2018 MEDICAL BENEFIT SUMMARY GRID:
DIRECT GOLD 1000

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
NPIN = Nonpreferred 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 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.

Cost-sharing (unless otherwise indicated in the covered services section)	
Preventive care	$0
PCP	$30
Specialist	$45
Outpatient surgery	$250 after deductible
Inpatient, per admission	$500 after deductible
Skilled nursing facility	$500 after deductible
Emergency (waived, if admitted)	$150 after deductible
High-cost imaging	$200 after deductible
Lab outpatient and professional services	$20 after deductible
X-rays and diagnostic imaging	$20 after deductible
DME	20% after deductible
Pharmacy, retail (Tier 1)	$20
Pharmacy, retail (Tier 2)	$30
Pharmacy, retail (Tier 3)	$50
Pharmacy, mail-order (Tier 1)	$40
Pharmacy, mail-order (Tier 2)	$60
Pharmacy, mail-order (Tier 3)	$150

Annual deductible	
Medical deductible (individual)	$1,000
Medical deductible (family)*	$2,000
Pharmacy deductible (individual)	$0
Pharmacy deductible (family)*	$0
* Each individual in the family may contribute up to the individual deductible amount toward the family deductible.	

Annual maximum out-of-pocket (MOOP) per benefit year	
Combined pharmacy/medical MOOP (individual)	$5,000
Combined pharmacy/medical MOOP (family)*	$10,000*
* Each individual in the family may contribute up to the individual MOOP amount toward the family maximum.	

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?
Abortion	Covered IN	Related outpatient surgery cost-sharing may apply	No
Acupuncture	Covered IN if medically necessary to treat substance use	Depends on place of service	Yes
Adult day care	Not covered	Not covered	Not covered
Adult foster care	Not covered	Not covered	Not covered
Allergy shots	Covered IN if medically necessary	Related PCP or specialist cost-sharing may apply	No
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/dental services.	Related outpatient surgery cost-sharing may apply	Yes, see Provider Resource Center for specific services.
Anesthesia services	Covered IN if medically necessary. See pain management for additional PA requirements.	Depends on place of service	No
Apnea monitor	Covered IN if medically necessary	Related DME cost-sharing may apply	Yes, for DME greater than $1,000. See DME Payment Policy.
Audiologist	Exams and evaluations covered IN if medically necessary	Related specialist cost-sharing may apply	No
Biofeedback	Not covered	Not covered	Not covered
Bone density test	Covered IN if medically necessary Limit one test every two years.	Depends on place of service	Yes, if younger than 50 or frequency limit exceeded.
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	No
Breast pumps	Covered IN for pregnant members for a maximum benefit of one pump per pregnancy	No charge	Yes, for hospital grade electric pumps
Cardiac catheterization	Covered IN if medically necessary	Related inpatient cost-sharing may apply	No

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA required?
Cardiac rehabilitation	Covered IN if medically necessary	Related specialist cost-sharing may apply	No
Chemotherapy/ Radiation therapy	Covered IN	No charge after deductible	No
Chiropractic services	Covered IN	Related specialist cost-sharing may apply	No
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 adequate health and dental structures for orthodontic treatment, prosthetic management therapy, speech therapy, audiology, and nutrition services	Depends on place of service	No
Cosmetic surgery	Not covered	Not covered	Not covered
Court-ordered services	Covered IN if medically necessary, except for court-ordered lab services (see also Drug Screening service)	See specific service for cost-sharing	Yes
CPAP/BiPAP	May cover continuous positive airway pressure machine (CPAP) and bilevel positive airway pressure machine (BiPAP) IN after sleep study completed and reviewed	Related DME cost-sharing may apply	Yes
Custodial care	Not covered	Not covered	Not covered
Day habilitation	Not covered	Not covered	Not covered
Dental, emergency	Emergency services covered IN and OON if medically necessary. Includes emergency dental services and oral surgery by a physician as a result of an injury, accident, or other condition.	Related emergency cost-sharing may apply. Emergency cost-sharing waived if admitted. For OON emergency, plan will pay reasonable charge and member may be balance billed.	No
Dental, 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 coinsurance may apply	Yes, for orthodontia
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
Diagnostic procedures	Covered IN if medically necessary. Includes colonoscopy, sigmoidoscopy, and gastroscopy.	No charge	Yes, for endoscopy only
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	No

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA required?
Dialysis services	Covered IN if medically necessary. Includes labs, drugs, tubing change, adapter change, and training related to hemodialysis and peritoneal dialysis (intermittent, continuous cycling, and continuous ambulatory).	No charge after deductible	No
Drug screening	Covered IN if medically necessary. Not covered when court-ordered or otherwise legally required.	Depends on place of service	No
DME	Covered IN if medically necessary. Includes medical and surgical supplies.	Related DME cost-sharing may apply	See 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	No
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, Lab, X-Rays, etc. may carry additional cost sharing if provided. Emergency cost-sharing waived if admitted. For OON emergency, plan will pay reasonable charge and member may be balance billed.	No
Experimental services	Not covered. See our list of experimental and investigational procedures.	Not covered	Not covered
Family-planning	Covered IN for birth control and intrauterine devices (IUDs)	No charge	No
Fitness reimbursement	Covered for first three months. Excludes initiation fees. Must complete a fitness reimbursement form.	50% co-insurance for first three months	No
FluMist	Vaccine and administration covered IN for members ages 19 – 49 if medically necessary. Flu vaccine delivered intranasally by spray.	Depends on place of service	No
Gastric bypass surgery	Covered IN if medically necessary	Related inpatient cost-sharing may apply	Yes
Gender reassignment surgery	Covered if medically necessary	Related inpatient, specialist, PCP, or pharmacy cost-sharing may apply	Yes
Genetic testing	Covered IN if medically necessary	Related PCP, specialist, or lab services cost-sharing may apply	Yes
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

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA required?
Hepatitis B vaccine	Covered IN if medically necessary for adults age 19 and older. Includes vaccine and administration.	Depends on place of service	No
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.	No charge after deductible	Yes only if request is for daily visits or for requests greater than 6 months
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.	No charge after deductible	Yes
Human papillomavirus (HPV) vaccine	Covered IN if medically necessary for males and females ages 9 – 26	Depends on place of service	No
Immunization services	Covered IN if medically necessary. Vaccine administration covered. Covered for adults age 19 and older when required for school. Not covered if required for traveling outside the U.S.	Depends on place of service	No
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
Inpatient administrative days	Not covered	Not covered	Not covered
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 five business days prior to admission.	Related inpatient cost-sharing may apply	Yes
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	No
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	No
Nuclear cardiology	Covered IN if medically necessary. Contact National Imaging Associates to request PA.	Related specialist cost-sharing may apply	Yes

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA required?
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.	Related PCP or specialist cost-sharing may apply	No
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 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
Outpatient hospital services	Covered IN if medically necessary	See specific service for cost-sharing	See specific service for PA requirements
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 DME Payment Policy.
Pacemaker implant	Covered IN if medically necessary	Related inpatient cost-sharing may apply	No
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	Not covered	Not covered
Personal emergency response systems (PERS)	Covered IN if medically necessary	Related PCP, specialist, or DME cost-sharing may apply	No
Pharmacy, mail-order	Covered. Cost-sharing listed are for a three-month supply ordered through CVS/Caremark. Cost-sharing due at time of order. No cost-sharing for: • Birth control and family-planning supplies • Tobacco-cessation products	No charge as indicated Related pharmacy or DME cost-sharing may apply	See our *Preferred Drug List (PDL)*

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA required?
Pharmacy, retail	Covered. Cost-sharing listed are for a one-month supply from participating pharmacies. Cost-sharing due at time of service. No cost-sharing for: • Birth control and family-planning supplies • Tobacco-cessation products	No charge as indicated Related pharmacy or DME 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	No
Physician services	Covered IN. Includes PCP and specialty services, except for podiatric services.	Related PCP or specialist cost-sharing may apply	No
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. See Podiatry Payment Policy.
Postnatal care	Covered IN	First visit 21 – 56 days postpartum: No charge All other visits: Related PCP or specialist cost-sharing may apply	No
Prenatal care	Covered IN. Providers must submit a Prenatal Registration Form to MM.	No charge	No
Preventive testing for children	Covered IN for children 6 years old or younger. Includes physical, neuropsychiatric, developmental, or appropriate blood or urine exams.	No charge	No
Private duty nursing	Not covered	Not covered	Not covered
Prosthetics	Covered IN if medically necessary. Includes evaluation, fabrication, fitting, provision of prosthesis, and repairs.	Related DME cost-sharing may apply	Yes
Pulmonary function test	Covered IN if medically necessary	Depends on place of service	No
Pulmonary rehabilitation	Covered IN if medically necessary	Related specialist cost-sharing may apply	No
Qualified clinical trials	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 medications.	Depends on place of service	No
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

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA required?
Services, pursuant to court order or otherwise required, for the purpose of employment, education, or licensing	Not covered, except for vaccinations for school purposes	Depends on place of service for covered vaccinations	No, when covered
Shingles vaccine	Covered IN for members 60 years or older	Depends on place of service	No
Skilled nursing facility	Covered IN for up to 100 days per benefit year	Related skilled nursing facility cost-sharing may apply	Yes
Sleep study	Covered IN if medically necessary	Related inpatient cost-sharing may apply	No
Specialist	Covered IN if medically necessary	Related specialist cost-sharing may apply	No
Stress test	Covered IN if medically necessary	Related inpatient cost-sharing may apply	No
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
Therapy (Habilitative) — physical, occupational, and speech	Speech therapy covered IN. Habilitative physical and occupational therapy covered IN if medically necessary for up to 60 combined visits per member, per benefit year.	Related specialist cost-sharing may apply	Yes, PT/OT PA required after initial evaluation and 11 visits. ST PA required after 30 visits.
Therapy (Rehabilitative) — physical, occupational, and speech	Speech therapy covered IN. Rehabilitative physical and occupational therapy covered IN if medically necessary for up to 60 combined visits per member, per benefit year.	Related specialist cost-sharing may apply	Yes, PT/OT PA required after initial evaluation and 11 visits. ST PA required after 30 visits.
Tobacco cessation	Covered IN for individual and group tobacco-cessation counseling. Includes specific medications obtained from a pharmacy.	No charge	Some medications may require PA. See our *Preferred Drug List (PDL)*
Transportation, emergency	Covered IN and OON if medically necessary	No charge after deductible	No
Transportation, nonemergency	Covered IN if medically necessary for preauthorized transportation between facilities.	No charge after deductible	Yes

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA required?
Urgent care	Covered IN if medically necessary. Urgent care centers at OON hospitals are not covered.	Related PCP, specialist, or emergency services cost-sharing may apply	No, but PCP must be notified before going to any urgent care.
Vaccines	Vaccine administration covered IN if medically necessary for adults age 19 and older when required for school. Not covered if required for traveling outside the U.S.	Depends on place of service	No
Vasectomy	Covered IN	Related outpatient surgery cost-sharing may apply	No
Vision care — EyeMed	Covered IN for routine eye exams from participating providers once every 12 months for diabetic adults and children 18 years old or younger. Covered IN every 24 months for nondiabetic adults. Contact lenses, contact lens fittings, or any other services related to contact lenses not covered. Collection frames and lenses covered for children 18 years old or younger. Covered IN for vision therapy when medically necessary.	$30 copayment for services No charge for pediatric collection frames and lenses	Yes, for vision therapy only
Vocational rehabilitation	Not covered	Not covered	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	No
Wigs	Covered IN	Related DME cost-sharing may apply	No