

Direct Silver 2000 HSA

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*.

Note: 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 HDHP plans, please refer to <https://www.irs.gov/publications/p969>.

Your *Tufts Health Direct Plan* has a *Deductible*. A *Deductible* is the amount you must pay for certain *Covered Services* in a *Benefit Year* before *Tufts Health Plan* will begin to pay for those *Covered Services*. The *Deductible* applies to all *Covered Services* except as listed in the "*Benefit and Cost-Sharing Summary*". The amount of the *Deductible* which applies to you and the enrolled *Members* of your family (if applicable) each *Benefit Year* is:

ANNUAL COMBINED DEDUCTIBLE	
Individual (Self-only Plan)	\$2,000
Family (Two Members or more)*	\$4,000

ANNUAL COMBINED OUT-OF-POCKET MAXIMUM	
Individual	\$6,850
Family**	\$13,700

Deductible, Coinsurance and Copayments apply toward your *Out-of-pocket Maximum*.

*On the *Family Plan*, there is no individual *Deductible*, meaning that all *Members* of the family collectively work towards meeting the *Family Plan Deductible* and it is possible for one individual on their own to satisfy the family *Deductible*.

**An individual *Out-of-pocket Maximum* is embedded on the family *Plan*, meaning the individual out-of-pocket *Maximum* still applies to each individual *Member* of the family. Once the family meets the family *Out-of-pocket Maximum*, the entire family is considered to have met the *Out-of-pocket Maximum* and no *Member* of the family will have additional cost share for *Covered Services*.

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*.

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.
Abortion Services	See "Outpatient Surgery"	
Acupuncture	\$60 <i>Copayment</i> after <i>Deductible</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 <ul style="list-style-type: none"> Applied Behavioral Analysis (ABA) Physical, occupational, and speech therapy benefits available 	\$30 <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.
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	\$60 <i>Copayment</i> after <i>Deductible</i>	
Chemotherapy Administration	No charge after <i>Deductible</i>	
Chiropractic Care	\$60 <i>Copayment</i> after <i>Deductible</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 non-Preventive</i> office visit 	\$30 <i>Copayment</i> after <i>Deductible</i>	
<ul style="list-style-type: none"> <i>Specialist</i> 	\$60 <i>Copayment</i> after <i>Deductible</i>	
Diagnostic Testing (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> .
Dialysis Services	No charge after <i>Deductible</i>	
Disease Management Programs: <ul style="list-style-type: none"> Asthma Diabetes Chronic Obstructive Pulmonary Disease (COPD) Congestive-Heart Failure 	No charge	If <i>you</i> have any of these conditions, please contact us at 888.257.1985 to discuss our disease management programs.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
<p>Durable Medical Equipment</p> <ul style="list-style-type: none"> • Prosthetics • Orthotics • Oxygen and respiratory therapy equipment • Wigs 	<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 when the DME costs \$1,000 or more and for certain services, including prosthetic orthotics (see list at tuftshealthplan.com).</p>
<p>Early Intervention Services</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>Eye Care (Vision Care)</p>	<p>\$30 <i>Copayment</i> after <i>Deductible</i> (routine)</p> <p>\$60 <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 <i>Providers</i>.</p> <p>For non-routine vision services, please visit tuftshealthplan.com/ find-a-doctor.</p>

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)	\$60 <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>
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)	\$500 <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	\$30 <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.
Infertility Treatment	\$60 <i>Copayment</i> after <i>Deductible</i>	Requires <i>Prior Authorization</i> .
<i>Inpatient Medical Care</i> (including bariatric surgery)		
<ul style="list-style-type: none"> Facility fee (includes room and board for maternity/surgery/radiology services and lab work) 	\$750 <i>Copayment</i> per stay after <i>Deductible</i>	No <i>Prior Authorization</i> required for <i>Inpatient</i> admissions from the Emergency 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"> Professional fee 	No charge after <i>Deductible</i>	
<i>Inpatient Mental Health and/or Substance Use</i>	\$750 <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 <i>Inpatient</i> admission.
<ul style="list-style-type: none"> Intensive community based acute treatment (ICBAT) for children and adolescents 	No charge after <i>Deductible</i>	
Intermediate care, including Behavioral Health services for children and adolescents	No charge after <i>Deductible</i>	<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> .
• <i>Preventive</i> Labs	No charge	
• <i>Non-Preventive</i> Labs	\$60 <i>Copayment</i> after <i>Deductible</i>	
		No charge when billed in accordance with the Preventive Services Policy* , otherwise, related lab <i>Cost-Sharing</i> may apply.
Medication-Assisted Treatment (MAT) services	No charge after <i>Deductible</i>	Certain medication may require <i>Prior Authorization</i> .
Methadone treatment (dosing, counseling, labs)	No charge after <i>Deductible</i>	
MinuteClinic®	\$30 <i>Copayment</i> after <i>Deductible</i>	A walk-in clinic accessible at select CVS locations.
Nutritional counseling		
• <i>Preventive</i>	No Charge	No charge when billed in accordance with the Preventive Services Policy* . Otherwise, related <i>Cost-Sharing</i> may apply.
• <i>Non-Preventive</i>	\$60 <i>Copayment</i> after <i>Deductible</i>	

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Office Visits		
<ul style="list-style-type: none"> • <i>Primary Care Provider Preventive care/ screening/immunization/vaccine</i> 	No charge	
<ul style="list-style-type: none"> • <i>Primary Care Provider non-Preventive office visit</i> 	\$30 <i>Copayment</i> after <i>Deductible</i>	
<ul style="list-style-type: none"> • <i>Specialist</i> 	\$60 <i>Copayment</i> after <i>Deductible</i>	
<ul style="list-style-type: none"> • <i>Urgent Care Center (UCC) visit</i> 	\$60 <i>Copayment</i> after <i>Deductible</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. 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>
<ul style="list-style-type: none"> • Organ Transplant (including bone marrow transplants) 	See " <i>Inpatient Medical Care</i> "	Requires <i>Prior Authorization</i> .
<ul style="list-style-type: none"> • Outpatient Surgery (<i>Outpatient Hospital/ambulatory surgery centers</i>) 		<p><i>Prior Authorization</i> required for certain services. Please call us at 888.257.1985 for more information.</p>
<ul style="list-style-type: none"> • Professional/Surgeon Services 	No charge after <i>Deductible</i>	
<ul style="list-style-type: none"> • 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> after <i>Deductible</i>	See Formulary for specific <i>Prior Authorization</i> requirements.
• <i>Tier 2</i> (Preferred Brand Drugs)	\$60 <i>Copayment</i> after <i>Deductible</i>	<ul style="list-style-type: none"> Some drugs included in <i>Preventive</i> services mandates are covered in full. Refer to Formulary for a complete list.
• <i>Tier 3</i> (Non-Preferred Brand Drugs)	\$105 <i>Copayment</i> after <i>Deductible</i>	<p>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.</p>
Mail-order drugs (up to 90-Day supply)		
• <i>Tier 1</i> (Generic Drugs)	\$60 <i>Copayment</i> after <i>Deductible</i>	See Formulary for specific <i>Prior Authorization</i> requirements.
• <i>Tier 2</i> (Preferred Brand Drugs)	\$120 <i>Copayment</i> after <i>Deductible</i>	<ul style="list-style-type: none"> Some drugs included in <i>Preventive</i> services mandates are covered in full. Refer to Formulary for a complete list.
• <i>Tier 3</i> (Non-Preferred Brand Drugs)	\$315 <i>Copayment</i> after <i>Deductible</i>	<p>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.</p>
Physical/Occupational/Speech Therapy (Short-term <i>Outpatient</i> Rehabilitation)	\$60 <i>Copayment</i> after <i>Deductible</i>	<p>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.</p> <p>Physical Therapy and Occupational Therapy require a <i>Prior Authorization</i> after visit 11. Speech Therapy requires <i>Prior Authorization</i> after visit 30.</p>

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Podiatry	\$60 <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.
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 “ <i>Outpatient Surgery</i> ”	Please see the “ <i>Covered Services</i> ” section of the Tufts Health Direct Member Handbook for limitations. May require <i>Prior Authorization</i> .
Rehabilitation Hospital or Chronic Disease Hospital	\$750 <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> .
Skilled Nursing Facility	\$750 <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.
Substance Use Treatment Programs	Related <i>Outpatient</i> or <i>Inpatient Cost-Sharing</i> may apply	Please see the “ <i>Covered Behavioral Health (mental health and/or substance use) services</i> ” section of the Tufts Health Direct Member Handbook for more information about these services.
Telemedicine	Related <i>Outpatient Cost-Sharing</i> may apply	Please ask <i>your Providers’</i> office for information on telemedicine availability and access.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Urgent Care	\$60 <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>
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.