab Cost-Sharing may apply.
Non-Preventive Labs	$50 Copayment after Deductible	
Medical Benefit drugs	No charge after Deductible	Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit. Prior authorization may be required.
Medication-Assisted Treatment (MAT) services	No charge	Certain medication may require Prior Authorization.
Mental Health Wellness Exam	No charge	Annual mental health wellness examination performed by a Licensed Mental Health Professional Please Note: Your annual mental health wellness examination may also be provided by a PCP during your annual routine physical exam.
Methadone treatment (dosing, counseling, labs)	No charge	
MinuteClinic®	$30 Copayment per visit after Deductible	A walk-in clinic accessible at select CVS locations.
Nutritional counseling		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related Cost-Sharing may apply.
Non-Preventive	$65 Copayment per visit after Deductible	

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Office Visits		
Primary Care Provider Preventive Care/screening/immunization /vaccine	No charge	Includes community health center visits
Primary Care Provider Non-Preventive office visit	$30 Copayment per visit after Deductible	Includes community health center visits
Specialist	$65 Copayment per visit after Deductible	Includes community health center visits
Organ Transplant (including bone marrow transplants)	See "Inpatient Medical Care"	Requires Prior Authorization.
Outpatient Surgery (Outpatient Hospital/ambulatory surgery centers)		
Professional/Surgeon Services	No charge after Deductible	Prior Authorization required for certain services. Please call us at **888.257.1985** for mor information.
Surgery services and Facility Fee	$500 Copayment per visit after Deductible	
Pharmacy		
Retail drugs (up to 30-Day supply)		
• Tier 1 (primarily generic focused)	$30 Copayment	See Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost-Share. Refer to Formulary for a complete list.
• Tier 2 (includes some non-preferred generics and preferred brands)	$65 Copayment after Deductible	
• Tier 3 (includes high-cost generics, and non-preferred brands and specialty)	$100 Copayment after Deductible	
Mail-order drugs (up to 90-Day supply)		
• Tier 1 (Generic)	$60 Copayment	See Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost-Share. Refer to Formulary for a complete list.
• Tier 2 (Preferred Brands)	$130 Copayment after Deductible	
• Tier 3 (Non-preferred Brands and Specialty)	$300 Copayment after Deductible	
Podiatry	$65 Copayment per visit after Deductible	Non-routine podiatry services covered when medically necessary. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Prenatal care		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related Cost-Sharing may apply.
Non-Preventive	Related office visit or lab Cost-Sharing may apply	
Radiation Therapy	No charge after Deductible	May require Prior Authorization
Reconstructive Surgery and Procedures	See "Outpatient Surgery"	Please see the "Covered Services" section of the *Tufts Health Direct Member Handbook* for limitations. May require Prior Authorization.
Rehabilitation Hospital or Chronic Disease Hospital	$1,000 Copayment per stay after Deductible	Maximum of 60 Days total per Member per Benefit Year. May require Prior Authorization.
Rehabilitative Services (Physical, Occupational, Speech Therapy)	$65 Copayment per visit after Deductible	Maximum of 60 visits total combined Rehabilitative Physical and Occupational Therapy per Member per Benefit Year. No limit on Speech Therapy. Physical Therapy and Occupational Therapy require a Prior Authorization after initial evaluation and 11 visits. Speech Therapy requires Prior Authorization after visit 30.
Skilled Nursing Facility	$1,000 Copayment per stay after Deductible	Maximum of 100 Days total per Member per Benefit Year. Prior Authorization required.
Substance Use		
Substance Use Treatment Programs	Related Outpatient or Inpatient Cost-Sharing may apply	Please see the "Covered Behavioral Health (mental health and/or substance use) services" section of the *Tufts Health Direct Member Handbook* for more information about these services.
Recovery Coaches and Peer Specialist	No charge	Must be part of a licensed behavioral health treatment program, such as a licensed mental health clinic, substance use disorder clinic, or outpatient hospital clinic and under supervision of a licensed clinician, such as a licensed social worker, registered nurse, or clinical psychologist
Telehealth	Related Outpatient Medical Care Cost-Sharing may apply	Please ask your Providers' office for information on telehealth availability and access.
Urgent Care	$65 Copayment per visit after Deductible	You must visit a UCC in our Service Area [(all of Massachusetts EXCEPT Dukes and Nantucket Counties)] that is in our Network to be covered for services. In our Service Area, if you obtain services at an Out-of-network UCC or at a UCC in an Out-of-network Hospital, you will not be covered. Outside of our Service Area, Free-standing Urgent Care Centers (UCC) are covered at Out-of-network Provider sites, including Hospitals and clinics. Cost-Share may vary depending on place of service.

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Weight Loss Programs	No charge for 3 months of membership fees for a qualified program	You must be a Tufts Health Direct Member for three months and participate in a qualified weight loss program for at least three consecutive months. Each Member on a family Plan can request a weight loss program reimbursement once per Benefit Year. Must complete a Weight Loss Programs reimbursement form. See the *Tufts Health Direct Member Handbook* for more information on limitations.

Services not covered

See the section "Services not covered" in the *Tufts Health Direct Member Handbook* for the list of services not covered.

Direct Catastrophic

Benefit and Cost-Sharing Summary

This Benefit and Cost-Sharing Summary gives you information about your Tufts Health Direct Covered Services and costs you may have to pay. Make sure you review the services you are eligible for under the Benefit and Cost-Sharing Summary for your specific Plan Level. To see which Tufts Health Direct Plan Level you have, check your Tufts Health Plan Member ID Card.

Your Tufts Health Direct Plan may also have a Deductible. A Deductible is the amount you pay for certain Covered Services in a Benefit Year before your Tufts Health Direct Plan will begin to pay for those Covered Services. You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document.

This Summary gives you a general understanding of your benefits. If you want more information about your benefits and capitalized terms, see your *Tufts Health Direct Member Handbook*.

You must go to Providers (doctors, Hospitals, and other health care professionals) who are part of the Tufts Health Direct Provider Network to get services. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal. Services are only covered with In-network Providers, except for Emergency care and out of the Service Area Urgent Care.

Out-of-network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. [Service Area is all of Massachusetts EXCEPT Dukes and Nantucket Counties.]

Always check for the most up-to-date In-network Provider information. If you have questions about your Tufts Health Direct benefits or you need help locating an In-network Provider, call us at **888.257.1985** (TTY: 711).

ANNUAL DEDUCTIBLE	
Individual	$9,100
Family	$18,200
ANNUAL OUT-OF-POCKET MAXIMUM	
Individual	$9,100
Family	$18,200

Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The family Deductible and Out-of-pocket Maximum on this Plan have embedded individual Deductibles and Out-of-pocket Maximums, meaning the individual Deductible and Out-of-pocket Maximum above applies to each individual member of the family. This ensures that no single Member on a family Plan will ever have to satisfy the full family Deductible or Out-of-pocket Maximum on their own. Once any combination of family members meets the family Deductible and/or Out-of-pocket Maximum, the entire family is considered to have met the Deductible and/or Out-of-pocket Maximum.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Emergency Room Care	No charge after Deductible	Notification required within 48 hours, if admitted to the Hospital. Copayment waived, if admitted.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Abortion Services	No charge	
Acupuncture	No charge after Deductible	
Allergy testing	No charge after Deductible	Covered for up to 200 allergy tests per benefit year when administered by an In-Network provider. No prior authorization required.
Allergy treatments (Injections)	No charge after Deductible	Allergy immunotherapy covered as part of the pharmacy prescription benefit may require prior authorization and have separate pharmacy Cost-Sharing responsibility.
Ambulance	No charge after Deductible	Emergency transport covered without Prior Authorization; non-Emergency ambulance transport may be covered with Prior Authorization.
Autism Spectrum Disorder		
Applied Behavioral Analysis (ABA)	No charge after Deductible	Requires Prior Authorization. Includes assessments, evaluations, testing, and treatment; covered in home, Outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst for treatment of Autism Spectrum Disorder.
Habilitative and Rehabilitative Services (Physical, Occupational, Speech Therapy)	No charge after Deductible	Physical, occupational, and speech therapy benefit limitations do not apply.
Breastfeeding Services	No charge	Includes lactation consultants.
Breast Pumps	No charge after Deductible	Covered for the purchase of a manual or electric pump or the rental of a hospital-grade pump when deemed appropriate by the ordering provider in accordance with the Preventive Services Policy. Limit of one pump per pregnancy. No Prior Authorization required. Prescription required. Pump must be obtained from contracting DME provider. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related DME Cost-Sharing may apply.
Cardiac Rehabilitation	No charge after Deductible	
Chemotherapy Administration	No charge after Deductible	
Chiropractic Care	No charge after Deductible	

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Cleft Palate/Cleft Lip Care	No charge after Deductible Additional cost-sharing may apply based on place of service.	Covered for Members under the age of 18. Includes medical, dental, oral, and facial surgery, follow-up, and related services.
Clinical Trials (Qualified)	Based on place of service	Routine patient care services covered for Members in a qualified clinical trial pursuant to state and federal mandates.
Dental, Accidental	Based on place of service	Coverage for services related to teeth is limited to the emergency treatment of accidental injury to sound, natural and permanent teeth when caused by a source external to the mouth.
Dental Care (Pediatric Only), Non-Emergency (Delta Dental)		
Type I Services: Preventive & Diagnostic	No charge after Deductible	Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age. Medically Necessary orthodontia requires Prior Authorization. Members are eligible for pediatric services until the last day of the month in which they turn 19 years old. More information about pediatric dental is available in the Covered Services section of the *Tufts Health Direct Member Handbook*. Please call Delta Dental at 800.872.0500 for more information.
Type II Services: Basic Covered Services	No charge after Deductible	
Type III Services: Major Restorative Services	No charge after Deductible	
Type IV Services: Orthodontia (only as Medically Necessary)	No charge after Deductible	
Diabetes Education		
Primary Care Provider Non-Preventive office visit	$35 Copayment for first 3 non-Preventive PCP visits, then subject to Deductible	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit Cost-Sharing may apply. No charge for the Good Measures program available to Direct Members.
Specialist	No charge after Deductible	
Diagnostic Testing (including sleep studies outside of an Inpatient setting)	Related office visit or Inpatient Copayment/Cost-Share may be required	Sleep studies require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, Cost-Sharing may apply based on type and place of service.
Dialysis Services	No charge after Deductible	

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Disease Management Programs • Asthma • Diabetes • Chronic Obstructive Pulmonary Disease (COPD) • Congestive-Heart Failure	No charge	If you have any of these conditions, please contact us at **888.257.1985** to discuss our disease management programs.
Durable Medical Equipment (DME) • Medical Supplies • Orthotics • Oxygen and respiratory therapy equipment • Prosthetics • Wigs	No charge after Deductible	Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs. Prior Authorization is required for certain services, including prosthetic orthotics (see list at https://tuftshealthplan.com/documents/providers/guides/thpp-dme-pa-quick-reference-guide).
Early Intervention Services	No charge	Covered for Members up to age 3; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention Specialist.
Eye Care (Vision Care) Visits		
Routine Visit	No charge after Deductible	Pediatric services for members under 19 years of age: Coverage for routine eye exams once every 12 months; Eyeglasses covered once every 12 months Collection frames only or $150 allowance + 20% off expense beyond allowance. Members are eligible for pediatric services until the last day of the month in which they turn 19 years old. Adult Services for Members 19 years of age or older: Coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics. You must receive routine eye examinations from a Provider in the EyeMed Vision Care Select Network in order to obtain coverage for these services. Call EyeMed at 866.504.5908 for the names of EyeMed Select Providers.
Eye Care (Vision Care) Non-Routine Visit	No charge after Deductible	For non-routine vision services, please visit tuftshealthplan.com/find-a-doctor.
Family-planning Services		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit or lab Cost-Sharing may apply.
Non-Preventive	Related office visit or lab Cost-Sharing may apply	

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Fitness Center Reimbursement	Covered for 3 months	Covered for 3 months of membership at a standard fitness center; excludes initiation fees. This benefit is available to Members once every Benefit Year after being a Member for 4 months. See the *Tufts Health Direct Member Handbook* for more information on limitations. Must complete a Fitness Center Reimbursement form.
Habilitative Services (Physical, Occupational, Speech Therapy)	No charge after Deductible	Maximum of 60 visits total combined Habilitative Physical and Occupational Therapy per Member per Benefit Year. No limit on Speech Therapy. Physical Therapy and Occupational Therapy require a Prior Authorization after initial evaluation and 11 visits. Speech Therapy requires Prior Authorization after visit 30.
Hearing Aids	No charge after Deductible	Covered for Members 21 and younger. This includes the cost of one hearing aid per hearing-impaired ear up to $2,000 per ear every 36 months. This includes both the amount Tufts Health Direct pays and the applicable Member Cost-Share as listed in this document. Related services and supplies do not count toward the $2,000 limit.
Home Health Care	No charge after Deductible	Prior Authorization is required for all home care services and disciplines
Hospice	No charge after Deductible	Requires Prior Authorization
Imaging Services (Radiology)		
Preventive	No charge	Advanced imaging services require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related office visit or lab Cost-Sharing may apply.
X-ray Services and Diagnostic	No charge after Deductible	
Advanced: MRI, CT, PET	No charge after Deductible	
Individual therapy/Counseling	No charge after Deductible	No visit limits and no Prior Authorization required for Outpatient Behavioral Health therapy visits or substance use treatment.
Infertility Treatment	Cost-share varies based on type of service	Requires Prior Authorization. Medically necessary services may include Inpatient Medical Care, Outpatient Surgery, Laboratory Services, Imaging (x-ray/diagnostic), Office Visits (Specialist), Medical Drugs and/or Prescription Drugs.
Inpatient Medical Care		
Facility fee (includes room and board for maternity/surgery/radiology imaging services and lab work)	No charge after Deductible	No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission. Elective admissions require Prior Authorization and notification 5 business days before admission. Sleep studies may require Prior Authorization.
Professional fee	No charge after Deductible	

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Inpatient Mental Health and/or Substance Use	No charge after Deductible	No Prior Authorization required for admission. Notification to the Plan is required within 48 hours of the Inpatient admission.
Intensive community based acute treatment (ICBAT) for Children and adolescents	No charge after Deductible	No Prior Authorization required for admission. Notification to the Plan is required within 48 hours of the Inpatient admission.
Intermediate care, including Behavioral Health services for children and adolescents	No charge after Deductible	Prior Authorization is only required for certain Behavioral Health services for children and adolescents. Please see the "Covered Services" section of the *Tufts Health Direct Member Handbook* for more information about these services.
Laboratory Outpatient and Professional Services		
Preventive Labs	No charge	Includes blood tests, urinalysis, Pap smears, and throat cultures to maintain health and to test, diagnose, treat, and prevent disease. Laboratory must be In-network. Genetic testing may require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related lab Cost-Sharing may apply.
Non-Preventive Labs	No charge after Deductible	
Medical Benefit drugs	No charge after Deductible	Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit. Prior authorization may be required.
Medication-Assisted Treatment (MAT) services	No charge after Deductible	Certain medication may require Prior Authorization.
Mental Health Wellness Exam	No charge	Annual mental health wellness examination performed by a Licensed Mental Health Professional Please Note: Your annual mental health wellness examination may also be provided by a PCP during your annual routine physical exam.
Methadone treatment (dosing, counseling, labs)	No charge after Deductible	
MinuteClinic®	No charge after Deductible	A walk-in clinic accessible at select CVS locations.
Nutritional counseling		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related Cost-Sharing may apply.
Non-Preventive	No charge after Deductible	

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Office Visits		
Primary Care Provider Preventive Care/screening/immunization /vaccine	No charge	Includes community health center visits
Primary Care Provider Non-Preventive office visit	$35 Copayment for first 3 non-Preventive PCP visits, then subject to Deductible	Includes community health center visits
Specialist	No charge after Deductible	Includes community health center visits
Organ Transplant (including bone marrow transplants)	See "Inpatient Medical Care"	Requires Prior Authorization.
Outpatient Surgery (Outpatient Hospital/ambulatory surgery centers)		
Professional/Surgeon Services	No charge after Deductible	Prior Authorization required for certain services. Please call us at **888.257.1985** for mor information.
Surgery services and Facility Fee	No charge after Deductible	
Pharmacy		
Retail drugs (up to 30-Day supply)		
• Tier 1 (primarily generic focused)	No charge after Deductible	See Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost-Share. Refer to Formulary for a complete list.
• Tier 2 (includes some non-preferred generics and preferred brands)	No charge after Deductible	
• Tier 3 (includes high-cost generics, and non-preferred brands and specialty)	No charge after Deductible	
Mail-order drugs (up to 90-Day supply)		
• Tier 1 (Generic)	No charge after Deductible	See Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost-Share. Refer to Formulary for a complete list.
• Tier 2 (Preferred Brands)	No charge after Deductible	
• Tier 3 (Non-preferred Brands and Specialty)	No charge after Deductible	
Podiatry	No charge after Deductible	Non-routine podiatry services covered when medically necessary. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Prenatal care		
Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy***. Otherwise, related Cost-Sharing may apply.
Non-Preventive	Related office visit or lab Cost-Sharing may apply	
Radiation Therapy	No charge after Deductible	May require Prior Authorization
Reconstructive Surgery and Procedures	See "Outpatient Surgery"	Please see the "Covered Services" section of the *Tufts Health Direct Member Handbook* for limitations. May require Prior Authorization.
Rehabilitation Hospital or Chronic Disease Hospital	No charge after Deductible	Maximum of 60 Days total per Member per Benefit Year. May require Prior Authorization.
Rehabilitative Services (Physical, Occupational, Speech Therapy)	No charge after Deductible	Maximum of 60 visits total combined Rehabilitative Physical and Occupational Therapy per Member per Benefit Year. No limit on Speech Therapy. Physical Therapy and Occupational Therapy require a Prior Authorization after initial evaluation and 11 visits. Speech Therapy requires Prior Authorization after visit 30.
Skilled Nursing Facility	No charge after Deductible	Maximum of 100 Days total per Member per Benefit Year. Prior Authorization required.
Substance Use		
Substance Use Treatment Programs	Related Outpatient or Inpatient Cost-Sharing may apply	Please see the "Covered Behavioral Health (mental health and/or substance use) services" section of the *Tufts Health Direct Member Handbook* for more information about these services.
Recovery Coaches and Peer Specialist	No charge	Must be part of a licensed behavioral health treatment program, such as a licensed mental health clinic, substance use disorder clinic, or outpatient hospital clinic and under supervision of a licensed clinician, such as a licensed social worker, registered nurse, or clinical psychologist
Telehealth	Related Outpatient Medical Care Cost-Sharing may apply	Please ask your Providers' office for information on telehealth availability and access.
Urgent Care	No charge after Deductible	You must visit a UCC in our Service Area [(all of Massachusetts EXCEPT Dukes and Nantucket Counties)] that is in our Network to be covered for services. In our Service Area, if you obtain services at an Out-of-network UCC or at a UCC in an Out-of-network Hospital, you will not be covered. Outside of our Service Area, Free-standing Urgent Care Centers (UCC) are covered at Out-of-network Provider sites, including Hospitals and clinics. Cost-Share may vary depending on place of service.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Weight Loss Programs	No charge for 3 months of membership fees for a qualified program	You must be a Tufts Health Direct Member for three months and participate in a qualified weight loss program for at least three consecutive months. Each Member on a family Plan can request a weight loss program reimbursement once per Benefit Year. Must complete a Weight Loss Programs reimbursement form. See the *Tufts Health Direct Member Handbook* for more information on limitations.

Services not covered

See the section "Services not covered" in the *Tufts Health Direct Member Handbook* for the list of services not covered.

Appendix C: Schedule II and III Opioid Drug List

Schedule II drugs are defined under Massachusetts law as drugs: (1) with a high potential for abuse; (2) with a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions; and (3) whose abuse may lead to severe psychological or physical dependence.

Schedule III drugs are defined under Massachusetts law as drugs: (1) with a potential for abuse that is less than the drugs in Schedules I and II; (2) that have a currently accepted medical use in treatment in the United States; and (3) whose abuse may lead to moderate or low physical dependence or high psychological dependence.

In accordance with Massachusetts law, if you are prescribed any of these medications and wish to have a quantity less than what was prescribed, no additional cost or penalty will be imposed on you. This list is subject to change throughout the year. Please call a Member Services Representative at **888.257.1985** for the most current information about Schedule II and III medications covered by Tufts Health Plan.

Schedule II medications

- [acetaminophen/hydrocodone]
- [acetaminophen/oxycodone]
- [aspirin/oxycodone]
- [belladonna/opium suppositories]
- [brompheniramine/hydrocodone/phenylephrine]
- [brompheniramine/hydrocodone/pseudoephedrine]
- [chlorpheniramine polistirex/hydrocodone polistirex]
- [chlorpheniramine/hydrocodone]
- [chlorpheniramine/hydrocodone/phenylephrine]
- [chlorpheniramine/hydrocodone/pseudoephedrine]
- [codeine sulfate]
- [dexbrompheniramine/hydrocodone/phenylephrine]
- [dexchlorpheniramine/hydrocodone/phenylephrine]
- [diphenhydramine/hydrocodone/phenylephrine]
- [fentanyl]
- [guaifenesin/hydrocodone/phenylephrine]
- [guaifenesin/hydrocodone/pseudoephedrine]
- [hydrocodone]
- [hydrocodone ER]
- [hydrocodone/homatropine]
- [hydrocodone/ibuprofen]
- [hydrocodone/phenylephrine/pyrilamine]
- [hydrocodone/potassium guaiacolsulfonate]
- [hydrocodone/pseudoephedrine]

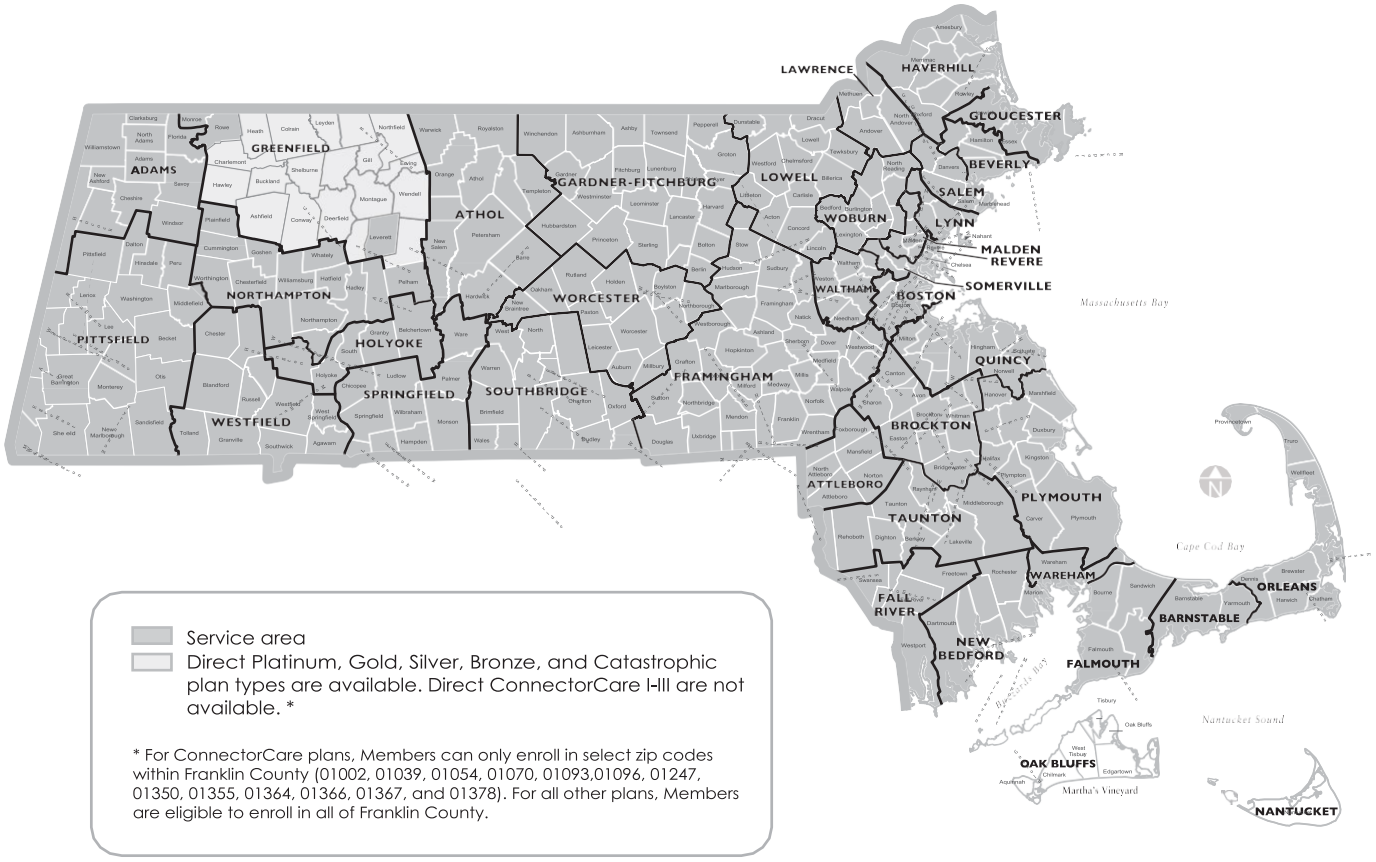
- [hydromorphone]
- [hydromorphone ER]
- [ibuprofen/oxycodone]
- [levorphanol tartrate]
- [meperidine]
- [meperidine/promethazine]
- [methadone]
- [morphine]
- [morphine ER]
- [morphine sulfate ER]
- [morphine/naltrexone]
- [naltrexone/oxycodone]
- [opium tincture]
- [oxycodone]
- [oxycodone ER]
- [oxymorphone]
- [oxymorphone ER]
- [tapentadol]

Schedule III medications

- [acetaminophen/butalbital/caffeine/codeine]
- [acetaminophen/caffeine/dihydrocodeine]
- [acetaminophen/chlorpheniramine/codeine]
- [acetaminophen/codeine]
- [aspirin/butalbital/caffeine/codeine]
- [aspirin/caffeine/dihydrocodeine]
- [aspirin/carisoprodol/codeine]
- [aspirin/codeine]
- [brompheniramine/dihydrocodeine/pseudoephedrine]
- [chlorpheniramine/codeine]
- [codeine/guaifenesin]
- [codeine/guaifenesin/pseudoephedrine]
- [dihydrocodeine/guaifenesin]
- [dihydrocodeine/guaifenesin/phenylephrine]
- [dihydrocodeine/phenylephrine/pyrilamine]

Appendix D: Service Area Map

Tufts Health Direct coverage area includes mainland Massachusetts. Martha's Vineyard and Nantucket are not included.



* For ConnectorCare plans, Members can only enroll in select zip codes within Franklin County (01002, 01039, 01054, 01070, 01093,01096, 01247, 01350, 01355, 01364, 01366, 01367, and 01378). For all other plans, Members are eligible to enroll in all of Franklin County.