Direct Bronze 2850

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 are 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 your Tufts Health Direct 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*.

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. [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 DEDUCTIBLE	
Individual	$2,850
Family	$5,700
ANNUAL OUT-OF-POCKET MAXIMUM	
Individual	$9,100
Family	$18,200

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	$400 Copayment per visit 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	No charge	
Acupuncture	$65 Copayment per visit after Deductible	
Allergy testing	$65 Copayment per visit after Deductible	Covered for up to 200 allergy tests per benefit year when administered by an In-Network provider. No prior authorization required.
Allergy treatments (Injections)	$10 Copayment per visit after Deductible	Allergy immunotherapy covered as part of the pharmacy prescription benefit may require prior authorization and have separate pharmacy Cost-Sharing responsibility.
Ambulance	No charge after Deductible	Emergency transport covered without Prior Authorization; non-Emergency ambulance transport may be covered with Prior Authorization.
Autism Spectrum Disorder		
Applied Behavioral Analysis (ABA)	$30 Copayment per visit after Deductible	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 for treatment of Autism Spectrum Disorder.
Habilitative and Rehabilitative Services (Physical, Occupational, Speech Therapy)	$65 Copayment per visit after Deductible	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.
Cardiac Rehabilitation	$65 Copayment per visit after Deductible	
Chemotherapy Administration	No charge after Deductible	
Chiropractic Care	$65 Copayment per visit after Deductible	

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Cleft Palate/Cleft Lip Care	No charge after Deductible Additional cost-sharing may apply based on place of service.	Covered for Members under the age of 18. Includes medical, dental, oral, and facial surgery, follow-up, and related services.
Clinical Trials (Qualified)	Based on place of service	Routine patient care services covered for Members in a qualified clinical trial pursuant to state and federal mandates.
Dental, Accidental	Based on place of service	Coverage for services related to teeth is limited to the emergency treatment of accidental injury to sound, natural and permanent teeth when caused by a source external to the mouth.
Dental Care (Pediatric Only), Non-Emergency (Delta Dental)		
Type I Services: Preventive & Diagnostic	No charge after Deductible	Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age. Medically Necessary orthodontia requires Prior Authorization. Members are eligible for pediatric services until the last day of the month in which they turn 19 years old. More information about pediatric dental is available in the Covered Services section of the *Tufts Health Direct Member Handbook*. Please call Delta Dental at 800.872.0500 for more information.
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		
Primary Care Provider Non-Preventive office visit	$30 Copayment per visit after Deductible	**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.
Specialist	$65 Copayment per visit 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. **No charge when billed in accordance with the Preventive Services Policy***. Otherwise, Cost-Sharing may apply based on type and place of service.
Dialysis Services	No charge after Deductible	

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
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) • Medical Supplies • Orthotics • Oxygen and respiratory therapy equipment • Prosthetics • 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 https://tuftshealthplan.com/documents/providers/guides/thpp-dme-pa-quick-reference-guide).
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) Visits		
Routine Visit	$30 Copayment per visit after Deductible	Pediatric services for members under 19 years of age: Coverage for routine eye exams once every 12 months; Eyeglasses covered once every 12 months Collection frames only or $150 allowance + 20% off expense beyond allowance. Members are eligible for pediatric services until the last day of the month in which they turn 19 years old. Adult Services for Members 19 years of age or older: Coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics. You must receive routine eye examinations from a Provider in the EyeMed Vision Care Select Network in order to obtain coverage for these services. Call EyeMed at 866.504.5908 for the names of EyeMed Select Providers.
Eye Care (Vision Care) Non-Routine Visit	$65 Copayment per visit after Deductible	For non-routine vision services, please visit tuftshealthplan.com/find-a-doctor.
Family-planning Services		
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	

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Fitness Center 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. Must complete a Fitness Center Reimbursement form.
Habilitative Services (Physical, Occupational, Speech Therapy)	$65 Copayment per visit 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 initial evaluation and 11 visits. Speech Therapy requires 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. 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 (Radiology)		
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	$100 Copayment after Deductible	
Advanced: MRI, CT, PET	$350 Copayment after Deductible	
Individual therapy/Counseling	$30 Copayment per visit after Deductible	No visit limits and no Prior Authorization required for Outpatient Behavioral Health therapy visits or substance use treatment.
Infertility Treatment	Cost-share varies based on type of service	Requires Prior Authorization. Medically necessary services may include Inpatient Medical Care, Outpatient Surgery, Laboratory Services, Imaging (x-ray/diagnostic), Office Visits (Specialist), Medical Drugs and/or Prescription Drugs.
Inpatient Medical Care		
Facility fee (includes room and board for maternity/surgery/radiology imaging services and lab work)	$1,000 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	

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Inpatient Mental Health and/or Substance Use	$1,000 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		
Preventive Labs	No charge	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.
Non-Preventive Labs	$50 Copayment after Deductible	
Medical Benefit drugs	No charge after Deductible	Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit. Prior authorization may be required.
Medication-Assisted Treatment (MAT) services	No charge	Certain medication may require Prior Authorization.
Mental Health Wellness Exam	No charge	Annual mental health wellness examination performed by a Licensed Mental Health Professional Please Note: Your annual mental health wellness examination may also be provided by a PCP during your annual routine physical exam.
Methadone treatment (dosing, counseling, labs)	No charge	
MinuteClinic®	$30 Copayment per visit after Deductible	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	$65 Copayment per visit after Deductible	

*Tufts Health Direct Preventive Services Policy

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Office Visits		
Primary Care Provider Preventive Care/screening/immunization /vaccine	No charge	Includes community health center visits
Primary Care Provider Non-Preventive office visit	$30 Copayment per visit after Deductible	Includes community health center visits
Specialist	$65 Copayment per visit after Deductible	Includes community health center visits
Organ Transplant (including bone marrow transplants)	See "Inpatient Medical Care"	Requires Prior Authorization.
Outpatient Surgery (Outpatient Hospital/ambulatory surgery centers)		
Professional/Surgeon Services	No charge after Deductible	Prior Authorization required for certain services. Please call us at **888.257.1985** for mor information.
Surgery services and Facility Fee	$500 Copayment per visit after Deductible	
Pharmacy		
Retail drugs (up to 30-Day supply)		
• Tier 1 (primarily generic focused)	$30 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.
• Tier 2 (includes some non-preferred generics and preferred brands)	$65 Copayment after Deductible	
• Tier 3 (includes high-cost generics, and non-preferred brands and specialty)	$100 Copayment after Deductible	
Mail-order drugs (up to 90-Day supply)		
• Tier 1 (Generic)	$60 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.
• Tier 2 (Preferred Brands)	$130 Copayment after Deductible	
• Tier 3 (Non-preferred Brands and Specialty)	$300 Copayment after Deductible	
Podiatry	$65 Copayment per visit after Deductible	Non-routine podiatry services covered when medically necessary. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
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	$1,000 Copayment per stay after Deductible	Maximum of 60 Days total per Member per Benefit Year. May require Prior Authorization.
Rehabilitative Services (Physical, Occupational, Speech Therapy)	$65 Copayment per visit 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 initial evaluation and 11 visits. Speech Therapy requires Prior Authorization after visit 30.
Skilled Nursing Facility	$1,000 Copayment per stay after Deductible	Maximum of 100 Days total per Member per Benefit Year. Prior Authorization required.
Substance Use		
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.
Recovery Coaches and Peer Specialist	No charge	Must be part of a licensed behavioral health treatment program, such as a licensed mental health clinic, substance use disorder clinic, or outpatient hospital clinic and under supervision of a licensed clinician, such as a licensed social worker, registered nurse, or clinical psychologist
Telehealth	Related Outpatient Medical Care Cost-Sharing may apply	Please ask your Providers' office for information on telehealth availability and access.
Urgent Care	$65 Copayment per visit 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, 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.

COVERED SERVICES	COST-SHARING	BENEFIT LIMITS & NOTES
Weight Loss Programs	No charge for 3 months of membership fees for a qualified program	You must be a Tufts Health Direct Member for three months and participate in a qualified weight loss program 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.