Direct Gold 2000

Benefit and Cost-sharing Summary

This Benefit and Cost-sharing Summary gives you information about your *Tufts Health Direct* covered services and costs you may have to pay. Make sure you review the services you're eligible for under the Benefit and Cost-sharing Summary for your specific plan level. To see which *Tufts Health Direct* plan level you have, check your Tufts Health Plan Member ID card.

Your *Tufts Health Direct* plan may also have a Deductible. A Deductible is the amount you pay for certain Covered Services in a Benefit Year before Tufts Health Plan will begin to pay for those Covered Services. You are responsible for paying the Deductible, Co-payment, and/or Co-insurance amounts listed in this document.

This summary gives you a general understanding of your benefits. If you want more information about your benefits and capitalized terms, see your ***Tufts Health Direct Member Handbook*** (https://tuftshealthplan.com/documents/members/handbooks/direct-member-handbook-2020).

You must go to Providers (doctors, Hospitals, and other health care professionals) who are part of the *Tufts Health Direct* Provider Network to get services. For Primary Care, you must see the Primary Care Provider (PCP) you have on record. Services are only covered for In-network Providers, except for Emergency care and out of the Service Area Urgent Care.

Out-of-network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care.

Always check **tuftshealthplan.com/find-a-doctor** for the most up-to-date In-network Provider information. If you have questions about your *Tufts Health Direct* benefits or you need help locating an In-network Provider, call us at **888.257.1985**.

ANNUAL DEDUCTIBLE	
Individual	$2,000 (medical)/ $250 (pharmacy)
Family	$4,000 (medical)/ $500 (pharmacy)

ANNUAL OUT-OF-POCKET MAXIMUM	
Individual	$5,600 (combined)
Family	$11,200 (combined)

Deductible, Co-insurance and Co-payments apply toward your Out-of-pocket Maximum. The family Deductible and Out-of-pocket Maximum on this plan have embedded individual deductibles and out of pocket maximums, meaning the individual Deductible and Out-of-pocket Maximum above applies to each individual Member of the family. This ensures that no single member on a family plan will ever have to satisfy the full family Deductible or Out-of-pocket Maximum on their own. Once any combination of family members meets the family Deductible and/or Out-of-pocket Maximum, the entire family is considered to have met the Deductible and/or Out-of-pocket Maximum.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Emergency Room Care	$350 Co-payment after Deductible	Notification required within 48 hours, if admitted to the hospital. Co-payment waived, if admitted.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Abortion Services	See “Outpatient Surgery”	
Acupuncture	$55 Co-payment	30 visits per Benefit Year. No limit for Behavioral Health treatment.
Ambulance	No charge after Deductible	Emergency transport only; non-emergency ambulance transport may be covered with Prior Authorization.
Autism Spectrum Disorder Treatment • Applied Behavioral Analysis (ABA)	$30 Co-payment	Requires Prior Authorization. Includes assessments, evaluations, testing, and treatment; covered in home, outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst. Does not count toward Individual therapy/Counseling benefit authorization requirements.
Breastfeeding Services	No charge	Includes lactation consultants.
Breast Pumps	20% Co-insurance after Deductible	Limited to a maximum benefit of one non hospital-grade pump per pregnancy. Hospital-grade breast pump requires Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy.*** Otherwise, related DME cost-sharing may apply.
Cardiac Rehabilitation	$55 Co-payment	
Chemotherapy	No charge after Deductible	
Chiropractic Care	$55 Co-payment	

 *Tufts Health Direct Preventive Services: https://tuftshealthplan.com/documents/providers/payment-policies/preventive-services

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Cleft Palate/Cleft Lip Care	No charge after Deductible. Related office visit or surgery Co-payment may apply.	Covered for Members 18 and younger. Includes medical, dental, oral, and facial surgery, follow-up, and related services.
Clinical Trials (Qualified)	Depends on place of service	Routine patient care services covered for Members in a qualified clinical trial in pursuant to state and federal mandates.
Dental (Pediatric Only), Non-Emergency (Delta Dental)		Please call Delta Dental at 800.872.0500 for more information.
Type I Services: Preventive & Diagnostic	No charge after Deductible	Covered 2 exams per year for pediatric dental checkup for Members 18 years and younger. Medically Necessary orthodontia requires Prior Authorization.
Type II Services: Basic Covered Services	25% Co-insurance after Deductible	
Type III Services: Major Restorative Services	50% Co-insurance after Deductible	
Type IV Services: Orthodontia (only as Medically Necessary)	50% Co-insurance after Deductible	
Diabetes Education		**No charge when billed in accordance with the Preventive Services Policy.*** Otherwise, related office visit cost-sharing may apply.
• Primary Care Provider non-preventive office visit	$30 Co-payment	
• Specialist	$55 Co-payment	
Diagnostic Testing (including sleep studies outside of an inpatient setting)	Related office visit or inpatient Co-payment/cost-share may be required	Sleep studies may require Prior Authorization.
Dialysis Services	No charge after Deductible	
Disease Management Programs: • Asthma • Diabetes • Chronic Obstructive Pulmonary Disease (COPD) • Congestive-Heart Failure	No charge	If you have any of these conditions, please contact us at **888.257.1985** to discuss our disease management programs.
Durable Medical Equipment • Prosthetics • Orthotics • Oxygen and respiratory therapy equipment • Wigs	20% Co-insurance after Deductible	Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs. Prior Authorization is required when the DME costs $1,000 or more and for certain services, including prosthetic orthotics (see list at tuftshealthplan.com).

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COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Early Intervention Services	No charge	Covered for Members 3 and younger; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention specialist.
Eye Care (Vision Care)	$30 Co-payment (routine) $55 Co-payment for all non-routine vision services	Coverage for routine eye exams for members 18 years and younger once every 12 months. For Members older than 18 years, coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics. Eye glasses covered once every 12 months for members 18 years and younger. Collection frames only. You must receive routine eye examinations from a Provider in the EyeMed Vision Care Network in order to obtain coverage for these services. Call EyeMed at 866.504.5908 for the names of EyeMed providers. For non-routine vision services, please visit tuftshealthplan.com/find-a-doctor.
Family planning		
• Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy.*** Otherwise, related office visit or lab cost-sharing may apply.
• Non-preventive	Related office visit or lab cost-sharing may apply	
Fitness Reimbursement	Covered for 3 months	Covered for 3 months at a standard fitness center; excludes initiation fees. This benefit is available to Subscribers once every Benefit Year after being a member for 4 months. See the *Tufts Health Direct Member Handbook* for more information on limitations.

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COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Habilitative Services (Physical/Occupational/Speech Therapy)	$55 Co-payment	Maximum of 60 visits total combined Habilitative Physical and Occupational Therapy per Member per Benefit Year. No limit on Speech Therapy. Prior authorization required in inpatient setting. In outpatient setting, Physical Therapy and Occupational Therapy require a Prior Authorization after visit 11. Speech Therapy requires a Prior Authorization after visit 30.
Hearing Aids	20% Co-insurance 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. Certain hearing aids may not be covered, including Completely in Canal (CIC) hearing aids.
Home Health Care	No charge after Deductible	Requires Prior Authorization if daily or longer than six months.
Hospice	No charge after Deductible	Requires Prior Authorization.
Imaging Services (Advanced: MRI, CT, PET)	$300 Co-payment after Deductible	Advanced imaging services require Prior Authorization.
Individual therapy/Counseling	$30 Co-payment	Prior Authorization required after 12 Behavioral Health outpatient therapy visits per Benefit Year. No Prior Authorization required for substance use treatment visits.
Infertility Treatment	$55 Co-payment	Requires Prior Authorization.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Inpatient Medical Care (including bariatric surgery)		
• Room and board (includes deliveries/surgery/radiology services/labs)	$750 Co-payment per stay after Deductible	No prior authorization required for inpatient admissions from the emergency room. Notification to the plan is required within 48 hours of the admission. Elective admissions require Prior Authorization and notification 5 business days before admission. Sleep studies may require Prior Authorization.
• Professional fee	No charge after Deductible	
Inpatient Mental Health and/or Substance Use	$750 Co-payment per stay after Deductible	No prior authorization required. Notification to the plan is required within 48 hours of the inpatient admission.
• Intensive community based acute treatment (ICBAT) for children and adolescents	No charge	
Intermediate care, including Behavioral Health services for children and adolescents	No charge	Prior Authorization is only required for certain Behavioral Health services for children and adolescents. Please see page 36 of your *Tufts Health Direct Member Handbook* for more information about these services.
Laboratory Outpatient and Professional Services		Includes blood tests, urinalysis, Pap smears, and throat cultures to maintain health and to test, diagnose, treat, and prevent disease. Laboratory must be In-network. Genetic testing may require Prior Authorization. **No charge when billed in accordance with the Preventive Services Policy.*** Otherwise, related cost-sharing may apply.
• Preventive Labs	No charge	
• Non-preventive Labs	$50 Co-payment after Deductible	
Medication-Assisted Treatment (MAT) services	$30 Co-payment	Certain medication may require Prior Authorization.
Methadone treatment (dosing, counseling, labs)	No charge	Treatment does not count toward Individual therapy/Counseling benefit authorization requirements.
MinuteClinic®	No charge	

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COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Nutritional counseling		
• Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy.*** Otherwise, related cost-sharing may apply.
• Non-preventive	$55 Co-payment	
Office Visits		
• Primary Care Provider preventive care/ screening/immunization/vaccine	No charge	
• Primary Care Provider non-preventive office visit	$30 Co-payment	
• Specialist	$55 Co-payment	If a referral is required, your Member ID card will say "PCP referral required."
• Urgent Care Center (UCC) visit	$55 Co-payment	
Organ Transplant (including bone marrow transplants)	See "Inpatient Medical Care"	Requires Prior Authorization.
Outpatient Surgery (outpatient hospital/ambulatory surgery centers)		Prior Authorization required for certain services. Please call us at **888.257.1985** for more information.
• Professional Services	No charge after Deductible	
• Facility Fee	$500 Co-payment after Deductible	
Pharmacy		
Retail drugs (up to 30-Day supply)		
• Tier 1 (primarily generic focused)	$25 Co-payment	See Formulary for specific Prior Authorization requirements. • Some drugs included in preventive services mandates are covered in full. Refer to Formulary for a complete list. **NOTE:** Prescribed, orally-administered anticancer medications used to kill or slow the growth of cancerous cells are covered at no cost-share for up to a 30-day supply.
• Tier 2 (includes some non-preferred generics and preferred brands)	$50 Co-payment after Deductible	
• Tier 3 (includes high-cost generics and preferred brands)	$125 Co-payment after Deductible	

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COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Pharmacy		
Mail-order drugs (up to 90-Day supply)		
• Tier 1 (primarily generic focused)	$50 Co-payment	See Formulary for specific Prior Authorization requirements. • Some drugs included in preventive services mandates are covered in full. Refer to Formulary for a complete list.
• Tier 2 (includes some non-preferred generics and preferred brands)	$100 Co-payment after Deductible	
• Tier 3 (includes high-cost generics and preferred brands)	$375 Co-payment after Deductible	
Physical/Occupational/Speech Therapy (Short-term Outpatient Rehabilitation)	$55 Co-payment	Maximum of 60 visits total combined Rehabilitative Physical and Occupational Therapy per Member per Benefit Year. No limit on Speech Therapy. Prior Authorization required in inpatient setting. In outpatient setting, Physical Therapy and Occupational Therapy require a Prior Authorization after visit 11. Speech Therapy requires Prior Authorization after visit 30.
Podiatry	$55 Co-payment	Routine foot care services for non-diabetics requires Prior Authorization.
Prenatal care	No charge	
• Preventive	No charge	**No charge when billed in accordance with the Preventive Services Policy.*** Otherwise, related cost-sharing may apply.
• Non-preventive	Related office visit or lab cost-sharing may apply	
Radiation Therapy	No charge after Deductible	May require Prior Authorization.
Reconstructive Surgery and Procedures	See “Outpatient Surgery”	Please see the “Covered Services” section of the *Tufts Health Direct Member Handbook* for limitations. May require Prior Authorization.
Rehabilitation Hospital or Chronic Disease Hospital	$750 Co-payment per stay after Deductible	Maximum of 60 Days total per Member per Benefit Year. May require Prior Authorization.
Skilled Nursing Facility	$750 Co-payment per stay after Deductible	Maximum of 100 Days total per Member per Benefit Year. Prior Authorization required.

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COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Substance Use Treatment Programs		Please see tuftshealthplan.com for a full listing of programs offered and Prior Authorization requirements.
• Enhanced acute treatment services (EATS) for substance use disorders	Related outpatient or inpatient cost-sharing may apply	
• Structured outpatient addiction program (SOAP)	Related outpatient or inpatient cost-sharing may apply	
Urgent Care	$55 Co-payment	Urgent care within the service area is covered without Prior Authorization at in-network urgent care centers/clinics or with in-network providers only. Out-of-network UCC within the service area requires prior authorization for coverage. Urgent care outside the service area is covered without prior authorization. Cost share may vary depending on place of service.
Weight Loss Programs	Covered for 3 months	You must be a *Tufts Health Direct* Member for three months and participate in a qualified weight loss program for at least three consecutive months. Each Member on a family plan can request a weight loss program reimbursement once per Benefit Year. Must complete a weight loss programs reimbursement form. See the *Tufts Health Direct Member Handbook* for more information on limitations.
X-ray Services and Diagnostic Imaging	$75 Co-payment after Deductible	

Services not covered

See the section “Services not covered” in the *Tufts Health Direct Member Handbook* for the list of services not covered.