2018

Tufts Health Direct

Member Handbook

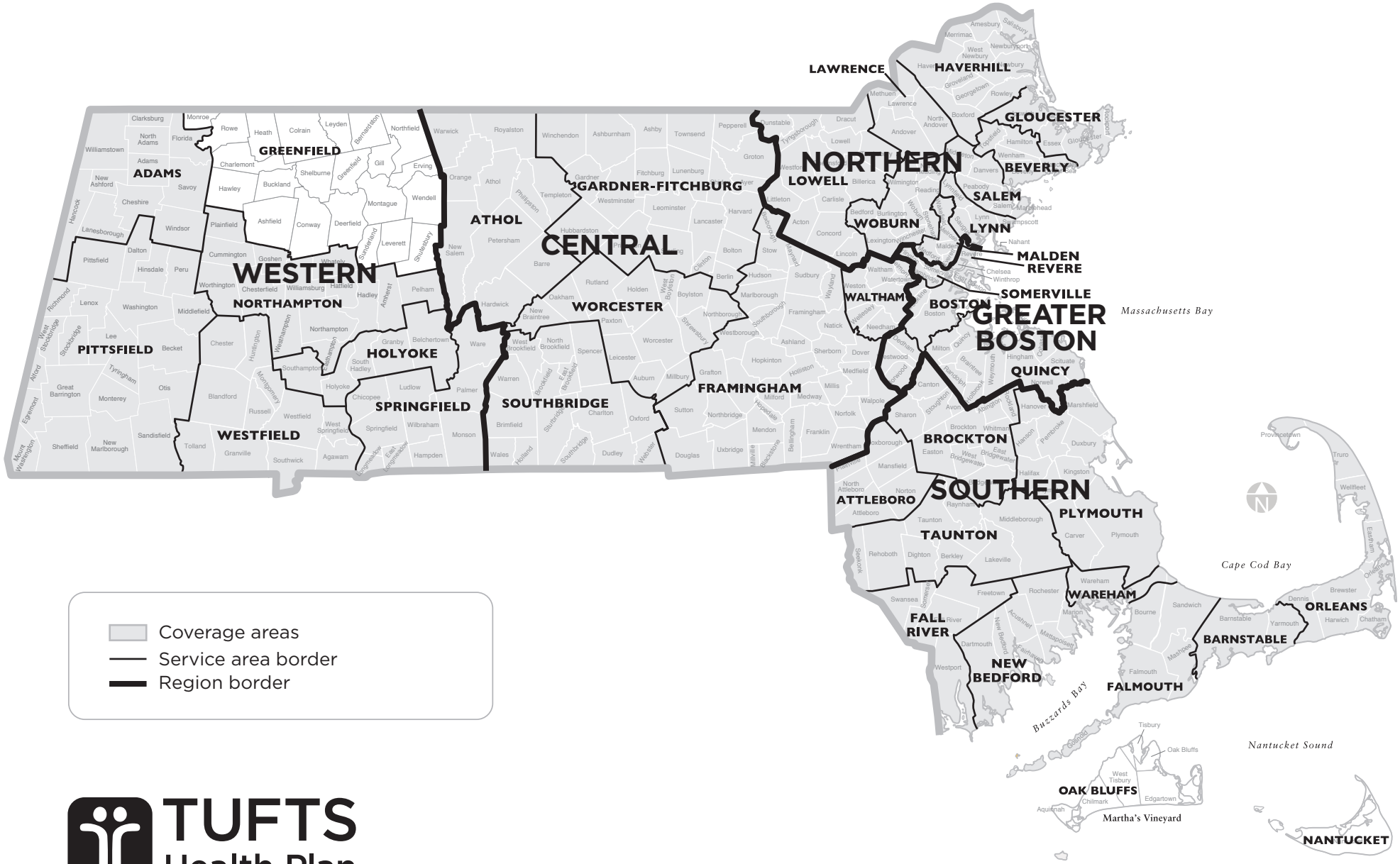
This health plan meets **Minimum Creditable Coverage standards** and will satisfy the individual mandate that you have health insurance. Please see page 5 for additional information.

Effective Date: January 1, 2018
Issue Date: January 1, 2018

TUFTS Health Plan

HEALTH PLAN NCQA ACCREDITATION ACCREDITED

Tufts Health Direct Coverage Area



TUFTS Health Plan

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Welcome!

This handbook is full of information about how your health plan works. If you want to know how to get care when you need it, what services are covered or who to talk to when you have a question, you'll find the answers here.

This page includes important information to keep handy.

Contact us:

888.257.1985, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays
TTY: 888.391.5535 (for people with partial or total hearing loss)
Web: tuftshealthplan.com
Mail: Tufts Health Plan, P.O. Box 9194, Watertown, MA 02471-9194

We have bilingual staff available and we offer translation services in 200 languages. All translation services are free to members.

Call us:

- **If you move or change your phone number**
  Don't risk losing your health benefits because we can't find you. If you move, you must call the Health Connector and us to tell us your new address and phone number. You should also put the last names of all *Tufts Health Direct* Members in your household on your mailbox. The post office may not deliver mail from the Health Connector or us to someone whose name is not listed on the mailbox.

  If you move, call the Health Connector's customer service center at 877.623.6765 (TTY: 877.623.7773), Monday through Friday, from 8 a.m. to 6 p.m., and Tufts Health Plan at **888.257.1985**, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays, to update your contact information.

  Also, tell the Health Connector about any changes in your income, family size, employment status or disability status; if you become pregnant; or if you have additional health insurance.
- **To find out if other household members are eligible for an affordable health plan**
  If other people in your home may be eligible for an affordable health plan, we can help! Call us at **888.257.1985**. They can also call the Health Connector's customer service center at 877.623.6765 (TTY: 877.623.7773), Monday through Friday, from 8 a.m. to 6 p.m.
- **If you want to change your Primary Care Provider (PCP)**
  You can switch your PCP for any reason by calling us at **888.257.1985** or by visiting us at tuftshealthplan.com.

IN AN EMERGENCY, GET CARE RIGHT AWAY:

Take immediate action if you believe that you are in a life-threatening Emergency situation.

- For medical or Behavioral Health (mental health and/or substance abuse) Emergencies, call 911 or go to the nearest Emergency room right away. For Behavioral Health Emergencies, you may also call the local Emergency Services Program (ESP) Provider in your area. Please call us at **888.257.1985** or visit us at tuftshealthplan.com for a complete list of emergency rooms and ESPs in Massachusetts, or call the statewide ESP directory at 877.382.1609 to find the closest ESP provider to you. You can also find this list in our online Provider Directory using our Find a Doctor, Hospital or Pharmacy tool, or call us at **888.257.1985** to ask for a copy of Provider information.
- Bring your *Tufts Health Direct* Member ID Card with you.
- Tell your PCP and if applicable, your Behavioral Health Provider within 48 hours of an Emergency to get any necessary follow-up care.

You don't need Prior Authorization for any Emergency care, including ambulance transportation.

IN AN URGENT CARE SITUATION, CALL YOUR PCP OR BEHAVIORAL HEALTH (MENTAL HEALTH AND/OR SUBSTANCE USE) PROVIDER:

If you need Urgent Care for a problem that is serious but does not put your life in danger or

risk permanent damage to your health, call your PCP or Behavioral Health Provider. Your PCP or Behavioral Health Provider can usually address these health problems.

You can contact any of your Providers' offices 24 hours a Day, seven Days a week.

Make an appointment if your Provider asks you to come in. If you request an Urgent Care appointment, your Provider must see you within 48 hours.

You may also visit an In-network Urgent Care Center (UCC) for your Urgent Care needs. For more information, see page 10.

Member Services hours:

If you want to talk to a Member Services representative who can answer your questions, call us at **888.257.1985**, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays.

24/7 NurseLine:

For general health information and support, call our 24/7 NurseLine at 888-MY-RN-LINE (888.697.6546) (TTY: 800.942.1859), 24 hours a Day, seven Days a week.

Visit us on the web!

Visit us at tuftshealthplan.com to:

- Find a PCP, Specialist, or health center near you in our *Tufts Health Direct* Network
- Find a Behavioral Health Provider near you in our *Tufts Health Direct* Network
- Sign up for *Tufts Health Member Connect*, and:
  - Change your address or phone number
  - Choose or change your PCP
  - Use the secure messaging center to send us information and questions
  - Get answers to your questions
- Download the forms to get your *Tufts Health Direct* EXTRAS
- Get important information, such as:
  - How we make sure you get the best care possible (Quality Management and Improvement Program)
  - How we make sure you get the right care in the right place (Utilization Management Program). Note: We never reward our staff for denying care.
  - How we use information your Providers give us to decide what services you need to make you better or keep you healthy (Utilization Review)
  - How you can file a Grievance or an Appeal
  - How you have the right to request an External Review if we deny an Appeal, as well as your other rights and responsibilities
  - How we may collect, use, protect, and release information about you and your health (your Protected Health Information) according to our privacy policy
- Learn much more!

A great health plan at a great price

Keep this handbook — it has all the information you need to make the most of your membership.

If you have any questions, please call us at **888.257.1985**. Members with partial or total hearing loss should call our TTY line at 888.391.5535 for assistance.

For no-cost translation in English, call **888.257.1985**.

Arabic للحصول على خدمة الترجمة المجانية باللغة العربية، يرجى الاتصال على الرقم 888-257-1985

Chinese 若需免費的中文版本，請撥打**888.257.1985**。

French Pour demander une traduction gratuite en français, composez le **888.257.1985**.

German Um eine kostenlose deutsche Übersetzung zu erhalten, rufen Sie bitte die folgende Telefonnummer an: **888.257.1985**.

Greek Για δωρεάν μετάφραση στα ελληνικά, καλέστε στο **888.257.1985**.

Haitian Creole Pou tradiksyon gratis nan Kreyòl Ayisyen, rele **888.257.1985**.

Italian Per la traduzione in italiano senza costi aggiuntivi, è possibile chiamare il numero **888.257.1985**.

Japanese 日本語の無料翻訳については **888.257.1985**に電話してください。

Khmer (Cambodian) **សម្រាប់សេវាបកប្រែដោយឥតគិតថ្លៃជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ**

888.257.1985។

Korean 한국어로 무료 통역을 원하시면, **888.257.1985**로 전화하십시오.

Laotian ສໍາລັບການແປພາສາເປັນພາສາລາວທີ່ບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີ **888.257.1985**.

Navajo Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **888.257.1985**.

Persian **برای ترجمه رایگان به فارسی به شماره تلفن 888.257.1985 زنگ بزنید.**

Polish Aby uzyskać bezpłatne tłumaczenie w języku polskim, należy zadzwonić na numer **888.257.1985**.

Portuguese Para tradução grátis para português, ligue para o número **888.257.1985**.

Russian Для получения услуг бесплатного перевода на русский язык позвоните по номеру **888.257.1985**.

Spanish Para servicio de traducción gratuito en español, llame al **888.257.1985**.

Tagalog Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **888.257.1985**.

Vietnamese Để có bản dịch tiếng Việt không phải trả phí, gọi theo số **888.257.1985**.

DISCRIMINATION IS AGAINST THE LAW

Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Tufts Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Tufts Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  — Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  — Qualified interpreters
  — Information written in other languages

If you need these services, contact Tufts Health Plan at 888.257.1985.

If you believe that Tufts Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Tufts Health Plan
Attention: Civil Rights Coordinator, Legal Dept.
705 Mount Auburn St.
Watertown, MA 02472
Phone: 888.880.8699 ext. 48000, (TTY 711 or 800.439.2370)
Fax: 617.972.9048
Email: OCRCoordinator@tufts-health.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Tufts Health Plan Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone: 800.368.1019, (TTY 800.537.7697)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Table of contents

Welcome

You deserve great care. We want you to get the most out of your *Tufts Health Direct* membership.

To bring you the best value in health care, we work with a high-quality Network of doctors, Hospitals and other Providers across Massachusetts. We serve *Tufts Health Direct* Members in all or parts of the following counties: Barnstable, Berkshire, Bristol, Essex, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk and Worcester. For a complete listing of our Providers or to see a map of our Service Area, please visit tuftshealthplan.com.

To help you understand what you need to know about your health plan, we have capitalized important words and terms throughout this *Member Handbook*. You can find definitions for each in the Glossary starting on page 55.

This plan is offered by Tufts Health Public Plans, Inc. Tufts Health Public Plans, Inc. is licensed as a health maintenance organization in Massachusetts but does business under the name Tufts Health Plan.

Translation and other formats

Call us at **888.257.1985**, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays, if you:

- Have questions
- Need this document orally translated
- Need someone to read this or other printed information to you
- Want to learn more about any of our benefits or Covered Services

We have bilingual staff available. And we offer translation services in 200 languages. All translation services are free to Members.

Your *Tufts Health Direct* Evidence of Coverage

This *Member Handbook*, including the "Benefit and Cost-sharing Summary" for each Plan Level at the end of this handbook, your *Preferred Drug List*, and any amendments we may send you, make up your Evidence of Coverage.

These documents are a contract between you and Tufts Health Plan. By signing and completing an enrollment application, and by choosing *Tufts Health Direct* as your health plan, you applied for coverage from Tufts Health Plan. You also agreed to all the terms and conditions of *Tufts Health Direct* that we set forth, and to the terms and conditions in this handbook.

This handbook explains your rights, benefits and responsibilities as a *Tufts Health Direct* Member.

It also explains our responsibilities to you. If there are any major plan changes, we'll mail you a letter 60 days before the changes go into effect.

Only an approved officer of Tufts Health Plan can change this *Member Handbook* and only in writing. No other actions, including any exceptions we make on a case-by-case basis, change this *Member Handbook*.

Minimum creditable coverage and mandatory health insurance requirement

Massachusetts law requires that Massachusetts residents, 18 years old and older, must have health coverage that meets the minimum creditable coverage standards that the Health Connector sets, unless waived by the Health Connector for affordability or individual hardship. For more information, call the Health Connector at 877.623.6765 (TTY:877.623.7773) or visit the Health Connector's website at MAhealthconnector.org.

This health plan meets minimum creditable coverage standards as part of the Massachusetts health care reform law and minimum essential coverage standards under the federal Affordable Care Act. If you enroll in this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS. BECAUSE THESE STANDARDS MAY CHANGE,

REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

Cost sharing

Premiums

Individuals and groups may have to pay a Premium for *Tufts Health Direct* coverage. A Premium is a monthly bill you pay for your *Tufts Health Direct* benefits. If you are part of a group, you pay your employer, who pays your Premium. You must send your Premium by the due date stated on the bill every month for your health benefits to continue. Please follow the payment directions on your bill when paying your Premiums.

If you have questions about your Premium, please call the number listed on your bill. Please note, we will send an annual notice with the Premium that must be paid.

If an individual or group is late (delinquent) in paying required Premiums, we, at our sole discretion, may stop payment of Claims and/or Prior Authorization of services until we get the full Premium payment.

Federal Premium Tax Credit and ConnectorCare plans

You might be eligible for a Federal Premium Tax Credit if your household income is up to 400% of the Federal Poverty Level (FPL). The Department of Health and Human Services sets the FPL. If you are eligible for a tax credit, then the United States government will pay part of your *Tufts Health Direct* Premiums directly to Tufts Health Plan, or alternatively, you can claim the credit when you file your tax return for the year.

You might also be eligible for a lower-cost ConnectorCare plan if your household income is up to 300% of the FPL. If you are eligible, the state of Massachusetts will pay part of your *Tufts Health Direct* Premiums directly to Tufts Health Plan. This would be in addition to any tax credits you might qualify for, further decreasing your share of the Premium cost. Under ConnectorCare plans, members also receive subsidized cost sharing (Co-payment, Deductible, and/or Co-insurance) because the federal and state governments pay some or all of the member responsibility amount through Cost-sharing Reduction (CSR) payments to Tufts Health Plan. In the event these CSR payments are reduced or terminated, Tufts Health Plan reserves the right to increase the premium for some or all Tufts Health Direct plans mid-benefit year.

The Health Connector can help you find out if you are eligible for a ConnectorCare plan and/or Federal Premium Tax Credit and, if so, how much.

Co-payments

Co-payments are set dollar amounts that are due when you get care or a service, or when billed by a Provider. You're responsible for paying all of the Co-payments listed in your Plan Level's "Benefit and Cost-sharing Summary" starting on page 61. Preventive services don't have any Co-payments. But you will need to pay a Co-payment for most Covered Services, such as doctors' visits, pharmacy services, advanced imaging (MRIs, PET, CT scans), emergency room visits and care you get in the Hospital. If you don't pay the Co-payment at the time of your visit, you'll still owe the money to the Provider. The Provider may use a legal method to collect the money from you. We are not responsible for paying the Provider the Co-payment that you owe.

American Indians and Alaskan Natives do not need to pay Co-payments or Co-insurance for services received through the Indian Health Service. American Indians and Alaskan Natives who make less than 300% of the FPL never pay Co-payments and Co-insurance regardless of where a service is received.

Deductibles

Your *Tufts Health Direct* plan may have an annual Deductible. The Deductible is the amount you pay for certain Covered Services in a Benefit Year before we will begin to pay for those Covered Services. Your "Benefit and Cost-sharing Summary" will show if you have any Deductible amounts. You may have a medical Deductible and a separate pharmacy Deductible. Once you meet your annual Deductible, you may still have to pay Co-payments and Co-insurance. Please see your

"Benefit and Cost-sharing Summary" for information specific to your Plan Level.

- Individual Deductible: the amount an individual Member pays each year for certain Covered Services before we as your health plan begin to pay for those services
- Family Deductible:
  - The family Deductible applies to all members of a family.
  - Any amount a family Member pays is applied to the family Deductible.
  - Once the family Deductible has been met during a Benefit Year, all Members in a family will have met their Deductibles for the rest of that Benefit Year.
  - Note: The family Deductible is embedded, meaning the individual Deductible still applies to members of the family. Once the family meets the family Deductible, then the entire family is considered to have met the Deductible.

Not all services apply toward a Deductible. There are services that require a Co-payment and/or Co-insurance, those with no charge and those that are subject to a Deductible.

Notes:
The following are not included in the Deductible:

- Co-payments, Co-insurance, Premiums and any payments you make for noncovered services
- Payments you made for Covered Services you got before the start of a Benefit Year are not counted toward your Deductible in the current Benefit Year.
  At the start of each new Benefit Year, your Deductible accumulation will begin at zero, and you will start building again toward your Deductible for the new Benefit Year.
- The amount credited toward a Member's Deductible is based on our allowed amount on the date of service.

Co-insurance

Co-insurance is a set percentage of the total allowed amount that you must pay for certain Covered Services. After you have met any Deductible you may have, you will be responsible for that set percentage. We will be responsible for the rest of the cost. You may be required to pay the Co-insurance on the date of service. If your Plan Level requires Co-insurance, the Co-insurance percentages are listed in your "Benefit and Cost-sharing Summary."

Note: Co-insurance you paid for Covered Services you got before the start of a Benefit Year is not counted toward your Out-of-pocket Maximum for your current Benefit Year. At the start of each new Benefit Year, your accumulation will begin at zero and you will start building again to your annual Out-of-pocket Maximum for the new Benefit Year.

Out-of-pocket Maximum

Your *Tufts Health Direct* plan has an Out-of-pocket Maximum. This is the maximum amount of cost sharing you have to pay in a Benefit Year for Covered Services.

The Out-of-pocket Maximum is made up of Deductibles, Co-payments and Co-insurance.

However, it does not include:

- Premiums
- Any amount you pay to an Out-of-network Provider in excess of the allowed amount for Covered Services paid by the plan to that Out-of-network Provider
- Costs for noncovered services

Once you meet your Out-of-pocket Maximum, you no longer pay Deductibles, Co-payments or Co-insurance for the rest of that Benefit Year.

- Individual Out-of-pocket Maximum: the maximum amount of cost sharing an individual has to pay in a Benefit Year for Covered Services
- Family Out-of-pocket Maximum:
  - Any amount a family Member pays is applied toward the family Out-of-pocket Maximum.
  - Once the family Out-of-pocket Maximum has been met during a Benefit Year, all Members in a family will have met their Out-of-pocket Maximum for the rest of that Benefit Year.
  - Note: The family Out-of-pocket Maximum is embedded, meaning the individual Out-of-pocket Maximum still applies to members of the family. Once the family meets the family Out-of-pocket Maximum, then the entire family is considered to have met the Out-of-pocket Maximum.

Note: Deductibles, Co-payments and Co-insurance you paid before the start of a Benefit Year are not counted toward your Out-of-pocket Maximum for your current Benefit Year. At the start of each new Benefit Year, your accumulation will begin at zero and you will start building again toward your annual Out-of-pocket Maximum for the new Benefit Year.

Benefit Year

The Benefit Year is the consecutive 12-month period during which:

- Health plan benefits are purchased and administered.
- Deductibles, Co-payments, Co-insurance and Out-of-pocket Maximums are calculated.
- Most benefit limits apply.

Note: In some cases, described in the following paragraphs, your first Benefit Year will not be a full 12 months.

For individual Subscribers:

- If you enrolled during an annual open enrollment period, your Benefit Year begins on your Effective Coverage Date and continues until December 31.
- If you enrolled (due to a qualifying event) at any other time of the year, your first Benefit Year begins on your Effective Coverage Date and continues until December 31. (This means your first Benefit Year is not a full 12 months.) See page 18 for more information.

For Subscribers enrolled through a group contract: Your Benefit Year begins on the group effective date (always the first of a calendar month) and continues for 12 months from that date. (For example, if the group effective date is April 1, your Benefit Year runs from April 1 to March 31.)

If you are a new employee who became a Subscriber after the group effective date, your Benefit Year ends the same date the Benefit Year ends for all Subscribers in your group. That means that your first Benefit Year will not be a full 12 months.

For new Dependents who are added during a Benefit Year (for example, a new baby or new spouse): The new Dependent's Benefit Year begins on his or her Effective Coverage Date and ends the same date the Subscriber's Benefit Year ends.

Getting the care you need

Your Member ID Card

Always carry your *Tufts Health Direct* Member ID Card with you. It has important information about you and your benefits that Providers and pharmacists need. Each person in your family with *Tufts Health Direct* will get a *Tufts Health Direct* Member ID Card.

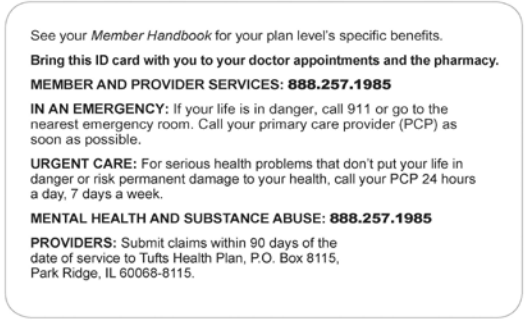

TUFTS Health Plan

Tufts Health Direct
A focused-network plan for individuals and small groups
Tufts Health Public Plans, Inc.

Member ID #: NXXXXXXXXXX
Member: SUSAN A SAMPLE
Cost sharing: OV: $XX/$XX
Preventive: $0
ER: $XXX
RX: $XX.XX/$X.XX/$X.XX
RX mail: $XX/$X.XX/$XX.XX
Plan level: CONNECTORCARE PLAN TYPE II
This space is for PCP Referral.

CVS/caremark customer service: 800.577.5339
RXBIN: 004336 RXPCN: ADV
RXGRP: RX1144

Member services:
888.257.1985 (TTY: 888.391.5535)
tuftshealthplan.com


See your *Member Handbook* for your plan level's specific benefits.

Bring this ID card with you to your doctor appointments and the pharmacy.

MEMBER AND PROVIDER SERVICES: 888.257.1985

IN AN EMERGENCY: If your life is in danger, call 911 or go to the nearest emergency room. Call your primary care provider (PCP) as soon as possible.

URGENT CARE: For serious health problems that don't put your life in danger or risk permanent damage to your health, call your PCP 24 hours a day, 7 days a week.

MENTAL HEALTH AND SUBSTANCE ABUSE: 888.257.1985

PROVIDERS: Submit claims within 90 days of the date of service to Tufts Health Plan, P.O. Box 8115, Park Ridge, IL 60068-8115.

Emergency care

For medical and Behavioral Health (mental health and/or substance use) Emergencies, call 911 or go to the nearest emergency room right away. Please call us at **888.257.1985** or use the Find a Doctor, Hospital, or Pharmacy tool at tuftshealthplan.com for a complete list of emergency rooms in Massachusetts.

Bring your *Tufts Health Direct* Member ID Card with you. You don't need approval from us or your Provider to get Emergency care. You are covered for Emergency care 24 hours a Day, seven Days a week, wherever you are, even when you're traveling. We also cover

emergency-related ambulance transportation. A Provider will examine and treat your Emergency health needs before sending you home or moving you to another Hospital, if necessary. Continued services with an Out-of-network Provider after the Emergency condition has been treated or stabilized may not be covered if we determine, in coordination with your Providers, that it is safe to transport you to a Network facility, and it is appropriate and cost-effective to transport you.

Tell us, your Primary Care Provider (PCP) and, if applicable, your Behavioral Health Provider what happened within 48 hours of an Emergency to get any needed follow-up care. If the emergency department where you were seen notifies us or your PCP, then you don't need to tell us.

Examples of medical Emergencies:

- Chest pain
- Bleeding that won't stop
- Broken bones
- Seizures or convulsions
- Dizziness or fainting
- Poisoning or drug overdose
- Serious accidents
- Sudden confusion
- Severe burns
- Severe headaches
- Shortness of breath
- Vomiting that won't stop

Examples of Behavioral Health (mental health and/or substance use) Emergencies:

- Violent feelings toward yourself or others
- Hallucinations

Urgent Care

Call your PCP or Behavioral Health Provider if you need Urgent Care. You can contact any of your Providers' offices 24 hours a Day, seven Days a week. Provider offices have covering Providers who work after hours. A covering Provider is a Provider who can help you when your regular Provider is not available.

If needed, make an appointment to visit your Provider. Your Provider must see you within 48 hours for Urgent Care appointments. If your condition becomes an Emergency before your PCP or Behavioral Health Provider sees you, call 911 or go to the nearest emergency room.

In some areas, there are Urgent Care centers (UCC) you may go to that are *Tufts Health Direct* Providers. When going to a UCC, you should also try to contact your PCP. You must visit a UCC in our Network to be covered for services. To find UCCs in our Provider Network, go to tuftshealthplan.com and use our Find a Doctor, Hospital, or Pharmacy tool. If you obtain services at an out-of-network UCC or at a UCC in an out-of-network hospital, you will not be covered. Note: Emergency services are covered at both Network and out-of-network hospitals.

Getting Hospital services

If you need Hospital services for something that isn't an Emergency, please ask your Provider to help you get these services. If you need Hospital services for an Emergency, don't wait. Call 911 or go to the nearest emergency room right away.

Getting care after office hours

Talk to your PCP to find out how to get care after normal business hours. Some PCPs have longer office hours. If you need Urgent Care after regular business hours, call your PCP's office. PCPs have covering Providers who work after hours. A covering Provider is a Provider who can help you when your PCP is not available. If you have any problems seeing your PCP or any other Provider, please call us at **888.257.1985**.

You can also get free health support from our 24/7 NurseLine to help you stay healthy 24 hours a Day, seven Days a week. Call 888-MY-RN-LINE (888.697.6546) (TTY: 800.942.1859) anytime. You can get help in many languages. The 24/7 NurseLine staff do not give medical advice and do not replace your PCP.

Getting care away from home (outside the Service Area)

If you're traveling and need Emergency care, go to the nearest emergency room. If you need

Urgent Care, call your PCP's office and follow your Provider's directions. For other routine health care issues, call your PCP. For routine behavioral health issues, call your Behavioral Health Provider. If you're outside of *Tufts Health Direct*'s Service Area, including out of the country, we'll only cover Emergency care and Urgent Care. Continued services after the Emergency or Urgent condition has been treated or stabilized may not be covered if we determine, in coordination with your providers, that it is safe to transport you back into the Service Area, and it is appropriate and cost-effective to transport you back into the Service Area.

We won't cover:

- Tests or treatment that your PCP asked for but that you decided to get outside of the Service Area
- Routine or follow-up care that can wait until you return to the Service Area, such as physical exams, flu shots, stitch removal and Behavioral Health (mental health and/or substance use) counseling
- Care that you knew you were going to get before you left the Service Area, such as elective surgery

When you get care outside of *Tufts Health Direct*'s Service Area, the Provider might ask you to pay for that care at the time of service.

If you're asked to pay for Emergency care or Urgent care that you get outside of our Service Area, you should show your *Tufts Health Direct* Member ID Card. The Provider shouldn't ask you to pay. If you do pay for any of these services, you may ask us to pay you back. You will be responsible for paying the applicable In-network cost share under your plan. A Member should call Tufts Health Plan within 48 hours after Emergency care is received. If you are admitted as an inpatient, you or someone acting for you must call your PCP or Tufts Health Plan within 48 hours. In addition to your in-network cost share, you may be responsible for any bill received from the Provider for amounts in excess of the Reasonable Charge paid by the health plan. You may call our Member Services Team at **888.257.1985** for help with any bills that you get from a Provider.

Your *Tufts Health Direct* Providers

Getting information about *Tufts Health Direct* Providers

For the most up-to-date information about Providers (doctors and other professionals who contract with us to provide health care), visit us at tuftshealthplan.com and use the Find a Doctor, Hospital, or Pharmacy tool to find a *Tufts Health Direct* In-network Provider. To request a hard copy of the Provider Directory, to request information from our online Provider Directory or to get information about a Provider, call our Member Services Team at **888.257.1985**.

Our online Find a Doctor, Hospital, or Pharmacy tool lists the following types of *Tufts Health Direct* Providers:

- Primary care sites
- Primary Care Providers (PCPs)
- Hospitals
- Specialty Providers
- Behavioral Health (mental health and/or substance use) Providers

In our online Provider Directory, you can find important information like a Provider's address, phone number, hours of operation, handicap accessibility and languages spoken.

Our online Provider Directory also lists all *Tufts Health Direct* pharmacies, facilities, ancillary Providers, hospital emergency services and Durable Medical Equipment suppliers. You can find this information at tuftshealthplan.com.

Your PCP

As a *Tufts Health Direct* Member, you must have a Primary Care Provider (PCP) who is in our *Tufts Health Direct* Network. Your PCP is the Provider you should call for any nonemergency health care that you need. You will get the same Medically Necessary Covered Services whether you choose a Nurse Practitioner, a Physician Assistant or a doctor as your PCP, as long as they are services the Provider is legally authorized to provide. To

choose a *Tufts Health Direct* PCP and to find out where the PCP's office is located, please use the Find a Doctor, Hospital or Pharmacy tool at tuftshealthplan.com or call us at **888.257.1985**.

You can call your PCP's office 24 hours a Day, seven Days a week. If your PCP is not available, your PCP's office will direct you to somebody else who can help you. If you have problems contacting your PCP, or if you have any questions, please call our Member Services Team at **888.257.1985**.

Here's what your PCP can do for you:

- Give you regular checkups and health screenings, including Behavioral Health (mental health and/or substance use) screenings
- Make sure you get the health care you need
- Arrange necessary tests, laboratory procedures or hospital visits
- Keep your medical records
- Recommend Specialists, when necessary
- Provide information on Covered Services that need Prior Authorization before you get treatment
- Write prescriptions, when necessary
- Help you get Behavioral Health (mental health and/or substance use) services, when necessary

PCP assignment

We'll choose a PCP for you near to where you live and tell you your PCP's name within 15 Days of becoming a new *Tufts Health Direct* Member. It is important that you have a PCP in order to take full advantage of all your benefits. If you do not wish to use the PCP that has been selected for you, you may choose a different PCP in the *Tufts Health Direct* Network by calling us at **888.257.1985** or visiting tuftshealthplan.com.

Specialists

Sometimes you may need to visit a Specialist, such as a cardiologist, dermatologist or ophthalmologist. *Tufts Health Direct* also covers pediatric specialty care, including mental health care, by In-network pediatric Specialists. You can visit most Specialists without Prior Authorization as long as the Specialist is In-network.

To find a *Tufts Health Direct* Specialist, talk to your PCP. You can also call us at **888.257.1985** or visit tuftshealthplan.com to search for a Specialist. You should discuss your need for a Specialist with your PCP first and then call the Specialist to make an appointment.

If the Specialist your PCP wants to send you to is a Non-preferred In-network Provider, your PCP will need to ask us for Prior Authorization before you see this Specialist. By using the Find a Doctor, Hospital or Pharmacy tool at tuftshealthplan.com, you can check to see which Providers need Prior Authorization, or call **888.257.1985** to get this information. Remember, if we don't receive a Prior Authorization request and give written approval for you to see a Non-preferred In-network Provider, we won't cover the services. If you still choose to get the services, you'll be responsible for payment.

If you choose to get services outside of our Network, we won't cover the services. If you still choose to get the services anyway, the Specialist will bill you, and you will be responsible for paying the full cost of the care.

For more information about which services need Prior Authorization, please see your Plan Level's "Benefit and Cost-sharing Summary" section in this *Member Handbook*.

Referrals for specialty services

Some *Tufts Health Direct* Members may need their PCP to give them a Referral for certain specialty services. A Referral is a notification from your PCP to us that you can get care from a different Provider. The Referral helps your PCP better guide the care and services you get from the Providers you see. These services may include:

- Professional services, like a visit to a Specialist
- Outpatient hospital visits
- Surgical day care
- Your first evaluation for:
  - Speech therapy
  - Occupational therapy
  - Physical therapy

If your PCP needs to give you a Referral for these services, your Member ID Card will say "PCP Referral Required."

Second opinions

Tufts Health Direct Members can get a second opinion from a different In-network Provider about a medical or behavioral health condition, or proposed treatment and care plan. You don't need Prior Authorization to get a second opinion from an In-network Provider about a medical or behavioral health issue or concern. Even if no second opinion is available in the Network, there is no benefit for a second opinion out of the Network. You can see the most up-to-date list of our In-network Providers at tuftshealthplan.com. Please call us at **888.257.1985** for help or for more information about picking a Provider to see for the second opinion.

Prior Authorization

Your Primary Care Provider (PCP) will work with your other Providers to make sure you get the care you need. For certain services, your PCP or Behavioral Health Provider will need to ask us for Prior Authorization before sending you to get those services. Please see your Plan Level's "Benefit and Cost-sharing Summary" section in this *Member Handbook* for the most up-to-date list of services that require Prior Authorization consistent with Tufts Health Plan's Medical Necessity Guidelines in effect at the time the services or supplies are provided. This information is also available to you at tuftshealthplan.com or by calling the Member Services Team.

Your PCP knows when and how to ask us for Prior Authorization if it is required. When your PCP asks, we'll decide if the service is Medically Necessary and if we have a qualified In-network Provider who can provide the service.

If the service is Medically Necessary and we don't have an In-network Provider who can treat your health condition, we may approve and cover services from an Out-of-network Provider for you. You will be responsible for any cost share as if they were In-network. Out-of-network Providers need Prior Authorization from us before you can see them, even if the service is not listed as requiring Prior Authorization. Please visit us at tuftshealthplan.com for the most up-to-date list of our In-network Providers. You are responsible for ensuring that Prior Authorization for out-of-network services has been obtained. If Prior Authorization is not granted before you see an Out-of-network provider, coverage will be denied, and you will be responsible for payment.

Your PCP or Behavioral Health Specialist must ask us for and get Prior Authorization before you can see an Out-of-network Provider under these circumstances. You may ask your PCP or Behavioral Health Specialist to ask for the Prior Authorization.

You may be authorized to see an Out-of-network Provider in the following circumstances:

- When a participating In-network Provider is unavailable because of location
- When a delay in seeing a participating In-network Provider, other than a Member-related delay, would result in interrupted access to Medically Necessary services
- If there isn't a participating In-network Provider with the qualifications and expertise that you need to get and stay better

Many services don't need Prior Authorization, including: Emergency health care, In-network Family-planning Services, the first 12 Behavioral Health (mental health only) outpatient therapy visits with an In-network Provider each Benefit Year, and some In-network specialty visits. Substance use outpatient therapy visits, Level III community-based detoxification and Level IV detoxification do not require Prior Authorization. You can get Emergency care services from any Emergency care Provider. You can get Family-planning Services and the first 12 outpatient Behavioral Health (mental health only) therapy visits from any *Tufts Health Direct* In-network Provider. You do not need Prior Authorization for care provided by an In-network obstetrician, gynecologist, certified nurse midwife or family practitioner for an annual preventive gynecologic health examination, any follow-up care, maternity care, or treatment for an acute or emergency gynecological condition. And you won't have higher Co-payments or have more cost sharing for getting these services without Prior Authorization.

When you need Prior Authorization for a Behavioral Health service, a Licensed Mental Health Professional will make the decision about whether the service is Medically Necessary. We will not apply treatment

limitations or cost sharing to Behavioral Health services that we do not apply to medical services.

If you become a Tufts Health Plan Member by changing from another health plan, and a Provider who does not contract with us is treating you, we'll review that treatment and may let that Provider keep treating you. For more information, please see the "Continuity of Care" section on page 15. Remember, you must get Prior Authorization from us to see that Out-of-network Provider during and after the transition period.

Standard Prior Authorizations

We'll make an initial decision about a Prior Authorization within two business days of getting all necessary information. "Necessary information" includes, but is not limited to, the results of any face-to-face clinical evaluation, consults, second opinion, labs, and imaging and/or previous therapies. We'll let your Provider requesting the service know within 24 hours of our decision. We'll let you know in writing within one business day if we deny the Authorization request and within two business days if we approve Authorization.

Remember: If we don't approve you seeing a Provider or having a procedure that requires Prior Authorization, we won't pay for those visits or services.

Concurrent review

When you are a Hospital patient or are getting treatment for a condition that requires Authorization, we will review your situation to ensure that the right care is given in the right place. This is called a concurrent review. We make concurrent review decisions within one business day of getting all the necessary information from your Provider. "Necessary information" includes, but is not limited to, the results of any face-to-face clinical evaluation, consults, second opinion, labs, and imaging and/or previous therapies.

The Hospital or your Provider must notify us of an Emergency admission within 24 hours. If we approve a longer stay or extra services, we'll let the Hospital or your Provider know within one business day of receiving all necessary information. And we'll mail to you and fax to your Provider a confirmation within one business day after that.

The notification will include:

- The number of extended Days or the next review date
- The new total number of Days or services we've approved
- The date of admission or start of services

If we deny a longer stay or more services, we'll let your Provider know within one business day. And we'll mail you and fax your Provider confirmation of this Adverse Determination within one business day. You can keep getting the service at no cost to you until we notify you of our concurrent review decision.

You or your Provider may Appeal the decision before you are discharged. For information on the Expedited Internal Appeal process, please see page 46.

Prior Authorization approvals and denials

If we approve coverage for a service, we will clearly tell you and your Provider, if you identify one, which services we agree to cover. The Provider providing the service must have an Authorization letter from us before giving you care in order to be reimbursed. If you need more care than we approved, your Provider will ask us to approve more services. If we approve the request for more services, we'll send you and your Provider an Authorization letter.

If we don't approve any of the services requested, we'll send you, your Provider and your Authorized Representative a denial or Adverse Determination letter. We'll also send a notice if we decide to reduce, delay or stop covering services that we have previously approved.

The Adverse Determination letter we send will include a clinical explanation for our decision and will:

- Identify specific information we used
- Discuss your symptoms or condition, diagnosis, and the specific reasons why the evidence your Provider sent us fails to meet the relevant medical review criteria
- Specify alternate treatment options that we cover, if appropriate

- Reference and include applicable clinical practice guidelines and review criteria
- Tell you how to ask for an Appeal, including an Expedited Internal Appeal

If you disagree with any of these decisions, you can request a Standard Internal Appeal. For details on requesting a Standard Internal Appeal, please see the section "How to resolve concerns" starting on page 43.

Reconsideration of an Adverse Determination

If we have denied Authorization for services, the Provider treating you can ask us to reconsider our decision. The reconsideration process will occur within one business day after we get the request. A clinical peer reviewer will conduct the reconsideration and talk to your Provider.

If we don't change our decision, you, your Provider or your Authorized Representative may use the Appeal process described starting on page 43. You don't have to ask us to reconsider an Adverse Determination before requesting a Standard Internal Appeal or Expedited Internal Appeal.

Continuity of Care

We support Continuity of Care for new and current Members.

New Members

If you are a new *Tufts Health Direct* Member, we'll help you transition any covered care you are currently getting to an In-network Provider as smoothly as possible. To ensure Continuity of Care, we may be able to cover some health services, including Behavioral Health (mental health and/or substance use) services, from a Provider who isn't part of our Network, including from a Nurse Practitioner, for a limited period of time. For example, we will cover:

- Ongoing covered treatment or management of chronic or acute medical conditions (like dialysis, home health, chemotherapy and radiation) for up to 30 Days from your date of enrollment, including previously approved services or Covered Services
- Ongoing care for up to 30 Days from your date of enrollment if the Provider is your PCP

In specific circumstances, we offer longer Continuity of Care after Prior Authorization is obtained. For example, we will cover:

- Care you get from your current OB/GYN if you are at least three months pregnant (meaning you are starting your fourth month, based on your expected due date). You can keep seeing your current OB/GYN until you have the baby and a follow-up checkup within the first six weeks after delivery.
- Care from your Provider if you are terminally ill and in active treatment

Current Members

If your PCP or another Provider is disenrolled from our *Tufts Health Direct* Network for reasons not related to quality of care or Fraud, or if they are no longer in practice, we'll make every effort to tell you at least 30 Days before the disenrollment. To ensure Continuity of Care, we may be able to cover some health services, including Behavioral Health services, from a Provider who isn't part of our Network, including from a Nurse Practitioner.

For example, we will cover:

- Care you get from your current OB/GYN if you are at least three months pregnant (meaning you are starting your fourth month, based on your expected due date). You can keep seeing your current OB/GYN until you have the baby and a follow-up checkup within the first six weeks after delivery
- Ongoing covered treatment or management of chronic or acute conditions (like dialysis, home health, chemotherapy and radiation) for up to 90 Days from the date of disenrollment of your Provider, including previously approved services or Covered Services
- Ongoing care for up to 30 Days from the date of disenrollment of your Provider if the Provider is your PCP
- Care from your Provider if you are terminally ill and in active treatment

We will cover services from an Out-of-network Provider as if they were In-network. We will cover continued treatment with an Out-of-

network Provider for the time periods set forth in this section.

Conditions for coverage of Continuity of Care

Services provided by a disenrolled Provider or an Out-of- network Provider as described in this "Continuity of Care" section are covered *only* when you or your Provider obtains Prior Authorization from us for the continued services, when the services would otherwise be covered under this *Member Handbook*, and when the Provider agrees to:

- Accept payment from us at the rates we pay In-network Providers
- Accept such payment as payment in full and not charge you any more than you would have paid in cost sharing if the Provider was an In-network Provider
- Comply with our quality standards
- Provide us with necessary medical information related to the care provided
- Comply with our policies and procedures, including for Prior Authorization and providing Covered Services pursuant to a treatment plan we approve, if any

Eligibility, enrollment, renewal and disenrollment

Eligibility

The Health Connector determines eligibility for *Tufts Health Direct* Subscribers and their Dependents. Subscribers and their Dependents must meet these requirements to be enrolled in *Tufts Health Direct* through the Health Connector or directly with us. Eligible individuals include Massachusetts residents who live in our Service Area.

Please contact the Health Connector for more information about eligibility if you are applying for assistance paying for your health insurance coverage. We and the Health Connector may require reasonable verification of eligibility from time to time.

If you meet the applicable eligibility requirements, we will accept you into *Tufts Health Direct*. You may stay enrolled in *Tufts Health Direct* for as long as you keep meeting the eligibility requirements and your Premium is paid. When we get notice of your enrollment from the Health Connector, we will send you a Member ID Card and more information about your plan.

Acceptance into our plan is never based on your:

- Income
- Physical or mental condition
- Age
- Occupation
- Claims experience
- Duration of coverage
- Medical condition
- Gender
- Sexual orientation
- Religion
- Physical or mental disability
- Ethnicity or race
- Previous status as a Member
- Pre-existing conditions
- Actual or expected health condition

We do not use the results of genetic testing in making decisions about enrollment, eligibility, renewal, payment or coverage of Health Care Services. Also, we do not consider any history of domestic abuse or actual or suspected exposure to diethylstilbestrol (DES) in making these decisions.

Once you are enrolled in our plan, we will pay for Covered Services that are given to you on or after your Effective Coverage Date. (There are no Waiting Periods or Pre-existing Condition Limitations or exclusions.) We will not pay for any services you got before your Effective Coverage Date with our plan.

Dependent eligibility

The following individuals are eligible for enrollment as a Dependent of the Subscriber:

- A legally married spouse of a Subscriber
- A divorced spouse of a Subscriber is eligible to remain covered in accordance with Massachusetts law.
- The Subscriber's civil union partner according to the law of the state in which the Subscriber lives
- For individuals enrolled through an individual contract, we allow for same-sex and opposite-sex domestic partners of Subscribers to enroll as a Dependent.
- For groups, we allow for same-sex and opposite-sex domestic partners of Subscribers

to enroll in the plan if the group provides for such eligibility.
- Children who are recognized under a qualified medical child-support order as having the right to enroll for coverage under the plan
- A natural child of the Subscriber or of the Subscriber's spouse who is eligible for coverage, is eligible for coverage as a Dependent up to the Dependent's 26th birthday
- A stepchild of the Subscriber or of the Subscriber's spouse who is eligible for coverage, is eligible for coverage as a Dependent up to the Dependent's 26th birthday
- An adopted child of the Subscriber or of the Subscriber's spouse who is eligible for coverage, is eligible for coverage as a Dependent up to the Dependent's 26th birthday
    - The date of placement in the home for the purpose of adoption is the effective date of the child's coverage; or, if the child has been living in the home as a foster child for whom the beneficiary has received foster care payments, the effective date is the date of the filing of the petition to adopt.
- A person who is under the legal guardianship of a Subscriber is eligible for coverage as a Dependent up to the Dependent's 26th birthday.
    - Documentation must be provided that includes a court document signed by a judge indicating the child's name, the appointed legal guardian(s), the temporary or permanent designation, the effective date, and, if temporary legal guardianship, the termination date.
- A child of a Dependent of the Subscriber is eligible for coverage as a Dependent up to the child's 26th birthday. However, when the parent of such child is no longer a Dependent of the Subscriber, the child shall no longer be a Dependent.
- A disabled adult child of a Subscriber or the Subscriber's spouse is eligible for coverage

Divorce or separation

In the event of a divorce or legal separation, the person who was the spouse of the Subscriber before the divorce or legal separation will remain eligible for coverage in this plan under the Subscriber's group contract, whether or not the judgment was entered before the effective date of the group contract. This coverage requires no further Premium other than the normal cost of covering a current spouse. The former spouse remains eligible for this coverage only until one of the following happens:
- The Subscriber is no longer required by the judgment to provide health insurance for the former spouse.
- The Subscriber or former spouse remarries. However, if the Subscriber remarries, and the judgment so provides, the former spouse may keep coverage under the plan in accordance with Massachusetts law.
- The Subscriber disenrolls from the plan.

Newborn and adoptive children — eligibility, enrollment, and coverage

A newborn infant of a Member is eligible for coverage under the plan from the moment of birth as required by Massachusetts law.
- The Subscriber must properly enroll the newborn in the plan within 60 Days of the newborn's birth for the newborn to be covered from birth. Otherwise, the Subscriber must wait until the next open enrollment period to enroll the child.
- The Subscriber must enroll an adoptive child within 60 Days after the date of filing a petition to adopt the child, or the date the child is placed with the Subscriber for the purpose of adoption. Otherwise, the Subscriber must wait until the next open enrollment period to enroll an adoptive child.
- If payment of a specific premium is required to provide coverage for a child, the policy or contract may require that both the notification of birth of a newly born child or of filing of a petition to adopt a foster child or of placement of a child for purposes of adoption and the payment of the required premium be furnished to the insurer.
- If the Subscriber does not enroll a newborn within 30 Days of the newborn's birth, the plan will only cover the costs of routine nursery charges and well-newborn care. Any other charges for services to the newborn will not be covered.
- The Subscriber must choose a Primary Care Provider (PCP) for a newborn or adoptive child within 48 hours after the newborn's birth, or after the date of adoption or placement for adoption. This PCP can

manage the child's care from the time of birth or adoption.
- The Subscriber must contact the Health Connector for further information about enrollment of a newborn or an adoptive child.

Employee eligibility

An employee is eligible to enroll in *Tufts Health Direct* through an employer group if they:
- Reside or work within the *Tufts Health Direct* Service Area
- Are employed by a qualified contributing or non-contributing Massachusetts employer
- Meet all employer eligibility requirements

Change in eligibility status

It is your responsibility to tell the Health Connector of all changes that may affect your or your Dependents' eligibility under your plan or the amount of Premium you pay for coverage under your plan. Notification must occur **within 60 Days** of the event. These include the following:
- You have a baby or adopt a child
- One of your Dependents marries
- You have an address change
- You move out of our Service Area
- You have a job or income change
- You have a change in marital status
- Death of a Member
- You or a Dependent no longer meets the plan's eligibility requirements

Note: Changes in Dependents covered by the plan may result in a change to the Premium that an individual or group must pay. Changes could also affect the amount of federal or state subsidies or tax credits you can get.

We and the Health Connector need your current address and phone number so we can send you important information about benefits and services. To report eligibility, address or phone number changes, please call:
- The Health Connector customer service center at 877.623.6765 (TTY: 877.623.7773), Monday through Friday, from 8 a.m. to 6 p.m.
- Us at **888.257.1985**, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays

No waiting period or pre-existing condition limitations

There are no waiting periods or pre-existing condition limitations in our plan. All Covered Services are available to you as of your Effective Coverage Date, unless you are an inpatient on your Effective Coverage Date, and you have not notified us that you are an inpatient.

Effective Coverage Date

The Effective Coverage Date is the date you become a Member of *Tufts Health Direct* and are eligible to get Covered Services from *Tufts Health Direct* Providers. The Health Connector sets Effective Coverage Dates for new individual Subscribers and Dependents, in accordance with state and federal law. Please contact the Health Connector for more information. Your coverage will start at 12:01 a.m. on the first Day of the month your enrollment in *Tufts Health Direct* begins. Individuals who do not meet the requirements to enroll outside of the annual open enrollment period may seek an enrollment waiver. A waiver permits enrollment outside the open enrollment period. Contact the Health Connector or the MA Office of Patient Protection for more information about enrollment waivers.

For Subscribers enrolled through a group contract: You will have a group effective date (always the first of a calendar month). If your group does not meet the participation rules, you may have to apply as individuals during open enrollment or with a qualifying event.

Renewing your coverage

Individual/family *Tufts Health Direct* Subscribers

Individual coverage will renew on January 1 of each calendar year. An individual who enrolls or renews current coverage with an effective date of February 1 or later will have a short Benefit Year. All individuals will renew membership during the open enrollment period (November 1 – January 31). Monthly Premiums are based on your Effective Coverage Date.

We do not have to renew the Health Benefit Plan of an eligible person if he or she:

- Has not paid the required Premiums
- Has committed Fraud or misrepresented whether he or she qualifies for the plan, or misrepresented information needed to determine eligibility for a health plan or for specific health benefits
- Has failed to comply with our provisions, the member contract, or the Subscriber agreement, including but not limited to an individual, employee, or Dependent moving outside our Service Area
- Fails, at the time of renewal, to meet eligibility rules, provided that we collect enough information to make such a determination and make such information available to the Health Connector, when appropriate, upon request
- Has failed to comply with our reasonable request for information in an application for coverage

Group Plan participants

Employer groups renew membership 12 months after their Effective Coverage Date and every 12 months thereafter. Employee coverage renews 12 months after the employer group's Effective Coverage Date, regardless of the employee's Effective Coverage Date. Monthly Premiums are based on the employer group's Effective Coverage Date.

If a participating employer changes any of the following items, we or the Health Connector must revalidate the company at the time of the group's renewal. The Health Connector may ask for documentation to validate the information provided by the participating employer at renewal.

We or the Health Connector may not renew an employer's plan if the employer does not meet the eligibility or participation requirements at the time of renewal, or if the employer:

- Has not paid its Premiums
- Has committed Fraud or misrepresented its employees' eligibility for the plan
- Has misrepresented information needed to determine the group's size, participation rate or Premium rate
- Failed to comply with the plan's requirements, including, but not limited to, the employer or its employee(s) moving outside of the plan's Service Area
- Failed to comply with our or the Health Connector's reasonable request for information needed to verify the application for coverage
- Is not actively engaged in business
- Failed to satisfy the definition of an Eligible Small Business

Plan nonrenewal

We must provide at least 60 Days' prior notice to an eligible individual or Eligible Small Business of our intention not to renew their health benefit plan. We will include the specific reason(s) for the nonrenewal in accordance with our filed criteria. We must provide at least 90 Days' prior notice to affected eligible individuals or Eligible Small Businesses of our intention to stop offering a particular type of health plan.

Disenrollment

If you're disenrolled from *Tufts Health Direct*, we will provide coverage for covered services for you through 11:59 p.m. on the last Day of the month your enrollment ends.

Your enrollment in our plan can be ended if:

- You are an individual or group Member who has not paid the required Premium for 60 Days from the first Day of the coverage month for which the Premium was due (individuals enrolled in subsidized coverage will have 90 Days from the first day of the coverage month for which the Premium was due).
- You commit an act of physical or verbal abuse unrelated to your physical or mental condition, which poses a threat to any Provider, any other Member, or to the plan or a plan employee.
- You commit an act of intentional misrepresentation or Fraud related to coverage, obtaining Health Care Services or payment for such services (for example, obtaining or trying to obtain benefits under this *Member Handbook* for a person who is not a Member, or misrepresenting your eligibility for enrollment in our plan). Termination may be retroactive to your effective date, the date of the Fraud or misrepresentation, or to another date determined by us.
- You fail to comply with our rules under this *Member Handbook*. For groups, this may mean that the group failed to meet requirements related to group Premium

contributions, or that the group is not actively engaged in business.
- You fail to meet the Health Connector's or our eligibility requirements, such as moving out of the Service Area
- An individual or a group chooses to end coverage by notifying us or the Health Connector

Note: We will never request to end services for a Member due to a negative change in his or her health, or because of the Member's use of medical services, diminished mental capacity or uncooperative behavior resulting from his or her special needs.

Effective date of termination

We or the Health Connector will notify you of the date your coverage under the plan ends. If we or the Health Connector terminates your coverage because you did not pay your Premiums, the Health Connector will notify you at least 30 Days before termination. The time frames for termination depend on how you pay your Premiums:

- If you are an individual enrolled in unsubsidized coverage or a Member in a small group and you have not paid your Premium in two months, we or the Health Connector will terminate your coverage on the Day after the payment due date. Your coverage end date is the last Day of the month for which you made full payment. Your termination is retroactive. For example, if you made your last payment for coverage on January 1, but did not pay your Premium for February or March, we or the Health Connector would terminate your coverage on April 1, effective January 31.
- If you are an individual enrolled in a ConnectorCare plan or are getting a Federal Premium Tax Credit and you have not paid your Premium for three months, the Health Connector will terminate your coverage on the Day after the payment due date. Your coverage end date is the last Day of the first month for which you owed but did not make a payment. Your termination is retroactive with a 30-Day grace period. For example, if you made your last payment for coverage January 1, but did not pay your Premium for February, March, or April, the Health Connector would terminate your coverage on May 1, effective February 28.

Benefits after termination

We will not pay for services, supplies, or drugs* you get after your coverage ends, even if:

- You were receiving inpatient or outpatient care before your coverage ended
- You had a medical condition (known or unknown), such as pregnancy, that requires medical care after your coverage ends

* Requests for reimbursement for drugs must be submitted within one year from the date of service.

Health plan changes

We or the Health Connector will give you information about the yearly *Tufts Health Direct* open enrollment period. All current *Tufts Health Direct* Members can change plans for any reason during the open enrollment period.

Outside of the open enrollment period, all Members can change their health plan enrollment or coverage type (individual to family) for the following reasons (called "qualifying events"):

- Marriage
- Divorce, legal separation or annulment
- Birth, adoption or placement for adoption of a child
- Dependent spouse required to cover a child by court order
- Death of a spouse or Dependent
- Covered Dependent reaches the age limit for coverage, making him or her ineligible for coverage
- You, your spouse or eligible Dependent moves outside of your health plan's Service Area.
- You, your spouse or eligible Dependent begins or returns from an unpaid leave of absence.
- You, your spouse or eligible Dependent has a change in job status (for example: change from full-time to part-time employment or leaving employment) that affects eligibility for benefit coverage under the employer's plan or a plan of your spouse's or eligible Dependent's employer.
- You, your spouse or eligible Dependent becomes a U.S. citizen/national, a qualified immigrant or a lawfully present immigrant.
- You, your spouse or eligible Dependent is an Indian, as defined by section 4 of the Indian Self- Determination and Education Assistance Act. See Indian Self Determination and Education Assistance Act, 25 U.S.C. §450b(d). Such individual

may enroll in or change from one plan to another one time per month.
- You, your spouse or eligible Dependent is newly determined eligible for a Federal Premium Tax Credit or there is a change in eligibility for a ConnectorCare plan.
- Other exceptional circumstances. Please refer to the Health Connector for a complete list.

The qualifying event must be reported to the Health Connector within 60 Days of the event. Changes to health plan enrollment or coverage type will be effective as of the qualifying event date.

Continuing coverage for group Members

Continuation of group coverage under federal law (COBRA)

Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), group Members may be eligible to keep coverage under the group contract if:
- You were enrolled in a group that has 20 or more eligible employees
- You experience a qualifying event that would cause you to lose coverage under your group
- You elect coverage as provided under COBRA

Below is a brief summary of COBRA continuation coverage:
- **Qualifying events**: Qualifying events that may entitle you to COBRA continued coverage are as follows:
  - Termination of the Subscriber's employment (for reasons other than gross misconduct)
  - Reduction in the Subscriber's work hours
  - The Subscriber's divorce or legal separation
  - Death of the Subscriber
  - The Subscriber's entitlement to Medicare
  - Loss of status as an eligible Dependent
- **Period of continued coverage under COBRA**: The period of continued group coverage begins with the date of your qualifying event. The length of this continued group coverage will be between 18 – 36 months depending on the qualifying event.

  COBRA coverage will end at the end of the maximum period of coverage. However, coverage may end earlier if:
  - The Premium is not paid on time
  - Your group ceases to maintain any group plan
  - The group terminates its group contract with us or the Health Connector (in which case your coverage may continue under another health plan)
  - For other reasons such as the end of disability, or becoming eligible for or obtaining other coverage
- **Cost of coverage:** In most cases, you are responsible for payment of 102% of the cost of coverage.
- **Continued coverage for disabled Subscribers**: At the time of the Subscriber's termination of employment or reduction in work hours (or within 60 Days of the qualifying event under federal law), if a Subscriber or his or her eligible Dependent is determined to be disabled under Title II or Title XVI of the Social Security Act, continued group coverage will be available for up to 29 months from the date of the qualifying event. The Premium cost for the extra 11 months may be up to 150% of the Premium rate.
- **Enrollment**: To enroll, you must complete an election form and return it to your group. The form must be returned within 60 Days from your date of termination of group coverage or your notification (by your group) of eligibility, whichever is later. If you do not return the completed form, it will be considered a waiver. This means you will not be allowed to keep coverage in this plan under a group contract.

For more information about COBRA, contact your group or the Health Connector.

Continuation of group coverage under Massachusetts law

Under Massachusetts continuation coverage law, group Members may be eligible to keep coverage under the group contract if:
- You were enrolled in a group that has 2 – 19 eligible employees

- You experience a qualifying event that would cause you to lose coverage under your group
- You elect coverage as provided by Massachusetts law

Below is a brief summary of Massachusetts continuation coverage:

- **Qualifying events**: Qualifying events that may entitle you to keep coverage under Massachusetts law are as follows:
  - Termination of the Subscriber's employment (for reasons other than gross misconduct)
  - Reduction in the Subscriber's work hours
  - The Subscriber's divorce or legal separation
  - Death of the Subscriber
  - The Subscriber's entitlement to Medicare
  - Loss of status as an eligible Dependent
- **Period of continued coverage:** In most cases, continuation coverage is effective on the date following the Day group coverage ends. In most cases, it ends 18 or 36 months from the date of the qualifying event, depending on the type of qualifying event.
- **Cost of coverage:** In most cases, you are responsible for payment of 102% of the group Premium.
- **Enrollment:** To enroll, you must complete an election form and return it to your group. The form must be returned within 60 Days from your date of termination of group coverage or your notification (by your group) of eligibility, whichever is later. If you do not return the completed form, it will be considered a waiver. This means you will not be allowed to keep coverage in this plan under a group contract.

For more information about Massachusetts continuation coverage, contact your group or the Health Connector.

Coverage under an individual contract: If your group coverage ends, you may be eligible to enroll in coverage under an individual contract offered through the Health Connector or directly through us. Please be aware that coverage under an individual contract may differ from coverage under a group contract. For more information, call the Health Connector at 877.623.6765 (TTY: 877.623.7773) or call our Member Services Team at **888.257.1985**.

Covered Services

We cover Medically Necessary Covered Services listed in this handbook that are provided by In-network Providers (except Emergency services, which you can get anywhere). If a service or service category is not specifically listed as covered, then it is not covered under this agreement. (See the section "Services not covered" on page 35)

The following "Services we cover" section lists services we cover for *Tufts Health Direct* Members.

In addition, the Covered Services for each of the Plan Levels are listed in the section "Benefit and Cost-sharing Summary" starting on page 61. Check the summary for your Plan Level and for a list of services covered and Prior Authorization requirements for *Tufts Health Direct* Members. If you have any questions, call us at **888.257.1985**, Monday through Friday, from 8 a.m. to 5 p.m. We can give you more information about any of these Covered Services.

Covered Services are only covered if they are Medically Necessary. Medically Necessary services are services that we determine are consistent with generally accepted principles of medical practice. This means that they're the least intensive and most cost-effective available, and are:

- The most appropriate available supply or service for you based on potential benefits and harm to you
- Known to be effective in improving health outcomes based on scientific evidence, professional standards and expert opinion

In addition to any limitations in the "Benefit and Cost-sharing Summary," we may limit or require Prior Authorization for Covered Services on the basis of Medical Necessity.

Services we cover

Please note: Some or all of these services may require Prior Authorization. Please see our Medical Necessity Guidelines on tuftshealthplan.com.

Outpatient medical care

Abortion services

We cover abortion services you get from a *Tufts Health Direct* Provider. We must give Prior Authorization, requested by your PCP, for an abortion from a provider who does not participate in *Tufts Health Direct*'s Network.

Anesthesia

We cover Medically Necessary anesthesia services. If you need anesthesia, we provide coverage on a nondiscriminatory basis for Covered Services. This means you have the same coverage whether the service was given to you by an In-network Certified Nurse Anesthetist or by another In-network Provider. The Covered Services provided must be services the Provider is legally authorized to practice.

Cleft palate/cleft lip

We cover medical, dental, oral and facial surgery for Members 18 years and younger with a cleft palate and/or cleft lip. This includes surgical management and follow-up care by oral and plastic surgeons, as well as orthodontic treatment and management, preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy, Speech Therapy, audiology, and nutrition services, if prescribed by the treating physician or surgeon and the physician or surgeon certifies that the services are Medically Necessary.

Community health center visits and office visits

We cover community health center and office visits to *Tufts Health Direct* Providers for Primary Care or for specialty services. We must give Prior Authorization for office visits to all Out-of-network Providers. Call us at **888.257.1985** to find out more.

We cover community health center and office visits with/for:

- Your Primary Care Provider (PCP)
- Specialists

Hearing Aids

We cover Medically Necessary hearing aids for Members age 21 and younger. This includes the cost of one hearing aid per hearing-impaired ear for up to $2,000 each, every 36 months.

Outpatient surgery

We cover surgical procedures performed in an In-network outpatient surgical center or Hospital operating room. Some procedures require Prior Authorization.

Laboratory services

We cover In-network laboratory services (such as blood tests, urinalyses, Pap smears and throat cultures) that your Provider orders to diagnose, treat, and prevent disease, and to maintain your health, such as:

- Diagnostic laboratory tests, such as glycosylated hemoglobin (HbA1c) tests, urinary protein/microalbumin tests, and lipid profiles to diagnose and treat diabetes
- Human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to set up bone marrow transplant donor suitability. This includes testing for A, B, or DR antigens, or any combination, in accordance with Massachusetts Department of Public Health guidelines.

Certain laboratory tests may require prior authorization, such as genetic testing and others.

Radiology services

We cover radiology services, such as:

- X-rays
- Mammography
- MRIs
- PET and CT scans

Some of these — MRIs, MRAs, CT scans, outpatient nuclear cardiology and PET — require Prior Authorization. Please see the "Benefit and Cost-sharing Summary" for your Plan Level at the end of this *Member Handbook* for more details or call us at **888.257.1985** for more information.

Inpatient medical care

We cover 24-hour inpatient Medically Necessary medical services delivered in a

licensed Hospital setting with Prior Authorization. Prior Authorization is not required for Emergency care.

Reconstructive surgery and procedures

We cover Medically Necessary reconstructive surgery and procedures. These are covered only when the services are required to relieve pain or to improve or restore bodily function that is impaired as a result of:

- A birth defect
- Accidental injury
- Disease
- A covered surgical procedure

We also cover the following post-mastectomy services:

- Reconstruction of the breast affected by the mastectomy
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications of all stages of mastectomy (such as lymphedema)

Removal of breast implants is covered only when:

- There is a medical complication related to an implant (such as a breast implant rupture) or
- There is documented evidence of autoimmune disease.

We do not cover cosmetic procedures, except for post-mastectomy coverage as specifically described in this section.

Covered medications and pharmacy

Pharmacy program

We aim to provide high-quality, cost-effective options for drug therapy. We work with your Providers and pharmacists to make sure we cover the most important and useful drugs for a variety of conditions and diseases. We cover first-time prescriptions and refills.

Our pharmacy program doesn't cover all drugs and prescriptions. Some drugs must meet certain clinical guidelines before we can cover them. Your Provider must ask us for Prior Authorization before we'll cover these drugs.

Note: Requests for reimbursement for drugs must be submitted within one year of the date of service.

Prior Authorization drug program

We restrict the coverage of certain drug products that have a narrow indication for usage, may have safety concerns, and/or are extremely expensive, requiring the prescribing Provider to obtain prior approval from us for such drugs. Our *Preferred Drug List* states whether a drug requires Prior Authorization.

If we don't approve the request for Prior Authorization, you or your Authorized Representative can appeal the decision. For more information, please see the section "How to resolve concerns" starting on page 43. If you want more information about our pharmacy program, visit tuftshealthplan.com or call us at **888.257.1985**.

Preferred Drug List (*PDL*)

We use a *PDL* as our list of covered drugs. The *PDL* applies only to drugs you get at retail, mail-order and specialty pharmacies. The *PDL* doesn't apply to drugs you get if you're in the Hospital. For the most current *PDL* information, please visit tuftshealthplan.com or call us at **888.257.1985**.

Step-therapy program

Step therapy is a type of Prior Authorization program (usually automated) that uses a step-wise approach, requiring the use of the most therapeutically appropriate and cost-effective agents first, before other medications may be covered. Members must first try one or more medications on a lower step to treat a certain medical condition before a medication on a higher step is covered for that condition.

Quantity limits

To make sure the drugs you take are safe and that you are getting the right amount, we may limit how much you can get at one time. Your Provider can ask us for approval if you need more than we cover. One of our clinicians will review the request. We'll cover the drug according to our clinical guidelines if there is a medical reason you need this particular amount.

Specialty pharmacy program

We have designated specialty pharmacies that specialize in providing medications used to treat certain conditions, and are staffed with clinicians to provide support services for Members. Some medications must be obtained at a specialty pharmacy. Medications may be added to this program from time to time. Designated specialty pharmacies can dispense up to a 30-day supply of medication at one time, and the supply is delivered directly to the Member's home via mail. This is NOT part of the mail-order pharmacy benefit. Extended day supplies and Co-payment savings do not apply to these designated specialty drugs.

Generic drugs

Generic drugs have the same active ingredients and work the same as brand-name drugs. When generic drugs are available, we won't cover the brand-name drug without giving Prior Authorization. If you and your Provider feel that a generic drug is not right for your health condition and that the brand-name drug is Medically Necessary, your Provider can ask for Prior Authorization. One of our clinicians will then review the request.

New-to-market drugs

We review new drugs for safety and effectiveness before we add them to our *PDL*. A Provider who feels a new-to-market drug is Medically Necessary for you before we've reviewed it can submit a request for approval. One of our clinicians will review this request. If we approve the request, we'll cover the drug according to our clinical guidelines. If we don't approve it, you or your Authorized Representative can Appeal the decision.

Covered prescription drugs and supplies

In addition to the covered prescription drugs and supplies listed in the *PDL*, we cover:

- Off-label use of FDA-approved prescription drugs for the treatment of cancer or HIV/AIDS that have not been approved by the FDA for that indication. We also cover any Medically Necessary services associated with giving these drugs. These drugs must be recognized for such treatment in one of the standard reference compendia, in the medical literature or by the Massachusetts Commissioner of Insurance.
- Oral and injectable drug therapies used in the treatment of covered infertility services only when you have been approved for covered infertility treatment (see the section "Infertility services" on page 30)
- Compounded medications, if at least one active ingredient requires a prescription by law and is FDA-approved. Compounding kits that are not FDA-approved and include prescription ingredients that are readily available may not be covered. To confirm whether the specific medication or kit is covered under this plan, please call the Member Services Team.

Included in the *PDL* are:

- Hormone replacement therapy (HRT) for perimenopausal and postmenopausal women
- Oral and other forms of prescription drug contraceptives (birth control drugs)
- Hypodermic syringes or needles when Medically Necessary
- Insulin, insulin pens, insulin needles and syringes, and lancets; blood glucose, urine glucose and ketone monitoring strips; and oral diabetes medications only when your Provider has given you a prescription that meets all legal requirements
- Prescription smoking cessation agents

Noncovered drugs with suggested alternatives

While Tufts Health Plan covers a majority of drugs, a small number of drugs (less than 1%) are not covered because there are safe, effective and more affordable alternatives available. All of the alternative drug products are approved by the U.S. Food and Drug Administration (FDA) and are widely used and accepted in the medical community to treat the same conditions as the medications that are not covered.

Exclusions

We do not cover:

- Any drug products used for cosmetic purposes
- Experimental drugs, those that cannot be marketed lawfully without the approval of the FDA and such approval has not been granted at the time of their use or proposed use or such approval has been withdrawn

- Immunization agents administered or dispensed at a pharmacy, except for the influenza virus vaccine when administered by a pharmacist between August 1 and April 30 at a participating pharmacy to Members who are at least 18 years old*
- Medical supplies*
- Mifepristone (Mifeprex)*
- Prescription and over-the-counter homeopathic medications
- Drugs that by law do not require a prescription (unless listed as covered in the "Covered medications and pharmacy" section)
- Vitamins and dietary supplements (except prescription prenatal vitamins, vitamins as required by the Affordable Care Act, fluoride for children and supplements for the treatment of mitochondrial disease)
- Topical and oral fluorides for adults
- Medications for the treatment of idiopathic short stature
- Non-drug products, such as therapeutic or other prosthetic devices, appliances, supports or other non-medical products. These may be provided as described earlier in this section.
- Prescriptions written by Providers who do not participate in the *Tufts Health Direct* Network, except in cases of authorized referral or Emergency care
- Prescriptions filled at pharmacies other than Tufts Health Plan designated pharmacies, except for Emergency care
- Prescriptions filled through an internet pharmacy that is not a Verified Internet Pharmacy Practice Site certified by the National Association of Boards of Pharmacy
- Prescription medications once the same active ingredient or a modified version of an active ingredient that is therapeutically equivalent to a covered prescription medication becomes available over-the-counter. In this case, the specific medication may not be covered and the entire class of prescription medications may also not be covered.
- Prescription medications when packaged with non-prescription products
- Externally powered exoskeleton assistive devices and orthoses

* Certain drugs may be covered as a nonpharmacy benefit.

Covered Behavioral Health (mental health and/or substance use) services

Outpatient Behavioral Health (mental health and/or substance use) services

These services may require Prior Authorization. When treatment is for substance use disorder Outpatient services, Level III community-based detoxification and Level IV detoxification services, we do not require Prior Authorization for In-network providers. Please see our Medical Necessity Guidelines at tuftshealthplan.com/medicalnecessityguidelines.

We cover Medically Necessary Behavioral Health services provided in a face-to-face encounter in:

- An In-network licensed Hospital
- A mental health or substance use clinic licensed by the Massachusetts Department of Public Health
- A public community mental health center
- A professional office
- Home-based services by a licensed professional acting within the scope of his or her license

Biologically-based and nonbiologically based outpatient services are provided without annual, lifetime or visit/unit/ day limits. Outpatient Behavioral Health services include:

- Individual, group and family counseling
- Medication visits
- Community crisis counseling
- Family and case consultation
- Diagnostic evaluation
- Psychological testing
- Narcotic treatment services
- Electroconvulsive therapy

For each Benefit Year, we cover 12 Behavioral Health outpatient therapy visits without Prior Authorization; additional visits require Prior Authorization. Outpatient therapy visits for treatment of substance use disorder do not require Prior Authorization.

Intermediate Behavioral Health services

We cover Medically Necessary intermediate services for behavioral health disorders. Intermediate services are a range of services more intensive than outpatient services and

less intensive than inpatient services. Intermediate services do not have any annual, lifetime or visit/unit/day limits. Examples include:

- Day treatment programs
- Partial hospital programs
- Intensive outpatient programs
- Crisis stabilization
- In-home therapy services, such as family stabilization team services
- Acute residential treatment, such as community-based acute treatment (this is not a substance-use specific service)
- Clinically managed detoxification services
- Level III community-based detoxification services

These services may require Prior Authorization. When treatment is for substance use disorder, we do not require Prior Authorization for In-network Providers. Please see our Medical Necessity Guidelines at tuftshealthplan.com.

Other related services

We also cover:

- Medication management services
- Neuropsychological assessment and psychological testing. Prior Authorization is required.

Inpatient Behavioral Health (mental health and/or substance use) services

We cover Medically Necessary 24-hour clinical intervention services for Behavioral Health diagnoses delivered in:

- A licensed In-network Hospital
- A facility under the direction and supervision of the Department of Mental Health
- A private mental health hospital licensed by the Department of Mental Health
- A substance use facility licensed by the Massachusetts Department of Public Health

We cover an inpatient treatment if Medically Necessary. Biologically-based and nonbiologically based inpatient services are provided on a nondiscriminatory basis.

More Behavioral Health (mental health and/or substance use) services

We cover Medically Necessary outpatient, intermediate and inpatient Behavioral Health services to diagnose and treat mental disorders. This includes:

- Biologically-based mental disorders, such as schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia, panic disorder, obsessive-compulsive disorder, delirium and dementia, affective disorders, eating disorders, post-traumatic stress disorder, substance use disorders, autism, and other psychotic disorders or biologically-based mental disorders
- Autism spectrum disorder (ASD) services: We provide coverage for ASD in accordance with Massachusetts law without annual, lifetime or visit/unit/day limits.
    - ASD includes any of the pervasive developmental disorders (as defined by the most recent edition of the DSM), such as autistic disorder, Asperger's disorder and pervasive developmental disorders not otherwise specified.
    - Diagnosis of ASD includes: Medically Necessary assessments, evaluations (such as neuropsychological evaluations), genetic testing or other tests to diagnose whether a Member has an ASD.
    - Treatment for ASD includes: habilitative or rehabilitative care (such as applied behavioral analysis*), pharmacy care (under the pharmacy benefit), psychiatric care (direct or consultative services provided by a licensed psychiatrist), psychological care (direct or consultative services provided by a licensed psychologist), and therapeutic care (services provided by licensed or certified speech therapists, occupational therapists, physical therapists or social workers). Benefit limits applicable to the rehabilitation therapies benefit do not apply to therapeutic care services provided to Members with ASD. Services must be rendered by In-network autism services Providers (Providers who treat ASDs). These include board-certified behavior analysts,** psychiatrists, psychologists, pharmacies, and licensed or certified speech therapists, occupational therapists, physical therapists and social workers.

* Defined as the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in

human behavior. This includes the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

** Defined as a behavioral analyst credentialed by the behavior analyst certification board as a board-certified behavior analyst.

- Rape-related mental or emotional disorders

to victims of rape or victims of an assault with intent to commit rape
- All other nonbiologically based mental disorders

Mental health parity law

Tufts Health Plan complies with Massachusetts and federal laws on mental health parity. This means that, among other things, Co-payments, Co-insurance, Deductibles, and/or unit of service limits (e.g., hospital days, outpatient visits) are not greater for Behavioral Health or substance use disorders than those required for medical/surgical services, and office visit Co-payments are not greater than those required for Primary Care visits.

Home health care

We cover certain home health services provided by a home health agency in your home, as long as your home isn't a Hospital or skilled nursing or rehabilitation institution. The services also must be Medically Necessary as part of a Provider-approved home health services plan. Prior Authorization is required if the request is to receive daily visits or the visits exceed six months of service. You must be home bound to receive home health care services. Covered services include:
- Durable Medical Equipment (DME)
- Part-time or intermittent skilled nursing care
- Physical, Occupational and Speech Therapies
- Part-time or intermittent home health aide services
- Medical social work services
- Nutritional consults

Inpatient Skilled Nursing Facility

We cover daily Medically Necessary skilled nursing care in an inpatient setting for a maximum of 100 Days per Member per Benefit Year at a Skilled Nursing Facility. Prior Authorization is required.

Inpatient Rehabilitation Hospital

We cover daily Medically Necessary rehabilitative services provided in an inpatient setting for a maximum of 60 Days per Member per Benefit Year at an inpatient Rehabilitation Hospital. Prior Authorization is required.

Short-term outpatient rehabilitation and habilitative services (Physical, Occupational and Speech Therapies)

Physical and Occupational Therapies

We provide Physical and Occupational Therapy coverage with Prior Authorization.

Therapies are covered for evaluation and restorative short-term treatments that you need to attain your highest level of independent functioning. Care is provided in the timeliest manner possible and when we determine that the therapy will result in significant, sustained and measurable improvement of your condition. We may require Prior Authorization for rehabilitation and habilitative therapy services after the initial evaluation. Rehabilitative Physical and Occupational Therapy are covered only if Medically Necessary for up to 60 visits combined per member per Benefit Year. Habilitative Physical and Occupational Therapy are covered only if Medically Necessary for up to 60 visits combined per member per Benefit Year. Limit does not apply when these services are furnished to treat autism spectrum disorders.

Speech, hearing and language disorders

We cover the diagnosis and treatment of speech, hearing and language disorders when you get services from
a registered, licensed speech-language pathologist, audiologist, or therapist as part of a formal treatment plan for speech loss or impairment. We cover these services in a Hospital, clinic or private office. We require Prior Authorization after the initial evaluation.

Other benefits

Chiropractic care

We cover spinal manipulation, therapeutic exercise and attended electrical muscle stimulation for Members for 20 visits per Benefit Year.

Clinical trials

We cover limited services for Members enrolled in a qualified clinical trial of a treatment. Coverage will be under the terms and conditions provided for under Massachusetts and federal law. We cover the following services:

- Services that are Medically Necessary for the treatment of your condition, consistent with the study protocol of the clinical trial, and for which coverage is otherwise available under the plan
- Patient care services provided as part of a qualified clinical trial for the treatment of cancer or another life-threatening disease or condition (Prior Approval by an authorized reviewer may be required)

To the extent required by Massachusetts and federal law, patient care services provided as part of a qualified clinical trial conducted to prevent, detect, or treat cancer, or another life-threatening disease or condition, are covered to the same extent as those outpatient services would be covered if the Member did not receive care in a qualified clinical trial.

Diabetes treatment

We cover the following services for Members with diabetes if they are Medically Necessary to diagnose or treat insulin-dependent, insulin-using, non-insulin-dependent, or gestational diabetes:

- Diabetes outpatient self-management training and educational services. This includes medical nutrition therapy. An In-network Provider who is a certified diabetes Provider must provide these services.
- Podiatry services to treat podiatric conditions for Members diagnosed with diabetes, such as diagnostic lab tests and X-rays, surgery and necessary postoperative care, routine foot care (such as trimming of corns, nails or other hygienic care), and other Medically Necessary foot care
- Diabetes lab tests, such as glycosylated hemoglobin (or HbA1c) tests, urinary protein/microalbumin and lipid profiles
- Insulin pumps and insulin pump supplies (may need Prior Authorization when exceeding $1,000), insulin needles and syringes, diabetic test strips and lancets, blood glucose monitors for home use, voice synthesizers (with Prior Authorization), and visual magnifying aids when Medically Necessary for home use for the legally blind
- Therapeutic and molded shoes and shoe inserts for severe diabetic foot disease. An In-network Podiatrist or other qualified doctor must prescribe shoes/shoe inserts, and an In-network Podiatrist, orthotist, prosthetist or pedorthist must furnish them.
- Prescribed oral diabetes medications that influence blood sugar levels; insulin, insulin needles and syringes, insulin pens and lancets; and blood glucose, urine glucose and ketone monitoring strips. Our *Preferred Drug List* shows covered medications and diabetes supplies.

Durable Medical Equipment (DME)

We cover certain DME. Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs. Prior Authorization is required if the total cost is over $1,000.

Early intervention services

We cover, with Prior Authorization, early intervention services provided by an In-network Provider who is a certified early intervention specialist. These services must be part of an early intervention program meeting the standards of the Department of Public Health. This benefit is only for Members from birth through the age of 3 who meet set criteria. There are no charges, Co-payments, Deductibles or Co-insurance for these services. Benefit limits applicable to rehabilitation therapies do not apply to early intervention services. Early intervention services include the following:

- Physical Therapy
- Speech Therapy
- Occupational Therapy
- Nursing care
- Psychological counseling

Emergency transportation

We cover ground ambulance and air transportation services in an Emergency. We don't cover transportation to and from medical appointments. We cover facility-to-facility transfers In-network with Prior Authorization.

Family-planning Services

We cover Family-planning Services from an In-network physician (PCP, obstetrician or gynecologist), Nurse Practitioner, Physician Assistant or certified nurse midwife. These services include:

- Routine medical exams
- Medical consults
- Diagnostic tests
- Pregnancy testing
- Birth control counseling
- Prescription and nonprescription contraceptives that have been approved by the U.S. Food and Drug Administration, when given to you by an In-network Provider during an office visit. Our *Preferred Drug List* includes covered prescription contraceptives. Nonprescription contraceptives include, for example, IUDs, implantable contraceptives and cervical caps. For a complete list of nonprescription contraceptives, please see the preventive services list on tuftshealthplan.com.

Fitness center reimbursement

We cover three months of fitness center fees after you have been a *Tufts Health Direct* Member for three months. The reimbursement excludes initiation fees. See the "Benefit and Cost-sharing Summary" for your Plan Level at the end of this *Member Handbook* for more details.

If you are an individual plan Subscriber requesting this reimbursement, you may submit a reimbursement form, with itemized receipts attached, once per Benefit Year. We will reimburse individual-level fitness center membership fees only. The reimbursement will be paid to the individual plan Subscriber.

If you are a family plan Subscriber requesting this reimbursement, you may submit a reimbursement form, with itemized receipts attached, once per family per Benefit Year. Only the Subscriber may request this reimbursement on behalf of the family or individuals on the family plan. We will reimburse once per Benefit Year for individual- or family-level fitness center membership fees. The reimbursement will be paid to the family plan Subscriber.

Call us at **888.257.1985**, and we'll send you a reimbursement form to complete. You can also get the form at tuftshealthplan.com.

Note: This reimbursement covers membership fees of a standard fitness center. A standard fitness center offers cardio and strength-training machines and other programs for improved physical fitness. This reimbursement does not include luxury fitness centers, country clubs, social clubs, tennis clubs, gymnastics centers, martial arts centers, aerobic-only or pool-only centers, personal trainers, sports coaches or the purchase of personal or at-home exercise machines.

Hospice

We cover hospice care for terminally ill Members (terminally ill means having a life expectancy of six months or less as certified by an In-network Provider) who agree with their Providers not to go on with a curative treatment program. The services must be the equivalent of hospice services provided by a Medicare-certified hospice regulated by the Massachusetts Department of Public Health. We cover a package of services, such as:

- Nursing
- Medical and social services
- Provider care
- Counseling (for example, bereavement, dietary, spiritual)
- Physical, Occupational, and Speech-language Therapies
- Homemaker/home health aide services
- Medical supplies
- Drugs
- Biological supplies
- Short-term inpatient care services
- Institutional care services

The 100-Day limit for care at a Skilled Nursing Facility and a Rehabilitation Hospital described on your Plan Level's "Benefit and Cost-sharing Summary" does not apply to hospice services.

Immunizations

We cover:

- Routine preventive immunizations
- Medically Necessary immunizations

Infertility services

We cover the diagnosis and treatment of infertility. In-network Providers must provide services in accordance with Massachusetts law. "Infertility" is defined as the condition of an individual who is unable to conceive or produce conception during a period of:

- One year if the female is age 35 or younger or
- Six months if the female is over the age of 35

For meeting infertility criteria: If a person conceives but is unable to carry that pregnancy to live birth, the period of time she tried to conceive before achieving that pregnancy is included in the calculation of the one-year or six-month period, as applicable.

Infertility services are Covered Services only for Members who are diagnosed with infertility and:

- Who live in Massachusetts
- Who meet our clinical review criteria for coverage of infertility services, which are based on the Member's medical history, diagnostic testing and medical evaluations
- Who meet the eligibility requirements of In-network Providers of infertility services

To the extent that donor-related costs are not covered by the donor's health insurance or other health coverage and the Member is in active infertility treatment, covered services include the procurement and processing of donor eggs, sperm, or inseminated eggs, or the banking of donor sperm or embryos.

We cover the following Medically Necessary infertility services:

- The following services and supplies provided in connection with an infertility evaluation and/or treatment:
  - Diagnostic tests and procedures
  - Artificial insemination (intracervical or intrauterine) when done with non-donor (partner) sperm
  - Procurement, processing and long-term (longer than 90 Days) banking of sperm when associated with active infertility treatment
- The following procedures when approved in advance by a plan-approved reviewer in accordance with our clinical review criteria:
  - Artificial insemination (intracervical or intrauterine) when done with donor sperm* and/or gonadotropins
  - Procurement and processing of eggs or inseminated eggs and banking of embryos when associated with active infertility treatment
- The following "assisted reproductive technology" (ART) procedures** when approved in advance by a plan-approved reviewer in accordance with our clinical review criteria:
  - In vitro fertilization and embryo transfer (IVF-ET)
  - In conjunction with IVF, PGD is covered when either of the partners is a known carrier for certain genetic disorders
  - Gamete intrafallopian transfer (GIFT)
  - Intracytoplasmic sperm injection (ICSI) for the treatment of male-factor infertility
  - Zygote intrafallopian transfer (ZIFT)
  - Frozen embryo transfer (FET)
  - Donor oocyte (DO)

* Donor sperm is only covered when the partner has a male factor infertility diagnosis, or when donor sperm is being used as an alternative to preimplantation genetic diagnosis (PGD) when a couple meets the criteria for PGD.

** ART procedures include diagnostic evaluation, testing, ovarian stimulation, egg retrieval, procurement and processing of sperm and eggs or inseminated eggs, transfer of embryos, and banking of extra embryos when associated with active infertility treatment.

Under your prescription drug benefit: Oral and injectable drug therapies used in the treatment of covered infertility services are covered when you have been approved for covered infertility treatment and when obtained from an In-network pharmacy. Our *Preferred Drug List* includes covered drug therapies.

Related infertility services exclusions:

- Infertility services for any Member who does not live in Massachusetts
- Any experimental infertility procedure as defined by applicable Massachusetts regulation
- Surrogacy/gestational carrier
- Reversal of voluntary sterilization

Maternity care

Inpatient

We cover:

- Hospital and delivery services for the mother. The mother's inpatient stay is covered for at least:
  - 48 hours following a vaginal delivery
  - 96 hours following a caesarean delivery

Decisions to reduce the mother and child's inpatient stay are made only by the attending obstetrician, pediatrician or certified nurse midwife and mother (and not by the plan).

- Routine nursery charges and well-newborn care for a healthy newborn.* This includes:
  - Pediatric care
  - Routine circumcision by a Provider
  - Newborn hearing screening tests performed by an In-network Provider before the newborn child (an infant under three months of age) is discharged from the Hospital, or as provided by regulations of the Massachusetts Department of Public Health
- One home visit by an In-network Provider who is a registered nurse, physician or certified nurse midwife

* For newborns, we cover routine nursery charges and well-newborn care. The newborn must be enrolled in the plan within 30 Days of the date of birth for us to cover other Medically Necessary services for the newborn.

We cover more home visits by In-network Providers when Medically Necessary. These home visits may include parent education, assistance and training in breast or bottle feeding, and necessary and appropriate tests.

Note: Care that could have been foreseen before leaving the Service Area is not covered. This includes, but is not limited to, deliveries outside the Service Area within one month of the due date, including postpartum care and care provided to the newborn child.

There is no coverage outside the Service Area for delivery or problems with pregnancy any time after the 37th week of pregnancy or being told by your Provider that you are at risk for early delivery. Delivery is covered at In-network facilities only. You will need to register at your in-network facility of choice.

Outpatient

We cover the following outpatient maternity services:

- Prenatal exams and tests: routine outpatient prenatal care, such as evaluation and progress screening, physical exams, and recording of weight and blood pressure monitoring
- Postpartum exams and tests: routine outpatient postpartum care for the mother. This includes lactation consultations.
- Childbirth classes: You must obtain outpatient maternity care from an In-network Provider. Your In-network Provider must make arrangements for inpatient care.
- Breast pumps and related supplies

Medical formulas

We cover the following medical formulas with Prior Authorization to the extent required by Massachusetts law:

- Nonprescription enteral formulas, ordered by a Provider for home use, for the treatment of:
  - Malabsorption caused by Crohn's disease
  - Ulcerative colitis
  - Gastroesophageal reflux
  - Gastrointestinal motility
  - Chronic intestinal pseudo-obstruction
  - Inherited diseases of amino acids and organic acids
- Low-protein foods: We cover food products modified to be low-protein when ordered by a Provider and Medically Necessary to treat inherited diseases of amino and organic acids.
- Prescription formulas for the treatment of:
  - Phenylketonuria, and to protect the unborn fetuses of pregnant women with phenylketonuria
  - Tyrosinemia
  - Homocystinuria
  - Maple syrup urine disease
  - Propionic acidemia or methylmalonic acidemia in infants and children

Nutritional counseling

We cover nutritional counseling when Medically Necessary with a Prior Authorization. This includes nutrition-related diagnostic, therapeutic and counseling services furnished by a

registered dietician or nutrition professional for the purpose of disease management. Nutritional counseling includes an initial assessment of nutritional status followed by planned visits for dietary interventions to treat medical illness.

Organ transplant

We cover human organ transplants, including bone marrow transplants, with Prior Authorization. Members must meet the criteria set by the Massachusetts Department of Public Health. Transplants must be nonexperimental surgical procedures provided by an In-network Provider. Coverage includes cadaver donor costs and living donor costs if not covered by the donor's own coverage. We don't cover donor charges for Members who donate organs to nonmembers or recipients of transplants who aren't *Tufts Health Direct* Members. We don't cover personal searches for solid organs or stem cell donation outside the organ bank.

Orthotics

We provide coverage for nondental braces and other mechanical or molded devices when Medically Necessary, excluding oral devices.

We cover shoe inserts only for Members with diabetes without Prior Authorization.

Oxygen and respiratory therapy equipment services

We cover oxygen and respiratory therapy equipment with Prior Authorization, such as:

- Ambulatory liquid oxygen systems and refills
- Aspirators
- Compressor-driven nebulizers
- Intermittent positive pressure breathers
- Oxygen, oxygen gas, oxygen-generating devices and oxygen-therapy equipment rental

Pediatric dental care

We cover pediatric dental care services for members 18 years and younger. Dental care includes Medically Necessary preventive and restorative, basic and major restorative services. Orthodontia is covered when Medically Necessary and Prior Authorization is required. Please call Delta Dental for more information.

Podiatry

We cover Medically Necessary nonroutine podiatry services for Members when a licensed In-network Podiatrist performs the service. We cover routine foot care only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot.

Preventive health care services

We cover Preventive health care services in full to the extent required by the Affordable Care Act. The below list of Preventive health care services are the most common. For a complete and up-to-date list of covered Preventive health care services, please see our preventive services list on tuftshealthplan.com

For children

- Physical exam, history, measurements, sensory screening, neuropsychiatric evaluation and developmental screening, and assessment at the following intervals:
  - Six times during the child's first year after birth
  - Three times during the second year of life (age 1 to age 2)
  - Annually from age 2 through age 5 (until age 6)
- Hereditary and metabolic screening at birth
- Newborn hearing screening test before discharge from the Hospital or birthing center
- Newborn care for properly enrolled newborns and adoptive children, such as medically diagnosed congenital defects and birth abnormalities, or premature birth
- Immunizations, tuberculin tests, hematocrit, hemoglobin, blood lead screening, or other appropriate blood tests and urinalysis as recommended by a Provider
- Routine physical exams for children age 6 and older, including vision and auditory screening

For adults

- Routine medical exams (once per Benefit Year) and related routine lab tests and X-rays
- Routine hearing exams and screenings
- Recommended routine preventive immunizations

- Routine preventive screening tests and procedures (for example, screening colonoscopies in the absence of symptoms, with or without surgical intervention)
- Nutritional counseling and health education

For women, including pregnant women

- Routine gynecological exam. This includes a routine cytologic (Pap smear) screening once per Benefit Year. You must see an In-network Provider (PCP, obstetrician or gynecologist), Nurse Practitioner or certified nurse midwife.
- Prenatal care
- Baseline mammograms for women between the ages of 35 and 40, and routine annual screening mammograms once per Benefit Year for women age 40 and older
- Laboratory tests associated with routine maternity care:
  - Voluntary sterilization procedures
  - Breast pumps and related supplies
  - Lactation counseling and support from a trained In-network Provider
  - Prescription drug and nonprescription contraceptives listed on our *Preferred Drug List*, as described earlier in the Family-planning Services section

In addition, Tufts Health Plan covers as a preventive service through an In-network Provider an online diabetes/cardiovascular disease prevention program for people at risk of diabetes and/or cardiovascular disease. For more details, please visit our website.

Prosthetics

We cover certain prosthetic devices, including evaluation, fabrication, fitting and the provision and repair of the prosthesis, with Prior Authorization. This includes:

- Prosthetic arms, legs and eyes

Supplies

We cover prescribed, Medically Necessary disposable medical supplies used to treat a specific medical condition up to the limits documented in your "Benefit and Cost-sharing Summary" without Prior Authorization.

Vision care

We cover routine eye exams for Members once every 24 months from ophthalmologists or optometrists who are part of our Network. Members 18 years and younger are covered for routine eye exams every 12 months. For all Plan Levels, Members with diabetes are eligible for and are strongly encouraged to get vision exams every 12 months. Eyeglasses are covered for Members 18 years and younger. See "Benefit and Cost-sharing Summary" for more details on vision coverage.

Weight loss program reimbursement

You can request a reimbursement for a qualified weight loss program approved by your PCP. We will cover the first three months, not including any initiation fees and food costs.

You must be a *Tufts Health Direct* Member for three months and participate in a qualified weight loss program for at least three consecutive months. Each Member on a family plan can request a weight loss program reimbursement once per Benefit Year.

Call us at **888.257.1985**, and we'll send you a reimbursement form to complete. You can also get the form at tuftshealthplan.com.

Note: Only the following weight loss programs qualify for this reimbursement: Jenny Craig, Weight Watchers, and Nutrisystem.

If you get a bill for a Covered Service

You may get a bill for Co-payments, Co-insurance and/or a Deductible for some Covered Services, if you obtained services from an Out-of-network Provider. If you get a bill that you believe is a mistake, don't pay it and call us at **888.257.1985**.

Services not covered

Services we do not cover include, but are not limited to, the following:

- Acupuncture (except to treat substance use)
- Biofeedback
- Cosmetic services and procedures, unless required to restore bodily function or correct a functional physical impairment after an accidental injury, prior surgical procedure or congenital/birth defect. (Prior Authorization is required. No benefits are provided solely for the purpose of making you look better, whether or not these services are meant to make you feel better about yourself or treat a mental condition.)
- Custodial care
- Some types of Durable Medical Equipment:
  - Elevators
  - "Back-up" equipment
  - Whirlpool equipment, used for soothing/comfort
  - Hospital-type beds requiring installation in a home
  - Hygienic equipment that does not serve a primary medical purpose
  - Nonmedical equipment otherwise available to Members that does not serve a primary medical purpose
  - Bed lifters, not primarily medical
  - Nonhospital beds and mattresses
  - Hospital-type beds in full, queen and king sizes
  - Cushions, pads and pillows, except when Medically Necessary and we give Prior Authorization
  - Pulse tachometers
- Educational testing and evaluations
- Exams a third party requires (e.g., physical, psychiatric and psychological examinations, or testing by a third party, such as an employer, court or school)
- Experimental or investigational treatment
- Routine podiatry/foot care, except as noted on page 33
- Hearing aids for Members more than 21 years old (see "Benefit and Cost-sharing Summary" for more information)
- Laser eyesight correction or any other eye surgery to treat a condition that another treatment besides surgery can correct
- Services from Out-of-network Providers, unless we give Prior Authorization (except Emergency services, which never need Prior Authorization)
- Personal comfort items, such as air conditioners, air purifiers, chair lifts, dehumidifiers, radios, telephones and televisions
- Reversal of voluntary sterilization
- Any service or supply that is not Medically Necessary
- A Provider's charge for shipping and handling, or copying of records
- Medications, devices, treatments and procedures that have not been demonstrated to be medically effective
- Routine care, including routine prenatal care, when you're outside our Service Area
- Services for which there would be no charge in the absence of insurance
- Special equipment you need for sports or job purposes
- Any nonemergency dental services for Members 19 years and older
- A service or supply that is not covered by or at the direction of a *Tufts Health Direct* Provider, except for Emergency services
- Replacement of Durable Medical Equipment or prosthetics due to loss, intentional damage or negligence
- Services for which we did not give required Prior Authorization

Care Management

We provide Care Management services to help keep you well and improve your health. We accept and screen all referrals for our Care Management programs. Our Care Management services may include helping you to make and keep appointments, providing you with health information and coordinating your care with your Provider(s). Care Management includes four main types:

- Health and wellness support
- Disease management programs
- Transition of care
- Integrated care management, which includes medical care management for Members with complex care needs, intensive clinical management (ICM), behavioral health and social care management

Care Management doesn't replace the care you get from your Primary Care Provider (PCP) or other Providers but helps support it. Please remember to schedule regular and ongoing visits with your Providers.

Our care managers work with your Providers to coordinate your care and make sure you get the care you need when you need it. Call us at **888.257.1985** to talk to our Care Management team, Monday through Friday, from 8 a.m. to 5 p.m.

Health and wellness support

Maternal and child health program

We work closely with you and your Providers to make sure you get ongoing prenatal care if you're pregnant. We can also help coordinate care you may need after you deliver. For information about the benefits and services we offer pregnant *Tufts Health Direct* Members, see page 32.

24/7 NurseLine

We have a NurseLine for help with health questions, 24 hours a Day, seven Days a week. When you call our 24/7 NurseLine at 888-MY-RN-LINE (888.697.6546) (TTY: 800.942.1859), you can talk with a caring and supportive licensed health care professional at no cost.

24/7 NurseLine staff members can give you general health information and support on health care topics, such as symptoms, diagnoses, treatments, tests, test results and procedures your Provider orders. 24/7 NurseLine staff members do not give medical advice and are not a replacement for your Providers.

Help with quitting smoking

Tufts Health Direct Members can get medications from their doctor and counseling from the Massachusetts Tobacco Cessation & Prevention Program to help quit smoking. For more information about quitting smoking, talk to your PCP.

Disease management programs

We want to help you get the best health care possible. We use evidence-based guidelines (guidelines based on the best research) in our disease management programs. These programs help you live as healthfully as possible and feel your best. We have staff members who are experts on many health topics, so we can connect you with information and community resources you can really use. For more information, please visit us at tuftshealthplan.com or call us at **888.257.1985**. We have disease management programs for asthma and diabetes.

Asthma

There's a lot we can do to help keep asthma from keeping you down. Working with your Provider, we can help you avoid trips to the emergency room and live life to its fullest. With our free in-home asthma education program, we can even send a nurse to your home to help you get started.

The nurse can give you information and tools to help you understand asthma and its causes, triggers and symptoms. A visiting nurse can also help you:

- Learn how to spot the warning signs of a flare-up (attack) before it happens
- Look for problems in your home that may make your asthma worse
- Talk with you about an asthma action plan
- Review and educate you about your medications
- Take other steps to make sure you get any other services you might need

The visiting nurse, with Prior Authorization from us, can also order supplies such as a mattress and pillow covers for you. If you have asthma or think you have asthma, please contact our asthma program manager today at **888.257.1985**.

Diabetes

Our diabetes program has staff members available to help you manage type 1, type 2 and gestational diabetes. We cover diabetes supplies and lab work, such as HbA1c and lipids tests, as well as yearly dilated eye exams. One of our diabetes clinicians can arrange your care with your PCP and any Specialists you may need to see. You also can use our Behavioral Health and social care management programs. If you need it, you can take classes that are approved by the American Diabetes Association.

We stay in touch with our Members with diabetes. We may send you helpful information, such as information about why certain tests are important and how you can better manage diabetes. We may also call to remind you about yearly lab work and PCP appointments. Visiting Nurse Association services are available to help you get any needed ongoing medical care. We also offer, when appropriate, diabetes education if you're homebound.

Transition of care

When you leave a 24-hour care facility (like an acute-care Hospital, a Rehabilitation Hospital, a transitional care unit or a Skilled Nursing Facility), our care team will help you with your transition of care needs (the care you need to help you keep getting better). Our care team will work with ancillary Providers to make sure you get the services you need when you need them. Ancillary Providers include a Visiting Nurse Association or other home care agency and Durable Medical Equipment Providers.

The transition plan or transition of care plan includes:

- Providing you educational information about your condition, your medication, managing your disease and what you can expect
- Providing you with individual and integrated care management
- Developing a plan to help you get the services you need
- Coordinating your care needs with your Providers

Your Provider can ask us to provide you transition of care services by visiting tuftshealthplan.com or calling us at **888.257.1985**.

Behavioral Health (mental health and/or substance use) care services

We have different levels of Behavioral Health services, based on what type and how many services you need, and/or any medical condition you may have. You can find a list of these services (including inpatient, outpatient, substance use disorder and diversionary services) in the "Benefit and Cost-sharing Summary" at the end of this handbook. You don't need Prior Authorization for the first 12 outpatient Behavioral Health therapy visits each Benefit Year with an In-network provider. Therapy visits with an In-network Provider to treat substance use disorder do not require Prior Authorization. You can find a list of Behavioral Health Providers who can provide these services at tuftshealthplan.com or you may call us at **888.257.1985**.

Tufts Health Plan's Behavioral Health clinicians are licensed clinicians who can help you by:

- Monitoring your treatment
- Reviewing your need for ongoing care
- Participating with your health care team on discharge planning
- Giving you information about community-based services

Together we can help make sure you get the best care. We want to:

- Continue to improve your health and your family's health
- Make sure you have timely and easy access to the appropriate level of Behavioral Health care
- Involve you in your treatment planning and recovery
- Make sure your care continues smoothly if you change Providers or plans
- Coordinate your care among your Providers and, with your consent, make sure that your PCP and Behavioral Health Providers share relevant information regarding diagnoses, medication and/or treatment

Any time you're having a Behavioral Health Emergency, call 911 or go to the nearest Emergency room. For a complete list of Emergency rooms throughout the state, please visit us at tuftshealthplan.com or call us at **888.257.1985**.

Integrated care management

When appropriate, our Behavioral Health, medical and social care managers work closely with you and each other to coordinate the care you need. We call this an integrated care management model. It is designed to make sure you get the best care and results possible.

Integrated care management can help if you have complex and/or specific medical needs and conditions, like:

- A physical disability

- A special health condition like a high-risk pregnancy, cancer or HIV/AIDS
- A behavioral health problem
- Any other chronic health condition

Integrated care management can help you:
- Get health information from a care manager
- Find out what resources and benefits you can get
- Work with one of our Care Managers to coordinate your care with your Provider(s)

Our team of dedicated health care professionals includes:
- Nurses
- Behavioral Health (mental health and/or substance use) clinicians
- Social care managers

This team understands how to work with you if you have special health care needs. They will make sure you get care in the right place to help you get and stay healthy. This includes care at home, at a Provider's office, at a Hospital, in school, in person or by phone. Our team will work with you to:
- Answer your questions
- Address your needs
- Develop a plan to get you feeling better
- Monitor your health

Some Care Managers make home visits, explain how to manage a condition, and arrange for services and equipment. Other care managers may also help with any medical, behavioral health, social and financial needs.

Care Management services

We provide Care Management services, including:
- Complex care management
- Behavioral Health (mental health and/or substance use) intensive clinical management (ICM)
- Social care management

Complex Care Management

Our complex Care Management program is for Members with hard-to-manage, unstable, and/or fragile, long-lasting medical conditions. Members in these programs get help from a team of dedicated health care professionals who can help them get and stay healthy. They can also help to identify, reduce or remove social barriers to appropriate care.

Members with the following conditions may benefit from our complex care management services:
- Multiple health conditions that are hard to manage
- Intensive-care needs
- Cancer
- HIV/AIDS
- Organ transplantation
- Severe disability or impairment

Our Care Managers can give you valuable information and help coordinate your care. Call **888.257.1985** to talk to a Care Manager.

Behavioral Health (mental health and/or substance use) intensive clinical management (ICM)

We can offer you Behavioral Health ICM if you:
- Have severe Behavioral Health issues
- Have two or more Behavioral Health inpatient hospital admissions during a two-month period
- Haven't accessed or can't access community-based services
- Experience a catastrophic event
- Have a history of multiple hospitalizations
- Are newly diagnosed with a major mental illness
- Have special needs or cultural issues that require multiple agencies to coordinate service delivery

Call us at **888.257.1985** if you want more information or have questions about Behavioral Health ICM and how we determine the care we approve.

Social care management

Our social Care Management team can help you with more than health care issues. Social care managers are here to support you with anything in your life that could affect your health, including getting health care. Social care managers can help you:
- Ask for benefits like Supplemental Security Income (SSI) and Social Security and Disability Insurance (SSDI)
- Find emergency shelter
- Access community services in conjunction with services we provide
- Get information about programs that help pay for utilities (electricity or heat)
- Locate disability support groups
- Find school-based services

- Access Behavioral Health resources

Our clinical community outreach program is a two- to six-week program that will help you become familiar and involved with:
- Preventive Care services
- Health maintenance programs
- Community resources that are available to you as a Tufts Health Plan Member

Our clinical community outreach team can:
- Connect you to our programs that help you with any medical needs and conditions
- Help you find a doctor
- Support you in getting help with food, transportation and/or housing
- Make sure you know what benefits you can get

We will look at your situation and will then refer you to another member of our Care Management team, if we think it's necessary.

Call us at **888.257.1985** if you want more information or if you have questions about the clinical community outreach program.

Quality Management

We are committed to seeing that you get high-quality health care in the right place, at the right time, with the best possible results.

Our Quality Management and Improvement Program Description (QMIPD), produced annually, is:
- An overview of our Quality Management and improvement methods and measures
- A high-level overview of our care and disease management programs and activities
- A summary of our patient safety-focused work

The QMIPD includes:
- A description of our Quality Management programs, resources devoted to the programs, program structure and its governing body
- Both medical and Behavioral Health (mental health and/or substance use) care aspects of our quality program
- A discussion of our yearly Member survey that evaluates your satisfaction with access to:
  - Specialist services
  - Ancillary Services like lab tests
  - Hospitalization services
  - Durable Medical Equipment
  - Other Covered Services
- Objectives for serving our culturally and linguistically diverse membership and Members with complex health needs

We are committed to the improvement of Culturally and Linguistically Appropriate Services (CLAS) and to reducing disparities in health care. The U.S. Department of Health and Human Services defines cultural competence as the ability to:
- Understand the social, linguistic, moral, intellectual and behavioral characteristics of a community or population
- Translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations

The Quality Management and Improvement and Utilization Management Program Evaluations document our success in achieving measurable improvements in the quality of care and services. Some of our notable quality achievements include:
- For 2015 – 2016, we were rated 4.5 out of 5 among health insurance plans according to the National Committee for Quality Assurance (NCQA) Medicaid Health Insurance Plan Ratings with respect to our separate Medicaid plans, and we were the No. 1 Medicaid Health Plan in the U.S. for 2014 – 2015. NCQA's Health Plan Accreditation is developed with input and support from health plans, purchasers, unions and consumer groups. It is the nation's most trusted and comprehensive independent source for evaluating health care quality and value. The *Tufts Health Direct* (our qualified health plan) product is an NCQA-accredited Marketplace plan. NCQA does not currently rate Marketplace offerings.

If you have a concern about the quality of care you get from a Tufts Health Plan Provider or the services we provide, please contact us at **888.257.1985**, Monday through Friday, 8 a.m. to 5 p.m.

Utilization Management

Our Utilization Management (UM) program's purpose is to manage health care costs by reviewing whether certain medical services, supplies and drugs are Medically Necessary. We also review whether they are being given in the most clinically appropriate and cost-effective manner. We base all UM decisions on how appropriate the care is and your coverage. We don't reward Providers, UM clinical staff or consultants for denying care. We don't offer Network Providers, UM clinical staff or consultants money or financial incentives that could discourage them from making a certain service available to you.

Utilization Review — clinical guidelines and review criteria

Utilization review criteria are used to determine if services requested are Medically Necessary as defined by health care services that are consistent with generally accepted principles of professional medical practice. These guidelines are updated periodically and are available at tuftshealthplan.com/medicalnecessityguidelines.

For status or outcome of utilization review decisions, please call us at **888.257.1985**, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays, or log on to *Tufts Health Member Connect*. When deciding what services are best for your health care needs, we make consistent and objective decisions. Local practicing Providers help us create clinical guidelines and utilization review criteria. We also use standards that national accreditation organizations develop. We review these guidelines annually, or more often as new drugs, treatments and technologies become generally accepted. We always look at what's best for you first.

If you have questions about UM or want more information on how we determine the care we approve, please call us at **888.257.1985**, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays. Our staff is available to discuss utilization issues during these business hours, as well as to respond to voicemails and faxes. If you leave a voicemail or send a fax during nonbusiness hours, we will respond the next business day.

Experimental and/or investigational drugs and procedures

As new technologies come up, we have a way to consider whether or not to cover new (experimental) procedures, including clinical trials. Before we decide to cover new procedures, equipment and prescription drugs, we look at how safe they are and how well these treatments work. Our medical management team, led by our chief medical officer, makes all decisions on whether to cover experimental and/or investigational procedures. If you have questions about our pharmacy program or benefits, please call us at **888.257.1985**.

Tufts Health Direct EXTRAS

To help you get your healthiest, we reward you with *Tufts Health Direct* EXTRAS discounts and perks. See the following table for details about EXTRAS and how to get them. You must be a current, eligible *Tufts Health Direct* Member to get the EXTRAS we give our Members. However, some restrictions may apply, and we reserve the right to change or stop giving an EXTRA at any time.

EXTRAS	What It Is	How To Get It
CVS ExtraCare Health Card	With the CVS ExtraCare Health Card all new enrollees will receive 20% off regular-priced CVS/pharmacy brand, health-related items valued at $1 or more.	Watch your mail for your CVS ExtraCare Health Card, which should arrive in eight to 10 weeks.
$25 diabetes checkup supermarket gift card	If you have diabetes, we want to help you manage it. We'll give you a $25 supermarket gift card for completing five routine diabetes checkups: • An eye exam • Two blood sugar (HbA1c) tests • A protein test • A blood cholesterol test	• Call us at **888.257.1985** and ask to speak to a member of our staff. We'll send you a form with a list of screenings to complete in a calendar year. Getting these screenings will help you manage your diabetes. You can also get the form at tuftshealthplan.com/DirectExtras. • Visit your PCP, complete the tests and fill out the form • Have your PCP sign the form • Make a copy of the form to keep for yourself • Mail the completed form to: **Tufts Health Plan** **Attn: Claims Department** **P.O. Box 9194** **Watertown, MA 02471-9194** • Watch your mail for your $25 supermarket gift card, which should come in six to eight weeks NOTE: You must be a Tufts Health Plan Member when you get the five screenings and when we process your form. You can get one $25 supermarket gift card every 12 months for completing the five screenings.

Fitness band for completing your yearly checkup	If you get a yearly checkup, we will send you a fitness band that will help you track daily steps, calories, sleep monitoring and more.	• Call us at **888.257.1985** and ask to speak to a member of our staff. We'll send you a form to complete. You can also get the form at tuftshealthplan.com/DirectExtras. • Visit your PCP, complete your yearly checkup, and fill out the form • Have your PCP sign the form • Make a copy of the form to keep for yourself • Mail the completed form to: **Tufts Health Plan** **Attn: Claims Department** **P.O. Box 9194** **Watertown, MA 02471-9194** • NOTE: You must be a Tufts Health Plan Member when you get your yearly checkup and when we process your form. You can get one fitness band for completing your yearly checkup.
Car and booster seats gift cards	Members who are 28 or more weeks pregnant, or Members who are 8 years old or younger, are eligible to get a $50 department store gift card to use to buy a convertible car seat (for kids 5 – 40 pounds and 19 – 43 inches tall). Also, one year later, as long as your child is a Tufts Health Plan Member, you can get a $25 department store gift card to use to buy a booster car seat (for kids 30 – 100 pounds and 43 – 57 inches tall).	Call us at **888.257.1985** and ask to speak to a member of our staff. We'll send you a form to complete. You can also get the form at tuftshealthplan.com/DirectExtras. • Visit your PCP, complete the tests and fill out the form • Have your PCP sign the form. • Fill out the form and make a copy for yourself. • Mail the completed form to: **Tufts Health Plan** **Attn: Claims Department** **P.O. Box 9194** **Watertown, MA 02471-9194** • Watch your mail for your gift card, which should arrive in six to eight weeks.

How to resolve concerns

Inquiries

An Inquiry is any question or request that you may have about how we work. As a Tufts Health Plan Member, you have the right to make an Inquiry at any time. We'll resolve your Inquiries immediately or, at the latest, within three business days of the day we get it. We'll let you know the resolution the day we resolve your Inquiry.

Grievances

If you are dissatisfied with something Tufts Health Plan has done or not done, you have the right to file a Grievance. This means you can tell us why you are dissatisfied, and we will look into the situation and resolve it. (If you are dissatisfied with an Adverse Determination, you may file an Appeal; see the next section.)

You may file a Grievance up to 180 Days after the action or inaction that is of concern to you. You may file a Grievance for any reason, such as:

- If you're dissatisfied with the quality of care or services you get
- If one of your Providers or one of our employees is rude to you
- If you believe one of your Providers or one of our employees did not respect your rights
- If you disagree with our decision to extend the time frame for making an Authorization or a Standard Internal Appeal or Expedited Internal Appeal decision
- If you disagree with our decision not to expedite a Standard Internal Appeal request

Your Authorized Representative, if you identify one, can file a Grievance for you. You can appoint an Authorized Representative by sending us a signed Tufts Health Plan Authorized Representative Form. You can get a form at tuftshealthplan.com or by calling our Member Services Team at **888.257.1985**, Monday through Friday, from 8 a.m. to 5 p.m.

If we don't get your signed *Tufts Health Direct* Authorized Representative Form within 30 Days of someone other than you filing a Grievance on your behalf, we'll dismiss the Grievance.

How to file a Grievance

You or your Authorized Representative may file a Grievance in the following ways:

Telephone — call us at **888.257.1985**, Monday through Friday, from 8 a.m. to 5 p.m.

TTY/TTD — people with hearing loss can call our TTY line at 888.391.5535, Monday through Friday, from 8 a.m. to 5 p.m.

Mail — mail a Grievance to Tufts Health Plan, Attn: Appeal and Grievance Team, P.O. Box 9193, Watertown, MA 02471-9193

Email — email a Grievance via the "Contact us" section of our website at tuftshealthplan.com

Fax — fax a Grievance to us at 617.972.9509

In person — visit our office at 705 Mount Auburn Street (Watertown, Mass.), Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays

Once you file a Grievance, we will:

- Tell you or your Authorized Representative that we got your Grievance by sending you a written notice within five business days
- Look into and resolve your Grievance within 30 Days from when we get your Grievance
- Tell you or your Authorized Representative in writing of the outcome of your Grievance, which will include the information we considered and will explain our decision
- Provide interpreter services, if necessary

Appeals

As a *Tufts Health Direct* Member, you, your provider or your Authorized Representative has the right to request a Standard Internal Appeal if you disagree with any Adverse Determination.

How to request a Standard Internal Appeal

You or your Authorized Representative may request a Standard Internal Appeal within 180

Days of an Adverse Determination in the following ways:

Telephone — call us at **888.257.1985**, Monday through Friday, from 8 a.m. to 5 p.m. **TTY/TTD** — people with hearing loss can call our TTY line at 888.391.5535, Monday through Friday, from 8 a.m. to 5 p.m.

Mail — mail a request for a Standard Internal Appeal, with a copy of the notice of Adverse Determination and any more information about the Standard Internal Appeal, to: Tufts Health Plan, Attn: Appeal and Grievance Team, 9193, Watertown, MA 02471-9193

Email — request a Standard Internal Appeal by email via the "Contact us" section of our website at tuftshealthplan.com

Fax — request a Standard Internal Appeal by faxing us at 617.972.9509

In person — visit our office at 705 Mount Auburn Street (Watertown, Mass.), Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays

Although you have **180 Days** to request a Standard Internal Appeal, we encourage you to act as soon as possible.

We will let you know we got your Standard Internal Appeal request by sending you a written notice **within 48 hours** of receiving your written or verbal appeal.

Other people who can request a Standard Internal Appeal for you

Your Authorized Representative can request a Standard Internal Appeal for you. You need to tell us in writing if your Authorized Representative will request a Standard Internal Appeal for you.

You can appoint an Authorized Representative by sending us a signed Tufts Health Plan Authorized Representative Form. You can get a form by calling our Member Services Team at **888.257.1985**. You can also find this form at tuftshealthplan.com.

Note: If someone tries to request a standard appeal for you and you did not already send us an Authorized Representative Form for that person, we will tell you in writing that a request has been made and will send you a copy of the Authorized Representative Form to sign and return to us. We will not take further action until we get the signed Authorized Representative Form. If you do not send the form, we will dismiss the request, unless it is an Expedited Internal Appeal requested by a Provider.

Continuation of services during the appeal process

If your appeal concerns the termination of ongoing coverage or treatment, the disputed coverage shall remain in effect at our expense through the completion of the Internal Appeals Process. This will happen as long as you or your Authorized Representative requests the Standard or Expedited Internal Appeal in a timely manner. You will still need to pay your portion of cost sharing, as indicated in your "Benefit and Cost-sharing Summary." Only those services that were originally authorized by us and that were not terminated pursuant to a specific time or episode-related exclusion will continue to be covered.

Standard Internal Appeal time frames

We'll review and make a decision about your Standard Internal Appeal request within 30 Days* from the date we get your request. We may ask to extend the time frame if we need more information. The extra time will not be more than 30 Days.

* Any Appeal, including an Expedited Internal Appeal, not properly acted on by Tufts Health Plan within the time limits specified will be decided in your favor.

Reviewing medical records as part of the Standard Internal Appeal

You may send us written comments, documents or other information relating to your Standard Internal Appeal. You have the right to review your case file, which includes information like medical records and other documents and records we considered during the Appeal process.

Expedited Internal Appeals

You or your Authorized Representative may request an Expedited (fast) Internal Appeal if you or your Provider thinks that our standard time frame of 30 Days:

- Could seriously harm your life, health or ability to get back to maximum function
- Will cause you severe pain that cannot be adequately managed without the requested service

If you or your provider believes your appeal requests meets the criteria noted above, you or your Authorized Representative may request an Expedited Internal Appeal from us orally, in writing or in person, rather than requesting a Standard Internal Appeal. If the request is not made by a Provider, it will be reviewed by a Tufts Health Plan Physician Reviewer MD, to determine if the criteria for an expedited appeal have been met. You or your Authorized Representative will be notified of the status of your appeal no later than 24 hours of receipt of your request. You or your Authorized Representative may also request an expedited external review from the Office of Patient Protection (OPP) at the same time you request an Expedited Internal Appeal. For more information, please see the sections on Expedited External Reviews starting on page 46.

Time limits include any extensions made by mutual written agreement between you or your Authorized Representative and Tufts Health Plan.

There are four situations in which we may review a Standard Internal Appeal in a fast manner, and each situation has a certain time requirement in which we must decide the Standard Internal Appeal:

- If you're a patient in a Hospital, we must issue a decision before you're discharged from the Hospital.
- If a Provider tells us in writing that a delay in getting the requested service or supply would result in risk of substantial harm to you, we must issue a decision within 48 hours.

  Important note about prescription drugs: If your Provider feels it is Medically Necessary for you to take medications that are not on the formulary or restricted under any of the Tufts Health Plan pharmacy management programs, he or she may submit a request for coverage. We will review the request and provide you with notification of our coverage determination within 72 hours after receiving the request. We will approve the request if it meets our guidelines for coverage. For more information, you can call Member Services.

  Please note: You or your prescribing Provider may request an expedited exception process based on exigent circumstances. We will notify you and your prescribing Provider of our determination no later than 24 hours after receiving such a request. Exigent circumstances exist when a Member:
    - Is suffering from a health condition that may seriously jeopardize his or her life, health or ability to regain maximum function; or
    - Is undergoing a current course of treatment using a nonformulary drug.

- If you are requesting Durable Medical Equipment, we will issue a decision within 48 hours, or in less time when the Provider specifies a reasonable time.
- If you're terminally ill, we must review your Grievance or Standard Internal Appeal within five days, unless the request is for urgently needed services, in which case we must issue a decision within 72 hours.

Written notice of Appeal decisions

We will tell you our Appeal decisions in writing. For Adverse Determinations, this notice will include a clinical explanation for the decision, and will:

- Give specific information upon which we based an Adverse Determination
- Discuss your symptoms or condition, diagnosis, and the specific reasons why the evidence submitted doesn't meet the relevant medical review criteria
- Specify alternate treatment options we cover
- Reference and include applicable clinical practice guidelines and review criteria
- Let you or your Authorized Representative know your options to further appeal our decision, such as procedures for requesting an External Review and an Expedited External Review

External Review process

If you get a Final Adverse Determination from us, you have the opportunity to request an External Review from the Office of Patient Protection (OPP). You can ask for an Expedited Internal Appeal and an Expedited External Appeal at the same time. You or your Authorized Representative is responsible for starting the External Review process. We'll enclose an External Review Form any time we issue a Final Adverse Determination. To start the review, send the required form to the OPP at this address within four months of getting our Final Adverse Determination:

Health Policy Commission
Office of Patient Protection
50 Milk Street, Eighth Floor
Boston, MA 02109

If you've been getting a Covered Service and we end coverage of the service, the disputed coverage will continue at our expense through the end of the appeal process. This will happen as long as you request an External Review before the end of the second business day of getting your Final Adverse Determination. You will still need to pay your portion of cost sharing, as indicated in your "Benefit and Cost-sharing Summary." If the External Review Agency decides you should keep getting the service because there could be substantial harm to you if the service ends, we'll keep covering the service until the External Review is decided, no matter what the final External Review decision.

The OPP will screen all requests for External Reviews to see if they:

- Meet the requirements of the External Review
- Don't involve a service or benefit we specify in this *Member Handbook* as excluded from coverage
- Result from our issuing a Final Adverse Determination. (You won't need a Final Adverse Determination from us if we fail to act within the timelines for the Standard Internal Appeal or if you filed for an Expedited External Review from the OPP and an Expedited Internal Appeal from us at the same time.)

The OPP will screen your request for an External Review within five business days of receiving the request. Once your case is deemed eligible for External Review, the OPP will submit it to the External Review Agency. The External Review Agency will then send you a written decision within 45 Days.

Expedited External Reviews

You may request an Expedited External Review if your Provider tells the OPP in writing that a delay in providing the care would result in a serious threat to your health. The OPP will screen your review within 72 hours of receiving the request from us. Expedited External Reviews are resolved within four business days from when the External Review Agency gets the referral from the OPP. You may request an Expedited External Review at the same time you request an Expedited Internal Appeal from Tufts Health Plan.

When your External Review involves a decision by us to end a previously approved service

If the External Review involves ending ongoing coverage of services, you may apply to the OPP to keep getting the services during the External Review. You need to make the request before the end of the second business day after you get our Final Adverse Determination. If the External Review Agency decides you should keep getting the service because there could be substantial harm to you if the service ends, we'll keep covering the service until the External Review is decided, no matter what the final External Review decision is.

How to contact the Office of Patient Protection (OPP)

If you have questions about your rights as a Member or questions about the External Review process, you can contact the OPP at 800.436.7757 or by fax at 617.624.5046, or visit the OPP's website at mass.gov/hpc/opp.

You may also contact the OPP by email at HPC-OPP@state.ma.us or by mail at:

Health Policy Commission
Office of Patient Protection
50 Milk Street, Eighth Floor
Boston, MA 02109

Questions or concerns

If you have questions or concerns about the grievance and/or appeal process, please call our Member Services Team at **888.257.1985**, Monday through Friday, from 8 a.m. to 5 p.m.

If you need help, the Consumer Assistance Resource Program in Massachusetts can help you file your appeal. Contact:

Health Care for All
1 Federal Street
Boston, MA 02110
800.272.4232

Your rights and responsibilities

Your Member rights

As a Tufts Health Plan Member, you have the right to:

- Be treated with respect and dignity regardless of your race, ethnicity, creed, religious belief, sexual orientation or source of payment for care
- Get Medically Necessary treatment, including emergency care
- Get information about us and our services, Primary Care Providers (PCPs), Specialists, other Providers, and your rights and responsibilities
- Have a candid discussion of appropriate or Medically Necessary treatment options for your condition(s) regardless of cost or benefit coverage
- Work with your PCP, Specialists and other Providers to make decisions about your health care
- Accept or refuse medical or surgical treatment
- Call your PCP's and/or Behavioral Health (mental health and/or substance use) Provider's office 24 hours a Day, seven Days a week
- Expect that your health care records are private, and that we abide by all laws regarding confidentiality of patient records and personal information, in recognition of your right to privacy
- Get a second opinion for proposed treatments and care
- File a Grievance to express dissatisfaction with us, your Providers, or the quality of care or services you get
- Appeal a denial or Adverse Determination we make for your care or services
- Be free from any form of restraint or seclusion used as a means of coercion, discipline or retaliation
- Ask for more information or explanation of anything included in this *Member Handbook*, either orally or in writing
- Ask for a duplicate copy of this *Member Handbook* at any time
- Get written notice of any significant and final changes to our Provider Network, including but not limited to PCP, Specialist, Hospital and facility terminations that affect you
- Ask for and get copies of your medical records, and ask that we amend or correct the records, if necessary
- Get the services we cover (see page 22)
- Make recommendations about our Member rights and responsibilities policy
- Ask for and get this *Member Handbook* and other Tufts Health Plan information translated into your preferred language

Advance Directives

Advance Directives are written instructions, sometimes called a living will, for health care. Advance Directives are recognized under Massachusetts law and relate to getting health care when a person isn't capable of making a decision. If you're no longer able to make decisions about your health care, having an Advance Directive can help. These written instructions will tell your Providers how to treat you if you aren't able to make your own health care decisions.

In Massachusetts, if you're at least 18 years old and of sound mind, you can make decisions for yourself. You may also choose someone as your health care proxy. Your health care proxy can make health care decisions for you in the event that your Providers determine you're unable to make your own decisions.

As a Tufts Health Plan Member, you have certain rights that relate to an Advance Directive. To choose a health care proxy, you must fill out the standard Health Care Proxy form, available from your Provider or Tufts Health Plan. You can also request a Health Care Proxy form from the Commonwealth of

Massachusetts. Write to the address below and send a self-addressed and stamped envelope to:

Commonwealth of Massachusetts
Executive Office of Elder Affairs
1 Ashburton Place, Room 517
Boston, MA 02108

With Advance Directives, you also have the right to:

- Make decisions about your medical care
- Get the same level of care, and be free from any form of discrimination, whether or not you have an Advance Directive
- Get written information about your Provider's Advance Directive policies
- Have your Advance Directive in your medical record

Our Providers will comply with state law concerning Advance Directives. We also educate staff members and people they interact with in the community about Advance Directives.

Your Member responsibilities

As a Tufts Health Plan Member, you have the responsibility to:

- Treat all Providers with respect and dignity
- Keep appointments, be on time, or call if you'll be late or need to cancel an appointment
- Give us, your Primary Care Provider (PCP), Specialists and other Providers complete and correct information about your medical history, medicine you take, and other matters about your health
- Ask for more information from your PCP and other Providers if you don't understand what they tell you
- Participate with your PCP, Specialists, and other Providers to understand and help develop plans and goals to improve your health
- Follow plans and instructions for care that you've agreed to with your Providers
- Understand that refusing treatment may have serious effects on your health
- Contact your PCP or Behavioral Health Provider within 48 hours after you visit the emergency room, for follow-up care
- Change your PCP or Behavioral Health Provider if you aren't happy with your current care
- Voice your concerns and complaints clearly
- Tell us if you have access to any other insurance
- Tell us if you suspect potential Fraud and/or abuse
- Tell us and the Health Connector about any address, phone or PCP changes
- Tell us if you're pregnant

More information available to you

You can learn about other Members' experiences with Tufts Health Plan by calling us at **888.257.1985** (TTY: 888.391.5535), Monday through Friday, 8 a.m. to 5 p.m. Types of available information include *Tufts Health Direct* voluntary and involuntary disenrollment rates.

You can also get information about us from:

- The Massachusetts Board of Registration in Medicine at mass.gov/eohhs/gov/departments/borim, which may be able to give you information about Providers licensed to practice in Massachusetts
- The Office of Patient Protection (OPP), which can also give you information about your rights as a managed care member and about the External Review process
  - A list of sources of independently published information assessing Members' satisfaction and evaluating the quality of Health Care Services we offer
  - The percentage of Providers who voluntarily and involuntarily ended contracts with us during the previous calendar year, and the three most common reasons for voluntary and involuntary Provider disenrollment
  - The percentage of Premium revenue we spend for Health Care Services for our Members during the most recent year for which information is available
  - A summary report on Appeals, such as the number of Appeals filed, the number of Appeals approved internally, the number of Appeals denied internally and the number of Appeals withdrawn before resolution

Protecting your benefits

Help reduce health care Fraud and abuse. Examples of Fraud or abuse include:

- Receiving bills for Health Care Services you never got
- Individuals loaning their health insurance ID card to others for the purpose of getting Health Care Services or prescription drugs
- Being asked to provide false or misleading health care information

To report potential health care Fraud and abuse, or if you have questions, please call us at **888.257.1985** Monday through Friday, 8 a.m. to 5 p.m., or email fraudandabuse@tufts-health.com. We don't need your name or Member information. You can also call our confidential hotline anytime at 800.826.6762 or send an anonymous letter to us at:

Tufts Health Plan
Attn: Fraud and Abuse
705 Mount Auburn Street
Watertown, MA 02472

Our responsibilities

We're committed to protecting your rights and privacy. Our Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) and how you can access this information. Please review this section carefully. You can also read our complete Notice of Privacy Practices at tuftshealthplan.com or get another copy by calling us at **888.257.1985**, Monday through Friday, from 8 a.m. to 5 p.m.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE OF PRIVACY PRACTICES CAREFULLY.

Tufts Health Plan is committed to safeguarding the privacy of our members' protected health information ("PHI"). PHI is information that:

- Identifies you (or can reasonably be used to identify you); and
- Relates to your physical or mental health or condition, the provision of health care to you, or the payment for that care.

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI. This Notice of Privacy Practices describes how we may collect, use and disclose your PHI, and your rights concerning your PHI. This Notice applies to all members of Tufts Health Public Plans, Inc. ("Tufts Health Plan") health benefit plans.

How we obtain PHI. As a managed care plan, we engage in routine activities that result in our being given PHI from sources other than you. For example, health care providers — such as physicians and hospitals — submit claim forms containing PHI to enable us to pay them for the covered health care services they have provided to you.

How we use and disclose your PHI. We use and disclose PHI in a number of ways to carry out our responsibilities as a managed care plan. The following describes the types of uses and disclosures of PHI that federal law permits us to make without your specific authorization:

- Treatment: We may use and disclose your PHI to health care providers to help them treat you. For example, our Care Managers may disclose PHI to a home health care agency to make sure you get the services you need after discharge from a hospital.
- Payment purposes: We use and disclose your PHI for payment purposes, such as paying doctors and hospitals for covered services. Payment purposes also include activities such as determining eligibility for benefits, reviewing services for Medical Necessity, performing utilization review, obtaining premiums, coordinating benefits, subrogation and collection activities.
- Health care operations: We use and disclose your PHI for health care operations. For example, this includes population-based activities relating to improving health or reducing health care costs, coordinating/managing care, assessing and improving the quality of health care services, reviewing the qualifications and performance of providers, reviewing health plan performance, conducting medical reviews and resolving grievances. It also includes business activities such as underwriting, rating, placing or replacing coverage, determining coverage policies, business planning, obtaining reinsurance, arranging for legal and auditing services (including fraud and

abuse detection programs), and obtaining accreditations and licenses. We do not use or disclose PHI that is genetic information for underwriting purposes.

- Health and wellness information: We may use or disclose your PHI so that you may be contacted with information about appointment reminders; treatment alternatives; therapies; health care providers; settings of care; or other health-related benefits, services, and products that may be of interest to you. For example, you may receive information about smoking cessation or weight management programs.
- Organizations that assist us: In connection with treatment, payment, and health care operations, we may share your PHI with our affiliates and third-party "business associates" that perform activities for us or on our behalf (for example, our pharmacy benefit manager). We will obtain assurances from our business associates that they will appropriately safeguard your information.
- Government entities: You are enrolled in *Tufts Health Direct,* a plan sponsored by the Health Connector. We may disclose PHI to the Health Connector if required pursuant to federal or state law or for the lawful administration of providing your benefits.
- Public health and safety and health oversight: We may disclose your PHI to a public health authority for public health activities, such as responding to public health investigations; when authorized by law, to appropriate authorities, if we reasonably believe you are a victim of abuse, neglect, or domestic violence; when we believe in good faith that it is necessary to prevent or lessen a serious and imminent threat to your or others' health or safety; or to health oversight agencies for certain activities, such as audits, disciplinary actions, and licensure activity.
- Legal process; law enforcement; specialized government activities: We may disclose your PHI in the course of legal proceedings; in certain cases, in response to a subpoena, discovery request, or other lawful process; to law enforcement officials for such purposes as responding to a warrant or subpoena; to the government agency with which we contract to provide your insurance; or for specialized governmental activities, such as national security.
- Research; death; organ donation: We may disclose your PHI to researchers, provided that certain established measures are taken to protect your privacy. We may disclose PHI, in certain instances, to coroners, medical examiners, and in connection with organ donation.
- Workers' Compensation: We may disclose your PHI when authorized by Workers' Compensation laws.
- Family and friends: We may disclose PHI to a family member, relative, or friend, or anyone else you identify as follows: (i) when you are present prior to the use or disclosure and you agree; or (ii) when you are not present (or you are incapacitated or in an emergency situation) if, in the exercise of our professional judgment and in our experience with common practice, we determine that the disclosure is in your best interests. In these cases we will only disclose the PHI that is directly relevant to the person's involvement in your health care or payment related to your health care.
- Personal representatives: Unless prohibited by law, we may disclose your PHI to your personal representative, if any. A personal representative is a person who has legal authority to act on your behalf regarding your health care or health care benefits. For example, an individual named in a durable power of attorney or the parent or guardian of an unemancipated minor is a personal representative.
- Communications: We will communicate information containing PHI to the address or telephone number we have on record for the subscriber of your health benefits plan. Also, we may mail information containing your PHI to the subscriber. For example, communication regarding member requests for reimbursement may be addressed to the subscriber. We will not make separate mailings for enrolled dependents at different addresses, unless we are requested to do so and agree to the request. See below, "Right to receive confidential communications," for more information on how to make such a request.
- Required by law: We may use or disclose your PHI when we are required to do so by law. For example, we must disclose your PHI to the U.S. Department of Health and Human Services upon request if they wish to determine whether we are in compliance with federal privacy laws.

If one of the above reasons does not apply, we will not use or disclose your PHI without your

written permission ("authorization"). You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may later change your mind and revoke your authorization in writing. However, your written revocation will not affect actions we've already taken in reliance on your authorization. Where state or other federal laws offer you greater privacy protections, we will follow those more stringent requirements. For example, under certain circumstances, records that contain information about alcohol abuse treatment, drug abuse prevention or treatment, AIDS-related testing or treatment, or certain privileged communications, may not be disclosed without your written authorization. In addition, when applicable, we must have your written authorization before using or disclosing medical or treatment information for a member appeal. See below, "Who to contact for questions or complaints," if you would like more information.

How we protect PHI within our organization. Tufts Health Plan protects oral, written and electronic PHI throughout our organization. We do not sell PHI to anyone. We have many internal policies and procedures designed to control and protect the internal security of your PHI. These policies and procedures address, for example, use of PHI by our employees. In addition, we train all employees about these policies and procedures. Our policies and procedures are evaluated and updated for compliance with applicable laws.

Your individual rights. The following is a summary of your rights with respect to your PHI:

- Right of access to PHI: You have the right to inspect and get a copy of most PHI that Tufts Health Plan has about you, or a summary explanation of PHI if agreed to in advance by you. Requests must be made in writing and reasonably describe the information you would like to inspect or copy. If your PHI is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable cost-based fee for paper or electronic copies as established by state or federal law. Under certain circumstances, we may deny your request. If we do so, we will send you a written notice of denial describing the basis of our denial. You may request that we send a copy of your PHI directly to another person whom you designate. Your request must be in writing, be signed by you, and clearly identify the person and the address where the PHI should be sent.
- Right to request restrictions: You have the right to ask that we restrict uses or disclosures of your PHI to carry out treatment, payment, and health care operations; and disclosures to family members or friends. We will consider the request. However, we are not required to agree to it and, in certain cases, federal law does not permit a restriction. Requests may be made verbally or in writing to Tufts Health Plan.
- Right to receive confidential communications: You have the right to ask that we send communications of your PHI to you at an address of your choice or that we communicate with you in a certain way. For example, you may ask us to mail your information to an address other than the subscriber's address. We will accommodate your request if: (i) you state that disclosure of your PHI through our usual means could endanger you; (ii) your request is reasonable; (iii) it specifies the alternative means or location; and (iv) it contains information as to how payment, if any, will be handled. Requests may be made verbally or in writing to Tufts Health Plan.
- Right to amend PHI: You have the right to have us amend most PHI we have about you. We may deny your request under certain circumstances. If we deny your request, we will send you a written notice of denial. This notice will describe the reason for our denial and your right to submit a written statement disagreeing with the denial. Requests must be in writing to Tufts Health Plan and must include a reason to support the requested amendment.
- Right to receive an accounting of disclosures: You have the right to a written accounting of the disclosures of your PHI that we made in the six years prior to the date you request the accounting. However, except as otherwise provided by law, this right does not apply to: (i) disclosures we made for treatment, payment, or health care operations; (ii) disclosures made to you or people you have designated; (iii) disclosures you or your personal representative have authorized; (iv) disclosures made before April 14, 2003; and (v) certain other disclosures, such as disclosures for national security purposes. If you request an accounting more than once in a 12-month period, we may charge

you a reasonable fee. All requests for an accounting of disclosures must be made in writing to Tufts Health Plan.

- Right to authorize other use and disclosure: You have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing, or if we intended to sell your PHI. You may revoke an authorization at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.
- Right to receive a privacy breach notice: You have the right to receive written notification if we discover a breach of your unsecured PHI, and determine through a risk assessment that notification is required.
- Right to this Notice: You have a right to receive a paper copy of this Notice from us upon request.
- How to exercise your rights: To exercise any of the individual rights described above or for more information, please call member services at **888.257.1985** (TTY: 888.391.5535) or write to Compliance Department, Tufts Health Plan, 705 Mount Auburn Street, Watertown, MA 02472.

Effective date of Notice. This Notice takes effect October 1, 2015. We must follow the privacy practices described in this Notice while it is in effect. This Notice will remain in effect until we change it. This Notice replaces any other information you have previously received from us with respect to the privacy of your medical information.

Changes to this Notice of Privacy Practices. We may change the terms of this Notice at any time in the future and make the new Notice effective for all PHI that we maintain — whether created or received before or after the effective date of the new Notice. Whenever we make an important change, we will publish the updated Notice on our website at tuftshealthplan.com. In addition, we will use one of our periodic mailings to inform subscribers about the updated Notice.

Who to contact for questions or complaints. If you would like more information or a paper copy of this Notice, please contact a member services representative at the number listed above. You can also download a copy from our website at tuftshealthplan.com. If you believe your privacy rights may have been violated, you have a right to complain to Tufts Health Plan by calling the Privacy Officer at 800.2089549 or by writing to Privacy Officer, Compliance Department, Tufts Health Plan, 705 Mount Auburn Street, Watertown, MA 02472.

You also have a right to complain to the Secretary of Health and Human Services. We will not retaliate against you for filing a complaint.

When you have more insurance

You must tell us if you have any other health insurance coverage in addition to *Tufts Health Direct*. You must also let us know when there are any changes in your extra insurance coverage. The types of extra insurance you might have include:

- Coverage from an employer's group health insurance for employees or retirees, either for yourself or your spouse
- Coverage under Workers' Compensation because of a job-related illness or injury
- Coverage from Medicare or other public insurance
- Coverage for an accident where no-fault insurance or liability insurance is involved
- Coverage you have through veteran's benefits
- "Continuation coverage" that you have, such as through COBRA. COBRA is a law that requires employers with 20 or more employees to let employees and their Dependents keep their group health coverage for a time after they leave their Group Plan under certain conditions. See the section "Continuing coverage for group Members" on page 22 for more information.

Coordination of Benefits

When you have other health insurance coverage, we work with your other insurance to coordinate your *Tufts Health Direct* benefits consistent with Massachusetts law, 211 CMR 38.00 *et seq*. The way we work with the other companies depends on your situation. This process is called Coordination of Benefits. Through this Coordination of Benefits, you'll often get your health insurance coverage as usual through us. In other situations, such as for care we don't cover, another insurer other than us may be able to cover you.

We will coordinate benefits by determining which plan has to pay first when you make a claim, and which plan has to pay second. We determine the order of benefits using the first applicable rule set forth in 211 CMR 38.05 and pay or provide benefits pursuant to the rules set forth in 211 CMR 38.04 and 211 CMR 38.06. These regulations are available on the Massachusetts state website, www.mass.gov/code-of-massachusetts-regulations-cmr.

If you have more health insurance, please call us at **888.257.1985**, Monday through Friday, 8 a.m. to 5 p.m., to find out how payment will be handled.

Subrogation

If another person's action or omission injures you, your *Tufts Health Direct* benefits will be subrogated to any right you have to recover from another party or insurance company, including your own insurance company. Subrogation means that we may use your right to recover money from the person(s) who caused the injury or from any insurance company or other party. If another person or party is, or may be, liable to pay for services related to your illness or injury that we paid for or provided, we'll subrogate and succeed to all your rights to recover against such person or party 100% of the value of services we pay for or provide.

Your Provider should submit all Claims incurred as a result of any Subrogation case before any settlement. We may deny Claims for services rendered before a settlement that your Provider doesn't submit before that settlement is reached.

In the event another party or insurance company, including your own insurance company, pays you for your injuries, we are entitled to recover from you 100% of the amount you received regardless of whether the amount you receive is enough to compensate you in full for your injuries. Attorney's fees and/or expenses you incur won't reduce the amount you must pay back to us.

To enforce our Subrogation rights under this *Member Handbook,* we have the right to take legal action, with or without your consent, against any party to recover the value of services we provide or cover for which that party is, or may be, liable. Nothing in this *Member Handbook* may be interpreted to limit our right to use any means provided by law to enforce our rights to Subrogation under this plan.

We need you to follow all requirements for Prior Authorization even when third-party liability exists. Authorization isn't a guarantee of payment.

Member cooperation

As a *Tufts Health Direct* Member, you agree to cooperate with us in using our Coordination of Benefits and Subrogation rights. This means you must complete and sign all necessary documents to help us use our rights. You also must notify us before settling any Claim arising out of injuries you sustained by any liable party(s) for which we have provided coverage. You must not do anything that might limit our right to full payment.

We ask that you:

- Give us all information and documents we ask for
- Sign any documents we think are needed to protect our rights
- Promptly assign us any money you get for services that we've provided or paid for
- Promptly let us know of any possible Coordination of Benefits or Subrogation potential

You also must agree to do nothing to prejudice or interfere with our rights to Coordination of Benefits or Subrogation.

If you aren't willing to help us, you may have to pay for any expenses we incur, such as reasonable attorneys' fees, in enforcing our rights under this plan. Nothing in this *Member Handbook* may be interpreted to limit our right to use any means provided by law to enforce our rights to Coordination of Benefits or Subrogation under this plan.

Motor vehicle accidents and/or work-related injury/illness

If you're in a motor vehicle accident, regardless of fault, you may be entitled to medical benefits under your own or another individual's automobile coverage. These benefits are known as Personal Injury Protection (PIP) and Medical Payments (MedPay) benefits. PIP benefits under the automobile policy pays first, up to $2,000 in medical and funeral expenses. After PIP benefits are exhausted, our coverage becomes primary. If we pay for medical services connected to your motor vehicle accident before PIP benefits have been exhausted, we may recover the cost of those benefits as described above. MedPay is always secondary to our coverage. You must send us any explanation of payment or denial letters from an auto insurance carrier for us to consider paying a Claim that your Provider sends to us. In the case of a work-related injury or illness, the Workers' Compensation carrier will be responsible for those expenses first. You must send us any explanation of payment or denial letters from the Workers' Compensation carrier for us to consider paying a Claim that your Provider sends us.

Glossary

An **Advance Directive** is a legal document, sometimes called a living will, with written instructions that you create to manage your care if you are no longer capable of making decisions about your own health care. A living will gives instructions for treatment in the case of life-saving or life-sustaining situations. A health care proxy or a durable power of attorney for health care lets you choose someone specifically to make decisions for you if you become ill or incapacitated.

An **Adverse Determination** is a decision, based on a review of information you provide to us or our designated utilization review organization, to deny, reduce, modify, or end an admission, continued inpatient stay, experimental/ investigational service, or any other services, for failing to meet the requirements for coverage, based on Medical Necessity, appropriateness of health care setting, and level of care or effectiveness.

The **Affordable Care Act** (ACA) is the landmark federal health reform legislation passed in March 2010. The ACA began taking effect in 2010. The goal of the ACA is to extend health insurance coverage to millions of uninsured Americans, to help lower health care costs, and to make sure people can get insurance coverage even if they have pre-existing conditions.

Ancillary Services are tests, procedures, imaging, and support services (such as lab tests and radiology services) you get in a health care setting that help your Provider diagnose and/or treat your condition.

Appeal — see Standard Internal Appeal or Expedited Internal Appeal.

Authorization — see Prior Authorization.

An **Authorized Representative** is someone you approve in writing to act on your behalf regarding a specific Grievance, Appeal or External Review by the Office of Patient Protection (OPP). If you're unable to pick an Authorized Representative, your Provider, a guardian, conservator, or holder of a power of attorney may be your Authorized Representative. You can give your Authorized Representative a standing authorization to act on your behalf if you make this request in writing. This standing authorization will remain in effect until you revoke it. If you're a minor, and you're able by law to consent to a medical procedure, you may appeal our denial of the medical procedure without parent or guardian consent. In that case, you can also pick an Authorized Representative without parent or guardian consent.

Behavioral Health (mental health and/or substance use) services include visits, consultations, counseling, screenings, and assessments for mental health and/or substance use, as well as inpatient, outpatient, detoxification and diversionary services.

The **"Benefit and Cost-sharing Summary"** is the section included at the end of this *Member Handbook* to provide a general description of your *Tufts Health Direct* Plan Level's Covered Services. It lists benefits, Co-payment and Co- insurance amounts, if any, and any limits on the benefits your policy covers.

A **Benefit Year** is the consecutive 12-month period during which health plan benefits are purchased and administered; Deductibles, Co-insurance and the Out-of-pocket Maximums are calculated; and most benefit limits apply. Note: In some cases, your first Benefit Year will not be a full 12 months.

Care Management is how we regularly evaluate, coordinate, and help you with your medical, Behavioral Health (mental health and/or substance use), and/or social care needs. Through Care Management, we do our best to make sure you can access high-quality, cost-effective and appropriate care; get information about disease prevention and wellness; and help you get and stay healthy.

A **Certified Nurse Anesthetist** is certified by the board of registration in nursing to provide anesthesia services within the scope of Massachusetts law.

A **Claim** is a bill your Provider sends us to ask us to pay for services you get.

Co-insurance is an amount, stated as a percentage, that you must pay for certain Covered Services.

A **ConnectorCare Plan** is a subsidized non-Group Plan available only to Members with a household income of 0%–300% of the Federal

Poverty Level. Members must apply for and purchase a ConnectorCare Plan through the Health Connector.

Continuity of Care is how we make sure you keep getting the care you need when your doctor is no longer in our Network, or when you first become a Member and you were getting care from another doctor who is not in our Network.

Coordination of Benefits is how we get money from other sources to pay for your health care needs when you have coverage from more than one insurer.

A **Co-payment** is a fixed amount you may have to pay for a covered pharmacy or medical service.

The **Cost-sharing Reduction** program lets eligible members pay lower Out-of-pocket Maximum payments, Co-insurance and Co-payments based on income. To qualify for a Cost-sharing Reduction, you must apply for and purchase your insurance through the Health Connector.

Covered Services are the services and supplies *Tufts Health Direct* covers. The "Benefit and Cost-sharing Summary" we include in this *Member Handbook* includes all of your Covered Services and supplies.

Day means a calendar day, unless business day is specified.

The **Deductible** is the amount you pay for certain Covered Services in a Benefit Year before we will begin to pay for those Covered Services.

The **Department of Health and Human Services** is the United States department in charge of all federal programs dealing with health and welfare.

Dependents include the following individuals, until their 26th birthday: the Subscriber or spouse's natural child, stepchild or adoptive child; the Dependent child of an enrolled child; a Subscriber or spouse's disabled Dependent, who can be older than 26; and a child for whom the Subscriber or spouse is the court-appointed legal guardian. A child is an adoptive child as of the date he or she is legally adopted by the Subscriber or placed for adoption with the Subscriber, where "placed for adoption" means that the Subscriber has assumed a legal obligation for the partial or total support of a child in anticipation of adoption. If the legal obligation ends, the child is no longer considered to be placed for adoption (as required by state law, a foster child is considered an adoptive child as of the date that a petition to adopt was filed).

Durable Medical Equipment (DME) is equipment that can stand repeated use, is primarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury and is appropriate for use in the home.

Effective Coverage Date means the date on which you become a Member of *Tufts Health Direct* and are eligible to get Covered Services from *Tufts Health Direct* Providers.

An **Eligible Small Business or Group** as defined in accordance with the applicable law.

An **Emergency** is a medical or behavioral health (mental health and/or substance use) condition with such serious symptoms, including such severe pain, that a person with an average knowledge of health and medicine could realistically expect that not getting medical attention right away would result in the health of the Member (or in the case of a pregnant woman, the health of the woman and/or her unborn child) being put in serious danger; this danger could include serious damage to bodily function or a serious problem with any body organ or part. In the case of a pregnant woman who is having contractions, it would be an Emergency if there isn't enough time to safely transfer to another hospital before delivery, or if that transfer could be harmful to the health of the woman or her unborn child.

Essential Health Benefits are the minimum Health Care Services that health plans must cover, according to the Affordable Care Act. Essential Health Benefits include: Emergency services; hospitalization; maternity and newborn care; Behavioral Health (mental health and/or substance use) services, including Behavioral Health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Evidence of Coverage (EOC), also referred to as the *Member Handbook*, means this document. It was developed by Tufts Health Plan and filed with the Health Connector and the Division of Insurance (DOI). It details Covered Services provided by *Tufts Health Direct*, including, without limitation, any certificate, contract, or agreement of health insurance, including riders, amendments, endorsements, and any other supplementary inserts or a summary plan description issued to a Member.

An **Expedited External Review** is a request for a quick resolution to an External Review involving immediate and urgently needed services. You may request an Expedited External Review at the same time you request an Expedited Internal Appeal from Tufts Health Plan.

An **Expedited Internal Appeal** is an oral or written request for a fast review of an Adverse Determination when your life, health, or ability to attain, maintain, or regain maximum function will be at risk if we follow our standard time frames when reviewing your request. We will review Expedited Internal Appeals and make a decision about a request within 72 hours.

An **External Review** is a request for an External Review Agency to review Tufts Health Plan's final Standard Internal Appeal decision.

An **External Review Agency** is an accredited company under contract with the Office of Patient Protection and separate from Tufts Health Plan that looks at decisions made by Tufts Health Plan about a member's coverage. Providers who work at the designated External Review Agency review all appropriate medical records according to objective, evidence-based medical standards to make a final decision about a Member's Final Adverse Determination.

Family-planning Services include birth control methods, exams, counseling, education, pregnancy testing, follow-up health care and some lab tests.

The **Federal Poverty Level** is set each year by the Department of Health and Human Services. The Federal Poverty Level is the lowest amount of total income an individual or family needs for food, clothing, transportation, shelter and other necessities.

A **Federal Premium Tax Credit** is a way that the United States government can help you pay your premiums if your household income is less than or equal to 400% of the Federal Poverty Level. To qualify for a Federal Premium Tax Credit, you must apply for and purchase your insurance through the Health Connector.

A **Final Adverse Determination** is an Adverse Determination made after you have exhausted all remedies available through Tufts Health Plan's formal Appeal process.

Fraud is when someone dishonestly gets services or payment for services but doesn't have a right to them. An example of Fraud is Members lending their *Tufts Health Direct* Member ID Cards to other people so they can get health care or pharmacy services.

A **Grievance** is any expression of dissatisfaction by you or your Authorized Representative, if you identify one, about any action or inaction by Tufts Health Plan other than an Adverse Determination. Reasons to file Grievances may include, but aren't limited to, the quality of care or services provided, rudeness on the part of a Provider or employee of Tufts Health Plan, failure to respect your rights, a disagreement you may have with our decision not to approve a request to speed up a Standard Internal Appeal, a disagreement with our request to extend the time frame for resolving an authorization decision or an Appeal, and the retroactive ending of coverage due to fraud.

A **Group Plan** is an employee welfare benefit plan, as defined in the Employee Retirement Income Security Act. This means that the plan provides medical care, including items and services paid for as medical care to employees or their Dependents.

Habilitative Services are health care services provided in accordance with the federal Affordable Care Act (ACA) in order for a person to attain, maintain or prevent deterioration of a life skill or function never learned or acquired due to a disabling condition. These services may include physical and occupational therapy, speech-language pathology services in various Inpatient and Outpatient settings.

A **Health Benefit Plan** is 1) any individual, general, blanket, or group policy of health, accident, and sickness insurance issued by a licensed insurer; 2) an individual or group hospital service plan issued by a nonprofit

hospital service corporation; 3) an individual or group medical service plan issued by a nonprofit medical service corporation; or 4) an individual or group health maintenance contract issued by a health maintenance organization.

Health Care Services are services for the diagnosis, prevention, treatment, cure, or relief of a physical, behavioral, substance use disorder or mental health condition, illness, injury or disease.

The **Health Connector** is an independent state agency that helps eligible Massachusetts residents find affordable health care coverage. The Health Connector is the designated health insurance exchange for Massachusetts. The Health Connector reviews health plans offered by private insurance companies and approves plans that meet service and cost standards. The Health Connector also helps residents and employers choose the plan that best meets their needs.

A **Hospital** is any licensed facility that provides medical and surgical care for patients who have acute illnesses or injuries, and that the American Hospital Association (AHA) lists as a Hospital or that The Joint Commission accredits.

A *Tufts Health Direct* Member Identification Card **(ID Card)** is the card that identifies you as a Member of *Tufts Health Direct*. Your Member ID Card includes your name and your Member identification number, and must be shown to Providers before you get services.

In-network describes a Provider who Tufts Health Plan contracts with to provide Covered Services to Members.

Inpatient Services are services that need at least one overnight stay in a hospital setting. This generally applies to services you get in licensed facilities, such as Hospitals and Skilled Nursing Facilities.

An **Inquiry** is any question or request you have for us.

A **Licensed Mental Health Professional** is a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist, a licensed alcohol and drug counselor I, as defined in section 1 of chapter IIIJ, or a licensed marriage and family therapist.

Medically Necessary and **Medical Necessity** describe services that are, within reason, intended to prevent, diagnose, stop the worsening of, improve, correct, or cure conditions that endanger your life, cause suffering or pain, cause physical deformity or malfunction, may cause or worsen a disability, or that could result in making you very sick. Medically Necessary services are consistent with generally accepted principles of professional medical practice as determined by whether the service is 1) the most appropriate available supply or level of service for the Member in question, considering potential benefits and harms to the individual; 2) known to be effective, based on scientific evidence, professional standards, and expert opinion, in improving health outcomes; or 3) not in widespread use, as based on scientific evidence.

A **Member** is anyone enrolled in a Tufts Health Plan plan by choice.

Your ***Member Handbook*** is this document. It details Covered Services you get with *Tufts Health Direct*. It is our agreement with you, and includes any riders, amendments, or other documents that add to the details of Covered Services.

Member Services Team is the team at Tufts Health Plan that handles all of your questions about policies, procedures, requests and concerns. You can reach our Member Services Team at **888.257.1985**. For people with partial or total hearing loss, you can reach our Member Services Team at our TTY line: 888.391.5535. We are available Monday through Friday, from 8 a.m. to 5 p.m.

Network is the collective group of health care Providers who have contracted with Tufts Health Plan to provide Covered Services.

Non-preferred In-network Providers are Providers you can't see unless we give Prior Authorization. If you see a Non-preferred In-network Provider without Prior Authorization, we may not cover the cost.

Our **Notice of Privacy Practices** tells you about how we may use and disclose your Protected Health Information (PHI). We send

you our Notice of Privacy Practices upon enrollment.

Our 24/7 **NurseLine** is our helpline for health questions, 24 hours a Day, seven Days a week. When you call our NurseLine at 888-MY-RN-LINE (888.697.6546), you can talk with a caring and supportive health care professional at any hour and at no cost. 24/7 NurseLine staff members can give you information and support on health care issues like symptoms, diagnoses, and test results, as well as treatments, tests and procedures your Provider has ordered. 24/7 NurseLine staff members don't give medical advice or replace your Provider.

A **Nurse Practitioner** is a registered nurse who holds authorization in advanced nursing practice as a Nurse Practitioner under Massachusetts law.

Occupational Therapy helps people gain the knowledge, skills and attitude necessary to perform the activities of daily life.

An **Out-of-network Provider** is a Provider we don't contract with to provide Covered Services to Members.

Out-of-pocket Maximum is the maximum amount of cost sharing you are required to pay in a Benefit Year for Covered Services. All *Tufts Health Direct* plans have an Out-of-pocket Maximum.

Outpatient Medical Care refers to the services provided in a Provider's office, a day surgery or ambulatory care unit, an emergency room or outpatient clinic, or other location. Outpatient services include all services that aren't Inpatient Services.

Physical Therapy refers to the treatment of disease, injury, or disability by physical and mechanical means, such as massage, regulated exercise, or water, light, heat, or electrical therapy.

A **Physician Assistant** is a health care provider licensed to practice medicine with physician supervision.

Plan Level refers to the kind of cost sharing your specific *Tufts Health Direct* plan has. There are four Plan Levels (some of the levels have sub-levels):

- Platinum plans: Highest monthly Premiums, but low out-of-pocket costs
- Gold plans: Higher monthly Premiums, but low out-of-pocket costs
- Silver plans: Moderate monthly Premiums and moderate out-of-pocket costs
- Bronze plans: Lower monthly Premiums, but higher out-of-pocket costs

Your Member ID Card will show your specific *Tufts Health Direct* Plan Level.

A **Podiatrist** is a specialist who provides medical and surgical foot care services within the scope of practice of a licensed Podiatrist under Massachusetts law.

Premium is the monthly financial contribution that *Tufts Health Direct* Members pay for coverage.

Preventive Care includes a variety of services for adults and children, such as annual physicals, blood pressure screenings, immunizations, behavioral assessments for children, and many other services to help keep you from getting sick, that must be covered without cost-sharing under the Affordable Care Act.

Primary Care is the arrangement of coordinated, comprehensive medical services you get during a first visit with a Provider and at any later time. Primary Care involves an initial medical history intake, medical diagnosis and treatment, Behavioral Health (mental health and/or substance use) screenings, communication of information about illness prevention, health maintenance and Prior Authorizations.

A **Primary Care Provider** (PCP) is the individual Provider or team you select, or to whom we assign you, to provide general medical care for common health care problems. A PCP supervises, coordinates, prescribes, or otherwise provides or proposes Health Care Services; initiates Referrals for Specialists; and maintains Continuity of Care within the scope of practice. PCPs who are doctors must practice one of the following specialties: family practice, internal medicine, general practice, adolescent and pediatric medicine, or obstetrics/gynecology (for women only). PCPs must be board-certified or eligible for board certification in their specialty. You may also choose a licensed Nurse Practitioner or a licensed Physician Assistant as your PCP if the Nurse Practitioner or Physician Assistant is

a Provider in our Network. PCPs for people with disabilities, including people with HIV/AIDS, may include practitioners in other specialties.

Prior Authorization is a process that determines if you need a specific Health Care Service or where you can get a specific Health Care Service. Tufts Health Plan must approve certain types of services and Providers before you can get the service or see the Provider. We take into account the benefit, any benefit limits, the Provider's Network status and other factors when we make our decision.

Protected Health Information (PHI) is any information (oral, written, or electronic) about your past, present, or future physical or mental health or condition, or about your health care, or payment for your health care. PHI includes any individually identifiable health information, which includes any health information that a person could use to identify you.

A **Provider** is an appropriately credentialed and licensed individual, facility, agency, institution, organization, or other entity that has an agreement with Tufts Health Plan, or its subcontractor, to deliver the Covered Services under this contract.

The online **Provider Directory** lists *Tufts Health Direct*'s contracted health care facilities and professionals, including all PCPs, Specialists listed by specialty, Hospitals, emergency rooms and Emergency Services Program Providers, pharmacies, Ancillary Services, and Behavioral Health (mental health and/or substance use) services. You can call us at **888.257.1985** to get a printed Provider Directory, free of charge. The Provider Directory is also available at tuftshealthplan.com through our Find a Doctor, Hospital or Pharmacy tool.

Quality Management is the process we use to monitor and improve the quality of care our Members get.

Reasonable Charge is the lesser of the: amount charged; or amount that we determine to be reasonable, based upon nationally accepted means and amounts of claims payment. Nationally accepted means and amounts of claims payment include, but are not limited to: Medicare fee schedules and allowed amounts, CMS medical coding policies, AMA CPT coding guidelines, nationally recognized academy and society coding and clinical guidelines. With respect to Emergency Care, Reasonable Charge is the highest of: (1) the median amount negotiated with in-network providers for the emergency service; (2) the amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary and reasonable (UCR) amount); or (3) the amount that would be paid under Medicare for the emergency service (collectively, minimum payment standards).

A **Reconsideration of a Standard Internal Appeal** is a request by you or your Authorized Representative, if you identify one, for us to review our Standard Internal Appeal decision a second time. We will review and make a decision about a Reconsideration of a Standard Internal Appeal request within 30 Days of the date we get the request

A **Referral** is notification from your Primary Care Provider to us that you can get care from a different Provider.

A **Rehabilitation Hospital** is a facility licensed to provide therapeutic services to help patients restore function after an illness or injury. These facilities provide Occupational, Physical, and Speech Therapy and skilled nursing care services.

A **Resident** is a person living in Massachusetts. Confinement in a nursing home, Hospital, or other institution is not by itself sufficient to qualify a person as a resident.

Service Area is the geographical area within which Tufts Health Plan has developed a Network of Providers for *Tufts Health Direct* plans to provide adequate access to Covered Services and is approved by the Health Connector to enroll Members.

A **Skilled Nursing Facility** is a licensed inpatient facility that provides skilled nursing to Members who don't require or no longer require the services of an acute-care Hospital.

A **Specialist** is a doctor who is trained to provide specialty medical services. Examples include cardiologists, obstetricians, and dermatologists, or for Behavioral Health (mental health and/or substance use) services, a psychologist, psychiatrist or social worker.

Speech Therapy refers to the evaluation and treatment of speech, language, voice, hearing and fluency disorders.

A **Standard Internal Appeal** is an oral or written request for Tufts Health Plan to review any Adverse Determination. We will review and make a decision about a Standard Internal Appeal request within 30 Days of the date we get the request.

Subrogation is the procedure under which Tufts Health Plan can recover the full or partial cost of benefits paid from a third person or entity, such as an insurer.

A **Subscriber** is the person who signs the membership application form on behalf of him or herself and any Dependents and in whose name the Premium is paid in accordance with either a group contract or an individual contract (as applicable). For an individual contract, a Subscriber must live in Massachusetts. For a group contract, a Subscriber is an employee of a group.

Urgent Care includes services that aren't emergency or routine.

Utilization Management (UM) is our constant process of reviewing and evaluating the care you get to make sure that it is appropriate and what you need.

Utilization Review is our process of reviewing information from doctors and other clinicians to help us decide what services you need to get better or stay healthy. Our formal review methods help us monitor the use of — or evaluate the clinical necessity, appropriateness or efficiency of — Covered Services, procedures or settings. The review methods may include but aren't limited to ambulatory review, prospective review, second opinion, certification, concurrent review, Care Management, discharge planning or retrospective review.

A **Waiting Period** is a specified period immediately following the effective date of an eligible Member's coverage under a health plan during which the plan does not pay for some or all medical expenses. There is no Waiting Period for *Tufts Health Direct* coverage.

Workers' Compensation is insurance coverage employers maintain under state and federal law to cover employees' injuries and illnesses under certain conditions.

Your Health Form is a series of questions we ask Members so that we can get their most up-to-date health information.

Direct ConnectorCare
Plan Type I

Benefit and Cost-sharing Summary

This "Benefit and Cost-sharing Summary" gives you information about your *Tufts Health Direct* Covered Services and costs you may have to pay. The fees for Covered Services are different depending on your Plan Level. Make sure you review the services you're eligible for under the "Benefit and Cost-sharing Summary" for your specific Plan Level. To see which Plan Level you have, check your Tufts Health Plan Member ID Card or call us at **888.257.1985**, Monday through Friday, 8 a.m. to 5 p.m.

For some of your Covered Services, you will have to pay a Co-payment and/or Co-insurance (check the "Benefit and Cost-sharing Summary" for your specific Plan Level). Co-insurance is an amount, stated as a percentage of the cost of the service, that you must pay for certain Covered Services. You don't have to pay a Co-payment for Preventive Care services, such as physical examinations, Family-planning Services, contraceptives, health screenings, or vaccinations. For a complete listing of the types of Preventive Care services covered, please visit the U.S. Preventive Services Task Force website at www.uspreventiveservicestaskforce.org.

Your *Tufts Health Direct* plan may also have a Deductible. A Deductible is the amount you pay for certain Covered Services in a Benefit Year before we will begin to pay for those Covered Services.

You're responsible for paying the Co-payment, Deductible, and/or Co-insurance amounts listed in this "Benefit and Cost-sharing Summary." If you don't pay the Co-payment, Deductible, and/or Co-insurance at the time of your visit, you will still owe the money to the Provider. The Provider may use a legal method to collect the money from you. Tufts Health Plan won't pay the Provider for the Co-payment and/or Co-insurance that you owe.

Direct ConnectorCare Plan Type I is available to qualified individuals who, through the Health Connector's eligibility determination process, are determined to meet the prescribed eligibility criteria. Under this plan, members receive reduced cost-sharing (Co-payment, Deductible, and/or Co-insurance). The amount of reduction a member receives under this plan is the difference between the cost-sharing in the chart listed below and the cost-sharing for Direct Silver 2500 with Coinsurance.

This summary gives you a general understanding of your benefits. If you want more information about your benefits, see the section "Covered Services" on page 22. This *Member Handbook* also has a list of services that aren't covered.

You must go to Providers (doctors, Hospitals, and other health care professionals) who are part of the *Tufts Health Direct* Provider Network to get services. For Primary Care, you must see the Primary Care Provider (PCP) you have on record. To choose your PCP, check on your assigned PCP, or change your PCP, please visit us at tuftshealthplan.com or call us at **888.257.1985**. Services are only covered for In-network Providers, except for emergency care and certain other cases.

All nonemergency Out-of-network visits require Prior Authorization.

Under the federal Affordable Care Act, there are no annual or lifetime dollar limits on Essential Health Benefits.

The *Tufts Health Direct* Provider Network can change at any time. Always check with Tufts Health Plan for the most up-to-date information.

If you have questions about your *Tufts Health Direct* benefits or you need help locating an In-network Provider, call us at **888.257.1985**. The Tufts Health Plan Member Services Team can help you Monday through Friday, from 8 a.m. to 5 p.m.

Direct ConnectorCare Plan Type I

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
OUTPATIENT MEDICAL CARE		
Office Visits		
• Primary Care Provider preventive care/ screening/immunization	No Co-payment	
• Primary Care Provider nonpreventive office visit	No Co-payment	
• Specialist	No Co-payment	
• Urgent Care Center (UCC) visit	No Co-payment	
Eye Care (Vision Care)	No Co-payment	Coverage for routine eye exams for members 18 years and younger once every 12 months. For members older than 18 years, coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics. Eye glasses covered once every 12 months for members 18 years and younger. Collection frames only.
Pediatric Dental		Covered for pediatric dental care services for Members 18 years and younger. Medically Necessary orthodontia requires Prior Authorization.
• Type I Services: Preventive & Diagnostic	No Co-payment	
• Type II Services: Basic Covered Services	No Co-payment	
• Type III Services: Major Restorative Services	No Co-payment	
• Type IV Services: Orthodontia (only as Medically Necessary)	No Co-payment	
Outpatient Surgery (outpatient hospital/ambulatory surgery centers)	No Co-payment	Covered if Medically Necessary at In-network outpatient facility. May require Prior Authorization.
Lab	No Co-payment	Covered if Medically Necessary. Includes blood tests, urinalysis, Pap smears, and throat cultures to maintain health and to test, diagnose, treat, and prevent disease. Genetic testing may require Prior Authorization.
X-ray Services	No Co-payment	Covered if Medically Necessary
Advanced Imaging Services (MRI, CT, PET)	No Co-payment	Requires Prior Authorization
Abortion Services	No Co-payment	
INPATIENT MEDICAL CARE		
Inpatient Medical Care Room and board (includes deliveries/surgery/radiology services/labs)	No Co-payment	Inpatient medical care covered according to Medical Necessity and subject to Prior Authorization. Elective admissions require submission of Prior Authorization form 5 business days before admission.
PHARMACY		
Pharmacy		Please see *Preferred Drug List* for specific Prior Authorization requirements
Retail drugs (up to 30-Day supply)		
• Tier 1 (primarily generic focused)	$1 Co-payment	
• Tier 2 (primarily preferred brand)	$3.65 Co-payment	No Co-payment for:
• Tier 3 (primarily nonpreferred brand)	$3.65 Co-payment	• Birth control and family-planning supplies
Mail-order drugs (up to 90-Day supply)		
• Tier 1 (primarily generic focused)	$2 Co-payment	
• Tier 2 (primarily preferred brand)	$7.30 Co-payment	
• Tier 3 (primarily nonpreferred brand)	$7.30 Co-payment	
EMERGENCY CARE		
Emergency Care	No Co-payment	Notification required within 24 hours, if admitted

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
MENTAL HEALTH AND/OR SUBSTANCE USE TREATMENT		
Inpatient Mental Health and/or Substance Use	No Co-payment	Inpatient mental health and/or substance use treatment services covered according to Medical Necessity and subject to Prior Authorization
Outpatient Mental Health and/or Substance Use Treatment		
• Individual therapy/Counseling	No Co-payment	• After 12 Behavioral Health outpatient therapy visits per Benefit Year, requires Prior Authorization except for substance use treatment visits or group therapy visits
• Methadone treatment (dosing, counseling, labs)	No Co-payment	• No Prior Authorization required; does not count toward initial 12 Behavioral Health outpatient therapy visits
• Autism spectrum disorder treatment o Applied behavioral analysis	No Co-payment	• Requires Prior Authorization; does not count toward initial 12 Behavioral Health outpatient therapy visits. Includes assessments, evaluations, testing, and treatment; covered in home, outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst
• Medication-Assisted Treatment (MAT) services	No Co-payment	• No Prior Authorization required
REHABILITATION AND HABILITATIVE SERVICES		
Cardiac Rehabilitation	No Co-payment	Requires Prior Authorization
Home Health Care	No Co-payment	Requires Prior Authorization if daily or longer than six months
Inpatient Skilled Nursing Facility	No Co-payment	Maximum of 100 Days total per Member per Benefit Year; requires Prior Authorization
Inpatient Rehabilitation Hospital or Chronic Disease Hospital	No Co-payment	Maximum of 60 Days total per Member per Benefit Year; requires Prior Authorization
Short-term Outpatient Rehabilitation	No Co-payment	Requires Prior Authorization
Physical/Occupational/Speech Therapy	No Co-payment	May require Prior Authorization after initial evaluation. Maximum of 60 visits total combined Physical and Occupational Rehabilitative Therapy per Member per Benefit Year. No limit on Speech Therapy.
Habilitative Services	No Co-payment	May require Prior Authorization after initial evaluation. Maximum of 60 visits total combined Physical and Occupational Habilitative Therapy per Member per Benefit Year. No limit on Speech Therapy.
OTHER BENEFITS		
Breastfeeding Services	No Co-payment	Includes one non-hospital grade breast pump per pregnancy, breastfeeding supplies, and lactation consultants
Chiropractic Care	No Co-payment	Doesn't require prior authorization
Cleft Palate/Cleft Lip Care	No Co-payment	Covered for Members 18 and younger. Includes medical, dental, oral, and facial surgery, follow-up, and related services. Requires Prior Authorization.
Durable Medical Equipment • Supplies • Prosthetics • Oxygen and respiratory therapy equipment	No Co-payment	May require Prior Authorization (see list at tuftshealthplan.com)
Early Intervention Services	No Co-payment	Covered for Members 3 and younger; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention specialist.
Fitness Reimbursement	50% Co-insurance for first 3 months	Covered for first 3 months; excludes initiation fees. This benefit is available to all Members once every Benefit Year.
Ground Ambulance	No Co-payment	Emergency transport only; nonemergency transport covered if Medically Necessary and with Prior Authorization.

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
Hearing Aids	No Co-payment	Only covered for Members 21 and younger. Full cost of one hearing aid per hearing-impaired ear up to $2,000 for each hearing aid for 36 months. Related services and supplies do not count toward the $2,000 limit.
Hospice	No Co-payment	Requires Prior Authorization
Infertility Services	No Co-payment	Requires Prior Authorization. Includes diagnosis and treatment, such as in vitro fertilization, gamete intrafallopian tube transfer, assisted hatching, and sperm banking. Must meet eligibility requirements. Some limitations apply.
Orthotics	No Co-payment	Requires Prior Authorization. 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 for diabetics only.
Podiatry	No Co-payment	Medically Necessary nonroutine foot care covered; requires Prior Authorization. Routine foot care services for diabetics don't require Prior Authorization.
Qualified Clinical Trials	No Co-payment	Covered only if Medically Necessary; requires Prior Authorization
Weight Loss Programs	No Co-payment for the first 3 months	Covered for first 3 months; excludes initiation fees and food
Wellness		
• Family planning	No Co-payment	Doesn't require Prior Authorization
• Nutritional counseling	No Co-payment	Requires Prior Authorization
• Prenatal care	No Co-payment	Doesn't require Prior Authorization
• Nurse midwife	No Co-payment	Doesn't require Prior Authorization

ANNUAL MEDICAL OUT-OF-POCKET MAXIMUM	
Individual	$0
Family	$0

ANNUAL PHARMACY OUT-OF-POCKET MAXIMUM	
Individual	$250
Family	$500

Co-insurance and Co-payments apply toward your Out-of-pocket Maximum.

Services not covered

See the section "Services not covered" on page 35 for the list of services not covered.

Direct ConnectorCare
Plan Type II

Benefit and Cost-sharing Summary

This "Benefit and Cost-sharing Summary" gives you information about your *Tufts Health Direct* Covered Services and costs you may have to pay. The fees for Covered Services are different depending on your Plan Level. Make sure you review the services you're eligible for under the "Benefit and Cost-sharing Summary" for your specific Plan Level. To see which Plan Level you have, check your Tufts Health Plan Member ID Card or call us at **888.257.1985**, Monday through Friday, 8 a.m. to 5 p.m.

For some of your Covered Services, you will have to pay a Co-payment and/or Co-insurance (check the "Benefit and Cost-sharing Summary" for your specific Plan Level). Co-insurance is an amount, stated as a percentage of the cost of the service, that you must pay for certain Covered Services. You don't have to pay a Co-payment for Preventive Care services, such as physical examinations, Family-planning Services, contraceptives, health screenings, or vaccinations. For a complete listing of the types of Preventive Care services covered, please visit the U.S. Preventive Services Task Force website at www.uspreventiveservicestaskforce.org.

Your *Tufts Health Direct* plan may also have a Deductible. A Deductible is the amount you pay for certain Covered Services in a Benefit Year before we will begin to pay for those Covered Services.

You're responsible for paying the Co-payment, Deductible, and/or Co-insurance amounts listed in this "Benefit and Cost-sharing Summary." If you don't pay the Co-payment, Deductible, and/or Co-insurance at the time of your visit, you will still owe the money to the Provider. The Provider may use a legal method to collect the money from you. Tufts Health Plan won't pay the Provider for the Co-payment and/or Co-insurance that you owe.

Direct ConnectorCare Plan Type II is available to qualified individuals who, through the Health Connector's eligibility determination process, are determined to meet the prescribed eligibility criteria. Under this plan, members receive reduced cost-sharing (Co-payment, Deductible, and/or Co-insurance). The amount of reduction a member receives under this plan is the difference between the cost-sharing in the chart listed below and the cost-sharing for Direct Silver 2500 with Coinsurance.

This summary gives you a general understanding of your benefits. If you want more information about your benefits, see the section "Covered Services" on page 22. This *Member Handbook* also has a list of services that aren't covered.

You must go to Providers (doctors, Hospitals, and other health care professionals) who are part of the *Tufts Health Direct* Provider Network to get services. For Primary Care, you must see the Primary Care Provider (PCP) you have on record. To choose your PCP, check on your assigned PCP, or change your PCP, please visit us at tuftshealthplan.com or call us at **888.257.1985**. Services are only covered for In-network Providers, except for emergency care and certain other cases.

All nonemergency Out-of-network visits require Prior Authorization.

Under the federal Affordable Care Act, there are no annual or lifetime dollar limits on Essential Health Benefits.

The *Tufts Health Direct* Provider Network can change at any time. Always check with Tufts Health Plan for the most up-to-date information.

If you have questions about your *Tufts Health Direct* benefits or you need help locating an In-network Provider, call us at **888.257.1985**. The Tufts Health Plan Member Services Team can help you Monday through Friday, from 8 a.m. to 5 p.m.

Direct ConnectorCare Plan Type II

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
OUTPATIENT MEDICAL CARE		
Office Visits		
• Primary Care Provider preventive care/ screening/immunization	No Co-payment	
• Primary Care Provider nonpreventive office visit	$10 Co-payment	
• Specialist	$18 Co-payment	
• Urgent Care Center (UCC) visit	$18 Co-payment	
Eye Care (Vision Care)	$10 Co-payment for routine eye exam $18 Co-payment for all other vision services	Coverage for routine eye exams for members 18 years and younger once every 12 months. For members older than 18 years, coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics. Eye glasses covered once every 12 months for members 18 years and younger. Collection frames only.
Pediatric Dental		Covered for pediatric dental care services for Members 18 years and younger. Medically Necessary orthodontia requires Prior Authorization.
• Type I Services: Preventive & Diagnostic	No Co-payment	
• Type II Services: Basic Covered Services	No Co-payment	
• Type III Services: Major Restorative Services	No Co-payment	
• Type IV Services: Orthodontia (only as Medically Necessary)	No Co-payment	
Outpatient Surgery (outpatient hospital/ambulatory surgery centers)	$50 Co-payment	Covered if Medically Necessary at In-network outpatient facility. May require Prior Authorization.
Lab	No Co-payment	Covered if Medically Necessary. Includes blood tests, urinalysis, Pap smears, and throat cultures to maintain health and to test, diagnose, treat, and prevent disease. Genetic testing may require Prior Authorization.
X-ray Services	No Co-payment	Covered if Medically Necessary
Advanced Imaging Services (MRI, CT, PET)	$30 Co-payment	Requires Prior Authorization
Abortion services	$50 Co-payment	
INPATIENT MEDICAL CARE		
Inpatient Medical Care Room and board (includes deliveries/surgery/radiology services/labs)	$50 Co-payment	Inpatient medical care covered according to Medical Necessity and subject to Prior Authorization. Elective admissions require submission of Prior Authorization form 5 business days before admission.
PHARMACY		
Pharmacy		Please see *Preferred Drug List* for specific Prior Authorization requirements
Retail drugs (up to 30-Day supply)		
• Tier 1 (primarily generic focused)	$10 Co-payment	
• Tier 2 (primarily preferred brand)	$20 Co-payment	No Co-payment for:
• Tier 3 (primarily nonpreferred brand)	$40 Co-payment	• Birth control and family-planning supplies
Mail-order drugs (up to 90-Day supply)		
• Tier 1 (primarily generic focused)	$20 Co-payment	
• Tier 2 (primarily preferred brand)	$40 Co-payment	
• Tier 3 (primarily nonpreferred brand)	$80 Co-payment	
EMERGENCY CARE		
Emergency Care	$50 Co-payment	Notification required within 24 hours, if admitted. Co-payment waived, if admitted.

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
MENTAL HEALTH AND/OR SUBSTANCE USE TREATMENT		
Inpatient Mental Health and/or Substance Use	$50 Co-payment per admission	Inpatient mental health and/or substance use treatment services covered according to Medical Necessity and subject to Prior Authorization
Outpatient Mental Health and/or Substance Use Treatment		
• Individual therapy/Counseling	$10 Co-payment per visit	• After 12 Behavioral Health outpatient therapy visits per Benefit Year, requires Prior Authorization except for substance use treatment visits or group therapy visits
• Methadone treatment (dosing, counseling, labs)	No Co-payment	• No Prior Authorization required; does not count toward initial 12 Behavioral Health outpatient therapy visits
• Autism spectrum disorder treatment o Applied behavioral analysis	$10 Co-payment per visit	• Requires Prior Authorization; does not count toward initial 12 Behavioral Health outpatient therapy visits. Includes assessments, evaluations, testing and treatment; covered in home, outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst
• Medication-Assisted Treatment (MAT) services	No Co-Payment	• No Prior Authorization required
REHABILITATION AND HABILITATIVE SERVICES		
Cardiac Rehabilitation	$18 Co-payment	Requires Prior Authorization
Home Health Care	No Co-payment	Requires Prior Authorization if daily or longer than six months
Inpatient Skilled Nursing Facility	No Co-payment	Maximum of 100 Days total per Member per Benefit Year; requires Prior Authorization
Inpatient Rehabilitation Hospital or Chronic Disease Hospital	$50 Co-payment	Maximum of 60 Days total per Member per Benefit Year; requires Prior Authorization
Short-term Outpatient Rehabilitation	$18 Co-payment	Requires Prior Authorization
Physical/Occupational/Speech Therapy	$10 Co-payment	May require Prior Authorization after initial evaluation. Maximum of 60 visits total combined Physical and Occupational Rehabilitative Therapy per Member per Benefit Year. No limit on Speech Therapy.
Habilitative Services	$10 Co-payment	May require Prior Authorization after initial evaluation. Maximum of 60 visits total combined Physical and Occupational Habilitative Therapy per Member per Benefit Year. No limit on Speech Therapy.
OTHER BENEFITS		
Breastfeeding Services	No Co-payment	Includes one non-hospital grade breast pump per pregnancy, breastfeeding supplies, and lactation consultants
Chiropractic Care	$18 Co-payment	Doesn't require prior authorization
Cleft Palate/Cleft Lip Care	Related office visit or surgery co-payment may apply	Covered for Members 18 and younger. Includes medical, dental, oral, and facial surgery, follow-up, and related services. Requires Prior Authorization.
Durable Medical Equipment • Supplies • Prosthetics • Oxygen and respiratory therapy equipment	No Co-payment	May require Prior Authorization (see list at tuftshealthplan.com)
Early Intervention Services	No Co-payment	Covered for Members 3 and younger; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention specialist.
Fitness Reimbursement	50% Co-insurance for first 3 months	Covered for first 3 months; excludes initiation fees. This benefit is available to all Members once every Benefit Year.
Ground Ambulance	No Co-payment	Emergency transport only; nonemergency transport covered if Medically Necessary and with Prior Authorization.

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
Hearing Aids	No Co-payment for device $10 Co-payment for PCP visit $18 Co-payment for Specialist visit	Only covered for Members 21 and younger. Full cost of one hearing aid per hearing-impaired ear up to $2,000 for each hearing aid for 36 months. Related services and supplies do not count toward the $2,000 limit.
Hospice	No Co-payment	Requires Prior Authorization
Infertility Services	Related office visit or surgery Co-payment may apply	Requires Prior Authorization. Includes diagnosis and treatment, such as in vitro fertilization, gamete intrafallopian tube transfer, assisted hatching, and sperm banking. Must meet eligibility requirements. Some limitations apply.
Orthotics	No Co-payment	Requires Prior Authorization. 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 for diabetics only.
Podiatry	$18 Co-payment for office visit	Medically Necessary nonroutine foot care covered; requires Prior Authorization. Routine foot care services for diabetics don't require Prior Authorization.
Qualified Clinical Trials	Related office visit or surgery Co-payment may apply	Covered only if Medically Necessary; requires Prior Authorization
Weight Loss Programs	No Co-payment for the first 3 months	Covered for first 3 months; excludes initiation fees and food
Wellness		
• **Family planning**	No Co-payment	Doesn't require Prior Authorization
• **Nutritional counseling**	No Co-payment	Requires Prior Authorization
• **Prenatal care**	No Co-payment	Doesn't require Prior Authorization
• **Nurse midwife**	No Co-payment	Doesn't require Prior Authorization

ANNUAL MEDICAL OUT-OF-POCKET MAXIMUM	
Individual	$750
Family	$1,500

ANNUAL PHARMACY OUT-OF-POCKET MAXIMUM	
Individual	$500
Family	$1,000

Co-insurance and Co-payments apply toward your Out-of-pocket Maximum.

Services not covered

See the section "Services not covered" on page 35 for the list of services not covered.

Direct ConnectorCare
Plan Type III

Benefit and Cost-sharing Summary

This "Benefit and Cost-sharing Summary" gives you information about your *Tufts Health Direct* Covered Services and costs you may have to pay. The fees for Covered Services are different depending on your Plan Level. Make sure you review the services you're eligible for under the "Benefit and Cost-sharing Summary" for your specific Plan Level. To see which Plan Level you have, check your Tufts Health Plan Member ID Card or call us at **888.257.1985**, Monday through Friday, 8 a.m. to 5 p.m.

For some of your Covered Services, you will have to pay a Co-payment and/or Co-insurance (check the "Benefit and Cost-sharing Summary" for your specific Plan Level). Co-insurance is an amount, stated as a percentage of the cost of the service, that you must pay for certain Covered Services. You don't have to pay a Co-payment for Preventive Care services, such as physical examinations, Family-planning Services, contraceptives, health screenings, or vaccinations. For a complete listing of the types of Preventive Care services covered, please visit the U.S. Preventive Services Task Force website at www.uspreventiveservicestaskforce.org.

Your *Tufts Health Direct* plan may also have a Deductible. A Deductible is the amount you pay for certain Covered Services in a Benefit Year before we will begin to pay for those Covered Services.

You're responsible for paying the Co-payment, Deductible, and/or Co-insurance amounts listed in this "Benefit and Cost-sharing Summary." If you don't pay the Co-payment, Deductible, and/or Co-insurance at the time of your visit, you will still owe the money to the Provider. The Provider may use a legal method to collect the money from you. Tufts Health Plan won't pay the Provider for the Co-payment and/or Co-insurance that you owe.

Direct ConnectorCare Plan Type III is available to qualified individuals who, through the Health Connector's eligibility determination process, are determined to meet the prescribed eligibility criteria. Under this plan, members receive reduced cost-sharing (Co-payment, Deductible, and/or Co-insurance). The amount of reduction a member receives under this plan is the difference between the cost-sharing in the chart listed below and the cost-sharing for Direct Silver 2500 with Coinsurance.

This summary gives you a general understanding of your benefits. If you want more information about your benefits, see the section "Covered Services" on page 22. This *Member Handbook* also has a list of services that aren't covered.

You must go to Providers (doctors, Hospitals, and other health care professionals) who are part of the *Tufts Health Direct* Provider Network to get services. For Primary Care, you must see the Primary Care Provider (PCP) you have on record. To choose your PCP, check on your assigned PCP, or change your PCP, please visit us at tuftshealthplan.com or call us at **888.257.1985**. Services are only covered for In-network Providers, except for emergency care and certain other cases (see page 9 for more information).

All nonemergency Out-of-network visits require Prior Authorization.

Under the federal Affordable Care Act, there are no annual or lifetime dollar limits on Essential Health Benefits.

The *Tufts Health Direct* Provider Network can change at any time. Always check with Tufts Health Plan for the most up-to-date information.

If you have questions about your *Tufts Health Direct* benefits or you need help locating an In-network Provider, call us at **888.257.1985**. The Tufts Health Plan Member Services Team can help you Monday through Friday, from 8 a.m. to 5 p.m.

Direct ConnectorCare Plan Type III

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
OUTPATIENT MEDICAL CARE		
Office Visits		
• Primary Care Provider preventive care/ screening/immunization	No Co-payment	
• Primary Care Provider nonpreventive office visit	$15 Co-payment	
• Specialist	$22 Co-payment	
• Urgent Care Center (UCC) visit	$22 Co-payment	
Eye Care (Vision Care)	$15 Co-payment for routine eye exam $22 Co-payment for all other vision services	Coverage for routine eye exams for members 18 years and younger once every 12 months. For members older than 18 years, coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics. Eye glasses covered once every 12 months for members 18 years and younger. Collection frames only.
Pediatric Dental		Covered for pediatric dental care services for Members 18 years and younger. Medically Necessary orthodontia requires Prior Authorization.
• Type I Services: Preventive & Diagnostic	No Co-payment	
• Type II Services: Basic Covered Services	No Co-payment	
• Type III Services: Major Restorative Services	No Co-payment	
• Type IV Services: Orthodontia (only as Medically Necessary)	No Co-payment	
Outpatient Surgery (outpatient hospital/ambulatory surgery centers)	$125 Co-payment	Covered if Medically Necessary at In-network outpatient facility. May require Prior Authorization.
Lab	No Co-payment	Covered if Medically Necessary. Includes blood tests, urinalysis, Pap smears, and throat cultures to maintain health and to test, diagnose, treat, and prevent disease. Genetic testing may require Prior Authorization.
X-ray Services	No Co-payment	Covered if Medically Necessary
Advanced Imaging Services (MRI, CT, PET)	$60 Co-payment	Requires Prior Authorization
Abortion Services	$125 Co-payment	
INPATIENT MEDICAL CARE		
Inpatient Medical Care Room and board (includes deliveries/surgery/radiology services/labs)	$250 Co-payment	Inpatient medical care covered according to Medical Necessity and subject to Prior Authorization. Elective admissions require submission of Prior Authorization form 5 business days before admission.
PHARMACY		
Pharmacy		Please see *Preferred Drug List* for specific Prior Authorization requirements
Retail drugs (up to 30-Day supply)		
• Tier 1 (primarily generic focused)	$12.50 Co-payment	
• Tier 2 (primarily preferred brand)	$25 Co-payment	No Co-payment for:
• Tier 3 (primarily nonpreferred brand)	$50 Co-payment	• Birth control and family-planning supplies
Mail-order drugs (up to 90-Day supply)		
• Tier 1 (primarily generic focused)	$25 Co-payment	
• Tier 2 (primarily preferred brand)	$50 Co-payment	
• Tier 3 (primarily nonpreferred brand)	$100 Co-payment	
EMERGENCY CARE		
Emergency Care	$100 Co-payment	Notification required within 24 hours, if admitted. Co-payment waived, if admitted.

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
MENTAL HEALTH AND/OR SUBSTANCE USE TREATMENT		
Inpatient Mental Health and/or Substance Use	$250 Co-payment per admission	Inpatient mental health and/or substance use treatment services covered according to Medical Necessity and subject to Prior Authorization
Outpatient Mental Health and/or Substance Use Treatment		
• Individual therapy/Counseling	$15 Co-payment per visit	• After 12 Behavioral Health outpatient therapy visits per Benefit Year, requires Prior Authorization, except for substance use treatment visits or group therapy visits
• Methadone treatment (dosing, counseling, labs)	No Co-payment per visit	• No Prior Authorization required; does not count toward initial 12 Behavioral Health outpatient therapy visits
• Autism spectrum disorder treatment o Applied behavioral analysis	$15 Co-payment per visit	• Requires Prior Authorization; does not count toward initial 12 Behavioral Health outpatient therapy visits. Includes assessments, evaluations, testing, and treatment; covered in home, outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst
• Medication-Assisted Treatment (MAT) services	No Co-payment	• No Prior Authorization required
REHABILITATION AND HABILITATIVE SERVICES		
Cardiac Rehabilitation	$22 Co-payment	Requires Prior Authorization
Home Health Care	No Co-payment	Requires Prior Authorization if daily or longer than six months
Inpatient Skilled Nursing Facility	No Co-payment	Maximum of 100 Days total per Member per Benefit Year; requires Prior Authorization
Inpatient Rehabilitation Hospital or Chronic Disease Hospital	$250 Co-payment	Maximum of 60 Days total per Member per Benefit Year; requires Prior Authorization
Short-term Outpatient Rehabilitation	$22 Co-payment	Requires Prior Authorization
Physical/Occupational/Speech Therapy	$20 Co-payment	May require Prior Authorization after initial evaluation. Maximum of 60 visits total combined Physical and Occupational Rehabilitative Therapy per Member per Benefit Year. No limit on Speech Therapy.
Habilitative Services	$20 Co-payment	May require Prior Authorization after initial evaluation. Maximum of 60 visits total combined Physical and Occupational Habilitative Therapy per Member per Benefit Year. No limit on Speech Therapy.
OTHER BENEFITS		
Breastfeeding Services	No Co-payment	Includes one non-hospital grade breast pump per pregnancy, breastfeeding supplies, and lactation consultants
Chiropractic Care	$22 Co-payment	Doesn't require prior authorization
Cleft Palate/Cleft Lip Care	Related office visit or surgery Co-payment may apply	Covered for Members 18 and younger. Includes medical, dental, oral, and facial surgery, follow-up, and related services. Requires Prior Authorization.
Durable Medical Equipment • Supplies • Prosthetics • Oxygen and respiratory therapy equipment	No Co-payment	May require Prior Authorization (see list at tuftshealthplan.com)
Early Intervention Services	No Co-payment	Covered for Members 3 and younger; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention specialist.
Fitness Reimbursement	50% Co-insurance for first 3 months	Covered for first 3 months; excludes initiation fees. This benefit is available to all Members once every Benefit Year.
Ground Ambulance	No Co-payment	Emergency transport only; nonemergency transport covered if Medically Necessary and with Prior Authorization.

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
Hearing Aids	No Co-payment for device $15 Co-payment for PCP visit $22 Co-payment for Specialist visit	Only covered for Members 21 and younger. Full cost of one hearing aid per hearing-impaired ear up to $2,000 for each hearing aid for 36 months. Related services and supplies do not count toward the $2,000 limit.
Hospice	No Co-payment	Requires Prior Authorization
Infertility Services	Related office visit or surgery Co-payment may apply	Requires Prior Authorization. Includes diagnosis and treatment, such as in vitro fertilization, gamete intrafallopian tube transfer, assisted hatching, and sperm banking. Must meet eligibility requirements. Some limitations apply.
Orthotics	No Co-payment	Requires Prior Authorization. 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 for diabetics only.
Podiatry	$22 Co-payment	Medically Necessary nonroutine foot care covered; requires Prior Authorization. Routine foot care services for diabetics don't require Prior Authorization.
Qualified Clinical Trials	Related office visit or surgery Co-payment may apply	Covered only if Medically Necessary; requires Prior Authorization
Weight Loss Programs	No Co-payment for the first 3 months	Covered for first 3 months; excludes initiation fees and food
Wellness		
• Family planning	No Co-payment	Doesn't require Prior Authorization
• Nutritional counseling	No Co-payment	Requires Prior Authorization
• Prenatal care	No Co-payment	Doesn't require Prior Authorization
• Nurse midwife	No Co-payment	Doesn't require Prior Authorization

ANNUAL MEDICAL OUT-OF-POCKET MAXIMUM	
Individual	$1,500
Family	$3,000

ANNUAL PHARMACY OUT-OF-POCKET MAXIMUM	
Individual	$750
Family	$1,500

Co-insurance and Co-payments apply toward your Out-of-pocket Maximum.

Services not covered

See the section "Services not covered" on page 35 for the list of services not covered.

Direct Platinum

Benefit and Cost-sharing Summary

This "Benefit and Cost-sharing Summary" gives you information about your *Tufts Health Direct* Covered Services and costs you may have to pay. The fees for Covered Services are different depending on your Plan Level. Make sure you review the services you're eligible for under the "Benefit and Cost-sharing Summary" for your specific Plan Level. To see which Plan Level you have, check your Tufts Health Plan Member ID Card or call us at **888.257.1985**, Monday through Friday, 8 a.m. to 5 p.m.

For some of your Covered Services, you will have to pay a Co-payment and/or Co-insurance (check the "Benefit and Cost-sharing Summary" for your specific Plan Level). Co-insurance is an amount, stated as a percentage of the cost of the service, that you must pay for certain Covered Services. You don't have to pay a Co-payment for Preventive Care services, such as physical examinations, Family-planning Services, contraceptives, health screenings, or vaccinations. For a complete listing of the types of Preventive Care services covered, please visit the U.S. Preventive Services Task Force website at www.uspreventiveservicestaskforce.org.

Your *Tufts Health Direct* plan may also have a Deductible. A Deductible is the amount you pay for certain Covered Services in a Benefit Year before we will begin to pay for those Covered Services.

You're responsible for paying the Co-payment, Deductible, and/or Co-insurance amounts listed in this "Benefit and Cost-sharing Summary." If you don't pay the Co-payment, Deductible, and/or Co-insurance at the time of your visit, you will still owe the money to the Provider. The Provider may use a legal method to collect the money from you. Tufts Health Plan won't pay the Provider for the Co-payment and/or Co-insurance that you owe.

This summary gives you a general understanding of your benefits. If you want more information about your benefits, see the section "Covered Services" on page 22. This *Member Handbook* also has a list of services that aren't covered.

You must go to Providers (doctors, Hospitals, and other health care professionals) who are part of the *Tufts Health Direct* Provider Network to get services. For Primary Care, you must see the Primary Care Provider (PCP) you have on record. To choose your PCP, check on your assigned PCP, or change your PCP, please visit us at tuftshealthplan.com or call us at **888.257.1985**. Services are only covered for In-network Providers, except for emergency care and certain other cases (see page 9 for more information).

All nonemergency Out-of-network visits require Prior Authorization.

Under the federal Affordable Care Act, there are no annual or lifetime dollar limits on Essential Health Benefits.

The *Tufts Health Direct* Provider Network can change at any time. Always check with Tufts Health Plan for the most up-to-date information.

If you have questions about your *Tufts Health Direct* benefits or you need help locating an In-network Provider, call us at **888.257.1985**. The Tufts Health Plan Member Services Team can help you Monday through Friday, from 8 a.m. to 5 p.m.

Direct Platinum

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
OUTPATIENT MEDICAL CARE		
Office Visits		
• Primary Care Provider preventive care/ screening/immunization	No Co-payment	
• Primary Care Provider nonpreventive office visit	$20 Co-payment	
• Specialist	$40 Co-payment	
• Urgent Care Center (UCC) visit	$40 Co-payment	
Eye Care (Vision Care)	$20 Co-payment for routine eye exam $40 Co-payment for all other vision services	Coverage for routine eye exams for members 18 years and younger once every 12 months. For members older than 18 years, coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics. Eye glasses covered once every 12 months for members 18 years and younger. Collection frames only.
Pediatric Dental		Covered for pediatric dental care services for Members 18 years and younger. Medically Necessary orthodontia requires Prior Authorization.
• Type I Services: Preventive & Diagnostic	No Co-payment	
• Type II Services: Basic Covered Services	25% Co-insurance	
• Type III Services: Major Restorative Services	50% Co-insurance	
• Type IV Services: Orthodontia (only as Medically Necessary)	50% Co-insurance	
Outpatient Surgery (outpatient hospital/ambulatory surgery centers)	$250 Co-payment	Covered if Medically Necessary at In-network outpatient facility. May require Prior Authorization.
Lab	No Co-payment	Covered if Medically Necessary. Includes blood tests, urinalysis, Pap smears, and throat cultures to maintain health and to test, diagnose, treat, and prevent disease. Genetic testing may require Prior Authorization.
X-ray Services	No Co-payment	Covered if Medically Necessary
Advanced Imaging Services (MRI, CT, PET)	$150 Co-payment	Requires Prior Authorization
Abortion Services	$250 Co-payment	
INPATIENT MEDICAL CARE		
Inpatient Medical Care Room and board (includes deliveries/surgery/radiology services/labs)	$500 Co-payment	Inpatient medical care covered according to Medical Necessity and subject to Prior Authorization. Elective admissions require submission of Prior Authorization form 5 business days before admission.
PHARMACY		
Pharmacy		Please see *Preferred Drug List* for specific Prior Authorization requirements
Retail drugs (up to 30-Day supply)		
• Tier 1 (primarily generic focused)	$10 Co-payment	
• Tier 2 (primarily preferred brand)	$25 Co-payment	No Co-payment for:
• Tier 3 (primarily nonpreferred brand)	$50 Co-payment	• Birth control and family-planning supplies
Mail-order drugs (up to 90-Day supply)		
• Tier 1 (primarily generic focused)	$20 Co-payment	
• Tier 2 (primarily preferred brand)	$50 Co-payment	
• Tier 3 (primarily nonpreferred brand)	$150 Co-payment	
EMERGENCY CARE		
Emergency Care	$150 Co-payment	Notification required within 24 hours, if admitted. Co-payment waived, if admitted.

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
MENTAL HEALTH AND/OR SUBSTANCE USE TREATMENT		
Inpatient Mental Health and/or Substance Use	$500 Co-payment per admission	Inpatient mental health and/or substance use treatment services covered according to Medical Necessity and subject to Prior Authorization
Outpatient Mental Health and/or Substance Use	$20 Co-payment per visit	
• Individual therapy/Counseling		• After 12 Behavioral Health outpatient therapy visits per Benefit Year, requires Prior Authorization, except for substance use treatment visits or group therapy visits
• Methadone treatment (dosing, counseling, labs)		• No Prior Authorization required; does not count toward initial 12 Behavioral Health outpatient therapy visits
• Autism spectrum disorder treatment o Applied behavioral analysis		• Requires Prior Authorization; does not count toward initial 12 Behavioral Health outpatient therapy visits. Includes assessments, evaluations, testing, and treatment; covered in home, outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst
• Medication-Assisted Treatment (MAT) services		• No Prior Authorization required
REHABILITATION AND HABILITATIVE SERVICES		
Cardiac Rehabilitation	$40 Co-payment	Requires Prior Authorization
Home Health Care	No Co-payment	Requires Prior Authorization if daily or longer than six months
Inpatient Skilled Nursing Facility	$500 Co-payment	Maximum of 100 Days total per Member per Benefit Year; requires Prior Authorization
Inpatient Rehabilitation Hospital or Chronic Disease Hospital	$500 Co-payment	Maximum of 60 Days total per Member per Benefit Year; requires Prior Authorization
Short-term Outpatient Rehabilitation	$40 Co-payment	Requires Prior Authorization
Physical/Occupational/Speech Therapy	$40 Co-payment	May require Prior Authorization after initial evaluation. Maximum of 60 visits total combined Physical and Occupational Rehabilitative Therapy per Member per Benefit Year. No limit on Speech Therapy.
Habilitative Services	$40 Co-payment	May require Prior Authorization after initial evaluation. Maximum of 60 visits total combined Physical and Occupational Habilitative Therapy per Member per Benefit Year. No limit on Speech Therapy.
OTHER BENEFITS		
Breastfeeding Services	No Co-payment	Includes one non-hospital grade breast pump per pregnancy, breastfeeding supplies, and lactation consultants
Chiropractic Care	$40 Co-payment	Doesn't require prior authorization
Cleft Palate/Cleft Lip Care	Related office visit or surgery Co-payment may apply	Covered for Members 18 and younger. Includes medical, dental, oral, and facial surgery, follow-up, and related services. Requires Prior Authorization.
Durable Medical Equipment • Supplies • Prosthetics • Oxygen and respiratory therapy equipment	20% Co-insurance	May require Prior Authorization (see list at tuftshealthplan.com)
Early Intervention Services	No Co-payment	Covered for Members 3 and younger; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention specialist.
Fitness Reimbursement	50% Co-insurance for first 3 months	Covered for first 3 months; excludes initiation fees. This benefit is available to all Members once every Benefit Year.
Ground Ambulance	No Co-payment	Emergency transport only; nonemergency transport covered if Medically Necessary and with Prior Authorization.

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
Hospice	No Co-payment	Requires Prior Authorization
Infertility Services	Related office visit or surgery Co-payment may apply	Requires Prior Authorization. Includes diagnosis and treatment, such as in vitro fertilization, gamete intrafallopian tube transfer, assisted hatching, and sperm banking. Must meet eligibility requirements. Some limitations apply.
Orthotics	20% Co-insurance	Requires Prior Authorization. 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 for diabetics only.
Podiatry	$40 Co-payment	Medically Necessary nonroutine foot care covered; requires Prior Authorization. Routine foot care services for diabetics don't require Prior Authorization.
Qualified Clinical Trials	Related office visit or surgery Co-payment may apply	Covered only if Medically Necessary; requires Prior Authorization
Weight Loss Programs	No Co-payment for the first 3 months	Covered for first 3 months; excludes initiation fees and food
Wellness		
• Family planning	No Co-payment	Doesn't require Prior Authorization
• Nutritional counseling	No Co-payment	Requires Prior Authorization
• Prenatal care	No Co-payment	Doesn't require Prior Authorization
• Nurse midwife	No Co-payment	Doesn't require Prior Authorization

ANNUAL DEDUCTIBLE	
Individual	$0
Family	$0

ANNUAL OUT-OF-POCKET MAXIMUM	
Individual	$3,000
Family	$6,000

Co-insurance and Co-payments apply toward your Out-of-pocket Maximum.

Services not covered

See the section "Services not covered" on page 35 for the list of services not covered.

Direct Gold 750 with Co-insurance

Benefit and Cost-sharing Summary

This "Benefit and Cost-sharing Summary" gives you information about your *Tufts Health Direct* Covered Services and costs you may have to pay. The fees for Covered Services are different depending on your Plan Level. Make sure you review the services you're eligible for under the "Benefit and Cost-sharing Summary" for your specific Plan Level. To see which Plan Level you have, check your Tufts Health Plan Member ID Card or call us at **888.257.1985**, Monday through Friday, 8 a.m. to 5 p.m.

For some of your Covered Services, you will have to pay a Co-payment and/or Co-insurance (check the "Benefit and Cost-sharing Summary" for your specific Plan Level). Co-insurance is an amount, stated as a percentage of the cost of the service, that you must pay for certain Covered Services. You don't have to pay a Co-payment for Preventive Care services, such as physical examinations, Family-planning Services, contraceptives, health screenings, or vaccinations. For a complete listing of the types of Preventive Care services covered, please visit the U.S. Preventive Services Task Force website at www.uspreventiveservicestaskforce.org.

Your *Tufts Health Direct* plan may also have a Deductible. A Deductible is the amount you pay for certain Covered Services in a Benefit Year before we will begin to pay for those Covered Services.

You're responsible for paying the Co-payment, Deductible, and/or Co-insurance amounts listed in this "Benefit and Cost-sharing Summary." If you don't pay the Co-payment, Deductible, and/or Co-insurance at the time of your visit, you will still owe the money to the Provider. The Provider may use a legal method to collect the money from you. Tufts Health Plan won't pay the Provider for the Co-payment and/or Co-insurance that you owe.

This summary gives you a general understanding of your benefits. If you want more information about your benefits, see the section "Covered Services" on page 22. This *Member Handbook* also has a list of services that aren't covered.

You must go to Providers (doctors, Hospitals, and other health care professionals) who are part of the *Tufts Health Direct* Provider Network to get services. For Primary Care, you must see the Primary Care Provider (PCP) you have on record. To choose your PCP, check on your assigned PCP, or change your PCP, please visit us at tuftshealthplan.com or call us at **888.257.1985**. Services are only covered for In-network Providers, except for emergency care and certain other cases (see page 9 for more information).

All nonemergency Out-of-network visits require Prior Authorization.

Under the federal Affordable Care Act, there are no annual or lifetime dollar limits on Essential Health Benefits.

The *Tufts Health Direct* Provider Network can change at any time. Always check with Tufts Health Plan for the most up-to-date information.

If you have questions about your *Tufts Health Direct* benefits or you need help locating an In-network Provider, call us at **888.257.1985**. The Tufts Health Plan Member Services Team can help you Monday through Friday,
from 8 a.m. to 5 p.m.

Direct Gold 750 with Co-insurance

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
OUTPATIENT MEDICAL CARE		
Office Visits		
• Primary Care Provider preventive care/ screening/immunization	No Co-payment	
• Primary Care Provider nonpreventive office visit	$20 Co-payment	
• Specialist	$35 Co-payment	
• Urgent Care Center (UCC) visit	$35 Co-payment	
Eye Care (Vision Care)	$20 Co-payment for eye exam $35 Co-payment for all other vision services	Coverage for routine eye exams for members 18 years and younger once every 12 months. For members older than 18 years, coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics. Eye glasses covered once every 12 months for members 18 years and younger. Collection frames only.
Pediatric Dental		Covered for pediatric dental care services for Members 18 years and younger. Medically Necessary orthodontia requires Prior Authorization.
• Type I Services: Preventive & Diagnostic	Subject to Deductible, then $0	
• Type II Services: Basic Covered Services	Subject to Deductible, then 25%	
• Type III Services: Major Restorative Services	Subject to Deductible, then 50%	
• Type IV Services: Orthodontia (only as Medically Necessary)	Subject to Deductible, then 50%	
Outpatient Surgery (outpatient hospital/ambulatory surgery centers)	30% Co-insurance after Deductible	Covered if Medically Necessary at In-network outpatient facility. May require Prior Authorization.
Lab	30% Co-insurance after Deductible	Covered if Medically Necessary. Includes blood tests, urinalysis, Pap smears, and throat cultures to maintain health and to test, diagnose, treat, and prevent disease. Genetic testing may require prior authorization.
X-ray Services	30% Co-insurance after Deductible	Covered if Medically Necessary
Advanced Imaging Services (MRI, CT, PET)	30% Co-insurance after Deductible	Requires Prior Authorization
Abortion Services	30% Co-insurance after Deductible	
INPATIENT MEDICAL CARE		
Inpatient Medical Care Room and board (includes deliveries/surgery/radiology services/labs)	30% Co-insurance after Deductible	Inpatient medical care covered according to Medical Necessity and subject to Prior Authorization. Elective admissions require submission of Prior Authorization form 5 business days before admission.
PHARMACY		
Pharmacy		Please see *Preferred Drug List* for specific Prior Authorization requirements
Retail drugs (up to 30-Day supply)		
• Tier 1 (primarily generic focused)	$15 Co-payment	
• Tier 2 (primarily preferred brand)	50% Co-insurance after Deductible	No Co-payment for:
• Tier 3 (primarily nonpreferred brand)	50% Co-insurance after Deductible	• Birth control and family-planning supplies
Mail-order drugs (up to 90-Day supply)		
• Tier 1 (primarily generic focused)	$30 Co-payment	
• Tier 2 (primarily preferred brand)	50% Co-insurance after Deductible	
• Tier 3 (primarily nonpreferred brand)	50% Co-insurance after Deductible	
EMERGENCY CARE		
Emergency Care	30% Co-insurance after Deductible	Notification required within 24 hours, if admitted. Co-payment waived, if admitted.

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
MENTAL HEALTH AND/OR SUBSTANCE USE TREATMENT		
Inpatient Mental Health and/or Substance Use	30% Co-insurance after Deductible	Inpatient mental health and/or substance use treatment services covered according to Medical Necessity and subject to Prior Authorization
Outpatient Mental Health and/or Substance use	$20 Co-payment per visit	
• Individual therapy/Counseling		• After 12 Behavioral Health outpatient therapy visits per Benefit Year, requires Prior Authorization, except for substance use treatment visits or group therapy visits
• Methadone treatment (dosing, counseling, labs)		• No Prior Authorization required; does not count toward initial 12 Behavioral Health outpatient therapy visits
• Autism spectrum disorder treatment o Applied behavioral analysis		• Requires Prior Authorization; does not count toward initial 12 Behavioral Health outpatient therapy visits. Includes assessments, evaluations, testing, and treatment; covered in home, outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst
• Medication-Assisted Treatment (MAT) services		• No Prior Authorization required
REHABILITATION AND HABILITATIVE SERVICES		
Cardiac Rehabilitation	$35 Co-payment	Requires Prior Authorization
Home Health Care	No Co-payment after Deductible	Requires Prior Authorization if daily or longer than six months
Inpatient Skilled Nursing Facility	30% Co-insurance after Deductible	Maximum of 100 Days total per Member per Benefit Year; requires Prior Authorization
Inpatient Rehabilitation Hospital or Chronic Disease Hospital	30% Co-insurance after Deductible	Maximum of 60 Days total per Member per Benefit Year; requires Prior Authorization
Short-term Outpatient Rehabilitation	$35 Co-payment	Requires Prior Authorization
Physical/Occupational/Speech Therapy	$35 Co-payment	May require Prior Authorization after initial evaluation. Maximum of 60 visits total combined Physical and Occupational Rehabilitative Therapy per Member per Benefit Year. No limit on Speech Therapy.
Habilitative Services	$35 Co-payment	May require Prior Authorization after initial evaluation. Maximum of 60 visits total combined Physical and Occupational Habilitative Therapy per Member per Benefit Year. No limit on Speech Therapy.
OTHER BENEFITS		
Breastfeeding Services	No Co-payment	Includes one non-hospital grade breast pump per pregnancy, breastfeeding supplies, and lactation consultants
Chiropractic Care	$35 Co-payment	Doesn't require prior authorization
Cleft Palate/Cleft Lip Care	Related office visit or surgery Co-payment may apply	Covered for Members 18 and younger. Includes medical, dental, oral, and facial surgery, follow-up, and related services. Requires Prior Authorization.
Durable Medical Equipment • Supplies • Prosthetics • Oxygen and respiratory therapy equipment	30% Co-insurance after Deductible	May require Prior Authorization (see list at tuftshealthplan.com)
Early Intervention Services	No Co-payment	Covered for Members 3 and younger; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention specialist.
Fitness Reimbursement	50% Co-insurance for first 3 months	Covered for first 3 months; excludes initiation fees. This benefit is available to all Members once every Benefit Year.
Ground Ambulance	No Co-payment after deductible	Emergency transport only; nonemergency transport covered if Medically Necessary and with Prior Authorization.

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
Hearing Aids	30% Co-insurance for device after deductible $20 Co-payment for PCP visit $35 Co-payment for Specialist visit	Only covered for Members 21 and younger. Full cost of one hearing aid per hearing-impaired ear up to $2,000 for each hearing aid for 36 months. Related services and supplies do not count toward the $2,000 limit.
Hospice	No Co-payment after Deductible	Requires Prior Authorization
Infertility Services	Related office visit or surgery Co-payment may apply	Requires Prior Authorization. Includes diagnosis and treatment, such as in vitro fertilization, gamete intrafallopian tube transfer, assisted hatching, and sperm banking. Must meet eligibility requirements. Some limitations apply.
Orthotics	30% Co-insurance after Deductible	Requires Prior Authorization. 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 for diabetics only.
Podiatry	$35 Co-payment	Medically Necessary nonroutine foot care covered; requires Prior Authorization. Routine foot care services for diabetics don't require Prior Authorization.
Qualified Clinical Trials	Related office visit or surgery Co-payment may apply	Covered only if Medically Necessary; requires Prior Authorization
Weight Loss Programs	No Co-payment for the first 3 months	Covered for first 3 months; excludes initiation fees and food
Wellness		
• Family planning	No Co-payment	Doesn't require Prior Authorization
• Nutritional counseling	No Co-payment	Requires Prior Authorization
• Prenatal care	No Co-payment	Doesn't require Prior Authorization
• Nurse midwife	No Co-payment	Doesn't require Prior Authorization

ANNUAL DEDUCTIBLE	
Individual	$750
Family	$1,500

ANNUAL OUT-OF-POCKET MAXIMUM	
Individual	$5,000
Family	$10,000

Deductible, Co-insurance, and Co-payments apply toward your Out-of-pocket Maximum.

Services not covered

See the section "Services not covered" on page 35 for the list of services not covered.

Direct Gold 1000

Benefit and Cost-sharing Summary

This "Benefit and Cost-sharing Summary" gives you information about your *Tufts Health Direct* Covered Services and costs you may have to pay. The fees for Covered Services are different depending on your Plan Level. Make sure you review the services you're eligible for under the "Benefit and Cost-sharing Summary" for your specific Plan Level. To see which Plan Level you have, check your Tufts Health Plan Member ID Card or call us at **888.257.1985**, Monday through Friday, 8 a.m. to 5 p.m.

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This summary gives you a general understanding of your benefits. If you want more information about your benefits, see the section "Covered Services" on page 22. This *Member Handbook* also has a list of services that aren't covered.

You must go to Providers (doctors, Hospitals, and other health care professionals) who are part of the *Tufts Health Direct* Provider Network to get services. For Primary Care, you must see the Primary Care Provider (PCP) you have on record. To choose your PCP, check on your assigned PCP, or change your PCP, please visit us at tuftshealthplan.com or call us at **888.257.1985**. Services are only covered for In-network Providers, except for emergency care and certain other cases (see page 9 for more information).

All nonemergency Out-of-network visits require Prior Authorization.

Under the federal Affordable Care Act, there are no annual or lifetime dollar limits on Essential Health Benefits.

The *Tufts Health Direct* Provider Network can change at any time. Always check with Tufts Health Plan for the most up-to-date information.

If you have questions about your *Tufts Health Direct* benefits or you need help locating an In-network Provider, call us at **888.257.1985**. The Tufts Health Plan Member Services Team can help you Monday through Friday, from 8 a.m. to 5 p.m.

Direct Gold 1000

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
OUTPATIENT MEDICAL CARE		
Office Visits		
• Primary Care Provider preventive care/ screening/immunization	No Co-payment	
• Primary Care Provider nonpreventive office visit	$30 Co-payment	
• Specialist	$45 Co-payment	
• Urgent Care Center (UCC) visit	$45 Co-payment	
Eye Care (Vision Care)	$30 Co-payment for eye exam $45 Co-payment for all other vision services	Coverage for routine eye exams for members 18 years and younger once every 12 months. For members older than 18 years coverage, for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics. Eye glasses covered once every 12 months for members 18 years and younger. Collection frames only.
Pediatric Dental		Covered for pediatric dental care services for Members 18 years and younger. Medically Necessary orthodontia requires Prior Authorization.
• Type I Services: Preventive & Diagnostic	Subject to Deductible, then $0	
• Type II Services: Basic Covered Services	Subject to Deductible, then 25%	
• Type III Services: Major Restorative Services	Subject to Deductible, then 50%	
• Type IV Services: Orthodontia (only as Medically Necessary)	Subject to Deductible, then 50%	
Outpatient Surgery (outpatient hospital/ambulatory surgery centers)	$250 Co-payment after Deductible	Covered if Medically Necessary at In-network outpatient facility. May require Prior Authorization.
Lab	$20 Co-payment after Deductible	Covered if Medically Necessary. Includes blood tests, urinalysis, Pap smears, and throat cultures to maintain health and to test, diagnose, treat, and prevent disease. Genetic testing may require Prior Authorization.
X-ray Services	$20 Co-payment after Deductible	Covered if Medically Necessary
Advanced Imaging Services (MRI, CT, PET)	$200 Co-payment after Deductible	Requires Prior Authorization
Abortion Services	$250 Co-payment after Deductible	
INPATIENT MEDICAL CARE		
Inpatient Medical Care Room and board (includes deliveries/surgery/radiology services/labs)	$500 Co-payment after Deductible	Inpatient medical care covered according to Medical Necessity and subject to Prior Authorization. Elective admissions require submission of Prior Authorization form 5 business days before admission.
PHARMACY		
Pharmacy		Please see *Preferred Drug List* for specific Prior Authorization requirements
Retail drugs (up to 30-Day supply)		
• Tier 1 (primarily generic focused)	$20 Co-payment	
• Tier 2 (primarily preferred brand)	$30 Co-payment	No Co-payment for:
• Tier 3 (primarily nonpreferred brand)	$50 Co-payment	• Birth control and family-planning supplies
Mail-order drugs (up to 90-Day supply)		
• Tier 1 (primarily generic focused)	$40 Co-payment	
• Tier 2 (primarily preferred brand)	$60 Co-payment	
• Tier 3 (primarily nonpreferred brand)	$150 Co-payment	
EMERGENCY CARE		
Emergency Care	$150 Co-payment after Deductible	Notification required within 24 hours, if admitted. Co-payment waived, if admitted.

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
MENTAL HEALTH AND/OR SUBSTANCE USE TREATMENT		
Inpatient Mental Health and/or Substance Use	$500 Co-payment per admission after Deductible	Inpatient mental health and/or substance use treatment services covered according to Medical Necessity and subject to Prior Authorization
Outpatient Mental Health and/or Substance Use	$30 Co-payment per visit	
• Individual therapy/Counseling		• After 12 Behavioral Health outpatient therapy visits per Benefit Year, requires Prior Authorization, except for substance use treatment visits
• Methadone treatment (dosing, counseling, labs)		• No Prior Authorization required; does not count toward initial 12 Behavioral Health outpatient therapy visits
• Autism spectrum disorder treatment o Applied behavioral analysis		• Requires Prior Authorization; does not count toward initial 12 Behavioral Health outpatient therapy visits. Includes assessments, evaluations, testing, and treatment; covered in home, outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst
• Medication-Assisted Treatment (MAT) services		• No Prior Authorization required
REHABILITATION AND HABILITATIVE SERVICES		
Cardiac Rehabilitation	$45 Co-payment	Requires Prior Authorization
Home Health Care	No Co-payment after Deductible	Requires Prior Authorization if daily or longer than six months
Inpatient Skilled Nursing Facility	$500 Co-payment after Deductible	Maximum of 100 Days total per Member per Benefit Year; requires Prior Authorization
Inpatient Rehabilitation Hospital or Chronic Disease Hospital	$500 Co-payment after Deductible	Maximum of 60 Days total per Member per Benefit Year; requires Prior Authorization
Short-term Outpatient Rehabilitation	$45 Co-payment	Requires Prior Authorization
Physical/Occupational/Speech Therapy	$45 Co-payment	May require Prior Authorization after initial evaluation. Maximum of 60 visits total combined Physical and Occupational Rehabilitative Therapy per Member per Benefit Year. No limit on Speech Therapy.
Habilitative Services	$45 Co-payment	May require Prior Authorization after initial evaluation. Maximum of 60 visits total combined Physical and Occupational Habilitative Therapy per Member per Benefit Year. No limit on Speech Therapy.
OTHER BENEFITS		
Breastfeeding Services	No Co-payment	Includes one non-hospital grade breast pump per pregnancy, breastfeeding supplies, and lactation consultants
Chiropractic Care	$45 Co-payment	Doesn't require prior authorization
Cleft Palate/Cleft Lip Care	Related office visit or surgery Co-payment may apply	Covered for Members 18 and younger. Includes medical, dental, oral, and facial surgery, follow-up, and related services. Requires Prior Authorization.
Durable Medical Equipment • Supplies • Prosthetics • Oxygen and respiratory therapy equipment	20% Co-insurance after Deductible	May require Prior Authorization (see list at tuftshealthplan.com)
Early Intervention Services	No Co-payment	Covered for Members 3 and younger; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention specialist.
Fitness Reimbursement	50% Co-insurance for first 3 months	Covered for first 3 months; excludes initiation fees. This benefit is available to all Members once every Benefit Year.
Ground Ambulance	No Co-payment after Deductible	Emergency transport only; nonemergency transport covered if Medically Necessary and with Prior Authorization.

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
Hearing Aids	20% Co-insurance for device after Deductible $30 Co-payment for PCP visit $45 Co-payment for Specialist visit	Only covered for Members 21 and younger. Full cost of one hearing aid per hearing-impaired ear up to $2,000 for each hearing aid for 36 months. Related services and supplies do not count toward the $2,000 limit.
Hospice	No Co-payment after Deductible	Requires Prior Authorization
Infertility Services	Related office visit or surgery Co-payment may apply	Requires Prior Authorization. Includes diagnosis and treatment, such as in vitro fertilization, gamete intrafallopian tube transfer, assisted hatching, and sperm banking. Must meet eligibility requirements. Some limitations apply.
Orthotics	20% Co-insurance after Deductible	Requires Prior Authorization. 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 for diabetics only.
Podiatry	$45 Co-payment	Medically Necessary nonroutine foot care covered; requires Prior Authorization. Routine foot care services for diabetics don't require Prior Authorization.
Qualified Clinical Trials	Related office visit or surgery Co-payment may apply	Covered only if Medically Necessary; requires Prior Authorization
Weight Loss Programs	No Co-payment for the first 3 months	Covered for first 3 months; excludes initiation fees and food
Wellness		
• Family planning	No Co-payment	Doesn't require Prior Authorization
• Nutritional counseling	No Co-payment	Requires Prior Authorization
• Prenatal care	No Co-payment	Doesn't require Prior Authorization
• Nurse midwife	No Co-payment	Doesn't require Prior Authorization

ANNUAL MEDICAL DEDUCTIBLE	
Individual	$1,000
Family	$2,000

ANNUAL OUT-OF-POCKET MAXIMUM	
Individual	$5,000
Family	$10,000

Deductible, Co-insurance, and Co-payments apply toward your Out-of-pocket Maximum.

Services not covered

See the section "Services not covered" on page 35 for the list of services not covered.

Direct Silver 2000

Benefit and Cost-sharing Summary

This "Benefit and Cost-sharing Summary" gives you information about your *Tufts Health Direct* Covered Services and costs you may have to pay. The fees for Covered Services are different depending on your Plan Level. Make sure you review the services you're eligible for under the "Benefit and Cost-sharing Summary" for your specific Plan Level. To see which Plan Level you have, check your Tufts Health Plan Member ID Card or call us at **888.257.1985**, Monday through Friday, 8 a.m. to 5 p.m.

For some of your Covered Services, you will have to pay a Co-payment and/or Co-insurance (check the "Benefit and Cost-sharing Summary" for your specific Plan Level). Co-insurance is an amount, stated as a percentage of the cost of the service, that you must pay for certain Covered Services. You don't have to pay a Co-payment for Preventive Care services, such as physical examinations, Family-planning Services, contraceptives, health screenings, or vaccinations. For a complete listing of the types of Preventive Care services covered, please visit the U.S. Preventive Services Task Force website at www.uspreventiveservicestaskforce.org.

Your *Tufts Health Direct* plan may also have a Deductible. A Deductible is the amount you pay for certain Covered Services in a Benefit Year before we will begin to pay for those Covered Services.

You're responsible for paying the Co-payment, Deductible, and/or Co-insurance amounts listed in this "Benefit and Cost-sharing Summary." If you don't pay the Co-payment, Deductible, and/or Co-insurance at the time of your visit, you will still owe the money to the Provider. The Provider may use a legal method to collect the money from you. Tufts Health Plan won't pay the Provider for the Co-payment and/or Co-insurance that you owe.

This summary gives you a general understanding of your benefits. If you want more information about your benefits, see the section "Covered Services" on page 22. This *Member Handbook* also has a list of services that aren't covered.

You must go to Providers (doctors, Hospitals, and other health care professionals) who are part of the *Tufts Health Direct* Provider Network to get services. For Primary Care, you must see the Primary Care Provider (PCP) you have on record. To choose your PCP, check on your assigned PCP, or change your PCP, please visit us at tuftshealthplan.com or call us at **888.257.1985**. Services are only covered for In-network Providers, except for emergency care and certain other cases (see page 9 for more information).

All nonemergency Out-of-network visits require Prior Authorization.

Under the federal Affordable Care Act, there are no annual or lifetime dollar limits on Essential Health Benefits.

The *Tufts Health Direct* Provider Network can change at any time. Always check with Tufts Health Plan for the most up-to-date information.

If you have questions about your *Tufts Health Direct* benefits or you need help locating an In-network Provider, call us at **888.257.1985**. The Tufts Health Plan Member Services Team can help you Monday through Friday, from 8 a.m. to 5 p.m.

Direct Silver 2000

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
OUTPATIENT MEDICAL CARE		
Office Visits		
• Primary Care Provider preventive care/ screening/immunization	No Co-payment	
• Primary Care Provider nonpreventive office visit	$30 Co-payment	
• Specialist	$50 Co-payment	
• Urgent Care Center (UCC) visit	$50 Co-payment $50 Co-payment	
Eye Care (Vision Care)	$30 Co-payment for eye exam $50 Co-payment for all other vision services	Coverage for routine eye exams for members 18 years and younger once every 12 months. For members older than 18 years, coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics. Eye glasses covered once every 12 months for members 18 years and younger. Collection frames only.
Pediatric Dental		Covered for pediatric dental care services for Members 18 years and younger. Medically Necessary orthodontia requires Prior Authorization.
• Type I Services: Preventive & Diagnostic	Subject to Deductible, then $0	
• Type II Services: Basic Covered Services	Subject to Deductible, then 25%	
• Type III Services: Major Restorative Services	Subject to Deductible, then 50%	
• Type IV Services: Orthodontia (only as Medically Necessary)	Subject to Deductible, then 50%	
Outpatient Surgery (outpatient hospital/ambulatory surgery centers)	$750 Co-payment after Deductible	Covered if Medically Necessary at In-network outpatient facility. May require Prior Authorization.
Lab	$25 Co-payment after Deductible	Covered if Medically Necessary. Includes blood tests, urinalysis, Pap smears, and throat cultures to maintain health and to test, diagnose, treat, and prevent disease. Genetic testing may require Prior Authorization.
X-ray Services	$25 Co-payment after Deductible	Covered if Medically Necessary
Advanced Imaging Services (MRI, CT, PET)	$500 Co-payment after Deductible	Requires Prior Authorization
Abortion Services	$750 Co-payment after Deductible	
INPATIENT MEDICAL CARE		
Inpatient Medical Care Room and board (includes deliveries/surgery/radiology services/labs)	$1,000 Co-payment after Deductible	Inpatient medical care covered according to Medical Necessity and subject to Prior Authorization. Elective admissions require submission of Prior Authorization form 5 business days before admission.
PHARMACY		
Pharmacy		Please see *Preferred Drug List* for specific Prior Authorization requirements
Retail drugs (up to 30-Day supply)		
• Tier 1 (primarily generic focused)	$20 Co-payment	
• Tier 2 (primarily preferred brand)	$60 Co-payment	No Co-payment for:
• Tier 3 (primarily nonpreferred brand)	$90 Co-payment after Deductible	• Birth control and family-planning supplies
Mail-order drugs (up to 90-Day supply)		
• Tier 1 (primarily generic focused)	$40 Co-payment	
• Tier 2 (primarily preferred brand)	$120 Co-payment	
• Tier 3 (primarily nonpreferred brand)	$270 Co-payment after Deductible	
EMERGENCY CARE		
Emergency Care	$700 Co-payment after Deductible	Notification required within 24 hours, if admitted. Co-payment waived, if admitted.

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
MENTAL HEALTH AND/OR SUBSTANCE USE TREATMENT		
Inpatient Mental Health and/or Substance Use	$1,000 Co-payment per admission after Deductible	Inpatient mental health and/or substance use treatment services covered according to Medical Necessity and subject to Prior Authorization
Outpatient Mental Health and/or Substance Use • Individual therapy/Counseling • Methadone treatment (dosing, counseling, labs) • Autism spectrum disorder treatment o Applied behavioral analysis • Medication-Assisted Treatment (MAT) services	$30 Co-payment per visit	• After 12 Behavioral Health outpatient therapy visits per Benefit Year, requires Prior Authorization, except for substance use treatment visits • No Prior Authorization required; does not count toward initial 12 Behavioral Health outpatient therapy visits • Requires Prior Authorization; does not count toward initial 12 Behavioral Health outpatient therapy visits. Includes assessments, evaluations, testing, and treatment; covered in home, outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst • No Prior Authorization required
REHABILITATION AND HABILITATIVE SERVICES		
Cardiac Rehabilitation	$50 Co-payment	Requires Prior Authorization
Home Health Care	No Co-payment after Deductible	Requires Prior Authorization if daily or longer than six months
Inpatient Skilled Nursing Facility	$1,000 Co-payment after Deductible	Maximum of 100 Days total per Member per Benefit Year; requires Prior Authorization
Inpatient Rehabilitation Hospital or Chronic Disease Hospital	$1,000 Co-payment after Deductible	Maximum of 60 Days total per Member per Benefit Year; requires Prior Authorization
Short-term Outpatient Rehabilitation	$50 Co-payment	Requires Prior Authorization
Physical/Occupational/Speech Therapy	$50 Co-payment	May require Prior Authorization after initial evaluation. Maximum of 60 visits total combined Physical and Occupational Rehabilitative Therapy per Member per Benefit Year. No limit on Speech Therapy.
Habilitative Services	$50 Co-payment	May require Prior Authorization after initial evaluation. Maximum of 60 visits total combined Physical and Occupational Habilitative Therapy per Member per Benefit Year. No limit on Speech Therapy.
OTHER BENEFITS		
Breastfeeding Services	No Co-payment	Includes one non-hospital grade breast pump per pregnancy, breastfeeding supplies, and lactation consultants
Chiropractic Care	$50 Co-payment	Doesn't require prior authorization
Cleft Palate/Cleft Lip Care	Related office visit or surgery Co-payment may apply	Covered for Members 18 and younger. Includes medical, dental, oral, and facial surgery, follow-up, and related services. Requires Prior Authorization.
Durable Medical Equipment • Supplies • Prosthetics • Oxygen and respiratory therapy equipment	20% Co-insurance after Deductible	May require Prior Authorization (see list at tuftshealthplan.com)
Early Intervention Services	No Co-payment	Covered for Members 3 and younger; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention specialist.
Fitness Reimbursement	50% Co-insurance for first 3 months	Covered for first 3 months; excludes initiation fees. This benefit is available to all Members once every Benefit Year.
Ground Ambulance	No Co-payment after Deductible	Emergency transport only; nonemergency transport covered if Medically Necessary and with Prior Authorization.

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
Hearing Aids	20% Co-insurance for device after Deductible $30 Co-payment for PCP visit $50 Co-payment for Specialist visit	Only covered for Members 21 and younger. Full cost of one hearing aid per hearing-impaired ear up to $2,000 for each hearing aid for 36 months. Related services and supplies do not count toward the $2,000 limit.
Hospice	No Co-payment after Deductible	Requires Prior Authorization
Infertility Services	Related office visit or surgery Co-payment may apply	Requires Prior Authorization. Includes diagnosis and treatment, such as in vitro fertilization, gamete intrafallopian tube transfer, assisted hatching, and sperm banking. Must meet eligibility requirements. Some limitations apply.
Orthotics	20% Co-insurance after Deductible	Requires Prior Authorization. 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 for diabetics only.
Podiatry	$50 Co-payment	Medically Necessary nonroutine foot care covered; requires Prior Authorization Routine foot care services for diabetics only doesn't require Prior Authorization
Qualified Clinical Trials	Related office visit or surgery Co-payment may apply	Covered only if Medically Necessary; requires Prior Authorization
Weight Loss Programs	No Co-payment for the first 3 months	Covered for first 3 months; excludes initiation fees and food
Wellness		
• Family planning	No Co-payment	Doesn't require Prior Authorization
• Nutritional counseling	No Co-payment	Requires Prior Authorization
• Prenatal care	No Co-payment	Doesn't require Prior Authorization
• Nurse midwife	No Co-payment	Doesn't require Prior Authorization

ANNUAL DEDUCTIBLE	
Individual	$2,000
Family	$4,000

ANNUAL OUT-OF-POCKET MAXIMUM	
Individual	$7,350
Family	$14,700

Deductible, Co-insurance, and Co-payments apply toward your Out-of-pocket Maximum.

Services not covered

See the section "Services not covered" on page 35 for the list of services not covered.

Direct Silver 2000 II

Benefit and Cost-sharing Summary

This "Benefit and Cost-sharing Summary" gives you information about your *Tufts Health Direct* Covered Services and costs you may have to pay. The fees for Covered Services are different depending on your Plan Level. Make sure you review the services you're eligible for under the "Benefit and Cost-sharing Summary" for your specific Plan Level. To see which Plan Level you have, check your Tufts Health Plan Member ID Card or call us at **888.257.1985**, Monday through Friday, 8 a.m. to 5 p.m.

For some of your Covered Services, you will have to pay a Co-payment and/or Co-insurance (check the "Benefit and Cost-sharing Summary" for your specific Plan Level). Co-insurance is an amount, stated as a percentage of the cost of the service, that you must pay for certain Covered Services. You don't have to pay a Co-payment for Preventive Care services, such as physical examinations, Family-planning Services, contraceptives, health screenings, or vaccinations. For a complete listing of the types of Preventive Care services covered, please visit the U.S. Preventive Services Task Force website at www.uspreventiveservicestaskforce.org.

Your *Tufts Health Direct* plan may also have a Deductible. A Deductible is the amount you pay for certain Covered Services in a Benefit Year before we will begin to pay for those Covered Services.

You're responsible for paying the Co-payment, Deductible, and/or Co-insurance amounts listed in this "Benefit and Cost-sharing Summary." If you don't pay the Co-payment, Deductible, and/or Co-insurance at the time of your visit, you will still owe the money to the Provider. The Provider may use a legal method to collect the money from you. Tufts Health Plan won't pay the Provider for the Co-payment and/or Co-insurance that you owe.

This summary gives you a general understanding of your benefits. If you want more information about your benefits, see the section "Covered Services" on page 22. This *Member Handbook* also has a list of services that aren't covered.

You must go to Providers (doctors, Hospitals, and other health care professionals) who are part of the *Tufts Health Direct* Provider Network to get services. For Primary Care, you must see the Primary Care Provider (PCP) you have on record. To choose your PCP, check on your assigned PCP, or change your PCP, please visit us at tuftshealthplan.com or call us at **888.257.1985**. Services are only covered for In-network Providers, except for emergency care and certain other cases (see page 9 for more information).

All nonemergency Out-of-network visits require Prior Authorization.

Under the federal Affordable Care Act, there are no annual or lifetime dollar limits on Essential Health Benefits.

The *Tufts Health Direct* Provider Network can change at any time. Always check with Tufts Health Plan for the most up-to-date information.

If you have questions about your *Tufts Health Direct* benefits or you need help locating an In-network Provider, call us at **888.257.1985**. The Tufts Health Plan Member Services Team can help you Monday through Friday, from 8 a.m. to 5 p.m.

Direct Silver 2000 II

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
OUTPATIENT MEDICAL CARE		
Office Visits		
• Primary Care Provider preventive care/ screening/immunization	No Co-payment	
• Primary Care Provider nonpreventive office visit	$30 Co-payment	
• Specialist	$50 Co-payment	
• Urgent Care Center (UCC) visit	$50 Co-payment $50 Co-payment	
Eye Care (Vision Care)	$30 Co-payment for eye exam $50 Co-payment for all other vision services	Coverage for routine eye exams for members 18 years and younger once every 12 months. For members older than 18 years, coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics. Eye glasses covered once every 12 months for members 18 years and younger. Collection frames only.
Pediatric Dental		Covered for pediatric dental care services for Members 18 years and younger. Medically Necessary orthodontia requires Prior Authorization.
• Type I Services: Preventive & Diagnostic	Subject to Deductible, then $0	
• Type II Services: Basic Covered Services	Subject to Deductible, then 25%	
• Type III Services: Major Restorative Services	Subject to Deductible, then 50%	
• Type IV Services: Orthodontia (only as Medically Necessary)	Subject to Deductible, then 50%	
Outpatient Surgery (outpatient hospital/ambulatory surgery centers)	$750 Co-payment after Deductible	Covered if Medically Necessary at In-network outpatient facility. May require Prior Authorization.
Lab	$25 Co-payment after Deductible	Covered if Medically Necessary. Includes blood tests, urinalysis, Pap smears, and throat cultures to maintain health and to test, diagnose, treat, and prevent disease. Genetic testing may require Prior Authorization.
X-ray Services	$25 Co-payment after Deductible	Covered if Medically Necessary
Advanced Imaging Services (MRI, CT, PET)	$500 Co-payment after Deductible	Requires Prior Authorization
Abortion Services	$750 Co-payment after Deductible	
INPATIENT MEDICAL CARE		
Inpatient Medical Care Room and board (includes deliveries/surgery/radiology services/labs)	$1,000 Co-payment after Deductible	Inpatient medical care covered according to Medical Necessity and subject to Prior Authorization. Elective admissions require submission of Prior Authorization form 5 business days before admission.
PHARMACY		
Pharmacy		Please see *Preferred Drug List* for specific Prior Authorization requirements
Retail drugs (up to 30-Day supply)		
• Tier 1 (primarily generic focused)	$20 Co-payment	
• Tier 2 (primarily preferred brand)	$60 Co-payment	No Co-payment for:
• Tier 3 (primarily nonpreferred brand)	$90 Co-payment after Deductible	• Birth control and Family-planning supplies
Mail-order drugs (up to 90-Day supply)		
• Tier 1 (primarily generic focused)	$40 Co-payment	
• Tier 2 (primarily preferred brand)	$120 Co-payment	
• Tier 3 (primarily nonpreferred brand)	$270 Co-payment after Deductible	
EMERGENCY CARE		
Emergency Care	$700 Co-payment after Deductible	Notification required within 24 hours, if admitted. Co-payment waived, if admitted.

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
MENTAL HEALTH AND/OR SUBSTANCE USE TREATMENT		
Inpatient Mental Health and/or Substance Use	$1,000 Co-payment per admission after Deductible	Inpatient mental health and/or substance use treatment services covered according to Medical Necessity and subject to Prior Authorization
Outpatient Mental Health and/or Substance Use	$30 Co-payment per visit	
• Individual therapy/Counseling		• After 12 Behavioral Health outpatient therapy visits per Benefit Year, requires Prior Authorization, except for substance use treatment visits
• Methadone treatment (dosing, counseling, labs)		• No Prior Authorization required; does not count toward initial 12 Behavioral Health outpatient therapy visits
• Autism spectrum disorder treatment o Applied behavioral analysis		• Requires Prior Authorization; does not count toward initial 12 Behavioral Health outpatient therapy visits. Includes assessments, evaluations, testing, and treatment; covered in home, outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst
• Medication-Assisted Treatment (MAT) services		• No Prior Authorization required
REHABILITATION AND HABILITATIVE SERVICES		
Cardiac Rehabilitation	$50 Co-payment	Requires Prior Authorization
Home Health Care	$5 Co-payment after Deductible	Requires Prior Authorization if daily or longer than six months
Inpatient Skilled Nursing Facility	$1,000 Co-payment after Deductible	Maximum of 100 Days total per Member per Benefit Year; requires Prior Authorization
Inpatient Rehabilitation Hospital or Chronic Disease Hospital	$1,000 Co-payment after Deductible	Maximum of 60 Days total per Member per Benefit Year; requires Prior Authorization
Short-term Outpatient Rehabilitation	$50 Co-payment	Requires Prior Authorization
Physical/Occupational/Speech Therapy	$50 Co-payment	May require Prior Authorization after initial evaluation. Maximum of 60 visits total combined Physical and Occupational Rehabilitative Therapy per Member per Benefit Year. No limit on Speech Therapy.
Habilitative Services	$50 Co-payment	May require Prior Authorization after initial evaluation. Maximum of 60 visits total combined Physical and Occupational Habilitative Therapy per Member per Benefit Year. No limit on Speech Therapy.
OTHER BENEFITS		
Breastfeeding Services	No Co-payment	Includes one non-hospital grade breast pump per pregnancy, breastfeeding supplies, and lactation consultants
Chiropractic Care	$50 Co-payment	Doesn't require prior authorization
Cleft Palate/Cleft Lip Care	Related office visit or surgery Co-payment may apply	Covered for Members 18 and younger. Includes medical, dental, oral, and facial surgery, follow-up, and related services. Requires Prior Authorization.
Durable Medical Equipment • Supplies • Prosthetics • Oxygen and respiratory therapy equipment	20% Co-insurance after Deductible	May require Prior Authorization (see list at tuftshealthplan.com)
Early Intervention Services	No Co-payment	Covered for Members 3 and younger; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention specialist.
Fitness Reimbursement	50% Co-insurance for first 3 months	Covered for first 3 months; excludes initiation fees. This benefit is available to all Members once every Benefit Year.
Ground Ambulance	No Co-payment after Deductible	Emergency transport only; nonemergency transport covered if Medically Necessary and with Prior Authorization.

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
Hearing Aids	20% Co-insurance for device after Deductible $30 Co-payment for PCP visit $50 Co-payment for Specialist visit	Only covered for Members 21 and younger. Full cost of one hearing aid per hearing-impaired ear up to $2,000 for each hearing aid for 36 months. Related services and supplies do not count toward the $2,000 limit.
Hospice	No Co-payment after Deductible	Requires Prior Authorization
Infertility Services	Related office visit or surgery Co-payment may apply	Requires Prior Authorization. Includes diagnosis and treatment, such as in vitro fertilization, gamete intrafallopian tube transfer, assisted hatching, and sperm banking. Must meet eligibility requirements. Some limitations apply.
Orthotics	20% Co-insurance after Deductible	Requires Prior Authorization. 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 for diabetics only.
Podiatry	$50 Co-payment	Medically Necessary nonroutine foot care covered; requires Prior Authorization Routine foot care services for diabetics only; doesn't require Prior Authorization
Qualified Clinical Trials	Related office visit or surgery Co-payment may apply	Covered only if Medically Necessary; requires Prior Authorization
Weight Loss Programs	No Co-payment for the first 3 months	Covered for first 3 months; excludes initiation fees and food
Wellness		
• Family planning	No Co-payment	Doesn't require Prior Authorization
• Nutritional counseling	No Co-payment	Requires Prior Authorization
• Prenatal care	No Co-payment	Doesn't require Prior Authorization
• Nurse midwife	No Co-payment	Doesn't require Prior Authorization

ANNUAL DEDUCTIBLE	
Individual	$2,000
Family	$4,000

ANNUAL OUT-OF-POCKET MAXIMUM	
Individual	$7,350
Family	$14,700

Deductible, Co-insurance, and Co-payments apply toward your Out-of-pocket Maximum.

Services not covered

See the section "Services not covered" on page 35 for the list of services not covered.

Direct Silver 2500 with Co-insurance

Benefit and Cost-sharing Summary

This "Benefit and Cost-sharing Summary" gives you information about your *Tufts Health Direct* Covered Services and costs you may have to pay. The fees for Covered Services are different depending on your Plan Level. Make sure you review the services you're eligible for under the "Benefit and Cost-sharing Summary" for your specific Plan Level. To see which Plan Level you have, check your Tufts Health Plan Member ID Card or call us at **888.257.1985**, Monday through Friday, 8 a.m. to 5 p.m.

For some of your Covered Services, you will have to pay a Co-payment and/or Co-insurance (check the "Benefit and Cost-sharing Summary" for your specific Plan Level). Co-insurance is an amount, stated as a percentage of the cost of the service, that you must pay for certain Covered Services. You don't have to pay a Co-payment for Preventive Care services, such as physical examinations, Family-planning Services, contraceptives, health screenings, or vaccinations. For a complete listing of the types of Preventive Care services covered, please visit the U.S. Preventive Services Task Force website at www.uspreventiveservicestaskforce.org.

Your *Tufts Health Direct* plan may also have a Deductible. A Deductible is the amount you pay for certain Covered Services in a Benefit Year before we will begin to pay for those Covered Services.

You're responsible for paying the Co-payment, Deductible, and/or Co-insurance amounts listed in this "Benefit and Cost-sharing Summary." If you don't pay the Co-payment, Deductible, and/or Co-insurance at the time of your visit, you will still owe the money to the Provider. The Provider may use a legal method to collect the money from you. Tufts Health Plan won't pay the Provider for the Co-payment and/or Co-insurance that you owe.

This summary gives you a general understanding of your benefits. If you want more information about your benefits, see the section "Covered Services" on page 22. This *Member Handbook* also has a list of services that aren't covered.

You must go to Providers (doctors, Hospitals, and other health care professionals) who are part of the *Tufts Health Direct* Provider Network to get services. For Primary Care, you must see the Primary Care Provider (PCP) you have on record. To choose your PCP, check on your assigned PCP, or change your PCP, please visit us at tuftshealthplan.com or call us at **888.257.1985**. Services are only covered for In-network Providers, except for Emergency care and certain other cases (see page 9 for more information).

All nonemergency Out-of-network visits require Prior Authorization.

Under the federal Affordable Care Act, there are no annual or lifetime dollar limits on Essential Health Benefits.

The *Tufts Health Direct* Provider Network can change at any time. Always check with Tufts Health Plan for the most up-to-date information.

If you have questions about your *Tufts Health Direct* benefits or you need help locating an In-network Provider, call us at **888.257.1985**. The Tufts Health Plan Member Services Team can help you Monday through Friday, from 8 a.m. to 5 p.m.

Direct Silver 2500 with Co-insurance

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
OUTPATIENT MEDICAL CARE		
Office Visits		
• Primary Care Provider preventive care/ screening/immunization	No Co-payment	
• Primary Care Provider nonpreventive office visit	$30 Co-payment	
• Specialist	$50 Co-payment after Deductible	
• Urgent Care Center (UCC) visit	$50 Co-payment after Deductible	
Eye Care (Vision care)	$30 Co-payment for eye exam $50 Co-payment for all other vision services after Deductible	Coverage for routine eye exams for members 18 years and younger once every 12 months. For members older than 18 years, coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics. Eye glasses covered once every 12 months for members 18 years and younger. Collection frames only.
Pediatric Dental		Covered for pediatric dental care services for Members 18 years and younger. Medically Necessary orthodontia requires Prior Authorization.
• Type I Services: Preventive & Diagnostic	Subject to Deductible, then $0	
• Type II Services: Basic Covered Services	Subject to Deductible, then 25%	
• Type III Services: Major Restorative Services	Subject to Deductible, then 50%	
• Type IV Services: Orthodontia (only as Medically Necessary)	Subject to Deductible, then 50%	
Outpatient Surgery (outpatient hospital/ambulatory surgery centers)	20% Co-insurance after Deductible	Covered if Medically Necessary at In-network outpatient facility. May require Prior Authorization.
Lab	20% Co-insurance after Deductible	Covered if Medically Necessary. Includes blood tests, urinalysis, Pap smears, and throat cultures to maintain health and to test, diagnose, treat, and prevent disease. Genetic testing may require Prior Authorization.
X-ray Services	20% Co-insurance after Deductible	Covered if Medically Necessary
Advanced Imaging Services (MRI, CT, PET)	20% Co-insurance after Deductible	Requires Prior Authorization
Abortion Services	30% Co-insurance after Deductible	
INPATIENT MEDICAL CARE		
Inpatient Medical Care Room and board (includes deliveries/surgery/radiology services/labs)	30% Co-insurance after Deductible	Inpatient medical care covered according to Medical Necessity and subject to Prior Authorization. Elective admissions require submission of Prior Authorization form 5 business days before admission.
PHARMACY		
Pharmacy		Please see *Preferred Drug List* for specific Prior Authorization requirements
Retail drugs (up to 30-Day supply)		
• Tier 1 (primarily generic focused)	$35 Co-payment after Deductible	
• Tier 2 (primarily preferred brand)	50% Co-insurance after Deductible	No Co-payment for:
• Tier 3 (primarily nonpreferred brand)	50% Co-insurance after Deductible	• Birth control and family-planning supplies
Mail-order drugs (up to 90-Day supply)		
• Tier 1 (primarily generic focused)	$70 Co-payment after Deductible	
• Tier 2 (primarily preferred brand)	50% Co-insurance after Deductible	
• Tier 3 (primarily nonpreferred brand)	50% Co-insurance after Deductible	
EMERGENCY CARE		
Emergency Care	$650 Co-payment after Deductible	Notification required within 24 hours, if admitted. Co-payment waived, if admitted.

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
MENTAL HEALTH AND/OR SUBSTANCE USE TREATMENT		
Inpatient Mental Health and/or Substance Use	30% Co-insurance after Deductible	Inpatient mental health and/or substance use treatment services covered according to Medical Necessity and subject to Prior Authorization
Outpatient Mental Health and/or Substance Use	$30 Co-payment per visit	
• Individual therapy/Counseling		• After 12 Behavioral Health outpatient therapy visits per Benefit Year, requires Prior Authorization, except for substance use treatment visits
• Methadone treatment (dosing, counseling, labs)		• No Prior Authorization required; does not count toward initial 12 Behavioral Health outpatient therapy visits
• Autism spectrum disorder treatment o Applied behavioral analysis		• Requires Prior Authorization; does not count toward initial 12 Behavioral Health outpatient therapy visits. Includes assessments, evaluations, testing, and treatment; covered in home, outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst
• Medication-Assisted Treatment (MAT) services		• No Prior Authorization required
REHABILITATION AND HABILITATIVE SERVICES		
Cardiac Rehabilitation	$50 Co-payment after Deductible	Requires Prior Authorization
Home Health Care	No Co-payment after Deductible	Requires Prior Authorization if daily or longer than six months
Inpatient Skilled Nursing Facility	30% Co-insurance after Deductible	Maximum of 100 Days total per Member per Benefit Year; requires Prior Authorization
Inpatient Rehabilitation Hospital or Chronic Disease Hospital	30% Co-insurance after Deductible	Maximum of 60 Days total per Member per Benefit Year; requires Prior Authorization
Short-term Outpatient Rehabilitation	$50 Co-payment after Deductible	Requires Prior Authorization
Physical/Occupational/Speech Therapy	$50 Co-payment after Deductible	May require Prior Authorization after initial evaluation. Maximum of 60 visits total combined Physical and Occupational Rehabilitative Therapy per Member per Benefit Year. No limit on Speech Therapy.
Habilitative Services	$50 Co-payment after Deductible	May require Prior Authorization after initial evaluation. Maximum of 60 visits total combined Physical and Occupational Habilitative Therapy per Member per Benefit Year. No limit on Speech Therapy.
OTHER BENEFITS		
Breastfeeding Services	No Co-payment	Includes one non-hospital grade breast pump per pregnancy, breastfeeding supplies, and lactation consultants
Chiropractic Care	$50 Co-payment after Deductible	Doesn't require prior authorization
Cleft Palate/Cleft Lip Care	Related office visit or surgery Co-payment may apply	Covered for Members 18 and younger. Includes medical, dental, oral, and facial surgery, follow-up, and related services. Requires Prior Authorization.
Durable Medical Equipment • Supplies • Prosthetics • Oxygen and respiratory therapy equipment	30% Co-insurance after Deductible	May require Prior Authorization (see list at tuftshealthplan.com)
Early Intervention Services	No Co-payment	Covered for Members 3 and younger; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention specialist.
Fitness Reimbursement	50% Co-insurance for first 3 months	Covered for first 3 months; excludes initiation fees. This benefit is available to all Members once every Benefit Year.
Ground Ambulance	No Co-payment after Deductible	Emergency transport only; nonemergency transport covered if Medically Necessary and with Prior Authorization.

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
Hearing Aids	30% Co-insurance for device after Deductible $30 Co-payment for PCP visit $50 Co-payment for Specialist visit after Deductible	Only covered for Members 21 and younger. Full cost of one hearing aid per hearing-impaired ear up to $2,000 for each hearing aid for 36 months. Related services and supplies do not count toward the $2,000 limit.
Hospice	No Co-payment after Deductible	Requires Prior Authorization
Infertility Services	Related office visit or surgery Co-payment may apply	Requires Prior Authorization. Includes diagnosis and treatment, such as in vitro fertilization, gamete intrafallopian tube transfer, assisted hatching, and sperm banking. Must meet eligibility requirements. Some limitations apply.
Orthotics	30% Co-insurance after Deductible	Requires Prior Authorization. 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 for diabetics only.
Podiatry	$50 Co-payment after Deductible	Medically Necessary nonroutine foot care covered; requires Prior Authorization. Routine foot care services for diabetics don't require Prior Authorization.
Qualified Clinical Trials	Related office visit or surgery Co-payment may apply	Covered only if Medically Necessary; requires Prior Authorization
Weight Loss Programs	No Co-payment for the first 3 months	Covered for first 3 months; excludes initiation fees and food
Wellness		
• Family planning	No Co-payment	Doesn't require Prior Authorization
• Nutritional counseling	No Co-payment	Requires Prior Authorization
• Prenatal care	No Co-payment	Doesn't require Prior Authorization
• Nurse midwife	No Co-payment	Doesn't require Prior Authorization

ANNUAL DEDUCTIBLE	
Individual	$2,500
Family	$5,000

ANNUAL OUT-OF-POCKET MAXIMUM	
Individual	$7,350
Family	$14,700

Deductible, Co-insurance, and Co-payments apply toward your Out-of-pocket Maximum.

Services not covered

See the section "Services not covered" on page 35 for the list of services not covered.

Direct Silver 2500 with Co-insurance II

Benefit and Cost-sharing Summary

This "Benefit and Cost-sharing Summary" gives you information about your *Tufts Health Direct* Covered Services and costs you may have to pay. The fees for Covered Services are different depending on your Plan Level. Make sure you review the services you're eligible for under the "Benefit and Cost-sharing Summary" for your specific Plan Level. To see which Plan Level you have, check your Tufts Health Plan Member ID Card or call us at **888.257.1985**, Monday through Friday, 8 a.m. to 5 p.m.

For some of your Covered Services, you will have to pay a Co-payment and/or Co-insurance (check the "Benefit and Cost-sharing Summary" for your specific Plan Level). Co-insurance is an amount, stated as a percentage of the cost of the service, that you must pay for certain Covered Services. You don't have to pay a Co-payment for Preventive Care services, such as physical examinations, Family-planning Services, contraceptives, health screenings, or vaccinations. For a complete listing of the types of Preventive Care services covered, please visit the U.S. Preventive Services Task Force website at www.uspreventiveservicestaskforce.org.

Your *Tufts Health Direct* plan may also have a Deductible. A Deductible is the amount you pay for certain Covered Services in a Benefit Year before we will begin to pay for those Covered Services.

You're responsible for paying the Co-payment, Deductible, and/or Co-insurance amounts listed in this "Benefit and Cost-sharing Summary." If you don't pay the Co-payment, Deductible, and/or Co-insurance at the time of your visit, you will still owe the money to the Provider. The Provider may use a legal method to collect the money from you. Tufts Health Plan won't pay the Provider for the Co-payment and/or Co-insurance that you owe.

This summary gives you a general understanding of your benefits. If you want more information about your benefits, see the section "Covered Services" on page 22. This *Member Handbook* also has a list of services that aren't covered.

You must go to Providers (doctors, Hospitals, and other health care professionals) who are part of the *Tufts Health Direct* Provider Network to get services. For Primary Care, you must see the Primary Care Provider (PCP) you have on record. To choose your PCP, check on your assigned PCP, or change your PCP, please visit us at tuftshealthplan.com or call us at **888.257.1985**. Services are only covered for In-network Providers, except for emergency care and certain other cases (see page 9 for more information).

All nonemergency Out-of-network visits require Prior Authorization.

Under the federal Affordable Care Act, there are no annual or lifetime dollar limits on Essential Health Benefits.

The *Tufts Health Direct* Provider Network can change at any time. Always check with Tufts Health Plan for the most up-to-date information.

If you have questions about your *Tufts Health Direct* benefits or you need help locating an In-network Provider, call us at **888.257.1985**. The Tufts Health Plan Member Services Team can help you Monday through Friday, from 8 a.m. to 5 p.m.

Direct Silver 2500 with Co-insurance II

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
OUTPATIENT MEDICAL CARE		
Office Visits		
• Primary Care Provider preventive care/ screening/immunization	No Co-payment	
• Primary Care Provider nonpreventive office visit	$30 Co-payment	
• Specialist	$50 Co-payment after Deductible	
• Urgent Care Center (UCC) visit	$50 Co-payment after Deductible	
Eye Care (vision Care)	$30 Co-payment for eye exam $50 Co-payment for all other vision services after Deductible	Coverage for routine eye exams for members 18 years and younger once every 12 months. For members older than 18 years, coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics. Eye glasses covered once every 12 months for members 18 years and younger. Collection frames only.
Pediatric Dental		Covered for pediatric dental care services for Members 18 years and younger. Medically Necessary orthodontia requires Prior Authorization.
• Type I Services: Preventive & Diagnostic	Subject to Deductible, then $0	
• Type II Services: Basic Covered Services	Subject to Deductible, then 25%	
• Type III Services: Major Restorative Services	Subject to Deductible, then 50%	
• Type IV Services: Orthodontia (only as Medically Necessary)	Subject to Deductible, then 50%	
Outpatient Surgery (outpatient hospital/ambulatory surgery centers)	20% Co-insurance after Deductible	Covered if Medically Necessary at In-network outpatient facility. May require Prior Authorization.
Lab	20% Co-insurance after Deductible	Covered if Medically Necessary. Includes blood tests, urinalysis, Pap smears, and throat cultures to maintain health and to test, diagnose, treat, and prevent disease. Genetic testing may require Prior Authorization.
X-ray Services	20% Co-insurance after Deductible	Covered if Medically Necessary
Advanced Imaging Services (MRI, CT, PET)	20% Co-insurance after Deductible	Requires Prior Authorization
Abortion Services	30% Co-insurance after Deductible	
INPATIENT MEDICAL CARE		
Inpatient Medical Care Room and board (includes deliveries/surgery/radiology services/labs)	30% Co-insurance after Deductible	Inpatient medical care covered according to Medical Necessity and subject to Prior Authorization. Elective admissions require submission of Prior Authorization form 5 business days before admission.
PHARMACY		
Pharmacy		Please see *Preferred Drug List* for specific Prior Authorization requirements
Retail drugs (up to 30-Day supply)		
• Tier 1 (primarily generic focused)	$35 Co-payment after Deductible	
• Tier 2 (primarily preferred brand)	50% Co-insurance after Deductible	No Co-payment for:
• Tier 3 (primarily nonpreferred brand)	50% Co-insurance after Deductible	• Birth control and Family-planning supplies
Mail-order drugs (up to 90-Day supply)		
• Tier 1 (primarily generic focused)	$70 Co-payment after Deductible	
• Tier 2 (primarily preferred brand)	50% Co-insurance after Deductible	
• Tier 3 (primarily nonpreferred brand)	50% Co-insurance after Deductible	
EMERGENCY CARE		
Emergency Care	$650 Co-payment after Deductible	Notification required within 24 hours, if admitted. Co-payment waived, if admitted.

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
MENTAL HEALTH AND/OR SUBSTANCE USE TREATMENT		
Inpatient Mental Health and/or Substance Use	30% Co-insurance after Deductible	Inpatient mental health and/or substance use treatment services covered according to Medical Necessity and subject to Prior Authorization
Outpatient Mental Health and/or Substance Use	$30 Co-payment per visit	
• Individual therapy/Counseling		• After 12 Behavioral Health outpatient therapy visits per Benefit Year, requires Prior Authorization, except for substance use treatment visits
• Methadone treatment (dosing, counseling, labs)		• No Prior Authorization required; does not count toward initial 12 Behavioral Health outpatient therapy visits
• Autism spectrum disorder treatment o Applied behavioral analysis		• Requires Prior Authorization; does not count toward initial 12 Behavioral Health outpatient therapy visits. Includes assessments, evaluations, testing, and treatment; covered in home, outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst
• Medication-Assisted Treatment (MAT) services		• No Prior Authorization required
REHABILITATION AND HABILITATIVE SERVICES		
Cardiac Rehabilitation	$50 Co-payment after Deductible	Requires Prior Authorization
Home Health Care	$5 Co-payment after Deductible	Requires Prior Authorization if daily or longer than six months
Inpatient Skilled Nursing Facility	30% Co-insurance after Deductible	Maximum of 100 Days total per Member per Benefit Year; requires Prior Authorization
Inpatient Rehabilitation Hospital or Chronic Disease Hospital	30% Co-insurance after Deductible	Maximum of 60 Days total per Member per Benefit Year; requires Prior Authorization
Short-term Outpatient Rehabilitation	$50 Co-payment after Deductible	Requires Prior Authorization
Physical/Occupational/Speech Therapy	$50 Co-payment after Deductible	May require Prior Authorization after initial evaluation. Maximum of 60 visits total combined Physical and Occupational Rehabilitative Therapy per Member per Benefit Year. No limit on Speech Therapy.
Habilitative Services	$50 Co-payment after Deductible	May require Prior Authorization after initial evaluation. Maximum of 60 visits total combined Physical and Occupational Habilitative Therapy per Member per Benefit Year. No limit on Speech Therapy.
OTHER BENEFITS		
Breastfeeding Services	No Co-payment	Includes one non-hospital grade breast pump per pregnancy, breastfeeding supplies, and lactation consultants
Chiropractic Care	$50 Co-payment after Deductible	Doesn't require prior authorization
Cleft Palate/Cleft Lip Care	Related office visit or surgery Co-payment may apply	Covered for Members 18 and younger. Includes medical, dental, oral, and facial surgery, follow-up, and related services. Requires Prior Authorization.
Durable Medical Equipment • Supplies • Prosthetics • Oxygen and respiratory therapy equipment	30% Co-insurance after Deductible	May require Prior Authorization (see list at tuftshealthplan.com)
Early Intervention Services	No Co-payment	Covered for Members 3 and younger; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention specialist.
Fitness Reimbursement	50% Co-insurance for first 3 months	Covered for first 3 months; excludes initiation fees. This benefit is available to all Members once every Benefit Year.
Ground Ambulance	No Co-payment after Deductible	Emergency transport only; nonemergency transport covered if Medically Necessary and with Prior Authorization

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
Hearing Aids	30% Co-insurance for device after Deductible $30 Co-payment for PCP visit $50 Co-payment for Specialist visit after Deductible	Only covered for Members 21 and younger. Full cost of one hearing aid per hearing-impaired ear up to $2,000 for each hearing aid for 36 months. Related services and supplies do not count toward the $2,000 limit.
Hospice	No Co-payment after Deductible	Requires Prior Authorization
Infertility Services	Related office visit or surgery Co-payment may apply	Requires Prior Authorization. Includes diagnosis and treatment, such as in vitro fertilization, gamete intrafallopian tube transfer, assisted hatching, and sperm banking. Must meet eligibility requirements. Some limitations apply.
Orthotics	30% Co-insurance after Deductible	Requires Prior Authorization. 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 for diabetics only.
Podiatry	$50 Co-payment after Deductible	Medically Necessary nonroutine foot care covered; requires Prior Authorization. Routine foot care services for diabetics don't require Prior Authorization.
Qualified Clinical Trials	Related office visit or surgery Co-payment may apply	Covered only if Medically Necessary; requires Prior Authorization
Weight Loss Programs	No Co-payment for the first 3 months	Covered for first 3 months; excludes initiation fees and food
Wellness		
• Family planning	No Co-payment	Doesn't require Prior Authorization
• Nutritional counseling	No Co-payment	Requires Prior Authorization
• Prenatal care	No Co-payment	Doesn't require Prior Authorization
• Nurse midwife	No Co-payment	Doesn't require Prior Authorization

ANNUAL DEDUCTIBLE	
Individual	$2,500
Family	$5,000

ANNUAL OUT-OF-POCKET MAXIMUM	
Individual	$7,350
Family	$14,700

Deductible, Co-insurance, and Co-payments apply toward your Out-of-pocket Maximum.

Services not covered

See the section "Services not covered" on page 35 for the list of services not covered.

Direct Bronze 2500

Benefit and Cost-sharing Summary

This "Benefit and Cost-sharing Summary" gives you information about your *Tufts Health Direct* Covered Services and costs you may have to pay. The fees for Covered Services are different depending on your Plan Level. Make sure you review the services you're eligible for under the "Benefit and Cost-sharing Summary" for your specific Plan Level. To see which Plan Level you have, check your Tufts Health Plan Member ID Card or call us at **888.257.1985**, Monday through Friday, 8 a.m. to 5 p.m.

For some of your Covered Services, you will have to pay a Co-payment and/or Co-insurance (check the "Benefit and Cost-sharing Summary" for your specific Plan Level). Co-insurance is an amount, stated as a percentage of the cost of the service, that you must pay for certain Covered Services. You don't have to pay a Co-payment for Preventive Care services, such as physical examinations, Family-planning Services, contraceptives, health screenings, or vaccinations. For a complete listing of the types of Preventive Care services covered, please visit the U.S. Preventive Services Task Force website at www.uspreventiveservicestaskforce.org.

Your *Tufts Health Direct* plan may also have a Deductible. A Deductible is the amount you pay for certain Covered Services in a Benefit Year before we will begin to pay for those Covered Services.

You're responsible for paying the Co-payment, Deductible, and/or Co-insurance amounts listed in this "Benefit and Cost-sharing Summary." If you don't pay the Co-payment, Deductible, and/or Co-insurance at the time of your visit, you will still owe the money to the Provider. The Provider may use a legal method to collect the money from you. Tufts Health Plan won't pay the Provider for the Co-payment and/or Co-insurance that you owe.

This summary gives you a general understanding of your benefits. If you want more information about your benefits, see the section "Covered Services" on page 22. This *Member Handbook* also has a list of services that aren't covered.

You must go to Providers (doctors, Hospitals, and other health care professionals) who are part of the *Tufts Health Direct* Provider Network to get services. For Primary Care, you must see the Primary Care Provider (PCP) you have on record. To choose your PCP, check on your assigned PCP, or change your PCP, please visit us at tuftshealthplan.com or call us at **888.257.1985**. Services are only covered for In-network Providers, except for Emergency care and certain other cases (see page 9 for more information).

All nonemergency Out-of-network visits require Prior Authorization.

Under the federal Affordable Care Act, there are no annual or lifetime dollar limits on Essential Health Benefits.

The *Tufts Health Direct* Provider Network can change at any time. Always check with Tufts Health Plan for the most up-to-date information.

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Direct Bronze 2500

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
OUTPATIENT MEDICAL CARE		
Office Visits		
• Primary Care Provider preventive care/ screening/immunization	No Co-payment	
• Primary Care Provider nonpreventive office visit	$30 Co-payment after Deductible	
• Specialist	$50 Co-payment after Deductible	
• Urgent Care Center (UCC) visit	$50 Co-payment after Deductible	
Eye Care (Vision Care)	$30 Co-payment for eye exam after Deductible $50 Co-payment for all other vision services after Deductible	Coverage for routine eye exams for members 18 years and younger once every 12 months. For members older than 18 years, coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics. Eye glasses covered once every 12 months for members 18 years and younger. Collection frames only.
Pediatric Dental		Covered for pediatric dental care services for Members 18 years and younger. Medically Necessary orthodontia requires Prior Authorization.
• Type I Services: Preventive & Diagnostic	Subject to Deductible, then $0	
• Type II Services: Basic Covered Services	Subject to Deductible, then 25%	
• Type III Services: Major Restorative Services	Subject to Deductible, then 50%	
• Type IV Services: Orthodontia (only as Medically Necessary)	Subject to Deductible, then 50%	
Outpatient Surgery (outpatient hospital/ambulatory surgery centers)	$750 Co-payment after Deductible	Covered if Medically Necessary at In-network outpatient facility. May require Prior Authorization.
Lab	$25 Co-payment after Deductible	Covered if Medically Necessary. Includes blood tests, urinalysis, Pap smears, and throat cultures to maintain health and to test, diagnose, treat, and prevent disease. Genetic testing may require Prior Authorization.
X-ray Services	$25 Co-payment after Deductible	Covered if Medically Necessary
Advanced Imaging Services (MRI, CT, PET)	$500 Co-payment after Deductible	Requires Prior Authorization
Abortion Services	$750 Co-payment after Deductible	
INPATIENT MEDICAL CARE		
Inpatient Medical Care Room and board (includes deliveries/surgery/radiology services/labs)	$1,000 Co-payment after Deductible	Inpatient medical care covered according to Medical Necessity and subject to Prior Authorization. Elective admissions require submission of Prior Authorization form 5 business days before admission.
PHARMACY		
Pharmacy		Please see *Preferred Drug List* for specific Prior Authorization requirements
Retail drugs (up to 30-Day supply)		
• Tier 1 (primarily generic focused)	$20 Co-payment	
• Tier 2 (primarily preferred brand)	$60 Co-payment after Deductible	No Co-payment for:
• Tier 3 (primarily nonpreferred brand)	$90 Co-payment after Deductible	• Birth control and family-planning supplies
Mail-order drugs (up to 90-Day supply)		
• Tier 1 (primarily generic focused)	$40 Co-payment	
• Tier 2 (primarily preferred brand)	$120 Co-payment after Deductible	
• Tier 3 (primarily nonpreferred brand)	$270 Co-payment after Deductible	
EMERGENCY CARE		
Emergency Care	$700 Co-payment after Deductible	Notification required within 24 hours, if admitted. Co-payment waived, if admitted.

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
MENTAL HEALTH AND/OR SUBSTANCE USE TREATMENT		
Inpatient Mental Health and/or Substance Use	$1,000 Co-payment after Deductible	Inpatient mental health and/or substance use treatment services covered according to Medical Necessity and subject to Prior Authorization
Outpatient Mental Health and/or Substance Use	$30 Co-payment per visit after Deductible	
• Individual therapy/Counseling		• After 12 Behavioral Health outpatient therapy visits per Benefit Year, requires Prior Authorization, except for substance use treatment visits
• Methadone treatment (dosing, counseling, labs)		• No Prior Authorization required; does not count toward initial 12 Behavioral Health outpatient therapy visits
• Autism spectrum disorder treatment o Applied behavioral analysis		• Requires Prior Authorization; does not count toward initial 12 Behavioral Health outpatient therapy visits. Includes assessments, evaluations, testing, and treatment; covered in home, outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst
• Medication-Assisted Treatment (MAT) services		• No Prior Authorization required
REHABILITATION AND HABILITATIVE SERVICES		
Cardiac Rehabilitation	$50 Co-payment after Deductible	Requires Prior Authorization
Home Health Care	No Co-payment after Deductible	Requires Prior Authorization if daily or longer than six months
Inpatient Skilled Nursing Facility	$1,000 Co-payment after Deductible	Maximum of 100 Days total per Member per Benefit Year; requires Prior Authorization
Inpatient Rehabilitation Hospital or Chronic Disease Hospital	$1,000 Co-payment after Deductible	Maximum of 60 Days total per Member per Benefit Year; requires Prior Authorization
Short-term Outpatient Rehabilitation	$50 Co-payment after Deductible	Requires Prior Authorization
Physical/Occupational/Speech Therapy	$50 Co-payment after Deductible	May require Prior Authorization after initial evaluation. Maximum of 60 visits total combined Physical and Occupational Rehabilitative Therapy per Member per Benefit Year. No limit on Speech Therapy.
Habilitative Services	$50 Co-payment after Deductible	May require Prior Authorization after initial evaluation. Maximum of 60 visits total combined Physical and Occupational Habilitative Therapy per Member per Benefit Year. No limit on Speech Therapy.
OTHER BENEFITS		
Breastfeeding Services	No Co-payment	Includes one non-hospital grade breast pump per pregnancy, breastfeeding supplies, and lactation consultants
Chiropractic Care	$50 Co-payment after Deductible	Doesn't require prior authorization
Cleft Palate/Cleft Lip Care	Related office visit or surgery Co-payment may apply	Covered for Members 18 and younger. Includes medical, dental, oral, and facial surgery, follow-up, and related services. Requires Prior Authorization.
Durable Medical Equipment • Supplies • Prosthetics • Oxygen and respiratory therapy equipment	20% Co-insurance after Deductible	May require Prior Authorization (see list at tuftshealthplan.com)
Early Intervention Services	No Co-payment	Covered for Members 3 and younger; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention specialist.
Fitness Reimbursement	50% Co-insurance for first 3 months	Covered for first 3 months; excludes initiation fees. This benefit is available to all Members once every Benefit Year.
Ground Ambulance	No Co-payment after Deductible	Emergency transport only; nonemergency transport covered if Medically Necessary and with Prior Authorization

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
Hearing Aids	20% Co-insurance for device after Deductible $30 Co-payment for PCP visit after Deductible $50 Co-payment for Specialist visit after Deductible	Only covered for Members 21 and younger. Full cost of one hearing aid per hearing-impaired ear up to $2,000 for each hearing aid for 36 months. Related services and supplies do not count toward the $2,000 limit.
Hospice	No Co-payment after Deductible	Requires Prior Authorization
Infertility Services	Related office visit or surgery Co-payment may apply	Requires Prior Authorization. Includes diagnosis and treatment, such as in vitro fertilization, gamete intrafallopian tube transfer, assisted hatching, and sperm banking. Must meet eligibility requirements. Some limitations apply.
Orthotics	20% Co-insurance after Deductible	Requires Prior Authorization. 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 for diabetics.
Podiatry	$50 Co-payment after Deductible	Medically Necessary nonroutine foot care covered; requires Prior Authorization. Routine foot care services for diabetics don't require Prior Authorization.
Qualified Clinical Trials	Related office visit or surgery Co-payment may apply	Covered only if Medically Necessary; requires Prior Authorization
Weight Loss Programs	No Co-payment for the first 3 months	Covered for first 3 months; excludes initiation fees and food
Wellness		
• Family planning	No Co-payment	Doesn't require Prior Authorization
• Nutritional counseling	No Co-payment	Requires Prior Authorization
• Prenatal care	No Co-payment	Doesn't require Prior Authorization
• Nurse midwife	No Co-payment	Doesn't require Prior Authorization

ANNUAL DEDUCTIBLE	
Individual	$2,500
Family	$5,000

ANNUAL OUT-OF-POCKET MAXIMUM	
Individual	$7,350
Family	$14,700

Deductible, Co-insurance, and Co-payments apply toward your Out-of-pocket Maximum.

Services not covered

See the section "Services not covered" on page 35 for the list of services not covered.

Direct Bronze 3500 with Co-insurance

Benefit and Cost-sharing Summary

This "Benefit and Cost-sharing Summary" gives you information about your *Tufts Health Direct* Covered Services and costs you may have to pay. The fees for Covered Services are different depending on your Plan Level. Make sure you review the services you're eligible for under the "Benefit and Cost-sharing Summary" for your specific Plan Level. To see which Plan Level you have, check your Tufts Health Plan Member ID Card or call us at **888.257.1985**, Monday through Friday, 8 a.m. to 5 p.m.

For some of your Covered Services, you will have to pay a Co-payment and/or Co-insurance (check the "Benefit and Cost-sharing Summary" for your specific Plan Level). Co-insurance is an amount, stated as a percentage of the cost of the service, that you must pay for certain Covered Services. You don't have to pay a Co-payment for Preventive Care services, such as physical examinations, Family-planning Services, contraceptives, health screenings, or vaccinations. For a complete listing of the types of Preventive Care services covered, please visit the U.S. Preventive Services Task Force website at www.uspreventiveservicestaskforce.org.

Your *Tufts Health Direct* plan may also have a Deductible. A Deductible is the amount you pay for certain Covered Services in a Benefit Year before we will begin to pay for those Covered Services.

You're responsible for paying the Co-payment, Deductible, and/or Co-insurance amounts listed in this "Benefit and Cost-sharing Summary." If you don't pay the Co-payment, Deductible, and/or Co-insurance at the time of your visit, you will still owe the money to the Provider. The Provider may use a legal method to collect the money from you. Tufts Health Plan won't pay the Provider for the Co-payment and/or Co-insurance that you owe.

This summary gives you a general understanding of your benefits. If you want more information about your benefits, see the section "Covered Services" on page 22. This *Member Handbook* also has a list of services that aren't covered.

You must go to Providers (doctors, Hospitals, and other health care professionals) who are part of the *Tufts Health Direct* Provider Network to get services. For Primary Care, you must see the Primary Care Provider (PCP) you have on record. To choose your PCP, check on your assigned PCP, or change your PCP, please visit us at tuftshealthplan.com or call us at **888.257.1985**. Services are only covered for In-network Providers, except for emergency care and certain other cases (see page 9 for more information).

All nonemergency Out-of-network visits require Prior Authorization.

Under the federal Affordable Care Act, there are no annual or lifetime dollar limits on Essential Health Benefits.

The *Tufts Health Direct* Provider Network can change at any time. Always check with Tufts Health Plan for the most up-to-date information.

If you have questions about your *Tufts Health Direct* benefits or you need help locating an In-network Provider, call us at **888.257.1985**. The Tufts Health Plan Member Services Team can help you Monday through Friday, from 8 a.m. to 5 p.m.

Direct Bronze 3500 with Co-insurance

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
OUTPATIENT MEDICAL CARE		
Office Visits		
• Primary Care Provider preventive care/ screening/immunization	No Co-payment	
• Primary Care Provider nonpreventive office visit	$35 Co-payment	
• Specialist	$70 Co-payment after Deductible	
• Urgent Care Center (UCC) visit	$70 Co-payment after Deductible	
Eye Care (Vision Care)	$35 Co-payment for eye exam $70 Co-payment for all other vision services after Deductible	Coverage for routine eye exams for members 18 years and younger once every 12 months. For members older than 18 years, coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics. Eye glasses covered once every 12 months for members 18 years and younger. Collection frames only.
Pediatric Dental		Covered for pediatric dental care services for Members 18 years and younger. Medically Necessary orthodontia requires Prior Authorization.
• Type I Services: Preventive & Diagnostic	Subject to Deductible, then $0	
• Type II Services: Basic Covered Services	Subject to Deductible, then 25%	
• Type III Services: Major Restorative Services	Subject to Deductible, then 50%	
• Type IV Services: Orthodontia (only as Medically Necessary)	Subject to Deductible, then 50%	
Outpatient Surgery (outpatient hospital/ambulatory surgery centers)	30% Co-insurance after Deductible	Covered if Medically Necessary at In-network outpatient facility. May require Prior Authorization.
Lab	30% Co-insurance after Deductible	Covered if Medically Necessary. Includes blood tests, urinalysis, Pap smears, and throat cultures to maintain health and to test, diagnose, treat, and prevent disease. Genetic testing may require Prior Authorization.
X-ray Services	30% Co-insurance after Deductible	Covered if Medically Necessary
Advanced Imaging Services (MRI, CT, PET)	30% Co-insurance after Deductible	Requires Prior Authorization
Abortion Services	30% Co-insurance after Deductible	
INPATIENT MEDICAL CARE		
Inpatient Medical Care Room and board (includes deliveries/surgery/radiology services/labs)	35% Co-insurance after Deductible	Inpatient medical care covered according to Medical Necessity and subject to Prior Authorization. Elective admissions require submission of Prior Authorization form 5 business days before admission.
PHARMACY		
Pharmacy		Please see *Preferred Drug List* for specific Prior Authorization requirements
Retail drugs (up to 30-Day supply)		
• Tier 1 (primarily generic focused)	$35 Co-payment after Deductible	
• Tier 2 (primarily preferred brand)	50% Co-insurance after Deductible	No Co-payment for:
• Tier 3 (primarily nonpreferred brand)	50% Co-insurance after Deductible	• Birth control and family-planning supplies
Mail-order drugs (up to 90-Day supply)		
• Tier 1 (primarily generic focused)	$70 Co-payment after Deductible	
• Tier 2 (primarily preferred brand)	50% Co-insurance after Deductible	
• Tier 3 (primarily nonpreferred brand)	50% Co-insurance after Deductible	
EMERGENCY CARE		
Emergency Care	35% Co-insurance after Deductible	Notification required within 24 hours, if admitted. Co-payment waived, if admitted.

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
MENTAL HEALTH AND/OR SUBSTANCE USE TREATMENT		
Inpatient Mental Health and/or Substance Use	35% Co-insurance after Deductible	Inpatient mental health and/or substance use treatment services covered according to Medical Necessity and subject to Prior Authorization
Outpatient Mental Health and/or Substance Use	$35 Co-payment	
• Individual therapy/Counseling		• After 12 Behavioral Health outpatient therapy visits per Benefit Year, requires Prior Authorization, except for substance use treatment visits
• Methadone treatment (dosing, counseling, labs)		• No Prior Authorization required; does not count toward initial 12 Behavioral Health outpatient therapy visits
• Autism spectrum disorder treatment o Applied behavioral analysis		• Requires Prior Authorization; does not count toward initial 12 Behavioral Health outpatient therapy visits. Includes assessments, evaluations, testing, and treatment; covered in home, outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst
• Medication-Assisted Treatment (MAT) services		• No Prior Authorization required
REHABILITATION AND HABILITATIVE SERVICES		
Cardiac Rehabilitation	$70 Co-payment after Deductible	Requires Prior Authorization
Home Health Care	No Co-payment after Deductible	Requires Prior Authorization if daily or longer than six months
Inpatient Skilled Nursing Facility	35% Co-insurance after Deductible	Maximum of 100 Days total per Member per Benefit Year; requires Prior Authorization
Inpatient Rehabilitation Hospital or Chronic Disease Hospital	35% Co-insurance after Deductible	Maximum of 60 Days total per Member per Benefit Year; requires Prior Authorization
Short-term Outpatient Rehabilitation	$70 Co-payment after Deductible	Requires Prior Authorization
Physical/Occupational/Speech Therapy	$70 Co-payment after Deductible	May require Prior Authorization after initial evaluation. Maximum of 60 visits total combined Physical and Occupational Rehabilitative Therapy per Member per Benefit Year. No limit on Speech Therapy.
Habilitative Services	$70 Co-payment after Deductible	May require Prior Authorization after initial evaluation. Maximum of 60 visits total combined Physical and Occupational Habilitative Therapy per Member per Benefit Year. No limit on Speech Therapy.
OTHER BENEFITS		
Breastfeeding Services	No Co-payment	Includes one non-hospital grade breast pump per pregnancy, breastfeeding supplies, and lactation consultants
Chiropractic Care	$70 Co-payment after Deductible	Doesn't require prior authorization
Cleft Palate/Cleft Lip Care	Related office visit or surgery Co-payment may apply	Covered for Members 18 and younger. Includes medical, dental, oral, and facial surgery, follow-up, and related services. Requires Prior Authorization.
Durable Medical Equipment • Supplies • Prosthetics • Oxygen and respiratory therapy equipment	30% Co-insurance after Deductible	May require Prior Authorization (see list at tuftshealthplan.com)
Early Intervention Services	No Co-payment	Covered for Members 3 and younger; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention specialist.
Fitness Reimbursement	50% Co-insurance for first 3 months	Covered for first 3 months; excludes initiation fees. This benefit is available to all Members once every Benefit Year.
Ground Ambulance	No Co-payment after Deductible	Emergency transport only; nonemergency transport covered if Medically Necessary and with Prior Authorization.

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
Hearing Aids	30% Co-insurance for device after Deductible $35 Co-payment for PCP visit $70 Co-payment for Specialist visit after Deductible	Only covered for Members 21 and younger. Full cost of one hearing aid per hearing-impaired ear up to $2,000 for each hearing aid for 36 months. Related services and supplies do not count toward the $2,000 limit.
Hospice	No Co-payment after Deductible	Requires Prior Authorization
Infertility Services	Related office visit or surgery Co-payment may apply	Requires Prior Authorization. Includes diagnosis and treatment, such as in vitro fertilization, gamete intrafallopian tube transfer, assisted hatching, and sperm banking. Must meet eligibility requirements. Some limitations apply.
Orthotics	30% Co-insurance after Deductible	Requires Prior Authorization. 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 for diabetics only.
Podiatry	$70 Co-payment after Deductible	Medically Necessary nonroutine foot care covered; requires Prior Authorization. Routine foot care services for diabetics don't require Prior Authorization.
Qualified Clinical Trials	Related office visit or surgery Co-payment may apply	Covered only if Medically Necessary; requires Prior Authorization
Weight Loss Programs	No Co-payment for the first 3 months	Covered for first 3 months; excludes initiation fees and food
Wellness		
• Family planning	No Co-payment	Doesn't require Prior Authorization
• Nutritional counseling	No Co-payment	Requires Prior Authorization
• Prenatal care	No Co-payment	Doesn't require Prior Authorization
• Nurse midwife	No Co-payment	Doesn't require Prior Authorization

ANNUAL DEDUCTIBLE	
Individual	$3,500
Family	$7,000

ANNUAL OUT-OF-POCKET MAXIMUM	
Individual	$7,350
Family	$14,700

Deductible, Co-insurance, and Co-payments apply toward your Out-of-pocket Maximum.

Services not covered

See the section "Services not covered" on page 35 for the list of services not covered.

Direct Catastrophic

Benefit and Cost-sharing Summary

The *Tufts Health Direct* Catastrophic Plan offers a low-cost health insurance option that covers you in your times of need. For the *Tufts Health Direct* Catastrophic Plan, the Deductible is equal to the Annual Out-of-pocket Maximum, which means that any Covered Service that is subject to the Deductible is paid for by the Member until the Annual Deductible/Annual Out-of-pocket Maximum is reached. Once the Annual Deductible/Annual Out-of-pocket Maximum is reached, Tufts Health Plan will cover any Covered Service.

This "Benefit and Cost-sharing Summary" gives you information about your *Tufts Health Direct* Covered Services and costs you may have to pay. The fees for Covered Services are different depending on your Plan Level. Make sure you review the services you're eligible for under the "Benefit and Cost-sharing Summary" for your specific Plan Level. To see which Plan Level you have, check your Tufts Health Plan Member ID Card or call us at **888.257.1985,** Monday through Friday, 8 a.m. to 5 p.m.

For some of your Covered Services, you will have to pay Co-insurance (check the "Benefit and Cost-sharing Summary" for your specific Plan Level). Co-insurance is an amount, stated as a percentage of the cost of the service, that you must pay for certain Covered Services. Preventive Care services such as physical examinations, Family-planning Services, contraceptives, or health screenings are not subject to Deductible. For a complete listing of the types of Preventive Care services covered, please visit the U.S. Preventive Services Task Force website at uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.

Your *Tufts Health Direct* plan may also have a Deductible. A Deductible is the amount you pay for certain Covered Services in a Benefit Year before we will begin to pay for those Covered Services.

You're responsible for paying the Co-insurance amounts listed in this "Benefit and Cost-sharing Summary." If you don't pay the Co-insurance at the time of your visit, you will still owe the money to the Provider. The Provider may use a legal method to collect the money from you. Tufts Health Plan won't pay the Provider for the Co-insurance that you owe.

This summary gives you a general understanding of your benefits. If you want more information about your benefits, see the section "Covered Services" on page 22. This *Member Handbook* also has a list of services that aren't covered.

You must go to Providers (doctors, Hospitals, and other health care professionals) who are part of the *Tufts Health Direct* Provider Network to get services. For Primary Care, you must see the Primary Care Provider (PCP) you have on record. To choose your PCP, check on your assigned PCP, or change your PCP, please visit us at tuftshealthplan.com or call us at **888.257.1985**. Services are only covered for In-network Providers, except for Emergency care and certain other cases (see page 9 for more information).

All nonemergency Out-of-network visits require Prior Authorization.

Under the federal Affordable Care Act, there are no annual or lifetime dollar limits on Essential Health Benefits.

The *Tufts Health Direct* Provider Network can change at any time. Always check with Tufts Health Plan for the most up-to-date information.

If you have questions about your *Tufts Health Direct* benefits or you need help locating an In-network Provider, call us at **888.257.1985**. The Tufts Health Plan Member Services Team can help you Monday through Friday, from 8 a.m. to 5 p.m.

Direct Catastrophic

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
OUTPATIENT MEDICAL CARE		
Office Visits		
• Primary Care Provider preventive care/ screening/immunization	No Co-payment	
• Primary Care Provider nonpreventive office visit	50% Co-insurance	• First 3 nonpreventive PCP office visits covered before Deductible
• Specialist	Subject to Deductible	
• Urgent Care Center (UCC) visit	Subject to Deductible	
Eye Care (Vision Care)	Subject to Deductible	Coverage for routine eye exams for members 18 years and younger once every 12 months. For members older than 18 years, coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics. Eye glasses covered once every 12 months for members 18 years and younger. Collection frames only.
Pediatric Dental		Covered for pediatric dental care services for Members 18 years and younger. Medically Necessary orthodontia requires Prior Authorization.
• Type I Services: Preventive & Diagnostic	Subject to Deductible	
• Type II Services: Basic Covered Services	Subject to Deductible	
• Type III Services: Major Restorative Services	Subject to Deductible	
• Type IV Services: Orthodontia (only as Medically Necessary)	Subject to Deductible	
Outpatient Surgery (outpatient hospital/ambulatory surgery centers)	Subject to Deductible	Covered if Medically Necessary at In-network outpatient facility. May require Prior Authorization.
Lab	Subject to Deductible	Covered if Medically Necessary
X-ray Services	Subject to Deductible	Covered if Medically Necessary
Advanced Imaging Services (MRI, CT, PET)	Subject to Deductible	Requires Prior Authorization
Abortion Services	Subject to Deductible	
INPATIENT MEDICAL CARE		
Inpatient Medical Care Room and board (includes deliveries/surgery/radiology services/labs)	Subject to Deductible	Inpatient medical care covered according to Medical Necessity and subject to Prior Authorization. Elective admissions require submission of Prior Authorization form 5 business days before admission.
PHARMACY		
Pharmacy		Please see *Preferred Drug List* for specific Prior Authorization requirements
Retail drugs (up to 30-Day supply)		
• Tier 1 (primarily generic focused)	Subject to Deductible	
• Tier 2 (primarily preferred brand)	Subject to Deductible	• Birth control and family-planning supplies not subject to Deductible
• Tier 3 (primarily nonpreferred brand)	Subject to Deductible	
Mail-order drugs (up to 90-Day supply)		
• Tier 1 (primarily generic focused)	Subject to Deductible	
• Tier 2 (primarily preferred brand)	Subject to Deductible	
• Tier 3 (primarily nonpreferred brand)	Subject to Deductible	
EMERGENCY CARE		
Emergency Care	Subject to Deductible	Notification required within 24 hours, if admitted

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
MENTAL HEALTH AND/OR SUBSTANCE USE TREATMENT		
Inpatient Mental Health and/or Substance Use	Subject to Deductible	Inpatient mental health and/or substance use treatment services covered according to Medical Necessity and subject to Prior Authorization
Outpatient Mental Health and/or Substance Use	Subject to Deductible	
• Individual therapy/Counseling		• After 12 Behavioral Health outpatient therapy visits per Benefit Year, requires Prior Authorization, except for substance use treatment visits
• Methadone treatment (dosing, counseling, labs)		• No Prior Authorization required; does not count toward initial 12 Behavioral Health outpatient therapy visits
• Autism spectrum disorder treatment o Applied behavioral analysis		• Requires Prior Authorization; does not count toward initial 12 Behavioral Health outpatient therapy visits. Includes assessments, evaluations, testing, and treatment; covered in home, outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst
• Medication-Assisted Treatment (MAT) services		• No Prior Authorization required
REHABILITATION AND HABILITATIVE SERVICES		
Cardiac Rehabilitation	Subject to Deductible	Requires Prior Authorization
Home Health Care	Subject to Deductible	Requires Prior Authorization if daily or longer than six months
Inpatient Skilled Nursing Facility	Subject to Deductible	Maximum of 100 Days total per Member per Benefit Year; requires Prior Authorization
Inpatient Rehabilitation Hospital or Chronic Disease Hospital	Subject to Deductible	Maximum of 60 Days total per Member per Benefit Year; requires Prior Authorization
Short-term Outpatient Rehabilitation	Subject to Deductible	Requires Prior Authorization
Physical/Occupational/Speech Therapy	Subject to Deductible	May require Prior Authorization after initial evaluation. Maximum of 60 visits total combined Physical and Occupational Rehabilitative Therapy per Member per Benefit Year. No limit on Speech Therapy.
Habilitative Services	Subject to Deductible	May require Prior Authorization after initial evaluation. Maximum of 60 visits total combined Physical and Occupational Habilitative Therapy per Member per Benefit Year. No limit on Speech Therapy.
OTHER BENEFITS		
Breastfeeding Services	No Co-payment	Includes one non-hospital grade breast pump per pregnancy, breastfeeding supplies, and lactation consultants
Chiropractic Care	Subject to Deductible	Doesn't require prior authorization
Cleft Palate/Cleft Lip Care	Subject to Deductible	Covered for Members 18 and younger. Includes medical, dental, oral, and facial surgery, follow-up, and related services. Requires Prior Authorization.
Durable Medical Equipment • Supplies • Prosthetics • Oxygen and respiratory therapy equipment	Subject to Deductible	May require Prior Authorization (see list at tuftshealthplan.com)
Early Intervention Services	Subject to Deductible	Covered for Members 3 and younger; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention specialist.
Fitness Reimbursement	Subject to Deductible	Covered for first 3 months; excludes initiation fees. This benefit is available to all Members once every Benefit Year.

Ground Ambulance	Subject to Deductible	Emergency transport only; nonemergency transport covered if Medically Necessary and with Prior Authorization.

COVERED SERVICES	CO-PAYMENTS & CO-INSURANCE	BENEFIT LIMITS & NOTES
Hearing Aids	Subject to Deductible	Only covered for Members 21 and younger. Full cost of one hearing aid per hearing-impaired ear up to $2,000 for each hearing aid for 36 months. Related services and supplies do not count toward the $2,000 limit.
Hospice	Subject to Deductible	Requires Prior Authorization
Infertility Services	Subject to Deductible	Requires Prior Authorization. Includes diagnosis and treatment, such as in vitro fertilization, gamete intrafallopian tube transfer, assisted hatching, and sperm banking. Must meet eligibility requirements. Some limitations apply.
Orthotics	Subject to Deductible	Requires Prior Authorization. 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 for diabetics only.
Podiatry	Subject to Deductible	Medically Necessary nonroutine foot care covered; requires Prior Authorization. Routine foot care services for diabetics don't require Prior Authorization
Qualified Clinical Trials	Subject to Deductible	Covered only if Medically Necessary; requires Prior Authorization
Weight Loss Programs	Subject to Deductible	Covered for first 3 months; excludes initiation fees and food
Wellness		
• Family planning	No Co-payment	Doesn't require Prior Authorization
• Nutritional counseling	No Co-payment	Requires Prior Authorization
• Prenatal care	No Co-payment	Doesn't require Prior Authorization
• Nurse midwife	No Co-payment	Doesn't require Prior Authorization

ANNUAL DEDUCTIBLE	
Individual	$7,150
Family	$14,300

ANNUAL OUT-OF-POCKET MAXIMUM	
Individual	$7,150
Family	$14,300

Deductible and Co-insurance apply toward your Out-of-pocket Maximum.

Services not covered

See the section "Services not covered" on page 35 for the list of services not covered.