2024

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 6 for additional information.

Effective Date: January 1, 2024
Form Number: EOC-DIRECT-001 Ed. 3-2024

TUFTS Health Plan

a Point32Health company

ACCREDITED NCQA HEALTH PLAN ACCREDITED

6496 073024

DISCRIMINATION IS AGAINST THE LAW

TUFTS Health Plan
a Point32Health company

Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Tufts Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Tufts Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

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

If you believe that Tufts Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Tufts Health Plan
Attention: Civil Rights Coordinator, Legal Dept.
1 Wellness Way
Canton, MA 02021-1166
Phone: 888.880.8699 ext. 48000, [TTY number— 800.439.2370 or 711]
Fax: 617.972.9048
Email: OCRCoordinator@point32health.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Tufts Health Plan Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

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

tuftshealthplan.com | **888.257.1985**

Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table of Contents

Introduction

This Handbook has 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 02021-524

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 1985-257-888 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) សម្រាប់ សេវាបកប្រែភាសាខ្មែរដោយឥតគិតថ្លៃ សូមទូរស័ព្ទទៅកាន់លេខ **888-257-1985**។

Korean 한국어로 무료 통역을 원하시면, **888-257-1985**로 전화하십시오.

Kru Inyu yangua ndonõl ni Kru sébèl **888-257-1985**.

Laotian ສໍາລັບການແປພາສາເປັນພາສາລາວທີ່ບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີ **888-257-1985**.

Navajo Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **888-257-1985**.

Persian. برای ترجمه رایگان به فارسی به شماره تلفن **888-257-1985** 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**.

Important Phone Numbers

See the table below for phone numbers and business hours for the agencies who are involved in your health Plan. Note – you enrolled either through the Health Connector or HSA Insurance.

Agency	Phone Number	Business Hours (excluding holidays)
Tufts Health Plan	888-257-1985 (TTY: 711)	Monday through Friday, from 8 a.m. to 5 p.m.
Health Connector	877-623-6765 (TTY: 877-623-7773)	Monday through Friday, from 8 a.m. to 6 p.m.
HSA Insurance	781-228-2222 (toll-free: 877-777-4414)	Monday through Friday, from 8:30 a.m. to 5 p.m.

IN AN EMERGENCY, GET CARE RIGHT AWAY

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

- For medical Emergencies, call 911
- For Behavioral Health (mental health and/or substance use) Emergencies, call 911 or 988 (Suicide and Crisis Lifeline).
- Go to the nearest Emergency room right away. Bring your Tufts Health Direct Member ID Card with you
- Tell your PCP within 48 hours of an Emergency to get any necessary follow-up care

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

IN AN URGENT CARE SITUATION

Urgent Care is for a problem that is serious but does not put your life in danger or risk permanent damage.

- Call your PCP or Behavioral Health (mental health and/or substance use) Provider. You can contact your Provider's office 24/7
- Go to an Urgent Care Center (UCC) or MinuteClinic® (a Limited Service Medical Clinic)
- For Behavioral Health (mental health and/or substance use) concerns, call or text: 833-773-2445 or Web Chat: masshelpline.com. The Behavioral Health (mental health and/or substance use) Help Line (BHHL) is a 24/7 clinical hotline. It is staffed by trained Behavioral Health (mental health and/or substance use) Providers and peer coaches. The BHHL offers clinical assessment, treatment referrals, and crisis triage services. The Help Line is available in more than 200 languages, 24/7, 365 days a year.

Tufts Health Direct Member Services

If you want to talk to a Member Services Representative, call us at **888-257-1985**, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays. Be sure to call us if:

- **You move or change your phone number**
  Call 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 to someone whose name is not listed.
- **You want to change your Primary Care Provider (PCP)**
  You can switch your PCP for any reason by calling us or by visiting us at tuftshealthplan.com/memberlogin.

24/7 NurseLine

For general health information and support, call our 24/7 NurseLine. Phone: 888-MY-RN-LINE (888-697-6546) (TTY: 800-942-1859).

Visit us on the web!

As a Member, you can take advantage of a wide range of helpful online tools and resource. Visit tuftshealthplan.com/memberlogin. First time users must create an account.

Your secure Member portal offers you a safe way to help manage your health care. You can:

- Find a PCP, Specialist, other Provider or health center in the Tufts Health Direct Network near you
- Change your address or phone number
- Change your PCP
- Check your Plan documents and look up benefits
- View you claims history and check your Deductible balance
- Find Prior Authorization status and details
- Use the secure messaging center to send us information and ask questions
- Download forms you need for reimbursements and Tufts Health Direct EXTRAS
- Get important information on:
  - Our Quality Management and Improvement Program
  - How you can file a Grievance or Appeal
  - How we may collect, use, protect, and disclose your Protected Health Information (PHI) and your rights concerning your PHI

Your Member portal also includes the Treatment Cost Estimator (TCE). The TCE allows you to compare costs for many types of Health Care Services. 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.

Fraud, Waste, and Abuse

Fraud, Waste, and Abuse is a serious matter. Please report any of the following concerns to us:

- You get a bill for services you never received
- Your ID card has been stolen
- Someone else is using your insurance

To let us know or ask questions, call us at 800-462-0224. You can also email us at THPP_Claims_Fraud_and_Abuse@point32health.org.

If you would like to report anonymously, call our hotline at 877-824-7123. You can also send a 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 Member Services at **888-257-1985**. To submit your Appeal or Grievance in writing, mail:

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

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, 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, 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.

To help you understand more about your health Plan, we have capitalized important words and terms throughout this Member Handbook. You can find definitions for each in the Glossary on page 64.

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

We have bilingual staff available. Member Services can read this or other printed information to you. We also offer translation services in 200 languages. This includes having this document orally translated. All translation services are free to Members.

Your Tufts Health Direct Evidence of Coverage

When you enroll in Tufts Health Direct, you receive the Covered Services described in this Handbook, the Schedule of Benefits, the Formulary, and amendments to those documents. These documents are a contract between you and Tufts Health Plan. Combined, they are your Evidence of Coverage (EOC).

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 set by the Health Connector. The Health Connector may waive this requirement for affordability or individual hardship. For more information, call the Health Connector at 877-623-6765 (TTY: 877-623-7773). You can also 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 on the bill. Please follow the payment directions on your bill when paying your Premium. 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. We will send an annual notice about the Premium that must be paid.

If an individual or Group is late in paying required Premiums, we may terminate coverage, which would include stopping payment of Claims until the Premiums are paid in full.

Advance Premium Tax Credit (APTC) and ConnectorCare Plans

We have low-cost Plans available through the Health Connector. This includes Plans with subsidies for those who qualify.

You might be eligible for Advance Premium Tax Credits (APTCs). If you are eligible for APTCs, the United States government pays part of your Premiums directly to Tufts Health Plan. Alternatively, you can claim the credit when you file your tax return for the year.

You might also be eligible for a lower-cost ConnectorCare Plan. If you are eligible, the Commonwealth of Massachusetts pays part of your Premiums directly to Tufts Health Plan. This is in addition to any APTCs you might qualify for.

The Health Connector can help you find out if you are eligible for APTCs and/or a ConnectorCare Plan.

Cost Sharing

Deductibles, Copayments, and Coinsurance are types of Cost Sharing. You may be responsible for Cost Sharing when getting medical care to diagnose, treat, or maintain a health condition. Your Schedule of Benefits in Appendix B includes descriptions and the specific Cost Sharing responsibilities for your Plan.

Your Cost Sharing responsibility is based on the Allowed Amount for the Covered Service. The Allowed Amount is the price that we negotiate with In-Network Providers to render Covered Services for Tufts Health Direct Members. The Allowed Amount is usually different and often less than the Billed Amount Providers charge. Please note, if the Allowed Amount of a drug or Covered Service is less than your Cost Sharing amount, you pay only the Allowed Amount of the drug or service.

Pay your Cost Sharing amounts directly to your Providers. If you do not pay at the time of your visit, you 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 may enroll in Plan variations that have no Cost Sharing responsibility for services received through the Indian Health Service. American Indians and Alaskan Natives who make less than 300% of the FPL may enroll in Plan variations with no Cost Sharing responsibility at all, regardless of where a service is received. The Health Connector can help you find out if you are eligible to enroll.

Deductibles

Your Plan may have an annual Deductible. The Deductible is the amount you pay for certain Covered Services in a Plan Year before Tufts Health Plan begins to pay.

The following health care costs do not apply to the Deductible:

- Premium payments
- Copayments or Coinsurance payments for Covered Services
- Payments you make for non-Covered Services
- Payments you make to an Out-of-network Provider over the allowed amount for Covered Services paid by the Plan to that Out-of-network Provider
- Payments you made for Covered Services you got before the start of the current Plan Year

Once you meet your annual Deductible, you may still have to pay Copayments and Coinsurance. At the start of each new Plan Year, your Deductible accumulation resets to zero.

Some Plan types have a combined medical and pharmacy Deductible. Other Plan types have separate medical and pharmacy Deductibles, or no Deductible at all. In addition, Plans may have Individual and Family Deductibles.

For the Health Savings Account-compatible Plan (Silver 2000 HSA), the Individual Annual Deductible amount applies when there is only one Member enrolled on the Plan. The Family Annual Deductible amount applies if there are two or more Members enrolled on the Plan. The Family Deductible is met when the full amount has been paid toward the Deductible by one or more Members on the Plan.

For all other Plan types, the Individual Deductible applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Deductible even if other Members on the family Plan have not. Once two or more Members on a family Plan meet the Family Annual Deductible, the entire family is considered to have met the Deductible for the Plan Year.

Please see the first page of your Schedule of Benefits in Appendix B for more information and the Deductible responsibilities specific to your Plan type.

Copayments

Copayments are set dollar amounts that you are responsible to pay for certain Covered Services. Examples of Covered Services that may require a Copayment are doctors' visits when you are sick, prescriptions, advanced imaging (MRIs, PET, CT scans), Emergency room visits, and care you get in the Hospital.

Please see your Schedule of Benefits in Appendix B for the Copayment responsibilities specific to your Plan.

Coinsurance

Coinsurance is a set percentage of the Allowed Amount that you are responsible to pay for certain Covered Services. Examples of Covered Services that may require Coinsurance are Durable Medical Equipment such as crutches or a wheelchair and pediatric dental care such as getting a tooth cavity filled.

Please see your Schedule of Benefits in Appendix B for the Coinsurance responsibilities specific to your Plan.

Services Subject to Deductible and Copayment or Coinsurance

Certain Covered Services are Subject to Deductible and may have Copayment or Coinsurance. This means if you have not yet met the Deductible, you are responsible to pay the remaining Deductible balance and then the applicable Copayment or Coinsurance up to the Allowed Amount. If you have met the Deductible, then you are only responsible for the Copayment or Coinsurance amount.

Please see your Schedule of Benefits in Appendix B to see which Covered Services are Subject to Deductible and have Copayment or Coinsurance.

Out-of-pocket Maximum

Your Tufts Health Direct Plan has an Out-of-pocket Maximum. This is the maximum amount of Cost Sharing you must pay in a Plan Year for Covered Services. Deductibles, Copayments, and Coinsurance all count toward your Out-of-Pocket Maximum.

The following health care costs do not apply to the Out-of-Pocket Maximum:

- Premium payments
- Payments you make for non-Covered Services
- Payments you make to an Out-of-network Provider over allowed amount for Covered Services paid by the Plan to that Out-of-network Provider
- Payments you made for Covered Services that you got before the start of the current Plan Year

Once you meet your Out-of-pocket Maximum, you no longer pay Deductibles, Copayments or Coinsurance for the rest of that Plan Year. At the start of each new Plan Year, your accumulation resets to zero.

Some Plan Types have a combined medical and pharmacy Out-of-Pocket Maximum. Other Plan types have separate medical and pharmacy Out-of-Pocket Maximums. In addition, Plans may have separate Individual and Family Out-of-Pocket Maximums.

For all Plan Types, a Member can meet the Individual Annual Out of Pocket Maximum on a self-only or a family Plan. Then, there is no Cost Sharing for Covered Services for the rest of the Plan Year. Two or more Members on a family Plan can meet the Family Out-of-Pocket Maximum. Then, no Member in the family has Cost Sharing for Covered Services for the rest of the Plan Year.

Please see the first page of your Schedule of Benefits in Appendix B for more information and the Out-of-Pocket Maximum specific to your Plan type.

Plan Year

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

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

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

In some cases, your first Plan Year will not be a full 12 months. For individual Subscribers:

- If you enrolled during an annual open enrollment period, your Plan Year begins on your Effective Date and continues until December 31. This means your first Plan 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 Plan Year begins on your Effective Date and continues until December 31. See page 20 for more information.

If you are a new employee who became a Subscriber after the Group Effective Date, your Plan Year ends on the same date the Plan Year ends for all Subscribers in your Group.

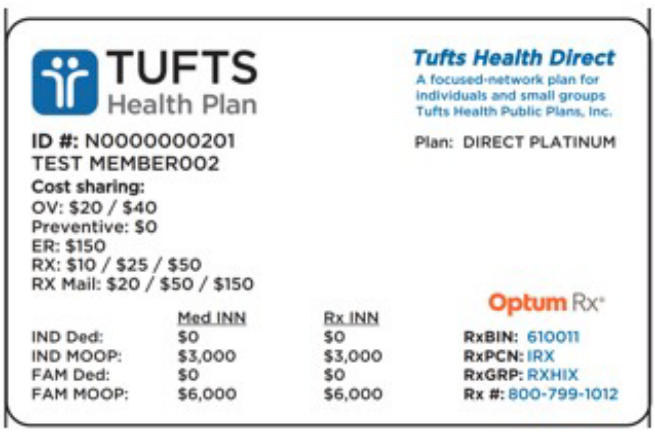
For new Dependents who are added during a Plan Year (e.g., a new baby, Adoptive Child or new Spouse): The new Dependent's Plan Year begins on his or her Effective Date and ends on the same date the Subscriber's Plan Year ends.

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 with no Cost Sharing. For more information, 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 that Providers and pharmacists need. Each person in your family with Tufts Health Direct will get a Tufts Health Direct Member ID Card. Show your ID card every time you request health services. If you do not, the Provider may not bill us, and you may need to pay for the cost of the service.



Your PCP Manages your care

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 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:

- Make sure you get the health care you need
- Arrange necessary tests, laboratory procedures or Hospital visits
- Give you regular checkups and health screenings
- Help you get Behavioral Health (mental health and/or substance use) services
- Keep your medical records

- Supply information on Covered Services that require Prior Authorization before you get treatment
- Write prescriptions

PCP selection or assignment

You may select a Nurse Practitioner, Physician Assistant or doctor as your PCP. This Provider must be part of the Tufts Health Direct Network. If you have not selected a PCP when you enroll, we will assign a PCP to you. We will choose one near to where you live. We tell you the name of your PCP when we send your ID Card. You may change your PCP at any time. To choose a PCP:

- Login to you Member portal at tuftshealthplan.com/memberlogin
- Use the Find a Doctor or Hospital tool at tuftshealthplan.com
- Call us at 888-257-1985

Specialists

Tufts Health Direct covers adult and pediatric specialty care. You can visit most Specialists without Prior Authorization (PA) if they are In-network at the location of your visit.

You should discuss your need for a Specialist with your PCP before making an appointment. To find a Tufts Health Direct Specialist:

- Login to you Member portal at tuftshealthplan.com/memberlogin
- Use the Find a Doctor or Hospital tool at tuftshealthplan.com
- Call us at 888-257-1985

We will not cover the services if you choose to get services outside of our Network. If you choose to get the services anyway, the Specialist will bill you, and you will need to pay for the full cost of the care.

For more information about which services require PA, please see your Plan Type's Schedule of Benefits section in this *Member Handbook*.

Second opinions

You are covered for a second opinion about a health condition or proposed treatment. This service does not require Prior Authorization from an In-network Provider.

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. Bring your Tufts Health Direct Member ID Card with you.

You are covered for Emergency care 24 hours a Day, seven Days a week. You may receive Emergency care wherever you are, even when you are traveling. We also cover Emergency ambulance transportation.

Prior Authorization is never needed for Emergency services. These services are available In-network or Out-of-network.

A Provider will examine and treat your Emergency health needs before sending you home. You may be moved to another Hospital if necessary.

From an Emergency room, you may be admitted for Observation, receive Outpatient Surgical services, or admitted as an Inpatient. Your Cost Share will vary depending on the services and/or level of admission.

We must be notified within 48 hours if you are admitted as an Inpatient after receiving Emergency care. In-Network Providers must notify us on your behalf. We also may be notified by the Emergency room or your PCP. Be sure to contact your PCP so you can get the follow-up care that you may need.

Note about Behavioral Health (mental health and/or substance use) Emergency Care: You may get Mobile Crisis Intervention (MCI) services at a Community Behavioral Health Centers (CBHC). These are short term, mobile, on-site, face-to-face therapeutic response services if you are having a Behavioral Health crisis. MCI is available 24 hours a Day, 7 days a week.

Urgent Care

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

If your condition becomes an Emergency before your Provider sees you, call 911 or go to the nearest Emergency room.

In our Service Area: There are In-network, Free-standing Urgent Care Centers (UCC). You are also covered at MinuteClinic® (a Limited Service Medical Clinic). To find the right choice closest to you:

- Login to you Member portal at tuftshealthplan.com/memberlogin
- Use the Find a Doctor or Hospital tool at tuftshealthplan.com
- Call us at 888-257-1985

Outside of our Service Area: You are covered all In-network and Out-of-network UCCs. This includes Urgent Care provided at Hospitals and clinics.

Hospital services

Please contact your PCP if you need Hospital services for non-Emergency care. Your PCP can coordinate your care.

Getting care after office hours

Talk to your PCP to find out how to get care after business hours. If you have any problems seeing your PCP or any other Provider, please call Member Services.

As a Tufts Health Direct Member, you have access to a registered nurse any time of day. Call our 24/7 NurseLine at 888-MY-RN-LINE (888-697-6546) (TTY: 800-942-1859). The 24/7 NurseLine is available 24 hours a Day, seven days a week.

Getting care outside of the Service Area

You are covered for Emergency and Urgent Care outside of the Service Area. This includes if you are out of the country.

After you have been treated or stabilized, we and your Providers may decide that it is safe to transport you to a Network facility. Continued services with an Out-of-network Provider may not be covered. Transportation back to the Service Area after stabilization may not be a covered.

You are not covered for any other Covered Services outside of the Service Area. This includes but is not limited the following:

- Tests or treatments requested by your PCP
- Routine or follow-up care. Examples include but are not limited to physical exams, flu shots, removal of stitches, counseling, and Physical Therapy

- Scheduled care, such as elective surgery
- Maternity care 36 weeks or more into your pregnancy or within 4 weeks of your due date or if you are told by your Provider that you are at risk for early delivery. This includes Delivery or problems with your pregnancy.

When you get Emergency or Urgent care outside Tufts Health Direct's Service Area, the Provider might ask you to pay for that care at the time of service. Show the Provider your Tufts Health Direct Member ID Card. The Provider should not ask you to pay. If you pay for any services or get a bill, please call Member Services. Also see "If you get a bill for covered services" on page 44 for more information.

Getting information about your Providers

Tufts Health Direct Providers are doctors and other professionals who contract with us to provide health care. For the most up-to-date information about our Provider Network:

- Login to you Member portal at tuftshealthplan.com/memberlogin
- Use the Find a Doctor or Hospital tool at tuftshealthplan.com
- Call us at **888-257-1985**. Our Member Services Team can help you find a Provider who is right for your age, condition, and type of treatment

Our online Find a Doctor or Hospital tool includes information such as a Provider's name, address, phone number, hours of operation, handicap accessibility, and languages spoken. It includes the following types of Tufts Health Direct Providers:

- Emergency rooms
- Behavioral Health (mental health and/or substance use) Providers
- Primary Care Providers (PCPs)
- Primary Care sites
- Specialists
- Hospitals
- Pharmacies
- Urgent Care Centers (UCCs)
- Durable Medical Equipment suppliers
- Ancillary Providers

To request a hard copy of the *Provider Directory* call our Member Services Team at **888-257-1985**.

Utilization Management

Utilization Management (UM) is our program to manage health care costs. We decide whether certain Health Care Services are Medically Necessary. Medically Necessary services are those that we decide are consistent with generally accepted principles of medical practice.

We follow Medical Necessity Guidelines (MNGs) in the UM process. MNGs include clinical criteria based on scientific evidence, professional standards, and expert opinion. We develop MNGs with input from local practicing Providers. We also use standards from national accreditation organizations.

We review these guidelines annually or more often as new drugs, treatments, and technologies become generally accepted. They are updated periodically and available at tuftshealthplan.com/medicalnecessityguidelines.

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.

For any questions, 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 UM issues during these business hours. Outside of these hours, we will respond to voicemails and faxes by the next business Day. You can also find information about UM requests by logging on to your secure Member portal.

Prior Authorization

The most common type of UM request is for Prior Authorization (PA). This is permission before a proposed treatment begins. Your Providers know when and how to ask us for PA. If PA is not approved before you receive care, coverage will be denied. You will need to pay for that care.

There are two reasons you may need PA. One is based on the specific Covered Service. The other is if the Provider is not part of the Tufts Health Direct Network. Read the sections below for details.

Covered Services

For certain services, your Provider needs PA before you begin treatment. To see which Covered Services need PA:

- Use this *Member Handbook*. Review the Covered Services section beginning on page 26. See Appendix B beginning on page 72
- Log into tuftshealthplan.com/memberlogin
- Call Member Services at **888-257-1985**

When you require PA for a Behavioral Health (mental health and/or substance use) service, a Licensed Mental Health Professional will decide if 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.

Out-of-Network Providers

Out-of-network Providers need PA before you can receive non-emergent or non-urgent care. We may authorize you to see an Out-of-network Provider in the following circumstances:

- There is not an In-network Provider with the expertise to take care of your health care needs.
- The Provider treated you in an Emergency department. We may approve two follow-up visits.
- You started Outpatient Behavioral Health (mental health and/or substance use) treatment before joining the Plan. Your Provider must say that stopping treatment is highly likely to cause you major harm.
- You are in the Continuity of Care period. See page 17 for more information.

Prior Authorization Request and Response

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

- Standard Requests: We will decide within 2 working days of receipt of all Necessary Information. This will not be later than 15 days from receipt of the request.
- Expedited Requests: We will decide as soon as possible considering Exigent circumstances. This will always be within 2 working days of receipt of all Necessary Information. This will not be later than 72 hours of receipt of the request.
- Planned Inpatient Requests: Prior Authorization is required at least five business days prior to any elective medical procedure that requires an Inpatient stay.

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 and Medical Benefit Drugs

- Standard Requests: We will decide within 2 business days from the date we receive the request.
- Exigent non-Formulary Request: Completed within 24 hours from the date we receive the request.
- Urgent Requests: We will decide within 48 hours.

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.

Prior Authorization approvals and denials

We will tell you and your Provider which services we agree to cover. The Provider must have a Prior Authorization (PA) letter from us before giving you care. If not, they may not be paid.

If you need more care than we approved, your Provider needs to ask us. If we approve the request for more services, we will send you and your Provider a PA letter.

If we do not approve a PA, we will not pay for those visits or services. We will send you, your Provider or your Designated Representative a denial letter. This is called an 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, and diagnosis. It will give the specific reasons why the evidence your Provider sent us did not meet medical review criteria
- Cite the specific information we used
- Include the Medical Necessity Guidelines used in the UM 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 Appeal. For details, please see "How to resolve concerns", page 53.

Concurrent review

Another type of UM request is for Concurrent review. This process applies if you are receiving Inpatient Services or are undergoing a continuous course of treatment. This type of UM reviews your situation to ensure that the right care is given in the right place at the right level of care.

We make concurrent review decisions within 24 hours of getting all the Necessary Information from your Provider. If we deny Authorization for a longer stay or more services, you can keep getting the service at no cost to you until we let you know of our concurrent review decision. 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

You or your Provider may Appeal the decision before or after you are discharged. For details, please see "How to resolve concerns", page 53.

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 Designated Representative may use the Appeals process described starting on page 54. You do not have to ask us to reconsider an Adverse Determination before requesting a Standard Internal Appeal or Expedited Internal Appeal.

Experimental and/or Investigational services

We use a standardized process to consider whether to cover Experimental and/or Investigational drugs, devices or treatments. The evaluation process includes:

- Determination of the FDA approval status of the device/product/drug in question
- Review of relevant clinical literature
- Consultation with actively practicing specialty care Providers to determine current standards of practice

Decisions are formulated into recommendations for changes in policy, and forwarded to our management for review and final implementation decisions.

Continuity of Care

We support Continuity of Care for new and current Members. Read the sections below for details.

New Members

We may cover a defined period for you to stay with your current Out-of-network Provider and treatment. This will extend until you can transition care to an In-network Provider. These situations include:

- Ongoing care from your PCP for up to 30 Days after enrollment
- Active treatment to care for an illness or disorder that has not stabilized. This may be for up to 30 Days after enrollment
- Ongoing Behavioral Health (mental health and/or substance use) services for up to 90 days in most situations
- Maternity services care if you are beyond 12 weeks gestation. You may continue care up to six weeks after delivery
- Hospice or Palliative care if you are terminally ill

Current Members

We may cover a defined period if your Provider disenrolls with us for reasons other than quality or Fraud.

- You may see your PCP for up to 30 days after disenrollment. If your PCP disenrolls, we will provide you notice at least 30 days in advance.
- If you are in an active course of treatment, the period can be up to 90 days. An active course of treatment is if you:
    - Are receiving Inpatient or institutionalized care
    - Had a scheduled nonelective surgery
    - Have a Serious and Complex Condition
- If you are pregnant, the period can be up to six weeks post-partum
- If you are terminally ill, until death

Note: a Serious and Complex Condition is an illness that requires acute or long-term specialized medical care to avoid the possibility of death or permanent harm. Examples include heart attack and stroke. Stable conditions such as diabetes, arthritis, and asthma, do not qualify.

Conditions for coverage of Continuity of Care

Your Provider must meet all the following conditions for Continuity of Care.

- Provide services that are Covered Services based on this *Member Handbook*
- Get an approved Prior Authorization before continuing care
- Accept payment at the rates we pay In-network Providers
- Accept such payment as payment in full
- Not charge you any more than your Cost Sharing responsibility
- Follow our quality standards

- Follow our policies and procedures
- 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. Eligible individuals include Massachusetts Residents who live in our Service Area. Please note, ConnectorCare Members can only enroll in select zip codes within Franklin County. For all other Plans, Members are eligible to enroll in all of Franklin County.

Please contact the Health Connector for more information about aid to pay for your health insurance coverage.

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. You may stay enrolled in Tufts Health Direct for as long as you meet the eligibility requirements and pay your Premium.

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
- Former 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.

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 legal civil union partner of a Subscriber, according to the law of the state in which the subscriber resides
- A domestic partner of a Subscriber
- A divorced or separated Spouse of a Subscriber as required by Massachusetts law

- A Child of a Subscriber or Subscribers' legal Spouse or domestic partner, until 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 Subscribers' legal Spouse or domestic partner, according to the law of the state in which the Subscriber resides
- A Child for whom the Subscriber or Subscriber's legal Spouse or domestic partner is the court appointed legal guardian
- A Dependent Child of an enrolled Child
- A Disabled adult Child over age 26 of a Subscriber or Subscriber's legal Spouse or domestic partner

Divorce or separation

A Spouse remains eligible for coverage in the event of a divorce or legal separation. This is true even if the judgment was entered before the Effective Date. This coverage requires no additional Premium. 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 former Spouse remarries
- 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.

Add newborns, adoptees, and foster children to your application within 30 days from when they become part of your household. It is best to add newborns within 10 days of birth to make sure their coverage takes effect right away. If you do not report on time, your family member may have a gap in coverage or may need to wait until the next Open Enrollment to get coverage.

If payment of a specific Premium is required to provide coverage for a Child, it must be paid. In addition, the policy or contract may require one or more of the following:

- Notification of birth of a newly born Child
- Filing of a petition to adopt a foster Child
- Placement of a Child for purposes of adoption

The Subscriber must choose a Primary Care Provider (PCP) within 48 hours after the newborn's birth or after the date of adoption or placement for 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 the employee:

- 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 communicate changes that may affect your eligibility. Notification must occur within 60 Days of the event. This includes changes to you or to the Dependents enrolled on your Plan. 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

Changes in Dependents and/or household income may result in a change to the Plan you are eligible for. They also may affect your Premium. These changes can also affect the amount of federal or state subsidies or tax credits you can get.

If any of the above apply, contact your enrollment source:

- Health Connector: 877-623-6765 (TTY: 877-623-7773). Hours - Monday through Friday, from 8 a.m. to 6 p.m.
- HSA Insurance: 781-228-2222 (toll-free: 877-777-4414). Hours - Monday through Friday, from 8:30 a.m. to 5 p.m.

Effective Date

The Effective Date is the date you become a Member of Tufts Health Direct. This is the date you are eligible to get Covered Services from Tufts Health Direct Providers. Your Effective Dates for new individual Subscribers and Dependents follow state and federal law. Your coverage begins at 12:01 a.m. on the first Day of the month your enrollment begins.

Note: Even if your membership begins while you are hospitalized, coverage starts on the Effective Date.

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 on your Effective Date.

Renewing your coverage

Individual/family Plans

All individuals renew membership during the annual open enrollment period. Outside of this period, individual may have a life event that qualifies them to enroll. Individuals may seek an enrollment waiver for other situations. A waiver allows enrollment outside of the open enrollment period. Contact the Health Connector for more information about enrollment waivers.

Individual coverage renews on January 1 of each calendar year. If you renew with an Effective Date of February 1 or later, you will have a short Plan Year.

We may not renew coverage of an eligible person if the individual:

- Has not paid the required Premiums
- Has committed Fraud
- Has misrepresented qualification for the Plan
- Has misrepresented information needed to determine eligibility for a health Plan or for specific health benefits
- Has failed to follow our provisions, the Member contract or the Subscriber agreement. This includes but is not limited to an individual, employee or Dependent moving outside of our Service Area
- Fails, at the time of renewal, to meet eligibility rules. This is if we collect enough information to make such a determination and make such information available to the Health Connector
- Has failed to follow our reasonable request for information in an application for coverage

Group Plan participants

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

You must notify the Health Connector or your Enrollment Administrator 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
- 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, the company may be revalidated at the time of the Group's renewal. The Health Connector or Enrollment Administrator may ask for documentation to confirm 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 confirm the Group's size, participation rate or Premium rate
- Did not follow the Plan's requirements, including but not limited to the employer or its employee(s) moving outside of the Plan's Service Area
- Did not follow our or the Health Connector's reasonable request for information needed to verify the application for coverage
- Is not actively engaged in business
- Did not satisfy the definition of a Small Group

Plan nonrenewal

We may choose not to renew a Health Benefit Plan for an eligible individual or Small Group. If so, we must give at least 60 Days' prior notice. We will include the specific reason(s) for the nonrenewal per our filed criteria.

We may choose to stop offering a particular Plan type. If so, we must give at least 90 Days' prior notice to affected eligible individuals or Eligible Small Groups.

Disenrollment

You may be disenrolled from Tufts Health Direct. If so, you are covered as a Member through 11:59 p.m. on the last Day of the month your enrollment ends. If you are a Group Member, coverage may end on your final Day of employment or on the final Day of the month. Please check with your employer.

Your enrollment in our Plan can be ended if:

- An individual or a Group chooses to end coverage
- You have not paid your Premiums
- 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, to the Plan or a Plan employee
- You commit an act of intentional misrepresentation or Fraud. This can relate to coverage, obtaining Health Care Services or payment for such services. Termination may be retroactive to your Effective Date, the date of the Fraud or misrepresentation or another date determined by us
- You do not follow our rules under this *Member Handbook*
- You do not meet eligibility requirements

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.

Coverage end date

You will be notified of the date coverage under the Plan ends.

If your coverage is ended because you did not pay your Premiums, you will be notified at least 30 Days before your end date. The time frame depends on how you pay your Premiums:

- If you have unsubsidized coverage or are in a Small Group, your coverage ends if you don't pay your Premium for two months. Coverage ends the Day after the payment due date. Your coverage end date is the last Day of the month you made full payment. Termination is retroactive. For instance, if your last payment was on January 1 and you didn't pay for February and March, your coverage ends on January 31.
- If you are on a ConnectorCare Plan or receive a Federal Premium Tax Credit and haven't paid your Premium for three months, your coverage ends the Day after the payment due date. The coverage end date is the last Day of the first month you owed but didn't pay. The termination is retroactive with a 30-Day grace period. For instance, if you last paid for coverage on January 1 but missed payments for February, March, and April, your coverage ends on February 28.

Benefits after termination

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

- You were receiving Inpatient or Outpatient care before your coverage ended
- You had a medical condition that required medical care after your coverage ended

Health Plan changes

We will give you information about the annual Tufts Health Direct open enrollment period. All Members can change Plans for any reason during this time.

Members can change their enrollment during a Special Enrollment Period if there is a qualifying event. The qualifying event must be reported to the Health Connector or your Enrollment Administrator within 60 Days of the event. Changes to health Plan are effective as of the qualifying event date. Examples include, but are not limited to:

- Getting married
- Change in household Dependents
- Loss of MassHealth coverage
- Loss of your insurance from a job
- The end of your Dependent status on someone else’s Plan
- Turning 26 years old and no longer qualifying as a Dependent in a family Plan
- Change in residency, such as a permanent move to Massachusetts, a permanent move within the state, or release from jail or prison
- Is an American Indian or Alaska Native, as defined by section 4 of the Indian Self-Determination and Education Assistance Act. Such an individual may enroll in a health Plan or change from one Plan to another once a month even if the open enrollment period is over
- Other exceptional circumstances

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 choose coverage as provided under COBRA

Below is a 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: COBRA offers continued group coverage for 18 to 36 months based on your qualifying event. Coverage may end earlier if premiums aren't paid on time, your group stops its Group Plan, or due to other reasons like disability or obtaining other coverage. For more information about COBRA, contact your Group or the Health Connector.

Cost of coverage: In most cases, you pay 102% of the cost of coverage.

Continued coverage for disabled Subscribers: When a Subscriber's employment ends or work hours are reduced, they or their eligible Dependent can continue group coverage for up to 29 months if they become disabled under Title II or Title XVI of the Social Security Act. This coverage must be within 60 Days of the qualifying event under federal law. The Premium cost for the added 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 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 either 18 or 36 months of federal COBRA continuation coverage. The maximum coverage period is 18 months for employment termination or reduced work hours. Certain qualifying events or a second qualifying event during the first coverage period can extend coverage to 36 months. See the "Duration of Coverage" table below for more details.

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 deemed disabled within the first 60 days of federal COBRA continuation coverage for these qualifying events, they and their family members may extend COBRA coverage for up to 11 more months. During this extended period, they may need to pay up to 150% of the COBRA coverage cost		

Continuation of Group coverage under Massachusetts law

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
- The Subscriber's or Spouse's enrolled Dependent ceases to be a Dependent Child

If a Member experiences a qualifying event, the Member 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 pay 102% of the Group Premium for Massachusetts continuation coverage.

Rules for Massachusetts continuation
Under a Massachusetts law like COBRA, you may be eligible for continuing coverage if you:

- Were enrolled in Tufts Health Direct Plan through a Massachusetts Group with 2-19 eligible employees;
- Experience a qualifying event that would cause you to lose Group coverage
- Choose this continuation coverage following the described procedure

A Member who is eligible for Massachusetts continuation of coverage is a "qualified beneficiary". This Member 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.

Plant Closing

Description of continuation available under a Group Contract
Under Massachusetts law, Subscribers whose employment is ended 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 must notify Subscribers of their eligibility. Call your Group or Member Services 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. 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).

Covered Services

We cover Medically Necessary Covered Services listed in this Handbook. Covered Services must be consistent with Tufts Health Plan's Medical Necessity Guidelines (MNGs) in effect at the time the services or supplies are provided. Please see our MNGs at tuftshealthplan.com/medicalnecessityguidelines.

Tufts Health Direct, In-network Providers must provide Covered Services. The only Out-of-network services we cover are Emergency and Urgent Care. If a service is not specifically listed as covered, then it is not covered under this agreement. See also "Services not covered" on page 44.

If a proposed Covered Service is not available In-network, we may cover it Out-of-network with Prior Authorization (PA). If so, your Cost Sharing amounts still apply. See also "Prior Authorization – Out-of-network Services" on page 14.

The following sections list services we cover for Tufts Health Direct Members. The Cost Sharing responsibility for your Plan type is listed in the Schedule of Benefits section in Appendix B.

In addition to limitations listed in the Schedule of Benefits, we may limit or require PA for Covered Services based on Medical Necessity. See also "Utilization Management" on page 14.

Covered medical benefits

Abortion services

We cover surgical or medication-based abortion and related care without PA. The following services are covered when provided 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 services

We cover acupuncture services without any visit limits.

Allergy services

We cover allergy testing and allergy immunotherapy (allergy injections). Coverage limits apply.

Ambulance services

In an Emergency, we cover ground, sea, and air transportation services without PA. Non-Emergency ambulance transportation may be covered with PA. Services to and from medical appointments and the use of chair cars are not covered.

Chemotherapy and Radiation Oncology services

We cover chemotherapy and radiation oncology services for cancer treatment. PA is required for some services.

Chiropractic care

We cover spinal manipulation, therapeutic exercise, and electrical muscle stimulation.

Cleft palate/cleft lip care

We cover surgery for Members under 18 years of age with a cleft palate and/or cleft lip, including:

- Surgery and care by oral and plastic surgeons
- Orthodontic treatment and management
- Preventive and restorative dentistry for related treatment

PA may be required.

Clinical trials

We cover routine costs for qualified individuals in approved clinical trials per Massachusetts and federal law without PA.

Dental – accidental

We cover Emergency treatment of accidental injury to sound, natural, and permanent teeth caused by an external source to the mouth.

Dental care, non-Emergency (Pediatric only, Delta Dental)

Delta Dental covers pediatric dental care services for Members under 19 years of age. Dental care includes preventive, basic, and restorative services. Orthodontia is covered when Medically Necessary and with PA. Please visit the Delta Dental website for more information.
https://deltadentalma.com/epo-find-a-dentist

Note: "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 to diagnose or treat various types of diabetes:

- Diabetes Outpatient self-management training and educational services, including medical nutrition therapy
- Podiatry services for Members diagnosed with diabetes
- Diabetes lab tests, such as glycosylated hemoglobin (HbA1c) tests, urinary protein/microalbumin, and lipid profiles
- Insulin pumps and insulin pump supplies, voice synthesizers, and visual magnifying aids for home use for the legally blind
- Therapeutic and molded shoes and shoe inserts for Members with severe diabetic foot disease
- Prescribed diabetes medications, including insulin, insulin pens, insulin needles and syringes, lancets, blood glucose, urine glucose, and ketone monitoring strips, and oral diabetes medications

Some services require PA.

Diagnostic Services (Outpatient lab tests, X-rays, Imaging, and other diagnostic tests)

We cover Outpatient laboratory, radiology imaging, and other diagnostic tests.

Laboratory services
We cover laboratory services ordered by a Physician, Physician Assistant, or Advanced Practice Registered Nurse and performed at a licensed laboratory. Certain laboratory tests, such as genetic testing, may require PA.

Please note that certain laboratory tests are routine Preventive Care and covered with no Cost Share. If a laboratory service is not billed according to this policy, it is subject to Cost Share.

Imaging services (Radiology)
We cover radiology imaging services, including X-rays, Mammograms, MRIs, PET, and CT scans. PA may be required.

Other diagnostic tests
Other diagnostic tests, such as EKGs and pulmonary function testing, may be covered. PA may be required.

Dialysis

We cover dialysis services.

Durable Medical Equipment (DME)

We provide coverage for certain Durable Medical Equipment (DME), including the rental or purchase of medical equipment, some replacement parts, and repairs. Some DME requires PA. Below are examples of the DME benefits we cover:

Hearing aids
For Members aged 21 and younger, we cover hearing aids, including one hearing aid per hearing-impaired ear, up to $2,000 per ear every 36 months. This coverage includes both Tufts Health Direct's payment and the Member's Cost Share. Additionally, related services like hearing aid evaluations, fitting and adjustment of hearing aids, and supplies such as ear molds are also covered.

Medical supplies
We cover prescribed disposable medical supplies for treating specific medical conditions. Examples of covered medical supplies include ostomy, tracheostomy, and catheter supplies.

Orthotics
Coverage includes nondental braces and other mechanical or molded devices, excluding oral devices. For Members with diabetes, shoe inserts are covered without PA.

Oxygen and respiratory therapy equipment services
We cover oxygen and respiratory therapy equipment with PA.

Prosthetic Devices
We cover the cost of breast prostheses and prosthetic arms and legs, including the cost of repairs. The coverage includes the most appropriate model that adequately meets the Member's needs. PA is required, except for breast prostheses when provided in connection with a mastectomy.

Scalp hair prostheses or wigs
We cover scalp hair prostheses made specifically for an individual. We cover wigs 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 (EI) services

We cover Early Intervention services. A certified EI Provider must provide EI services. These services must be part of an EI 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 is no Cost Share responsibility for these services.

Fitness center reimbursement

We cover three months of fitness center fees after you have been a Tufts Health Direct Member for four months. The reimbursement excludes initiation fees.

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.

Submit a reimbursement form by mail with itemized receipts attached. We will reimburse once per Plan 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 direct-fitness-reimbursement (tuftshealthplan.com).

Gender affirming services

We cover gender affirming services including reconstruction surgeries, hair removal, and speech therapy. PA is required.

Habilitative and Rehabilitative services: Physical, Occupational, and Speech Therapy

Physical and Occupational therapies
We cover therapies for evaluation and short-term restorative treatments to help you achieve your highest level of independent functioning. Care is provided promptly, with a focus on achieving significant, sustained, and measurable improvements in your condition.

PA is required after the initial evaluation and 11 visits. You can have up to 60 combined visits of Physical and Occupational Therapies per Member per Plan Year. Please note that these limits do not apply when the services are for treating 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. Services must be provided by 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 Hospitals, clinics, or private offices. PA is required after 30 visits.

Home health care

We cover certain home health services offered by a home health agency. To be eligible for home health care services, your home cannot be a Hospital or Skilled Nursing or Rehabilitation institution, and you must be homebound*.

The services covered 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

*To be considered homebound, you do not have to be bedridden. However, your condition should make it difficult to leave home without considerable effort. If you do leave home, you may still be considered homebound if absences are infrequent or short, or for medical treatment. This homebound requirement does not apply to palliative care.

Hospice

We cover hospice and palliative care for terminally ill Members who choose not to pursue curative treatments. PA is required. Services must meet the standards set by a Medicare-certified hospice Provider regulated by the Massachusetts Department of Public Health.

We cover a package of services, including biological supplies, counseling, drugs, homemaker/home health aide services, institutional care services, medical and social services, medical supplies, nursing, physical, occupational, and speech-language therapies, Provider care, and short-term Inpatient care services for respite.

The 100-Day limit for care at a Skilled Nursing Facility and Rehabilitation Hospital does not apply to hospice services.

Immunizations and Vaccinations

We cover routine preventive and Medically Necessary immunizations. More information is available in the Preventive Health Care Services section.

Infertility services

Infertility is defined as the inability of a woman aged 35 or younger to conceive or produce conception during a period of one year. In the case of a woman over age 35, the time period is reduced to 6 months. If a woman conceives but is unable to carry the pregnancy to live birth, the time she attempted to conceive prior to that pregnancy is included in the one year or 6 month period, as applicable.

The Plan covers the following diagnostic services for infertility:

- Consultation
- Evaluation
- Laboratory tests
- Preimplantation genetic testing (PGT)

When the Member meets Medical Necessity Guidelines, the Plan covers the following infertility treatment:

- Therapeutic artificial insemination (AI), including related sperm procurement and banking
- Donor egg procedures, including related egg and inseminated egg procurement, processing and banking
- Donor oocyte (DO/IVF)
- Donor embryo/frozen embryo transfer (DO/FET)
- Frozen embryo transfer (FET)
- Assisted hatching
- Gamete intrafallopian transfer (GIFT)
- Intra-cytoplasmic sperm injection (ICSI)
- Intra-uterine insemination (IUI)
- In-vitro fertilization and embryo transfer (IVF)
- Zygote intrafallopian transfer (ZIFT)
- Miscrosurgical epididiymal sperm aspiration (MESA)
- Testicular sperm extraction (TESE)
- Sperm collection, freezing and up to one year of storage is also covered for male Members in active infertility treatment
- Cryopreservation of eggs, sperm, and embryos

Note: We use evidence based clinical criteria to evaluate whether the use of infertility treatment is Medically Necessary. Infertility treatments evolve and new treatments may be developed. If you are planning to receive infertility treatment we recommend that you review the current Medical Necessity Guidelines online at https://tuftshealthplan.com/documents/providers/guidelines/medical-necessity-guidelines/arts-ma

Inpatient medical and surgical care

We cover 24-hour Inpatient medical services delivered in a licensed Hospital setting, including room and board, professional Provider services, preadmission testing, anesthesia, diagnostic services, and medication and supplies.

Inpatient admissions for elective procedures may require PA. However, for Emergency services, PA is not required, and Emergency services are available In-network or Out-of-network. If admitted from an Emergency room, please contact us within 48 hours of your Emergency admission.

Chronic Disease or Rehabilitation Hospital
We cover daily rehabilitative services provided in an inpatient setting for a maximum of 60 days per Member per Plan Year at an inpatient rehabilitation Hospital or chronic disease Hospital. PA is required.

Skilled Nursing Facility
We cover daily skilled nursing care in an inpatient setting for a maximum of 100 days per Member per Plan Year at a skilled nursing facility. PA is required.

Inpatient Surgery

Organ transplant
We cover human organ transplants, including bone marrow transplants. PA is required. To qualify, members must meet criteria set by the Massachusetts Department of Public Health. Transplants must be non-Experimental surgical procedures. Coverage includes costs for cadaver donors and living donors if not covered by the donor's own insurance. We do not cover donor charges for members donating organs to non-members or recipients who are not Tufts Health Direct members. Personal searches for solid organs or stem cell donation outside of the organ bank are also not covered.

Reconstructive procedures, mastectomy surgeries, and surgeries to treat functional deformity or impairment
Coverage is provided for services required to relieve pain or restore bodily function impaired due to congenital defects, birth abnormalities, traumatic injuries, or covered surgical procedures. This includes treatment of cleft lip or cleft palate for children under 18, as required by Massachusetts law.

For mastectomy, coverage includes reconstruction of the affected breast, surgery for the other breast to create symmetry, prostheses, and treatment of physical complications (including lymphedema) at all stages of mastectomy.

Breast implant removal is covered under specific conditions, such as post-mastectomy placement, documented rupture of a silicone implant, or evidence of auto-immune disease or infection.

Note: Cosmetic surgery is not covered.

Maternity Services and Well Newborn Care

Inpatient
We cover Hospital and delivery services for the mother at an In-network facility. Home birth is not covered. The mother's inpatient stay is covered for at least 48 hours following a vaginal delivery or 96 hours after a Caesarean delivery. Decisions to reduce the stay are made by attending obstetricians, pediatricians, or certified nurse midwives, along with the mother.

Routine nursery charges and well-newborn care for a healthy newborn are covered, including pediatric care, routine circumcision by a Provider, and newborn hearing screening tests for infants under three months of age.

Additional services 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
- 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)

Care that could have been foreseen before leaving the Service Area is not covered. There is no coverage outside of the Service Area for delivery or problems with pregnancy after the 36th week of pregnancy; or within 4 weeks of the due date; or if your Provider has told you that you are at risk for early delivery. This includes postpartum care as well as care provided to the newborn Child.

Outpatient
We cover Outpatient maternity services like breastfeeding classes, breast pumps, postpartum exams, routine prenatal exams, and home visits by registered nurses, physicians, or certified nurse midwives.

For childbirth classes and more information about this benefit, please contact Member Services.

Medical benefit drugs

We practitioner-administered, FDA-approved drugs and biologicals and the associated administration services. PA may be required.

Medical care Outpatient visits

Medical Care includes services to diagnose, treat, and maintain health conditions. We cover community health center and office visits to Tufts Health Direct Providers for Primary Care or specialty services. These services are provided by Providers within the Tufts Health Direct Network. Please note that services from Providers outside our Network are not covered, and you will be responsible for full payment. To find an In-Network Provider, contact Member Services at **888-257-1985** or visit tuftshealthplan.com/memberlogin.

Medical formulas

We cover medical formulas and low protein foods to treat certain conditions, including:

- Special medical formulas approved by the Massachusetts Department of Public Health and Medically Necessary for treating conditions like homocystinuria, maple syrup urine disease, phenylketonuria, propionic acidemia, methylmalonic acidemia, or tyrosinemia.
- Enteral formulas needed for home use and Medically Necessary for treating malabsorption caused by conditions like Crohn's disease, chronic intestinal pseudo-obstruction, gastroesophageal reflux, gastrointestinal motility issues, ulcerative colitis, or inherited amino acid and organic acid disorders.
- Medically necessary low protein food products for treating inherited amino acid and organic acid disorders (available for purchase directly from a distributor).

Nutritional counseling

We cover nutritional counseling, which may require PA. This includes diagnostic, therapeutic, and counseling services provided by a registered dietitian or nutrition professional for disease management. Nutritional counseling involves an initial nutritional status assessment followed by planned visits for dietary interventions to treat medical illnesses.

Outpatient Surgery

We cover surgical procedures and related anesthesia services performed in an Outpatient surgical center; Hospital operating room; or Provider’s office. Some procedures may require PA.

Pain Management

In compliance with Massachusetts law, we cover services and medications for pain management as alternatives to opioids.

Services include, but are not limited to:

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

Medications include, but are not limited to:

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

PA for these services may be required.

Podiatry

We cover non-routine podiatry services provided by a licensed Podiatrist. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot.

Preventive Health Care Services

Preventive Health Care includes routine screenings, check-ups, and counseling to prevent illnesses and other health problems. We cover these services without any cost share as required by the Affordable Care Act. Below are some common Preventive Health Care Services. For a complete and up-to-date list, visit tuftshealthplan.com/documents/providers/payment-policies/preventive-services.

Note: Some testing or lab screening ordered by a Provider during a routine visit may not qualify as Preventive Services and could be subject to Cost Sharing. Any follow-up care deemed Medically Necessary after a routine physical exam may be subject to cost sharing.

For Children

- Hereditary and metabolic screening at birth
- Immunizations, blood tests, urinalysis, and other recommended screenings
- Newborn hearing screening before discharge
- Care for newborns and Adoptive Children with congenital defects or premature birth
- Regular physical exams and developmental screenings at specific intervals
- Yearly physical exams and Behavioral Health (mental health and/or substance use) screenings for children aged 6 and older, including vision and auditory screening

For adults

- Nutritional counseling and health education
- Routine medical exams and related lab tests and X-rays (once per Plan Year)
- Recommended preventive immunizations
- Routine preventive screenings and procedures (e.g., screening colonoscopies)

For women, including pregnant women

- Baseline mammograms for women between 35 and 40, and annual screening mammograms for women 40 and older
- Laboratory tests for routine maternity care
- Voluntary sterilization procedures
- Breastfeeding services, breast pumps, and related supplies
- Lactation counseling and support
- Prescription and nonprescription contraceptives listed on our Formulary
- Prenatal care
- Routine gynecological exams, including pap smears once per Plan Year

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.

Family-planning Services
We cover Family-planning Services, including:

- Birth control counseling
- Diagnostic tests
- Medical consults
- Pregnancy testing
- Prescription and nonprescription contraceptives approved by the FDA
- Routine medical exams

Smoking Cessation Counseling Services
We cover Smoking/Tobacco Cessation Counseling Services, including individual, group, and telephonic counseling as per current guidelines by the US Department of Health and Human Services. Tufts Health Direct also covers prescription and generic over-the-counter smoking cessation agents prescribed by your PCP.

Telehealth

We cover Covered Services 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 (mental health and/or substance use) Provider through a video portal provided by the Provider.

Vision care

We offer coverage for routine eye exams for Members aged 19 or older once every 24 months. For Members under 19 years of age, routine eye exams are covered every 12 months. To get coverage for these services, you must visit a Provider in the EyeMed Vision Care Select Network. You can find EyeMed Select Providers by calling EyeMed at 866-504-5908 or visiting https://eyedoclocator.eyemedvisioncare.com/tuftsac/en/.

Members with diabetes are eligible for routine vision exams every 12 months, and we strongly encourage them to take advantage of this benefit.

Additionally, eyeglasses are covered for Members under 19 years of age. For more detailed information on vision coverage, please refer to the Schedule of Benefits.

Note: "Under 19 years of age" refers to the last Day of the month in which a Member turns 19 years old.

Weight loss program reimbursement

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

A qualified weight loss program is one that is either Hospital-based or non-Hospital-based and focuses on weight loss by modifying habits. The program requires participation in behavioral and lifestyle counseling with certified health professionals like nutritionists, registered dieticians, or exercise physiologists. Counseling sessions can be conducted in-person, over the phone, or online.

We do not cover individual nutrition counseling sessions, one-time initiation fees, pre-packaged meals, books, videos, scales, or other weight loss related items or supplies.

To be eligible for reimbursement, you must be a Tufts Health Direct Member for three months and actively 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 Plan Year.

To request a reimbursement form, please call us at **888-257-1985**. Or go to https://tuftshealthplan.com/documents/members/forms/direct-weight-loss-reimbursement

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

Some services may require Prior Authorization. Intermediate and Inpatient services require notification and we will conduct a concurrent UM review. See page 16 for details. No Prior Authorization is required for:

- Emergency services
- Outpatient Behavioral Health (mental health and/or substance use) therapy
- Outpatient substance use disorder services

For more information about the services available under this benefit, please call the Tufts Health Direct Plan Behavioral Health Department at **888-257-1985**. You may also see the Medical Necessity Guidelines on our website: https://tuftshealthplan.com/provider/resource-center/resource-center#?d=1a41c0|39dfde|845238|401109|c32f08&c=d64b83

Outpatient Behavioral Health Services

We cover Behavioral Health (mental health and/or substance use) services with Licensed Mental Health Professionals. These services may be provided in-person 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 and non-biologically based Outpatient services are provided without annual, lifetime, or visit/unit/Day limits.

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

- Annual mental health wellness examination performed by a Licensed Mental Health Professional or by a PCP during a routine physical exam
- Applied Behavior Analysis (ABA)
- Community crisis counseling
- Diagnostic evaluation
- Electroconvulsive therapy
- Family and case consultation
- Individual, group, and family counseling
- Medication management services
- Narcotic treatment services
- Neuropsychological assessment and psychological testing
- Psychiatric collaborative care by a primary care team in collaboration with a psychiatric consultant
- Recovery coaches and peer specialists if part of a licensed Behavioral Health treatment program

Intermediate Behavioral Health Services

We cover Intermediate services for Behavioral Health (mental health and/or substance use) disorders as defined by Massachusetts law. These services are more intensive than Outpatient services but less intensive than Inpatient services. Examples include:

- Acute residential treatment
- 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

Inpatient Behavioral Health Services

We cover 24-hour clinical intervention services for Behavioral Health (mental health and/or substance use) 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

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 services mentioned above, additional services are available to Children and adolescents until age 19, and their parents/caregivers when Medically Necessary.

Community-based acute treatment (CBAT)
CBAT services are provided in a staff-secure setting on a 24-hour basis. Clinical staffing ensures the safety for the Child or adolescent and provide intensive therapeutic services. These services may be used as an alternative to or transition from Inpatient Services.

Intensive community-based acute treatment (ICBAT)
ICBAT services are the same as CBAT, but with higher frequency and more intensive staffing. ICBAT programs can treat Members with clinical presentations similar Inpatient Behavioral Health services, but who are able to be cared for safely in an unlocked setting. ICBAT is not used as a step-down placement following discharge from a locked, 24-hour setting.

Youth Mobile crisis intervention (YMCI)
YMCI is 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.

In-home behavioral services
Services provide a combination of behavior management therapy and behavior management monitoring. Behavior management therapy may include short-term counseling and assistance. Services are provided where the Child resides.*

In-home therapy services
Services provide therapeutic clinical intervention or ongoing training, as well as therapeutic support. Services are provided where the Child resides.*

Intensive care coordination (ICC)
ICC is targeted case management services to Children and adolescents with a serious emotional disturbance, including co-occurring conditions. ICC services work to meet the medical, Behavioral Health, and psychosocial needs of the Member and the Member's family. ICC is delivered in office, home or other setting.

Family support and training
Services provided to a parent or other caregiver of a Child to improve their capacity to work with the Child's emotional or behavioral needs. Services are provided where the Child resides.*

Therapeutic mentoring services
Services provided to support a Child's age-appropriate social functioning. Services are provided where the Child resides.*

*Note: This includes the Child's home, a foster home, a therapeutic foster home or another community setting.

Autism spectrum disorder (ASD) services

We cover the diagnosis and treatment of Autism Spectrum Disorders. This includes:

- Assessments, evaluations, genetic testing, or other tests to diagnose whether an individual has one of the Autism spectrum disorders
- Professional services by Plan Providers
- Rehabilitation and Habilitation Services, including, but not limited to, applied behavior analysis
- Prescription drug coverage

There is no coverage for services related to autism spectrum disorders provided under an individualized education program (IEP).

Additional Behavioral Health Services

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

- Biologically based mental disorders
- Rape-related mental or emotional disorders
- All other non-biologically based mental disorders

Mental Health Parity Law

We comply with Massachusetts and federal laws on mental health parity. This means that Copayments, Coinsurance, Deductibles, and/or unit of service limits are not greater for Behavioral Health (mental health and/or substance use) services than those required for medical or surgical services.

Prescription Drugs and Supplies

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. To fill a prescription, make sure an In-network Provider writes the prescription, except in cases of Emergency care.

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.

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**.

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. We require Prior Authorization 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 Designated Representative can appeal the decision. For more information, please see the section "How to resolve concerns" starting on page 53.

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 call us at **888-257-1985**.

Step-therapy program

Step therapy is a type of Prior Authorization program that uses a stepwise approach. It requires 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 Designated 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 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 Plan 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.

Limited Distribution Drugs

Limited distribution drugs treat complex conditions and are only available through certain pharmacies. Select limited distribution drugs will be limited to a 30-Day supply. The Prescription Drug List will indicate when a limited distribution drug is limited to a 30-Day supply.

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 Designated 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 31.)
- 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:

- Drugs not listed on the Formulary
- Drugs listed as non-Formulary on the Formulary except when approved through the Formulary Exception Process

- Drugs that are not Medically Necessary for preventive care or for treating illness, injury or pregnancy
- Drugs in excess of coverage limitations imposed by the Plan. (Limitations may be placed on the quantity of a drug covered; the medical conditions for which a drug may be prescribed; and/or whether another drug must be tried first.)
- 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 for both safety and effectiveness (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
- Non-prescription items or medical supplies other than those listed as covered in the "Covered medications and pharmacy" section or listed on the Formulary as covered. Drugs packaged for institutional use will be excluded from the pharmacy benefit coverage unless otherwise noted on the Formulary as covered
- Drugs provided to you anywhere other than an Outpatient pharmacy. Certain drugs may be covered as a non-pharmacy benefit, e.g., infused or injected drugs, which are covered under your medical benefits
- Drugs prescribed as part of a course of treatment that we do not cover
- 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 those listed on the Formulary as covered.)
- 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 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

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 act on exception requests according to the timelines below:

- Step therapy drugs: Within three (3) business days following the receipt of all Necessary Information needed to make a medical necessity determination
- Drugs not subject to step therapy: Within 48 hours of receiving your prescribing Provider's statement of the reasons an exception is Medically Necessary
- Expedited exception requests: Within 24 hours of receiving the expedited request

We will notify you and your Provider about our decision. Please note:

- If the request for a Non-Formulary 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 Out-of-network Providers may be reimbursable. Some examples include:

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

You are not responsible to pay 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, send us the following information:

- a completed, signed Member Reimbursement Medical Claim Form. Click on the link below or contact Member Services to get the form
- the documents listed on the Member Reimbursement Medical Claim Form that are required for proof of service and payment

Medical Reimbursement Medical Claim Form:
https://tuftshealthplan.com/documents/members/forms/thpp-member-reimbursement

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

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.

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
- 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 (mental health and/or substance use) 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 34
- Private duty nursing (block or non-intermittent nursing)
- Hearing aids for Members more than 21 years old (see Schedule of Benefits 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 . 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 supermarket gift card for completing your yearly checkup	Members can earn a $25 supermarket gift card for having a yearly checkup	• Call us at **888-257-1985**. We will send you a form to complete or
		• You can download the form at https://tuftshealthplan.com/documents/members/forms/direct-extras-reward-form.
		• Fill out the **Member Information** section of the form.
		  ○ If you are filling out the form for a Child, use the Child's name and Tufts Health Plan Member ID #.
		  ○ Fill out one form for each Member.
		• Make a copy of the form to keep for yourself.
		• Mail or fax us the completed form:
		Tufts Health Plan
		Attn: Claims Department
		P.O. Box 524
		Canton, MA 02021
		Fax 857-304-6300
		We will begin processing your request when we receive the completed form. You should get your reward 6–8 weeks later.
		Note: You must be a Tufts Health Direct Member when you get your yearly checkup and when we process your form.

EXTRAS	What It Is	How to Get It

$25 supermarket gift card for diabetes screenings	If you have diabetes, we want to help you manage it. We will give you a $25 supermarket gift card for completing 5 routine diabetes screenings in 1 calendar year: 1 eye exam, 2 blood sugar (HbA1c) tests, 1 protein test and 1 cholesterol (LDL) test	• Call us at **888-257-1985**. We will send you a form with a list of screenings to complete, or
		• Download the form from https://tuftshealthplan.com/documents/members/forms/direct-extras-reward-form.
		• Fill out the Member Information section of this form.
		  ○ If you are filling out the form for a Child, use the Child's name and Tufts Health Plan Member ID #.
		  ○ Fill out one form for each Member.
		• Make a copy of the form to keep for yourself.
		• Mail or fax us the completed form:
		Tufts Health Plan
		Attn: Claims Department
		P.O. Box 524
		Canton, MA 02021
		Fax 857.304.6300
		We will begin processing your request when we receive the completed form. You should get your reward 6–8 weeks later.
		Note: You must be a Tufts Health Direct Member when you complete your diabetes screenings and when we process your form.

Car and booster seats gift cards	Members may be eligible to get one $25 gift card to purchase a booster seat and one $50 gift card to purchase a convertible car seat, one year later as long as your Child is a Tufts Health Plan Member. You can get up to two gift cards during their membership. You can get the reward if you are:
	• 28 or more weeks pregnant
	• A Child 0–8 years old
		• Call us at **888-257-1985**. We will send you a form to complete or
		• Download the form at https://tuftshealthplan.com/documents/members/forms/direct-extras-car-seat-form
		• Fill out the **Member Information** section of the form.
		  ○ If you are filling out the form for a Child, use the Child's name and Tufts Health Plan Member ID #.
		  ○ Fill out one form for each Member.
		• Make a copy of the form to keep for yourself.
		• Mail or fax us the completed form.
		Tufts Health Plan
		Attn: Claims Department
		P.O. Box 524
		Canton, MA 02021
		Fax 857.304.6300
		We will begin processing your request when we receive the completed form. You should get your reward 6–8 weeks later.
		Note: You must be a Tufts Health Direct Member when you request this EXTRA and when we process your form.

Care Management

Care Management (CM) helps you stay healthy and improve your health. Our CM services may include assisting with appointments, giving health information, and arranging care with your Providers. While Care Management aids, it doesn't replace care from your PCP or other Providers.

Read the sections below to learn more about our CM programs. 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.

Maternal and Child Health Program

We collaborate closely with you and your Providers to ensure you receive care during pregnancy. We can also assist in coordinating the care you need after childbirth. To learn more about Covered Services available to expecting Members, please refer to page 32.

Integrated Care Management

Integrated Care Management (ICM) is a model of care with a focus on your specific needs. Our Behavioral Health (mental health and/or substance use), medical, and Community Health Workers collaborate closely to provide the care you need. Our team can help with health care, social, and financial matters.

ICM is helpful for complex situations, like mental health, substance use, physical disabilities, or special health conditions (e.g., high-risk pregnancy, cancer, HIV/AIDS).

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

We offer a wide range of Behavioral Health (mental health and/or substance use) services to support your well-being. Our licensed experts can:

- Inform you about community-based services
- Monitor your treatment progress
- Collaborate with your Providers for discharge planning
- Review your ongoing care needs

We help make sure you get the best care by as we work to

- Enhance your health and your family’s well-being
- Coordinate care among your Providers
- Engage you in treatment planning
- Ensure seamless care during Provider or Plan changes
- Facilitate timely access to the correct level of Behavioral Health care

We also provide Behavioral Health (mental health and/or substance use) Care Management if you

- Need help after a new mental health or substance use diagnosis
- Struggle with managing a Behavioral Health condition
- Have multiple admissions for Behavioral Health concerns
- Face challenges in getting community-based services
- Experience a catastrophic event
- Need multi-agency coordination for diverse needs or cultural considerations

Transition of Care (ToC)

When you leave a 24-hour care facility, our care team will help you with your transition of care needs. This is the care you need to keep getting better at home. Our care team will work with Providers to make sure you get the services you need when you need them.

The ToC 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 medications, and managing your disease

Complex Care Management (CCM)

Our Complex Care Management program is for Members with complex health care concerns. If you have one or more health care conditions that are difficult to manage, we can help. These may be medical and/or Behavioral Health (mental health and/or substance use) in nature. We have a team of dedicated health care professionals who can help you get and stay healthy. They can also help you remove barriers to getting care.

Members with the following conditions may benefit from our CCM 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

Disease Management

Our Care Managers can assist you with Disease Management for asthma, diabetes, chronic obstructive pulmonary disease (COPD) or heart failure.

We offer information and tools to help you understand your disease better. Working with your Providers, we can help you avoid trips to the Emergency room. We explain why certain tests are important and may call you to remind you about yearly lab work and PCP appointments

If you meet home-care criteria, you may receive services from a visiting nurse. We also have specialized CHWs who can help provide education and resources.

Community Health

Community health is the well-being of people in a community. The Community Health Services program connects members with Community Health Workers (CHWs). CHWs are certified public health workers who understand the communities they serve. They help in different ways:

CHWs stand out because they:

- Are chosen for knowing their communities well
- Spend time reaching out in the communities
- Have experience working in communities
- Help people overcome care obstacles
- Give direct help, like talking and coordinating care
- Give caring and cultural education for community well-being
- Share health info to help the community
- Bridge between people, communities, and services
- Connect members to local groups for needed services
- Speak up for community and individual needs

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.

We produce our Quality Management and Improvement Program Description (QMIPD) annually. The QMIPD includes:

- A description of our Quality Management programs
- The 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 satisfaction with access to services
- Clear goals focused on our diverse membership and those 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:

- Deeply grasp the social, linguistic, moral, intellectual, and behavioral traits of a community or population
- Use this understanding to enhance the effectiveness of health care delivery to diverse groups

Our commitment to providing affordable, high-quality health care is clear in our NCQA rating. We stand among the top health Plans, recognized for our quality and Member satisfaction.

We have been NCQA accredited since 1994. From 1999-2019, our products achieved “Excellent” accreditation status from NCQA, which is the highest possible achievement. With a change of criteria in 2020, "Excellent" accreditation has become "Accredited." Our HMO/POS and PPO products now carry the “Accredited” Level.

The present accreditation has been valid since 2021. Our next NCQA accreditation review is in 2024.

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 you may have about how we work. You can make an Inquiry anytime. We will resolve your Inquiry right away or within three business days of receiving it. We will inform you of the result on the same Day we resolve it.

Grievances

You have the right to file a Grievance if you are unhappy with something we have done or not done. We will research the situation and resolve it. Note: You may file an Appeal about any denial about your benefits. See the next section for details.

You may file a Grievance at any time. Reasons may include:

- Poor quality of care or services
- Rudeness by a Provider or one of our employees
- Lack of respect for your rights by a Provider or one of our employees
- Extension for us to decide about an Authorization or Appeal
- Decision not to expedite a Standard Internal Appeal request

Your Designated Representative (or simply, Representative) can file a Grievance for you. You can appoint a Representative by sending us a signed Tufts Health Plan Designated Representative Form. You can get a form at online or by calling Member Services. See details below.

You have 30 days between when a Representative may file a Grievance for you and when we receive the form. Otherwise, we will dismiss the Grievance.

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

Appeals

You, your Provider or your Representative all have the right to request a Standard Internal Appeal if you disagree with any denial based on your benefits or Medical Necessity (Adverse Determination). You have **180 Days** to request a Standard Internal Appeal. We encourage you to act as soon as possible.

How to request a Standard Internal Appeal
You or your 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

We will let you know we got your Standard Internal Appeal request by sending you a written notice within 15 days of receiving it.

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

You can appoint a Representative by sending us a signed Tufts Health Plan Designated Representative Form. You can get a Form by calling our Member Services Team at **888-257-1985**. You can also find this form at online.

If someone tries to submit a Standard Internal Appeal for you without us having a Designated Representative Form on file, we will tell you in writing that a request has been made. We will include the form for you to sign and return. We will not take further action until we get the signed form. If we do not receive the form, we will dismiss the request.

Continuation of services during the Appeal process
If your Appeal concerns the termination of ongoing Covered Services, we will continue coverage through the completion of the Internal Appeal Process. You or your Representative must request the Appeal in a timely manner. You are responsible for related Cost Sharing. 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 decide 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 that we do not properly act on within the time limits specified will be decided in your favor.

There are situations in which we may review an Appeal in a fast manner. Each situation has a certain time requirement in which we must decide:

- If you are a patient in a Hospital: We must issue a decision before you are discharged
- If you are requesting Durable Medical Equipment: We must issue a decision within 48 hours or in less time when the Provider specifies a reasonable time
- If you are terminally ill: We must issue a decision within five business days of receipt of the Appeal

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

Expedited Internal Appeal
You or your Representative may request an Expedited Internal Appeal of an Adverse Determination 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

You, your Provider or your Representative may request an Expedited Internal Appeal from us orally, in writing or in person. You may request this instead of asking for a Standard Internal Appeal.

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, we will reverse the decision within forty-eight (48) hours after the review is started pending outcome of the Expedited Appeal decision.

If you or your Representative submit the request, a Physician will review the request to decide if the criteria for an Expedited Appeal have been met. You will be notified of the decision within 72 hours after the review has begun.

You or your Representative may also request an Expedited External Review from the Office of Patient Protection (OPP). You may ask for this at the same time you ask us for an Expedited Internal Appeal. For more information, please see the sections on Expedited External Reviews, starting on page 56.

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, the Provider may submit a request for coverage. We will review the request and let you know of our decision within 72 hours after receiving the request.

You or your prescribing Provider may request an expedited exception process for a prescription drug based on Exigent circumstances. We will let you and your prescribing Provider know of our decision no later than 24 hours after receiving the request.

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 given 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 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, you can 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 Representative must start 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 within four months of getting our Final Adverse Determination:

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

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.

Payment disputes are not eligible for External Review, except when the Appeal is filed to decide 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 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 617-624-5046 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
- 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 (mental health and/or substance use) Provider within 48 hours after you visit the Emergency room, for follow-up care
- Change your PCP or Behavioral Health (mental health and/or substance use) 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 or explanations of benefits 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
- Offering you something of value in exchange for agreeing to receive Health Care 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 877-824-7123 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 24 for more information.

Coordination of Benefits

You may have benefits from another Plan to cover health care expenses. Our Coordination of Benefits (COB) program prevents duplication of payment for the same Health Care Services. We ensure benefits for Covered Services are coordinated with other plans. We determine which Plan must pay first when you make a Claim, and which Plan has to pay second. We coordinate benefits for prescription drug Claims pursuant to our secondary payer allowed amount in all cases. Our COB program follows Massachusetts law, 211 CMR 38.00 et seq.

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 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
- 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
- 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
- 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 who is legally adopted by the Subscriber or placed for adoption with them. "Placed for adoption" means the Subscriber has taken a legal obligation to support the Child partially or fully in preparation for adoption. If the legal obligation ends, the Child is no longer considered placed for adoption. A foster Child is also considered an Adoptive Child from the date of the adoption petition filing, as required by state law. See also Dependent.

An **Advance Premium Tax Credit (APTC)** is a tax credit you can use to lower your monthly Premium. The APTC is based on your income and household information. To qualify, you must apply for and purchase your insurance through the Health Connector

An **Adverse Determination** is our decision 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 a US healthcare reform law. The goal of the ACA is to increase access to healthcare. It aims to help reduce costs and improve quality. It also ends pre-existing condition exclusions.

The **Allowed Amount i**s the price that we negotiate with In-Network Providers to render Covered Services for Members of Tufts Health Direct**.** Deductible and Coinsurance responsibilities are based on the Allowed Amount.

Appeal—see Standard Internal Appeal or Expedited Internal Appeal.

Authorization—see Prior Authorization.

Behavioral Health (mental health and/or substance use) services include Emergency, Inpatient, intermediate, and Outpatient mental health and substance use disorder services for the treatment of mental health and substance use disorders.

The **Billed Amount** is the amount a Provider charges for a drug or service. This amount is usually different than the Allowed Amount we contract with our Providers.

A **Child** is one of the following individuals, until the last Day of the month of the individual's 26th birthday:

- The Subscriber or Spouse's biological Child, stepchild or Adoptive Child
- The Dependent Child of an enrolled Child
- A Subscriber or Spouse's or domestic partner's Disabled adult Child, who is currently disabled and remains financially dependent on the Subscriber.
- A Child for whom the Subscriber or Spouse or domestic partner is the court-appointed legal guardian

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

Coinsurance is a type of Cost Sharing. It is a percentage of the Allowed Amount that you must pay for a Covered Service,

A **ConnectorCare Plan** is a subsidized non-Group Plan available individuals 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 not In-network. This can be if you are getting active care when you first become a Member. It may also be when one of our Providers leaves our Network for reasons other than quality or Fraud.

Coordination of Benefits is a program that prevents duplication of payment for the same services when you have more than one insurance Plan.

A **Copayment** is a type of Cost Sharing. It is a fixed amount you may have to pay for a Covered Service.

Cost Sharing is the amount you pay for certain Covered Services. Cost Sharing includes Deductibles, Copayments, and/or Coinsurance.

Covered Services are the services Tufts Health Direct covers. The Schedule of Benefits we include in this *Member Handbook* includes all your Covered Services.

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 (mental health and/or substance use) 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
- Routine maintenance of colostomies, ileostomies, and urinary catheters
- 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.

A **Deductible** is a type of Cost Sharing. It is the amount you pay for certain Covered Services in a Plan Year before we will begin to pay.

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

A **Dependent** is the Subscriber's Spouse, Child or Disabled Dependent.

A **Designated Representative (**or, **Representative)** is someone you are choose in writing to make decisions related to your benefit Plan and receive information related to your healthcare.

A **Designated Representative Form** is a form to choose a representative to act your behalf and authorize Tufts Health Plan to disclose your protected health information.

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) Medical equipment that is ordered by a Provider for use in the home. These items must be reusable, such as walkers, wheelchairs, or hospital beds.

Effective 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 **Emergency** is a medical or Behavioral Health (mental health and/or substance use) condition with severe symptoms that require immediate medical attention. If not addressed promptly, your health could be seriously jeopardized. In the case of a pregnant individual, the health of the individual and/or unborn Child is at risk. This danger may lead to significant damage to bodily functions or affect any body organ or part.

Some examples of conditions that need Emergency care include severe pain, a broken leg, loss of consciousness, vomiting blood, chest pain, difficulty breathing, uncontrollable urges to harm oneself or others, or a medical condition that is rapidly deteriorating.

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.

Evidence of Coverage (EOC), also referred to as the *Member Handbook* or Handbook, means this document and any future amendments. The EOC also includes the Schedule of Benefits for your Plan type, Formulary, and any amendments we may send you.

Exigent circumstances are when someone is suffering from a health condition that may seriously jeopardize life, health, or ability to regain maximum function. For pharmacy services, it applies to when a person is undergoing a current course of treatment using a non-Formulary drug.

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. This is available when your life, health or ability to attain, maintain or regain maximum function will be at risk if we follow our standard time frames. We will review Expedited Internal Appeals and decide within 72 hours.

Experimental or **Investigational** services do not have approval for use in mainstream healthcare. These services are often part of medical research and not yet established as standard practice. As a result, they may not be Medically Necessary. The definition is fully explained in its MNG. https://tuftshealthplan.com/documents/providers/guidelines/medical-necessity-guidelines/noncovered-Investigational-services-me

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 our coverage decisions. Providers 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, Hospitals, or Free-standing facilities 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.

Family planning services help Members make decisions about having children. Services may include contraceptives, counseling, and medical support.

The **Federal Poverty Level (FPL)** is set each year by the U.S. government. It is the minimum income needed to cover basic living expenses. The FPL varies by household size and address.

A **Final Adverse Determination** is an Adverse Determination made after you have exhausted all remedies available through our formal Appeal process.

A **Formulary** is our list of covered drugs. See list at https://tuftshealthplan.com/member/tufts-health-direct-plans/pharmacy/pharmacy.

Fraud is knowingly making or allowing someone else to make false statements to obtain unauthorized services, items, or payments. Examples of Fraud include submitting false information on a membership application, making false reimbursement requests, not notifying us of eligibility-affecting changes, or sharing a Member ID Card to access Covered Services.

A **Free-standing Urgent Care Center (UCC)** is a medical facility that offers treatment for non-life-threatening injuries and illnesses requiring immediate care. It provides an alternative to visiting the Emergency room for members who cannot see their PCP promptly. A UCC is not part of a Hospital or Hospital system and are not MinuteClinic®. A UCC does not handle life-threatening conditions. If you have a severe or life-threatening condition, go to the Emergency room instead.

A **Grievance** is any expression of dissatisfaction by you or Designated Representative about an action or inaction by Tufts Health Plan.

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 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 help people with disabilities learn or improve life skills. They prevent skill deterioration and can be provided Inpatient and Outpatient. Services include Physical Therapy, Occupational Therapy, and Speech-language pathology. These services address skills never learned or acquired due to the disabling condition.

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

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

Health Care Services include diagnosis, prevention, treatment, cure or relief of a health care condition.

The **Health Connector** is a state-based health insurance marketplace established under the ACA. It helps Massachusetts residents find affordable health insurance plans, offering subsidies and easy enrollment. Additionally, the Health Connector reviews and approves Qualified Health Plans (QHPs) to ensure they meet quality and coverage standards for consumers.

A **Health Savings Account (HSA)** is a special savings account for medical expenses. It lets you set aside pre-tax money from your paycheck. The funds in the HSA can be used for healthcare expenses like doctor visits, prescriptions, and medical treatments. Funds may not be used to pay Premiums. To qualify for an HSA, you must have a high-Deductible health insurance Plan.

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 a licensed facility that offers medical and surgical care to patients with acute illnesses or injuries. It must be listed with the American Hospital Association (AHA) or accredited by the The Joint Commission.

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

A Member **Identification Card (ID Card)** 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 a walk-in retail-based clinic with licensed Nurse Practitioners or Physician Assistants providing care. For instance, MinuteClinic® offers an alternative to certain Emergency room visits for non-emergent cases or when patients can't see their PCP promptly. It treats common illnesses like strep throat, eye, ear, sinus, or bronchial infections for patients aged 24 months or older. It is not suitable for emergencies, wounds, injuries, x-rays, stitches, or life-threatening conditions. Such cases should be directed to an Emergency room.

Medically Necessary services aim to prevent, diagnose, stop worsening, improve, correct, or cure life-threatening, painful, disabling, or sickness-inducing conditions. They align with accepted medical practices based on appropriateness, proven effectiveness, and scientific evidence. Our Medical Necessity Guidelines (MNGs) are available on our website at https://tuftshealthplan.com/provider/resource-center.

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 amendments or other documents that add to the details of Covered Services.

Our **Member Services** team handles all your questions about policies, procedures, requests, and concerns. You can reach them at **888-257-1985**; TTY line: 711. We are available Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays.

Necessary Information includes, but is not limited to, the results of any face-to-face clinical evaluation, consults, second opinion, labs, imaging, and/or previous therapies

Network refers to the collective group of health care Providers who have contracted with Tufts Health Direct to provide Covered Services. Network Providers are located throughout the Service Area

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

Call 888-MY-RN-LINE (888-697-6546) for our **24/7 NurseLine**. This is a free helpline with caring health professionals. Get info and support on symptoms, diagnoses, treatments, and tests ordered by your Provider. Note: NurseLine doesn't provide medical advice or replace your Provider.

A **Nurse Practitioner (NP)** is registered nurse with advanced training. NPs may diagnose and treat illnesses, prescribe medications, and provide healthcare services.

Observation involves using Hospital services for treatment and evaluation. The goal is either discharge within 48 hours or diagnosis and treatment plan. In some cases, an Observation stay may lead to an Inpatient admission for further treatment.

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

An **Out-of-network Provider** one 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 Plan 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.

Outpatient Surgery refers to surgical procedures when the patient is expected to leave on the same Day or within twenty-four hours. It is also known as Day Surgery, Ambulatory Surgery or Surgical Day Care.

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

A **Physician Assistant (PA)** is medical professional with advanced training. PAs may diagnose and treat illnesses, prescribe medications, and provide healthcare services.

Plan Type refers to the specific Tufts Health Direct Plan you enrolled in. Each Plan Type has different Premiums and Cost Sharing structures. Your Member ID Card lists your Plan Type.

A **Plan Year** is the consecutive 12-month period during which health Plan benefits are purchased and administered. Cost Sharing responsibilities and benefit limits apply to each Plan Year. In some cases, first Plan Year will not be a full 12 months. Also called Benefit Year.

A **Podiatrist** is a Specialist who provides medical and surgical foot care services.

Premium is the monthly bill for your Tufts Health Direct benefits.

Preventive Care is routine health care that includes screenings, check-ups, and counseling to prevent illnesses, disease, or other health problems. Preventive Care services must be covered without Cost Share under the Affordable Care Act.

Primary Care is the first stop in healthcare. It includes basic medical help, preventive services, and ongoing management of common health issues. Your PCP provides these services, aiming to keep you healthy and address non-Emergency medical needs.

A **Primary Care Provider (PCP)** is a Tufts Health Direct Provider that you choose from our Provider Directory or we assign to you. Your PCP offers general medical care for common health issues and coordinate Covered Services. They serve as the starting point for all medical care and can refer you to Specialists if needed. PCPs must be doctors in family practice, internal medicine, general practice, adolescent and pediatric medicine, or obstetrics/gynecology, board-certified or eligible for certification. You may also choose a licensed Nurse Practitioner or Physician Assistant as your PCP. People with disabilities, including those with HIV/AIDS, may have PCPs from other specialties.

Prior Authorization (PA) is permission from Tufts Health Plan before a proposed treatment begins. There are two reasons you may require PA. One is based on the specific Covered Service. The other is if the Provider is not part of the Tufts Health Direct Network. Your Providers know when and how to ask us for PA. If PA is not approved before you receive care, coverage will be denied. You will need to pay for the services you received.

Protected Health Information (PHI) is any information (oral, written or electronic) about your past, present or future physical or mental health or condition. PHI includes information about your health care or payment for your health care. PHI also 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 **Provider Directory** lists Tufts Health Direct's contracted health care facilities and professionals, including all PCPs, Specialists listed by specialty, Hospitals, Emergency rooms and Community Behavioral Health Centers (CBHCs), pharmacies, Ancillary Services, and Behavioral Health (mental health and/or substance use) services. The Provider Directory is available online or hardcopy.

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

A **Reconsideration of a Standard Internal Appeal** is a request by you or your Designated Representative for us to review our Standard Internal Appeal decision a second time. We will review and decide 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.

The **Schedule of Benefits** is the section included in Appendix B at the end of this *Member Handbook.* It provides a general description of your Tufts Health Direct Plan Type's Covered Services. It lists benefits, Cost Sharing amounts, Prior Authorization requirements, and any limits on the benefits your policy covers.

A Serious and Complex Condition is:

- 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.

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

The Service Area is all of Massachusetts EXCEPT Dukes and Nantucket Counties. For ConnectorCare Plans in Franklin County: Members can only enroll in select zip codes: 01002, 01039, 01054, 01070, 01093, 01096, 01247, 01350, 01355, 01364, 01366, 01367, 01378

A **Skilled Nursing Facility** is a licensed inpatient facility providing specialized nursing care to individuals who do not need acute care Hospital services.

A **Small 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.

A **Specialist** is a doctor who is trained to provide specialty services. Examples include cardiologists, psychologists, obstetricians, and dermatologists.

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. This includes a divorced Spouse as required by Massachusetts law. Spouse also includes the spousal equivalent of the Subscriber. This refers to someone who is registered as a domestic partner, civil union partner, or any other legally recognized partner of the Subscriber. The person must reside in a state or municipal jurisdiction that grants such legal recognition or equivalent spousal rights.

A **Standard Internal Appeal** is an oral or written request for Tufts Health Plan to review any Adverse Determination. We will review and decide 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 and in whose name the Premium is paid in accordance with either a Group Contract or an individual contract. 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.

Terminally Ill means having a life expectancy of six months or less, as certified by an In-network Provider.

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 danger, but you need immediate medical attention. Examples for 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. 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 evaluates whether Health Care Services provided to Members are: (1) Medically Necessary; and (2) provided in the most appropriate and efficient manner.

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 evaluate the clinical necessity, appropriateness, or efficiency of Covered Services and settings. 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.

Appendix B: Schedule of Benefits

Direct ConnectorCare AIAN
Schedule of Benefits

TUFTS Health Plan
a Point32Health company

This Schedule of Benefits 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 Schedule of Benefits for your specific Plan Type. To see which Tufts Health Direct Plan Type you have, check your Tufts Health Plan Member ID Card.

If you want more information about your benefits and capitalized terms, see your *Tufts Health Direct Member Handbook* https://tuftshealthplan.com/documents/members/handbooks/direct-member-handbook-2024.

You must go to Providers who are part of the Tufts Health Direct Provider Network to get services. Out-of-network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal.

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).

This zero cost sharing Plan is made available by the Massachusetts Health Connector for all American Indian/Alaskan Natives with incomes below 300% FPL that are eligible for Federal APTC. The amounts of the Annual Deductible and Annual Out-of-Pocket Maximum which apply to you and the enrolled Members of your family each Plan Year are:

ANNUAL DEDUCTIBLE	AMOUNT
Individual	$0
Family	$0

ANNUAL OUT-OF-POCKET MAXIMUM	AMOUNT
Individual	$0
Family	$0

Covered Services	Cost Sharing	Benefit Limit & Notes
Abortion services	No charge	No Prior Authorization required.
Acupuncture services	No charge	No Prior Authorization required. No visit limits.
Allergy services		
Allergy testing	No charge	No Prior Authorization required. Covered for up to 200 allergy tests per Plan Year.
Allergy treatments (injections)	No charge	Note: Allergy immunotherapy covered as part of the pharmacy prescription benefit may require Prior Authorization and have separate pharmacy Cost Sharing responsibility.
Outpatient medical office visits	No charge	
Ambulance services		
Emergency	No charge	No Prior Authorization required.
Other non-Emergency transportation	No charge	Prior Authorization required.
Behavioral Health services - Mental Health & Substance Use Disorder		
Inpatient services		No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission from the Emergency Room. Planned admissions require Prior Authorization 5 business days before admission.
Facility fee	No charge	Includes room and board and services supplied by the facility during the inpatient stay
Professional fee	No charge	Includes physician and other covered professional Provider services
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.
Outpatient services		
Individual therapy/Counseling	No charge	No Prior Authorization required. No visit limits.
Intermediate care, including Behavioral Health (mental health and/or substance use) services for children and adolescents	No charge	Prior Authorization is required for certain Behavioral Health (mental health and/or substance use) services for children and adolescents. Please see the "Covered Services" section of the Tufts Health Direct Member Handbook for more information about these services.
Medication-Assisted Treatment services	No charge	Certain medication may require Prior Authorization.

Covered Services	Cost Sharing	Benefit Limit & Notes
Behavioral Health services - Mental Health & Substance Use Disorder, continued		
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	No charge	No Prior Authorization required. Includes dosing, counseling, and lab services
Recovery Coaches and Peer Specialists	No charge	No Prior Authorization required.
Substance Use Treatment Programs	No charge	
Autism Spectrum Disorder Services		
Applied Behavioral Analysis (ABA)	No charge	Prior Authorization required. 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	No charge	Physical, occupational, and speech therapy benefit limits do not apply.
Chemotherapy and radiation oncology services	No charge	Certain services require Prior Authorization.
Chiropractic care	No charge	No Prior Authorization required.
Cleft palate and cleft lip care	No charge	Covered for Members under the age of 18. Includes medical, dental, oral, and facial surgery, follow-up, and related services
Clinical trials	No charge	No Prior Authorization required. Routine patient care services covered for Members in a qualified clinical trial pursuant to state and federal mandates.
Dental care, accidental	No charge	No Prior Authorization required. 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.

Covered Services	Cost Sharing	Benefit Limit & Notes
Dental care, non-Emergency (Pediatric only, Delta Dental)		
Members are eligible for services until the last Day of the month in which they turn 19 years old. Please call Delta Dental at 800-872-0500 for more information and for Prior Authorization requirements.		
Type I: Preventive & Diagnostic	No charge	Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age.
Type II: Basic covered services	No charge	
Type III: Major restorative services	No charge	
Type IV: Orthodontia	No charge	Medically Necessary orthodontia requires Prior Authorization.
Diabetes education and treatment	No charge	Prior Authorization required for certain services. No charge for the Good Measures program.
Diagnostic services (Outpatient laboratory services, imaging, radiology, and other diagnostic testing)		
Laboratory services	No charge	Includes blood tests, urinalysis, and throat cultures to maintain health and to test, diagnose, and treat disease. Genetic testing requires Prior Authorization.
X-rays	No charge	No Prior Authorization required.
Advanced imaging (MRI, CT, PET scans)	No charge	Prior Authorization required.
Sleep studies	No charge	Prior Authorization required.
Other diagnostic testing	No charge	Certain services require Prior Authorization.
Dialysis services	No charge	No Prior Authorization required.
Disease Management Programs	No charge	For Members with asthma, diabetes, chronic obstructive pulmonary disease (COPD) or congestive heart failure. If you have any of these conditions, please contact us at **888-257-1985** to discuss our disease management programs.
Durable Medical Equipment (DME)		
Covered medical equipment rented or purchased for home use	No charge	Prior Authorization is required for certain services, including prosthetic orthotics. Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs.
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.

Covered Services	Cost Sharing	Benefit Limit & Notes
Early Intervention services	No charge	No Prior Authorization required. 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.
Emergency Room care	No charge	No Prior Authorization required. Emergency Room Cost Share waived if held for *Observation services,* sent for *Outpatient surgery services* or admitted for *Inpatient medical or surgical care*. If admitted to the Hospital, Notification required within 48 hours.
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 Plan 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.
Gender affirming services	No charge	Prior Authorization required. Medically necessary services may include Inpatient medical and surgical care, Outpatient surgery, Diagnostic services, Speech therapy, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies among other services
Habilitative and rehabilitative services	No charge	Includes cardiac rehabilitation; physical therapy; occupational therapy; and speech, hearing, and language therapy services. See below for specific details.
Limits:		
Cardiac rehabilitation		
Physical and occupational therapy		Prior Authorization required after initial evaluation and 11 visits. Maximum of 60 visits total Physical and Occupational Therapy per Member per Plan Year.
Speech, hearing, and language therapy		Prior Authorization required after visit 30. No visit limits.
Home health care	No charge	Prior Authorization is required for all home care services and disciplines.
Hospice services	No charge	Prior Authorization required.
Infertility services	No charge	Prior Authorization required. Medically necessary services may include I*npatient medical and surgical care*, *Outpatient surgery*, *Diagnostic services*, *Medical care Outpatient services*, *Medical benefit drugs* and/or *Prescription drugs and supplies* among other services.

Covered Services	Cost Sharing	Benefit Limit & Notes
Inpatient medical and surgical care Hospital; Chronic Disease Hospital; Rehabilitation Hospital; or Skilled Nursing Facility (SNF)		No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission from the Emergency Room. Planned admissions require Prior Authorization 5 business days before admission.
Facility Fee	No charge	Includes room and board and services supplied by the facility during the inpatient stay, including preadmission testing, anesthesia, diagnostic services, and medication and supplies
Professional Fee	No charge	Includes physician and other covered professional Provider services
Limits:		
Chronic Disease or Rehabilitation Hospital		Maximum of 60 Days total per Member per Plan Year
Skilled Nursing Facility		Maximum of 100 Days total per Member per Plan Year
Maternity services and Well Newborn care		
Childbirth classes	Covered for cost of childbirth education course	Complete a Member Reimbursement Medical Claim Form and submit by mail with proof of payment.
Routine prenatal and postpartum care	No charge	All Outpatient routine prenatal and postpartum office visits are covered as well as breastfeeding services and supports.
Non-routine prenatal care	No charge	Any Outpatient maternity services not considered routine or those related to complications or risks with a pregnancy, may be subject to Cost Sharing. Some examples of services not considered routine include, but are not limited to, amniocentesis, fetal stress testing, and OB ultrasounds.
Hospital and delivery services	No charge	Well newborn care is included as part of covered maternity admission.
Breast pumps	No charge	No Prior Authorization required. One breast pump per birth including related parts and supplies. 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. Pump must be obtained from contracting DME Provider.
Medical benefit drugs	No charge	Prior Authorization required for certain drugs. Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit.

Covered Services	Cost Sharing	Benefit Limit & Notes
Medical care Outpatient visits		
Medical Care includes services to diagnose, treat, and maintain a health condition. Medical care services are covered by Providers in the Tufts Health Direct Network. You are not covered for services from Providers outside of our Network and will be responsible for payment in full. Contact Member Services at **888-257-1985** or visit tuftshealthplan.com/memberlogin to find an In-network Provider. See *Preventive health services* for information about routine health care.		
Office and community health center visits		
Primary Care Provider (PCP)	No charge	No Prior Authorization required.
Specialist	No charge	Prior Authorization required for certain specialist visits.
MinuteClinic	No charge	No Prior Authorization required. A walk-in clinic accessible at select CVS locations
Nutritional counseling	No charge	Prior Authorization required.
Observation services	No charge	No Prior Authorization required. 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.
Organ or bone marrow transplant	No charge	Prior Authorization required.
Outpatient surgery services		
Outpatient Day surgery		
Outpatient Hospital or Ambulatory Surgery Center facility fee	No charge	Prior Authorization required for certain services.
Professional fee	No charge	Includes physician and other covered professional Provider services
Office and community health center surgical services	No charge	
Pain management	No charge	Certain services require Prior Authorization. Cost Sharing based on type of service, for example Acupuncture, Nutritional counseling, Physical therapy or Chiropractic care.
Podiatry care	No charge	No Prior Authorization required. 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 Limit & Notes
Prescription drugs and supplies		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.
Retail pharmacy		
Tier 1	No charge	Primarily generic drugs
Tier 2	No charge	Includes some non-preferred generics and preferred brands
Tier 3	No charge	Includes high-cost generics, non-preferred brands, and Specialty drugs
Mail order pharmacy		
Tier 1	No charge	Primarily generic drugs
Tier 2	No charge	Includes some non-preferred generics and preferred brands
Tier 3	No charge	Includes high-cost generics, non-preferred brands, and Specialty drugs
Preventive health services		
Preventive Health services are routine health care that include screenings, check-ups, and counseling to prevent illnesses, disease, or other health problems. Certain Preventive health services may require Prior Authorization. Work with your PCP to use the Preventive Services Policy to review specific requirements.		
Routine pediatric care	No charge	Includes but is not limited to routine exams; immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning
Routine adult care	No charge	Includes but is not limited to routine exams; immunizations; routine lab tests and x-rays; routine mammograms; and routine colonoscopies
Routine gynecological (GYN) care	No charge	Includes but is not limited to routine exams and cervical cancer screenings (Pap smear tests)
Family planning	No charge	
Smoking Cessation Counseling Services	No charge	
Reconstructive surgery and procedures	No charge	Certain services may require Prior Authorization.
Telehealth	No charge	Please ask your Providers' office for information on telehealth availability and access.
Urgent care	No charge	No Prior Authorization required. In our Service Area, you must visit a UCC that is in our Network to be covered for services. Outside of our Service Area, free-standing Urgent Care Centers (UCCs) are covered at Out-of-network Provider sites, including Hospitals and clinics.

Covered Services	Cost Sharing	Benefit Limit & Notes
Vision care		
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.		
Routine pediatric care (under 19 years of age)	No charge	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.
Routine adult care (age 19 or older)	No charge	Coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics.
Medical eye and vision care	No charge	
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 Plan Year. Must complete a Weight Loss Program 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 I

Schedule of Benefits

a Point32Health company

This Schedule of Benefits 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 Schedule of Benefits for your specific Plan Type. To see which Tufts Health Direct Plan Type you have, check your Tufts Health Plan Member ID Card.

If you want more information about your benefits and capitalized terms, see your *Tufts Health Direct Member Handbook* https://tuftshealthplan.com/documents/members/handbooks/direct-member-handbook-2024.

You must go to Providers who are part of the Tufts Health Direct Provider Network to get services. Out-of-network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal.

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).

You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document. Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The amounts of the Annual Deductible and Annual Out-of-Pocket Maximum which apply to you and the enrolled Members of your family each Plan Year are:

ANNUAL DEDUCTIBLE	AMOUNT	NOTES
Individual	$0	The Individual Deductible applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Deductible even if other Members on the family Plan have not.
Family	$0	Once two or more Members on a family Plan meet the Family Annual Deductible, the entire family is considered to have met the Deductible for the Plan Year.

ANNUAL OUT-OF-POCKET MAXIMUM	AMOUNT	NOTES
Individual	Medical: $0 Pharmacy: $250	The Individual Out-of-Pocket Maximum applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Out-of-Pocket Maximum even if other Members on the family Plan have not.
Family	Medical: $0 Pharmacy: $500	Once two or more Members on a family Plan meet the Family Annual Out-of-pocket Maximum amount, the entire family is considered to have met the Out-of-pocket Maximum for the Plan Year.
Notice for American Indian and Alaskan Native (AI/AN) Members: All American Indian/Alaskan Native Members, regardless of income, can enroll in a limited cost sharing Plan at any metal level, which means no Copayments, Deductibles, or Coinsurance when receiving care from Indian health care Providers. The Massachusetts Health Connector determines your eligibility to enroll in this Plan variation as part of your application process.		

Covered Services	Cost Sharing	Benefit Limit & Notes
Abortion services	No charge	No Prior Authorization required.
Acupuncture services	No charge	No Prior Authorization required. No visit limits.
Allergy services		
Allergy testing	No charge	No Prior Authorization required. Covered for up to 200 allergy tests per Plan Year.
Allergy treatments (injections)	No charge	Note: Allergy immunotherapy covered as part of the pharmacy prescription benefit may require Prior Authorization and have separate pharmacy Cost Sharing responsibility.
Outpatient medical office visits	No charge	
Ambulance services		
Emergency	No charge	No Prior Authorization required.
Other non-Emergency transportation	No charge	Prior Authorization required.
Behavioral Health services - Mental Health & Substance Use Disorder		
Inpatient services		No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission from the Emergency Room. Planned admissions require Prior Authorization 5 business days before admission.
Facility fee	No charge	Includes room and board and services supplied by the facility during the inpatient stay
Professional fee	No charge	Includes physician and other covered professional Provider services
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.
Outpatient services		
Individual therapy/Counseling	No charge	No Prior Authorization required. No visit limits.
Intermediate care, including Behavioral Health (mental health and/or substance use) services for children and adolescents	No charge	Prior Authorization is required for certain Behavioral Health (mental health and/or substance use) services for children and adolescents. Please see the "Covered Services" section of the Tufts Health Direct Member Handbook for more information about these services.
Medication-Assisted Treatment services	No charge	Certain medication may require Prior Authorization.

Covered Services	Cost Sharing	Benefit Limit & Notes
Behavioral Health services - Mental Health & Substance Use Disorder, continued		
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	No charge	No Prior Authorization required. Includes dosing, counseling, and lab services
Recovery Coaches and Peer Specialists	No charge	No Prior Authorization required.
Substance Use Treatment Programs	No charge	
Autism Spectrum Disorder Services		
Applied Behavioral Analysis (ABA)	No charge	Prior Authorization required. 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	No charge	Physical, occupational, and speech therapy benefit limits do not apply.
Chemotherapy and radiation oncology services	No charge	Certain services require Prior Authorization.
Chiropractic care	No charge	No Prior Authorization required.
Cleft palate and cleft lip care	No charge	Covered for Members under the age of 18. Includes medical, dental, oral, and facial surgery, follow-up, and related services.
Clinical trials	No charge	No Prior Authorization required. Routine patient care services covered for Members in a qualified clinical trial pursuant to state and federal mandates.
Dental care, accidental	No charge	No Prior Authorization required. 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.

Covered Services	Cost Sharing	Benefit Limit & Notes
Dental care, non-Emergency (Pediatric only, Delta Dental)		
Members are eligible for services until the last Day of the month in which they turn 19 years old. Please call Delta Dental at 800-872-0500 for more information and for Prior Authorization requirements.		
Type I: Preventive & Diagnostic	No charge	Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age.
Type II: Basic covered services	No charge	
Type III: Major restorative services	No charge	
Type IV: Orthodontia	No charge	Medically Necessary orthodontia requires Prior Authorization.
Diabetes education and treatment	No charge	Prior Authorization required for certain services. No charge for the Good Measures program.
Diagnostic services (Outpatient laboratory services, imaging, radiology, and other diagnostic testing)		
Laboratory services	No charge	Includes blood tests, urinalysis, and throat cultures to maintain health and to test, diagnose, and treat disease. Genetic testing requires Prior Authorization.
X-rays	No charge	No Prior Authorization required.
Advanced imaging (MRI, CT, PET scans)	No charge	Prior Authorization required.
Sleep studies	No charge	Prior Authorization required.
Other diagnostic testing	No charge	Certain services require Prior Authorization.
Dialysis services	No charge	No Prior Authorization required.
Disease Management Programs	No charge	For Members with asthma, diabetes, chronic obstructive pulmonary disease (COPD) or congestive heart failure. If you have any of these conditions, please contact us at **888-257-1985** to discuss our disease management programs.
Durable Medical Equipment (DME)		
Covered medical equipment rented or purchased for home use	No charge	Prior Authorization is required for certain services, including prosthetic orthotics. Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs.
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.

Covered Services	Cost Sharing	Benefit Limit & Notes
Early Intervention services	No charge	No Prior Authorization required. 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.
Emergency Room care	No charge	No Prior Authorization required. Emergency Room Cost Share waived if held for *Observation services,* sent for *Outpatient surgery services* or admitted for *Inpatient medical or surgical care*. If admitted to the Hospital, Notification required within 48 hours.
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 Plan 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.
Gender affirming services	No charge	Prior Authorization required. Medically necessary services may include Inpatient medical and surgical care, Outpatient surgery, Diagnostic services, Speech therapy, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies among other services
Habilitative and rehabilitative services	No charge	Includes cardiac rehabilitation; physical therapy; occupational therapy; and speech, hearing, and language therapy services. See below for specific details.
Limits:		
Cardiac rehabilitation		
Physical and occupational therapy		Prior Authorization required after initial evaluation and 11 visits. Maximum of 60 visits total Physical and Occupational Therapy per Member per Plan Year.
Speech, hearing, and language therapy		Prior Authorization required after visit 30. No visit limits.
Home health care	No charge	Prior Authorization is required for all home care services and disciplines.
Hospice services	No charge	Prior Authorization required.
Infertility services	No charge	Prior Authorization required. Medically necessary services may include I*npatient medical and surgical care*, *Outpatient surgery*, *Diagnostic services*, *Medical care outpatient services*, *Medical benefit drugs* and/or *Prescription drugs and supplies* among other services.

Covered Services	Cost Sharing	Benefit Limit & Notes
Inpatient medical and surgical care Hospital; Chronic Disease Hospital; Rehabilitation Hospital; or Skilled Nursing Facility (SNF)		No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission from the Emergency Room. Planned admissions require Prior Authorization 5 business days before admission.
Facility Fee	No charge	Includes room and board and services supplied by the facility during the inpatient stay, including preadmission testing, anesthesia, diagnostic services, and medication and supplies
Professional Fee	No charge	Includes physician and other covered professional Provider services
Limits:		
Chronic Disease or Rehabilitation Hospital		Maximum of 60 Days total per Member per Plan Year
Skilled Nursing Facility		Maximum of 100 Days total per Member per Plan Year
Maternity services and Well Newborn care		
Childbirth classes	Covered for cost of childbirth education course	Complete a Member Reimbursement Medical Claim Form and submit by mail with proof of payment.
Routine prenatal and postpartum care	No charge	All Outpatient routine prenatal and postpartum office visits are covered as well as breastfeeding services and supports.
Non-routine prenatal care	No charge	Any Outpatient maternity services not considered routine or those related to complications or risks with a pregnancy, may be subject to Cost Sharing. Some examples of services not considered routine include, but are not limited to, amniocentesis, fetal stress testing, and OB ultrasounds.
Hospital and delivery services	No charge	Well newborn care is included as part of covered maternity admission.
Breast pumps	No charge	No Prior Authorization required. One breast pump per birth including related parts and supplies. 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. Pump must be obtained from contracting DME Provider.
Medical benefit drugs	No charge	Prior Authorization required for certain drugs. Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit.

Covered Services	Cost Sharing	Benefit Limit & Notes
Medical care Outpatient visits		
Medical Care includes services to diagnose, treat, and maintain a health condition. Medical care services are covered by Providers in the Tufts Health Direct Network. You are not covered for services from Providers outside of our Network and will be responsible for payment in full. Contact Member Services at **888-257-1985** or visit tuftshealthplan.com/memberlogin to find an In-network Provider. See *Preventive health services* for information about routine health care.		
Office and community health center visits		
Primary Care Provider (PCP)	No charge	No Prior Authorization required.
Specialist	No charge	Prior Authorization required for certain specialist visits.
MinuteClinic	No charge	No Prior Authorization required. A walk-in clinic accessible at select CVS locations
Nutritional counseling	No charge	Prior Authorization required.
Observation services	No charge	No Prior Authorization required. 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.
Organ or bone marrow transplant	No charge	Prior Authorization required.
Outpatient surgery services		
Outpatient Day surgery		
Outpatient Hospital or Ambulatory Surgery Center facility fee	No charge	Prior Authorization required for certain services.
Professional fee	No charge	Includes physician and other covered professional Provider services
Office and community health center surgical services	No charge	
Pain management	No charge	Certain services require Prior Authorization. Cost Sharing based on type of service, for example Acupuncture, Nutritional counseling, Physical therapy or Chiropractic care.
Podiatry care	No charge	No Prior Authorization required. 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 Limit & Notes
Prescription drugs and supplies		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.
Retail pharmacy		
Tier 1	$1.00 Copayment	Primarily generic drugs
Tier 2	$3.65 Copayment	Includes some non-preferred generics and preferred brands
Tier 3	$3.65 Copayment	Includes high-cost generics, non-preferred brands, and Specialty drugs
Mail order pharmacy		
Tier 1	$2.00 Copayment	Primarily generic drugs
Tier 2	$7.30 Copayment	Includes some non-preferred generics and preferred brands
Tier 3	$7.30 Copayment	Includes high-cost generics, non-preferred brands, and Specialty drugs
Preventive health services		
Preventive Health services are routine health care that include screenings, check-ups, and counseling to prevent illnesses, disease, or other health problems. Certain Preventive health services may require Prior Authorization. Work with your PCP to use the Preventive Services Policy to review specific requirements.		
Routine pediatric care	No charge	Includes but is not limited to routine exams; immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning
Routine adult care	No charge	Includes but is not limited to routine exams; immunizations; routine lab tests and x-rays; routine mammograms; and routine colonoscopies
Routine gynecological (GYN) care	No charge	Includes but is not limited to routine exams and cervical cancer screenings (Pap smear tests)
Family planning	No charge	
Smoking Cessation Counseling Services	No charge	
Reconstructive surgery and procedures	No charge	Certain services may require Prior Authorization.
Telehealth	No charge	Please ask your Providers' office for information on telehealth availability and access.
Urgent care	No charge	No Prior Authorization required. In our Service Area, you must visit a UCC that is in our Network to be covered for services. Outside of our Service Area, free-standing Urgent Care Centers (UCCs) are covered at Out-of-network Provider sites, including Hospitals and clinics.

Covered Services	Cost Sharing	Benefit Limit & Notes
Vision care		
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.		
Routine pediatric care (under 19 years of age)	No charge	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.
Routine adult care (age 19 or older)	No charge	Coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics.
Medical eye and vision care	No charge	
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 Plan Year. Must complete a Weight Loss Program 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

Schedule of Benefits

a Point32Health company

This Schedule of Benefits 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 Schedule of Benefits for your specific Plan Type. To see which Tufts Health Direct Plan Type you have, check your Tufts Health Plan Member ID Card.

If you want more information about your benefits and capitalized terms, see your *Tufts Health Direct Member Handbook* https://tuftshealthplan.com/documents/members/handbooks/direct-member-handbook-2024.

You must go to Providers who are part of the Tufts Health Direct Provider Network to get services. Out-of-network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal.

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).

You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document. Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The amounts of the Annual Deductible and Annual Out-of-Pocket Maximum which apply to you and the enrolled Members of your family each Plan Year are:

ANNUAL DEDUCTIBLE	AMOUNT	NOTES
Individual	$0	The Individual Deductible applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Deductible even if other Members on the family Plan have not.
Family	$0	Once two or more Members on a family Plan meet the Family Annual Deductible, the entire family is considered to have met the Deductible for the Plan Year.

ANNUAL OUT-OF-POCKET MAXIMUM	AMOUNT	NOTES
Individual	Medical: $750 Pharmacy: $500	The Individual Out-of-Pocket Maximum applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Out-of-Pocket Maximum even if other Members on the family Plan have not.
Family	Medical: $1,500 Pharmacy: $1,000	Once two or more Members on a family Plan meet the Family Annual Out-of-pocket Maximum amount, the entire family is considered to have met the Out-of-pocket Maximum for the Plan Year.
Notice for American Indian and Alaskan Native (AI/AN) Members: All American Indian/Alaskan Native Members, regardless of income, can enroll in a limited cost sharing Plan at any metal level, which means no Copayments, Deductibles, or Coinsurance when receiving care from Indian health care Providers. The Massachusetts Health Connector determines your eligibility to enroll in this Plan variation as part of your application process.		

Covered Services	Cost Sharing	Benefit Limit & Notes
Abortion services	No charge	No Prior Authorization required.
Acupuncture services	$18 Copayment per visit	No Prior Authorization required. No visit limits.
Allergy services		
Allergy testing	$18 Copayment per visit	No Prior Authorization required. Covered for up to 200 allergy tests per Plan Year.
Allergy treatments (injections)	$5 Copayment per injection	Note: Allergy immunotherapy covered as part of the pharmacy prescription benefit may require Prior Authorization and have separate pharmacy Cost Sharing responsibility.
Outpatient medical office visits	See *Medical care Outpatient visits*	
Ambulance services		
Emergency	No charge	No Prior Authorization required.
Other non-Emergency transportation	No charge	Prior Authorization required.
Behavioral Health services - Mental Health & Substance Use Disorder		
Inpatient services		No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission from the Emergency Room. Planned admissions require Prior Authorization 5 business days before admission.
Facility fee	$50 Copayment per stay	Includes room and board and services supplied by the facility during the inpatient stay
Professional fee	No charge	Includes physician and other covered professional Provider services
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.
Outpatient services		
Individual therapy/Counseling	No charge	No Prior Authorization required. No visit limits.
Intermediate care, including Behavioral Health (mental health and/or substance use) services for children and adolescents	No charge	Prior Authorization is required for certain Behavioral Health (mental health and/or substance use) services for children and adolescents. Please see the "Covered Services" section of the Tufts Health Direct Member Handbook for more information about these services.
Medication-Assisted Treatment services	No charge	Certain medication may require Prior Authorization.

Covered Services	Cost Sharing	Benefit Limit & Notes
Behavioral Health services - Mental Health & Substance Use Disorder, continued		
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	No charge	No Prior Authorization required. Includes dosing, counseling, and lab services
Recovery Coaches and Peer Specialists	No charge	No Prior Authorization required.
Substance Use Treatment Programs	Cost sharing varies based on type and place of service.	
Autism Spectrum Disorder Services		
Applied Behavioral Analysis (ABA)	No charge	Prior Authorization required. 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	$10 Copayment per visit	Physical, occupational, and speech therapy benefit limits do not apply.
Chemotherapy and radiation oncology services	No charge	Certain services require Prior Authorization.
Chiropractic care	$18 Copayment per visit	No Prior Authorization required.
Cleft palate and 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	Based on place of service	No Prior Authorization required. Routine patient care services covered for Members in a qualified clinical trial pursuant to state and federal mandates.
Dental care, accidental	Based on place of service	No Prior Authorization required. 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.

Covered Services	Cost Sharing	Benefit Limit & Notes
Dental care, non-Emergency (Pediatric only, Delta Dental)		
Members are eligible for services until the last Day of the month in which they turn 19 years old. Please call Delta Dental at 800-872-0500 for more information and for Prior Authorization requirements.		
Type I: Preventive & Diagnostic	No charge	Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age.
Type II: Basic covered services	No charge	
Type III: Major restorative services	No charge	
Type IV: Orthodontia	No charge	Medically Necessary orthodontia requires Prior Authorization.
Diabetes education and treatment	Cost Sharing varies based on type and place of service.	Prior Authorization required for certain services. No charge for the Good Measures program.
Diagnostic services (Outpatient laboratory services, imaging, radiology, and other diagnostic testing)		
Laboratory services	No charge	Includes blood tests, urinalysis, and throat cultures to maintain health and to test, diagnose, and treat disease. Genetic testing requires Prior Authorization.
X-rays	No charge	No Prior Authorization required.
Advanced imaging (MRI, CT, PET scans)	$30 Copayment	Prior Authorization required.
Sleep studies	Related *Medical care Outpatient visit* or *Inpatient medical care* Cost Sharing may be required	Prior Authorization required.
Other diagnostic testing	No charge	Certain services require Prior Authorization.
Dialysis services	No charge	No Prior Authorization required.
Disease Management Programs	No charge	For Members with asthma, diabetes, chronic obstructive pulmonary disease (COPD) or congestive heart failure. If you have any of these conditions, please contact us at **888-257-1985** to discuss our disease management programs.

Covered Services	Cost Sharing	Benefit Limit & Notes
Durable Medical Equipment (DME)		
Covered medical equipment rented or purchased for home use	No charge	Prior Authorization is required for certain services, including prosthetic orthotics. Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs.
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.
Early Intervention services	No charge	No Prior Authorization required. 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.
Emergency Room care	$50 Copayment per visit	No Prior Authorization required. Emergency Room Cost Share waived if held for *Observation services,* sent for *Outpatient surgery services* or admitted for *Inpatient medical or surgical care*. If admitted to the Hospital, Notification required within 48 hours.
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 Plan 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.
Gender affirming services	Cost Sharing varies based on type and place of service.	Prior Authorization required. Medically necessary services may include Inpatient medical and surgical care, Outpatient surgery, Diagnostic services, Speech therapy, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies among other services.

Covered Services	Cost Sharing	Benefit Limit & Notes
Habilitative and rehabilitative services	$10 Copayment per visit	Includes cardiac rehabilitation; physical therapy; occupational therapy; and speech, hearing, and language therapy services. See below for specific details.
Limits:		
Cardiac rehabilitation		
Physical and occupational therapy		Prior Authorization required after initial evaluation and 11 visits. Maximum of 60 visits total Physical and Occupational Therapy per Member per Plan Year.
Speech, hearing, and language therapy		Prior Authorization required after visit 30. No visit limits.
Home health care	No charge	Prior Authorization is required for all home care services and disciplines.
Hospice services	No charge	Prior Authorization required.
Infertility services	Cost Sharing varies based on type and place of service.	Prior Authorization required. Medically necessary services may include I*npatient medical and surgical care*, *Outpatient surgery*, *Diagnostic services*, *Medical care Outpatient services*, *Medical benefit drugs* and/or *Prescription drugs and supplies* among other services.
Inpatient medical and surgical care Hospital; Chronic Disease Hospital; Rehabilitation Hospital; or Skilled Nursing Facility (SNF)		No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission from the Emergency Room. Planned admissions require Prior Authorization 5 business days before admission.
Facility Fee	$50 Copayment per stay	Includes room and board and services supplied by the facility during the inpatient stay, including preadmission testing, anesthesia, diagnostic services, and medication and supplies
Professional Fee	No charge	Includes physician and other covered professional Provider services
Limits:		
Chronic Disease or Rehabilitation Hospital		Maximum of 60 Days total per Member per Plan Year
Skilled Nursing Facility	No charge	Maximum of 100 Days total per Member per Plan Year

Covered Services	Cost Sharing	Benefit Limit & Notes
Maternity services and Well Newborn care		
Childbirth classes	Covered for cost of childbirth education course	Complete a Member Reimbursement Medical Claim Form and submit by mail with proof of payment.
Routine prenatal and postpartum care	No charge	All Outpatient routine prenatal and postpartum office visits are covered as well as breastfeeding services and supports.
Non-routine prenatal care	Cost Sharing varies based on type and place of service.	Any Outpatient maternity services not considered routine or those related to complications or risks with a pregnancy, may be subject to Cost Sharing. Some examples of services not considered routine include, but are not limited to, amniocentesis, fetal stress testing, and OB ultrasounds.
Hospital and delivery services	See *Inpatient medical and surgical care*	Well newborn care is included as part of covered maternity admission.
Breast pumps	No charge	No Prior Authorization required. One breast pump per birth including related parts and supplies. 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. Pump must be obtained from contracting DME Provider.
Medical benefit drugs	No charge	Prior Authorization required for certain drugs. Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit.
Medical care Outpatient visits		
Medical Care includes services to diagnose, treat, and maintain a health condition. Medical care services are covered by Providers in the Tufts Health Direct Network. You are not covered for services from Providers outside of our Network and will be responsible for payment in full. Contact Member Services at **888-257-1985** or visit tuftshealthplan.com/memberlogin to find an In-network Provider. See *Preventive health services* for information about routine health care.		
Office and community health center visits		
Primary Care Provider (PCP)	No charge	No Prior Authorization required.
Specialist	$18 Copayment per visit	Prior Authorization required for certain specialist visits.
MinuteClinic	No charge	No Prior Authorization required. A walk-in clinic accessible at select CVS locations
Nutritional counseling	See *Medical care Outpatient visits*	Prior Authorization required.
Observation services	$50 Copayment per visit	No Prior Authorization required. 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.

Covered Services	Cost Sharing	Benefit Limit & Notes
Organ or bone marrow transplant	See *Inpatient medical and surgical care*	Prior Authorization required.
Outpatient surgery services		
Outpatient day surgery		
Outpatient Hospital or Ambulatory Surgery Center facility fee	$50 Copayment per visit	Prior Authorization required for certain services.
Professional fee	No charge	Includes physician and other covered professional Provider services
Office and community health center surgical services	See *Medical care Outpatient visits*	
Pain management	Cost Sharing varies based on type and place of service.	Certain services require Prior Authorization. Cost Sharing based on type of service, for example Acupuncture, Nutritional counseling, Physical therapy or Chiropractic care.
Podiatry care	See *Medical care Outpatient visits*	No Prior Authorization required. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot.
Prescription drugs and supplies		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.
Retail pharmacy		
Tier 1	$10 Copayment	Primarily generic drugs
Tier 2	$20 Copayment	Includes some non-preferred generics and preferred brands
Tier 3	$40 Copayment	Includes high-cost generics, non-preferred brands, and Specialty drugs
Mail order pharmacy		
Tier 1	$20 Copayment	Primarily generic drugs
Tier 2	$40 Copayment	Includes some non-preferred generics and preferred brands
Tier 3	$80 Copayment	Includes high-cost generics, non-preferred brands, and Specialty drugs

Covered Services	Cost Sharing	Benefit Limit & Notes
Preventive health services		
Preventive Health services are routine health care that include screenings, check-ups, and counseling to prevent illnesses, disease, or other health problems. Certain Preventive health services may require Prior Authorization. Work with your PCP to use the Preventive Services Policy to review specific requirements.		
Routine pediatric care	No charge	Includes but is not limited to routine exams; immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning
Routine adult care	No charge	Includes but is not limited to routine exams; immunizations; routine lab tests and x-rays; routine mammograms; and routine colonoscopies
Routine gynecological (GYN) care	No charge	Includes but is not limited to routine exams and cervical cancer screenings (Pap smear tests)
Family planning	No charge	
Smoking Cessation Counseling Services	No charge	
Reconstructive surgery and procedures	See *Outpatient surgery* or *Inpatient medical and surgical care*	Certain services may require Prior Authorization.
Telehealth	See *Medical care Outpatient visits*	Please ask your Providers' office for information on telehealth availability and access.
Urgent care	$18 Copayment per visit	No Prior Authorization required. In our Service Area, you must visit a UCC that is in our Network to be covered for services. Outside of our Service Area, free-standing Urgent Care Centers (UCCs) are covered at Out-of-network Provider sites, including Hospitals and clinics.
Vision care		
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.		
Routine pediatric care (under 19 years of age)	No charge	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.
Routine adult care (age 19 or older)	No charge	Coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics.
Medical eye and vision care	See *Medical care Outpatient visits*	

Covered Services	Cost Sharing	Benefit Limit & 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 Plan Year. Must complete a Weight Loss Program 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

Schedule of Benefits

a Point32Health company

This Schedule of Benefits 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 Schedule of Benefits for your specific Plan Type. To see which Tufts Health Direct Plan Type you have, check your Tufts Health Plan Member ID Card.

If you want more information about your benefits and capitalized terms, see your *Tufts Health Direct Member Handbook* https://tuftshealthplan.com/documents/members/handbooks/direct-member-handbook-2024.

You must go to Providers who are part of the Tufts Health Direct Provider Network to get services. Out-of-network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal.

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).

You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document. Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The amounts of the Annual Deductible and Annual Out-of-Pocket Maximum which apply to you and the enrolled Members of your family each Plan Year are:

ANNUAL DEDUCTIBLE	AMOUNT	NOTES
Individual	$0	The Individual Deductible applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Deductible even if other Members on the family Plan have not.
Family	$0	Once two or more Members on a family Plan meet the Family Annual Deductible, the entire family is considered to have met the Deductible for the Plan Year.

ANNUAL OUT-OF-POCKET MAXIMUM	AMOUNT	NOTES
Individual	Medical: $1,500 Pharmacy: $750	The Individual Out-of-Pocket Maximum applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Out-of-Pocket Maximum even if other Members on the family Plan have not.
Family	Medical: $3,000 Pharmacy: $1,500	Once two or more Members on a family Plan meet the Family Annual Out-of-pocket Maximum amount, the entire family is considered to have met the Out-of-pocket Maximum for the Plan Year.
Notice for American Indian and Alaskan Native (AI/AN) Members: All American Indian/Alaskan Native Members, regardless of income, can enroll in a limited cost sharing Plan at any metal level, which means no Copayments, Deductibles, or Coinsurance when receiving care from Indian health care Providers. The Massachusetts Health Connector determines your eligibility to enroll in this Plan variation as part of your application process.		

Covered Services	Cost Sharing	Benefit Limit & Notes
Abortion services	No charge	No Prior Authorization required.
Acupuncture services	$22 Copayment per visit	No Prior Authorization required. No visit limits.
Allergy services		
Allergy testing	$22 Copayment per visit	No Prior Authorization required. Covered for up to 200 allergy tests per Plan Year.
Allergy treatments (injections)	$7 Copayment per injection	Note: Allergy immunotherapy covered as part of the pharmacy prescription benefit may require Prior Authorization and have separate pharmacy Cost Sharing responsibility.
Outpatient medical office visits	See *Medical care outpatient visits*	
Ambulance services		
Emergency	No charge	No Prior Authorization required.
Other non-Emergency transportation	No charge	Prior Authorization required.
Behavioral Health services - Mental Health & Substance Use Disorder		
Inpatient services		No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission from the Emergency Room. Planned admissions require Prior Authorization 5 business days before admission.
Facility fee	$250 Copayment per stay	Includes room and board and services supplied by the facility during the inpatient stay
Professional fee	No charge	Includes physician and other covered professional Provider services
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.
Outpatient services		
Individual therapy/Counseling	No charge	No Prior Authorization required. No visit limits.
Intermediate care, including Behavioral Health (mental health and/or substance use) services for children and adolescents	No charge	Prior Authorization is required for certain Behavioral Health (mental health and/or substance use) services for children and adolescents. Please see the "Covered Services" section of the Tufts Health Direct Member Handbook for more information about these services.
Medication-Assisted Treatment services	No charge	Certain medication may require Prior Authorization.

Covered Services	Cost Sharing	Benefit Limit & Notes
Behavioral Health services - Mental Health & Substance Use Disorder, continued		
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	No charge	No Prior Authorization required. Includes dosing, counseling, and lab services
Recovery Coaches and Peer Specialists	No charge	No Prior Authorization required.
Substance Use Treatment Programs	Cost sharing varies based on type and place of service.	
Autism Spectrum Disorder Services		
Applied Behavioral Analysis (ABA)	No charge	Prior Authorization required. 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	$20 Copayment per visit	Physical, occupational, and speech therapy benefit limits do not apply.
Chemotherapy and radiation oncology services	No charge	Certain services require Prior Authorization.
Chiropractic care	$22 Copayment per visit	No Prior Authorization required.
Cleft palate and 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	Based on place of service	No Prior Authorization required. Routine patient care services covered for Members in a qualified clinical trial pursuant to state and federal mandates.
Dental care, accidental	Based on place of service	No Prior Authorization required. 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.

Covered Services	Cost Sharing	Benefit Limit & Notes
Dental care, non-Emergency (Pediatric only, Delta Dental)		
Members are eligible for services until the last Day of the month in which they turn 19 years old. Please call Delta Dental at 800-872-0500 for more information and for Prior Authorization requirements.		
Type I: Preventive & Diagnostic	No charge	Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age.
Type II: Basic covered services	No charge	
Type III: Major restorative services	No charge	
Type IV: Orthodontia	No charge	Medically Necessary orthodontia requires Prior Authorization.
Diabetes education and treatment	Cost Sharing varies based on type and place of service.	Prior Authorization required for certain services. No charge for the Good Measures program.
Diagnostic services (Outpatient laboratory services, imaging, radiology, and other diagnostic testing)		
Laboratory services	No charge	Includes blood tests, urinalysis, and throat cultures to maintain health and to test, diagnose, and treat disease. Genetic testing requires Prior Authorization.
X-rays	No charge	No Prior Authorization required.
Advanced imaging (MRI, CT, PET scans)	$60 Copayment	Prior Authorization required.
Sleep studies	Related *Medical care outpatient visit* or *Inpatient medical care* Cost Sharing may be required	Prior Authorization required.
Other diagnostic testing	No charge	Certain services require Prior Authorization
Dialysis services	No charge	No Prior Authorization required.
Disease Management Programs	No charge	For Members with asthma, diabetes, chronic obstructive pulmonary disease (COPD) or congestive heart failure. If you have any of these conditions, please contact us at **888-257-1985** to discuss our disease management programs.

Covered Services	Cost Sharing	Benefit Limit & Notes
Durable Medical Equipment (DME)		
Covered medical equipment rented or purchased for home use	No charge	Prior Authorization is required for certain services, including prosthetic orthotics. Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs.
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.
Early Intervention services	No charge	No Prior Authorization required. 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.
Emergency Room care	$100 Copayment per visit	No Prior Authorization required. Emergency Room Cost Share waived if held for *Observation services,* sent for *Outpatient surgery services* or admitted for *Inpatient medical or surgical care*. If admitted to the Hospital, Notification required within 48 hours.
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 Plan 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.
Gender affirming services	Cost Sharing varies based on type and place of service.	Prior Authorization required. Medically necessary services may include Inpatient medical and surgical care, Outpatient surgery, Diagnostic services, Speech therapy, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies among other services

Covered Services	Cost Sharing	Benefit Limit & Notes
Habilitative and rehabilitative services	$20 Copayment per visit	Includes cardiac rehabilitation; physical therapy; occupational therapy; and speech, hearing, and language therapy services. See below for specific details.
Limits:		
Cardiac rehabilitation		
Physical and occupational therapy		Prior Authorization required after initial evaluation and 11 visits. Maximum of 60 visits total Physical and Occupational Therapy per Member per Plan Year.
Speech, hearing, and language therapy		Prior Authorization required after visit 30. No visit limits.
Home health care	No charge	Prior Authorization is required for all home care services and disciplines.
Hospice services	No charge	Prior Authorization required.
Infertility services	Cost Sharing varies based on type and place of service.	Prior Authorization required. Medically necessary services may include I*npatient medical and surgical care*, *Outpatient surgery*, *Diagnostic services*, *Medical care outpatient services*, *Medical benefit drugs* and/or *Prescription drugs and supplies* among other services.
Inpatient medical and surgical care Hospital; Chronic Disease Hospital; Rehabilitation Hospital; or Skilled Nursing Facility (SNF)		No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission from the Emergency Room. Planned admissions require Prior Authorization 5 business days before admission.
Facility Fee	$250 Copayment per stay	Includes room and board and services supplied by the facility during the inpatient stay, including preadmission testing, anesthesia, diagnostic services, and medication and supplies
Professional Fee	No charge	Includes physician and other covered professional Provider services
Limits:		
Chronic Disease or Rehabilitation Hospital		Maximum of 60 Days total per Member per Plan Year
Skilled Nursing Facility	No charge	Maximum of 100 Days total per Member per Plan Year

Covered Services	Cost Sharing	Benefit Limit & Notes
Maternity services and Well Newborn care		
Childbirth classes	Covered for cost of childbirth education course	Complete a Member Reimbursement Medical Claim Form and submit by mail with proof of payment.
Routine prenatal and postpartum care	No charge	All Outpatient routine prenatal and postpartum office visits are covered as well as breastfeeding services and supports.
Non-routine prenatal care	Cost Sharing varies based on type and place of service.	Any Outpatient maternity services not considered routine or those related to complications or risks with a pregnancy, may be subject to Cost Sharing. Some examples of services not considered routine include, but are not limited to, amniocentesis, fetal stress testing, and OB ultrasounds.
Hospital and delivery services	See *Inpatient medical and surgical care*	Well newborn care is included as part of covered maternity admission.
Breast pumps	No charge	No Prior Authorization required. One breast pump per birth including related parts and supplies. 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. Pump must be obtained from contracting DME Provider.
Medical benefit drugs	No charge	Prior Authorization required for certain drugs. Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit.
Medical care Outpatient visits		
Medical Care includes services to diagnose, treat, and maintain a health condition. Medical care services are covered by Providers in the Tufts Health Direct Network. You are not covered for services from Providers outside of our Network and will be responsible for payment in full. Contact Member Services at **888-257-1985** or visit tuftshealthplan.com/memberlogin to find an In-network Provider. See *Preventive health services* for information about routine health care.		
Office and community health center visits		
Primary Care Provider (PCP)	No charge	No Prior Authorization required.
Specialist	$22 Copayment per visit	Prior Authorization required for certain specialist visits.
MinuteClinic	No charge	No Prior Authorization required. A walk-in clinic accessible at select CVS locations
Nutritional counseling	See *Medical care Outpatient visits*	Prior Authorization required.

Covered Services	Cost Sharing	Benefit Limit & Notes
Observation services	$100 Copayment per visit	No Prior Authorization required. 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.
Organ or bone marrow transplant	See *Inpatient medical and surgical care*	Prior Authorization required.
Outpatient surgery services		
Outpatient day surgery		
Outpatient Hospital or Ambulatory Surgery Center facility fee	$125 Copayment per visit	Prior Authorization required for certain services.
Professional fee	No charge	Includes physician and other covered professional Provider services
Office and community health center surgical services	See *Medical care Outpatient visits*	
Pain management	Cost Sharing varies based on type and place of service.	Certain services require Prior Authorization. Cost Sharing based on type of service, for example Acupuncture, Nutritional counseling, Physical therapy or Chiropractic care.
Podiatry care	See *Medical care Outpatient visits*	No Prior Authorization required. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot.
Prescription drugs and supplies		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.
Retail pharmacy		
Tier 1	$12.50 Copayment	Primarily generic drugs
Tier 2	$25 Copayment	Includes some non-preferred generics and preferred brands
Tier 3	$50 Copayment	Includes high-cost generics, non-preferred brands, and Specialty drugs
Mail order pharmacy		
Tier 1	$25 Copayment	Primarily generic drugs
Tier 2	$50 Copayment	Includes some non-preferred generics and preferred brands
Tier 3	$100 Copayment	Includes high-cost generics, non-preferred brands, and Specialty drugs

Covered Services	Cost Sharing	Benefit Limit & Notes
Preventive health services		
Preventive Health services are routine health care that include screenings, check-ups, and counseling to prevent illnesses, disease, or other health problems. Certain Preventive health services may require Prior Authorization. Work with your PCP to use the Preventive Services Policy to review specific requirements.		
Routine pediatric care	No charge	Includes but is not limited to routine exams; immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning
Routine adult care	No charge	Includes but is not limited to routine exams; immunizations; routine lab tests and x-rays; routine mammograms; and routine colonoscopies
Routine gynecological (GYN) care	No charge	Includes but is not limited to routine exams and cervical cancer screenings (Pap smear tests)
Family planning	No charge	
Smoking Cessation Counseling Services	No charge	
Reconstructive surgery and procedures	See *Outpatient surgery* or *Inpatient medical and surgical care*	Certain services may require Prior Authorization.
Telehealth	See *Medical care Outpatient visits*	Please ask your Providers' office for information on telehealth availability and access.
Urgent care	$22 Copayment per visit	No Prior Authorization required. In our Service Area, you must visit a UCC that is in our Network to be covered for services. Outside of our Service Area, free-standing Urgent Care Centers (UCCs) are covered at Out-of-network Provider sites, including Hospitals and clinics.
Vision care		
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.		
Routine pediatric care (under 19 years of age)	No charge	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.
Routine adult care (age 19 or older)	No charge	Coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics.
Medical eye and vision care	See *Medical care Outpatient visits*	

Covered Services	Cost Sharing	Benefit Limit & 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 Plan Year. Must complete a Weight Loss Program 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

Schedule of Benefits

a Point32Health company

This Schedule of Benefits 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 Schedule of Benefits for your specific Plan Type. To see which Tufts Health Direct Plan Type you have, check your Tufts Health Plan Member ID Card.

If you want more information about your benefits and capitalized terms, see your *Tufts Health Direct Member Handbook* https://tuftshealthplan.com/documents/members/handbooks/direct-member-handbook-2024.

You must go to Providers who are part of the Tufts Health Direct Provider Network to get services. Out-of-network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal.

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).

You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document. Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The amounts of the Annual Deductible and Annual Out-of-Pocket Maximum which apply to you and the enrolled Members of your family each Plan Year are:

ANNUAL DEDUCTIBLE	AMOUNT	NOTES
Individual	$0	The Individual Deductible applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Deductible even if other Members on the family Plan have not.
Family	$0	Once two or more Members on a family Plan meet the Family Annual Deductible, the entire family is considered to have met the Deductible for the Plan Year.

ANNUAL OUT-OF-POCKET MAXIMUM	AMOUNT	NOTES
Individual	$3,000	The Individual Out-of-Pocket Maximum applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Out-of-Pocket Maximum even if other Members on the family Plan have not.
Family	$6,000	Once two or more Members on a family Plan meet the Family Annual Out-of-pocket Maximum amount, the entire family is considered to have met the Out-of-pocket Maximum for the Plan Year.
Notice for American Indian and Alaskan Native (AI/AN) Members: All American Indian/Alaskan Native Members, regardless of income, can enroll in a limited cost sharing Plan at any metal level, which means no Copayments, Deductibles, or Coinsurance when receiving care from Indian health care Providers. The Massachusetts Health Connector determines your eligibility to enroll in this Plan variation as part of your application process.		

Covered Services	Cost Sharing	Benefit Limit & Notes
Abortion services	No charge	No Prior Authorization required.
Acupuncture services	$40 Copayment per visit	No Prior Authorization required. No visit limits.
Allergy services		
Allergy testing	$40 Copayment per visit	No Prior Authorization required. Covered for up to 200 allergy tests per Plan Year.
Allergy treatments (injections)	$10 Copayment per injection	Note: Allergy immunotherapy covered as part of the pharmacy prescription benefit may require Prior Authorization and have separate pharmacy Cost Sharing responsibility.
Outpatient medical office visits	See *Medical care outpatient visits*	
Ambulance services		
Emergency	No charge	No Prior Authorization required.
Other non-Emergency transportation	No charge	Prior Authorization required.
Behavioral Health services - Mental Health & Substance Use Disorder		
Inpatient services		No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission from the Emergency Room. Planned admissions require Prior Authorization 5 business days before admission.
Facility fee	$500 Copayment per stay	Includes room and board and services supplied by the facility during the inpatient stay
Professional fee	No charge	Includes physician and other covered professional Provider services
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.
Outpatient services		
Individual therapy/Counseling	$20 Copayment per visit	No Prior Authorization required. No visit limits.
Intermediate care, including Behavioral Health (mental health and/or substance use) services for children and adolescents	No charge	Prior Authorization is required for certain Behavioral Health (mental health and/or substance use) services for children and adolescents. Please see the "Covered Services" section of the Tufts Health Direct Member Handbook for more information about these services.
Medication-Assisted Treatment services	No charge	Certain medication may require Prior Authorization.

Covered Services	Cost Sharing	Benefit Limit & Notes
Behavioral Health services - Mental Health & Substance Use Disorder, continued		
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	No charge	No Prior Authorization required. Includes dosing, counseling, and lab services
Recovery Coaches and Peer Specialists	No charge	No Prior Authorization required.
Substance Use Treatment Programs	Cost sharing varies based on type and place of service.	
Autism Spectrum Disorder Services		
Applied Behavioral Analysis (ABA)	$20 Copayment per visit	Prior Authorization required. 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	$40 Copayment per visit	Physical, occupational, and speech therapy benefit limits do not apply.
Chemotherapy and radiation oncology services	No charge	Certain services require Prior Authorization.
Chiropractic care	$40 Copayment per visit	No Prior Authorization required.
Cleft palate and 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	Based on place of service	No Prior Authorization required. Routine patient care services covered for Members in a qualified clinical trial pursuant to state and federal mandates.
Dental care, accidental	Based on place of service	No Prior Authorization required. 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.

Covered Services	Cost Sharing	Benefit Limit & Notes
Dental care, non-Emergency (Pediatric only, Delta Dental)		
Members are eligible for services until the last Day of the month in which they turn 19 years old. Please call Delta Dental at 800-872-0500 for more information and for Prior Authorization requirements.		
Type I: Preventive & Diagnostic	No charge	Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age.
Type II: Basic covered services	25% Coinsurance	
Type III: Major restorative services	50% Coinsurance	
Type IV: Orthodontia	50% Coinsurance	Medically Necessary orthodontia requires Prior Authorization.
Diabetes education and treatment	Cost Sharing varies based on type and place of service.	Prior Authorization required for certain services. No charge for the Good Measures program.
Diagnostic services (Outpatient laboratory services, imaging, radiology, and other diagnostic testing)		
Laboratory services	No charge	Includes blood tests, urinalysis, and throat cultures to maintain health and to test, diagnose, and treat disease. Genetic testing requires Prior Authorization.
X-rays	No charge	No Prior Authorization required.
Advanced imaging (MRI, CT, PET scans)	$150 Copayment	Prior Authorization required.
Sleep studies	Related *Medical care outpatient visit* or *Inpatient medical care* Cost Sharing may be required	Prior Authorization required.
Other diagnostic testing	No charge	Certain services require Prior Authorization.
Dialysis services	No charge	No Prior Authorization required.
Disease Management Programs	No charge	For Members with asthma, diabetes, chronic obstructive pulmonary disease (COPD) or congestive heart failure. If you have any of these conditions, please contact us at **888-257-1985** to discuss our disease management programs.

Covered Services	Cost Sharing	Benefit Limit & Notes
Durable Medical Equipment (DME)		
Covered medical equipment rented or purchased for home use	20% Coinsurance	Prior Authorization is required for certain services, including prosthetic orthotics. Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs.
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.
Early Intervention services	No charge	No Prior Authorization required. 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.
Emergency Room care	$150 Copayment per visit	No Prior Authorization required. Emergency Room Cost Share waived if held for *Observation services,* sent for *Outpatient surgery services* or admitted for *Inpatient medical or surgical care*. If admitted to the Hospital, Notification required within 48 hours.
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 Plan 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.
Gender affirming services	Cost Sharing varies based on type and place of service.	Prior Authorization required. Medically necessary services may include Inpatient medical and surgical care, Outpatient surgery, Diagnostic services, Speech therapy, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies among other services.

Covered Services	Cost Sharing	Benefit Limit & Notes
Habilitative and rehabilitative services	$40 Copayment per visit	Includes cardiac rehabilitation; physical therapy; occupational therapy; and speech, hearing, and language therapy services. See below for specific details.
Limits:		
Cardiac rehabilitation		
Physical and occupational therapy		Prior Authorization required after initial evaluation and 11 visits. Maximum of 60 visits total Physical and Occupational Therapy per Member per Plan Year.
Speech, hearing, and language therapy		Prior Authorization required after visit 30. No visit limits.
Home health care	No charge	Prior Authorization is required for all home care services and disciplines.
Hospice services	No charge	Prior Authorization required.
Infertility services	Cost Sharing varies based on type and place of service.	Prior Authorization required. Medically necessary services may include I*npatient medical and surgical care*, *Outpatient surgery*, *Diagnostic services*, *Medical care outpatient services*, *Medical benefit drugs* and/or *Prescription drugs and supplies* among other services.
Inpatient medical and surgical care Hospital; Chronic Disease Hospital; Rehabilitation Hospital; or Skilled Nursing Facility (SNF)		No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission from the Emergency Room. Planned admissions require Prior Authorization 5 business days before admission.
Facility Fee	$500 Copayment per stay	Includes room and board and services supplied by the facility during the inpatient stay, including preadmission testing, anesthesia, diagnostic services, and medication and supplies
Professional Fee	No charge	Includes physician and other covered professional Provider services
Limits:		
Chronic Disease or Rehabilitation Hospital		Maximum of 60 Days total per Member per Plan Year
Skilled Nursing Facility		Maximum of 100 Days total per Member per Plan Year

Covered Services	Cost Sharing	Benefit Limit & Notes
Maternity services and Well Newborn care		
Childbirth classes	Covered for cost of childbirth education course	Complete a Member Reimbursement Medical Claim Form and submit by mail with proof of payment.
Routine prenatal and postpartum care	No charge	All Outpatient routine prenatal and postpartum office visits are covered as well as breastfeeding services and supports.
Non-routine prenatal care	Cost Sharing varies based on type and place of service.	Any Outpatient maternity services not considered routine or those related to complications or risks with a pregnancy, may be subject to Cost Sharing. Some examples of services not considered routine include, but are not limited to, amniocentesis, fetal stress testing, and OB ultrasounds.
Hospital and delivery services	See *Inpatient medical and surgical care*	Well newborn care is included as part of covered maternity admission.
Breast pumps	No charge if billed per Preventive Services Policy; Otherwise, 20% Coinsurance	No Prior Authorization required. One breast pump per birth including related parts and supplies. 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. Pump must be obtained from contracting DME Provider.
Medical benefit drugs	No charge	Prior Authorization required for certain drugs. Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit.
Medical care Outpatient visits		
Medical Care includes services to diagnose, treat, and maintain a health condition. Medical care services are covered by Providers in the Tufts Health Direct Network. You are not covered for services from Providers outside of our Network and will be responsible for payment in full. Contact Member Services at **888-257-1985** or visit tuftshealthplan.com/memberlogin to find an In-network Provider. See *Preventive health services* for information about routine health care.		
Office and community health center visits		
Primary Care Provider (PCP)	$20 Copayment per visit	No Prior Authorization required.
Specialist	$40 Copayment per visit	Prior Authorization required for certain specialist visits.
MinuteClinic	$20 Copayment per visit	No Prior Authorization required. A walk-in clinic accessible at select CVS locations
Nutritional counseling	See *Medical care Outpatient visits*	Prior Authorization required.

Covered Services	Cost Sharing	Benefit Limit & Notes
Observation services	$150 Copayment per visit	No Prior Authorization required. 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.
Organ or bone marrow transplant	See *Inpatient medical and surgical care*	Prior Authorization required.
Outpatient surgery services		
Outpatient day surgery		
Outpatient Hospital or Ambulatory Surgery Center facility fee	$250 Copayment per visit	Prior Authorization required for certain services.
Professional fee	No charge	Includes physician and other covered professional Provider services
Office and community health center surgical services	See *Medical care Outpatient visits*	
Pain management	Cost Sharing varies based on type and place of service.	Certain services require Prior Authorization. Cost Sharing based on type of service, for example Acupuncture, Nutritional counseling, Physical therapy or Chiropractic care.
Podiatry care	See *Medical care Outpatient visits*	No Prior Authorization required. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot.
Prescription drugs and supplies		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.
Retail pharmacy		
Tier 1	$10 Copayment	Primarily generic drugs
Tier 2	$25 Copayment	Includes some non-preferred generics and preferred brands
Tier 3	$50 Copayment	Includes high-cost generics, non-preferred brands, and Specialty drugs
Mail order pharmacy		
Tier 1	$20 Copayment	Primarily generic drugs
Tier 2	$50 Copayment	Includes some non-preferred generics and preferred brands
Tier 3	$150 Copayment	Includes high-cost generics, non-preferred brands, and Specialty drugs

Covered Services	Cost Sharing	Benefit Limit & Notes
Preventive health services		
Preventive Health services are routine health care that include screenings, check-ups, and counseling to prevent illnesses, disease, or other health problems. Certain Preventive health services may require Prior Authorization. Work with your PCP to use the Preventive Services Policy to review specific requirements.		
Routine pediatric care	No charge	Includes but is not limited to routine exams; immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning
Routine adult care	No charge	Includes but is not limited to routine exams; immunizations; routine lab tests and x-rays; routine mammograms; and routine colonoscopies
Routine gynecological (GYN) care	No charge	Includes but is not limited to routine exams and cervical cancer screenings (Pap smear tests)
Family planning	No charge	
Smoking Cessation Counseling Services	No charge	
Reconstructive surgery and procedures	See *Outpatient surgery* or *Inpatient medical and surgical care*	Certain services may require Prior Authorization.
Telehealth	See *Medical care Outpatient visits*	Please ask your Providers' office for information on telehealth availability and access.
Urgent care	$40 Copayment per visit	No Prior Authorization required. In our Service Area, you must visit a UCC that is in our Network to be covered for services. Outside of our Service Area, free-standing Urgent Care Centers (UCCs) are covered at Out-of-network Provider sites, including Hospitals and clinics.
Vision care		
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.		
Routine pediatric care (under 19 years of age)	$20 Copayment per visit	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.
Routine adult care (age 19 or older)	$20 Copayment per visit	Coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics.
Medical eye and vision care	See *Medical care Outpatient visits*	

Covered Services	Cost Sharing	Benefit Limit & 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 Plan Year. Must complete a Weight Loss Program 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

Schedule of Benefits

a Point32Health company

This Schedule of Benefits 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 Schedule of Benefits for your specific Plan Type. To see which Tufts Health Direct Plan Type you have, check your Tufts Health Plan Member ID Card.

If you want more information about your benefits and capitalized terms, see your *Tufts Health Direct Member Handbook* https://tuftshealthplan.com/documents/members/handbooks/direct-member-handbook-2024.

You must go to Providers who are part of the Tufts Health Direct Provider Network to get services. Out-of-network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal.

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).

You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document. Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The amounts of the Annual Deductible and Annual Out-of-Pocket Maximum which apply to you and the enrolled Members of your family each Plan Year are:

ANNUAL DEDUCTIBLE	AMOUNT	NOTES
Individual	$0	The Individual Deductible applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Deductible even if other Members on the family Plan have not.
Family	$0	Once two or more Members on a family Plan meet the Family Annual Deductible, the entire family is considered to have met the Deductible for the Plan Year.

ANNUAL OUT-OF-POCKET MAXIMUM	AMOUNT	NOTES
Individual	$6,000	The Individual Out-of-Pocket Maximum applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Out-of-Pocket Maximum even if other Members on the family Plan have not.
Family	$12,000	Once two or more Members on a family Plan meet the Family Annual Out-of-pocket Maximum amount, the entire family is considered to have met the Out-of-pocket Maximum for the Plan Year.
Notice for American Indian and Alaskan Native (AI/AN) Members: All American Indian/Alaskan Native Members, regardless of income, can enroll in a limited cost sharing Plan at any metal level, which means no Copayments, Deductibles, or Coinsurance when receiving care from Indian health care Providers. The Massachusetts Health Connector determines your eligibility to enroll in this Plan variation as part of your application process.		

Covered Services	Cost Sharing	Benefit Limit & Notes
Abortion services	No charge	No Prior Authorization required.
Acupuncture services	$55 Copayment per visit	No Prior Authorization required. No visit limits.
Allergy services		
Allergy testing	$55 Copayment per visit	No Prior Authorization required. Covered for up to 200 allergy tests per Plan Year.
Allergy treatments (injections)	$10 Copayment per injection	Note: Allergy immunotherapy covered as part of the pharmacy prescription benefit may require Prior Authorization and have separate pharmacy Cost Sharing responsibility.
Outpatient medical office visits	See *Medical care outpatient visits*	
Ambulance services		
Emergency	No charge	No Prior Authorization required.
Other non-Emergency transportation	No charge	Prior Authorization required.
Behavioral Health services - Mental Health & Substance Use Disorder		
Inpatient services		No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission from the Emergency Room. Planned admissions require Prior Authorization 5 business days before admission.
Facility fee	$750 Copayment per stay	Includes room and board and services supplied by the facility during the inpatient stay
Professional fee	No charge	Includes physician and other covered professional Provider services
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.
Outpatient services		
Individual therapy/Counseling	$30 Copayment per visit	No Prior Authorization required. No visit limits.
Intermediate care, including Behavioral Health (mental health and/or substance use) services for children and adolescents	No charge	Prior Authorization is required for certain Behavioral Health (mental health and/or substance use) services for children and adolescents. Please see the "Covered Services" section of the Tufts Health Direct Member Handbook for more information about these services.
Medication-Assisted Treatment services	No charge	Certain medication may require Prior Authorization.

Covered Services	Cost Sharing	Benefit Limit & Notes
Behavioral Health services - Mental Health & Substance Use Disorder, continued		
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	No charge	No Prior Authorization required. Includes dosing, counseling, and lab services
Recovery Coaches and Peer Specialists	No charge	No Prior Authorization required.
Substance Use Treatment Programs	Cost sharing varies based on type and place of service.	
Autism Spectrum Disorder Services		
Applied Behavioral Analysis (ABA)	$30 Copayment per visit	Prior Authorization required. 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	$55 Copayment per visit	Physical, occupational, and speech therapy benefit limits do not apply.
Chemotherapy and radiation oncology services	No charge	Certain services require Prior Authorization.
Chiropractic care	$55 Copayment per visit	No Prior Authorization required.
Cleft palate and 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	Based on place of service	No Prior Authorization required. Routine patient care services covered for Members in a qualified clinical trial pursuant to state and federal mandates.
Dental care, accidental	Based on place of service	No Prior Authorization required. 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.

Covered Services	Cost Sharing	Benefit Limit & Notes
Dental care, non-Emergency (Pediatric only, Delta Dental)		
Members are eligible for services until the last Day of the month in which they turn 19 years old. Please call Delta Dental at 800-872-0500 for more information and for Prior Authorization requirements.		
Type I: Preventive & Diagnostic	No charge	Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age.
Type II: Basic covered services	25% Coinsurance	
Type III: Major restorative services	50% Coinsurance	
Type IV: Orthodontia	50% Coinsurance	Medically Necessary orthodontia requires Prior Authorization.
Diabetes education and treatment	Cost Sharing varies based on type and place of service.	Prior Authorization required for certain services. No charge for the Good Measures program.
Diagnostic services (Outpatient laboratory services, imaging, radiology, and other diagnostic testing)		
Laboratory services	$25 Copayment	Includes blood tests, urinalysis, and throat cultures to maintain health and to test, diagnose, and treat disease. Genetic testing requires Prior Authorization.
X-rays	$75 Copayment	No Prior Authorization required.
Advanced imaging (MRI, CT, PET scans)	$250 Copayment	Prior Authorization required.
Sleep studies	Related *Medical care outpatient visit* or *Inpatient medical care* Cost Sharing may be required	Prior Authorization required.
Other diagnostic testing	$25 Copayment	Certain services require Prior Authorization.
Dialysis services	No charge	No Prior Authorization required.
Disease Management Programs	No charge	For Members with asthma, diabetes, chronic obstructive pulmonary disease (COPD) or congestive heart failure. If you have any of these conditions, please contact us at **888-257-1985** to discuss our disease management programs.

Covered Services	Cost Sharing	Benefit Limit & Notes
Durable Medical Equipment (DME)		
Covered medical equipment rented or purchased for home use	20% Coinsurance	Prior Authorization is required for certain services, including prosthetic orthotics. Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs.
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.
Early Intervention services	No charge	No Prior Authorization required. 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.
Emergency Room care	$350 Copayment per visit	No Prior Authorization required. Emergency Room Cost Share waived if held for *Observation services,* sent for *Outpatient surgery services* or admitted for *Inpatient medical or surgical care*. If admitted to the Hospital, Notification required within 48 hours.
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 Plan 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.
Gender affirming services	Cost Sharing varies based on type and place of service.	Prior Authorization required. Medically necessary services may include Inpatient medical and surgical care, Outpatient surgery, Diagnostic services, Speech therapy, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies among other services.

Covered Services	Cost Sharing	Benefit Limit & Notes
Habilitative and rehabilitative services	$55 Copayment per visit	Includes cardiac rehabilitation; physical therapy; occupational therapy; and speech, hearing, and language therapy services. See below for specific details.
Limits:		
Cardiac rehabilitation		
Physical and occupational therapy		Prior Authorization required after initial evaluation and 11 visits. Maximum of 60 visits total Physical and Occupational Therapy per Member per Plan Year.
Speech, hearing, and language therapy		Prior Authorization required after visit 30. No visit limits.
Home health care	No charge	Prior Authorization is required for all home care services and disciplines.
Hospice services	No charge	Prior Authorization required.
Infertility services	Cost Sharing varies based on type and place of service.	Prior Authorization required. Medically necessary services may include I*npatient medical and surgical care*, *Outpatient surgery*, *Diagnostic services*, *Medical care outpatient services*, *Medical benefit drugs* and/or *Prescription drugs and supplies* among other services.
Inpatient medical and surgical care Hospital; Chronic Disease Hospital; Rehabilitation Hospital; or Skilled Nursing Facility (SNF)		No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission from the Emergency Room. Planned admissions require Prior Authorization 5 business days before admission.
Facility Fee	$750 Copayment per stay	Includes room and board and services supplied by the facility during the inpatient stay, including preadmission testing, anesthesia, diagnostic services, and medication and supplies
Professional Fee	No charge	Includes physician and other covered professional Provider services
Limits:		
Chronic Disease or Rehabilitation Hospital		Maximum of 60 Days total per Member per Plan Year
Skilled Nursing Facility		Maximum of 100 Days total per Member per Plan Year

Covered Services	Cost Sharing	Benefit Limit & Notes
Maternity services and Well Newborn care		
Childbirth classes	Covered for cost of childbirth education course	Complete a Member Reimbursement Medical Claim Form and submit by mail with proof of payment.
Routine prenatal and postpartum care	No charge	All Outpatient routine prenatal and postpartum office visits are covered as well as breastfeeding services and supports.
Non-routine prenatal care	Cost Sharing varies based on type and place of service.	Any Outpatient maternity services not considered routine or those related to complications or risks with a pregnancy, may be subject to Cost Sharing. Some examples of services not considered routine include, but are not limited to, amniocentesis, fetal stress testing, and OB ultrasounds.
Hospital and delivery services	See *Inpatient medical and surgical care*	Well newborn care is included as part of covered maternity admission.
Breast pumps	No charge if billed per Preventive Services Policy; Otherwise, 20% Coinsurance	No Prior Authorization required. One breast pump per birth including related parts and supplies. 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. Pump must be obtained from contracting DME Provider.
Medical benefit drugs	No charge	Prior Authorization required for certain drugs. Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit.
Medical care Outpatient visits		
Medical Care includes services to diagnose, treat, and maintain a health condition. Medical care services are covered by Providers in the Tufts Health Direct Network. You are not covered for services from Providers outside of our Network and will be responsible for payment in full. Contact Member Services at **888-257-1985** or visit tuftshealthplan.com/memberlogin to find an In-network Provider. See *Preventive health services* for information about routine health care.		
Office and community health center visits		
Primary Care Provider (PCP)	$30 Copayment per visit	No Prior Authorization required.
Specialist	$55 Copayment per visit	Prior Authorization required for certain specialist visits.
MinuteClinic	$30 Copayment per visit	No Prior Authorization required. A walk-in clinic accessible at select CVS locations
Nutritional counseling	See *Medical care Outpatient visits*	Prior Authorization required.

Covered Services	Cost Sharing	Benefit Limit & Notes
Observation services	$350 Copayment per visit	No Prior Authorization required. 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.
Organ or bone marrow transplant	See *Inpatient medical and surgical care*	Prior Authorization required.
Outpatient surgery services		
Outpatient day surgery		
Outpatient Hospital or Ambulatory Surgery Center facility fee	$500 Copayment per visit	Prior Authorization required for certain services.
Professional fee	No charge	Includes physician and other covered professional Provider services
Office and community health center surgical services	See *Medical care Outpatient visits*	
Pain management	Cost Sharing varies based on type and place of service.	Certain services require Prior Authorization. Cost Sharing based on type of service, for example Acupuncture, Nutritional counseling, Physical therapy or Chiropractic care.
Podiatry care	See *Medical care Outpatient visits*	No Prior Authorization required. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot.
Prescription drugs and supplies		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.
Retail pharmacy		
Tier 1	$30 Copayment	Primarily generic drugs
Tier 2	$60 Copayment	Includes some non-preferred generics and preferred brands
Tier 3	$90 Copayment	Includes high-cost generics, non-preferred brands, and Specialty drugs
Mail order pharmacy		
Tier 1	$60 Copayment	Primarily generic drugs
Tier 2	$120 Copayment	Includes some non-preferred generics and preferred brands
Tier 3	$270 Copayment	Includes high-cost generics, non-preferred brands, and Specialty drugs

Covered Services	Cost Sharing	Benefit Limit & Notes
Preventive health services		
Preventive Health services are routine health care that include screenings, check-ups, and counseling to prevent illnesses, disease, or other health problems. Certain Preventive health services may require Prior Authorization. Work with your PCP to use the Preventive Services Policy to review specific requirements.		
Routine pediatric care	No charge	Includes but is not limited to routine exams; immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning
Routine adult care	No charge	Includes but is not limited to routine exams; immunizations; routine lab tests and x-rays; routine mammograms; and routine colonoscopies
Routine gynecological (GYN) care	No charge	Includes but is not limited to routine exams and cervical cancer screenings (Pap smear tests)
Family planning	No charge	
Smoking Cessation Counseling Services	No charge	
Reconstructive surgery and procedures	See *Outpatient surgery* or *Inpatient medical and surgical care*	Certain services may require Prior Authorization.
Telehealth	See *Medical care Outpatient visits*	Please ask your Providers' office for information on telehealth availability and access.
Urgent care	$55 Copayment per visit	No Prior Authorization required. In our Service Area, you must visit a UCC that is in our Network to be covered for services. Outside of our Service Area, free-standing Urgent Care Centers (UCCs) are covered at Out-of-network Provider sites, including Hospitals and clinics.
Vision care		
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.		
Routine pediatric care (under 19 years of age)	$30 Copayment per visit	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.
Routine adult care (age 19 or older)	$30 Copayment per visit	Coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics.
Medical eye and vision care	See *Medical care Outpatient visits*	

Covered Services	Cost Sharing	Benefit Limit & 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 Plan Year. Must complete a Weight Loss Program 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 1600

Schedule of Benefits

a Point32Health company

This Schedule of Benefits 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 Schedule of Benefits for your specific Plan Type. To see which Tufts Health Direct Plan Type you have, check your Tufts Health Plan Member ID Card.

If you want more information about your benefits and capitalized terms, see your *Tufts Health Direct Member Handbook* https://tuftshealthplan.com/documents/members/handbooks/direct-member-handbook-2024.

You must go to Providers who are part of the Tufts Health Direct Provider Network to get services. Out-of-network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal.

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).

You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document. Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The amounts of the Annual Deductible and Annual Out-of-Pocket Maximum which apply to you and the enrolled Members of your family each Plan Year are:

ANNUAL DEDUCTIBLE	AMOUNT	NOTES
Individual	Medical: $1,600 Pharmacy: $180	The Individual Deductible applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Deductible even if other Members on the family Plan have not.
Family	Medical: $3,200 Pharmacy: $360	Once two or more Members on a family Plan meet the Family Annual Deductible, the entire family is considered to have met the Deductible for the Plan Year.

ANNUAL OUT-OF-POCKET MAXIMUM	AMOUNT	NOTES
Individual	$5,500	The Individual Out-of-Pocket Maximum applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Out-of-Pocket Maximum even if other Members on the family Plan have not.
Family	$11,000	Once two or more Members on a family Plan meet the Family Annual Out-of-pocket Maximum amount, the entire family is considered to have met the Out-of-pocket Maximum for the Plan Year.
Notice for American Indian and Alaskan Native (AI/AN) Members: All American Indian/Alaskan Native Members, regardless of income, can enroll in a limited cost sharing Plan at any metal level, which means no Copayments, Deductibles, or Coinsurance when receiving care from Indian health care Providers. The Massachusetts Health Connector determines your eligibility to enroll in this Plan variation as part of your application process.		

Covered Services	Cost Sharing	Benefit Limit & Notes
Abortion services	No charge	No Prior Authorization required.
Acupuncture services	$55 Copayment per visit	No Prior Authorization required. No visit limits.
Allergy services		
Allergy testing	$55 Copayment per visit	No Prior Authorization required. Covered for up to 200 allergy tests per Plan Year.
Allergy treatments (injections)	$10 Copayment per visit after Deductible	Note: Allergy immunotherapy covered as part of the pharmacy prescription benefit may require Prior Authorization and have separate pharmacy Cost Sharing responsibility.
Outpatient medical office visits	See *Medical care Outpatient visits*	
Ambulance services		
Emergency	No charge after Deductible	No Prior Authorization required.
Other non-Emergency transportation	No charge after Deductible	Prior Authorization required.
Behavioral Health services - Mental Health & Substance Use Disorder		
Inpatient services		No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission from the Emergency Room. Planned admissions require Prior Authorization 5 business days before admission.
Facility fee	$750 Copayment per stay after Deductible	Includes room and board and services supplied by the facility during the inpatient stay
Professional fee	No charge after Deductible	Includes physician and other covered professional Provider services
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.
Outpatient services		
Individual therapy/Counseling	$35 Copayment per visit	No Prior Authorization required. No visit limits.
Intermediate care, including Behavioral Health (mental health and/or substance use) services for children and adolescents	No charge	Prior Authorization is required for certain Behavioral Health (mental health and/or substance use) services for children and adolescents. Please see the "Covered Services" section of the Tufts Health Direct Member Handbook for more information about these services.
Medication-Assisted Treatment services	No charge	Certain medication may require Prior Authorization.

Covered Services	Cost Sharing	Benefit Limit & Notes
Behavioral Health services - Mental Health & Substance Use Disorder, continued		
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	No charge	No Prior Authorization required. Includes dosing, counseling, and lab services
Recovery Coaches and Peer Specialists	No charge	No Prior Authorization required.
Substance Use Treatment Programs	Cost sharing varies based on type and place of service.	
Autism Spectrum Disorder Services		
Applied Behavioral Analysis (ABA)	$35 Copayment per visit	Prior Authorization required. 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	$55 Copayment per visit	Physical, occupational, and speech therapy benefit limits do not apply.
Chemotherapy and radiation oncology services	No charge after Deductible	Certain services require Prior Authorization.
Chiropractic care	$55 Copayment per visit	No Prior Authorization required.
Cleft palate and 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	Based on place of service	No Prior Authorization required. Routine patient care services covered for Members in a qualified clinical trial pursuant to state and federal mandates.
Dental care, accidental	Based on place of service	No Prior Authorization required. 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.

Covered Services	Cost Sharing	Benefit Limit & Notes
Dental care, non-Emergency (Pediatric only, Delta Dental)		
Members are eligible for services until the last Day of the month in which they turn 19 years old. Please call Delta Dental at 800-872-0500 for more information and for Prior Authorization requirements.		
Type I: Preventive & Diagnostic	No charge	Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age.
Type II: Basic covered services	25% Coinsurance after Deductible	
Type III: Major restorative services	50% Coinsurance after Deductible	
Type IV: Orthodontia	50% Coinsurance after Deductible	Medically Necessary orthodontia requires Prior Authorization.
Diabetes education and treatment	Cost Sharing varies based on type and place of service.	Prior Authorization required for certain services. No charge for the Good Measures program.
Diagnostic services (Outpatient laboratory services, imaging, radiology, and other diagnostic testing)		
Laboratory services	$50 Copayment after Deductible	Includes blood tests, urinalysis, and throat cultures to maintain health and to test, diagnose, and treat disease. Genetic testing requires Prior Authorization.
X-rays	$75 Copayment after Deductible	No Prior Authorization required.
Advanced imaging (MRI, CT, PET scans)	$300 Copayment after Deductible	Prior Authorization required.
Sleep studies	Related *Medical care Outpatient visit* or *Inpatient medical care* Cost Sharing may be required	Prior Authorization required.
Other diagnostic testing	$50 Copayment after Deductible	Certain services require Prior Authorization.
Dialysis services	No charge after Deductible	No Prior Authorization required.
Disease Management Programs	No charge	For Members with asthma, diabetes, chronic obstructive pulmonary disease (COPD) or congestive heart failure. If you have any of these conditions, please contact us at **888-257-1985** to discuss our disease management programs.

Covered Services	Cost Sharing	Benefit Limit & Notes
Durable Medical Equipment (DME)		
Covered medical equipment rented or purchased for home use	20% Coinsurance after Deductible	Prior Authorization is required for certain services, including prosthetic orthotics. Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs.
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.
Early Intervention services	No charge	No Prior Authorization required. 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.
Emergency Room care	$400 Copayment per visit after Deductible	No Prior Authorization required. Emergency Room Cost Share waived if held for *Observation services,* sent for *Outpatient surgery services* or admitted for *Inpatient medical or surgical care*. If admitted to the Hospital, Notification required within 48 hours.
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 Plan 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.
Gender affirming services	Cost Sharing varies based on type and place of service.	Prior Authorization required. Medically necessary services may include Inpatient medical and surgical care, Outpatient surgery, Diagnostic services, Speech therapy, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies among other services.

Covered Services	Cost Sharing	Benefit Limit & Notes
Habilitative and rehabilitative services	$55 Copayment per visit	Includes cardiac rehabilitation; physical therapy; occupational therapy; and speech, hearing, and language therapy services. See below for specific details.
Limits:		
Cardiac rehabilitation		
Physical and occupational therapy		Prior Authorization required after initial evaluation and 11 visits. Maximum of 60 visits total Physical and Occupational Therapy per Member per Plan Year.
Speech, hearing, and language therapy		Prior Authorization required after visit 30. No visit limits.
Home health care	No charge after Deductible	Prior Authorization is required for all home care services and disciplines.
Hospice services	No charge after Deductible	Prior Authorization required.
Infertility services	Cost Sharing varies based on type and place of service.	Prior Authorization required. Medically necessary services may include I*npatient medical and surgical care*, *Outpatient surgery*, *Diagnostic services*, *Medical care Outpatient services*, *Medical benefit drugs* and/or *Prescription drugs and supplies* among other services.
Inpatient medical and surgical care Hospital; Chronic Disease Hospital; Rehabilitation Hospital; or Skilled Nursing Facility (SNF)		No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission from the Emergency Room. Planned admissions require Prior Authorization 5 business days before admission.
Facility Fee	$750 Copayment per stay after Deductible	Includes room and board and services supplied by the facility during the inpatient stay, including preadmission testing, anesthesia, diagnostic services, and medication and supplies
Professional Fee	No charge after Deductible	Includes physician and other covered professional Provider services
Limits:		
Chronic Disease or Rehabilitation Hospital		Maximum of 60 Days total per Member per Plan Year
Skilled Nursing Facility		Maximum of 100 Days total per Member per Plan Year

Covered Services	Cost Sharing	Benefit Limit & Notes
Maternity services and Well Newborn care		
Childbirth classes	Covered for cost of childbirth education course	Complete a Member Reimbursement Medical Claim Form and submit by mail with proof of payment.
Routine prenatal and postpartum care	No charge	All Outpatient routine prenatal and postpartum office visits are covered as well as breastfeeding services and supports.
Non-routine prenatal care	Cost Sharing varies based on type and place of service.	Any Outpatient maternity services not considered routine or those related to complications or risks with a pregnancy, may be subject to Cost Sharing. Some examples of services not considered routine include, but are not limited to, amniocentesis, fetal stress testing, and OB ultrasounds.
Hospital and delivery services	See *Inpatient medical and surgical care*	Well newborn care is included as part of covered maternity admission.
Breast pumps	No charge if billed per Preventive Services Policy; Otherwise, 20% Coinsurance after Deductible	No Prior Authorization required. One breast pump per birth including related parts and supplies. 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. Pump must be obtained from contracting DME Provider.
Medical benefit drugs	No charge after Deductible	Prior Authorization required for certain drugs. Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit.
Medical care Outpatient visits		
Medical Care includes services to diagnose, treat, and maintain a health condition. Medical care services are covered by Providers in the Tufts Health Direct Network. You are not covered for services from Providers outside of our Network and will be responsible for payment in full. Contact Member Services at **888-257-1985** or visit tuftshealthplan.com/memberlogin to find an In-Network Provider. See *Preventive health services* for information about routine health care.		
Office and community health center visits		
Primary Care Provider (PCP)	$35 Copayment per visit	No Prior Authorization required.
Specialist	$55 Copayment per visit	Prior Authorization required for certain specialist visits.
MinuteClinic	$35 Copayment per visit	No Prior Authorization required. A walk-in clinic accessible at select CVS locations
Nutritional counseling	See *Medical care Outpatient visits*	Prior Authorization required.

Covered Services	Cost Sharing	Benefit Limit & Notes
Observation services	$400 Copayment after Deductible	No Prior Authorization required. 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.
Organ or bone marrow transplant	See *Inpatient medical and surgical care*	Prior Authorization required.
Outpatient surgery services		
Outpatient day surgery		
Outpatient Hospital or Ambulatory Surgery Center facility fee	$500 Copayment per visit after Deductible	Prior Authorization required for certain services.
Professional fee	No charge after Deductible	Includes physician and other covered professional Provider services
Office and community health center surgical services	See *Medical care Outpatient visits*	
Pain management	Cost Sharing varies based on type and place of service.	Certain services require Prior Authorization. Cost Sharing based on type of service, for example Acupuncture, Nutritional counseling, Physical therapy or Chiropractic care.
Podiatry care	See *Medical care Outpatient visits*	No Prior Authorization required. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot.
Prescription drugs and supplies		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.
Retail pharmacy		
Tier 1	$25	Primarily generic drugs
Tier 2	$50 Copayment after Deductible	Includes some non-preferred generics and preferred brands
Tier 3	$125 Copayment after Deductible	Includes high-cost generics, non-preferred brands, and Specialty drugs
Mail order pharmacy		
Tier 1	$50 Copayment	Primarily generic drugs
Tier 2	$100 Copayment after Deductible	Includes some non-preferred generics and preferred brands
Tier 3	$375 Copayment after Deductible	Includes high-cost generics, non-preferred brands, and Specialty drugs

Covered Services	Cost Sharing	Benefit Limit & Notes
Preventive health services		
Preventive Health services are routine health care that include screenings, check-ups, and counseling to prevent illnesses, disease, or other health problems. Certain Preventive health services may require Prior Authorization. Work with your PCP to use the Preventive Services Policy to review specific requirements.		
Routine pediatric care	No charge	Includes but is not limited to routine exams; immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning
Routine adult care	No charge	Includes but is not limited to routine exams; immunizations; routine lab tests and x-rays; routine mammograms; and routine colonoscopies
Routine gynecological (GYN) care	No charge	Includes but is not limited to routine exams and cervical cancer screenings (Pap smear tests)
Family planning	No charge	
Smoking Cessation Counseling Services	No charge	
Reconstructive surgery and procedures	See *Outpatient surgery* or *Inpatient medical and surgical care*	Certain services may require Prior Authorization.
Telehealth	See *Medical care Outpatient visits*	Please ask your Providers' office for information on telehealth availability and access.
Urgent care	$55 Copayment per visit	No Prior Authorization required. In our Service Area, you must visit a UCC that is in our Network to be covered for services. Outside of our Service Area, free-standing Urgent Care Centers (UCCs) are covered at Out-of-network Provider sites, including Hospitals and clinics.
Vision care		
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.		
Routine pediatric care (under 19 years of age)	$35 Copayment per visit	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.
Routine adult care (age 19 or older)	$35 Copayment per visit	Coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics.
Medical eye and vision care	See *Medical care Outpatient visits*	

Covered Services	Cost Sharing	Benefit Limit & 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 Plan Year. Must complete a Weight Loss Program 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

Schedule of Benefits

a Point32Health company

This Schedule of Benefits 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 Schedule of Benefits for your specific Plan Type. To see which Tufts Health Direct Plan Type you have, check your Tufts Health Plan Member ID Card.

If you want more information about your benefits and capitalized terms, see your *Tufts Health Direct Member Handbook* https://tuftshealthplan.com/documents/members/handbooks/direct-member-handbook-2024.

You must go to Providers who are part of the Tufts Health Direct Provider Network to get services. Out-of-network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal.

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).

You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document. Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The amounts of the Annual Deductible and Annual Out-of-Pocket Maximum which apply to you and the enrolled Members of your family each Plan Year are:

ANNUAL DEDUCTIBLE	AMOUNT	NOTES
Individual	$2,000	The Individual Deductible applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Deductible even if other Members on the family Plan have not.
Family	$4,000	Once two or more Members on a family Plan meet the Family Annual Deductible, the entire family is considered to have met the Deductible for the Plan Year.

ANNUAL OUT-OF-POCKET MAXIMUM	AMOUNT	NOTES
Individual	$9,450	The Individual Out-of-Pocket Maximum applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Out-of-Pocket Maximum even if other Members on the family Plan have not.
Family	$18,900	Once two or more Members on a family Plan meet the Family Annual Out-of-pocket Maximum amount, the entire family is considered to have met the Out-of-pocket Maximum for the Plan Year.
Notice for American Indian and Alaskan Native (AI/AN) Members: All American Indian/Alaskan Native Members, regardless of income, can enroll in a limited cost sharing Plan at any metal level, which means no Copayments, Deductibles, or Coinsurance when receiving care from Indian health care Providers. The Massachusetts Health Connector determines your eligibility to enroll in this Plan variation as part of your application process.		

Covered Services	Cost Sharing	Benefit Limit & Notes
Abortion services	No charge	No Prior Authorization required.
Acupuncture services	$60 Copayment per visit	No Prior Authorization required. No visit limits.
Allergy services		
Allergy testing	$60 Copayment per visit	No Prior Authorization required. Covered for up to 200 allergy tests per Plan Year.
Allergy treatments (injections)	$10 Copayment per visit after Deductible	Note: Allergy immunotherapy covered as part of the pharmacy prescription benefit may require Prior Authorization and have separate pharmacy Cost Sharing responsibility.
Outpatient medical office visits	See *Medical care Outpatient visits*	
Ambulance services		
Emergency	No charge after Deductible	No Prior Authorization required.
Other non-Emergency transportation	No charge after Deductible	Prior Authorization required.
Behavioral Health services - Mental Health & Substance Use Disorder		
Inpatient services		No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission from the Emergency Room. Planned admissions require Prior Authorization 5 business days before admission.
Facility fee	$1,000 Copayment per stay after Deductible	Includes room and board and services supplied by the facility during the inpatient stay.
Professional fee	No charge after Deductible	Includes physician and other covered professional Provider services
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.
Outpatient services		
Individual therapy/Counseling	$25 Copayment per visit	No Prior Authorization required. No visit limits.
Intermediate care, including Behavioral Health (mental health and/or substance use) services for children and adolescents	No charge	Prior Authorization is required for certain Behavioral Health (mental health and/or substance use) services for children and adolescents. Please see the "Covered Services" section of the Tufts Health Direct Member Handbook for more information about these services.
Medication-Assisted Treatment services	No charge	Certain medication may require Prior Authorization.

Covered Services	Cost Sharing	Benefit Limit & Notes
Behavioral Health services - Mental Health & Substance Use Disorder, continued		
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	No charge	No Prior Authorization required. Includes dosing, counseling, and lab services
Recovery Coaches and Peer Specialists	No charge	No Prior Authorization required.
Substance Use Treatment Programs	Cost sharing varies based on type and place of service.	
Autism Spectrum Disorder Services		
Applied Behavioral Analysis (ABA)	$25 Copayment per visit	Prior Authorization required. 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	$60 Copayment per visit	Physical, occupational, and speech therapy benefit limits do not apply.
Chemotherapy and radiation oncology services	No charge after Deductible	Certain services require Prior Authorization.
Chiropractic care	$60 Copayment per visit	No Prior Authorization required.
Cleft palate and 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	Based on place of service	No Prior Authorization required. Routine patient care services covered for Members in a qualified clinical trial pursuant to state and federal mandates.
Dental care, accidental	Based on place of service	No Prior Authorization required. 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.

Covered Services	Cost Sharing	Benefit Limit & Notes
Dental care, non-Emergency (Pediatric only, Delta Dental)		
Members are eligible for services until the last Day of the month in which they turn 19 years old. Please call Delta Dental at 800-872-0500 for more information and for Prior Authorization requirements.		
Type I: Preventive & Diagnostic	No charge	Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age.
Type II: Basic covered services	25% Coinsurance after Deductible	
Type III: Major restorative services	50% Coinsurance after Deductible	
Type IV: Orthodontia	50% Coinsurance after Deductible	Medically Necessary orthodontia requires Prior Authorization.
Diabetes education and treatment	Cost Sharing varies based on type and place of service.	Prior Authorization required for certain services. No charge for the Good Measures program.
Diagnostic services (Outpatient laboratory services, imaging, radiology, and other diagnostic testing)		
Laboratory services	$25 Copayment after Deductible	Includes blood tests, urinalysis, and throat cultures to maintain health and to test, diagnose, and treat disease. Genetic testing requires Prior Authorization.
X-rays	$50 Copayment after Deductible	No Prior Authorization required.
Advanced imaging (MRI, CT, PET scans)	$350 Copayment after Deductible	Prior Authorization required.
Sleep studies	Related *Medical care Outpatient visit* or *Inpatient medical care* Cost Sharing may be required	Prior Authorization required.
Other diagnostic testing	$25 Copayment after Deductible	Certain services require Prior Authorization.
Dialysis services	No charge after Deductible	No Prior Authorization required.
Disease Management Programs	No charge	For Members with asthma, diabetes, chronic obstructive pulmonary disease (COPD) or congestive heart failure. If you have any of these conditions, please contact us at **888-257-1985** to discuss our disease management programs.

Covered Services	Cost Sharing	Benefit Limit & Notes
Durable Medical Equipment (DME)		
Covered medical equipment rented or purchased for home use	20% Coinsurance after Deductible	Prior Authorization is required for certain services, including prosthetic orthotics. Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs.
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.
Early Intervention services	No charge	No Prior Authorization required. 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.
Emergency Room care	$350 Copayment per visit after Deductible	No Prior Authorization required. Emergency Room Cost Share waived if held for *Observation services,* sent for *Outpatient surgery services* or admitted for *Inpatient medical or surgical care*. If admitted to the Hospital, Notification required within 48 hours.
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 Plan 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.
Gender affirming services	Cost Sharing varies based on type and place of service.	Prior Authorization required. Medically necessary services may include Inpatient medical and surgical care, Outpatient surgery, Diagnostic services, Speech therapy, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies among other services.

Covered Services	Cost Sharing	Benefit Limit & Notes
Habilitative and rehabilitative services	$60 Copayment per visit	Includes cardiac rehabilitation; physical therapy; occupational therapy; and speech, hearing, and language therapy services. See below for specific details.
Limits:		
Cardiac rehabilitation		
Physical and occupational therapy		Prior Authorization required after initial evaluation and 11 visits. Maximum of 60 visits total Physical and Occupational Therapy per Member per Plan Year.
Speech, hearing, and language therapy		Prior Authorization required after visit 30. No visit limits.
Home health care	No charge after Deductible	Prior Authorization is required for all home care services and disciplines.
Hospice services	No charge after Deductible	Prior Authorization required.
Infertility services	Cost Sharing varies based on type and place of service.	Prior Authorization required. Medically necessary services may include I*npatient medical and surgical care*, *Outpatient surgery*, *Diagnostic services*, *Medical care Outpatient services*, *Medical benefit drugs* and/or *Prescription drugs and supplies* among other services.
Inpatient medical and surgical care Hospital; Chronic Disease Hospital; Rehabilitation Hospital; or Skilled Nursing Facility (SNF)		No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission from the Emergency Room. Planned admissions require Prior Authorization 5 business days before admission.
Facility Fee	$1,000 Copayment per stay after Deductible	Includes room and board and services supplied by the facility during the inpatient stay, including preadmission testing, anesthesia, diagnostic services, and medication and supplies
Professional Fee	No charge after Deductible	Includes physician and other covered professional Provider services
Limits:		
Chronic Disease or Rehabilitation Hospital		Maximum of 60 Days total per Member per Plan Year
Skilled Nursing Facility		Maximum of 100 Days total per Member per Plan Year

Covered Services	Cost Sharing	Benefit Limit & Notes
Maternity services and Well Newborn care		
Childbirth classes	Covered for cost of childbirth education course	Complete a Member Reimbursement Medical Claim Form and submit by mail with proof of payment.
Routine prenatal and postpartum care	No charge	All Outpatient routine prenatal and postpartum office visits are covered as well as breastfeeding services and supports.
Non-routine prenatal care	Cost Sharing varies based on type and place of service.	Any Outpatient maternity services not considered routine or those related to complications or risks with a pregnancy, may be subject to Cost Sharing. Some examples of services not considered routine include, but are not limited to, amniocentesis, fetal stress testing, and OB ultrasounds.
Hospital and delivery services	See *Inpatient medical and surgical care*	Well newborn care is included as part of covered maternity admission.
Breast pumps	No charge if billed per Preventive Services Policy; Otherwise, 20% Coinsurance after Deductible	No Prior Authorization required. One breast pump per birth including related parts and supplies. 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. Pump must be obtained from contracting DME Provider.
Medical benefit drugs	No charge after Deductible	Prior Authorization required for certain drugs. Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit.
Medical care Outpatient visits		
Medical Care includes services to diagnose, treat, and maintain a health condition. Medical care services are covered by Providers in the Tufts Health Direct Network. You are not covered for services from Providers outside of our Network and will be responsible for payment in full. Contact Member Services at **888-257-1985** or visit tuftshealthplan.com/memberlogin to find an In-Network Provider. See *Preventive health services* for information about routine health care.		
Office and community health center visits		
Primary Care Provider (PCP)	$25 Copayment per visit	No Prior Authorization required.
Specialist	$60 Copayment per visit	Prior Authorization required for certain specialist visits.
MinuteClinic	$25 Copayment per visit	No Prior Authorization required. A walk-in clinic accessible at select CVS locations
Nutritional counseling	See *Medical care Outpatient visits*	Prior Authorization required.

Covered Services	Cost Sharing	Benefit Limit & Notes
Observation services	$350 Copayment after Deductible	No Prior Authorization required. 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.
Organ or bone marrow transplant	See *Inpatient medical and surgical care*	Prior Authorization required.
Outpatient surgery services		
Outpatient day surgery		
Outpatient Hospital or Ambulatory Surgery Center facility fee	$500 Copayment per visit after Deductible	Prior Authorization required for certain services.
Professional fee	No charge after Deductible	Includes physician and other covered professional Provider services
Office and community health center surgical services	See *Medical care Outpatient visits*	
Pain management	Cost Sharing varies based on type and place of service.	Certain services require Prior Authorization. Cost Sharing based on type of service, for example Acupuncture, Nutritional counseling, Physical therapy or Chiropractic care.
Podiatry care	See *Medical care Outpatient visits*	No Prior Authorization required. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot.
Prescription drugs and supplies		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.
Retail pharmacy		
Tier 1	$30 Copayment	Primarily generic drugs
Tier 2	$55 Copayment	Includes some non-preferred generics and preferred brands
Tier 3	$75 Copayment after Deductible	Includes high-cost generics, non-preferred brands, and Specialty drugs
Mail order pharmacy		
Tier 1	$60 Copayment	Primarily generic drugs
Tier 2	$110 Copayment	Includes some non-preferred generics and preferred brands
Tier 3	$225 Copayment after Deductible	Includes high-cost generics, non-preferred brands, and Specialty drugs

Covered Services	Cost Sharing	Benefit Limit & Notes
Preventive health services		
Preventive Health services are routine health care that include screenings, check-ups, and counseling to prevent illnesses, disease, or other health problems. Certain Preventive health services may require Prior Authorization. Work with your PCP to use the Preventive Services Policy to review specific requirements.		
Routine pediatric care	No charge	Includes but is not limited to routine exams; immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning
Routine adult care	No charge	Includes but is not limited to routine exams; immunizations; routine lab tests and x-rays; routine mammograms; and routine colonoscopies
Routine gynecological (GYN) care	No charge	Includes but is not limited to routine exams and cervical cancer screenings (Pap smear tests)
Family planning	No charge	
Smoking Cessation Counseling Services	No charge	
Reconstructive surgery and procedures	See *Outpatient surgery* or *Inpatient medical and surgical care*	Certain services may require Prior Authorization.
Telehealth	See *Medical care Outpatient visits*	Please ask your Providers' office for information on telehealth availability and access.
Urgent care	$60 Copayment per visit	No Prior Authorization required. In our Service Area, you must visit a UCC that is in our Network to be covered for services. Outside of our Service Area, free-standing Urgent Care Centers (UCCs) are covered at Out-of-network Provider sites, including Hospitals and clinics.
Vision care		
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.		
Routine pediatric care (under 19 years of age)	$25 Copayment per visit	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.
Routine adult care (age 19 or older)	$25 Copayment per visit	Coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics.
Medical eye and vision care	See *Medical care Outpatient visits*	

Covered Services	Cost Sharing	Benefit Limit & 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 Plan Year. Must complete a Weight Loss Program 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

Schedule of Benefits

a Point32Health company

This Schedule of Benefits 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 Schedule of Benefits for your specific Plan Type. To see which Tufts Health Direct Plan Type you have, check your Tufts Health Plan Member ID Card.

If you want more information about your benefits and capitalized terms, see your *Tufts Health Direct Member Handbook* https://tuftshealthplan.com/documents/members/handbooks/direct-member-handbook-2024.

You must go to Providers who are part of the Tufts Health Direct Provider Network to get services. Out-of-network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal.

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).

You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document. Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The amounts of the Annual Deductible and Annual Out-of-Pocket Maximum which apply to you and the enrolled Members of your family each Plan Year are:

ANNUAL DEDUCTIBLE	AMOUNT	NOTES
Individual	$2,000	The Individual Deductible applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Deductible even if other Members on the family Plan have not.
Family	$4,000	Once two or more Members on a family Plan meet the Family Annual Deductible, the entire family is considered to have met the Deductible for the Plan Year.

ANNUAL OUT-OF-POCKET MAXIMUM	AMOUNT	NOTES
Individual	$9,450	The Individual Out-of-Pocket Maximum applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Out-of-Pocket Maximum even if other Members on the family Plan have not.
Family	$18,900	Once two or more Members on a family Plan meet the Family Annual Out-of-pocket Maximum amount, the entire family is considered to have met the Out-of-pocket Maximum for the Plan Year.
Notice for American Indian and Alaskan Native (AI/AN) Members: All American Indian/Alaskan Native Members, regardless of income, can enroll in a limited cost sharing Plan at any metal level, which means no Copayments, Deductibles, or Coinsurance when receiving care from Indian health care Providers. The Massachusetts Health Connector determines your eligibility to enroll in this Plan variation as part of your application process.		

Covered Services	Cost Sharing	Benefit Limit & Notes
Abortion services	No charge	No Prior Authorization required.
Acupuncture services	$60 Copayment per visit	No Prior Authorization required. No visit limits.
Allergy services		
Allergy testing	$60 Copayment per visit	No Prior Authorization required. Covered for up to 200 allergy tests per Plan Year.
Allergy treatments (injections)	$10 Copayment per visit after Deductible	Note: Allergy immunotherapy covered as part of the pharmacy prescription benefit may require Prior Authorization and have separate pharmacy Cost Sharing responsibility.
Outpatient medical office visits	See *Medical care Outpatient visits*	
Ambulance services		
Emergency	No charge after Deductible	No Prior Authorization required.
Other non-Emergency transportation	No charge after Deductible	Prior Authorization required.
Behavioral Health services - Mental Health & Substance Use Disorder		
Inpatient services		No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission from the Emergency Room. Planned admissions require Prior Authorization 5 business days before admission.
Facility fee	$1,000 Copayment per stay after Deductible	Includes room and board and services supplied by the facility during the inpatient stay.
Professional fee	No charge after Deductible	Includes physician and other covered professional Provider services
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.
Outpatient services		
Individual therapy/Counseling	$25 Copayment per visit	No Prior Authorization required. No visit limits.
Intermediate care, including Behavioral Health (mental health and/or substance use) services for children and adolescents	No charge	Prior Authorization is required for certain Behavioral Health (mental health and/or substance use) services for children and adolescents. Please see the "Covered Services" section of the Tufts Health Direct Member Handbook for more information about these services.
Medication-Assisted Treatment services	No charge	Certain medication may require Prior Authorization.

Covered Services	Cost Sharing	Benefit Limit & Notes
Behavioral Health services - Mental Health & Substance Use Disorder, continued		
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	No charge	No Prior Authorization required. Includes dosing, counseling, and lab services
Recovery Coaches and Peer Specialists	No charge	No Prior Authorization required.
Substance Use Treatment Programs	Cost sharing varies based on type and place of service.	
Autism Spectrum Disorder Services		
Applied Behavioral Analysis (ABA)	$25 Copayment per visit	Prior Authorization required. 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	$60 Copayment per visit	Physical, occupational, and speech therapy benefit limits do not apply.
Chemotherapy and radiation oncology services	No charge after Deductible	Certain services require Prior Authorization.
Chiropractic care	$60 Copayment per visit	No Prior Authorization required.
Cleft palate and 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	Based on place of service	No Prior Authorization required. Routine patient care services covered for Members in a qualified clinical trial pursuant to state and federal mandates.
Dental care, accidental	Based on place of service	No Prior Authorization required. 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.

Covered Services	Cost Sharing	Benefit Limit & Notes
Dental care, non-Emergency (Pediatric only, Delta Dental)		
Members are eligible for services until the last Day of the month in which they turn 19 years old. Please call Delta Dental at 800-872-0500 for more information and for Prior Authorization requirements.		
Type I: Preventive & Diagnostic	No charge	Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age.
Type II: Basic covered services	25% Coinsurance after Deductible	
Type III: Major restorative services	50% Coinsurance after Deductible	
Type IV: Orthodontia	50% Coinsurance after Deductible	Medically Necessary orthodontia requires Prior Authorization.
Diabetes education and treatment	Cost Sharing varies based on type and place of service.	Prior Authorization required for certain services. No charge for the Good Measures program.
Diagnostic services (Outpatient laboratory services, imaging, radiology, and other diagnostic testing)		
Laboratory services	$25 Copayment after Deductible	Includes blood tests, urinalysis, and throat cultures to maintain health and to test, diagnose, and treat disease. Genetic testing requires Prior Authorization.
X-rays	$50 Copayment after Deductible	No Prior Authorization required.
Advanced imaging (MRI, CT, PET scans)	$350 Copayment after Deductible	Prior Authorization required.
Sleep studies	Related *Medical care Outpatient visit* or *Inpatient medical care* Cost Sharing may be required	Prior Authorization required.
Other diagnostic testing	$25 Copayment after Deductible	Certain services require Prior Authorization.
Dialysis services	No charge after Deductible	No Prior Authorization required.
Disease Management Programs	No charge	For Members with asthma, diabetes, chronic obstructive pulmonary disease (COPD) or congestive heart failure. If you have any of these conditions, please contact us at **888-257-1985** to discuss our disease management programs.

Covered Services	Cost Sharing	Benefit Limit & Notes
Durable Medical Equipment (DME)		
Covered medical equipment rented or purchased for home use	20% Coinsurance after Deductible	Prior Authorization is required for certain services, including prosthetic orthotics. Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs.
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.
Early Intervention services	No charge	No Prior Authorization required. 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.
Emergency Room care	$350 Copayment per visit after Deductible	No Prior Authorization required. Emergency Room Cost Share waived if held for *Observation services,* sent for *Outpatient surgery services* or admitted for *Inpatient medical or surgical care*. If admitted to the Hospital, Notification required within 48 hours.
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 Plan 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.
Gender affirming services	Cost Sharing varies based on type and place of service.	Prior Authorization required. Medically necessary services may include Inpatient medical and surgical care, Outpatient surgery, Diagnostic services, Speech therapy, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies among other services.

Covered Services	Cost Sharing	Benefit Limit & Notes
Habilitative and rehabilitative services	$60 Copayment per visit	Includes cardiac rehabilitation; physical therapy; occupational therapy; and speech, hearing, and language therapy services. See below for specific details.
Limits:		
Cardiac rehabilitation		
Physical and occupational therapy		Prior Authorization required after initial evaluation and 11 visits. Maximum of 60 visits total Physical and Occupational Therapy per Member per Plan Year.
Speech, hearing, and language therapy		Prior Authorization required after visit 30. No visit limits.
Home health care	$5 Copayment per visit after Deductible	Prior Authorization is required for all home care services and disciplines.
Hospice services	No charge after Deductible	Prior Authorization required.
Infertility services	Cost Sharing varies based on type and place of service.	Prior Authorization required. Medically necessary services may include I*npatient medical and surgical care*, *Outpatient surgery*, *Diagnostic services*, *Medical care Outpatient services*, *Medical benefit drugs* and/or *Prescription drugs and supplies* among other services.
Inpatient medical and surgical care Hospital; Chronic Disease Hospital; Rehabilitation Hospital; or Skilled Nursing Facility (SNF)		No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission from the Emergency Room. Planned admissions require Prior Authorization 5 business days before admission.
Facility Fee	$1,000 Copayment per stay after Deductible	Includes room and board and services supplied by the facility during the inpatient stay, including preadmission testing, anesthesia, diagnostic services, and medication and supplies
Professional Fee	No charge after Deductible	Includes physician and other covered professional Provider services
Limits:		
Chronic Disease or Rehabilitation Hospital		Maximum of 60 Days total per Member per Plan Year
Skilled Nursing Facility		Maximum of 100 Days total per Member per Plan Year

Covered Services	Cost Sharing	Benefit Limit & Notes
Maternity services and Well Newborn care		
Childbirth classes	Covered for cost of childbirth education course	Complete a Member Reimbursement Medical Claim Form and submit by mail with proof of payment.
Routine prenatal and postpartum care	No charge	All Outpatient routine prenatal and postpartum office visits are covered as well as breastfeeding services and supports.
Non-routine prenatal care	Cost Sharing varies based on type and place of service.	Any Outpatient maternity services not considered routine or those related to complications or risks with a pregnancy, may be subject to Cost Sharing. Some examples of services not considered routine include, but are not limited to, amniocentesis, fetal stress testing, and OB ultrasounds.
Hospital and delivery services	See *Inpatient medical and surgical care*	Well newborn care is included as part of covered maternity admission.
Breast pumps	No charge if billed per Preventive Services Policy; Otherwise, 20% Coinsurance after Deductible	No Prior Authorization required. One breast pump per birth including related parts and supplies. 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. Pump must be obtained from contracting DME Provider.
Medical benefit drugs	No charge after Deductible	Prior Authorization required for certain drugs. Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit.
Medical care Outpatient visits		
Medical Care includes services to diagnose, treat, and maintain a health condition. Medical care services are covered by Providers in the Tufts Health Direct Network. You are not covered for services from Providers outside of our Network and will be responsible for payment in full. Contact Member Services at **888-257-1985** or visit tuftshealthplan.com/memberlogin to find an In-Network Provider. See *Preventive health services* for information about routine health care.		
Office and community health center visits		
Primary Care Provider (PCP)	$25 Copayment per visit	No Prior Authorization required.
Specialist	$60 Copayment per visit	Prior Authorization required for certain specialist visits.
MinuteClinic	$25 Copayment per visit	No Prior Authorization required. A walk-in clinic accessible at select CVS locations
Nutritional counseling	See *Medical care Outpatient visits*	Prior Authorization required.

Covered Services	Cost Sharing	Benefit Limit & Notes
Observation services	$350 Copayment after Deductible	No Prior Authorization required. 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.
Organ or bone marrow transplant	See *Inpatient medical and surgical care*	Prior Authorization required.
Outpatient surgery services		
Outpatient day surgery		
Outpatient Hospital or Ambulatory Surgery Center facility fee	$500 Copayment per visit after Deductible	Prior Authorization required for certain services.
Professional fee	No charge after Deductible	Includes physician and other covered professional Provider services
Office and community health center surgical services	See *Medical care Outpatient visits*	
Pain management	Cost Sharing varies based on type and place of service.	Certain services require Prior Authorization. Cost Sharing based on type of service, for example Acupuncture, Nutritional counseling, Physical therapy or Chiropractic care.
Podiatry care	See *Medical care Outpatient visits*	No Prior Authorization required. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot.
Prescription drugs and supplies		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.
Retail pharmacy		
Tier 1	$30 Copayment	Primarily generic drugs
Tier 2	$55 Copayment	Includes some non-preferred generics and preferred brands
Tier 3	$75 Copayment after Deductible	Includes high-cost generics, non-preferred brands, and Specialty drugs
Mail order pharmacy		
Tier 1	$60 Copayment	Primarily generic drugs
Tier 2	$110 Copayment	Includes some non-preferred generics and preferred brands
Tier 3	$225 Copayment after Deductible	Includes high-cost generics, non-preferred brands, and Specialty drugs

Covered Services	Cost Sharing	Benefit Limit & Notes
Preventive health services		
Preventive Health services are routine health care that include screenings, check-ups, and counseling to prevent illnesses, disease, or other health problems. Certain Preventive health services may require Prior Authorization. Work with your PCP to use the Preventive Services Policy to review specific requirements.		
Routine pediatric care	No charge	Includes but is not limited to routine exams; immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning
Routine adult care	No charge	Includes but is not limited to routine exams; immunizations; routine lab tests and x-rays; routine mammograms; and routine colonoscopies
Routine gynecological (GYN) care	No charge	Includes but is not limited to routine exams and cervical cancer screenings (Pap smear tests)
Family planning	No charge	
Smoking Cessation Counseling Services	No charge	
Reconstructive surgery and procedures	See *Outpatient surgery* or *Inpatient medical and surgical care*	Certain services may require Prior Authorization.
Telehealth	See *Medical care Outpatient visits*	Please ask your Providers' office for information on telehealth availability and access.
Urgent care	$60 Copayment per visit	No Prior Authorization required. In our Service Area, you must visit a UCC that is in our Network to be covered for services. Outside of our Service Area, free-standing Urgent Care Centers (UCCs) are covered at Out-of-network Provider sites, including Hospitals and clinics.
Vision care		
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.		
Routine pediatric care (under 19 years of age)	$25 Copayment per visit	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.
Routine adult care (age 19 or older)	$25 Copayment per visit	Coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics.
Medical eye and vision care	See *Medical care Outpatient visits*	

Covered Services	Cost Sharing	Benefit Limit & 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 Plan Year. Must complete a Weight Loss Program 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

Schedule of Benefits

a Point32Health company

This Schedule of Benefits 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 Schedule of Benefits for your specific Plan Type. To see which Tufts Health Direct Plan Type you have, check your Tufts Health Direct Plan Member ID Card.

If you want more information about your benefits and capitalized terms, see your *Tufts Health Direct Member Handbook* https://tuftshealthplan.com/documents/members/handbooks/direct-member-handbook-2024.

You must go to Providers who are part of the Tufts Health Direct Provider Network to get services. Out-of-network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal.

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).

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 HDHPs, please refer to https://www.irs.gov/publications/p969.

You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document. Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The amounts of the Annual Deductible and Annual Out-of-Pocket Maximum which apply to you and the enrolled Members of your family each Plan Year are:

ANNUAL DEDUCTIBLE	AMOUNT	NOTES
Individual **(Self-only Plan)**	$2,000	Individual Annual Deductible amount applies when there is only one Member enrolled on the Plan.
Family **(two Members or more)**	$4,000	Family Annual Deductible amount applies if there are two or more Members enrolled on the Plan. The Family Deductible is met when a total of $4,000 has been paid toward the Deductible by one or more Members on the Plan.

ANNUAL OUT-OF-POCKET MAXIMUM	AMOUNT	NOTES
Individual	$7,050	A Member can meet the Individual Annual Out of Pocket Maximum on a self-only or a family Plan and then does not have additional Cost Sharing for Covered Services for the remainder of the Plan Year.
Family	$14,100	Two or more Members on a family Plan can meet the Family Out-of-Pocket Maximum and then no Member of the family has additional Cost Sharing for Covered Services for the remainder of the Plan Year.

Covered Services	Cost Sharing	Benefit Limit & Notes
Abortion services	No charge after Deductible	No Prior Authorization required.
Acupuncture services	$60 Copayment per visit after Deductible	No Prior Authorization required. No visit limits.
Allergy services		
Allergy testing	$60 Copayment per visit after Deductible	No Prior Authorization required. Covered for up to 200 allergy tests per Plan Year.
Allergy treatments (injections)	$10 Copayment per visit after Deductible	Note: Allergy immunotherapy covered as part of the pharmacy prescription benefit may require Prior Authorization and have separate pharmacy Cost Sharing responsibility.
Outpatient medical office visits	See *Medical care Outpatient visits*	
Ambulance services		
Emergency	No charge after Deductible	No Prior Authorization required.
Other non-Emergency transportation	No charge after Deductible	Prior Authorization required.
Behavioral Health services - Mental Health & Substance Use Disorder		
Inpatient services		No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission from the Emergency Room. Planned admissions require Prior Authorization 5 business days before admission.
Facility fee	$750 Copayment per stay after Deductible	Includes room and board and services supplied by the facility during the inpatient stay
Professional fee	No charge after Deductible	Includes physician and other covered professional Provider services
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.
Outpatient services		
Individual therapy/Counseling	$30 Copayment per visit after Deductible	No Prior Authorization required. No visit limits.
Intermediate care, including Behavioral Health (mental health and/or substance use) services for children and adolescents	No charge after Deductible	Prior Authorization is required for certain Behavioral Health (mental health and/or substance use) services for children and adolescents. Please see the "Covered Services" section of the Tufts Health Direct Member Handbook for more information about these services.
Medication-Assisted Treatment services	No charge after Deductible	Certain medication may require Prior Authorization.

Covered Services	Cost Sharing	Benefit Limit & Notes
Behavioral Health services - Mental Health & Substance Use Disorder, continued		
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	No charge after Deductible	No Prior Authorization required. Includes dosing, counseling, and lab services
Recovery Coaches and Peer Specialists	No charge after Deductible	No Prior Authorization required.
Substance Use Treatment Programs	Cost sharing varies based on type and place of service.	
Autism Spectrum Disorder Services		
Applied Behavioral Analysis (ABA)	$30 Copayment per visit after Deductible	Prior Authorization required. 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	$60 Copayment per visit after Deductible	Physical, occupational, and speech therapy benefit limits do not apply.
Chemotherapy and radiation oncology services	No charge after Deductible	Certain services require Prior Authorization.
Chiropractic care	$60 Copayment per visit after Deductible	No Prior Authorization required.
Cleft palate and 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	Based on place of service	No Prior Authorization required. Routine patient care services covered for Members in a qualified clinical trial pursuant to state and federal mandates.
Dental care, accidental	Based on place of service	No Prior Authorization required. 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.

Covered Services	Cost Sharing	Benefit Limit & Notes
Dental care, non-Emergency (Pediatric only, Delta Dental)		
Members are eligible for services until the last Day of the month in which they turn 19 years old. Please call Delta Dental at 800-872-0500 for more information and for Prior Authorization requirements.		
Type I: Preventive & Diagnostic	No charge	Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age.
Type II: Basic covered services	25% Coinsurance after Deductible	
Type III: Major restorative services	50% Coinsurance after Deductible	
Type IV: Orthodontia	50% Coinsurance after Deductible	Medically Necessary orthodontia requires Prior Authorization.
Diabetes education and treatment	Cost Sharing varies based on type and place of service.	Prior Authorization required for certain services. No charge for the Good Measures program.
Diagnostic services (Outpatient laboratory services, imaging, radiology, and other diagnostic testing)		
Laboratory services	$60 Copayment after Deductible	Includes blood tests, urinalysis, and throat cultures to maintain health and to test, diagnose, and treat disease. Genetic testing requires Prior Authorization.
X-rays	$75 Copayment after Deductible	No Prior Authorization required.
Advanced imaging (MRI, CT, PET scans)	$500 Copayment after Deductible	Prior Authorization required.
Sleep studies	Related *Medical care Outpatient visit* or *Inpatient medical care* Cost Sharing may be required	Prior Authorization required.
Other diagnostic testing	$60 Copayment after Deductible	Certain services require Prior Authorization.
Dialysis services	No charge after Deductible	No Prior Authorization required.
Disease Management Programs	No charge	For Members with asthma, diabetes, chronic obstructive pulmonary disease (COPD) or congestive heart failure. If you have any of these conditions, please contact us at **888-257-1985** to discuss our disease management programs.

Covered Services	Cost Sharing	Benefit Limit & Notes
Durable Medical Equipment (DME)		
Covered medical equipment rented or purchased for home use	20% Coinsurance after Deductible	Prior Authorization is required for certain services, including prosthetic orthotics. Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs.
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.
Early Intervention services	No charge	No Prior Authorization required. 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.
Emergency Room care	$300 Copayment per visit after Deductible	No Prior Authorization required. Emergency Room Cost Share waived if held for *Observation services,* sent for *Outpatient surgery services* or admitted for *Inpatient medical or surgical care*. If admitted to the Hospital, Notification required within 48 hours.
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 Plan 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.
Gender affirming services	Cost Sharing varies based on type and place of service.	Prior Authorization required. Medically necessary services may include Inpatient medical and surgical care, Outpatient surgery, Diagnostic services, Speech therapy, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies among other services.

Covered Services	Cost Sharing	Benefit Limit & Notes
Habilitative and rehabilitative services	$60 Copayment per visit after Deductible	Includes cardiac rehabilitation; physical therapy; occupational therapy; and speech, hearing, and language therapy services. See below for specific details.
Limits:		
Cardiac rehabilitation		
Physical and occupational therapy		Prior Authorization required after initial evaluation and 11 visits. Maximum of 60 visits total Physical and Occupational Therapy per Member per Plan Year.
Speech, hearing, and language therapy		Prior Authorization required after visit 30. No visit limits.
Home health care	No charge after Deductible	Prior Authorization is required for all home care services and disciplines.
Hospice services	No charge after Deductible	Prior Authorization required.
Infertility services	Cost Sharing varies based on type and place of service.	Prior Authorization required. Medically necessary services may include I*npatient medical and surgical care*, *Outpatient surgery*, *Diagnostic services*, *Medical care Outpatient services*, *Medical benefit drugs* and/or *Prescription drugs and supplies* among other services
Inpatient medical and surgical care Hospital; Chronic Disease Hospital; Rehabilitation Hospital; or Skilled Nursing Facility (SNF)		No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission from the Emergency Room. Planned admissions require Prior Authorization 5 business days before admission.
Facility Fee	$750 Copayment per stay after Deductible	Includes room and board and services supplied by the facility during the inpatient stay, including preadmission testing, anesthesia, diagnostic services, and medication and supplies
Professional Fee	No charge after Deductible	Includes physician and other covered professional Provider services
Limits:		
Chronic Disease or Rehabilitation Hospital		Maximum of 60 Days total per Member per Plan Year
Skilled Nursing Facility		Maximum of 100 Days total per Member per Plan Year

Covered Services	Cost Sharing	Benefit Limit & Notes
Maternity services and Well Newborn care		
Childbirth classes	Covered for cost of childbirth education course	Complete a Member Reimbursement Medical Claim Form and submit by mail with proof of payment.
Routine prenatal and postpartum care	No charge	All Outpatient routine prenatal and postpartum office visits are covered as well as breastfeeding services and supports.
Non-routine prenatal care	Cost Sharing varies based on type and place of service.	Any Outpatient maternity services not considered routine or those related to complications or risks with a pregnancy, may be subject to Cost Sharing. Some examples of services not considered routine include, but are not limited to, amniocentesis, fetal stress testing, and OB ultrasounds.
Hospital and delivery services	See *Inpatient medical and surgical care*	Well newborn care is included as part of covered maternity admission.
Breast pumps	No charge if billed per Preventive Services Policy; Otherwise, 20% Coinsurance after Deductible	No Prior Authorization required. One breast pump per birth including related parts and supplies. 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. Pump must be obtained from contracting DME Provider.
Medical benefit drugs	No charge after Deductible	Prior Authorization required for certain drugs. Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit.
Medical care Outpatient visits		
Medical Care includes services to diagnose, treat, and maintain a health condition. Medical care services are covered by Providers in the Tufts Health Direct Network. You are not covered for services from Providers outside of our Network and will be responsible for payment in full. Contact Member Services at **888-257-1985** or visit tuftshealthplan.com/memberlogin to find an In-Network Provider. See *Preventive health services* for information about routine health care.		
Office and community health center visits		
Primary Care Provider (PCP)	$30 Copayment per visit after Deductible	No Prior Authorization required.
Specialist	$60 Copayment per visit after Deductible	Prior Authorization required for certain specialist visits.
MinuteClinic	$30 Copayment per visit after Deductible	No Prior Authorization required. A walk-in clinic accessible at select CVS locations
Nutritional counseling	See *Medical care Outpatient visits*	Prior Authorization required.

Covered Services	Cost Sharing	Benefit Limit & Notes
Observation services	$300 Copayment after Deductible	No Prior Authorization required. 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.
Organ or bone marrow transplant	See *Inpatient medical and surgical care*	Prior Authorization required.
Outpatient surgery services		
Outpatient day surgery		
Outpatient Hospital or Ambulatory Surgery Center facility fee	$500 Copayment per visit after Deductible	Prior Authorization required for certain services.
Professional fee	No charge after Deductible	Includes physician and other covered professional Provider services
Office and community health center surgical services	See *Medical care Outpatient visits*	
Pain management	Cost Sharing varies based on type and place of service.	Certain services require Prior Authorization. Cost Sharing based on type of service, for example Acupuncture, Nutritional counseling, Physical therapy or Chiropractic care.
Podiatry care	See *Medical care Outpatient visits*	No Prior Authorization required. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot.
Prescription drugs and supplies		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.
Retail pharmacy		
Tier 1	$30 Copayment after Deductible	Primarily generic drugs
Tier 2	$60 Copayment after Deductible	Includes some non-preferred generics and preferred brands
Tier 3	$105 Copayment after Deductible	Includes high-cost generics, non-preferred brands, and Specialty drugs
Mail order pharmacy		
Tier 1	$60 Copayment after Deductible	Primarily generic drugs
Tier 2	$120 Copayment after Deductible	Includes some non-preferred generics and preferred brands
Tier 3	$315 Copayment after Deductible	Includes high-cost generics, non-preferred brands, and Specialty drugs

Covered Services	Cost Sharing	Benefit Limit & Notes
Preventive health services		
Preventive Health services are routine health care that include screenings, check-ups, and counseling to prevent illnesses, disease, or other health problems. Certain Preventive health services may require Prior Authorization. Work with your PCP to use the Preventive Services Policy to review specific requirements.		
Routine pediatric care	No charge	Includes but is not limited to routine exams; immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning
Routine adult care	No charge	Includes but is not limited to routine exams; immunizations; routine lab tests and x-rays; routine mammograms; and routine colonoscopies
Routine gynecological (GYN) care	No charge	Includes but is not limited to routine exams and cervical cancer screenings (Pap smear tests)
Family planning	No charge	
Smoking Cessation Counseling Services	No charge	
Reconstructive surgery and procedures	See *Outpatient surgery* or *Inpatient medical and surgical care*	Certain services may require Prior Authorization.
Telehealth	See *Medical care Outpatient visits*	Please ask your Providers' office for information on telehealth availability and access.
Urgent care	$60 Copayment per visit after Deductible	No Prior Authorization required. In our Service Area, you must visit a UCC that is in our Network to be covered for services. Outside of our Service Area, free-standing Urgent Care Centers (UCCs) are covered at Out-of-network Provider sites, including Hospitals and clinics.
Vision care		
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.		
Routine pediatric care (under 19 years of age)	$30 Copayment per visit after Deductible	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.
Routine adult care (age 19 or older)	$30 Copayment per visit after Deductible	Coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics.
Medical eye and vision care	See *Medical care Outpatient visits*	

Covered Services	Cost Sharing	Benefit Limit & 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 Plan Year. Must complete a Weight Loss Program 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

Schedule of Benefits

a Point32Health company

This Schedule of Benefits 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 Schedule of Benefits for your specific Plan Type. To see which Tufts Health Direct Plan Type you have, check your Tufts Health Plan Member ID Card.

If you want more information about your benefits and capitalized terms, see your *Tufts Health Direct Member Handbook* https://tuftshealthplan.com/documents/members/handbooks/direct-member-handbook-2024.

You must go to Providers who are part of the Tufts Health Direct Provider Network to get services. Out-of-network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal.

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).

You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document. Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The amounts of the Annual Deductible and Annual Out-of-Pocket Maximum which apply to you and the enrolled Members of your family each Plan Year are:

ANNUAL DEDUCTIBLE	AMOUNT	NOTES
Individual	$2,850	The Individual Deductible applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Deductible even if other Members on the family Plan have not.
Family	$5,700	Once two or more Members on a family Plan meet the Family Annual Deductible, the entire family is considered to have met the Deductible for the Plan Year.

ANNUAL OUT-OF-POCKET MAXIMUM	AMOUNT	NOTES
Individual	$9,450	The Individual Out-of-Pocket Maximum applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Out-of-Pocket Maximum even if other Members on the family Plan have not.
Family	$18,900	Once two or more Members on a family Plan meet the Family Annual Out-of-pocket Maximum amount, the entire family is considered to have met the Out-of-pocket Maximum for the Plan Year.
Notice for American Indian and Alaskan Native (AI/AN) Members: All American Indian/Alaskan Native Members, regardless of income, can enroll in a limited cost sharing Plan at any metal level, which means no Copayments, Deductibles, or Coinsurance when receiving care from Indian health care Providers. The Massachusetts Health Connector determines your eligibility to enroll in this Plan variation as part of your application process.		

Covered Services	Cost Sharing	Benefit Limit & Notes
Abortion services	No charge	No Prior Authorization required.
Acupuncture services	$65 Copayment per visit after Deductible	No Prior Authorization required. No visit limits.
Allergy services		
Allergy testing	$65 Copayment per visit after Deductible	No Prior Authorization required. Covered for up to 200 allergy tests per Plan Year.
Allergy treatments (injections)	$10 Copayment per visit after Deductible	Note: Allergy immunotherapy covered as part of the pharmacy prescription benefit may require Prior Authorization and have separate pharmacy Cost Sharing responsibility.
Outpatient medical office visits	See *Medical care Outpatient visits*	
Ambulance services		
Emergency	No charge after Deductible	No Prior Authorization required.
Other non-Emergency transportation	No charge after Deductible	Prior Authorization required.
Behavioral Health services - Mental Health & Substance Use Disorder		
Inpatient services		No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission from the Emergency Room. Planned admissions require Prior Authorization 5 business days before admission.
Facility fee	$1,000 Copayment per stay after Deductible	Includes room and board and services supplied by the facility during the inpatient stay.
Professional fee	No charge after Deductible	Includes physician and other covered professional Provider services
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.
Outpatient services		
Individual therapy/Counseling	$30 Copayment per visit after Deductible	No Prior Authorization required. No visit limits.
Intermediate care, including Behavioral Health (mental health and/or substance use) services for children and adolescents	No charge	Prior Authorization is required for certain Behavioral Health (mental health and/or substance use) services for children and adolescents. Please see the "Covered Services" section of the Tufts Health Direct Member Handbook for more information about these services.
Medication-Assisted Treatment services	No charge	Certain medication may require Prior Authorization.

Covered Services	Cost Sharing	Benefit Limit & Notes
Behavioral Health services - Mental Health & Substance Use Disorder, continued		
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	No charge	No Prior Authorization required. Includes dosing, counseling, and lab services
Recovery Coaches and Peer Specialists	No charge	No Prior Authorization required.
Substance Use Treatment Programs	Cost sharing varies based on type and place of service.	
Autism Spectrum Disorder Services		
Applied Behavioral Analysis (ABA)	$30 Copayment per visit after Deductible	Prior Authorization required. 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	$65 Copayment per visit after Deductible	Physical, occupational, and speech therapy benefit limits do not apply.
Chemotherapy and radiation oncology services	No charge after Deductible	Certain services require Prior Authorization.
Chiropractic care	$65 Copayment per visit after Deductible	No Prior Authorization required.
Cleft palate and 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	Based on place of service	No Prior Authorization required. Routine patient care services covered for Members in a qualified clinical trial pursuant to state and federal mandates.
Dental care, accidental	Based on place of service	No Prior Authorization required. 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.

Covered Services	Cost Sharing	Benefit Limit & Notes
Dental care, non-Emergency (Pediatric only, Delta Dental)		
Members are eligible for services until the last Day of the month in which they turn 19 years old. Please call Delta Dental at 800-872-0500 for more information and for Prior Authorization requirements.		
Type I: Preventive & Diagnostic	No charge	Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age.
Type II: Basic covered services	25% Coinsurance after Deductible	
Type III: Major restorative services	50% Coinsurance after Deductible	
Type IV: Orthodontia	50% Coinsurance after Deductible	Medically Necessary orthodontia requires Prior Authorization.
Diabetes education and treatment	Cost Sharing varies based on type and place of service.	Prior Authorization required for certain services. No charge for the Good Measures program.
Diagnostic services (Outpatient laboratory services, imaging, radiology, and other diagnostic testing)		
Laboratory services	$50 Copayment after Deductible	Includes blood tests, urinalysis, and throat cultures to maintain health and to test, diagnose, and treat disease. Genetic testing requires Prior Authorization.
X-rays	$100 Copayment after Deductible	No Prior Authorization required.
Advanced imaging (MRI, CT, PET scans)	$350 Copayment after Deductible	Prior Authorization required.
Sleep studies	Related *Medical care Outpatient visit* or *Inpatient medical care* Cost Sharing may be required	Prior Authorization required.
Other diagnostic testing	$50 Copayment after Deductible	Certain services require Prior Authorization .
Dialysis services	No charge after Deductible	No Prior Authorization required.
Disease Management Programs	No charge	For Members with asthma, diabetes, chronic obstructive pulmonary disease (COPD) or congestive heart failure. If you have any of these conditions, please contact us at **888-257-1985** to discuss our disease management programs.

Covered Services	Cost Sharing	Benefit Limit & Notes
Durable Medical Equipment (DME)		
Covered medical equipment rented or purchased for home use	20% Coinsurance after Deductible	Prior Authorization is required for certain services, including prosthetic orthotics. Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs.
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.
Early Intervention services	No charge	No Prior Authorization required. 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.
Emergency Room care	$400 Copayment per visit after Deductible	No Prior Authorization required. Emergency Room Cost Share waived if held for *Observation services,* sent for *Outpatient surgery services* or admitted for *Inpatient medical or surgical care*. If admitted to the Hospital, Notification required within 48 hours.
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 Plan 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.
Gender affirming services	Cost Sharing varies based on type and place of service.	Prior Authorization required. Medically necessary services may include Inpatient medical and surgical care, Outpatient surgery, Diagnostic services, Speech therapy, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies among other services.

Covered Services	Cost Sharing	Benefit Limit & Notes
Habilitative and rehabilitative services	$65 Copayment per visit after Deductible	Includes cardiac rehabilitation; physical therapy; occupational therapy; and speech, hearing, and language therapy services. See below for specific details.
Limits:		
Cardiac rehabilitation		
Physical and occupational therapy		Prior Authorization required after initial evaluation and 11 visits. Maximum of 60 visits total Physical and Occupational Therapy per Member per Plan Year.
Speech, hearing, and language therapy		Prior Authorization required after visit 30. No visit limits.
Home health care	No charge after Deductible	Prior Authorization is required for all home care services and disciplines.
Hospice services	No charge after Deductible	Prior Authorization required.
Infertility services	Cost Sharing varies based on type and place of service.	Prior Authorization required. Medically necessary services may include I*npatient medical and surgical care*, *Outpatient surgery*, *Diagnostic services*, *Medical care Outpatient services*, *Medical benefit drugs* and/or *Prescription drugs and supplies* among other services.
Inpatient medical and surgical care Hospital; Chronic Disease Hospital; Rehabilitation Hospital; or Skilled Nursing Facility (SNF)		No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission from the Emergency Room. Planned admissions require Prior Authorization 5 business days before admission.
Facility Fee	$1,000 Copayment per stay after Deductible	Includes room and board and services supplied by the facility during the inpatient stay, including preadmission testing, anesthesia, diagnostic services, and medication and supplies
Professional Fee	No charge after Deductible	Includes physician and other covered professional Provider services
Limits:		
Chronic Disease or Rehabilitation Hospital		Maximum of 60 Days total per Member per Plan Year
Skilled Nursing Facility		Maximum of 100 Days total per Member per Plan Year

Covered Services	Cost Sharing	Benefit Limit & Notes
Maternity services and Well Newborn care		
Childbirth classes	Covered for cost of childbirth education course	Complete a Member Reimbursement Medical Claim Form and submit by mail with proof of payment.
Routine prenatal and postpartum care	No charge	All Outpatient routine prenatal and postpartum office visits are covered as well as breastfeeding services and supports.
Non-routine prenatal care	Cost Sharing varies based on type and place of service.	Any Outpatient maternity services not considered routine or those related to complications or risks with a pregnancy, may be subject to Cost Sharing. Some examples of services not considered routine include, but are not limited to, amniocentesis, fetal stress testing, and OB ultrasounds.
Hospital and delivery services	See *Inpatient medical and surgical care*	Well newborn care is included as part of covered maternity admission.
Breast pumps	No charge if billed per Preventive Services Policy; Otherwise, 20% Coinsurance after Deductible	No Prior Authorization required. One breast pump per birth including related parts and supplies. 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. Pump must be obtained from contracting DME Provider.
Medical benefit drugs	No charge after Deductible	Prior Authorization required for certain drugs. Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit.
Medical care Outpatient visits		
Medical Care includes services to diagnose, treat, and maintain a health condition. Medical care services are covered by Providers in the Tufts Health Direct Network. You are not covered for services from Providers outside of our Network and will be responsible for payment in full. Contact Member Services at **888-257-1985** or visit tuftshealthplan.com/memberlogin to find an In-network Provider. See *Preventive health services* for information about routine health care.		
Office and community health center visits		
Primary Care Provider (PCP)	$30 Copayment per visit after Deductible	No Prior Authorization required.
Specialist	$65 Copayment per visit after Deductible	Prior Authorization required for certain specialist visits.
MinuteClinic	$30 Copayment per visit after Deductible	No Prior Authorization required. A walk-in clinic accessible at select CVS locations
Nutritional counseling	See *Medical care Outpatient visits*	Prior Authorization required.

Covered Services	Cost Sharing	Benefit Limit & Notes
Observation services	$400 Copayment after Deductible	No Prior Authorization required. 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.
Organ or bone marrow transplant	See *Inpatient medical and surgical care*	Prior Authorization required.
Outpatient surgery services		
Outpatient day surgery		
Outpatient Hospital or Ambulatory Surgery Center facility fee	$500 Copayment per visit after Deductible	Prior Authorization required for certain services.
Professional fee	No charge after Deductible	Includes physician and other covered professional Provider services
Office and community health center surgical services	See *Medical care Outpatient visits*	
Pain management	Cost Sharing varies based on type and place of service.	Certain services require Prior Authorization. Cost Sharing based on type of service, for example Acupuncture, Nutritional counseling, Physical therapy or Chiropractic care
Podiatry care	See *Medical care Outpatient visits*	No Prior Authorization required. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot.
Prescription drugs and supplies		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.
Retail pharmacy		
Tier 1	$30 Copayment	Primarily generic drugs
Tier 2	$65 Copayment after Deductible	Includes some non-preferred generics and preferred brands
Tier 3	$100 Copayment after Deductible	Includes high-cost generics, non-preferred brands, and Specialty drugs
Mail order pharmacy		
Tier 1	$60 Copayment	Primarily generic drugs
Tier 2	$130 Copayment after Deductible	Includes some non-preferred generics and preferred brands
Tier 3	$300 Copayment after Deductible	Includes high-cost generics, non-preferred brands, and Specialty drugs

Covered Services	Cost Sharing	Benefit Limit & Notes
Preventive health services		
Preventive Health services are routine health care that include screenings, check-ups, and counseling to prevent illnesses, disease, or other health problems. Certain Preventive health services may require Prior Authorization. Work with your PCP to use the Preventive Services Policy to review specific requirements.		
Routine pediatric care	No charge	Includes but is not limited to routine exams; immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning
Routine adult care	No charge	Includes but is not limited to routine exams; immunizations; routine lab tests and x-rays; routine mammograms; and routine colonoscopies
Routine gynecological (GYN) care	No charge	Includes but is not limited to routine exams and cervical cancer screenings (Pap smear tests)
Family planning	No charge	
Smoking Cessation Counseling Services	No charge	
Reconstructive surgery and procedures	See *Outpatient surgery* or *Inpatient medical and surgical care*	Certain services may require Prior Authorization.
Telehealth	See *Medical care Outpatient visits*	Please ask your Providers' office for information on telehealth availability and access.
Urgent care	$65 Copayment per visit after Deductible	No Prior Authorization required. In our Service Area, you must visit a UCC that is in our Network to be covered for services. Outside of our Service Area, free-standing Urgent Care Centers (UCCs) are covered at Out-of-network Provider sites, including Hospitals and clinics.
Vision care		
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.		
Routine pediatric care (under 19 years of age)	$30 Copayment per visit after Deductible	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.
Routine adult care (age 19 or older)	$30 Copayment per visit after Deductible	Coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics.
Medical eye and vision care	See *Medical care Outpatient visits*	

Covered Services	Cost Sharing	Benefit Limit & 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 Plan Year. Must complete a Weight Loss Program 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

Schedule of Benefits

a Point32Health company

This Schedule of Benefits 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 Schedule of Benefits for your specific Plan Type. To see which Tufts Health Direct Plan Type you have, check your Tufts Health Plan Member ID Card.

If you want more information about your benefits and capitalized terms, see your *Tufts Health Direct Member Handbook* https://tuftshealthplan.com/documents/members/handbooks/direct-member-handbook-2024.

You must go to Providers who are part of the Tufts Health Direct Provider Network to get services. Out-of-network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal.

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).

You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document. Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The amounts of the Annual Deductible and Annual Out-of-Pocket Maximum which apply to you and the enrolled Members of your family each Plan Year are:

ANNUAL DEDUCTIBLE	AMOUNT	NOTES
Individual	$9,450	The Individual Deductible applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family plan can meet the Individual Deductible even if other Members on the family Plan have not.
Family	$18,900	Once two or more Members on a family Plan meet the Family Annual Deductible, the entire family is considered to have met the Deductible for the Plan Year.

ANNUAL OUT-OF-POCKET MAXIMUM	AMOUNT	NOTES
Individual	$9,450	The Individual Out-of-Pocket Maximum applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Out-of-Pocket Maximum even if other Members on the family Plan have not.
Family	$18,900	Once two or more Members on a family Plan meet the Family Annual Out-of-pocket Maximum amount, the entire family is considered to have met the Out-of-pocket Maximum for the Plan Year.
Notice for American Indian and Alaskan Native (AI/AN) Members: All American Indian/Alaskan Native Members, regardless of income, can enroll in a limited cost sharing Plan at any metal level, which means no Copayments, Deductibles, or Coinsurance when receiving care from Indian health care Providers. The Massachusetts Health Connector determines your eligibility to enroll in this Plan variation as part of your application process.		

Covered Services	Cost Sharing	Benefit Limit & Notes
Abortion services	No charge	No Prior Authorization required.
Acupuncture services	No charge after Deductible	No Prior Authorization required. No visit limits.
Allergy services		
Allergy testing	No charge after Deductible	No Prior Authorization required. Covered for up to 200 allergy tests per Plan Year.
Allergy treatments (injections)	No charge after Deductible	Note: Allergy immunotherapy covered as part of the pharmacy prescription benefit may require Prior Authorization and have separate pharmacy Cost Sharing responsibility.
Outpatient medical office visits	No charge after Deductible	
Ambulance services		
Emergency	No charge after Deductible	No Prior Authorization required.
Other non-Emergency transportation	No charge after Deductible	Prior Authorization required.
Behavioral Health services - Mental Health & Substance Use Disorder		
Inpatient services		No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission from the Emergency Room. Planned admissions require Prior Authorization 5 business days before admission.
Facility fee	No charge after Deductible	Includes room and board and services supplied by the facility during the inpatient stay
Professional fee	No charge after Deductible	Includes physician and other covered professional Provider services
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.
Outpatient services		
Individual therapy/Counseling	No charge after Deductible	No Prior Authorization required. No visit limits.
Intermediate care, including Behavioral Health (mental health and/or substance use) services for children and adolescents	No charge after Deductible	Prior Authorization is required for certain Behavioral Health (mental health and/or substance use) services for children and adolescents. Please see the "Covered Services" section of the Tufts Health Direct Member Handbook for more information about these services.
Medication-Assisted Treatment services	No charge after Deductible	Certain medication may require Prior Authorization.

Covered Services	Cost Sharing	Benefit Limit & Notes
Behavioral Health services - Mental Health & Substance Use Disorder, continued		
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	No charge after Deductible	No Prior Authorization required. Includes dosing, counseling, and lab services
Recovery Coaches and Peer Specialists	No charge	No Prior Authorization required.
Substance Use Treatment Programs	Cost sharing varies based on type and place of service.	
Autism Spectrum Disorder Services		
Applied Behavioral Analysis (ABA)	No charge after Deductible	Prior Authorization required. 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	No charge after Deductible	Physical, occupational, and speech therapy benefit limits do not apply.
Chemotherapy and radiation oncology services	No charge after Deductible	Certain services require Prior Authorization.
Chiropractic care	No charge after Deductible	No Prior Authorization required.
Cleft palate and 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	Based on place of service	No Prior Authorization required. Routine patient care services covered for Members in a qualified clinical trial pursuant to state and federal mandates.
Dental care, accidental	Based on place of service	No Prior Authorization required. 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.

Covered Services	Cost Sharing	Benefit Limit & Notes
Dental care, non-Emergency (Pediatric only, Delta Dental)		
Members are eligible for services until the last Day of the month in which they turn 19 years old. Please call Delta Dental at 800-872-0500 for more information and for Prior Authorization requirements.		
Type I: Preventive & Diagnostic	No charge	Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age.
Type II: Basic covered services	No charge after Deductible	
Type III: Major restorative services	No charge after Deductible	
Type IV: Orthodontia	No charge after Deductible	Medically Necessary orthodontia requires Prior Authorization.
Diabetes education and treatment	Cost Sharing varies based on type and place of service.	Prior Authorization required for certain services. No charge for the Good Measures program.
Diagnostic services (Outpatient laboratory services, imaging, radiology, and other diagnostic testing)		
Laboratory services	No charge after Deductible	Includes blood tests, urinalysis, and throat cultures to maintain health and to test, diagnose, and treat disease. Genetic testing requires Prior Authorization.
X-rays	No charge after Deductible	No Prior Authorization required.
Advanced imaging (MRI, CT, PET scans)	No charge after Deductible	Prior Authorization required.
Sleep studies	Related *Medical care Outpatient visit* or *Inpatient medical care* Cost Sharing may be required	Prior Authorization required.
Other diagnostic testing	No charge after Deductible	Certain services require Prior Authorization.
Dialysis services	No charge after Deductible	No Prior Authorization required.
Disease Management Programs	No charge	For Members with asthma, diabetes, chronic obstructive pulmonary disease (COPD) or congestive heart failure. If you have any of these conditions, please contact us at **888-257-1985** to discuss our disease management programs.

Covered Services	Cost Sharing	Benefit Limit & Notes
Durable Medical Equipment (DME)		
Covered medical equipment rented or purchased for home use	No charge after Deductible	Prior Authorization is required for certain services, including prosthetic orthotics. Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs.
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.
Early Intervention services	No charge	No Prior Authorization required. 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.
Emergency Room care	No charge after Deductible	No Prior Authorization required. Emergency Room Cost Share waived if held for *Observation services,* sent for *Outpatient surgery services* or admitted for *Inpatient medical or surgical care*. If admitted to the Hospital, Notification required within 48 hours.
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 Plan 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.
Gender affirming services	Cost Sharing varies based on type and place of service.	Prior Authorization required. Medically necessary services may include Inpatient medical and surgical care, Outpatient surgery, Diagnostic services, Speech therapy, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies among other services.

Covered Services	Cost Sharing	Benefit Limit & Notes
Habilitative and rehabilitative services	No charge after Deductible	Includes cardiac rehabilitation; physical therapy; occupational therapy; and speech, hearing, and language therapy services. See below for specific details.
Limits:		
Cardiac rehabilitation		
Physical and occupational therapy		Prior Authorization required after initial evaluation and 11 visits. Maximum of 60 visits total Physical and Occupational Therapy per Member per Plan Year.
Speech, hearing, and language therapy		Prior Authorization required after visit 30. No visit limits.
Home health care	No charge after Deductible	Prior Authorization is required for all home care services and disciplines.
Hospice services	No charge after Deductible	Prior Authorization required.
Infertility services	Cost Sharing varies based on type and place of service.	Prior Authorization required. Medically necessary services may include I*npatient medical and surgical care*, *Outpatient surgery*, *Diagnostic services*, *Medical care Outpatient services*, *Medical benefit drugs* and/or *Prescription drugs and supplies* among other services.
Inpatient medical and surgical care Hospital; Chronic Disease Hospital; Rehabilitation Hospital; or Skilled Nursing Facility (SNF)		No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission from the Emergency Room. Planned admissions require Prior Authorization 5 business days before admission.
Facility Fee	No charge after Deductible	Includes room and board and services supplied by the facility during the inpatient stay, including preadmission testing, anesthesia, diagnostic services, and medication and supplies
Professional Fee	No charge after Deductible	Includes physician and other covered professional Provider services
Limits:		
Chronic Disease or Rehabilitation Hospital		Maximum of 60 Days total per Member per Plan Year
Skilled Nursing Facility		Maximum of 100 Days total per Member per Plan Year

Covered Services	Cost Sharing	Benefit Limit & Notes
Maternity services and Well Newborn care		
Childbirth classes	Covered for cost of childbirth education course	Complete a Member Reimbursement Medical Claim Form and submit by mail with proof of payment.
Routine prenatal and postpartum care	No charge	All Outpatient routine prenatal and postpartum office visits are covered as well as breastfeeding services and supports.
Non-routine prenatal care	Cost Sharing varies based on type and place of service.	Any Outpatient maternity services not considered routine or those related to complications or risks with a pregnancy, may be subject to Cost Sharing. Some examples of services not considered routine include, but are not limited to, amniocentesis, fetal stress testing, and OB ultrasounds.
Hospital and delivery services	See *Inpatient medical and surgical care*	Well newborn care is included as part of covered maternity admission.
Breast pumps	No charge if billed per Preventive Services Policy; Otherwise, No charge after Deductible	No Prior Authorization required. One breast pump per birth including related parts and supplies. 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. Pump must be obtained from contracting DME Provider.
Medical benefit drugs	No charge after Deductible	Prior Authorization required for certain drugs. Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit.
Medical care Outpatient visits		
Medical Care includes services to diagnose, treat, and maintain a health condition. Medical care services are covered by Providers in the Tufts Health Direct Network. You are not covered for services from Providers outside of our Network and will be responsible for payment in full. Contact Member Services at **888-257-1985** or visit tuftshealthplan.com/memberlogin to find an In-Network Provider. See *Preventive health services* for information about routine health care.		
Office and community health center visits		
Primary Care Provider (PCP)	$35 Copayment for first 3 non-Preventive PCP visits, then subject to Deductible	No Prior Authorization required.
Specialist	No charge after Deductible	Prior Authorization required for certain specialist visits.
MinuteClinic	No charge after Deductible	No Prior Authorization required. A walk-in clinic accessible at select CVS locations
Nutritional counseling	See *Medical care Outpatient visits*	Prior Authorization required.

Covered Services	Cost Sharing	Benefit Limit & Notes
Observation services	No charge after Deductible	No Prior Authorization required. 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.
Organ or bone marrow transplant	See *Inpatient medical and surgical care*	Prior Authorization required.
Outpatient surgery services		
Outpatient day surgery		
Outpatient Hospital or Ambulatory Surgery Center facility fee	No charge after Deductible	Prior Authorization required for certain services.
Professional fee	No charge after Deductible	Includes physician and other covered professional Provider services
Office and community health center surgical services	See *Medical care Outpatient visits*	
Pain management	Cost Sharing varies based on type and place of service.	Certain services require Prior Authorization. Cost Sharing based on type of service, for example Acupuncture, Nutritional counseling, Physical therapy or Chiropractic care.
Podiatry care	See *Medical care Outpatient visits*	No Prior Authorization required. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot.
Prescription drugs and supplies		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.
Retail pharmacy		
Tier 1	No charge after Deductible	Primarily generic drugs
Tier 2	No charge after Deductible	Includes some non-preferred generics and preferred brands
Tier 3	No charge after Deductible	Includes high-cost generics, non-preferred brands, and Specialty drugs
Mail order pharmacy		
Tier 1	No charge after Deductible	Primarily generic drugs
Tier 2	No charge after Deductible	Includes some non-preferred generics and preferred brands
Tier 3	No charge after Deductible	Includes high-cost generics, non-preferred brands, and Specialty drugs

Covered Services	Cost Sharing	Benefit Limit & Notes
Preventive health services		
Preventive Health services are routine health care that include screenings, check-ups, and counseling to prevent illnesses, disease, or other health problems. Certain Preventive health services may require Prior Authorization. Work with your PCP to use the Preventive Services Policy to review specific requirements.		
Routine pediatric care	No charge	Includes but is not limited to routine exams; immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning
Routine adult care	No charge	Includes but is not limited to routine exams; immunizations; routine lab tests and x-rays; routine mammograms; and routine colonoscopies
Routine gynecological (GYN) care	No charge	Includes but is not limited to routine exams and cervical cancer screenings (Pap smear tests)
Family planning	No charge	
Smoking Cessation Counseling Services	No charge	
Reconstructive surgery and procedures	See *Outpatient surgery* or *Inpatient medical and surgical care*	Certain services may require Prior Authorization.
Telehealth	See *Medical care Outpatient visits*	Please ask your Providers' office for information on telehealth availability and access.
Urgent care	No charge after Deductible	No Prior Authorization required. In our Service Area, you must visit a UCC that is in our Network to be covered for services. Outside of our Service Area, free-standing Urgent Care Centers (UCCs) are covered at Out-of-network Provider sites, including Hospitals and clinics.
Vision care		
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.		
Routine pediatric care (under 19 years of age)	No charge after Deductible	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.
Routine adult care (age 19 or older)	No charge after Deductible	Coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics.
Medical eye and vision care	See *Medical care Outpatient visits*	

Covered Services	Cost Sharing	Benefit Limit & 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 Plan Year. Must complete a Weight Loss Program 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. 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. 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.