Direct Catastrophic

Benefit and Cost-sharing Summary

TUFTS Health Plan

Annual Medical Out-of-Pocket Maximum

Individual	Family
$7,900	$15,800

Annual Pharmacy Out-of-Pocket Maximum

Individual	Family
$7,900	$15,800

Important Notes:

1. **Deductible**, **Co-insurance** and **Co-payments** apply toward your Out-of-Pocket Maximum.
2. Your PCP knows when and how to ask us for Prior Authorization if it is required.

OUTPATIENT MEDICAL CARE

Office Visits

Primary Care Provider preventive care/ screening/immunization

No Co-payment.

Primary Care Provider nonpreventive office visit

Subject to deductible. First 3 nonpreventative PCP office visits covered before deductible.

Specialist

Subject to deductible.

Urgent Care Center (UCC) visit

Subject to deductible.

Emergency Care

Subject to deductible. Required within 48 hours, if admitted. Co-payment waived, if admitted.

Eye Care (Vision Care)

Routine eye exam

Subject to deductible.

All other vision services

Subject to deductible.

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.

Outpatient Surgery

Outpatient hospital/ambulatory surgery centers

Subject to deductible. May require Prior Authorization.

Lab

Subject to deductible. Covered if medically necessary. Laboratory must be in-network.

X-ray Services

Subject to deductible.

Advanced Imaging Services (MRI, CT, PET)

Subject to deductible. Requires Prior Authorization.

Abortion Services

Subject to deductible.

INPATIENT MEDICAL CARE

Inpatient Medical Care

Room and Board

(includes deliveries/surgery/radiology services/labs)

Subject to deductible. Requires Prior Authorization. Elective admissions require submission of Prior Authorization form 5 business days before admission.

MENTAL HEALTH AND/OR SUBSTANCE USE TREATMENT

Inpatient Mental Health and/or Substance Use

Subject to deductible. Some services may require Prior Authorization. No Prior Authorization required to begin services for in-network substance use treatment.

Outpatient Mental Health and/or Substance Use

Individual therapy/Counseling

Subject to deductible. Prior Authorization required after 12 Behavioral Health outpatient therapy visits per Benefit Year. No Prior Authorization required for substance use treatment visits.

Methadone treatment

(dosing, counseling, labs)

Subject to deductible. No Prior Authorization required; does not count toward initial 12 Behavioral Health outpatient therapy visits.

Autism spectrum disorder treatment

(Applied Behavioral Analysis)

Subject to deductible. Requires Prior Authorization; does not count toward initial 12 Behavioral Health outpatient therapy visits. Includes assessments, evaluations, testing, and treatment; covered in home, outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst.

Medication-Assisted Treatment (MAT) services

Subject to deductible. No Prior Authorization required.

Rehabilitation and Habilitative Services

Cardiac Rehabilitation

Subject to deductible.

Home Health Care

Subject to deductible. Requires Prior Authorization if daily or longer than six months.

Inpatient Skilled Nursing Facility

Subject to deductible. Maximum of 100 Days total per Member per Benefit Year; requires Prior Authorization.

Inpatient Rehabilitation Hospital or Chronic Disease Hospital

Subject to deductible. Maximum of 60 Days total per Member per Benefit Year; may require Prior Authorization.

Rehabilitation and Habilitative Services *continued*

Short-term Outpatient Rehabilitation Physical/Occupational/Speech Therapy

Subject to deductible.

Maximum of 60 visits total combined Rehabilitative Physical and Occupational Therapy per Member per Benefit Year. No limit on Speech Therapy. May require Prior Authorization in outpatient setting after initial evaluation. Prior Authorization required in inpatient setting.

Habilitative Services

Subject to deductible.

Maximum of 60 visits total combined Habilitative Physical and Occupational Therapy per Member per Benefit Year. No limit on Speech Therapy. May require Prior Authorization in outpatient setting after initial evaluation. Prior Authorization required in inpatient setting.

Pediatric Dental

Type I Services: Preventive & Diagnostic

Subject to deductible.

Type II Services: Basic Covered Services

Subject to deductible.

Type III Services: Major Restorative Services

Subject to deductible.

Type IV Services: Orthodontia

(only as Medically Necessary)

Subject to deductible.

Covered 2 exams per year for pediatric dental checkup for Members 18 years and younger. Medically Necessary orthodontia requires Prior Authorization.

Pharmacy

Retail drugs (up to 90-Day supply)

Tier 1 (primarily generic focused)
Subject to deductible.

Tier 2 (includes some non-preferred generics and preferred brands)
Subject to deductible.

Tier 3 (includes high cost generics and preferred brands)
Subject to deductible.

Mail-order drugs (up to 90-Day supply)

Tier 1 (primarily generic focused)
Subject to deductible.

Tier 2 (includes some non-preferred generics and preferred brands)
Subject to deductible.

Tier 3 (includes high cost generics and preferred brands)
Subject to deductible.

Please see our Formulary for specific Prior Authorization requirements. No Co-payment for some drugs included in preventive services. Mandates are covered at no Co-payment. Refer to Formulary for complete list.

Wellness

Family Planning

No Co-payment. No Prior Authorization required.

Nutritional Counseling

No Co-payment. May require Prior Authorization.

Prenatal Care

No Co-payment. No Prior Authorization required.

Nurse midwife

No Co-payment. No Prior Authorization required.

Other Benefits

Breastfeeding Services

No Co-payment. Includes one non-hospital grade breast pump per pregnancy, breastfeeding supplies and lactation consultants.

Chiropractic Care

Subject to deductible. May require Prior Authorization.

Cleft Palate/Cleft Lip Care

Subject to deductible. Covered for Members 18 and younger. Includes medical, dental, oral and facial surgery, follow-up, and related services. May require Prior Authorization.

Durable Medical Equipment

(Supplies, Prosthetics, Oxygen and Respirtatory Therapy Equipment)

Subject to deductible. May require Prior Authorization (see list at tuftshealthplan.com).

Early Intervention Services

Subject to deductible. 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.

Fitness Reimbursement

Subject to deductible. First 3 months covered at a standard fitness center; exlcudes initiation fees. This benefit is available to Subscribers once every Benefit Year.

Ground Ambulance

Subject to deductible. Emergency transport only; nonemergency transport covered with Prior Authorization.

Hearing Aids

Subject to deductible.

No Prior Authorization required. Covered for Members 21 and younger. Full cost of one hearing aid per hearing-impaired ear up to $2,000 for each hearing aid for 36 months. Related services and supplies do not count toward the $2,000 limit.

Other Benefits *continued*

Hospice

Subject to deductible. Requires Prior Authorization.

Infertility Services

Subject to deductible. Requires Prior Authorization. Includes diagnosis and treatment, such as in vitro fertilization, gamete intrafallopian tube transfer, assisted hatching, and sperm banking. Must meet eligibility requirements. Some limitations may apply.

Orthotics

Subject to deductible. May require Prior Authorization. Includes braces and other mechanical or molded devices that support or correct any defect of form or function of the human body. Includes repairs. Limit one pair of shoes per 12-month period. Shoe inserts for diabetics only.

Podiatry

Subject to deductible. Non-routine foot care services do not require Prior Authorization. Routine foot care services for diabetics do not require Prior Authorization.

Qualified Clinical Trials

Subject to deductible. Covered only if Medically Necessary. Requires Prior Authorization.

Weight Loss Programs

Subject to deductible. Covered for first 3 months for qualified programs; excludes initiation fees and food. This benefit is available to Members once every Benefit Year.