TUFTS Health Plan

MEDICAL BENEFIT SUMMARY GRID:
TUFTS HEALTH UNIFY (Medicare-Medicaid One Care for people ages 21 – 64)

Benefit Year: January 1, 2019 – December 31, 2019

ABBREVIATIONS

BH: Behavioral Health
ICT: Interdisciplinary Care Team
IN: In-network
MM: Medical Management Team (Tufts Health Plan)
OON: Out of Network
PA: Prior Authroization
PCP: Primary Care Provider

Annual co-payment maximum per calendar year per member

Medical and BH = $0
Pharmacy = $0

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 OON providers require prior authorization.

Please note: We do not list services that apply to children, since *Tufts Health Unify* does not cover members younger than 21.

Tufts Health Plan covers health care screenings, including preventive screenings, and prenatal and postpartum services for pregnant enrollees, as specified in Executive Office for Health and Human Services (EOHHS) guidelines or in accordance with nationally accepted standards and practices.

SERVICE	COVERAGE/LIMITS/CONDITIONS	PA REQUIRED		NOTIFICATION REQUIRED	RELATED PAYMENT POLICY
		IN NETWORK	OUT OF NETWORK		
Abortion	Covered	NO	YES	N/A	
Acupuncture	Covered for pain relief or anesthesia when medically necessary. Covered if medically necessary to treat substance use (detoxification treatment).	NO	YES	N/A	
Acute inpatient stay	Covered if medically necessary	YES	YES	YES *Within 1 business day*	Acute Inpatient Hospital Admissions

Adult day health services	Covered in a contracted community-based setting if rendered by a provider participating in Medicare/Medicaid. Includes transportation to a site outside the home.	YES	YES	N/A	
Adult foster care	Covered if delivered in a home- or community-based setting when rendered by a contracted provider participating in Medicare/Medicaid	YES	YES	N/A	
Allergy shots	Covered if medically necessary	NO	YES	N/A	
Ambulatory surgery/ Outpatient surgery/ Surgical day care/ Same-day surgery	Covered if medically necessary when surgical procedure performed at in-network outpatient facility. Includes outpatient, surgical, related diagnostic, medical, and dental services.	NO	YES	N/A	
Anesthesia services	Covered if medically necessary	NO	NO	N/A	Anesthesia Services
Audiologist	Exams and evaluations covered if medically necessary	NO	YES	N/A	
Biofeedback	Covered if medically necessary. Coverage limitations based on medical necessity.	YES	YES	N/A	
Bone density testing	Covered if medically necessary.	NO *Except for members younger than 50 or members whose test frequency exceeds one test every two years.*	YES	N/A	
Breast pumps	Breast pumps, one per birth or as medically necessary, including double electric pumps, are provided to expectant and new mothers as specifically prescribed by their attending physicians and consistent with state and	YES: *Electric hospital-grade pumps* NO: *All other*	YES: *All pumps*	N/A	

	federal law.	*pumps*			
Cardiac catheterization	Covered if medically necessary	NO	YES	N/A	
Cardiac rehabilitation	Covered if medically necessary	NO	YES	N/A	
Care management	Covered when provided by Tufts Health Plan care managers	NO	NO	N/A	
Care transition assistance	Covered for members recently discharged from a nursing facility who require a one-time setup of a household in the community and are not enrolled in assisted living, adult foster care, 24-hour residential habilitation, or family surrogate services	YES	YES	N/A	
Chemotherapy/ Radiation therapy	Covered if medically necessary	NO	YES	N/A	
Chiropractic services	Covered if medically necessary for manipulative treatment, office visits, radiology services, or any combination of these services	YES *PA Required after 20 visits*	YES	N/A	
Community health workers (CHWs) and community health center services	Covered	YES	YES	N/A	
Cosmetic surgery	Not covered	N/A	N/A	N/A	N/A
CPAP/BiPAP	May cover continuous positive airway pressure machine (CPAP) and bilevel positive airway pressure machine (BiPAP) after sleep study completed and reviewed.	YES	YES	N/A	
Custodial care	Covered Service	YES	YES	N/A	
Day habilitation	Covered when rendered in a contracted community-based setting	YES	YES	N/A	
Day services	Covered	YES	YES	N/A	
Dental, emergency	Covered if medically necessary. Includes emergency dental services and oral surgery performed in an outpatient	NO	NO	N/A	

	setting to treat a medical or BH condition.				
Dental, nonemergency	Covered. Includes preventive, restorative, and basic services to prevent and control dental disease and maintain oral health. Includes two cleanings per year and one X-ray panel every two years. Call DentaQuest at 855-418-1625 with dental benefit questions.	YES	YES	N/A	
Diabetes self-management training	Covered if medically necessary. Includes educational and training services by a physician or other accredited provider (registered nurse, physician assistant, nurse practitioner, licensed dietitian, or nutritionist) to treat prediabetes or diabetes.	NO	NO	N/A	
Diagnostic procedures	Covered if medically necessary. Includes colonoscopy, sigmoidoscopy, and gastroscopy.	YES: *Upper GI Endoscopy* NO: *All other diagnostic procedures*	YES: *All diagnostic procedures*	N/A	
Diagnostic testing	Covered if medically necessary. Includes labs, X-rays, EKGs, EEGs, and ultrasounds.	NO	NO: *Labs* YES: *All other diagnostic testing*	N/A	
Dialysis services	Covered if medically necessary. Includes labs, drugs, tubing change, adapter change, training related to hemodialysis, and peritoneal dialysis (intermittent, continuous cycling, and continuous ambulatory).	NO	YES	N/A	
Drug screening	Covered if medically necessary. Not covered when court ordered, legally required , or when	NO	YES	N/A	

	required for residential monitoring.				
Durable medical equipment (DME)	Covered if medically necessary. Includes medical and surgical supplies.	NO: *Nebulizers* YES: *See payment policy*	NO: *Nebulizers* YES: *All other DME*	N/A	DME
DME training in usage, repair, and modification	Covered if a DME item does not function properly, does not provide therapeutic benefits, or is irreparably damaged. The modification must improve, restore, or maintain the function of an injured body part, or it must minimize or prevent the deterioration of the member's condition or ability to function.	YES	YES	N/A	
Emergency services	Covered for inpatient and outpatient medical and BH emergency services provided within the U.S. or its territories	NO	NO	YES *Within 1 business day if admitted*	Emergency Room Services
Environmental aids and assistive adaptive technology	Covered. A contracted physical, occupational, and/or speech therapist must complete a home evaluation or assessment before rendering services.	NO: *Assisted Augmented Communication* YES: *All others*	YES	N/A	
Exams/Other treatment	Not covered, including services related to or for the purpose of employment, education, licensing or court order	N/A	N/A	N/A	
Experimental services	Not covered, including experimental drugs, devices, treatments, or investigational procedures. For more information, see our list of experimental and investigational	N/A	N/A	N/A	Clinical Trials Payment Policy

	procedures.				
Family-planning	Covered for basic services. Includes birth control, intrauterine devices (IUDs), medical and counseling services, follow-up health care, outreach, and community education. Not covered for infertility services and their treatment, including in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), reversal of voluntary sterilization, and sperm banking.	NO	NO	N/A	
Genetic testing	Covered if medically necessary	YES	YES	N/A	Genetic Testing
Group adult foster care	Covered. Includes the following services: • Daily assistance for members with disabilities or chronic medical conditions so they may remain safely in their homes • Personal care in an assisted living community or elder/public housing complex for members at imminent risk of institutionalization • Daily assistance with personal care, medication management, meals and snacks, homemaking, laundry, and medical transportation	YES	YES	N/A	
Hearing aids	Covered if medically necessary. Includes ear mold, ear impressions, and loan of a hearing aid if necessary. No PA required for batteries, accessories, aid, instruction on use/care/ maintenance, and servicing during the lifetime of the hearing aid.	YES: *Monaural (one ear) more than $500 or binaural (two ears) more than $1,000* NO: *All other hearing aids*	YES	N/A	
Hepatitis B vaccine	Covered for vaccine and administration	NO	YES	N/A	Vaccine and

					Immunization Services
Home care/ Homemaker services	Covered with the following conditions for members who require assistance in daily household chores, medication pickup, or other nonmedical tasks: • Members must have a disabling condition preventing them from performing these activities • Member must live alone or with another adult who is unable to perform homemaking duties either due to their own disability or to having dependent children younger than 18 • Legally blind members should utilize homemaking services from the Massachusetts Commission for the Blind	YES	YES	N/A	
Home health care services	Covered if medically necessary when a member demonstrates a need for nursing and/or therapy services. Includes DME associated with services, part-time or intermittent skilled nursing, physical/occupational/speech therapy, and part-time or intermittent home health aide services.	YES *Only if request is for Daily visits or requests greater than 6 months regardless of service (e.g., skilled nursing, PT, OT and speech)*	YES	N/A	
Home infusion therapy	Covered if medically necessary	YES *Some drugs may require a PA*	YES	N/A	
Home modifications	Covered for members in their primary residence only. Home evaluation and assessment must be completed and	YES	YES	N/A	

	submitted with request for modifications by a contracted provider (e.g., physical therapist, occupational therapist, or DME vendor).				
Hospice care	Covered	YES	YES	N/A	
Human papillomavirus (HPV) vaccine	Covered if medically necessary for males and females ages 21 – 26	NO	NO	N/A	Vaccine and Immunization Services
Immunization services	Covered if medically necessary. Vaccine administration covered. Not covered if required for traveling outside U.S.	NO	NO	N/A	Vaccine and Immunization Services
Infertility services	Covered if medically necessary. Includes diagnosis and treatment. Not covered for infertility services and their treatment, including in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), reversal of voluntary sterilization, and sperm banking.	YES	YES	N/A	
Inpatient hospitalization	Covered if medically necessary as follows: • Members receiving medical and BH services — covered	YES *Elective admissions require PA 5 business days prior to admission*	YES *Elective admissions require PA 5 business days prior to admission*	YES *Within 1 business day of hospitalization*	
Laboratory services	Covered if medically necessary to maintain health and diagnose, treat and prevent disease. Includes blood tests, urinalysis, Pap smears, throat cultures and vaccines not covered by the Department of Public Health. Please reference "Drug Screening and Genetic Testing" above.	NO	NO	N/A	
Long-term services and supports (LTSS)	May be covered after review by the ICT coordinator. See specific LTSS service	See specific service for	See specific service for	N/A	

	for additional details.	PA requirement	PA requirement		
Maternity care/Prenatal and postpartum services	Covered. IN or OON providers must submit a Prenatal Registration Form to MM.	NO	YES	N/A	
Medical services outside the U.S. or its territories	Not covered	N/A	N/A	N/A	
Medication management	Covered for members as part of their weekly medication schedule or who require assistive aids (i.e., pill boxes) to maintain adherence to a medication schedule	YES	YES	N/A	
Nuclear cardiology	Covered if medically necessary.	YES	YES	N/A	
Nurse midwife services	Covered	NO	YES	N/A	
Nurse practitioner services	Covered if contracted as a Primary Care Provider or part of a contracted practice.	NO	YES	N/A	
Nutritional counseling	Covered if rendered by an accredited provider (physician, licensed dietitian, licensed nutritionist, registered nurse, physician assistant, or nurse practitioner). Includes nutritional, diagnostic, therapy, and counseling services for a medical and/or behavioral health condition.	NO	YES	N/A	
Nutritional supplements	Covered if medically necessary	NO	YES	N/A	
Nutritional therapy	Covered if medically necessary	NO	YES	N/A	
Observation day	Covered if medically necessary.	YES *For stays longer than 48 hours*	YES	NO	
Organ/Bone marrow transplants	Covered if medically necessary. Experimental and investigational transplants not covered.	YES	YES	N/A	
Orthotics	Covered if medically necessary. Includes braces and other mechanical or molded devices to support or correct any defect of form or function of the human body. Includes repairs. Limit of one pair of shoes per 12-	YES	YES	N/A	Orthotic Services

	month period. Shoe inserts covered for diabetics only. Certain limitations apply.				
Outpatient hospital services	Covered if medically necessary	See specific service for PA requirement	See specific service for PA requirement		
Outpatient therapy — physical, occupational, speech	Covered if medically necessary. Includes individual treatment (orthotics, prosthetics, assistive technology devices), comprehensive evaluation, and group therapy.	YES: • *PT and OT: After initial evaluation and 11 visits* • *ST: After 30 visits*	YES	N/A	Outpatient Therapy
Over-the-counter (OTC) drugs	Select OTC drugs are covered if requested with a prescription written by an IN or OON physician. Must be obtained at a participating pharmacy. Examples include: • Aspirin/Acetaminophen/Ibuprofen • Allergy medication/decongestant • Diabetic supplies (e.g., strips, lancets) • Multivitamins and iron/calcium supplements	See Over-the-Counter list	See Over-the-Counter list	N/A	
Oxygen and respiratory therapy equipment	Covered if medically necessary. Includes ambulatory liquid oxygen systems and refills, aspirators, compressor-driven nebulizers, intermittent positive pressure breather, oxygen, oxygen gas, oxygen-generating devices, and oxygen therapy equipment rental.	See Payment Policy	YES	N/A	DME
Pacemaker implant	Covered if medically necessary			N/A	
Pain management	Covered if medically necessary	YES	YES	N/A	Anesthesia Services
Peer	Covered	YES	YES	N/A	

support/Counseling/ Navigation					
Personal assistance services	Covered. Includes cueing and monitoring.	YES	YES	N/A	
Personal care attendant (PCA)	Covered for medical and/or BH needs provided in the home, outside the home, or in both locations if the following criteria are met: • Member has a permanent or chronic disability that prevents them from taking care of themselves or their personal needs • Member needs monitoring and/or physical assistance with at least two of the seven activities of daily living (ADLs) or instrumental ADLs (IADLs) • Member does not reside in a nursing, inpatient, or intermediate care facility • MD or nurse practitioner orders the PCA services and a personal care manager completes an evaluation Includes, but is not limited to, household management tasks, meal preparation, and transportation to medical providers	YES	YES	N/A	
Personal emergency response systems (PERS)	Covered if medically necessary.	NO	YES	N/A	
Pharmacy	Get more information about our *Tufts Health Unify* pharmacy program or see our *List of Covered Drugs*.			N/A	*List of Covered Drugs*
Physician services	Covered, including PCP and specialty services. .	No	NO	N/A	
Podiatry	Covered for medical conditions. Includes medical, radiological, surgical, and	YES	YES	N/A	Podiatry Services

	laboratory care. Includes routine foot care for diabetics and other conditions that compromise the foot.				
Preventive health care services	Covered. Includes, but not limited to: • Screenings and appropriate follow-up treatments, including screenings for cancer, diabetes, obesity, substance use, and sexually transmitted diseases • Welcome to Medicare and annual wellness visits	See specific service for PA requirement	See specific service for PA requirement	N/A	
Private duty nursing/ Continuous skilled nursing/ Independent nursing	Covered for members who require more intense individualized and continuous 24-hour nursing care than the home health care benefit. Not intended to supplement the caregiving responsibility of a family or guardian.	YES	YES	N/A	
Program of assertive community treatments (PACT)	Covered for members recovering from serious mental health illness who experience symptoms that interfere with daily activities such as employment, personal affairs, and interpersonal relationships.	YES	YES	N/A	
Prosthetic services and devices	Covered. Includes evaluation, fabrication, fitting, provision of prosthesis, and repairs. Certain limitations apply.	YES	YES	N/A	Prosthetic Services
Pulmonary function test	Covered if medically necessary.	NO	NO	N/A	
Pulmonary rehabilitation	Covered if medically necessary.	NO	YES	N/A	
Radiology/X-rays	Covered if medically necessary. Advanced imaging services (MRI, MRA, CAT, nuclear cardiology, PET) require PA through NIA.	YES	YES	N/A	• Radiology Imaging Services • Therapeutic Radiology Services
School-based health center	Covered if medically necessary.	NO	NO	N/A	
Shingles vaccine	Covered only for members 50 and older.	NO	NO	N/A	Vaccine and

					Immunization Services
Skilled nursing facility	Covered if medically necessary, if received in an inpatient setting	YES	YES	NO	
Sleep study	Covered if medically necessary	NO	NO	NO	
Specialist	Covered if medically necessary. Some members may require PCP referral for specialty services. However, no Prior Authorization or notification is required for IN.	NO	YES	N/A	Specialty Services Referral Requirement
Stress test	Covered if medically necessary	NO	YES	N/A	
Temporomandibular joint (TMJ) treatment	Covered for surgery if medically necessary. Not covered for physical therapy, corrective devices, and/or other treatments.	YES	YES	N/A	
Tobacco cessation	Covered for individual and group tobacco-cessation counseling rendered by an IN provider. Includes specific medication obtained from a pharmacy and nicotine replacement therapy.	NO	YES	N/A	
Transportation, emergency	Covered if medically necessary. Includes land and air. Includes specialty care transport between facilities.	NO	NO	NO	
Transportation, nonemergency	Includes ambulance, chair car, taxi, or common carriers as appropriate within the state or a 50-mile radius of the border	NO	YES	NO	
Transgender surgery	Covered if medically necessary	YES	YES	NO	
Urgent care	Covered for medically necessary IN and OON services provided within the U.S. or its territories.	NO *If billed with place of service code "20"*	NO *If billed with place of service code "20"*	NO	
Vaccines	Covered if medically necessary. Vaccine administration covered. Not covered if required for traveling outside the U.S.	NO	NO	N/A	Vaccine and Immunization Services
Vasectomy	Covered, except for reversal of voluntary sterilization	NO	YES	N/A	

Vision care	Covered for routine eye examinations from participating providers once every 12 months. Covered for one pair of eyeglasses or contact lenses every 24 months.	NO *Eye Exams (1x every 12 months)* YES *Eyewear*	YES *Eye Exams (1x every 12 months)* YES *Eyewear*	N/A	Vision Services
Vocational rehabilitation	Covered	YES	YES	N/A	
Wigs	Covered if medically necessary pursuant to 130 CMR 450.204. Must be ordered or prescribed by a provider. Must be reasonably priced pursuant to 130 CMR 450.204(A)(2)"	NO	YES	N/A	