TUFTS Health Plan

a Point32Health company

MEDICAL BENEFIT SUMMARY GRID:
***TUFTS HEALTH UNIFY* (Medicare-Medicaid One Care for people ages 21 – 64)**
Benefit Year: January 1, 2022 – December 31, 2022

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
Abortion (Pregnancy termination services)	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
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
Ambulatory surgery/ Outpatient surgery/ Surgical day care/ Same-day surgery	Covered if medically necessary.	PA required for certain surgical services
Audiologist services	Exams and evaluations covered if medically necessary.	No PA required
Cardiac rehabilitation	Covered if medically necessary.	No PA required
Care management	Covered when provided by Cityblock Health care managers.	No PA required
Care transitions assistance	Covered for services to help with transitions between care settings for members who qualify.	No PA required
Chemotherapy	Covered if medically necessary.	No PA required

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Chiropractic services	Covered if medically necessary for manipulative treatment, office visits, radiology services, or any combination of these services.	No PA required
Chore services	Covered. Includes activities that assist members to maintain their homes and/or to correct or prevent environmental defects that may be hazardous to a member's health and safety.	PA required
Community health center services	Covered.	No PA required
Community health workers (CHWs)	Covered. Includes health education in the home or community, counseling, support and screenings.	No PA required
Companion services	Covered. Includes services that allow healthy individuals to remain at home by providing assistance. The plan covers services related to socialization, assistance with preparation of light snacks, help with shopping and errands and escort to medical appointments, nutrition sites and walks.	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
Dental, non-emergency	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
Diagnostic testing	Covered if medically necessary. Includes labs, EKGs, EEGs, PFTs, ultrasounds, and sleep studies.	PA required for specific services

SERVICE	COVERAGE/LIMITS/CONDITIONS	PA REQUIREMENTS
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
Durable medical equipment (DME)	Covered if medically necessary.	PA may be required for certain items or services, refer to the Provider Resource Center
DME training in usage, repair, and modification	Covered.	No 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
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
Genetic testing	Covered if medically necessary.	PA required
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. Completely-in-Canal (CIC) hearing aids are **not** covered.	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
Home care/ Homemaker services	Covered for services provided in the home or community for members who qualify.	PA required
Home delivered meals	Covered. Services include preparing, packaging, and delivering meals to member homes.	PA required
Home health care services	Covered if medically necessary.	PA required for daily skilled nursing/therapy visits or requests greater than 6 months

SERVICE	COVERAGE/LIMITS/CONDITIONS	PA REQUIREMENTS
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
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
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
Medical services outside the U.S. or its territories	Not covered.	N/A
Medication management	Covered for services from a support worker, such as a caregiver or personal care attendant (PCA) for members who qualify. Services include help taking medication, observing, reminders, reading labels and answering questions.	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
Nutritional counseling/therapy	Covered for nutritional diagnostic therapy and counseling services to help manage a medical condition.	No PA required
Nutritional supplements	Covered if medically necessary.	PA required
Organ/Bone marrow transplants	Covered if medically necessary.	PA required
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
Outpatient hospital services	Covered if medically necessary.	PA required for specific services
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

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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
Pain management	Covered if medically necessary.	No PA required
Peer support/Counseling/ Navigation	Covered.	No PA required
Personal assistance services	Covered. Includes cueing and monitoring.	PA required
Personal care attendant (PCA)	Covered for services to assist with activities of daily living and instrumental activities of daily living for members who qualify. May also include Personal Assistance Services, such as cueing and monitoring.	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
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.	No PA required
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 may be required for certain services, refer to the Provider Resource Center
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
Radiology/X-rays	Covered if medically necessary.	Advanced imaging services (MRI, MRA, CAT, nuclear cardiology, PET) require PA through NIA
Skilled nursing facility	Covered if medically necessary.	PA required
Tobacco cessation	Covered for individual and group tobacco-cessation counseling. Includes	No PA required

SERVICE	COVERAGE/LIMITS/CONDITIONS	PA REQUIREMENTS
	specific medication obtained from a pharmacy and nicotine replacement therapy.	
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
Transportation, non-emergency	Covered if medically necessary.	No PA required
Transportation, non-medical	Covered for transportation to community services and activities that help member's stay independent and active in the community. Non-medical transportation is covered for trips to recovery meetings and trips to obtain food resources, such as the grocery store and food bank. For all other destinations, non-medical transportation is covered only if it is determined that it is necessary for the member's health goals, aligned and listed in their Individualized Personal Care Plan, and approved in advance. These trips need to be requested 48 hours in advance. For more information, the member should contact their Care Coordinator.	No PA required
Urgent care	Covered for medically necessary IN and OON services provided within the U.S. or its territories.	No PA required
Vaccines/immunizations	Covered if medically necessary. Vaccine administration covered. Not covered if required for traveling outside the U.S.	No PA required
Vision Care	Covered for routine eye examinations from participating providers once per benefit year. Covered for one pair of eyeglasses or contact lenses every 2 years. The routine vision benefit is administered through EyeMed Vision Care. For more information refer to the EyeMed Vision Care website or call 888.581.3648. Ophthalmologists and optometrists may provide nonroutine medical eye services to members, according to their health services agreement.	No PA required for routine services PA may be required for certain nonroutine medical eye services