

Direct Silver 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*, *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 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	\$2,000
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Family	\$4,000
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ANNUAL COMBINED OUT-OF-POCKET MAXIMUM

Individual	\$8,550
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Family	\$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
Emergency Room Care	\$300 <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
Abortion Services	See "Outpatient Surgery"	
Acupuncture	\$50 <i>Copayment</i>	
Ambulance	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> .
Autism Spectrum Disorder Treatment	\$25 <i>Copayment</i>	Requires <i>Prior Authorization</i> . 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.
<ul style="list-style-type: none"> Applied Behavioral Analysis (ABA) Physical, occupational, and speech therapy benefits available 		
Breastfeeding Services	No charge	Includes lactation consultants.
Breast Pumps	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. No charge when billed in accordance with the Preventive Services Policy* , otherwise, related DME <i>Cost-Sharing</i> may apply.
Cardiac Rehabilitation	\$50 <i>Copayment</i>	
Chemotherapy Administration	No charge after <i>Deductible</i>	
Chiropractic Care	\$50 <i>Copayment</i>	

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Cleft Palate/Cleft Lip Care	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.
Clinical Trials (Qualified)	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.
Dental (Pediatric Only), Non-Emergency (Delta Dental)		Please call Delta Dental at 800.872.0500 for more information.
Type I Services: <i>Preventive & 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. <i>Medically Necessary</i> orthodontia requires <i>Prior Authorization</i> . More information about pediatric dental is available in the <i>Covered Services</i> section of the Tufts Health Direct Member Handbook .
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>	
Diabetes Education		No charge when billed in accordance with the Preventive Services Policy. * Otherwise, related office visit <i>Cost-Sharing</i> may apply. No charge for the Good Measures program available to Direct Members .
<ul style="list-style-type: none"> <i>Primary Care Provider</i> non-<i>Preventive</i> office visit 	\$25 <i>Copayment</i>	
<ul style="list-style-type: none"> <i>Specialist</i> 	\$50 <i>Copayment</i>	
Diagnostic Testing (including sleep studies outside of an inpatient setting)	Related office visit or inpatient <i>Copayment/Cost-Share</i> may be required	Sleep studies require <i>Prior Authorization</i> .
Dialysis Services	No charge after <i>Deductible</i>	
Disease Management Programs:	No charge	If <i>you</i> have any of these conditions, please contact us at 888.257.1985 to discuss our disease management programs.
<ul style="list-style-type: none"> Asthma Diabetes Chronic Obstructive Pulmonary Disease (COPD) Congestive-Heart Failure 		

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Durable Medical Equipment <ul style="list-style-type: none"> • Prosthetics • Orthotics • Oxygen and respiratory therapy equipment • Wigs 	20% <i>Coinsurance</i> after <i>Deductible</i>	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 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 <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 specialist.
Eye Care (Vision Care)	\$25 <i>Copayment</i> (routine) \$50 <i>Copayment</i> for non-routine vision services	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. You 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. For non-routine vision services, please visit tuftshealthplan.com/ find-a-doctor .

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Family planning		
<ul style="list-style-type: none"> <i>Preventive</i> 	No charge	No charge when billed in accordance with the Preventive Services Policy. * Otherwise, related office visit or lab <i>Cost-Sharing</i> may apply.
<ul style="list-style-type: none"> <i>Non-Preventive</i> 	Related office visit or lab <i>Cost-Sharing</i> 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 <i>Benefit Year</i> after being a <i>Member</i> for 4 months. See the Tufts Health Direct Member Handbook for more information on limitations.
Habilitative Services (Physical/Occupational/Speech Therapy)	\$50 <i>Copayment</i>	<p>Maximum of 60 visits total combined <i>Habilitative Physical and Occupational Therapy</i> per <i>Member</i> per <i>Benefit Year</i>. No limit on <i>Speech Therapy</i>.</p> <p><i>Physical Therapy</i> and <i>Occupational Therapy</i> require a <i>Prior Authorization</i> after visit 11. <i>Speech Therapy</i> requires a <i>Prior Authorization</i> after visit 30.</p>
Hearing Aids	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.
Home Health Care	No charge after <i>Deductible</i>	Requires <i>Prior Authorization</i> if daily or for longer than six months.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Hospice	No charge after <i>Deductible</i>	Requires <i>Prior Authorization</i> .
Imaging Services (Advanced: MRI, CT, PET)	\$400 <i>Copayment</i> after <i>Deductible</i>	Advanced imaging services require <i>Prior Authorization</i> .
Imaging (X-ray Services and Diagnostic)	\$75 <i>Copayment</i> after <i>Deductible</i>	
Individual therapy/Counseling	\$25 <i>Copayment</i>	No visit limits and no <i>Prior Authorization</i> required for <i>Outpatient</i> behavioral health therapy visits or substance use treatment.
Infertility Treatment	\$50 <i>Copayment</i>	Requires <i>Prior Authorization</i> .
Inpatient Medical Care (including bariatric surgery)		
<ul style="list-style-type: none"> Facility fee (includes room and board for maternity/surgery/radiology services and lab work) 	\$1,000 <i>Copayment</i> per stay after <i>Deductible</i>	No <i>Prior Authorization</i> required for inpatient admissions from the <i>Emergency</i> room. Notification to the <i>Plan</i> is required within 48 hours of the admission.
<ul style="list-style-type: none"> Professional fee 	No charge after <i>Deductible</i>	<p>Elective admissions require <i>Prior Authorization</i> and notification 5 business days before admission.</p> <p>Sleep studies may require <i>Prior Authorization</i>.</p>
Inpatient Mental Health and/or Substance Use	\$1,000 <i>Copayment</i> per stay 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 inpatient admission.
<ul style="list-style-type: none"> Intensive community based acute treatment (ICBAT) for children and adolescents 	No Charge	
Intermediate care, including Behavioral Health services for children and adolescents	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 Tufts Health Direct Member Handbook for more information about these services.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Laboratory <i>Outpatient</i> 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 <i>In-network</i> . Genetic testing may require <i>Prior Authorization</i> . No charge when billed in accordance with the Preventive Services Policy* , otherwise, related lab <i>Cost-Sharing</i> may apply.
• <i>Preventive</i> Labs	No charge	
• <i>Non-Preventive</i> Labs	\$50 <i>Copayment</i> after <i>Deductible</i>	
Medication-Assisted Treatment (MAT) services	No charge	Certain medication may require <i>Prior Authorization</i> .
Methadone treatment (dosing, counseling, labs)	No charge	
MinuteClinic®	\$25 <i>Copayment</i>	A walk-in clinic accessible at select CVS locations.
Nutritional counseling		No charge when billed in accordance with the Preventive Services Policy* . Otherwise, related <i>Cost-Sharing</i> may apply.
• <i>Preventive</i>	No charge	
• <i>Non-Preventive</i>	\$50 <i>Copayment</i>	

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Office Visits		
• <i>Primary Care Provider Preventive care/ screening/immunization/vaccine</i>	No charge	
• <i>Primary Care Provider non-Preventive office visit</i>	\$25 <i>Copayment</i>	
• <i>Specialist</i>	\$50 <i>Copayment</i>	
• <i>Urgent Care Center (UCC) visit</i>	\$50 <i>Copayment</i>	<p><i>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.</i></p> <p><i>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.</i></p> <p><i>Cost share may vary depending on place of service.</i></p>
Organ Transplant (including bone marrow transplants)	See "Inpatient Medical Care"	Requires <i>Prior Authorization</i> .
Outpatient Surgery (outpatient <i>Hospital</i> /ambulatory surgery centers)		<i>Prior Authorization</i> required for certain services. Please call us at 888.257.1985 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)	\$25 <i>Copayment</i>	See Formulary for specific <i>Prior Authorization</i> requirements. • Some drugs included in <i>Preventive</i> 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 <i>Cost-Share</i> for up to a 30-day supply.
• <i>Tier 2</i> (Preferred Brand Drugs)	\$50 <i>Copayment</i>	
• <i>Tier 3</i> (Non-Preferred Brand Drugs)	\$75 <i>Copayment</i> after <i>Deductible</i>	
Mail-order drugs (up to 90-Day supply)		
• <i>Tier 1</i> (Generic Drugs)	\$50 <i>Copayment</i>	See Formulary for specific <i>Prior Authorization</i> requirements. • Some drugs included in <i>Preventive</i> 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 <i>Cost-Share</i> for up to a 30-day supply.
• <i>Tier 2</i> (Preferred Brand Drugs)	\$100 <i>Copayment</i>	
• <i>Tier 3</i> (Non-Preferred Brand Drugs)	\$225 <i>Copayment</i> after <i>Deductible</i>	
Physical/Occupational/Speech Therapy (Short-term <i>Outpatient</i> Rehabilitation)	\$50 <i>Copayment</i>	Maximum of 60 visits total combined Rehabilitative Physical and Occupational Therapy per <i>Member</i> per <i>Benefit Year</i> . No limit on Speech Therapy. Physical Therapy and Occupational Therapy require a <i>Prior Authorization</i> after visit 11. Speech Therapy requires <i>Prior Authorization</i> after visit 30.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Podiatry	\$50 <i>Copayment</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.
Prenatal care		
• Preventive	No charge	No charge when billed in accordance with the Preventive Services Policy. * Otherwise, related <i>Cost-Sharing</i> may apply.
• Non-Preventive	Related office visit or lab <i>Cost-Sharing</i> may apply	
Radiation Therapy	No charge after <i>Deductible</i>	May require <i>Prior Authorization</i> .
Reconstructive Surgery and Procedures	See "Outpatient Surgery"	Please see the "Covered Services" section of the Tufts Health Direct Member Handbook for limitations. May require <i>Prior Authorization</i> .
Rehabilitation Hospital or Chronic Disease Hospital	\$1,000 <i>Copayment</i> per stay after <i>Deductible</i>	Maximum of 60 Days total per <i>Member</i> per <i>Benefit Year</i> . May require <i>Prior Authorization</i> .
Skilled Nursing Facility	\$1,000 <i>Copayment</i> per stay after <i>Deductible</i>	Maximum of 100 Days total per <i>Member</i> per <i>Benefit Year</i> . <i>Prior Authorization</i> required.
Substance Use Treatment Programs	Related outpatient or inpatient <i>Cost-Sharing</i> 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 <i>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
Urgent Care	\$50 Copayment	<p>You must visit a UCC in our Service Area (all of Massachusetts EXCEPT Dukes and Nantucket Counties) that is in our <i>Network</i> to be covered for services. In our Service Area, 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 Service Area, <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>
Weight Loss Programs	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 weight loss programs reimbursement form.</p> <p>See the Tufts Health Direct Member Handbook 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.