MEDICAL BENEFIT SUMMARY GRID:
Tufts Health RITogether

ABBREVIATIONS
BH = Behavioral health
DME = Durable medical equipment
IN = In-network
MM = Medical management team at Tufts Health Plan
OON = Out-of-network
PA = Prior authorization
PCP = Primary care provider

BENEFIT YEAR
July 1–June 30

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.
- Some members may require a PCP referral for specialty services. If we require prior authorization, we do not require a referral as well.

Co-payments (only applicable to RIte Care Extended Family Planning)	
Health care provider visits	$2
Thirty-day (30) Supply of Contraceptives	$1
Voluntary Sterilization Procedures	$15
Office Visits	$5
Ambulatory Surgical Procedures	$15
Prescriptions	$2
Inpatient Hospital Admission	$25
Non-Emergency Use of Emergency Transportation	$35

All other RIte Care members pay a $0 co-payment on all drugs covered under the pharmacy benefit.
All Rhody Health Partners Expansion members pay $0 on all drugs covered under the pharmacy benefit.
All Rhody Health Partners members pay $0 on all drugs covered under the pharmacy benefit.

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	Co-payment	PA required?
Abortion Services	Not covered — except to preserve the life of the woman, or in cases of rape or incest	$0	No
Acupuncture	Covered as part of Pain Management program when medically necessary	$0	No
Adult Day Services	Covered when medically necessary	$0	Yes
AIDS/HIV Non-Medical Targeted Case Management	Covered — these services are for members living with AIDS and for those at a high risk of acquiring HIV. Benefits include but are not limited to counseling, assistance with accessing food, housing, transportation and referrals to community program.	$0	No
Allergy Shots	Covered when medically necessary	$0	No
Ambulatory Surgery/Same-day Surgery/Outpatient Surgery/Surgical Day Care	Covered when medically necessary	$0	Yes. Some services require PA.
Apnea Monitor	Covered under DME when medically necessary	$0	No
Audiologist	Covered for exams and evaluations when medically necessary	$0	No
Biofeedback	Not covered	Not covered	Not covered
Bone Density Test	Covered when medically necessary	$0	No
Breast Pump	Manual breast pumps, electric breast pumps covered one per child. Hospital-grade electric breast pumps require PA.	$0	Hospital-grade breast pumps require PA
Breast Reconstruction	Covered following a mastectomy	$0	Yes
Cardiac Catheterization	Covered when medically necessary	$0	Yes
Cardiac Rehabilitation	Covered when medically necessary	$0	No
Chemotherapy/Radiation Therapy	Covered when medically necessary	$0	No
Children's Evaluations	RIte Care only. Coverage as needed, including evaluations for sexual abuse, parent/child evaluations, fire setter, PANDA clinic and other evaluations as medically necessary.	$0	No
Cosmetic Service	Not covered except medically necessary surgery to treat illness or injury to restore or provide function	$0	Yes

TUFTS Health Plan

Service	Coverage/Limits/Conditions	Co-payment	PA required?
Day Habilitation	Covered	$0	Yes
Dental Care (Inpatient and Outpatient)	Routine dental care is not an in-plan benefit. Checkups and treatment are covered using your Rhode Island Medicaid (Anchor) card or Rite Smiles card (for children born on or after May 1, 2000).	Refer to Rhode Island Medicaid or Rite Smiles (for children born on or after May 1, 2000)	No
Diabetes Services	Covered — education, visits and supplies (glucose meters, test strips, lancets, insulin injection aids, syringes and molded shoes)	$0	No
Diagnostic Procedures	Covered	$0	Yes. Some services require PA.
Dialysis (Inpatient or Outpatient)	Covered based on medical necessity. Covers the following services: dialysis supplies, diagnostic testing and medications.	$0	Yes for OON
Drugs (Prescription and Over-the-Counter)	Covered — generic substitution required. Some over-the-counter drugs are covered, such as routine nicotine cessation, aspirin and cold medicines. Nutritional supplements are covered when medically necessary. Not covered — medications for sexual or erectile dysfunction.	$0 (Extended Family Planning members will have a $1 co-payment for a 30-day supply of contraceptives)	Yes for some prescriptions
Durable Medical Equipment (DME)	Covered when ordered by a network provider as medically necessary. Includes surgical appliances, prosthetic devices, orthotic devices, assistive technology and medical supplies as covered by Rhode Island Medicaid program.	$0	Yes for DME over $1,000
Early Intervention	Covered for children up to age 3	$0	No
Early Periodic Screening, Diagnosis, and Treatment (EPSDT)	Covered for all children and young adults up to age 21. Includes periodic screenings, multidisciplinary evaluation and treatment for children with significant development disabilities or delays.	$0	No
Education Classes	Covered (including but not limited to childbirth, parenting, smoking cessation, diabetes, asthma and nutrition services)	$0	No
Emergency Room Services	Covered — emergency room services are covered both in and out of state for emergency services. Covered only within the U.S. or territories.	$0	No
Emergency Transportation Services	Covered as medically necessary	$0	No

TUFTS Health Plan

Service	Coverage/Limits/Conditions	Co-payment	PA required?
Eye Care (EyeMed)	Covered for adults 21 and older — routine eye exams, including refractions and one pair of glasses as needed, every 24 months. Exams and treatment for illness or injury as ordered by your PCP. Annual eye exams for members with diabetes. Eyeglass frames covered only every 2 years. Covered for children under 21 — as medically necessary with no other limitations. Coverage includes lenses, frames and dispensing fee.	$0	No
Experimental Procedures	Not covered — except when a state mandate for coverage exists	$0	PA required for ages over 21
Family-planning Methods (Prescription and Non-prescription)	Covered — limited to 12–30 day supplies per year. Covered contraceptives include oral contraceptives, IUD, cervical cap, diaphragm and Dep-Provera. Covered non-prescription methods include foam, spermicidal jelly and condoms. Emergency contraceptives as needed. Sterilization is covered in many cases. Must meet state and federal guidelines and have Rhode Island Medicaid Consent Form signed at least 30 days in advance.	$0 (Extended Family Planning members will have a $1 co-payment for a 30-day supply of contraceptives)	No
Family-planning Services	Covered — enrolled family members have freedom of choice of Providers for certain family-planning services, including family-planning exam and medical treatment, family-planning lab and diagnostic tests, family-planning methods and supplies, etc.	$0 (Extended Family Planning members will have a $1 co-payment for a 30-day supply of contraceptives and a $2 co-payment for PCP appointments)	No
Gender Dysphoria Treatment	Covered — when ordered by a network provider	$0	Yes for some services
Genetic Testing	Covered when medically necessary	$0	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.	$0	Yes
Home Health Services	Covered when ordered by a network provider and must be provided by a home health agency. Includes but is not limited to the following services: full-time, part-time or intermittent skilled nursing, certified nursing assistant and home health aide services. Physical therapy, occupational therapy, pulmonary therapy and speech therapy, medical and social services.	$0	Yes for daily visits or services extending over 6 months

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Service	Coverage/Limits/Conditions	Co-payment	PA required?
Home Infusion Therapy	Covered IN if medically necessary	$0	Yes
Hospice Care	Services are limited to those services covered by Medicare, including drugs to treat symptoms and pain, short-term respite care, home care	$0	Yes
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.	$0	No
Inpatient Hospital Care	Covered — inpatient services covered. Private room not covered unless medically necessary at an IN hospital	$0	Yes
Infertility Treatment	Not covered	Not covered	Not covered
Interpreters	Covered — 72-hour advance notice for languages and a 14-day advance notice for American Sign Language	$0	No
Laboratory Test	Covered for diagnosis, screening and monitoring services when medically necessary	$0	No
Language Therapy	Covered when ordered by your PCP	$0	Yes
Nursing Home Care and Skilled Nursing Facility	Covered (including custodial care) when ordered by a network provider up to 30 consecutive days for Rhody Health Partners and Medicaid Expansion. RIte Care covered until placed in a long-term facility.	$0	No
Nutritional Counseling	Covered by a licensed dietitian and when ordered by a network provider for certain medical conditions	$0	No
Observation Day	Covered when medically necessary	$0	Yes for stays more than 48 hours
Outpatient Hospital Services	Covered when ordered by a network provider. Includes physical therapy, occupational therapy, speech therapy, language therapy, hearing therapy, respiratory therapy and other Medicaid-covered services delivered in an outpatient hospital setting.	$0	Yes
Outpatient Rehabilitation Services	Covered when ordered by a network provider. Includes physical, occupational, speech, language, hearing, cardiac and respiratory therapies.	$0	Yes
Pacemaker Implant	Covered when medically necessary	$0	Yes
Pain Management	Covered when medically necessary	$0	Yes
Pain Management Program	Chiropractic, acupuncture or massage therapy covered by Pain Management programs when medically necessary	$0	Yes
Personal Care Attendant/Items	Covered when medically necessary as part of home care services	$0	No
Personal Emergency Response Systems (PERS)	Covered when medically necessary	$0	No

TUFTS Health Plan

Service	Coverage/Limits/Conditions	Co-payment	PA required?
Physician Assistant Services	Covered if credentialed for billing as a PCP or under an IN supervising PCP	$0	No
Physician Services (Primary and Specialty Care)	Covered — including PCP and specialty services	$0	No
Podiatry (Foot Care)	Covered when ordered by a network provider	$0	No
Post-stabilization Services	Covered for services related to an emergency medical condition that are provided after the condition is stabilized	$0	No
Pregnancy Care	Covered — including minimum hospital stay of 48 hours after a vaginal birth and 96 hours after a Cesarean birth (unless the mother requests an early discharge). Also includes prenatal, postpartum care, lactation services and breast pumps.	$0	No
Preventive Testing for Children	Covered IN for children 6 years old or younger. Includes physical, neuropsychiatric, developmental or appropriate blood or urine exams.	$0	No
Private Duty Nursing	Covered when medically necessary as part of home health care services	$0	Yes
Pulmonary Function Test	Covered when medically necessary	$0	No
Pulmonary Rehabilitation	Covered when medically necessary	$0	No
Qualified Clinical Trials	Covered when medically necessary for members diagnosed with cancer. Includes the same level of care as for cancer patients not enrolled in a clinical trial. Not covered for medications.	$0	No
Radiology/X-rays	Covered when medically necessary. Advanced imaging services (MRI, MRA, CAT, nuclear cardiology, PET) require PA. Contact National Imaging Associates to request PA.	$0	Yes for high-tech imaging only
School-based Health Center Services	Covered as medically necessary at all designated sites	$0	No
Sleep Study	Covered when medically necessary	$0	Yes
Stress Test	Covered when medically necessary	$0	No
Surgery	Covered when ordered by a network provider. Emergency surgery is covered. Second surgical opinions are covered.	$0	Yes for certain surgical procedures
Specialist	Covered when medically necessary	$0	PA for OON
Therapy — Physical, Occupational, Speech and Hearing	Covered — physical therapy, occupational therapy and speech therapy as medically necessary	$0	Yes
Transplant Services	Covered when ordered by a network provider	$0	Yes
Transportation, Emergency	Covered IN and OON if medically necessary	$0	No

Service	Coverage/Limits/Conditions	Co-payment	PA required?
Transportation, Nonemergency	Rhode Island Medicaid covers non-emergency transportation services through MTM effective January 1, 2019. Covered IN if medically necessary for preauthorized transportation between facilities.	$0	Yes
Urgent Care	Covered	$0	No
Vaccines	Covered vaccines include pneumonia, flu shots once a year in the fall or winter, hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis and other vaccines if you are at risk and meet the Rhode Island Medicaid coverage rules	$0	No
Vasectomy	Covered	$0	No
Vocational Rehabilitation	Not covered	Not covered	Not covered
Weight-Loss Programs	Covered for counseling to help you lose weight and when rendered in a primary care setting	$0	No
Wigs	Covered	$0	No