

PCP Required	√	Referral Required	√
In-Network Coverage	√	Out-of-Network Coverage	
Copayments	√	Deductible/Coinsurance	√

## Description

The Choice Copay plans allow employer groups to offer a variable copayment structure for physician and other professional visits, inpatient admissions, and surgical day facility costs. Not every plan includes tiered copayments for both inpatient and outpatient care, some employers may choose to have one or the other. The HMO, POS and EPO Choice Copay options require a Member to choose a PCP who is responsible for managing or providing the Member's care.

## Coverage

The plan covers appropriately authorized, medically necessary covered services at 100% minus the applicable copayment. Copayments vary by employer group plan design and can be verified by referencing one of our [electronic services](#) options.

Members with the Choice Copay option are responsible for different copayments, depending on the type of provider they are seeing and where the services are being rendered.

- Office visit copayments vary based on whether the care is provided by a PCP or specialist. Members who are seen by a PCP or PCP/specialist are responsible for a lower copayment. Members seen by a specialist are responsible for a higher copayment.
- Outpatient mental health, substance abuse, detoxification, OB/GYN (including In Vitro Fertilization (IVF)/Assisted Reproductive Technology (ART), and routine eye exam services are at the lower copayment level, regardless of the type of specialist that delivers the services.
- Other specialty services, such as spinal manipulation, physical therapy, occupational therapy, and speech therapy may have either the higher (specialist) copayment or the lower (PCP) copayment, depending on employer group requests.
- Members of HMO and EPO Choice Copay plans do not have coverage for unauthorized, non-emergency or non-urgent care.
- Members of POS Choice Copay plans are responsible for paying the applicable deductible and coinsurance for covered services obtained at the unauthorized level of benefits.
- Surgical day care (SDC) and inpatient copayments vary based on whether the care is provided in a community or tertiary facility. Members who receive services at a community hospital or freestanding surgical facility are responsible for a lower copayment. Members who receive services at a tertiary hospital are responsible for a higher copayment.

Refer to the list of tertiary facilities as they relate to the HMO, EPO and POS Choice Copay Option only.

- Beth Israel/Deaconess Medical Center
- Boston Medical Center
- Brigham & Women's Hospital
- Children's Hospital
- Dana Farber Cancer Institute
- Lahey Clinic (Burlington and Peabody)
- Mary Hitchcock Memorial Hospital
- Massachusetts Eye and Ear Infirmary
- Massachusetts General Hospital
- New England Baptist Hospital
- New England Medical Center
- Rhode Island Hospital, including Hasbro Children's Hospital
- UMASS Memorial Medical Center

## Authorization

For HMO, EPO, and POS Members, specialty care must be authorized by the PCP with either an electronic or written referral to be covered, at the authorized level of benefits. In most cases the Member will be directed to Tufts Health Plan contracted specialists within their PCP's hospital affiliation. In the rare instance that it is necessary for a Choice Copay Member to be treated by a provider outside of the Tufts Health Plan network, a paper referral form must be completed and signed by the PCP and the Physician Reviewer associated with the PCP's Provider Organization.

Prior to submitting a referral request to a Physician Reviewer, the PCP should confirm that a specialist in the Tufts Health Plan network could not provide a comparable level of care. Referrals that require physician reviewer approval should be sent directly to the attention of the provider organization Physician Reviewer before being sent to Tufts Health Plan.

The Physician Reviewer is responsible for reviewing referrals issued to specialty care providers who are not affiliated with Tufts Health Plan or for out-of-area specialty care services. The Physician Reviewer will either approve and sign the referral form or offer an appropriate in-plan provider option. If the Member is referred for specialty care to a provider out of the Tufts Health Plan network, the referral must also be authorized by the PCP's Physician Reviewer in order to be covered.

POS Choice Copay Members can choose to use the unauthorized level of their benefits by seeking specialty care outside of the Tufts Health Plan network without a referral, and are then responsible for deductible and coinsurance.

[Preregistration](#) is required for all inpatient admissions prior to rendering services.

[Prior authorization](#) by Tufts Health Plan's Precertification Department is required for certain procedures and services. For a complete description of Tufts Health Plans authorization and notification requirements, reference the [Authorization and Notification Payment Policy](#).

## Mental Health/Substance Abuse

### **Outpatient**

Outpatient mental health/substance abuse (MH/SA) and detoxification services are at the lower copayment level regardless of where the services are provided among the list of tertiary facilities.

### **Inpatient**

Inpatient MH/SA and detoxification services are at the lower copayment level regardless of where the services are provided among the list of contracting facilities.