



**2018 MEDICAL BENEFIT SUMMARY GRID:
DIRECT SILVER 2000 II**

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 | \$50 |
| Outpatient surgery | \$750 after deductible |
| Inpatient, per admission | \$1,000 after deductible |
| Skilled nursing facility | \$1,000 after deductible |
| Emergency (waived, if admitted) | \$700 after deductible |
| High-cost imaging | \$500 after deductible |
| Lab outpatient and professional services | \$25 after deductible |
| X-rays and diagnostic imaging | \$25 after deductible |
| DME | 20% after deductible |
| Pharmacy, retail (Tier 1) | \$20 |
| Pharmacy, retail (Tier 2) | \$60 |
| Pharmacy, retail (Tier 3) | \$90 after deductible |
| Pharmacy, mail-order (Tier 1) | \$40 |
| Pharmacy, mail-order (Tier 2) | \$120 |
| Pharmacy, mail-order (Tier 3) | \$270 after deductible |

| Annual deductible | |
|---|---------|
| Combined pharmacy/medical deductible (individual) | \$2,000 |
| Combined pharmacy/medical deductible (family)* | \$4,000 |
| * 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) | \$7,350 |
| Combined pharmacy/medical MOOP (family)* | \$14,700 |
| * 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: <ul style="list-style-type: none"> • 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. | \$5 copayment 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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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 |