Summary of 2019 *Tufts Health Direct* Individual & Small-Group (SG) Plan Offerings

Effective January 1, 2019. **All plans are for both Individual & SG unless noted otherwise. Please see footnotes.**

BENEFITS	*Direct ConnectorCare* Plan Type I	*Direct ConnectorCare* Plan Type II	*Direct ConnectorCare* Plan Type III	*Direct Platinum*	*Direct Gold 1000*	*Direct Gold 2000*	*Direct Silver 2000 & Direct Silver 2000 II++*	*Direct Silver 2000 HSA**** **(SG only)**	*Direct Silver 2500 with Co-insurance*	*Direct Bronze 2750*	*Direct Bronze 3500 with Co-insurance*	*Direct Catastrophic+* **(Individual only)**
Deductible	$0 (ind./fam.)	$0 (ind./fam.)	$0 (ind./fam.)	$0 (ind./fam.)	**Medical only:** $1,000 (ind.) $2,000 (fam.)	$2,000 (ind.) $4,000 (fam.)	$2,000 (ind.) $4,000 (fam.)	$2,000 (ind.) $4,000 (fam.)	$2,500 (ind.) $5,000 (fam.)	$2,750 (ind.) $5,500 (fam.)	$3,500 (ind.) $7,000 (fam.)	$7,900 (ind.) $15,800(fam.)
Maximum out-of-pocket	$0 Med / $250 Rx (ind.) $0 Med / $500 Rx (fam.)	$750 Med / $500 Rx (ind.) $1,500 Med / $1,000 Rx (fam.)	$1,500 Med / $750 Rx (ind.) $3,000 Med / $1,500 Rx (fam.)	$3,000 (ind.) $6,000 (fam.)	$5,000 (ind.) $10,000 (fam.)	$5,500 (ind.) $11,000 (fam.)	$7,900 (ind.) $15,800 (fam.)	$6,700 (ind.) $13,400 (fam.)	$7,350 (ind.) $14,700 (fam.)	$7,900 (ind.) $15,800 (fam.)	$7,900 (ind.) $15,800 (fam.)	$7,900 (ind.) $15,800 (fam.)
Cost-sharing												
Preventive services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
PCP & MH/BH/SA office visits	$0	$10	$15	$20+++	$25	$30	$30	$25*	$30	$25*	$35	$0**
Specialist office visits	$0	$18	$22	$40+++	$45	$35	$55	$50*	$50*	$50*	$70*	$0*
Routine eye exam	$0	$10	$15	$20	$25	$30	$30	$25	$30	$25*	$35	$0*
Emergency room	$0	$50	$100	$150	$150*	$350	$300*	$250*	$650*	$250*	35%*	$0*
Outpatient surgery	$0	$50	$125	$250	$250*	$500*	$500*	$250*	20%*	$500*	35%*	$0*
Inpatient hospitalization	$0	$50	$250	$500	$500*	$750*	$1,000*	$500*	30%*	$750*	35%*	$0*
High-cost imaging	$0	$30	$60	$150	$200*	$250*	$500*	$250*	20%*	$500*	35%*	$0*
Therapy (speech, occupational, physical)	$0	$10	$20	$40	$45	$50	$55	$50*	$50*	$50*	$70*	$0*
Lab outpatient and professional services	$0	$0	$0	$0	$25*	$50*	$50*	$50*	20%*	$50*	35%*	$0*
X-rays and diagnostic imaging	$0	$0	$0	$0	$25*	$50*	$50*	$50*	20%*	$50*	35%*	$0*
Skilled nursing facility	$0	$0	$0	$500	$500*	$750*	$1,000*	$500*	30%*	$750*	35%*	$0*
Durable medical equipment (DME)	$0	$0	$0	20%+++	20%*	20%*	20%*	20%*	30%*	20%*	30%*	$0*
Pharmacy (retail)												
Tier 1	$1	$10	$12.50	$10	$20	$25	$25	$25*	$35*	$25	$35*	$0*
Tier 2	$3.65	$20	$25	$25	$40	$50*	$50	$50*	50%*	$50*	50%*	$0*
Tier 3	$3.65	$40	$50	$50	$60	$100*	$75*	$75*	50%*	$100*	50%*	$0*
Pharmacy (mail-order)												
Tier 1	$2	$20	$25	$20	$40	$50	$50	$50*	$70*	$50	$70*	$0*
Tier 2	$7.30	$40	$50	$50	$80	$100*	$100	$100*	50%*	$100*	50%*	$0*
Tier 3	$7.30	$80	$100	$150	$180	$300*	$225*	$300*	50%*	$300*	50%*	$0*

***** Subject to deductible ****** $0 for the first 3 non-preventive PCP visits. After the first three PCP visits, services are subject to deductible. ******* HSA = Health Savings Account compatible plan

+ For individuals under age 30 or individuals who are not subject to the Federal individual mandate as defined in Section 1302(e) of the ACA.

++ Silver 2000 has a Home Health co-pay of No charge after deductible; Silver 2000 II has an additional $5 Home Health co-pay after deductible.

+++ Platinum has cost shares of $15 and $22 for PCP and Specialist visits related to hearing aids, and no co-payment for hearing aid devices.

All plans will include in-network pediatric dental and pediatric vision as required by the Affordable Care Act. This table is not intended to be a comprehensive explanation of all benefits. For more detailed information, visit tuftshealthplan.com/member/our-plans/tufts-health-direct.

Tufts Health Public Plans
2019 *TUFTS HEALTH DIRECT* MEDICAL BENEFIT SUMMARY GRID

Note: This benefit grid is only a summary. Refer to the *Tufts Health Direct* Member Handbook, Medical Necessity Guidelines and Payment Policies for the most up-to-date benefit information.

ABBREVIATIONS
BH = Behavioral health
DME = Durable Medical Equipment
IN = In-network
MM = Medical management team at Tufts Health Plan
OON = Out-of-network
PA = Prior authorization
PCP = Primary care provider

BENEFIT YEAR*
Individual = January 1–December 31
Small-group = 12 months from effective date
* In some cases, a benefit year will not be a full 12 months.

Prior authorizations and referrals

- If we require prior authorization, providers must submit a prior authorization request five business days prior to the service start date.
- **All services rendered by OON providers require prior authorization.**
- Some members may require a PCP referral for specialty services.

Covered services
Tufts Health Plan only covers services rendered by in-network providers, unless otherwise noted. Providers must submit a prior authorization request, if required, five business days prior to the service start date.

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA required? Yes = for IN services	Medical Necessity Guidelines (MNG) and/or Payment Policies (if available)
Abortion	Covered IN	Related outpatient service cost-sharing may apply		
Acupuncture	Covered IN if medically necessary to treat substance use	Depends on place of service		MNG: BH - Acupuncture Detoxification Level of Care
Adult day care	Not covered			
Adult foster care	Not covered			
Ambulatory surgery/ Same-day surgery/ Outpatient surgery/ Surgical day care	Covered IN if medically necessary when surgical procedure performed at IN outpatient facility. Includes outpatient, surgical, and related diagnostic and medical services.	Related outpatient surgery cost-sharing may apply	Yes, see Provider Resource Center for specific services.	Outpatient Facility Payment Policy
Anesthesia services	Covered IN if medically necessary. See pain management for additional PA requirements.	Depends on place of service	Please see Anesthesia Services Payment Policy	Anesthesia Services Payment Policy Obstetric Anesthesia Services Payment Policy
Apnea monitor	Covered IN if medically necessary	Related DME cost-sharing may apply	Yes, for DME $1,000 or more, and for specific DME and medical supplies regardless of reimbursement rate. See payment policy.	DME Payment Policy
Audiologist	Exams and evaluations covered IN if medically necessary	Related specialist cost-sharing may apply		MNG: Rehabilitative Services: Speech Therapy
Bariatric Surgery	Covered IN if medically necessary	Depends on place of service	Yes	MNG: Bariatric Surgery MNG: Bariatric Reoperation for Complications
Biofeedback	Not covered except for: • The treatment of urinary incontinence • Neuromuscular stimulators and related supplies	If covered, related DME cost-sharing may apply	If covered, may be required	

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA required? Yes = for IN services	Medical Necessity Guidelines (MNG) and/or Payment Policies (if available)
Bone density test	Covered IN if medically necessary. Limit one test every two years. Covered for postmenopausal women younger than 65 years who are at increased risk of osteoporosis **or** women 65 years and older.	Depends on place of service	May be required if frequency limit is exceeded. Please see coverage limitations to the left.	Preventive Services — search "Osteoporosis Screening"
Bone marrow transplants for patients diagnosed with breast cancer	Covered IN if medically necessary	Depends on place of service	Yes	
Breastfeeding services	Covered IN. Includes breastfeeding supplies and lactation consultants.	No charge		
Breast pumps	Covered IN for pregnant members for a maximum benefit of one pump per pregnancy	No charge for preventive services. Related DME cost-sharing may apply.		DME Payment Policy For preventive codes, see Preventive Services MNG: Breast Pumps
Cardiac catheterization	Covered IN if medically necessary	Related inpatient cost-sharing may apply		
Cardiac rehabilitation	Covered IN if medically necessary	Related outpatient therapy cost-sharing may apply		
Chemotherapy/ Radiation therapy	Covered IN	Applicable cost-sharing may apply		Therapeutic Radiology Services Payment Policy
Chiropractic services	Covered IN	Related specialist cost-sharing may apply		Chiropractic Services Payment Policy

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA required? Yes = for IN services	Medical Necessity Guidelines (MNG) and/or Payment Policies (if available)
Cleft palate/lip	Covered IN for members 18 years old and younger. Includes: • Medical, dental, oral and facial surgery • Surgical management and follow-up care by oral and plastic surgeons • Orthodontic treatment and management • Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy, speech therapy, audiology and nutrition services, if prescribed by the treating physician or surgeon and the physician or surgeon certifies that the services are medically necessary	Depends on place of service		MNG: Cleft Lip and Cleft Palate
Clinical trials (qualified)	Covered IN if medically necessary for members diagnosed with cancer or other life-threatening diseases. Includes the same level of care as for patients not enrolled in a clinical trial. Not covered for experimental medications or devices.	Depends on place of service		Clinical Trials Payment Policy MNG: Clinical Trials Routine Costs
Cosmetic surgery	Tufts Health Plan may provide coverage for reconstructive surgery and procedures when they meet Medical Necessity Guidelines and are determined to be medically necessary as defined in the Medical Necessity Guidelines: Reconstructive and Cosmetic Surgery.	Depends on place of service	Yes	MNG: Reconstructive and Cosmetic Surgery

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA required? Yes = for IN services	Medical Necessity Guidelines (MNG) and/or Payment Policies (if available)
CPAP/BiPAP	May cover continuous positive airway pressure machine (CPAP) and bilevel positive airway pressure machine (BiPAP)	Related DME cost-sharing may apply	Yes	DME Payment Policy
Custodial care	Not covered			
Day habilitation	Not covered			
Dental (Pediatric ONLY), nonemergency – Delta Dental	Covered IN **for members 18 years old and younger**. Dental care includes preventive and restorative, basic, and major restorative services. Orthodontia is covered when medically necessary with a PA.	Related dental cost-sharing may apply	Yes, for orthodontia. **Please call Delta Dental at 800.872.0500 for more information.**	
Dental Procedures Requiring Hospitalization	Covered IN if medically necessary	Depends on place of service	Yes	MNG: Dental Procedures Requiring Hospitalization
Diabetes education	Covered IN if medically necessary. Includes educational and training services by a physician or other provider (registered nurse, physician assistant, nurse practitioner or licensed dietitian) to treat prediabetes or diabetes.	Depends on place of service. No charge for Good Measures.		
Diagnostic testing	Covered IN if medically necessary. Includes, but is not limited to, labs, X-rays, EKGs and EEGs.	Related lab outpatient or X-ray cost-sharing may apply		
Dialysis services	Covered IN if medically necessary. Includes labs, drugs, tubing change, adapter change and training related to hemodialysis and peritoneal dialysis.	Related outpatient cost-sharing may apply		

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA required? Yes = for IN services	Medical Necessity Guidelines (MNG) and/or Payment Policies (if available)
Drug screening	Covered IN if medically necessary. We do not cover urine drug testing in any of the following circumstances: – Testing ordered by third parties, such as school, courts, or employers or requested by a provider for the sole purpose of meeting the requirements of a third party – Testing for residential monitoring – Routine urinalysis for confirmation of specimen integrity	Depends on place of service		MNG: Urine Drug Testing
Durable Medical Equipment (DME)	Covered IN if medically necessary. Includes medical and surgical supplies.	Related DME cost-sharing may apply	See DME Payment Policy	DME Payment Policy
Early intervention (EI) services	Covered IN if medically necessary for members age 3 and younger, when rendered by a certified EI specialist. Includes intake screenings, evaluations and assessments, child- and center-based individual visits, and group sessions (community, early intervention-only and parent-focused).	No charge		Early Intervention Services Payment Policy
Emergency services	**Covered IN and OON** for emergency medical and BH services	Related emergency cost-sharing may apply. **Please note:** Individual services, such as DME, labs and X-rays, may carry additional cost-sharing if provided. Emergency cost-sharing waived if admitted to the hospital.		Emergency Department Services Payment Policy
Experimental services	Not covered. See our list of Non-covered Investigational Services experimental and investigational procedures.			

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA required? Yes = for IN services	Medical Necessity Guidelines (MNG) and/or Payment Policies (if available)
Family-planning	Covered IN for consultation, birth control, intrauterine devices (IUDs), implantable contraceptives (including Long-Acting Reversible Contraceptive) and cervical caps	No charge when in accordance with the Preventive Services Policy		Preventive Services — search "Contraceptives"
Fitness reimbursement	Covered for first three months. Excludes initiation fees. Must complete a fitness reimbursement form. **Note:** This reimbursement covers membership fees of a standard fitness center. A standard fitness center offers cardio and strength training machines and other programs for improved physical fitness. This reimbursement does not include luxury fitness centers, country clubs, social clubs, tennis clubs, gymnastics centers, martial arts centers, aerobic-only or pool-only centers, personal trainers, sports coaches or the purchase of personal or at-home exercise machines.	50% co-insurance for first three months. Direct Catastrophic plan is subject to deductible before benefit is covered.		
FluMist	Vaccine and administration covered for members ages 18–49 if medically necessary. Flu vaccine delivered intranasally by spray.	Depends on place of service	Yes, when not administered in an office setting (e.g., at a pharmacy)	Vaccine and Immunization Services Payment Policy
Gastroenterology diagnostic procedures	Covered IN if medically necessary for adults ages 50–75 for colonoscopy. See policies for details regarding other procedures and coverage.	Depends on place of service. No charge when in accordance with the Preventive Services Policy.	Yes, for endoscopy only	Preventive Services — see "Colorectal Cancer Screening" section MNG: Video Capsule Endoscopy

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA required? Yes = for IN services	Medical Necessity Guidelines (MNG) and/or Payment Policies (if available)
Gastric bypass surgery	Covered IN if medically necessary	Related inpatient cost-sharing may apply	Yes	MNG: Bariatric Surgery MNG: Bariatric Reoperation for Complications
Gender-affirming surgery	Covered if medically necessary	Related inpatient, outpatient, specialist, PCP or pharmacy cost-sharing may apply	Yes	MNG: Transgender Surgical Procedures
Genetic testing	Covered IN if medically necessary	Related PCP, specialist or lab services cost-sharing may apply	Depends on test. Prior Authorization is not required for certain prenatal and newborn genetic tests, in accordance with state regulations.	Genetic Testing Payment Policy See the Provider Resource Center for specific genetic testing MNG information
Hearing aids	Covered IN for members age 21 and younger. Includes the cost of one hearing aid per hearing-impaired ear for up to $2,000 each, every 36 months. Related services and supplies do not count toward the $2,000 limit.	Related PCP, specialist or DME cost-sharing may apply	Yes	MNG: Hearing Aids
Hepatitis B vaccine	Covered IN if medically necessary for persons at high risk. Includes vaccine and administration. Not covered if required for traveling outside the U.S.	Depends on place of service		Preventive Services
HIV screening	Covered for: - Adolescents and adults ages 15–65 - Younger adolescents and older adults at high risk - Pregnant women	Related cost-sharing may apply. No charge when in accordance with the Preventive Services Policy.		Preventive Services

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA required? Yes = for IN services	Medical Necessity Guidelines (MNG) and/or Payment Policies (if available)
Home health care services	Covered IN if medically necessary. Includes associated DME, physical/occupational/speech therapies, and part-time or intermittent skilled nursing care or home health aide services. Custodial care is not covered.	Related cost-sharing applies	Yes, only if request is for daily visits or for requests greater than six months	MNG: Home Health Care Services
Home infusion therapy	Covered IN if medically necessary	Depends on place of service	Yes	
Hormone replacement therapy	Covered IN for perimenopausal and postmenopausal women	Depends on place of service	Some hormones may require PA. See *Preferred Drug List (PDL)*.	
Hospice care	Covered IN if medically necessary for terminally ill members, if not in active treatment. Nursing, medical and social services covered.	Related hospice cost-sharing may apply	Yes	Hospice Payment Policy MNG: Hospice Services
Human papillomavirus (HPV) vaccine	Covered IN	Depends on place of service. No charge when in accordance with the Preventive Services Policy.		Preventive Services
Immunization services	Covered IN if medically necessary. Vaccine administration covered. Not covered if required for traveling outside the U.S.	Depends on place of service. No charge when in accordance with the Preventive Services Policy.		
Infertility services	Covered IN for infertility diagnosis and treatment, such as in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), assisted hatching and sperm banking. Must meet medical necessity guidelines. Some limitations apply.	Depends on place of service	Yes	MNG: Infertility Services

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA required? Yes = for IN services	Medical Necessity Guidelines (MNG) and/or Payment Policies (if available)
Inpatient chronic or rehabilitation care	Covered IN if medically necessary. Daily inpatient rehabilitative services provided for up to 60 days per benefit year.	Related inpatient cost-sharing may apply	Yes	
Inpatient hospitalization	Covered IN if medically necessary. Elective admissions require submission of PA form and notification of the admission five business days prior to admission.	Related inpatient cost-sharing may apply	Yes	See the Provider Resource Center for more information.
Laboratory services	Covered if medically necessary. Includes blood tests, urinalysis and throat cultures to aid in diagnosis, treatment and prevention of disease.	Related lab outpatient cost-sharing may apply. **Please note:** Some testing ordered during a preventive examination may not be part of the preventive services. Lab outpatient cost-sharing may apply.	Certain laboratory tests may require Prior Authorization, such as genetic testing.	
Maternity care/ Nurse midwife services	Covered IN. Providers must submit a Prenatal Registration Form to MM. See prenatal and postnatal care for more information.	Related inpatient cost-sharing may apply		
Nuclear cardiology	Covered IN if medically necessary. Contact National Imaging Associates to request PA.	Related specialist cost-sharing may apply	Contact National Imaging Associates to request PA.	
Nutritional counseling	Covered IN if rendered by an accredited provider (physician, licensed dietitian, nutritionist, registered nurse, physician assistant or nurse practitioner). Includes nutritional, diagnostic, therapeutic and counseling services for a medical condition.	Depends on place of service. Related PCP or specialist cost-sharing may apply.		

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA required? Yes = for IN services	Medical Necessity Guidelines (MNG) and/or Payment Policies (if available)
Nutritional supplements	Covered IN if medically necessary and prescribed for a medical condition. Nonprescription enteral formulas covered only for treatment of malabsorption.	Related DME or Rx cost-sharing may apply	Yes	
Observation day	Covered IN if medically necessary	Related inpatient cost-sharing may apply	Yes, for stays longer than 48 hours. See payment policy.	Observation Services Facility Payment Policy
Organ/Bone marrow transplants	Covered IN if medically necessary. Experimental and investigational transplants not covered.	Related inpatient cost-sharing may apply	Yes	
Orthotics	Covered IN if medically necessary. 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 covered for diabetics only.	Related DME cost-sharing may apply	Yes	Orthotic Services Payment Policy
Outpatient hospital services	Covered IN if medically necessary	See specific service for cost-sharing	See specific service for PA requirements	Outpatient Facility Payment Policy
Oxygen/Respiratory therapy equipment	Covered IN if medically necessary. Includes ambulatory oxygen systems and refills, aspirators, compressor-driven nebulizers, intermittent positive pressure breather, oxygen, oxygen gas, oxygen-generating devices and oxygen therapy equipment rental.	Related DME cost-sharing may apply	Yes. See Payment Policy.	DME Payment Policy MNG: Oxygen and Respiratory Therapy Equipment
Pacemaker implant	Covered IN if medically necessary	Related inpatient cost-sharing may apply		
Pain management	Covered IN if medically necessary. Contact National Imaging Associates to request PA.	Related specialist cost-sharing may apply	Yes	
Personal care attendant/items	Not covered			

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA required? Yes = for IN services	Medical Necessity Guidelines (MNG) and/or Payment Policies (if available)
Personal emergency response systems (PERS)	Covered IN if medically necessary	Related PCP, specialist or DME cost-sharing may apply		DME Payment Policy
Pharmacy, retail and mail-order	Up to a 90-day retail supply (with certain exceptions), up to a 90-day mail-order supply. Cost share may be waived for certain covered drugs. May require PA.	Related pharmacy cost-sharing may apply	See our *Preferred Drug List (PDL)*	
Physician assistant services	Covered IN if credentialed for billing as a PCP or under an IN supervising PCP	Related PCP cost-sharing may apply		
Physician services	Covered IN. Includes PCP and specialty services, except for podiatric services.	Related PCP or specialist cost-sharing may apply		
Podiatry	Non-routine foot care covered IN when medically necessary. Routine foot care covered for members with diabetes or other systemic conditions.	Related specialist cost-sharing may apply	Yes, only for routine foot care for members without diabetes or other systemic conditions	Podiatry Payment Policy
Prenatal care	Covered IN. Providers must submit a Prenatal Registration Form to MM.	No charge		
Preventive Services	Covered IN. Members may still be required to pay a co-payment, deductible or co-insurance for preventive services received at OON provider locations (such as labs or radiology, including, but not limited to, mammograms), or for non-preventive services received in conjunction with a preventive services visit.	No charge		Preventive Services
Preventive testing for children	Covered IN. Includes physical, neuropsychiatric, developmental, or appropriate blood or urine exams.	No charge		Preventive Services
Private duty nursing	Not covered			

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA required? Yes = for IN services	Medical Necessity Guidelines (MNG) and/or Payment Policies (if available)
Prosthetics	Covered IN if medically necessary. Includes evaluation, fabrication, fitting, provision of prosthesis and repairs.	Related DME cost-sharing may apply. **Exception:** For the Direct Silver 2500 with Co-Insurance plan, the cost-share is 20% co-insurance after deductible for arm and leg prosthetics.	Yes	Prosthetic Services Payment Policy
Pulmonary function test	Covered IN if medically necessary	Depends on place of service		
Pulmonary rehabilitation	Covered IN if medically necessary	Related specialist cost-sharing may apply		
Radiology/X-rays	Covered IN if medically necessary. Advanced imaging services (MRI, MRA, CAT, nuclear cardiology, PET) require PA and have different cost-sharing. Contact National Imaging Associates to request PA.	Related X-ray or high-cost imaging cost-sharing may apply	Yes, for advanced imaging services	Radiology Imaging Services Payment Policy High-Tech Imaging Prior Authorization Program
Skilled nursing facility	Covered for daily medically necessary skilled nursing care in an inpatient setting for a maximum of 100 days per member per benefit year at an IN skilled nursing facility	Related skilled nursing facility cost-sharing may apply	Yes	
Sleep study	Covered IN if medically necessary	Related inpatient cost-sharing may apply		
Specialist	Covered IN if medically necessary	Related specialist cost-sharing may apply	Referral may be required. To confirm, see front of member ID card for "PCP Referral Required."	Specialty Services Payment Policy
Stress test	Covered IN if medically necessary	Related inpatient cost-sharing may apply		
Temporomandibular joint (TMJ) treatment	Covered IN for surgery if medically necessary. Not covered for physical therapy, corrective devices and/or other treatments.	Related inpatient cost-sharing may apply	Yes	MNG: Temporomandibular Joint (TMJ) Disorder Treatment

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA required? Yes = for IN services	Medical Necessity Guidelines (MNG) and/or Payment Policies (if available)
Therapy (Habilitative) — physical, occupational and speech	Maximum of 60 visits total combined habilitative physical and occupational therapy per member per benefit year. No limit on speech therapy. May require PA in outpatient setting after initial evaluation.	Related therapy cost-sharing may apply	Yes, PT/OT PA required after initial evaluation and 11 visits. ST PA required after the initial evaluation and up to 29 covered visits.	Outpatient Therapy Services Payment Policy MNG: Habilitative Services for Physical Therapy, Occupational Therapy and Speech Therapy MNG: Autism Services: Physical, Occupational and Speech Therapy for Members with Autism Spectrum Disorders
Therapy (Rehabilitative) — physical, occupational and speech	Maximum of 60 visits total combined rehabilitative physical and occupational therapy per member per benefit year. No limit on speech therapy. May require PA in outpatient setting after initial evaluation.	Related therapy cost-sharing may apply	Yes, PT/OT PA required after initial evaluation and 11 visits. ST PA required after the initial evaluation and up to 29 covered visits.	Outpatient Therapy Services Payment Policy MNG: Rehabilitative Services: Physical Therapy MNG: Rehabilitative Services: Occupational Therapy MNG: Rehabilitative Services: Speech Therapy MNG: Autism Services: Physical, Occupational and Speech Therapy for Members with Autism Spectrum Disorders
Tobacco cessation	Covered IN for individual and group tobacco-cessation counseling. Includes specific medications obtained from a pharmacy.	No charge when in accordance with the Preventive Services Policy	Some medications may require PA. See our *Preferred Drug List (PDL)*	
Transportation, emergency	Covered IN and OON if medically necessary	Related emergency/non-emergency transportation cost-sharing may apply		Ambulance Transport Services Payment Policy

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA required? Yes = for IN services	Medical Necessity Guidelines (MNG) and/or Payment Policies (if available)
Transportation, nonemergency	Covered IN if medically necessary for preauthorized transportation between facilities	Related emergency/non-emergency transportation cost-sharing may apply	Yes	Ambulance Transport Services Payment Policy MNG: Non-Emergency Ambulance Transportation – Ground MNG: Non-Emergency Ambulance Transportation – Air
Urgent care	Covered IN if medically necessary. Urgent care centers at OON locations (out of Mass., and on Martha's Vineyard and Nantucket) are covered.	Related PCP, specialist, urgent care or emergency services cost-sharing may apply		
Vaccines	Covered if medically necessary. Vaccine administration covered. Not covered if required for traveling outside U.S.	Depends on place of service		Vaccine and Immunization Services Payment Policy Preventive Services
Vasectomy	Covered IN	Related outpatient surgery cost-sharing may apply		

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA required? Yes = for IN services	Medical Necessity Guidelines (MNG) and/or Payment Policies (if available)
Vision care — EyeMed	**You must receive routine eye examinations from a provider in the EyeMed Vision Care Network in order to obtain coverage for these services.** We cover routine eye exams for members age 19 and older once every 24 months. Members 18 years and younger are covered for routine eye exams every 12 months. Members with diabetes are eligible for and are strongly encouraged to get vision exams every 12 months. Eyeglasses are covered for members 18 years and younger.	Related vision care cost-sharing may apply	**Call EyeMed at 866.504.5908 for the names of EyeMed providers.**	Vision Services Payment Policy
Vision therapy	Covered IN for vision therapy when medically necessary	Related outpatient cost-sharing may apply	Yes	Vision Services Payment Policy MNG: Vision Therapy
Vocational rehabilitation	Not covered			
Weight loss programs	Covered for first three months. Excludes initiation fees and food. Must complete a weight loss programs reimbursement form.	No charge for the covered time frame		
Wigs	Covered for one standard wig (i.e., synthetic, non-human hair) for medical conditions	Related DME cost-sharing may apply		