Summary of 2020 *Tufts Health Direct* Individual & Small-Group (SG) Plan Offerings

Effective January 1, 2020. 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*	*Direct Silver 2500 with Co-insurance*	*Direct Bronze 2900*	*Direct Bronze 3550 with Co-insurance*	*Direct Catastrophic*
Deductible	**Combined**	**Combined**	**Combined**	**Combined**	**Med | Rx**	**Med | Rx**	**Combined**	**Combined**	**Combined**	**Combined**	**Combined**	**Combined**
Individual	$0	$0	$0	$0	$1,000 | $0	$2,000 | $250	$2,000	$2,000	$2,500	$2,900	$3,550	$8,150
Family	$0	$0	$0	$0	$2,000 | $0	$4,000 | $500	$4,000	$4,000	$5,000	$5,800	$7,100	$16,300
Maximum Out of Pocket	**Med | Rx**	**Med | Rx**	**Med | Rx**	**Combined**	**Combined**	**Combined**	**Combined**	**Combined**	**Combined**	**Combined**	**Combined**	**Combined**
Individual	$0 | $250	$750 | $500	$1,500 | $750	$3,000	$5,000	$5,600	$8,150	$6,850	$7,350	$8,150	$8,150	$8,150
Family	$0 | $500	$1,500 | $1,000	$3,000 | $1,500	$6,000	$10,000	$11,200	$16,300	$13,700	$14,700	$16,300	$16,300	$16,300
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	$30*	$30	$30*	$50	$35**
Specialist office visits	$0	$18	$22	$40	$45	$55	$60	$60*	$50*	$60*	$90*	$0*
Routine eye exam	$0	$10	$15	$20	$25	$30	$30	$30*	$30	$30*	$50	$0*
Emergency room	$0	$50	$100	$150	$150*	$350*	$350*	$300*	$650*	$350*	40%*	$0*
Outpatient surgery	$0	$50	$125	$250	$250*	$500*	$500*	$500*	20%*	$500*	40%*	$0*
Inpatient hospitalization	$0	$50	$250	$500	$500*	$750*	$1,000*	$750*	30%*	$750*	40%*	$0*
High-cost imaging	$0	$30	$60	$150	$200*	$300*	$500*	$500*	20%*	$500*	40%*	$0*
Therapy (speech, occupational, physical)	$0	$10	$20	$40	$45	$55	$60	$60*	$50*	$60*	$90*	$0*
Lab outpatient and professional services	$0	$0	$0	$0	$25*	$50*	$60*	$60*	20%*	$60*	40%*	$0*
X-rays and diagnostic imaging	$0	$0	$0	$0	$25*	$75*	$75*	$75*	20%*	$75*	40%*	$0*
Skilled nursing facility	$0	$0	$0	$500	$500*	$750*	$1,000*	$750*	30%*	$750*	40%*	$0*
Durable medical equipment (DME)	$0	$0	$0	20%	20%*	20%*	20%*	20%*	30%*+	20%*	30%*	$0*
Pharmacy (retail)	[Up to 30-Day supply]											
Tier 1 (generics)	$1	$10	$12.50	$10	$20	$25	$30	$30*	$35*	$30	$35*	$0*
Tier 2 (non-preferred generics/preferred brands)	$3.65	$20	$25	$25	$40	$50*	$60	$60*	50%*	$60*	50%*	$0*
Tier 3 (high-cost generics/preferred brands)	$3.65	$40	$50	$50	$60	$125*	$100*	$105*	50%*	$125*	50%*	$0*
Pharmacy (mail-order)	[Up to 90-Day supply]											
Tier 1 (generics)	$2	$20	$25	$20	$40	$50	$60	$60*	$70*	$60	$70*	$0*
Tier 2 (non-preferred generics/preferred brands)	$7.30	$40	$50	$50	$80	$100*	$120	$120*	50%*	$120*	50%*	$0*
Tier 3 (high-cost generics/preferred brands)	$7.30	$80	$100	$150	$180	$375*	$300*	$315*	50%*	$375*	50%*	$0*

***** Subject to deductible ****** $35 for the first 3 non-preventive PCP visits. After the first three PCP visits, services are subject to deductible.
+ For arm and leg prosthetics, coinsurance will not exceed 20% after deductible.

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
2020 *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
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 requirements	Medical Necessity Guidelines (MNG) and/or Payment Policies (if available)
Abortion	Covered IN	See Outpatient Surgery	No PA required	Outpatient Facility Payment Policy
Acupuncture	Covered IN up to 30 visits per benefit year. **Important: No limit for Behavioral Health treatment**	Subject to specialist office visit co-payment	No PA required	
Chemotherapy	Covered IN	No charge, subject to deductible if applicable	No PA required	
Chiropractic services	Covered IN for spinal manipulation, therapeutic exercise and attended electrical muscle stimulation.	Subject to specialist office visit co-payment	No PA required	Chiropractic Services Payment Policy
Cleft palate/lip	Covered IN for members 18 and younger. Includes medical, dental, oral, and facial surgery, follow-up, and related services.	Subject to applicable cost-sharing based on place of service	For PA requirements, refer to the MNG	MNG: Cleft Lip and Cleft Palate
Clinical trials (qualified)	Covered IN for routine services rendered during qualified clinical trials for members diagnosed with cancer or other life-threatening conditions.	Subject to applicable cost-sharing based on place of service	No PA required	Clinical Trials Payment Policy MNG: Clinical Trials Routine Costs
Cosmetic and reconstructive surgery and procedures	Covered IN if medically necessary.	Subject to inpatient or outpatient surgery cost-sharing	PA required	MNG: Reconstructive and Cosmetic Surgery

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA requirements	Medical Necessity Guidelines (MNG) and/or Payment Policies (if available)
Dental procedures requiring hospitalization	Hospitalization covered IN if medically necessary.	Subject to inpatient/outpatient surgery cost-sharing	PA required	MNG: Dental Procedures Requiring Hospitalization
Diagnostic testing	Covered IN if medically necessary. Includes, but is not limited to: Labs, EKGs and EEGs, PFTs, gastroenterology services, and sleep studies.	No charge when in accordance with the Preventive Services Policy, otherwise subject to applicable cost-sharing based on place of service	Certain tests may require PA, such as endoscopies, genetic testing, and sleep studies	See the Provider Resource Center for specific Payment Policy and MNG information.
Dialysis services	Covered IN	No charge, subject to deductible if applicable	No PA required	
Durable Medical Equipment (DME)	Covered IN if medically necessary. Includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs.	Subject to DME cost-sharing	PA is required when DME costs $1,000 or more and for certain services	DME Payment Policy
Early intervention (EI) services	Covered IN for members age 3 and younger.	No charge	No PA required	Early Intervention Services Payment Policy
Emergency services	**Covered IN and OON** for emergency medical and BH services.	Subject to emergency cost-sharing	Urgent or emergency admissions must be reported by providers within one business day	Emergency Department Services Payment Policy
Gender-affirming surgery	Covered if medically necessary.	Subject to applicable cost-sharing based on place of service	PA required	MNG: Transgender Surgical Procedures
Hearing aids	Covered IN for members age 21 and younger.	DME cost-sharing applies with coverage limited to $2000 per ear, every 36 months	PA required	MNG: Hearing Aids

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA requirements	Medical Necessity Guidelines (MNG) and/or Payment Policies (if available)
Home health care services	Covered IN if medically necessary. Member must be homebound.	Subject to applicable cost-sharing	PA required if request is for daily visits or longer than six months	MNG: Home Health Care Services
Hospice care	Covered IN	No charge, subject to deductible if applicable	PA required	Hospice Payment Policy MNG: Hospice Services
Infertility services	Covered IN for infertility diagnosis and treatment. Some limitations apply.	Subject to applicable cost-sharing based on place of service	PA required	MNG: Infertility Services
Inpatient maternity care	Covered IN	Subject to inpatient cost-sharing	Providers must submit a Prenatal Registration Form	Newborn Payment Policy Obstetric Anesthesia Services Payment Policy
Inpatient medical care	Covered IN if medically necessary.	Subject to inpatient cost-sharing	PA required, elective admissions require notification five business days prior to admission; urgent or emergency admissions within one business day	See the Provider Resource Center for more information.
Inpatient rehabilitation or chronic disease hospital	Covered IN if medically necessary. Maximum of 60 days total per member per benefit year.	Subject to inpatient cost-sharing	PA required	
Medical formulas	Covered IN if medically necessary.	Subject to DME cost-sharing	PA required	MNG: Oral Formula DME Payment Policy

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA requirements	Medical Necessity Guidelines (MNG) and/or Payment Policies (if available)
Nutritional counseling	Covered IN	No charge when in accordance with the Preventive Services Policy, otherwise subject to PCP or specialist office visit cost-sharing		Preventive Services
Organ transplant (including bone marrow transplants)	Covered IN if medically necessary.	Subject to inpatient cost-sharing	PA required	Transplant Facility Payment Policy
Outpatient surgery (outpatient hospital/ ambulatory surgery centers)	Covered IN if medically necessary.	Subject to outpatient surgery cost-sharing	PA required for specific services, see Provider Resource Center	Outpatient Facility Payment Policy
Podiatry	Covered IN for non-routine foot care. Routine foot care covered IN for members with diabetes or other systemic conditions.	Subject to specialist office visit co-payment	No PA required	Podiatry Payment Policy
Prenatal and postnatal care	Covered IN	No charge when in accordance with the Preventive Services Policy, otherwise subject to applicable cost-sharing based on place of service	Providers must submit a Prenatal Registration Form	
Preventive Services	Covered IN	No charge when in accordance with the Preventive Services Policy, otherwise subject to applicable cost-sharing based on place of service	No PA required	Preventive Services

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA requirements	Medical Necessity Guidelines (MNG) and/or Payment Policies (if available)
Radiation therapy	Covered IN if medically necessary.	No charge, subject to deductible if applicable	PA required	Therapeutic Radiology Services Payment Policy
Radiology/X-rays	Covered IN if medically necessary.	Subject to X-ray or high-cost imaging cost-sharing	PA required for high-cost imaging services (MRI, MRA, CAT, nuclear cardiology, PET) Contact National Imaging Associates to request PA.	Radiology Imaging Services Payment Policy High-Tech Imaging Prior Authorization Program
Skilled nursing facility	Covered IN for medically necessary skilled nursing care in an inpatient setting for a maximum of 100 days per member per benefit year.	Subject to SNF cost-sharing	PA required	Skilled Nursing Facility Payment Policy
Therapy (Habilitative) — physical, occupational and speech	Covered IN	Subject to outpatient therapy cost-sharing	PT/OT PA required after initial evaluation and 11 visits ST PA required after the initial evaluation and 29 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 **Note:** This is not an all-inclusive list. See the Provider Resource Center for specific Payment Policy and MNG information.

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA requirements	Medical Necessity Guidelines (MNG) and/or Payment Policies (if available)
Therapy (Rehabilitative) — physical, occupational and speech	Covered IN for a maximum of 60 visits total combined rehabilitative physical and occupational therapy per member per benefit year. No limit on speech therapy. Limit does not apply when services are furnished to treat autism spectrum disorders.	Subject to outpatient therapy cost-sharing	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 **Note:** This is not an all-inclusive list. See the Provider Resource Center for specific Payment Policy and MNG information.
Transportation, emergency	Covered IN and OON	No charge, subject to deductible if applicable	No PA required	Ambulance Transport Services Payment Policy
Transportation, nonemergency	Covered IN and OON if medically necessary.	No charge, subject to deductible if applicable	PA required	Ambulance Transport Services Payment Policy MNG: Non-Emergency Ambulance Transportation – Ground MNG: Non-Emergency Ambulance Transportation – Air

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA requirements	Medical Necessity Guidelines (MNG) and/or Payment Policies (if available)
Urgent care center	Covered IN within the service area and OON outside of the service area.	Subject to cost-sharing based on place of service	No PA required	
Vaccine and immunization services	Covered IN	No charge when in accordance with the Preventive Services Policy, otherwise subject to applicable cost-sharing based on place of service	No PA required	Vaccine and Immunization Services Payment Policy Preventive Services
Vision care (routine) - EyeMed	We cover routine eye exams for members: • Age 19 and older once every 24 months • Age 18 and younger once every 12 months • With diabetes once every 12 months	Subject to routine eye exam cost-sharing	**Must receive routine eye examinations from a provider in the EyeMed Vision Care Network**	Vision Services Payment Policy