Direct Silver 2000 II

Benefit and Cost-sharing Summary

TUFTS Health Plan

Annual Deductible

Individual	Family
$2,000	$4,000

Annual 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

$30 Co-payment.

Specialist

$55 Co-payment.

Urgent Care Center (UCC) visit

$55 Co-payment.

Emergency Care

$300 Co-payment after deductible. Notification required within 48 hours, if admitted. Co-payment waived, if admitted.

Eye Care (Vision Care)

Routine eye exam

$30 Co-payment.

All other vision services

$55 Co-payment.

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

$500 Co-payment after deductible. May require Prior Authorization.

Lab

$50 Co-payment after deductible. 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.

X-ray Services

$50 Co-payment after deductible.

Advanced Imaging Services (MRI, CT, PET)

$500 Co-payment after deductible. Requires Prior Authorization.

Abortion Services

$500 Co-payment after deductible.

INPATIENT MEDICAL CARE

Inpatient Medical Care

Room and Board

(includes deliveries/surgery/radiology services/labs)

$1,000 Co-payment after 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

$1,000 Co-payment after 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

Up to $30 Co-payment. 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)

Up to $30 Co-payment. No Prior Authorization required; does not count toward initial 12 Behavioral Health outpatient therapy visits.

Autism spectrum disorder treatment

(Applied Behavioral Analysis)

Up to $30 Co-payment. 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

Up to $30 Co-payment. No Prior Authorization required.

Rehabilitation and Habilitative Services

Cardiac Rehabilitation

$55 Co-payment.

Home Health Care

$5 Co-payment after deductible. Requires Prior Authorization if daily or longer than six months.

Inpatient Skilled Nursing Facility

$1,000 Co-payment after deductible. Maximum of 100 Days total per Member per Benefit Year; requires Prior Authorization.

Inpatient Rehabilitation Hospital or Chronic Disease Hospital

$1,000 Co-payment after 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

$55 Co-payment.

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

$55 Co-payment.

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, then $0.

Type II Services: Basic Covered Services

Subject to deductible, then 25% Co-insurance.

Type III Services: Major Restorative Services

Subject to deductible, then 50% Co-insurance.

Type IV Services: Orthodontia

(only as Medically Necessary)

Subject to deductible, then 50% Co-insurance.

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)
$25 Co-payment.

Tier 2 (includes some non-preferred generics and preferred brands)
$50 Co-payment.

Tier 3 (includes high cost generics and preferred brands)
$75 Co-payment after deductible.

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

Tier 1 (primarily generic focused)
$50 Co-payment.

Tier 2 (includes some non-preferred generics and preferred brands)
$100 Co-payment.

Tier 3 (includes high cost generics and preferred brands)
$225 Co-payment after 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.

Fitness Reimbursement

50% Co-insurance for first 3 months. Covered for first 3 months at a standard fitness center; exlcudes initiation fees. This benefit is available to Subscribers once every Benefit Year.

Nurse midwife

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.

Other Benefits

Breastfeeding Services

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

Chiropractic Care

$55 Co-payment. May require Prior Authorization.

Cleft Palate/Cleft Lip Care

Related office visit or surgery, Co-payment may apply. 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)

20% Co-insurance after deductible. May require Prior Authorization (see list at tuftshealthplan.com).

Early Intervention Services

No Co-payment. 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.

Ground Ambulance

No Co-payment after deductible. Emergency transport only; nonemergency transport covered with Prior Authorization.

Hearing Aids

20% Co-insurance for device after deductible.
$30 Co-payment for PCP visit.
$55 Co-payment for Specialist visit.

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

No Co-payment after deductible. Requires Prior Authorization.

Infertility Services

Related office visit or surgery, Co-payment may apply. 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

20% Co-insurance after 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

$55 Co-payment. Non-routine foot care services do not require Prior Authorization. Routine foot care services for diabetics do not require Prior Authorization.

Qualified Clinical Trials

Related office visit or surgery, Co-payment may apply. Routine patient care services covered for Members in a qualified clinical trial. Requires Prior Authorization.

Weight Loss Programs

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