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-2022).

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 with 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. The Service Area is all of Massachusetts EXCEPT Dukes and Nantucket Counties.

Always check 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
Family	$4,000
ANNUAL COMBINED OUT-OF-POCKET MAXIMUM	
Individual	$8,700
Family	$17,400

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 Copayment 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	$50 Copayment per visit	
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	$25 Copayment per visit	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	20% Coinsurance after Deductible	Covered for the purchase of a manual or electric pump, or the rental of a hospital-grade pump when deemed appropriate by the ordering provider in accordance with the Preventive Services Policy. Limit of one pump per pregnancy. No Prior Authorization required. Prescription required. Pump must be obtained from contracting DME provider. **No charge when billed in accordance with the *Preventive Services Policy.** ** Otherwise, related DME Cost-Sharing may apply.

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

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Cardiac Rehabilitation	$50 Copayment per visit	
Chemotherapy Administration	No charge after Deductible	
Chiropractic Care	$50 Copayment per visit	
Cleft Palate/Cleft Lip Care	No charge after Deductible Additional Cost-Sharing may apply based on place of service	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	$25 Copayment per visit	
• Specialist	$50 Copayment per visit	
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. **No charge when billed in accordance with the *Preventive Services Policy*.*** Otherwise, Cost-

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COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
		Sharing may apply based on type and place of service.
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 (DME) • Prosthetics • Orthotics • Oxygen and respiratory therapy equipment • Wigs	20% Coinsurance 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 for certain services, including prosthetic orthotics (see list at tuftshealthplan.com).
Early Intervention Services	No charge	Covered for Members up to age 3; 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 Copayment per visit (routine) $50 Copayment per visit for medical (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. Eyeglasses 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

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COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
		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 of membership at a standard fitness center; excludes initiation fees. This benefit is available to Members 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)	$50 Copayment per visit	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 12. Speech Therapy requires a Prior Authorization after visit 30.
Hearing Aids	20% 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.

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		Related services and supplies do not count toward the $2,000 limit.
Home Health Care	No charge after Deductible	Prior Authorization is required for all home care services and disciplines.
Hospice	No charge after Deductible	Requires Prior Authorization.
Imaging Services		
Preventive	No charge	Advanced imaging services require Prior Authorization. **No charge when billed in accordance with the *Preventive Services Policy*.*** Otherwise, related office visit or lab Cost-Sharing may apply.
X-ray Services and Diagnostic	$75 Copayment after Deductible	
(Advanced: MRI, CT, PET)	$375 Copayment after Deductible	
Individual Therapy/Counseling	$25 Copayment per visit	No visit limits and no Prior Authorization required for Outpatient Behavioral Health therapy visits or substance use treatment.
Infertility Treatment	$50 Copayment per visit	Requires Prior Authorization.
Inpatient Medical Care (including bariatric surgery)		
• Facility fee (includes room and board for maternity/surgery/radiology services and lab work)	$750 Copayment 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	

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COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Inpatient Mental Health and/or Substance Use	$750 Copayment per stay 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	No Prior Authorization required for admission. Notification to the Plan is required within 48 hours of the Inpatient admission.
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.
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	$45 Copayment after Deductible	
Medication-Assisted Treatment (MAT) Services	No charge	Certain medication may require Prior Authorization.
Methadone Treatment (dosing, counseling, labs)	No charge	
MinuteClinic®	$25 Copayment per visit	A walk-in clinic accessible at select CVS locations.
Nutritional Counseling		
• Preventive	No charge	

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COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
• Non-Preventive	$50 Copayment per visit	**No charge when billed in accordance with the *Preventive Services Policy*.*** Otherwise, related Cost-Sharing may apply.
Office Visits		
• Primary Care Provider Preventive care/ screening/immunization/vaccine	No charge	
• Primary Care Provider non-Preventive office visit	$25 Copayment per visit	
• Specialist	$50 Copayment per visit	
• Urgent Care Center (UCC) visit	$50 Copayment per visit	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, 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	No charge after Deductible	
• Surgery services and Facility Fee	$500 Copayment after Deductible	

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COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Pharmacy		
Retail drugs (up to 30-Day supply)		
• Tier 1 (primarily generic focused)	$25 Copayment	See Formulary for specific Prior Authorization requirements. • Some drugs included in Preventive services mandates are covered with no Cost-Share. 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 (includes some non-preferred generics and preferred)	$50 Copayment	
• Tier 3 (includes high-cost generics and non-preferred brands)	$75 Copayment after Deductible	
Mail-order drugs (up to 90-Day supply)		
• Tier 1 (primarily generic focused)	$50 Copayment	See Formulary for specific Prior Authorization requirements. • Some drugs included in Preventive services mandates are covered with no Cost-Share. 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 (includes some non-preferred generics and preferred brands)	$100 Copayment	
• Tier 3 (Non-Preferred Brand Drugs)	$225 Copayment after Deductible	
Physical/Occupational/Speech Therapy (Short-term Outpatient Rehabilitation)	$50 Copayment per visit	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 12. Speech Therapy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
		requires Prior Authorization after visit 30.
Podiatry	$50 Copayment per visit	Non-routine podiatry services covered when medically necessary. Prior authorization may be required. 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	$750 Copayment after Deductible	Maximum of 60 Days total per Member per Benefit Year. May require Prior Authorization.
Skilled Nursing Facility	$750 Copayment 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.

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Telemedicine	Related Outpatient Medical Care Cost-Sharing may apply	Please ask your Provider's office for information on telemedicine availability and access.
Urgent Care	$50 Copayment per visit	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, 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	No charge for first 3 months of approved programs	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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