Direct Bronze 3550 with Coinsurance

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).

***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** 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	
Individual	$3,550
Family	$7,100
ANNUAL COMBINED OUT-OF-POCKET MAXIMUM	
Individual	$8,550
Family	$17,100

Deductible, *Coinsurance* and *Copayment*s 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**	40% *Coinsurance* after *Deductible*	Notification required within 48 hours, if admitted to the *Hospital*. *Copayment* waived, if admitted.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Abortion Services	See "*Outpatient* Surgery"	
Acupuncture	$150 *Copayment* after *Deductible*	
Ambulance	No charge after *Deductible*	*Emergency* transport covered without *Prior Authorization*; non-*Emergency* ambulance transport may be covered with *Prior Authorization*.
Autism Spectrum Disorder Treatment • Applied Behavioral Analysis (ABA) • Physical, occupational, and speech therapy benefits available	$90 *Copayment*	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. Physical, occupational, and speech therapy benefit limitations do not apply.
Breastfeeding Services	No charge	Includes lactation consultants.
Breast Pumps	30% *Coinsurance* after *Deductible*	Limited to a maximum benefit of one non *Hospital*-grade pump per pregnancy. No *Prior Authorization* required. **No charge when billed in accordance with the *Preventive* Services Policy***, otherwise, related DME *Cost-Sharing* may apply.
Cardiac Rehabilitation	$150 *Copayment* after *Deductible*	
Chemotherapy Administration	No charge after deductible	
Chiropractic Care	$150 *Copayment* after *Deductible*	

**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* Additional office visit or surgery *Copayment* 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 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*. More information about pediatric dental is available in the *Covered Services* section of the ***Tufts Health Direct Member Handbook.***
Type II Services: Basic *Covered Services*	25% *Coinsurance* after *Deductible*	
Type III Services: Major Restorative Services	50% *Coinsurance* after *Deductible*	
Type IV Services: Orthodontia (only as Medically Necessary)	50% *Coinsurance* after *Deductible*	
Diabetes Education		**No charge when billed in accordance with the *Preventive* Services Policy.*** Otherwise, related office visit *Cost-Sharing* may apply. No charge for the Good Measures program available to Direct *Members*.
• *Primary Care Provider non-Preventive* office visit	$90 *Copayment*	
• *Specialist*	$150 *Copayment* after *Deductible*	
Diagnostic Testing (including sleep studies outside of an *Inpatient* setting)	Related office visit or *Inpatient Copayment*/*Cost-Share* may be required	Sleep studies require *Prior Authorization*.
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.

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COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Durable Medical Equipment • Prosthetics • Orthotics • Oxygen and respiratory therapy equipment • Wigs	30% *Coinsurance* after *Deductible* 25% *Coinsurance* after *Deductible* applies to arm and leg prosthetics.	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).
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)	$90 *Copayment* (routine) $150 *Copayment* after *Deductible* for 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.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
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 of membership 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.
Habilitative Services (Physical/Occupational/Speech Therapy)	$150 *Copayment* after *Deductible*	Maximum of 60 visits total combined Habilitative Physical and Occupational Therapy per *Member* per *Benefit Year*. No limit on Speech Therapy. Physical Therapy and Occupational Therapy require a *Prior Authorization* after visit 11. Speech Therapy requires a *Prior Authorization* after visit 30.
Hearing Aids	30% *Coinsurance* after *Deductible*	Covered for *Members* 21 and younger. This includes the cost of one hearing aid per hearing-impaired ear up to $2,000 per ear every 36 months. This includes both the amount *Tufts Health Direct* pays and the applicable *Member* cost share as listed in this document. Related services and supplies do not count toward the $2,000 limit.
Home Health Care	No charge after *Deductible*	Requires *Prior Authorization* if daily or for longer than six months.
Hospice	No charge after *Deductible*	Requires *Prior Authorization*.

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COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Imaging Services (Advanced: MRI, CT, PET)	40% *Coinsurance* after *Deductible*	Advanced imaging services require *Prior Authorization*.
Imaging (X-ray Services and Diagnostic)	40% *Coinsurance* after *Deductible*	
Individual therapy/Counseling	$90 *Copayment*	No visit limits and no *Prior Authorization* required for *Outpatient* behavioral health therapy visits or substance use treatment.
Infertility Treatment	$150 *Copayment* after *Deductible*	Requires *Prior Authorization*.
***Inpatient* Medical Care** (including bariatric surgery)		
• Facility fee (includes room and board for maternity/surgery/radiology services and lab work)	40% *Coinsurance* 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	40% *Coinsurance* after *Deductible*	
***Inpatient* Mental Health and/or Substance Use**	40% *Coinsurance* after *Deductible*	No *Prior Authorization* required for admission. Notification to the *Plan* is required within 48 hours of the *Inpatient* admission.
• Intensive community based acute treatment (ICBAT) for children and adolescents	No charge	
Intermediate care, including Behavioral Health services for children and adolescents	No charge	*Prior Authorization* is only required for certain Behavioral Health services for children and adolescents. Please see the "*Covered Services*" section of the ***Tufts Health Direct Member Handbook*** for more information about these services.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
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 lab *Cost-Sharing* may apply.
• *Preventive* Labs	No charge	
• Non-*Preventive* Labs	40% *Coinsurance* after *Deductible*	
Medication-Assisted Treatment (MAT) services	No charge	Certain medication may require *Prior Authorization*.
Methadone treatment (dosing, counseling, labs)	No charge	
MinuteClinic®	$90 *Copayment*	A walk-in clinic accessible at select CVS locations.
Nutritional counseling		
• *Preventive*	No charge	**No charge when billed in accordance with the *Preventive* Services Policy.*** Otherwise, related *Cost-Sharing* may apply.
• Non-*Preventive*	$150 *Copayment* after *Deductible*	

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COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Office Visits		
• *Primary Care Provider Preventive Care*/ screening/immunization/vaccine	No charge	
• *Primary Care Provider non-Preventive* office visit	$90 *Copayment*	
• *Specialist*	$150 *Copayment* after *Deductible*	
• *Urgent Care* Center (UCC) visit	$150 *Copayment* after *Deductible*	*You* must visit a UCC in our *Service Area* (all of Massachusetts EXCEPT Dukes and Nantucket Counties) that is in our *Network* to be covered for services. In our *Service Area*, if *you* obtain services at an *Out-of-network* UCC or at a UCC in an *Out-of-network Hospital*, *you* will not be covered. Outside of our *Service Area*, *Emergency* services and Free-standing *Urgent Care* Centers (UCC) are covered at *Out-of-network Provider* sites, including *Hospitals* and clinics. Cost share may vary depending on place of service.
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/Surgeon Services	40% *Coinsurance* after *Deductible*	
• Surgery services and Facility Fee	40% *Coinsurance* after *Deductible*	

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Pharmacy		
Retail drugs (up to 30-*Day* supply)		
• *Tier 1* (Generic Drugs)	$35 *Copayment* after *Deductible*	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, 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.
• *Tier 2* (Preferred Brand Drugs)	50% *Coinsurance* after *Deductible*	
• *Tier 3* (Non-Preferred brand Drugs)	50% *Coinsurance* after *Deductible*	
Mail-order drugs (up to 90-*Day* supply)		
• *Tier 1* (Generic Drugs)	$70 *Copayment* after *Deductible*	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, 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.
• *Tier 2* (Preferred Brand Drugs)	50% *Coinsurance* after *Deductible*	
• *Tier 3* (Non-Preferred brand Drugs)	50% *Coinsurance* after *Deductible*	
Physical/Occupational/Speech Therapy (Short-term *Outpatient* Rehabilitation)	$150 *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
Podiatry	$150 *Copayment* after *Deductible*	Routine foot care is covered only for *Members* with diabetes and other systemic illnesses that compromise the blood supply to the foot.
Prenatal care		
• ***Preventive***	No charge	**No charge when billed in accordance with the *Preventive* Services Policy.*** Otherwise, related *Cost-Sharing* may apply.
• **Non-*Preventive***	Related office visit or lab *Cost-Sharing* may apply	
Radiation Therapy	No charge after *Deductible*	May require *Prior Authorization*.
Reconstructive Surgery and Procedures	See "*Outpatient* Surgery"	Please see the "*Covered Services*" section of the ***Tufts Health Direct Member Handbook*** for limitations. May require *Prior Authorization*.
Rehabilitation *Hospital* or Chronic Disease *Hospital*	40% *Coinsurance* after *Deductible*	Maximum of 60 Days total per *Member* per *Benefit Year*. May require *Prior Authorization*.
Skilled Nursing Facility	40% *Coinsurance* after *Deductible*	Maximum of 100 Days total per *Member* per *Benefit Year*. *Prior Authorization* required.
Substance Use Treatment Programs	Related *Outpatient* or *Inpatient Cost-Sharing* may apply	Please see the "Covered Behavioral Health (mental health and/or substance use) services" section of the ***Tufts Health Direct Member Handbook*** for more information about these services.
Telemedicine	Related *Outpatient Cost-Sharing* may apply	Please ask *your* providers' office for information on telemedicine availability and access.

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COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Urgent Care	$150 *Copayment* after *Deductible*	*You* must visit a UCC in our *Service Area* (all of Massachusetts EXCEPT Dukes and Nantucket Counties) that is in our *Network* to be covered for services. In our *Service Area*, if *you* obtain services at an *Out-of-network* UCC or at a UCC in an *Out-of-network Hospital*, *you* will not be covered. Outside of our *Service Area*, *Emergency* services and Free-standing *Urgent Care* Centers (UCC) are covered at *Out-of-network Provider* sites, including *Hospitals* and clinics. Cost share may vary depending on place of service.
Weight Loss Programs	Covered for 3 months	*You* must be a *Tufts Health Direct Member* 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 *Member* on a family *Plan* can request a weight loss program reimbursement once per *Benefit Year*. Must complete a weight loss programs reimbursement form. See the ***Tufts Health Direct Member Handbook*** for more information on limitations.

Services not covered

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

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