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

Benefit Year: January 1, 2020 – December 31, 2020

ABBREVIATIONS

BH: Behavioral Health
ICT: Interdisciplinary Care Team
IN: In-network
OON: Out of Network
PA: Prior Authorization
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.

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 REQUIREMENTS	RELATED PAYMENT POLICY AND/OR MEDICAL NECESSITY GUIDELINES (IF AVAILABLE)
Abortion	Covered.	No PA required	
Acupuncture	Covered for pain relief or anesthesia when medically necessary. Covered if medically necessary to treat substance use (detoxification treatment).	No PA required	MNG: Acupuncture Detoxification Level of Care
Adult day health	Covered for services from adult day health providers at an organized program.	PA required	
Adult foster care	Covered for services from adult foster care providers in a residential setting.	PA required	

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SERVICE	COVERAGE/LIMITS/CONDITIONS	PA REQUIREMENTS	RELATED PAYMENT POLICY AND/OR MEDICAL NECESSITY GUIDELINES (IF AVAILABLE)
Ambulatory surgery/ Outpatient surgery/ Surgical day care/ Same-day surgery	Covered if medically necessary.	PA required for certain surgical services	Outpatient Facility Payment Policy
Audiologist services	Exams and evaluations covered if medically necessary.	No PA required	Audiology Professional Payment Policy
Cardiac rehabilitation	Covered if medically necessary.	No PA required	
Care management	Covered when provided by Tufts Health Plan care managers.	No PA required	
Care transition assistance	Covered for services to help with transitions between care settings for members who qualify.	PA required	
Chemotherapy	Covered if medically necessary.	No PA required	
Chiropractic services	Covered if medically necessary for manipulative treatment, office visits, radiology services, or any combination of these services.	PA required after 20 visits	Chiropractic Services Payment Policy
Community health center services	Covered.	PA required	
Community health workers (CHWs)	Covered. Includes health education in the home or community, counseling, support and screenings.	PA required	
Day habilitation	Covered for a program of services offered by day habilitation providers for members who qualify because of an intellectual or developmental disability.	PA required	
Day services	Covered for structured day activities at a program to help members learn skills needed to live independently in the community.	PA required	
Dental, emergency	Covered if medically necessary. Includes emergency dental services and oral surgery performed in an outpatient setting.	No PA required	

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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. Dental services are managed by DentaQuest. Call 855-418-1625 with dental benefit questions.	PA required for specific services	
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 PA required	
Diagnostic procedures	Covered if medically necessary. Includes, but not limited to: colonoscopy, sigmoidoscopy, and gastroscopy.	PA required for specific services	Refer to the Provider Resource Center
Diagnostic testing	Covered if medically necessary. Includes labs, EKGs, EEGs, PFTs, ultrasounds, and sleep studies.	PA required for specific services	Refer to the Provider Resource Center
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 PA required	

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Durable medical equipment (DME)	Covered if medically necessary.	PA required for DME > $1,000 PA may be required for certain items or services, refer to the Provider Resource Center	Durable Medical Equipment and Medical Supplies Payment Policy MNG: Durable Medical Equipment and Supplies Costing Over $1,000
DME training in usage, repair, and modification	Covered.	PA required	
Emergency services	Covered for inpatient and outpatient medical and BH emergency services provided within the U.S. or its territories.	No PA required Urgent or emergency admissions must be reported by providers within one business day	Emergency Department Services Payment Policy
Environmental aids and assistive adaptive technology	Covered if medically necessary.	PA required	
Family-planning	Covered for basic services like birth control, intrauterine devices (IUDs), medical counseling services, follow-up health care, outreach, and community education. Infertility services are covered, including counseling and diagnosis of infertility and treatment for medical conditions of infertility. (Family planning does not include artificial ways to become pregnant.)	No PA required	

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Genetic testing	Covered if medically necessary.	PA required	Genetic Testing Payment Policy
Group adult foster care	Covered for services provided by group adult foster care providers in a group-supported housing environment for members who qualify.	PA required	
Hearing aids	Covered if medically necessary. Includes ear mold, ear impressions, and loan of a hearing aid if necessary.	PA required for monaural (one ear) more than $500 or binaural (two ears) more than $1,000 No PA required for accessories, maintenance, and servicing	Audiology Professional Payment Policy MNG: Hearing Aids
Home care/ Homemaker services	Covered for services provided in the home or community for members who qualify.	PA required	
Home health care services	Covered if medically necessary.	PA required for daily skilled nursing/therapy visits or requests greater than 6 months	Home Health Care Services Payment Policy MNG: Home Health Care Services for Tufts Health Together, Tufts Health RITogether, and Unify
Home infusion therapy	Covered if medically necessary.	PA required for some drugs	
Home modifications	Covered for members who qualify.	PA required	
Hospice care	Covered.	PA required	Hospice Payment Policy

SERVICE	COVERAGE/LIMITS/CONDITIONS	PA REQUIREMENTS	RELATED PAYMENT POLICY AND/OR MEDICAL NECESSITY GUIDELINES (IF AVAILABLE)
Inpatient hospitalization	Covered if medically necessary.	Elective admissions must be reported no later than five business days prior to admission, urgent or emergency within one business day Specific services may require PA	Diagnosis Related Group (DRG) Inpatient Facility Payment Policy
Long-term services and supports (LTSS)	May be covered after review by the ICT coordinator. See specific LTSS service for additional details.	PA required for specific services	
Maternity care/Prenatal and postpartum services	Covered. Providers must submit a Prenatal Registration Form .	No PA required	Newborn Payment Policy
Medical services outside the U.S. or its territories	Not covered.	N/A	
Medication management	Covered for services from a support worker for members who qualify.	PA required	
Nurse midwife services	Covered.	No PA required	
Nurse practitioner services	Covered if contracted as a Primary Care Provider or part of a contracted practice.	No PA required	Nurse Practitioner as Primary Care Provider and Specialist Payment Policy
Nutritional counseling/therapy	Covered for nutritional diagnostic therapy and counseling services to help manage a medical condition.	No PA required	Nutritional Counseling Professional Payment Policy
Nutritional supplements	Covered if medically necessary.	PA required	MNG: Enteral Nutrition Products for Adults and Children
Organ/Bone marrow transplants	Covered if medically necessary.	PA required	Transplant Facility Payment Policy

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SERVICE	COVERAGE/LIMITS/CONDITIONS	PA REQUIREMENTS	RELATED PAYMENT POLICY AND/OR MEDICAL NECESSITY GUIDELINES (IF AVAILABLE)
Orthotics	Covered if medically necessary. Includes braces and other mechanical or molded devices to support or correct the form or function of the human body.	Specific services require PA, refer to the Provider Resource Center	Orthotic Services Payment Policy
Outpatient hospital services	Covered if medically necessary.	PA required for specific services	Outpatient Facility Payment Policy
Outpatient therapy — physical, occupational, speech	Covered if medically necessary. Includes individual treatment (orthotics, prosthetics, assistive technology devices), comprehensive evaluation, and group therapy.	PT/OT: PA required after initial evaluation and 11 visits ST: PA required after 30 visits	Outpatient Therapy Services Payment Policy MNG: Outpatient Physical Therapy, Occupational Therapy and speech Therapy
Over-the-counter (OTC) drugs	Select OTC drugs are covered if requested with a prescription written by a physician. Must be obtained at a participating pharmacy.	See the MassHealth Over-the-Counter Drug List	
Oxygen and respiratory therapy equipment	Covered if medically necessary. Includes oxygen systems, refills, and oxygen therapy equipment rental.	PA required	Durable Medical Equipment and Medical Supplies Payment Policy MNG: Oxygen and Respiratory Therapy Equipment
Pain management	Covered if medically necessary.	No PA required	
Peer support/Counseling/ Navigation	Covered.	PA required	
Personal assistance services	Covered. Includes cueing and monitoring.	PA required	

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Personal care attendant (PCA)	Covered for services to assist with activities of daily living and instrumental activities of daily living for members who qualify.	PA required	
Pharmacy	Get more information about our *Tufts Health Unify* pharmacy program or see our *List of Covered Drugs*.	Certain drugs require PA	
Physician services	Covered, including PCP and specialty services.	Specific services may require PA, refer to the Provider Resource Center	Professional Services and Facilities Payment Policy Specialty Services Payment Policy
Podiatry	Covered for medical conditions. Includes medical, radiological, surgical, and laboratory care. Includes routine foot care for diabetics and other conditions that compromise the foot.	PA required	Podiatry Services Payment Policy
Preventive health care services	Covered.	PA required for specific services	
Private duty nursing/ Continuous skilled nursing/ Independent nursing	Covered if medically necessary.	PA required	
Prosthetic services and devices	Covered for evaluation, fabrication, and fitting of prosthesis. Includes related supplies, repair, and replacement.	PA required for items and repairs costing over $1,000 PA may be required for certain services, refer to the Provider Resource Center	Prosthetic Services Payment Policy

SERVICE	COVERAGE/LIMITS/CONDITIONS	PA REQUIREMENTS	RELATED PAYMENT POLICY AND/OR MEDICAL NECESSITY GUIDELINES (IF AVAILABLE)
Pulmonary rehabilitation	Covered if medically necessary.	No PA required	
Radiation therapy	Covered if medically necessary.	PA required for Proton Beam Therapy and Stereotactic Body Radiotherapy	MNG: Proton Beam Therapy (PBT) MNG: Stereotactic Radiosurgery and Stereotactic Body Radiotherapy
Radiology/X-rays	Covered if medically necessary.	Advanced imaging services (MRI, MRA, CAT, nuclear cardiology, PET) require PA through NIA	Radiology Imaging Services Payment Policy
Skilled nursing facility	Covered if medically necessary.	PA required	Skilled Nursing Facility Payment Policy MNG: Level of Care, Inpatient (Medical/Surgical)
Tobacco cessation	Covered for individual and group tobacco-cessation counseling. Includes specific medication obtained from a pharmacy and nicotine replacement therapy.	No PA required	
Transgender surgery	Covered if medically necessary.	PA required	
Transportation, emergency	Covered if medically necessary. Includes land and air. Includes specialty care transport between facilities.	No PA required	Ambulance and Transportation Services Payment Policy
Transportation, nonemergency	Covered.	No PA required	Ambulance and Transportation Services Payment Policy
Urgent care	Covered for medically necessary IN and OON services provided within the U.S. or its territories.	No PA required	

SERVICE	COVERAGE/LIMITS/CONDITIONS	PA REQUIREMENTS	RELATED PAYMENT POLICY AND/OR MEDICAL NECESSITY GUIDELINES (IF AVAILABLE)
Vaccines/immunizations	Covered if medically necessary. Vaccine administration covered. Not covered if required for traveling outside the U.S.	No PA required	Vaccine and Immunization Services Payment Policy
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.	PA required for eyewear	Vision Services Payment Policy