MEDICAL BENEFIT SUMMARY GRID:
TUFTS HEALTH TOGETHER (MASSHEALTH)
CAREPLUS

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

Benefit year = January 1 – December 31, 2019

Annual co-payment maximum per calendar year per member
Medical and BH = $0
Pharmacy = $250

Please note:
- Providers must submit prior authorization requests, if required, five business days prior to the service start date. All services rendered by NPIN or OON providers require prior authorization.
- Some members may require a PCP referral for specialty services. If we require prior authorization, we do not require a referral as well.

Service	Coverage/Limits/Conditions	Related payment policy	Co-payment	PA required?
Abortion	Covered		$0	None
Acupuncture	Covered for pain relief or anesthesia. Also covered if medically necessary to treat substance abuse.		$0	OON
Acute inpatient stay	Covered if medically necessary	Diagnosis Related Group (DRG) Inpatient Facility, Non-Diagnosis Related Group (DRG) Inpatient Facility	$0	IN and OON
Adult day care	Not covered		Not covered	Not covered
Adult foster care	Not covered		Not covered	Not covered
Ambulatory surgery/ Same-day surgery/ Outpatient surgery/ Surgical day care	Covered if medically necessary when surgical procedure performed at IN outpatient facility. Includes outpatient, surgical, and related diagnostic and medical/dental services.		$0	IN for certain services (see specific entries) OON: All
Anesthesia services	Covered if medically necessary. For additional PA requirements, see pain management.	Anesthesia Services, Obstetric Anesthesia Services	$0	IN
Apnea monitor	Covered if medically necessary	Durable Medical Equipment (DME)	$0	OON: All
Audiologist	Exams and evaluations covered if medically necessary		$0	OON
Autologous chondrocyte implant of the knee	Covered if medically necessary		$0	IN and OON

Service	Coverage/Limits/Conditions	Related payment policy	Co-payment	PA required?
Benign prostatic hypertrophy (BPH) treatments	Covered if medically necessary		$0	IN and OON
Breast pumps	Breast pumps, one per birth or as medically necessary, including double electric pumps, are provided to expectant and new mothers as specifically prescribed by their attending physicians and consistent with the provisions of the Affordable Care Act of 2010 and Section 274 of Chapter 165 of the Acts of 2014.		$0	IN: Electric hospital-grade pumps OON: All pumps
Chemotherapy/ Radiation therapy	Covered if medically necessary		$0	OON
Chiropractic services	Covered for up to 20 office visits per benefit year. Includes chiropractic manipulative treatments, office visits or any combination thereof.	Chiropractic Services	$0	OON
Cholycystectomy	Covered if medically necessary		$0	IN and OON
Cosmetic surgery	Not covered		Not covered	Not covered
Court-ordered services	Covered if medically necessary, except for court-ordered lab services		$0	IN and OON
CPAP/BiPAP	May cover continuous positive airway pressure machine (CPAP) and bilevel positive airway pressure machine (BiPAP) if medically necessary after sleep study completed and reviewed	DME	$0	IN and OON
Day habilitation	Not covered		Not covered	Not covered
Dental, emergency	Covered if medically necessary. Includes emergency dental services and oral surgery by a physician as a result of an injury, accident or other condition.		$0	None
Dental, nonemergency	Covered by MassHealth if medically necessary for preventive and basic services to prevent and control dental disease and maintain oral health		$0	Contact MassHealth at 800.841.2900
Diabetes education	Covered if medically necessary. Includes educational and training services by a physician or other provider (registered nurses, physician assistants, nurse practitioners and licensed dietitians) to treat prediabetes or diabetes.		$0	None
Diagnostic testing	Covered if medically necessary. Includes labs, X-rays, EKGs, EEGs and ultrasounds.		$0	OON: All services except labs
Dialysis services	Covered if medically necessary. Includes labs, drugs, tubing change, adapter change, training related to hemodialysis and peritoneal dialysis (intermittent, continuous cycling and continuous ambulatory).		$0	IN and OON

Service	Coverage/Limits/Conditions	Related payment policy	Co-payment	PA required?
Durable medical equipment (DME)	Covered if medically necessary. Includes medical and surgical supplies.	DME	$0	IN: See payment policy OON: All Nebulizers: None
Emergency services	Covered for emergency medical and BH services	Emergency Room Services	$0	Notification required within 24 hours, if admitted
Experimental services	Not covered. See our list of experimental and investigational procedures.		Not covered	Not covered
Family planning	Covered for basic services. Includes birth control and intrauterine devices (IUDs). Infertility services and their treatment not covered, including in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), reversal of voluntary sterilization and sperm banking.		$0	None
FluMist	Vaccine and administration covered for members ages 19–49 if medically necessary. Flu vaccine delivered intranasally by spray.		$0	OON
Gastric bypass surgery	Covered if medically necessary		$0	IN and OON
Hearing aids	Covered if medically necessary. Includes loan and purchase of hearing aids, ear molds, ear impressions, batteries, accessories and aid/instruction in the use, care and maintenance of the hearing aid.		$0	IN and OON
Holter monitor	Covered if medically necessary	DME	$0	IN: See payment policy OON: All
Home health care services	Covered if medically necessary, after an inpatient stay, and if member demonstrates a need for nursing or therapy services. Includes associated DME, part-time or intermittent skilled nursing care, physical/occupational/speech therapies, and part-time or intermittent home health aide services.	Home Health Care Services	$0	IN only if request is for daily visits or for requests greater than 6 months and OON
Hospice care	Covered if medically necessary for terminally ill members, if provider agrees not to continue with a curative treatment program. Nursing, medical and social services covered.		$0	IN and OON
Hysterectomy	Covered if medically necessary		$0	IN and OON

Service	Coverage/Limits/Conditions	Related payment policy	Co-payment	PA required?
Infertility services	Covered only for the diagnosis of infertility and treatment of an underlying medical condition. Other infertility services and their diagnosis/treatment not covered, including in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), reversal of voluntary sterilization and sperm banking.		$0	IN and OON
Inpatient chronic or rehabilitation care	Covered if medically necessary. Daily inpatient rehabilitative services provided for up to 100 days per benefit year.		$0	IN and OON
Inpatient hospitalization	Covered if medically necessary		$0	IN and OON Elective admissions: Submit PA form 5 business days prior to admission
Institutional care	Not covered		Not covered	Not covered
Knee Arthroscopy	Covered if medically necessary		$0	IN and OON
Laboratory services	Covered if medically necessary. Includes blood tests, urinalysis, Pap smears, and throat cultures to maintain health and diagnose, treat and prevent disease.		$0	None
Myringotomy with Tubes	Covered if medically necessary		$0	IN and OON
Nutritional counseling	Covered if rendered by an accredited provider (physician, licensed dietitian, licensed nutritionist, registered nurse, physician assistant or nurse practitioner). Includes nutritional, diagnostic, therapy and counseling services for a medical condition.		$0	IN and OON
Observation day	Covered if medically necessary	Observation Services	$0	IN: Stays longer than 48 hours OON: All
Orthotics	Covered if medically necessary. Includes nondental braces and other mechanical or molded devices to 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.	Orthotic Services	$0	IN and OON
Outpatient hospital services	Covered if medically necessary		$0	See specific service for PA requirement

Service	Coverage/Limits/Conditions	Related payment policy	Co-payment	PA required?
Over-the-counter (OTC) drugs	Covered if requested with a prescription written by an IN or OON physician. Must be obtained at a participating pharmacy. Examples include: • Aspirin/Acetaminophen/Ibuprofen • Allergy medication/Decongestant • Tobacco cessation products • Diabetic supplies (e.g., strips, lancets) • Multivitamins and iron/calcium supplements		Contraceptive agents: $0 Covered OTC drugs: $0–$3.65 for a 30-day supply	No
Oxygen/Respiratory therapy equipment	Covered if medically necessary. Includes ambulatory oxygen systems and refills, aspirators, compressor-driven nebulizers, intermittent positive pressure breathers, oxygen, oxygen gas, oxygen-generating devices and oxygen therapy equipment rental.	DME	$0	IN: See payment policy OON: All
Percutaneous vertebroplasty and kyphoplasty	Covered if medically necessary		$0	IN and OON
Personal care attendant/items	Not covered		Not covered	Not covered
Pharmacy	Co-payments for one-month supply via participating pharmacies. Co-payments due at time of service. No co-payment for: • Birth control and family-planning supplies • Members while pregnant or up to 60 days after giving birth • Prescription diabetes/asthma supplies		$0 as indicated $1–$3.65 (Tier 1) $3.65 (Tier 2) Tufts Health Plan pharmacy co-payments	See our *Preferred Drug List (PDL)* for PA requirements
Physician services	Covered, including PCP and specialty services with the exception of podiatry and orthotics. Some members may require PCP referral for specialty services.		$0	PCP: NPIN and OON Specialist: NPIN and OON
Podiatry	Covered for medical conditions. Includes routine foot care for diabetics.	Podiatry Services	$0	IN: Nondiabetic routine care OON: All
Prosthetics	Covered. Includes evaluation, fabrication, fitting, provision of prosthesis and repairs.	Prosthetic Services	$0	IN and OON
Radiation therapy, internal selective	Covered if medically necessary		$0	IN and OON
Radiology/X-rays	Covered if medically necessary. MRIs, MRAs, CAT scans, nuclear cardiology and PET scans require PA. Contact National Imaging Associates to request PA.	Radiology Imaging Services, Therapeutic Radiology Services	$0	IN: See coverage conditions at left OON: All

Service	Coverage/Limits/Conditions	Related payment policy	Co-payment	PA required?
School-based health center	Covered if medically necessary		$0	OON
Shoulder arthroscopy	Covered if medically necessary		$0	IN and OON
Sinusotomy endoscopic – frontal and maxillary sinus	Covered if medically necessary		$0	IN and OON
Skilled nursing facility	Covered if medically necessary when received in an inpatient setting for up to 100 days per benefit year		$0	IN and OON
Spinal cord/Dorsal column stimulation/Elective spinal procedures	Covered if medically necessary		$0	IN and OON
Therapy — physical, occupational, speech and hearing	Covered if medically necessary	Outpatient Therapy	$0	IN: After initial evaluation and 11 visits for PT and OT IN: After 30 visits for ST and hearing OON: All
Tobacco cessation	Covered for individual and group tobacco-cessation counseling rendered by an IN provider. Includes specific medications obtained from a pharmacy.		$3.65 for pharmacy medications	OON
Transportation, emergency	Covered if medically necessary	Ambulance Transport Services	$0	None
Transportation, nonemergency	Covered for transport to an out-of-state location farther than a 50-mile radius of the Massachusetts border. MassHealth covers in-state nonemergency transportation or transport within a 50-mile radius of the Massachusetts border.	Ambulance Transport Services	$0	IN and OON
Upper GI endoscopy	Covered if medically necessary		$0	IN and OON
Vision care — Tufts Health Plan providers	Covered for routine eye examinations from participating providers once every 24 months for nondiabetic members and members ages 21 and older, and once every 12 months for diabetic members and members younger than 21. MassHealth covers all nonmedical vision care, including certain eyeglasses or contact lenses, vision training and other visual aids. Contact lens fittings not covered.	Vision Services	$0	IN: Vision therapy OON: All Contact MassHealth at 800.841.2900 for wraparound benefits

Service	Coverage/Limits/Conditions	Related payment policy	Co-payment	PA required?
Wellness	See coverage conditions for family-planning, nutrition and maternity/prenatal/nurse midwife services		$0	See specific service for PA requirement
Wigs	Covered if medically necessary		$0	OON