2021 BEHAVIORAL HEALTH BENEFIT SUMMARY GRID: *TUFTS HEALTH DIRECT*

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
IN = In-network
OON = Out-of-network
PA = Prior authorization

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

Member cost sharing per admission or visit

Plan Level	*Direct Connector Care I*	*Direct Connector Care II*	*Direct Connector Care III*	*Direct Platinum*	*Direct Gold*	*Direct Gold 2000*	*Direct Silver 2000* and *Direct Silver 2000 II*	*Direct Silver 2000 HSA*	*Direct Silver 2500 with Coinsurance*
Inpatient	$0	$50	$250	$500	$750	Deductible, then $750	Deductible, then $1,000	Deductible, then $750	Deductible, then 30%
Outpatient	$0	$10	$15	$20	$25	$35	$25	Deductible, then $30	$30

Plan Level	*Direct Bronze 2700*	*Direct Bronze 3550 with Coinsurance*	*Direct Catastrophic*
Inpatient	Deductible, then $1200	Deductible, then 40%	Deductible, then no cost sharing
Outpatient	Deductible, then $40	$90	Deductible, then no cost sharing

TUFTS Health Plan

Tufts Health Plan only covers services rendered by in-network providers.

SERVICE	COVERAGE/LIMITS/ CONDITIONS	PA REQUIRED		NOTIFICATION REQUIRED	RELATED PAYMENT POLICY
		IN NETWORK	OUT OF NETWORK		
INPATIENT SERVICES – Related Inpatient Cost-Sharing May Apply					
Inpatient mental health services	Covered if medically necessary	YES *Starting 1st business day following admission*	YES	YES *Provider notifies THP 1st business day following admission*	
Inpatient substance use disorder services (Level IV)	Covered if medically necessary	YES *After 14 days*	YES	YES *Provider notifies THP within 2 business days of admission*	
Observation/Holding beds	Covered if medically necessary	YES *Starting 1st business day following admission*	YES	YES *Provider notifies THP 1st business day following admission*	Observation Services Facility Payment Policy
Administratively Necessary Days	Covered when clinically appropriate	YES	YES	NO	

SERVICE	COVERAGE/LIMITS/ CONDITIONS	PA REQUIRED		NOTIFICATION REQUIRED	RELATED PAYMENT POLICY
		IN NETWORK	OUT OF NETWORK		
24-HOUR DIVERSIONARY SERVICES – Related Inpatient or Outpatient Cost-Sharing May Apply					
Acute Treatment Services (ATS) for Substance Use Disorders (ASAM Level 3.7)	Covered if medically necessary	YES *After 14 days*	YES	YES *Provider notifies THP within 2 business days of admission*	ATS Notification Form

SERVICE	COVERAGE/LIMITS/ CONDITIONS	PA REQUIRED		NOTIFICATION REQUIRED	RELATED PAYMENT POLICY
		IN NETWORK	OUT OF NETWORK		
Community Crisis Stabilization (CCS)	Covered if medically necessary	YES *Starting 1st business day following admission.* *PA not required for urgent admission from ED. PA required for stepdown from inpatient facility.*	YES	YES *Provider notifies THP 1st business day following admission*	
Clinical Stabilization Services (CSS, ASAM Level 3.5)	Covered if medically necessary	YES *After 14 days (Notification needed after 10 days)*	YES	YES *After day 10* • *No Notification days 1-10* • *Provider notifies THP for days 11-14*	
Community-based acute treatment (CBAT) for children and adolescents	Covered if medically necessary	YES *Starting 1st business day following admission.* *PA not required for urgent admission from ED. PA required for stepdown from inpatient facility.*	YES	YES *Provider notifies THP 1st business day following admission*	

SERVICE	COVERAGE/LIMITS/ CONDITIONS	PA REQUIRED		NOTIFICATION REQUIRED	RELATED PAYMENT POLICY
		IN NETWORK	OUT OF NETWORK		
Dual Diagnosis Acute Residential Treatment (DDART) (ASAM Level 3.7 Enhanced)	Covered if medically necessary	YES *After 14 days*	YES	YES *Within 2 business days of admission*	
Enhanced Acute Treatment Services (EATS) for Substance Use Disorders (ASAM Level 3.7 Enhanced)	Covered if medically necessary	YES *After 14 days*	YES	YES *Within 2 business days of admission*	
Intensive community-based acute treatment (ICBAT) for children and adolescents	Covered if medically necessary	YES *Starting 1st business day following admission.* *PA not required for urgent admission from ED. PA required for stepdown from inpatient facility.*	YES	YES *Provider notifies THP 1st business day following admission*	

SERVICE	COVERAGE/LIMITS/ CONDITIONS	PA REQUIRED		NOTIFICATION REQUIRED	RELATED PAYMENT POLICY
		IN NETWORK	OUT OF NETWORK		
NON-24-HOUR DIVERSIONARY SERVICES – Related Inpatient or Outpatient Cost-Sharing May Apply					
Community Support Program (CSP)	Covered if medically necessary	YES *After 60 days or 240 units*	YES	NO	

SERVICE	COVERAGE/LIMITS/ CONDITIONS	PA REQUIRED		NOTIFICATION REQUIRED	RELATED PAYMENT POLICY
		IN NETWORK	OUT OF NETWORK		
Family Stabilization Team (FST)	Covered if medically necessary	YES	YES	NO	
Intensive Outpatient Program (IOP)	Covered if medically necessary	YES (*After 1st visit for substance use treatment)* *PA required for non-substance use treatment.*	YES	YES *Notification required after 1st visit for substance use treatment.* *PA required for subsequent visits.*	
Partial Hospitalization Program (PHP)	Covered if medically necessary	YES (*After 1st visit for substance use treatment)* *PA required for non-substance use treatment.*	YES	YES *Notification required after 1st visit for substance use treatment.* *PA required for subsequent visits.*	
Psychiatric Day Treatment	Covered if medically necessary	YES (*After 1st visit for substance use treatment)*	YES	NO	
Structured Outpatient Addiction Program (SOAP)	Covered if medically necessary	YES *(After 1st visit for substance use treatment)*	YES	YES *For 1st visit*	

SERVICE	COVERAGE/LIMITS/ CONDITIONS	PA REQUIRED		NOTIFICATION REQUIRED	RELATED PAYMENT POLICY
		IN NETWORK	OUT OF NETWORK		
OUTPATIENT SERVICES – Related Outpatient Cost-Sharing May Apply					
Acupuncture Detoxification Treatment	Covered if medically necessary	NO	YES	YES *For first visit*	Medical Necessity Guidelines: Acupuncture Detoxification
Applied behavioral analysis (ABA) for treatment of autism spectrum disorders (ASD)	Covered when rendered in the home, outpatient, or office setting by a qualified professional who is either a board-certified behavior analyst (BCBA) or board-certified assistant behavior analyst (BCaBA).	YES	YES	NO	
Autism treatment	Covered. Includes medically necessary evaluations (including neuropsychological evaluations), genetic testing, and treatment by licensed physicians, psychologists, and habilitative, rehabilitative, pharmacy, ABA, and other autism service providers.	YES	YES	NO	
Case consultation	Covered if medically necessary	NO	YES	NO	
Couples/Family Treatment	Covered if medically necessary	NO	YES	NO	
Diagnostic Evaluation	Covered if medically necessary	NO	YES	NO	
Dialectical Behavioral Therapy (DBT)	Covered if medically necessary	YES	YES	NO	
Family Consultation	Covered if medically necessary	NO	YES	NO	

SERVICE	COVERAGE/LIMITS/ CONDITIONS	PA REQUIRED		NOTIFICATION REQUIRED	RELATED PAYMENT POLICY
		IN NETWORK	OUT OF NETWORK		
Group Treatment	Covered if medically necessary	NO	YES	NO	
Individual Treatment	Covered if medically necessary	NO	YES	NO	
Medication management	Covered if medically necessary	NO	YES	NO	
Methadone maintenance	Covered if medically necessary	NO	YES	NO	
Psychological Testing	Covered if medically necessary	YES	YES	NO	

SERVICE	COVERAGE/LIMITS/ CONDITIONS	PA REQUIRED		NOTIFICATION REQUIRED	RELATED PAYMENT POLICY
		IN NETWORK	OUT OF NETWORK		
INTENSIVE HOME OR COMMUNITY-BASED SERVICES FOR YOUTH					
Family Support and Training	Covered if medically necessary for members <19.	NO	YES	YES *For days 1-30, if FS&T is provided in conjunction with Intensive Care Coordination (ICC)* NO *If FS&T is provided in conjunction with IHT or Outpatient as the hub*	
In-home behavioral services	Covered if medically necessary for members <19.	YES	YES	NO	
In-home therapy services	Covered if medically necessary for members <19.	YES	YES	NO	
Intensive care coordination	Covered if medically necessary for members <19.	YES *After 30 days*	YES	YES *For days 1-30*	
Therapeutic Mentoring Services	Covered if medically necessary for members <19.	NO	YES	NO	

SERVICE	COVERAGE/LIMITS/ CONDITIONS	PA REQUIRED		NOTIFICATION REQUIRED	RELATED PAYMENT POLICY
		IN NETWORK	OUT OF NETWORK		
OTHER BEHAVIORAL HEALTH SERVICES – Related Inpatient or Outpatient Cost-Sharing May Apply					
Electroconvulsive Therapy (ECT)	Covered if medically necessary	NO	YES	NO	
Specialing	Covered if medically necessary	YES	YES	NO	
Transcranial Magnetic Stimulation (TMS)	Covered if medically necessary	YES	YES	NO	