



**2018 MEDICAL BENEFIT SUMMARY GRID:  
DIRECT GOLD 750 WITH COINSURANCE**

**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.

<b>Cost-sharing (unless otherwise indicated in the covered services section)</b>	
Preventive care	\$0
PCP	\$20
Specialist	\$35
Outpatient surgery	30% after deductible
Inpatient, per admission	30% after deductible
Skilled nursing facility	30% after deductible
Emergency (waived, if admitted)	30% after deductible
High-cost imaging	30% after deductible
Lab outpatient and professional services	30% after deductible
X-rays and diagnostic imaging	30% after deductible
DME	30% after deductible
Pharmacy, retail (Tier 1)	\$15
Pharmacy, retail (Tier 2)	50% after deductible
Pharmacy, retail (Tier 3)	50% after deductible
Pharmacy, mail-order (Tier 1)	\$30
Pharmacy, mail-order (Tier 2)	50% after deductible
Pharmacy, mail-order (Tier 3)	50% after deductible

<b>Annual deductible</b>	
Combined pharmacy/medical deductible (individual)	\$750
Combined pharmacy/medical deductible (family)*	\$1,500
* Each individual in the family may contribute up to the individual deductible amount toward the family deductible.	

<b>Annual maximum out-of-pocket (MOOP) per benefit year</b>	
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.

<b>Service</b>	<b>Coverage/Limits/Conditions</b>	<b>Cost-sharing (deductible may apply)</b>	<b>PA required?</b>
<b>Abortion</b>	Covered IN	Related outpatient surgery cost-sharing may apply	No
<b>Acupuncture</b>	Covered IN if medically necessary to treat substance use	Depends on place of service	Yes
<b>Adult day care</b>	Not covered	Not covered	Not covered
<b>Adult foster care</b>	Not covered	Not covered	Not covered
<b>Allergy shots</b>	Covered IN if medically necessary	Related PCP or specialist cost-sharing may apply	No
<b>Ambulatory surgery/ Same-day surgery/ Outpatient surgery/ Surgical day care</b>	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 <a href="#">Provider Resource Center</a> for specific services.
<b>Anesthesia services</b>	Covered IN if medically necessary. See <a href="#">pain management</a> for additional PA requirements.	Depends on place of service	No
<b>Apnea monitor</b>	Covered IN if medically necessary	Related DME cost-sharing may apply	Yes, for DME greater than \$1,000. See <a href="#">DME Payment Policy</a> .
<b>Audiologist</b>	Exams and evaluations covered IN if medically necessary	Related specialist cost-sharing may apply	No
<b>Biofeedback</b>	Not covered	Not covered	Not covered
<b>Bone density test</b>	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.
<b>Bone marrow transplants for patients diagnosed with breast cancer</b>	Covered IN if medically necessary	Depends on place of service	Yes
<b>Breastfeeding services</b>	Covered IN. Includes breastfeeding supplies and lactation consultants.	No charge	No
<b>Breast pumps</b>	Covered IN for pregnant members for a maximum benefit of one pump per pregnancy	No charge	Yes, for hospital grade electric pumps
<b>Cardiac catheterization</b>	Covered IN if medically necessary	Related inpatient cost-sharing may apply	No

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA required?
<b>Cardiac rehabilitation</b>	Covered IN if medically necessary	Related specialist cost-sharing may apply	No
<b>Chemotherapy/ Radiation therapy</b>	Covered IN	No charge after deductible	No
<b>Chiropractic services</b>	Covered IN	Related specialist cost-sharing may apply	No
<b>Cleft palate/lip</b>	Covered IN for members 18 years old and younger. Includes: <ul style="list-style-type: none"> <li>• Medical, dental, oral, and facial surgery</li> <li>• Surgical management and follow-up care by oral and plastic surgeons</li> <li>• Orthodontic treatment and management</li> <li>• Preventive and restorative dentistry to ensure adequate health and dental structures for orthodontic treatment, prosthetic management therapy, speech therapy, audiology, and nutrition services</li> </ul>	Depends on place of service	No
<b>Cosmetic surgery</b>	Not covered	Not covered	Not covered
<b>Court-ordered services</b>	Covered IN if medically necessary, except for court-ordered lab services (see also Drug Screening service)	See specific service for cost-sharing	Yes
<b>CPAP/BiPAP</b>	May cover continuous positive airway pressure machine (CPAP) and bilevel positive airway pressure machine (BiPAP) IN after <a href="#">sleep study</a> completed and reviewed	Related DME cost-sharing may apply	Yes
<b>Custodial care</b>	Not covered	Not covered	Not covered
<b>Day habilitation</b>	Not covered	Not covered	Not covered
<b>Dental, emergency</b>	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
<b>Dental, nonemergency – Delta Dental</b>	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
<b>Diabetes education</b>	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
<b>Diagnostic procedures</b>	Covered IN if medically necessary. Includes colonoscopy, sigmoidoscopy, and gastroscopy.	No charge	Yes, for endoscopy only
<b>Diagnostic testing</b>	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?
<b>Dialysis services</b>	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
<b>Drug screening</b>	Covered IN if medically necessary. Not covered when court-ordered or otherwise legally required.	Depends on place of service	No
<b>DME</b>	Covered IN if medically necessary. Includes medical and surgical supplies.	Related DME cost-sharing may apply	See <a href="#">payment policy</a>
<b>Early intervention (EI) services</b>	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
<b>Emergency services</b>	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
<b>Experimental services</b>	Not covered. See our <a href="#">list of experimental and investigational procedures</a> .	Not covered	Not covered
<b>Family-planning</b>	Covered IN for birth control and intrauterine devices (IUDs)	No charge	No
<b>Fitness reimbursement</b>	Covered for first three months. Excludes initiation fees. Must complete a <a href="#">fitness reimbursement form</a> .	50% co-insurance for first three months	No
<b>FluMist</b>	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
<b>Gastric bypass surgery</b>	Covered IN if medically necessary	Related inpatient cost-sharing may apply	Yes
<b>Gender reassignment surgery</b>	Covered if medically necessary	Related inpatient, specialist, PCP, or pharmacy cost-sharing may apply	Yes
<b>Genetic testing</b>	Covered IN if medically necessary	Related PCP, specialist, or lab services cost-sharing may apply	Yes
<b>Hearing aids</b>	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?
<b>Hepatitis B vaccine</b>	Covered IN if medically necessary for adults age 19 and older. Includes vaccine and administration.	Depends on place of service	No
<b>Home health care services</b>	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
<b>Home infusion therapy</b>	Covered IN if medically necessary	Depends on place of service	Yes
<b>Hormone replacement therapy</b>	Covered IN for perimenopausal and postmenopausal women	Depends on place of service	Some hormones may require PA. See <a href="#">Preferred Drug List (PDL)</a> .
<b>Hospice care</b>	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
<b>Human papillomavirus (HPV) vaccine</b>	Covered IN if medically necessary for males and females ages 9 – 26	Depends on place of service	No
<b>Immunization services</b>	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
<b>Infertility services</b>	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
<b>Inpatient administrative days</b>	Not covered	Not covered	Not covered
<b>Inpatient chronic or rehabilitation care</b>	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
<b>Inpatient hospitalization</b>	Covered IN if medically necessary. Elective admissions require submission of <a href="#">PA form</a> five business days prior to admission.	Related inpatient cost-sharing may apply	Yes
<b>Laboratory services</b>	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
<b>Maternity care/ Nurse midwife services</b>	Covered IN. Providers must submit a <a href="#">Prenatal Registration Form</a> to MM. See <a href="#">prenatal</a> and <a href="#">postnatal</a> care for more information.	Related inpatient cost-sharing may apply	No
<b>Nuclear cardiology</b>	Covered IN if medically necessary. Contact <a href="#">National Imaging Associates</a> to request PA.	Related specialist cost-sharing may apply	Yes

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA required?
<b>Nutritional counseling</b>	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
<b>Nutritional supplements</b>	Covered IN if medically necessary and prescribed for a medical condition. <a href="#">Nonprescription enteral formulas</a> covered only for treatment of malabsorption.	Related DME or Rx cost-sharing may apply	Yes
<b>Observation day</b>	Covered IN if medically necessary	Related inpatient cost-sharing may apply	Yes, for stays longer than 48 hours. See <a href="#">Observation Services Facility Payment Policy</a> .
<b>Organ/Bone marrow transplants</b>	Covered IN if medically necessary. Experimental and investigational transplants not covered.	Related inpatient cost-sharing may apply	Yes
<b>Orthotics</b>	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
<b>Outpatient hospital services</b>	Covered IN if medically necessary	See specific service for cost-sharing	See specific service for PA requirements
<b>Oxygen/Respiratory therapy equipment</b>	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 <a href="#">DME Payment Policy</a> .
<b>Pacemaker implant</b>	Covered IN if medically necessary	Related inpatient cost-sharing may apply	No
<b>Pain management</b>	Covered IN if medically necessary. Contact <a href="#">National Imaging Associates</a> to request PA.	Related specialist cost-sharing may apply	Yes
<b>Personal care attendant/items</b>	Not covered	Not covered	Not covered
<b>Personal emergency response systems (PERS)</b>	Covered IN if medically necessary	Related PCP, specialist, or DME cost-sharing may apply	No
<b>Pharmacy, mail-order</b>	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: <ul style="list-style-type: none"> <li>• Birth control and family-planning supplies</li> <li>• Tobacco-cessation products</li> </ul>	No charge as indicated Related pharmacy or DME cost-sharing may apply	See our <a href="#">Preferred Drug List (PDL)</a>

Service	Coverage/Limits/Conditions	Cost-sharing (deductible may apply)	PA required?
<b>Pharmacy, retail</b>	Covered. Cost-sharing listed are for a one-month supply from participating pharmacies. Cost-sharing due at time of service. No cost-sharing for: <ul style="list-style-type: none"> <li>• Birth control and family-planning supplies</li> <li>• Tobacco-cessation products</li> </ul>	No charge as indicated Related pharmacy or DME cost-sharing may apply	See our <a href="#">Preferred Drug List (PDL)</a>
<b>Physician assistant services</b>	Covered IN if credentialed for billing as a PCP or under an IN supervising PCP	Related PCP cost-sharing may apply	No
<b>Physician services</b>	Covered IN. Includes PCP and specialty services, except for podiatric services.	Related PCP or specialist cost-sharing may apply	No
<b>Podiatry</b>	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 <a href="#">Podiatry Payment Policy</a> .
<b>Postnatal care</b>	Covered IN	First visit 21 – 56 days postpartum: No charge All other visits: Related PCP or specialist cost-sharing may apply	No
<b>Prenatal care</b>	Covered IN. Providers must submit a <a href="#">Prenatal Registration Form</a> to MM.	No charge	No
<b>Preventive testing for children</b>	Covered IN for children 6 years old or younger. Includes physical, neuropsychiatric, developmental, or appropriate blood or urine exams.	No charge	No
<b>Private duty nursing</b>	Not covered	Not covered	Not covered
<b>Prosthetics</b>	Covered IN if medically necessary. Includes evaluation, fabrication, fitting, provision of prosthesis, and repairs.	Related DME cost-sharing may apply	Yes
<b>Pulmonary function test</b>	Covered IN if medically necessary	Depends on place of service	No
<b>Pulmonary rehabilitation</b>	Covered IN if medically necessary	Related specialist cost-sharing may apply	No
<b>Qualified clinical trials</b>	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
<b>Radiology/X-rays</b>	Covered IN if medically necessary. Advanced imaging services (MRI, MRA, CAT, nuclear cardiology, PET) require PA and have different cost-sharing. Contact <a href="#">National Imaging Associates</a> 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 <a href="#">Preferred Drug List (PDL)</a>
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?
<b>Urgent care</b>	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.
<b>Vaccines</b>	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
<b>Vasectomy</b>	Covered IN	Related outpatient surgery cost-sharing may apply	No
<b>Vision care — EyeMed</b>	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.	\$20 copayment for services No charge for pediatric collection frames and lenses	Yes, for vision therapy only
<b>Vocational rehabilitation</b>	Not covered	Not covered	Not covered
<b>Weight loss programs</b>	Covered for first three months. Excludes initiation fees and food. Must complete a <a href="#">weight loss programs reimbursement form</a> .	No charge for the covered time frame	No
<b>Wigs</b>	Covered IN	Related DME cost-sharing may apply	No