

# Direct Bronze 2700

## 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*, *Copayment*, and/or *Coinsurance* amounts listed in this document.

This *Summary* gives you a general understanding of your benefits. If you want more information about your benefits and capitalized terms, see your [Tufts Health Direct Member Handbook](https://tuftshealthplan.com/documents/members/handbooks/direct-member-handbook-2021) (<https://tuftshealthplan.com/documents/members/handbooks/direct-member-handbook-2021>).

**You must go to Providers (doctors, Hospitals, and other health care professionals) who are part of the Tufts Health Direct Provider Network to get services.** For *Primary Care*, you must see the *Primary Care Provider (PCP)* you have on record in the *Member Portal*. Services are only covered 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*. *Service Area* is all of Massachusetts EXCEPT *Dukes* and *Nantucket Counties*.

Always check [tuftshealthplan.com/find-a-doctor](https://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** (TTY: 711).

### ANNUAL COMBINED DEDUCTIBLE

<b>Individual</b>	\$2,700
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<b>Family</b>	\$5,400
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### ANNUAL COMBINED OUT-OF-POCKET MAXIMUM

<b>Individual</b>	\$8,550
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<b>Family</b>	\$17,100
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*Deductible*, *Coinsurance* and *Copayments* apply toward your *Out-of-pocket Maximum*. The family *Deductible* and *Out-of-pocket Maximum* on this *Plan* have embedded individual *Deductibles* and out of pocket maximums, meaning the individual *Deductible* and *Out-of-pocket Maximum* above applies to each individual *Member* of the family. This ensures that no single *Member* on a family *Plan* will ever have to satisfy the full family *Deductible* or *Out-of-pocket Maximum* on their own. Once any combination of family *Members* meets the family *Deductible* and/or *Out-of-pocket Maximum*, the entire family is considered to have met the *Deductible* and/or *Out-of-pocket Maximum*.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
<b>Emergency Room Care</b>	\$750 <i>Copayment</i> after <i>Deductible</i>	Notification required within 48 hours, if admitted to the <i>Hospital</i> . <i>Copayment</i> waived, if admitted.
COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
<b>Abortion Services</b>	See "Outpatient Surgery"	
<b>Acupuncture</b>	\$90 <i>Copayment</i> after <i>Deductible</i>	
<b>Ambulance</b>	No charge after <i>Deductible</i>	<i>Emergency</i> transport covered without <i>Prior Authorization</i> ; non- <i>Emergency</i> ambulance transport may be covered with <i>Prior Authorization</i> .
<b>Autism Spectrum Disorder Treatment</b>	\$40 <i>Copayment</i> after <i>Deductible</i>	Requires <i>Prior Authorization</i> . Includes assessments, evaluations, testing, and treatment; covered in home, <i>Outpatient</i> , or office setting by board-certified behavior analyst or board-certified assistant behavior analyst. Physical, occupational, and speech therapy benefit limitations do not apply.
<ul style="list-style-type: none"> <li>• Applied Behavioral Analysis (ABA)</li> <li>• Physical, occupational, and speech therapy benefits available</li> </ul>		
<b>Breastfeeding Services</b>	No charge	Includes lactation consultants.
<b>Breast Pumps</b>	20% <i>Coinsurance</i> after <i>Deductible</i>	Limited to a maximum benefit of one non <i>Hospital</i> -grade pump per pregnancy. No <i>Prior Authorization</i> required.  <b>No charge when billed in accordance with the <a href="#">Preventive Services Policy</a>*</b> , otherwise, related DME <i>Cost-Sharing</i> may apply.
<b>Cardiac Rehabilitation</b>	\$90 <i>Copayment</i> after <i>Deductible</i>	
<b>Chemotherapy Administration</b>	No charge after <i>Deductible</i>	
<b>Chiropractic Care</b>	\$90 <i>Copayment</i> after <i>Deductible</i>	

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
<b>Cleft Palate/Cleft Lip Care</b>	No charge after <i>Deductible</i>  Additional office visit or surgery <i>Copayment</i> may apply	Covered for <i>Members</i> 18 and younger. Includes medical, dental, oral, and facial surgery, follow-up, and related services.
<b>Clinical Trials (Qualified)</b>	Depends on place of service	Routine patient care services covered for <i>Members</i> in a qualified clinical trial pursuant to state and federal mandates.
<b>Dental (Pediatric Only), Non-Emergency (Delta Dental)</b>		Please call Delta Dental at 800.872.0500 for more information.
Type I Services: <i>Preventive &amp; Diagnostic</i>	No charge after <i>Deductible</i>	Covered 2 exams per year for pediatric dental checkup for <i>Members</i> 18 years and younger. Medically Necessary orthodontia requires <i>Prior Authorization</i> .  More information about pediatric dental is available in the <i>Covered Services</i> section of the <a href="#">Tufts Health Direct Member Handbook</a> .
Type II Services: <i>Basic Covered Services</i>	25% <i>Coinsurance</i> after <i>Deductible</i>	
Type III Services: <i>Major Restorative Services</i>	50% <i>Coinsurance</i> after <i>Deductible</i>	
Type IV Services: <i>Orthodontia (only as Medically Necessary)</i>	50% <i>Coinsurance</i> after <i>Deductible</i>	
<b>Diabetes Education</b>		<b>No charge when billed in accordance with the <a href="#">Preventive Services Policy</a>.</b> * Otherwise, related office visit <i>Cost-Sharing</i> may apply.  No charge for the <a href="#">Good Measures program available to Direct Members</a> .
<ul style="list-style-type: none"> <li><i>Primary Care Provider non-Preventive</i> office visit</li> </ul>	\$40 <i>Copayment</i> after <i>Deductible</i>	
<ul style="list-style-type: none"> <li><i>Specialist</i></li> </ul>	\$90 <i>Copayment</i> after <i>Deductible</i>	
<b>Diagnostic Testing</b> (including sleep studies outside of an <i>Inpatient</i> setting)	Related office visit or <i>Inpatient Copayment/Cost-Share</i> may be required	Sleep studies require <i>Prior Authorization</i> .
<b>Dialysis Services</b>	No charge after <i>Deductible</i>	
<b>Disease Management Programs:</b>	No charge	If <i>you</i> have any of these conditions, please contact us at <b>888.257.1985</b> to discuss our disease management programs.
<ul style="list-style-type: none"> <li>Asthma</li> <li>Diabetes</li> <li>Chronic Obstructive Pulmonary Disease (COPD)</li> <li>Congestive-Heart Failure</li> </ul>		

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
<p><b>Durable Medical Equipment</b></p> <ul style="list-style-type: none"> <li>• Prosthetics</li> <li>• Orthotics</li> <li>• Oxygen and respiratory therapy equipment</li> <li>• Wigs</li> </ul>	<p>20% <i>Coinsurance</i> after <i>Deductible</i></p>	<p>Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs. <i>Prior Authorization</i> is required for certain services, including prosthetic orthotics (see list at <a href="http://tuftshealthplan.com">tuftshealthplan.com</a>).</p>
<p><b>Early Intervention Services</b></p>	<p>No charge</p>	<p>Covered for <i>Members</i> 3 and younger; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention <i>Specialist</i>.</p>
<p><b>Eye Care (Vision Care)</b></p>	<p>\$40 <i>Copayment</i> after <i>Deductible</i> (routine)</p> <p>\$90 <i>Copayment</i> after <i>Deductible</i> for non-routine vision services</p>	<p>Coverage for routine eye exams for <i>Members</i> 18 years and younger once every 12 months. For <i>Members</i> 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 <i>Members</i> 18 years and younger. Collection frames only.</p> <p><i>You</i> must receive routine eye examinations from a <i>Provider</i> in the EyeMed Vision Care <i>Network</i> in order to obtain coverage for these services. Call EyeMed at 866.504.5908 for the names of EyeMed providers.</p> <p>For non-routine vision services, please visit <a href="http://tuftshealthplan.com/find-a-doctor">tuftshealthplan.com/find-a-doctor</a>.</p>

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
<b>Family planning</b>		
<ul style="list-style-type: none"> <li>Preventive</li> </ul>	No charge	<b>No charge when billed in accordance with the <a href="#">Preventive Services Policy</a>.</b> * Otherwise, related office visit or lab <i>Cost-Sharing</i> may apply.
<ul style="list-style-type: none"> <li>Non-Preventive</li> </ul>	Related office visit or lab <i>Cost-Sharing</i> may apply	
<b>Fitness Reimbursement</b>	Covered for 3 months	Covered for 3 months of membership at a standard fitness center; excludes initiation fees. This benefit is available to Subscribers once every <i>Benefit Year</i> after being a <i>Member</i> for 4 months. See the <a href="#">Tufts Health Direct Member Handbook</a> for more information on limitations.
<b>Habilitative Services (Physical/Occupational/Speech Therapy)</b>	\$90 <i>Copayment</i> after <i>Deductible</i>	<p>Maximum of 60 visits total combined Habilitative Physical and Occupational Therapy per <i>Member</i> per <i>Benefit Year</i>. No limit on Speech Therapy.</p> <p>Physical Therapy and Occupational Therapy require a <i>Prior Authorization</i> after visit 11. Speech Therapy requires a <i>Prior Authorization</i> after visit 30.</p>
<b>Hearing Aids</b>	20% <i>Coinsurance</i> after <i>Deductible</i>	Covered for <i>Members</i> 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 <i>Tufts Health Direct</i> pays and the applicable <i>Member</i> cost share as listed in this document. Related services and supplies do not count toward the \$2,000 limit.
<b>Home Health Care</b>	No charge after <i>Deductible</i>	Requires <i>Prior Authorization</i> if daily or for longer than six months.

<b>COVERED SERVICES</b>	<b>COST-SHARING</b>	<b>BENEFIT LIMITS &amp; NOTES</b>
<b>Hospice</b>	No charge after <i>Deductible</i>	Requires <i>Prior Authorization</i> .
<b>Imaging Services (Advanced: MRI, CT, PET)</b>	\$1,000 <i>Copayment</i> after <i>Deductible</i>	Advanced imaging services require <i>Prior Authorization</i> .
<b>Imaging (X-ray Services and Diagnostic)</b>	\$100 <i>Copayment</i> after <i>Deductible</i>	
<b>Individual therapy/Counseling</b>	\$40 <i>Copayment</i> after <i>Deductible</i>	No visit limits and no <i>Prior Authorization</i> required for <i>Outpatient</i> behavioral health therapy visits or substance use treatment.
<b>Infertility Treatment</b>	\$90 <i>Copayment</i> after <i>Deductible</i>	Requires <i>Prior Authorization</i> .
<b>Inpatient Medical Care</b> (including bariatric surgery)		
<ul style="list-style-type: none"> <li>Facility fee (includes room and board for maternity/surgery/radiology services and lab work)</li> </ul>	\$1,200 <i>Copayment</i> after <i>Deductible</i>	No <i>Prior Authorization</i> required for <i>Inpatient</i> admissions from the <i>Emergency</i> room. Notification to the <i>Plan</i> is required within 48 hours of the admission.  Elective admissions require <i>Prior Authorization</i> and notification 5 business days before admission.  Sleep studies may require <i>Prior Authorization</i> .
<ul style="list-style-type: none"> <li>Professional fee</li> </ul>	No charge after <i>Deductible</i>	
<b>Inpatient Mental Health and/or Substance Use</b>	\$1,200 <i>Copayment</i> after <i>Deductible</i>	No <i>Prior Authorization</i> required for admission. Notification to the <i>Plan</i> is required within 48 hours of the <i>Inpatient</i> admission.
<ul style="list-style-type: none"> <li>Intensive community based acute treatment (ICBAT) for children and adolescents</li> </ul>	No charge	
<b>Intermediate care, including Behavioral Health services for children and adolescents</b>	No charge	<i>Prior Authorization</i> is only required for certain Behavioral Health services for children and adolescents. Please see the "Covered Services" section of the <a href="#">Tufts Health Direct Member Handbook</a> for more information about these services.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
<b>Laboratory <i>Outpatient</i> and Professional Services</b>		Includes blood tests, urinalysis, Pap smears, and throat cultures to maintain health and to test, diagnose, treat, and prevent disease. Laboratory must be <i>In-network</i> . Genetic testing may require <i>Prior Authorization</i> .
• <i>Preventive</i> Labs	No charge	
• <i>Non-Preventive</i> Labs	\$75 <i>Copayment</i> after <i>Deductible</i>	
		<b>No charge when billed in accordance with the <a href="#">Preventive Services Policy</a>*</b> , otherwise, related lab <i>Cost-Sharing</i> may apply.
<b>Medication-Assisted Treatment (MAT) services</b>	No charge	Certain medication may require <i>Prior Authorization</i> .
<b>Methadone treatment (dosing, counseling, labs)</b>	No charge	
<b>MinuteClinic®</b>	\$40 <i>Copayment</i> after <i>Deductible</i>	A walk-in clinic accessible at select CVS locations.
<b>Nutritional counseling</b>		
• <i>Preventive</i>	No charge	<b>No charge when billed in accordance with the <a href="#">Preventive Services Policy</a>*</b> . Otherwise, related <i>Cost-Sharing</i> may apply.
• <i>Non-Preventive</i>	\$90 <i>Copayment</i> after <i>Deductible</i>	

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
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**Office Visits**

• <i>Primary Care Provider Preventive Care/ screening/immunization/vaccine</i>	No charge	
• <i>Primary Care Provider non- Preventive office visit</i>	\$40 <i>Copayment</i> after <i>Deductible</i>	
• <i>Specialist</i>	\$90 <i>Copayment</i> after <i>Deductible</i>	
• <i>Urgent Care Center (UCC) visit</i>	\$90 <i>Copayment</i> after <i>Deductible</i>	<p>You must visit a UCC in our <i>Service Area</i> (all of Massachusetts EXCEPT Dukes and Nantucket Counties) that is in our <i>Network</i> to be covered for services. In our <i>Service Area</i>, if you obtain services at an <i>Out-of-network</i> UCC or at a UCC in an <i>Out-of-network Hospital</i>, you will not be covered.</p> <p>Outside of our <i>Service Area</i>, <i>Emergency</i> services and Free-standing <i>Urgent Care Centers (UCC)</i> are covered at <i>Out-of-network Provider sites</i>, including <i>Hospitals</i> and clinics.</p> <p>Cost share may vary depending on place of service.</p>

<b>Organ Transplant</b> (including bone marrow transplants)	See "Inpatient Medical Care"	Requires <i>Prior Authorization</i> .
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<b>Outpatient Surgery</b> ( <i>Outpatient Hospital/ambulatory surgery centers</i> )		<i>Prior Authorization</i> required for certain services. Please call us at <b>888.257.1985</b> for more information.
• Professional/Surgeon Services	No charge after <i>Deductible</i>	
• Surgery services and Facility Fee	\$500 <i>Copayment</i> after <i>Deductible</i>	



**COVERED SERVICES**
**COST-SHARING**
**BENEFIT LIMITS & NOTES**
**Pharmacy**

## Retail drugs (up to 30-Day supply)

• <i>Tier 1</i> (Generic Drugs)	\$30 <i>Copayment</i>	See <a href="#">Formulary</a> for specific <i>Prior Authorization</i> requirements. • Some drugs included in <i>Preventive</i> services mandates are covered in full. Refer to <a href="#">Formulary</a> for a complete list.
• <i>Tier 2</i> (Preferred Brand Drugs)	\$100 <i>Copayment</i> after <i>Deductible</i>	
• <i>Tier 3</i> (Non-Preferred brand Drugs)	\$150 <i>Copayment</i> after <i>Deductible</i>	

**NOTE:** Prescribed, self-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.

## Mail-order drugs (up to 90-Day supply)

• <i>Tier 1</i> (Generic Drugs)	\$60 <i>Copayment</i>	See <a href="#">Formulary</a> for specific <i>Prior Authorization</i> requirements. • Some drugs included in <i>Preventive</i> services mandates are covered in full. Refer to <a href="#">Formulary</a> for a complete list.
• <i>Tier 2</i> (Preferred Brand Drugs)	\$200 <i>Copayment</i> after <i>Deductible</i>	
• <i>Tier 3</i> (Non-Preferred brand Drugs)	\$450 <i>Copayment</i> after <i>Deductible</i>	

**NOTE:** Prescribed, self-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.

**Physical/Occupational/Speech Therapy (Short-term Outpatient Rehabilitation)**

 \$90 *Copayment* after *Deductible*

Maximum of 60 visits total combined Rehabilitative Physical and Occupational Therapy per *Member* per *Benefit Year*. No limit on Speech Therapy.

Physical Therapy and Occupational Therapy require a *Prior Authorization* after visit 11. Speech Therapy requires *Prior Authorization* after visit 30.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
<b>Podiatry</b>	\$90 <i>Copayment</i> after <i>Deductible</i>	Routine foot care is covered only for <i>Members</i> with diabetes and other systemic illnesses that compromise the blood supply to the foot.
<b>Prenatal care</b>		
• <b>Preventive</b>	No charge	<b>No charge when billed in accordance with the <a href="#">Preventive Services Policy</a>.</b> * Otherwise, related <i>Cost-Sharing</i> may apply.
• <b>Non-Preventive</b>	Related office visit or lab <i>Cost-Sharing</i> may apply	
<b>Radiation Therapy</b>	No charge after <i>Deductible</i>	May require <i>Prior Authorization</i> .
<b>Reconstructive Surgery and Procedures</b>	See "Outpatient Surgery"	Please see the "Covered Services" section of the <a href="#">Tufts Health Direct Member Handbook</a> for limitations. May require <i>Prior Authorization</i> .
<b>Rehabilitation Hospital or Chronic Disease Hospital</b>	\$1,200 <i>Copayment</i> after <i>Deductible</i>	Maximum of 60 Days total per <i>Member</i> per <i>Benefit Year</i> . May require <i>Prior Authorization</i> .
<b>Skilled Nursing Facility</b>	\$1,200 <i>Copayment</i> after <i>Deductible</i>	Maximum of 100 Days total per <i>Member</i> per <i>Benefit Year</i> . <i>Prior Authorization</i> required.
<b>Substance Use Treatment Programs</b>	Related <i>Outpatient</i> or <i>Inpatient Cost-Sharing</i> may apply	Please see the "Covered Behavioral Health (mental health and/or substance use) services" section of the <a href="#">Tufts Health Direct Member Handbook</a> for more information about these services.
<b>Telemedicine</b>	Related <i>Outpatient Cost-Sharing</i> may apply	Please ask <i>your</i> providers' office for information on telemedicine availability and access.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
<b>Urgent Care</b>	\$90 <i>Copayment</i> after <i>Deductible</i>	<p>You must visit a UCC in our <i>Service Area</i> (all of Massachusetts EXCEPT Dukes and Nantucket Counties) that is in our <i>Network</i> to be covered for services. In our <i>Service Area</i>, if you obtain services at an <i>Out-of-network</i> UCC or at a UCC in an <i>Out-of-network Hospital</i>, you will not be covered.</p> <p>Outside of our <i>Service Area</i>, <i>Emergency</i> services and Free-standing <i>Urgent Care</i> Centers (UCC) are covered at <i>Out-of-network Provider</i> sites, including <i>Hospitals</i> and clinics.</p> <p>Cost share may vary depending on place of service.</p>
<b>Weight Loss Programs</b>	Covered for 3 months	<p>You must be a <i>Tufts Health Direct Member</i> for three months and participate in a qualified weight loss program (current programs are Jenny Craig, Weight Watchers, and Nutrisystem) for at least three consecutive months. Each <i>Member</i> on a family <i>Plan</i> can request a weight loss program reimbursement once per <i>Benefit Year</i>.</p> <p>Must complete a <a href="#">weight loss programs reimbursement form</a>.</p> <p>See the <a href="#">Tufts Health Direct Member Handbook</a> for more information on limitations.</p>

### Services not covered

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