

2026

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 6 for additional information.

Effective Date: January 1, 2026

Form Number: EOC-DIRECT-001 Ed. 1-2026



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Language Assistance Services

Arabic (العربية) انتباه: إذا كنت تتحدث لغة أخرى غير الإنجليزية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً. يرجى الاتصال بالرقم الموجود على بطاقة هوية العضو الخاصة بك.

French (Français) ATTENTION : Si vous parlez une langue autre que l'anglais, des services d'assistance linguistique gratuits sont à votre disposition. Veuillez appeler le numéro indiqué sur votre carte d'adhérent.

Greek (Ελληνικά) ΠΡΟΣΟΧΗ: Εάν μιλάτε κάποια άλλη γλώσσα πέρα από τα αγγλικά, γλωσσικές υπηρεσίες χωρίς χρέωση είναι στη διάθεσή σας. Καλέστε τον αριθμό στην κάρτα μέλους σας.

Gujarati (ગુજરાતી) ધ્યાન આપો: જો તમે અંગ્રેજી સવાય બીજી ભાષા બોલો છો, તો ભાષા હિાય વિાઓ, તમારા માટે મફત ઉપલબ્ધ છે. કૃપા કરીને તમારા ભિ્ય આઈડી કાસ પરના નંબર પર કોલ કરો.

Haitian Creole (Kreyòl Ayisyen) ATANSYON: Si w pale yon lang ki pa Anglè, gen sèvis èd pou lang ki disponib gratis pou ou. Tanpri rele nimewo ki sou kat ID manm ou a.

Hindi (हिंदी) ध्यान दें: अगर आप अंग्रेजी के अलावा कोई दूसरी भाषा बोलते हैं, तो भाषा सहायता सेवाएं आपके ललए ननःशुल्क उपलब्ध हैं। कृपया अपने सदस्य आईडी कार्ड पर ददए गए नंबर पर कॉल करें।

Italian (Italiano) ATTENZIONE: se parli una lingua diversa dall'inglese, sono disponibili gratuitamente servizi di assistenza linguistica. Chiama il numero indicato sulla tua tessera membro identificativa.

Khmer (ភាសាខ្មែរ) បុរសិនបរអុន កនិយាយភាសាបសដេបប្រាំពីភាសាអង់បលរ ស បសវាកម្មមជ្ឈម ន្ទ យភាសា ដលៃឥតលិតថ្លៃ លំអាចរកបានសហារអុន ក្រ មូហ្វហ្វកាន់បលខហល ID កាតសាជីករសអុន ក្រ

Korean (한국어) 알림: 영어 이외의 언어를 사용하신다면 언어 지원 서비스를 무료로 제공해 드립니다. 가입자 ID 카드에 명시된 번호로 전화하시기 바랍니다.

Lao (ພາສາລາວ) ກະລຸນາ ຮັບຊາບ: ຖ້າ ທ່ານເວົ້າພາສາອື່ນີ້ທ່ບ ແມ່ນພາສາ ອັງກດ, ທ່ານສາມາດໃຊ້ບໍລິການພາສາໄ ດ໌ ໂດຍບໍ່ເສຍ ຄ່າ. ກະລຸນາໂທຫາເບີ ຢໃນ ບັດປະຈໍາ ຕົວສະມາຊິກຂອງ ທ່ານ.

Polish (polski) UWAGA: Jeśli posługujesz się językiem innym niż angielski, możesz bezpłatnie korzystać z usług pomocy językowej. Zadzwoń pod numer podany na Twojej karcie członkowskiej.

Portuguese (Português) ATENÇÃO: caso fale outro idioma que não o inglês, são-lhe disponibilizados gratuitamente serviços de assistência linguística. Ligue para o número no seu cartão de identificação de membro.

Russian (Русский) ВНИМАНИЕ! Если вы не говорите на английском языке, то можете бесплатно воспользоваться услугами языковой поддержки. Позвоните по номеру, указанному на вашей идентификационной карте участника.

Spanish (Español) ATENCIÓN: Si usted habla un idioma que no sea inglés, están disponibles para usted, sin costo, servicios de asistencia en otros idiomas. Llame al número que figura en su tarjeta de identificación de miembro.

Traditional Chinese (繁體中文) 注意事項: 如果您講非英語的其他語言, 我們可以為您提供免費的語言協助服務。請撥打您會員 ID 卡上的電話號碼。

Vietnamese (Tiếng Việt) LƯU Ý: Nếu quý vị nói ngôn ngữ khác không phải tiếng Anh, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Vui lòng gọi đến số điện thoại trên thẻ ID hội viên của quý vị.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Please call the number on your member ID card.

DISCRIMINATION IS AGAINST THE LAW



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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, sex, sexual orientation, or gender identity.

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 and 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.

1 Wellness Way

Canton, MA 02021-1166

Phone: 888.880.8699 ext. 48000, [TTY number— 800.439.2370 or 711]

Fax: 617.972.9048

Email: OCRCoordinator@point32health.org

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, 800.537.7697 (TDD)

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

tuftshealthplan.com | **888.257.1985**

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Introduction

This Handbook has information about how your health Plan benefits work. If you want to know how to get care when you need it, what services are covered or whom to talk to when you have a question, you will find the answers here.

This page includes important information to keep handy.

Contact us

- **Telephone:** 888-257-1985, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays
- **TTY:** 711 (for people with partial or total hearing loss)
- **Web:** tuftshealthplan.com/memberlogin
- **Mail:** Tufts Health Plan, P.O. Box 524, Canton, MA 02021-524

Important Phone Numbers

See below for phone numbers and business hours of the agencies involved in your health Plan. Note: You enrolled either through the Health Connector, HSA Insurance, or Small Business Service Bureau (SBSB).

| Agency | Phone Number | Business Hours (excluding holidays) |
|---|---|--|
| Tufts Health Plan | 888-257-1985 (TTY: 711, for people with partial or total hearing loss) | Monday through Friday, from 8 a.m. to 5 p.m. |
| Health Connector | 1-877-MA-ENROLL (1-877-623-6765), or TTY: 711 for people who are deaf, hard of hearing, or speech disabled. | Monday through Friday, from 8 a.m. to 6 p.m. |
| HSA Insurance | 781-228-2222 (phone & TTY for people with partial or total hearing loss) | Monday through Friday, from 8:30 a.m. to 5 p.m. |
| Small Business Service Bureau (SBSB) | 800-472-7199 (phone & TTY for people with partial or total hearing loss) | Monday through Friday, from 8:30 a.m. to 5 p.m. |

IN AN EMERGENCY, GET CARE RIGHT AWAY

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

- For medical Emergencies, call 911.
- For Mental Health and Substance Use Disorder Emergencies:
 - call 911
 - call 988 (Suicide and Crisis Lifeline)
 - call or text 833-773-2445 or chat masshelpline.com for the Behavioral Health Help Line (BHHL)

- Go to the nearest Emergency room right away. Bring your Tufts Health Direct Member ID Card with you.
- Tell your PCP within 48 hours of an Emergency to get any necessary follow-up care.

Prior Authorization is not required for any Emergency care, including Emergency ambulance transportation.

IN AN URGENT CARE SITUATION

Urgent Care is for a problem that is serious but does not put your life in danger or risk permanent damage.

- Call your PCP .
- Go to an Urgent Care Center (UCC)
- For Mental Health and Substance Use Disorder concerns:
 - call 911
 - call 988 (Suicide and Crisis Lifeline)
 - call or text 833-773-2445 or chat [masshelpline.com](https://www.masshelpline.com) for the Behavioral Health Help Line (BHHL)

Tufts Health Direct Member Services

If you want to talk to a Member Services Representative, call us at 888-257-1985, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays. Be sure to call us if:

- **You move or change your phone number**

Call or visit tuftshealthplan.com/memberlogin 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 to someone whose name is not listed.

- **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 tuftshealthplan.com/memberlogin.

24/7 NurseLine for Tufts Health Direct

For general health information and support, call our 24/7 NurseLine. Phone: 888-MY-RN-LINE (888-697-6546) (TTY: 800-942-1859, for people with partial or total hearing loss).

Member Portal: Visit us on the web!

As a Member, you can take advantage of a wide range of helpful online tools and resources on our Member portal. Visit tuftshealthplan.com/memberlogin. First time users must create an account.

Your secure Member portal offers you a safe way to help manage your health care. You can:

- Find a PCP, Specialist, other Provider or health center in the Tufts Health Direct Network near you
- Change your address or phone number

- Change your PCP
- Check your Plan documents and look up benefits
- View your Claims history and check your Deductible balance
- Find Prior Authorization status and details
- Use the secure messaging center to send us information and ask questions
- Download forms you need for reimbursements and Tufts Health Direct EXTRAS
- Get important information on:
 - Our Quality Management and Improvement Program
 - How you can file a Grievance or Appeal
 - How we may collect, use, protect, and disclose your Protected Health Information (PHI) and your rights concerning your PHI

Your Member portal also includes the Treatment Cost Estimator (TCE). The TCE allows you to compare costs for many types of Health Care Services. The cost estimates generated by the tool are binding to the extent required by Massachusetts law. The actual amount you may be responsible for paying may vary due to unforeseen services that arise out of the proposed admission, procedure or service.

Your Concerns

If you need to call about a concern or file an Appeal, contact Member Services at 888-257-1985. To submit your Appeal or Grievance in writing, mail, or fax at:

Tufts Health Plan
 Attn: Appeals and Grievances
 1 Wellness Way
 Canton, MA 02021
 Fax: 857-304-6321

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 across mainland Massachusetts and in all the following counties: Barnstable, Berkshire, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester.

To help you understand more about your health Plan, we have capitalized important words and terms throughout this Member Handbook. You can find definitions for each in the Glossary on page 72.

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

Language services and other formats

We have bilingual staff available. Member Services can read this document or other printed information to you. You can request printed information in other formats such as braille or large print. We also offer translation and interpreter services in over 200 languages. This document can be orally translated for you by an interpreter over the phone, or you can request a written translation of the document. You can call Member Services at 888-257-1985 (TTY: 711, for people with partial or total hearing loss) to request translation, interpreter services, or documents in other formats. All language services and other formats are free to Members.

Your Tufts Health Direct Evidence of Coverage

When you enroll in Tufts Health Direct, you are eligible for the Covered Services described in this Handbook, the Schedule of Benefits, the Formulary, and amendments to those documents. These documents are a contract between you and Tufts Health Plan. Combined, they are your Evidence of Coverage (EOC).

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 will mail you a letter 60 Days before the changes go into effect.

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 set by the Health Connector. The Health Connector may waive this requirement for affordability or individual hardship. For more information, call the Health Connector at 1-877-MA-ENROLL (1-877-623-6765), or TTY: 711 for people who are deaf, hard of hearing, or speech disabled. You can also 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.

Health Care Costs

Premiums

A Premium is a monthly bill for your Tufts Health Direct benefits. If you have an individual Plan, you must pay your Premium to your Enrollment Administrator every month by the due date on the bill. Please follow the payment directions on your bill when paying your Premium. If you have questions about your Premium, please call the number listed on your bill. Do not send your Premium payments to us.

If you are part of a Group, please note that your employer pays your Premium. We will send an annual notice about the Premium that must be paid.

If an individual or Group is late in paying required Premiums, we may terminate coverage, which would include stopping payment of Claims until the Premiums are paid in full.

Advance Premium Tax Credit (APTC) and ConnectorCare Plans

We offer low-cost Plans through the Health Connector, including Plans with subsidies for those who qualify.

You might be eligible for Advance Premium Tax Credits (APTCs). If you are eligible for APTCs, the United States government pays part of your Premium directly to Tufts Health Plan. 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 you are eligible, the Commonwealth of Massachusetts pays part of your Premium directly to Tufts Health Plan. This is in addition to any APTCs you might qualify for.

The Health Connector can help you find out if you are eligible for APTCs and/or a ConnectorCare Plan; call 1-877-MA-ENROLL (1-877-623-6765), or TTY: 711 for people who are deaf, hard of hearing, or speech disabled.

Cost Sharing

Deductibles, Copayments, and Coinsurance are types of Cost Sharing. You may be responsible for Cost Sharing when getting medical care to diagnose, treat, or maintain a health condition. Your Schedule of Benefits in Appendix B includes descriptions and the specific Cost Sharing responsibilities for your Plan.

Your Cost Sharing responsibility is based on the Allowed Amount for the Covered Service. The Allowed Amount is the price that we negotiate with In-Network Providers to render Covered Services for Tufts Health Direct Members. The Allowed Amount is usually different and often less than the Billed Amount Providers charge. Please note, if the Allowed Amount of a drug or Covered Service is less than your Cost Sharing amount, you pay only the Allowed Amount.

Pay your Cost Sharing amounts directly to your Providers. If you do not pay at the time of your visit, you still owe the money to the Provider. The Provider may use a legal method to collect the money from you. Tufts Health Plan is not responsible for paying the Provider the Cost Sharing that you owe.

American Indians and Alaskan Natives may enroll in Plan variations that have no Cost Sharing responsibility for services received through the Indian Health Service. American Indians and Alaskan Natives who make less than 300% of the FPL may enroll in Plan variations with no Cost Sharing responsibility at all, regardless of where a service is received. The Health Connector can help you find out if you are eligible to enroll.

Deductibles

Your Plan may have an annual Deductible. The Deductible is the amount you pay for certain Covered Services in a Plan Year before Tufts Health Plan begins to pay.

The following health care costs do not apply to the Deductible:

- Premium payments
- Copayments or Coinsurance payments for Covered Services
- Payments you make for non-Covered Services

- Payments you make to an Out-of-Network Provider over the Allowed Amount for Covered Services paid by the Plan
- Payments you made for Covered Services you got before the start of the current Plan Year

Once you meet your annual Deductible, you may still have to pay Copayments and Coinsurance. At the start of each new Plan Year, your Deductible accumulation resets to zero.

Some Plans have a combined medical and pharmacy Deductible. Other Plans have separate medical and pharmacy Deductibles, or no Deductible at all. In addition, Plans may have Individual and Family Deductibles.

For Health Savings Account-compatible Plans, the Individual Annual Deductible amount applies when there is only one Member enrolled on the Plan. The Family Annual Deductible amount applies if there are two or more Members enrolled on the Plan. The Family Deductible is met when the full amount has been paid toward the Deductible by one or more Members on the Plan.

For all other Plans, the Individual Deductible applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Deductible even if other Members on the family Plan have not. Once two or more Members on a family Plan meet the Family Annual Deductible, the entire family is considered to have met the Deductible for the Plan Year.

Please see the first page of your Schedule of Benefits in Appendix B for more information and the Deductible responsibilities specific to your Plan.

Copayments

Copayments are fixed dollar amounts that you are responsible to pay for certain Covered Services. Examples of Covered Services that may require a Copayment are doctor visits when you are sick, prescriptions, advanced imaging (MRIs, PET, CT scans), Emergency room visits, and care you get in the Hospital.

Please see your Schedule of Benefits in Appendix B for the Copayment responsibilities specific to your Plan.

Coinsurance

Coinsurance is a fixed percentage of the Allowed Amount that you are responsible to pay for certain Covered Services. Examples of Covered Services that may require Coinsurance are Durable Medical Equipment such as crutches or a wheelchair and pediatric dental care such as getting a tooth cavity filled.

Please see your Schedule of Benefits in Appendix B for the Coinsurance responsibilities specific to your Plan.

Services subject to Deductible and Copayment or Coinsurance

Certain Covered Services are subject to Deductible and may have Copayment or Coinsurance. This means if you have not yet met the Deductible, you are responsible to pay the remaining Deductible balance and then the applicable Copayment or Coinsurance up to the Allowed Amount. If you have met the Deductible, then you are only responsible for the Copayment or Coinsurance amount.

Please see your Schedule of Benefits in Appendix B to see which Covered Services are subject to Deductible and have Copayment or Coinsurance.

Out-of-pocket Maximum

Your Tufts Health Direct Plan has an Out-of-pocket Maximum. This is the maximum amount of Cost Sharing you must pay in a Plan Year for Covered Services. Deductibles, Copayments, and Coinsurance all count toward your Out-of-pocket Maximum.

The following health care costs do not apply to the Out-of-pocket Maximum:

- Premium payments
- Payments you make for non-Covered Services
- Payments you make to an Out-of-Network Provider over Allowed Amount for Covered Services paid by the Plan to that Out-of-Network Provider
- Payments you made for Covered Services that you got before the start of the current Plan Year

Once you meet your Out-of-pocket Maximum, you no longer pay Deductibles, Copayments or Coinsurance for the rest of that Plan Year. At the start of each new Plan Year, your accumulation resets to zero.

Some Plans have a combined medical and pharmacy Out-of-pocket Maximum. Other Plans have separate medical and pharmacy Out-of-pocket Maximums. In addition, Plans may have separate Individual and Family Out-of-pocket Maximums.

For all Plans, a Member can meet the Individual Annual Out of Pocket Maximum on a self-only or a family Plan. Then, there is no Cost Sharing for Covered Services for the rest of the Plan Year. Two or more Members on a family Plan can meet the Family Out-of-pocket Maximum. Then, no Member in the family has Cost Sharing for Covered Services for the rest of the Plan Year.

Please see the first page of your Schedule of Benefits in Appendix B for more information and the Out-of-pocket Maximum specific to your Plan.

Plan Year

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

- Health Plan benefits are purchased and administered
- Deductibles, Copayments, Coinsurance, and Out-of-pocket Maximums are calculated
- Most benefit limits apply

For Subscribers enrolled through a Group Plan: Your Plan Year begins on the Group Effective Date and continues for 12 months from that date. For example, if the Group Effective Date is April 1, your Plan Year runs from April 1 to March 31. The Group Effective Date is always the first of the month.

In some cases, your first Plan Year will not be a full 12 months:

- For individual Subscribers:
 - If you enrolled during an annual open enrollment period, your Plan Year begins on your Effective Date and continues until December 31st. This means your first Plan Year may not be a full 12 months if you enroll on a date after January 1st.
 - If you enrolled due to a qualifying event at any other time of the year, your first Plan Year begins on your Effective Date and continues until December 31st. See page 24 for more information.
- For new Dependents who are added during a Plan Year (e.g., a new baby, Adoptive Child or new Spouse): The new Dependent's Plan Year begins on their Effective Date and ends on the same date the Subscriber's Plan Year ends.
- For Group Subscribers: If you are a new employee who became a Subscriber after the Group Effective Date, your Plan Year ends on the same date the Plan Year ends for all Subscribers in your Group.

Surprise Bills

A Surprise Bill is an unexpected bill received from an Out-of-Network Provider, that you did not knowingly select, who provided services to you while you were receiving Covered Services from an In-Network Provider. If you get a Surprise Bill, you are only responsible for the applicable Member Cost Sharing that would apply if the Covered Service was provided by an In-Network Provider, unless you had a reasonable opportunity to choose to have the service performed by an In-Network Provider.

Important Information About Your Cost Sharing Amounts

In accordance with the Affordable Care Act (ACA), Preventive Care services - including women's Preventive Health Care services, Preventive Care visits, certain prescription medications, and certain over-the-counter medications when prescribed by a licensed Provider and dispensed at a pharmacy pursuant to a prescription—are covered with no Cost Sharing. For more information, please see the *Preventive Services* policy in the *Patient Protection and Affordable Care Act* chapter of our Provider Manual at <https://point32health.org/provider/provider-manuals/tufts-health-public-plans-provider-manual/>. If you have any questions about whether specific services are considered preventive under the ACA, please call Member Services.

Getting the care you need

Your Member ID Card

Always carry your Tufts Health Direct Member ID Card with you. It has important information that Providers and pharmacists need. Each person in your family with Tufts Health Direct will get a Tufts Health Direct Member ID Card. Show your ID card every time you request health services. If you do not, the Provider may not bill us, and you may need to pay for the cost of the service.

Your PCP manages your care

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 non-Emergency health care that you need. 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, call Member Services at 888-257-1985.

Here is what your PCP can do for you:

- Make sure you get the health care you need
- Arrange necessary tests, laboratory procedures, or Hospital visits
- Give you regular checkups and health screenings
- Help you get Mental Health or Substance Use Disorder services
- Keep your medical records
- Supply information on Covered Services that require Prior Authorization before you get treatment
- Write prescriptions

Specialists

Tufts Health Direct covers adult and pediatric specialty care. Referrals are not required by the Plan to see a Specialist. You can visit most Specialists without Prior Authorization if they are In-Network at the location of your visit.

You should discuss your need for a Specialist with your PCP before making an appointment. To find a Tufts Health Direct Specialist:

- Log into your Member portal at tuftshealthplan.com/memberlogin
- Use the Find a doctor, hospital & more tool at tuftshealthplan.com/find-a-doctor
- Call us at 888-257-1985

We will not cover services you choose to get outside of our Network. If you choose to get the services anyway, the Specialist will bill you, and you will need to pay the full cost.

For more information about which services require Prior Authorization, please see your Plan's Schedule of Benefits in Appendix B of this Member Handbook.

PCP selection or assignment

You may select a Nurse Practitioner, Physician Assistant, or doctor as your PCP. This Provider must be part of the Tufts Health Direct Network. If you have not selected a PCP when you enroll, we will assign a PCP to you. We will choose one near where you live. We tell you the name of your PCP when we send your ID Card. You may change your PCP at any time. To choose a PCP:

- Log into your Member portal at tuftshealthplan.com/memberlogin
- Use the Find a doctor, hospital & more tool at tuftshealthplan.com/find-a-doctor
- Call us at 888-257-1985

Second opinions

You are covered for a second opinion about a health condition or proposed treatment. This service does not require Prior Authorization from an In-Network Provider.

Emergency care

For a medical Emergency, including an Emergency related to a substance use disorder or mental health condition, call 911, 988 for the Suicide and Crisis Lifeline or go to the nearest Emergency facility right away. Bring your Tufts Health Direct Member ID Card with you.

You are covered for Emergency care 24 hours a Day, seven Days a week. You may receive Emergency care wherever you are, even when you are traveling. We also cover Emergency ambulance transportation.

Prior Authorization is never needed for Emergency services. These services are available In-Network or Out-of-Network.

A Provider will examine and treat your Emergency health needs before sending you home. You may be moved to another Hospital if necessary.

From an Emergency room, you may be admitted for Observation, receive Outpatient Surgical services, or be admitted as an Inpatient. Your Cost Share will vary depending on the services and/or level of admission. Be sure to contact your PCP so you can get the follow-up care that you may need.

Notes about Mental health and Substance Use Disorder Emergency Care:

- The Behavioral Health Help Line (BHHL) is available 24/7, 365 days per year. You can call or text 833-773-2445. You can also chat online at masshelpline.com
- You may get Mobile Crisis Intervention (MCI) services at a Community Behavioral Health Centers (CBHC). These are short term, mobile, on-site, face-to-face therapeutic response services if you are having a crisis. MCI is available 24 hours a Day, 7 Days a week.

Urgent Care

Call your PCP or Mental Health or Substance Use Disorder 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.

If your condition becomes an Emergency before your Provider sees you, call 911 or go to the nearest Emergency room.

In our Service Area: There are In-Network, Free-standing Urgent Care Centers (UCC). You are also covered at CVS MinuteClinic® (a Limited Service Medical Clinic) of Massachusetts. To find the right choice closest to you:

- Log into your Member portal at tuftshealthplan.com/memberlogin
- Use the Find a doctor, hospital & more tool at tuftshealthplan.com/find-a-doctor
- Call us at 888-257-1985

Outside of our Service Area: You are covered In-Network and Out-of-Network. This includes Urgent Care provided at Freestanding Urgent Care Centers, Hospitals, and clinics.

Hospital services

Please contact your PCP if you need Hospital services for non-Emergency care. Your PCP can coordinate your care.

Getting care after office hours

Talk to your PCP to find out how to get care after business hours. If you have any problems seeing your PCP or any other Provider, please call Member Services.

As a Tufts Health Direct Member, you have access to a registered nurse any time of Day. Call our 24/7 NurseLine at 888-MY-RN-LINE (888-697-6546) (TTY: 800-942-1859, for people with partial or total hearing loss). The Tufts Health Direct 24/7 NurseLine is available 24 hours a Day, seven Days a week.

Getting care outside of the Service Area

You are covered for Emergency and Urgent Care outside of the Service Area. This includes if you are out of the country.

After you have been treated or stabilized, we and your Providers may decide that it is safe to transport you to an In-Network facility. If that is the case, continued services with an Out-of-Network Provider may not be covered. Additionally, transportation back to the Service Area after stabilization may not be covered.

You are not covered for any other Covered Services outside of the Service Area. This includes but is not limited the following:

- Tests or treatments requested by your PCP
- Routine or follow-up care. Examples include but are not limited to: physical exams, flu shots, removal of stitches, counseling, and Physical Therapy
- Scheduled care, such as elective surgery
- Maternity care 36 weeks or more into your pregnancy or within 4 weeks of your due date or if you are told by your Provider that you are at risk for early delivery. This includes Delivery or problems with your pregnancy.

When you get Emergency or Urgent care outside the Tufts Health Direct Service Area, the Provider might ask you to pay for that care at the time of service. Show the Provider your Tufts Health Direct Member ID Card. The Provider should not ask you to pay. If you pay for any services or get a Surprise Bill, please call Member Services. Also see "If you get a bill for Covered Services" on page 48 for more information.

See Appendix D on page 174 for our Service Area map.

Getting information about your Providers

Tufts Health Direct Providers are doctors and other professionals who contract with us to provide health care. For the most up-to-date information about our Provider Network:

- Log into your Member portal at tuftshealthplan.com/memberlogin
- Use the Find a doctor, hospital & more tool at tuftshealthplan.com/find-a-doctor
- Call us at 888-257-1985. Our Member Services team can help you find a Provider who is right for your age, condition, and type of treatment

Our online Find a doctor, hospital & more tool includes information such as a Provider's name, address, phone number, hours of operation, handicap accessibility, languages spoken, professional qualifications, specialty, medical school attended, residency completion, and board certification status. It includes the following types of Tufts Health Direct Providers:

- Emergency rooms
- Mental Health and Substance Use Disorder Providers
- Primary Care Providers (PCPs)
- Primary Care sites
- Specialists
- Hospitals
- Pharmacies
- Urgent Care Centers (UCCs)
- Durable Medical Equipment suppliers
- Ancillary Providers

To request a paper copy of the Provider Directory at no cost, call Member Services at 888-257-1985.

Utilization Management

Utilization Management (UM) is our program to manage health care costs. We determine whether certain Health Care Services are Medically Necessary. Medically Necessary services are those that are consistent with generally accepted principles of medical practice.

Tufts Health Plan may perform UM prospectively, concurrently, or retrospectively for selected inpatient and outpatient health care services to determine whether services are medically necessary as defined in the Member's Evidence of Coverage (EOC):

- Prospective UM helps determine whether a proposed treatment is medically necessary before the treatment begins. This is called Prior Authorization.

- Concurrent UM monitors treatment as it occurs and determines when the treatment is no longer medically necessary. This is called Concurrent Review.
- Retrospective UM evaluates care received by members after the care has been provided to determine whether services were medically necessary. This is called Retrospective Review.

We follow Medical Necessity Guidelines (MNGs) in the UM process. MNGs include clinical criteria based on scientific evidence, professional standards, and expert opinion. We develop MNGs with input from local practicing Providers. We also use standards from national accreditation organizations.

We review these guidelines annually or more often as new drugs, treatments, and technologies become generally accepted. They are updated periodically and available at point32health.org/provider/medical-necessity-guidelines.

We do not reward Providers, UM clinical staff, or consultants for denying care. We do not offer Network Providers, UM clinical staff, or consultants money or financial incentives that could discourage them from making a certain service available to you.

For any questions, please call us at 888-257-1985 (TTY: 711, for people with partial or total hearing loss), Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays. Our staff is available to discuss UM issues during these business hours. Outside of these hours, we will respond to voicemails and faxes by the next business Day. We have bilingual staff available, and we offer translation services in 200 languages free to members. You can also find information about UM requests by logging on to your secure Member portal.

Prior Authorization

The most common type of UM request is for Prior Authorization. This is permission before a proposed treatment begins. Your Providers know when and how to ask us for Prior Authorization. If Prior Authorization is not approved before you receive care, coverage will be denied. You will need to pay for that care.

There are two reasons you may need Prior Authorization. One is based on the specific Covered Service. The other is if the Provider is not part of the Tufts Health Direct Network. Read the sections below for details.

Covered Services

For certain services, your Provider needs to obtain Prior Authorization before you begin treatment. To see which Covered Services need Prior Authorization:

- Use this Member Handbook. Review the Covered Services section beginning on page 28. See Appendix B beginning on page 82
- Log into tuftshealthplan.com/memberlogin
- Call Member Services at 888-257-1985

When you require Prior Authorization for a Mental Health or Substance Use Disorder service, a Licensed Mental Health Professional will decide if the service is Medically Necessary. We will not apply treatment limitations or Cost Sharing to Mental Health or Substance Use Disorder services that we do not apply to medical services.

Out-of-Network Providers

Out of Network Care must be obtained from a provider that is qualified with appropriate training and experience. Out-of-Network Providers need Prior Authorization before you can receive non-emergency or non-urgent care. We may authorize you to see an Out-of-Network Provider in the following circumstances:

- There are no In-Network Providers with the expertise to take care of your health care needs.
- The Provider treated you in an Emergency department. We may approve two follow-up visits.
- You started Outpatient Mental Health or Substance Use Disorder treatment before joining the Plan. Your Provider must say that stopping treatment is highly likely to cause you major harm.
- You are in the Continuity of Care period. See page 17 for more information.

With Prior Authorization, we cover the approved services and you are responsible for the applicable Member Cost Sharing that would apply if the Covered Service was provided by an In-Network Provider. We limit the amount we will pay for services from Out-of-Network Providers. The most we will pay for approved services is the Allowed Amount unless it is a Surprise Bill. You may have to pay the balance if the Claim is for more than the Allowed Amount unless it is a Surprise Bill. For example, If the Allowed Amount is \$1,000 and the applicable Member Cost Sharing for the services is a \$200 Copayment, the maximum amount we will pay is \$800.

Prior Authorization Request and Response

Medical and Mental Health and Substance Use Disorder Services

We will decide standard Prior Authorization requests within 2 business days of receipt of all Necessary Information. We will decide expedited requests within 2 Days of receipt of request not to exceed 72 hours.

We will decide a Prior Authorization request for admission or transition to a post-acute care facility or agency by the next business day following receipt of all Necessary Information.

Prior Authorization is required at least 5 business days prior to any elective medical procedure that requires an Inpatient stay. Urgent levels of care do not require Prior Authorization.

We will let your requesting Provider know of our decision within 24 hours when a decision has been made. We will let you know in writing within one business day if we deny the request and within two business days if we approve the request.

Pharmacy and Medical Drugs

- Standard Requests: We will decide within 2 business days from the date we receive the request.
- Exigent non-Formulary Request: We will decide within 24 hours from the date we receive the request.
- Urgent Requests: We will decide within 48 hours.

We will let your Provider requesting drug coverage know within 24 hours of our decision. We will let you know in writing within 24 hours of our decision.

Prior Authorization approvals and denials

We will tell you and your Provider which services we agree to cover. The Provider must have a Prior Authorization letter from us before giving you care. If not, they may not be paid.

If you need more care than we approved, your Provider needs to ask us. If we approve the request for more services, we will send you and your Provider a Prior Authorization letter.

If we do not approve a Prior Authorization, we will not pay for those visits or services. We will send you, your Provider, or your Designated Representative a denial letter. This is called an Adverse Determination letter. We will 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:

- Discuss your symptoms or condition, and diagnosis. It will give the specific reasons why the evidence your Provider sent us did not meet medical review criteria
- Cite the specific information we used
- Include the Medical Necessity Guidelines used in the UM process
- Specify alternative treatment options that we cover, if appropriate
- Tell you how to ask for an Appeal, including an Expedited Internal Appeal

If you disagree with any of these decisions, you can Appeal. For details, please see “How to resolve concerns,” page 59.

Concurrent review

Another type of UM request is for Concurrent review. This process applies if you are receiving Inpatient Services or are undergoing a continuous course of treatment. This type of UM reviews your situation to ensure that the right care is given in the right place at the right level of care.

We make concurrent review decisions within 24 hours of getting all the Necessary Information from your Provider. If we deny Authorization for a longer stay or more services, you can keep getting the service at no cost to you until we let you know of our concurrent review decision. We will mail you and fax your Provider a written confirmation within 24 hours of receipt of request.

Notification to the Member and to the Provider will include:

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

You or your Provider may Appeal the decision before or after you are discharged. For details, please see “How to resolve concerns,” page 59.

Reconsideration of an Adverse Determination

If your Prior Authorization request or concurrent review for coverage for services was denied, 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 of the same or similar specialty will conduct the Reconsideration and talk to your Provider.

If your Provider has requested a Reconsideration and we do not change our decision, you, your Provider or your Designated Representative may use the Appeals process described starting on page 60. You do not have to ask us to reconsider an Adverse Determination before requesting a Standard Internal Appeal or Expedited Internal Appeal.

Experimental and/or Investigational services

We use a standardized process to consider whether to cover new technology and Experimental and/or Investigational drugs, devices, or treatments. The evaluation process includes:

- Determination of the FDA approval status of the device/product/drug in question
- Review of relevant clinical literature
- Consultation with actively practicing specialty care Providers to determine current standards of practice

Decisions are formulated into recommendations for changes in policy and forwarded to our management for review and final implementation decisions.

Continuity of Care

We support Continuity of Care for new and current Members. Read the sections below for details.

New Members

We may cover a defined period for you to stay with your current Out-of-Network Provider and treatment. This period will last until you can transition care to an In-Network Provider. These situations include:

- Ongoing care from your PCP for up to 30 Days after enrollment
- Active treatment to care for an illness or disorder that has not stabilized. This may be for up to 30 Days after enrollment
- Ongoing Mental Health and Substance Use Disorder services for up to 90 Days in most situations
- Maternity services care if you are beyond 12 weeks gestation. You may continue care up to six weeks after delivery
- Hospice or Palliative care if you are Terminally Ill

Current Members

We may cover a defined period if your Provider disenrolls with us for reasons other than quality or Fraud.

- You may see your PCP for up to 30 Days after disenrollment. If your PCP disenrolls, we will provide you notice at least 30 Days in advance
- If you are in an active course of treatment, the period can be up to 90 Days. An active course of treatment is if you:
 - Are receiving Inpatient or care at an Acute Care Hospital; Long Term Acute Care Hospital; Acute Rehabilitation Hospital; or Skilled Nursing Facility.
 - Had a scheduled nonelective surgery
 - Have a Serious and Complex Condition
- If you are pregnant, the period can be up to six weeks postpartum
- If you are Terminally Ill, until death

Note: A Serious and Complex Condition is an illness that requires acute or long-term specialized medical care to avoid the possibility of death or permanent harm. Examples include heart attack and stroke. Stable conditions such as diabetes, arthritis, and asthma, do not qualify.

Conditions for coverage of Continuity of Care

Your Provider must meet all the following conditions for Continuity of Care.

- Provide services that are Covered Services based on this Member Handbook
- Get an approved Prior Authorization before continuing care
- Accept payment at the rates we pay In-Network Providers
- Accept such payment as payment in full
- Not charge you any more than your Cost Sharing responsibility
- Follow our quality standards
- Follow our policies and procedures
- Give us necessary medical information related to the care provided

Eligibility, enrollment, renewal, and disenrollment

The Health Connector or the Enrollment Administrator determines eligibility for Tufts Health Direct Subscribers and their Dependents.

Please contact the Health Connector for more information about aid to pay for your health insurance coverage.

When we get notice of your enrollment from the Health Connector or Enrollment Administrator, we will send you a Member ID Card and more information about your Plan. You may stay enrolled in Tufts Health Direct for as long as you meet the eligibility requirements and pay your Premium.

Acceptance into our Plan is never based on your:

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

We do not use the results of genetic testing when making decisions about enrollment, eligibility, renewal, payment, or coverage of Health Care Services.

Dependent eligibility

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

- A legal Spouse of a Subscriber, according to the law of the state in which the Subscriber resides
- A legal civil union partner of a Subscriber, according to the law of the state in which the subscriber resides
- A domestic partner of a Subscriber
- A divorced or separated Spouse of a Subscriber as required by Massachusetts law
- A Child of a Subscriber or Subscribers' legal Spouse or domestic partner, until age twenty-six (26), defined as:
 - A biological Child or
 - A stepchild or
 - A legally adopted Child or Child placed for adoption with the Subscriber or Subscribers' legal Spouse or domestic partner, according to the law of the state in which the Subscriber resides
 - A Child for whom the Subscriber or Subscriber's legal Spouse or domestic partner is the court appointed legal guardian
 - A Dependent Child of an enrolled Child

- A Disabled adult Child over age 26 of a Subscriber or Subscriber's legal Spouse or domestic partner

Divorce or separation

A Spouse remains eligible for coverage in the event of a divorce or legal separation. This is true even if the judgment was entered before the Effective Date. This coverage requires no additional Premium. In instances of remarriage, there may be an additional cost. 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 former Spouse remarries
- The Subscriber disenrolls from the Plan

Newborn and Adoptive Children

A newborn infant of a Member is eligible for coverage under the Plan from the moment of birth as required by Massachusetts law.

Add newborns, adoptees, and foster children to your application within 30 Days from when they become part of your household. It is best to add newborns within 10 Days of birth to make sure their coverage takes effect right away. If you do not report on time, your family member may have a gap in coverage or may need to wait until the next Open Enrollment to get coverage.

If payment of a specific Premium is required to provide coverage for a Child, it must be paid. In addition, the policy or contract may require one or more of the following:

- Notification of birth of a newly born Child
- Filing of a petition to adopt a foster Child
- Placement of a Child for purposes of adoption

The Subscriber must choose a Primary Care Provider (PCP) within 48 hours after the newborn's birth or after the date of adoption or placement for adoption.

The Subscriber must contact the Health Connector or their Enrollment Administrator 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 the employee:

- Is employed by a qualified contributing Massachusetts employer
- Meets all employer eligibility requirements
- Resides or works within the Tufts Health Direct Service Area

Change in eligibility status

It is your responsibility to communicate changes that may affect your eligibility. Notification must occur within 60 Days of the event. This includes changes to you or to the Dependents enrolled on your Plan. Changes that affect your eligibility or your Dependents' eligibility include the following:

- A Member or Dependent dies
- One of your Dependents marries
- You have an address change
- You have a baby or adopt a Child
- You have a change in marital status
- You have a job or income change
- You or a Dependent no longer meets the Plan's eligibility requirements
- You move out of our Service Area

Changes in Dependents and/or household income may result in a change to the Plan you are eligible for. They also may affect your Premium. These changes can also affect the amount of federal or state subsidies or tax credits you can get.

If any of the above apply, contact your enrollment source:

- Health Connector: 1-877-MA-ENROLL (1-877-623-6765), or TTY: 711 for people who are deaf, hard of hearing, or speech disabled. Hours - Monday through Friday, from 8 a.m. to 6 p.m.
- HSA Insurance: 781-228-2222 (phone & TTY, for people with partial or total hearing loss). Hours - Monday through Friday, from 8:30 a.m. to 5 p.m.
- Small Business Service Bureau (SBSB): 800-472-7199 (phone & TTY, for people with partial or total hearing loss). Hours Monday through Friday, from 8:30 a.m. to 5 p.m.

Effective Date

The Effective Date is the date you become a Member of Tufts Health Direct. This is the date you are eligible to get Covered Services from Tufts Health Direct Providers. Your Effective Dates for new individual Subscribers and Dependents follow state and federal law. Your coverage begins at 12:01 a.m. on the first Day of the month your enrollment begins.

Note: Even if your membership begins while you are hospitalized, coverage starts on the Effective Date.

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 on your Effective Date.

Renewing your coverage

Individual/family Plans

All individuals renew membership during the annual open enrollment period. Outside of this period, individual may have a life event that qualifies them to enroll. Individuals may seek an enrollment waiver for other situations. A waiver allows enrollment outside of the open enrollment period. Contact the Health Connector for more information about enrollment waivers.

Individual coverage renews on January 1 of each calendar year. If you renew with an Effective Date of February 1 or later, you will have a short Plan Year.

We may not renew coverage of an eligible person if the individual:

- Has not paid the required Premiums
- Has committed Fraud
- Has misrepresented qualification for the Plan
- Has misrepresented information needed to determine eligibility for a health Plan or for specific health benefits
- Has failed to follow our provisions, the Member contract, or the Subscriber agreement. This includes but is not limited to an individual, employee, or Dependent moving outside of our Service Area
- Fails, at the time of renewal, to meet eligibility rules. This is if we collect enough information to make such a determination and make such information available to the Health Connector
- Has failed to follow our reasonable request for information in an application for coverage

Group Plan participants

Employer Groups renew membership every 12 months after their Effective Date. Employee coverage renews 12 months after the employer Group's Effective Date, regardless of the employee's Effective Date. Monthly Premiums are based on the employer Group's Effective Date.

You must notify the Health Connector or your Enrollment Administrator of any changes that affect you or your Dependents' eligibility. Examples of these changes are:

- Address changes
- Birth, adoption, changes in marital status, or death
- Changes in an enrolled Dependent's status as a Child or Disabled Dependent
- Moving out of the Service Area
- Temporarily residing out of the Service Area for more than 90 consecutive Days
- Your remarriage or the remarriage of your former Spouse when the former Spouse is an enrolled Dependent under your Family Coverage

If a participating employer changes any of the above items, the company may be revalidated at the time of the Group's renewal. The Health Connector or Enrollment Administrator may ask for documentation to confirm the information provided by the participating employer at renewal.

We, the Health Connector or Enrollment Administrator 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 confirm the Group's size, participation rate or Premium rate
- Did not follow the Plan's requirements, including but not limited to the employer or its employee(s) moving outside of the Plan's Service Area
- Did not follow our or the Health Connector's reasonable request for information needed to verify the application for coverage
- Is not actively engaged in business
- Did not satisfy the definition of a Small Group

Plan Nonrenewal

We may choose not to renew a Health Benefit Plan for an eligible individual or Small Group. If so, we must give at least 60 Days' prior notice. We will include the specific reason(s) for the nonrenewal per our filed criteria.

We may choose to stop offering a particular Plan. If so, we must give at least 90 Days' prior notice to affected eligible individuals or Eligible Small Groups.

Disenrollment

You may be disenrolled from Tufts Health Direct. If so, you are covered as a Member through 11:59 p.m. on the last Day of the month your enrollment ends. If you are a Group Member, coverage may end on your final Day of employment or on the final Day of the month. Please check with your employer.

Your enrollment in our Plan can be ended if:

- An individual or a Group chooses to end coverage
- You have not paid your Premiums
- You commit an act of physical or verbal abuse unrelated to your physical or mental condition that poses a threat to any Provider, any other Member, to the Plan or a Plan employee
- You commit an act of intentional misrepresentation or Fraud. This can relate to coverage, obtaining Health Care Services, or payment for such services. Termination may be retroactive to your Effective Date, the date of the Fraud or misrepresentation or another date determined by us

- You do not follow our rules under this Member Handbook
- You do not meet eligibility requirements

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

Coverage end date

You will be notified of the date coverage under the Plan ends.

If your coverage is ended because you did not pay your Premiums, you will be notified at least 30 Days before your end date. The time frame depends on how you pay your Premiums:

- If you have unsubsidized coverage or are in a Small Group, your coverage ends if you don't pay your Premium for two months. Coverage ends the Day after the payment due date. Your coverage end date is the last Day of the month you made full payment. Termination is retroactive. For instance, if your last payment was on January 1 and you didn't pay for February and March, your coverage ends on January 31.
- If you are on a ConnectorCare Plan or receive a Federal Premium Tax Credit and haven't paid your Premium for three months, your coverage ends the Day after the payment due date. The coverage end date is the last Day of the first month you owed but didn't pay. The termination is retroactive with a 30-Day grace period. For instance, if you last paid for coverage on January 1 but missed payments for February, March, and April, your coverage ends on February 28.

Benefits after termination

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

- You were receiving Inpatient or Outpatient care before your coverage ended
- You had a medical condition that required medical care after your coverage ended

Health Plan changes

We will give you information about the annual Tufts Health Direct open enrollment period. All Members can change Plans for any reason during this time.

Members can change their enrollment during a Special Enrollment Period if there is a qualifying event. The qualifying event must be reported to the Health Connector or your Enrollment Administrator within 60 Days of the event. Changes to health Plan are effective as of the qualifying event date. Examples include, but are not limited to:

- Getting married
- Change in household Dependents
- Loss of MassHealth coverage
- Loss of your insurance from a job

- The end of your Dependent status on someone else's Plan
- Turning 26 years old and no longer qualifying as a Dependent in a family Plan
- Change in residency, such as a permanent move to Massachusetts, a permanent move within the state, or release from jail or prison
- Is an American Indian or Alaska Native, as defined by section 4 of the Indian Self-Determination and Education Assistance Act. Such an individual may enroll in a health Plan or change from one Plan to another once a month even if the open enrollment period is over
- Other exceptional circumstances

Continuing coverage for Group Members

Continuation of 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 choose coverage as provided under COBRA

Below is a 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

COBRA offers continued group coverage for 18 to 36 months based on your qualifying event. Coverage may end earlier if Premiums aren't paid on time, your group stops its Group Plan, or due to other reasons like disability or obtaining other coverage. For more information about COBRA, contact your Group or the Health Connector.

Cost of coverage

In most cases, you pay 102% of the cost of coverage.

Continued coverage for disabled Subscribers

When a Subscriber's employment ends or work hours are reduced, they or their eligible Dependent can continue group coverage for up to 29 months if they become disabled under Title II or Title XVI of the Social Security Act. This coverage must be within 60 Days of the qualifying event under federal law. The Premium cost for the added 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 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.

Qualified beneficiaries

Qualified beneficiaries are eligible for either 18 or 36 months of federal COBRA continuation coverage. The maximum coverage period is 18 months for employment termination or reduced work hours. Certain qualifying events or a second qualifying event during the first coverage period can extend coverage to 36 months. See the "Duration of Coverage" table below for more details.

| Federal COBRA – Duration of Coverage | | |
|---|--|----------------------------|
| Qualifying Event(s) | Qualified Beneficiaries | Maximum Period of Coverage |
| Termination of Subscriber's employment for any reason other than gross misconduct Reduction in the Subscriber's work hours | Subscriber, Spouse, and Dependent Children | 18 months* |
| Subscriber's divorce, legal separation, entitlement to Medicare, or death | Spouse and Dependent Children | 36 months |
| Subscriber's or Spouse's enrolled Dependent ceases to be a Dependent | Dependent Child | 36 months |

Important Note: If a qualified beneficiary is deemed disabled within the first 60 Days of federal COBRA continuation coverage for these qualifying events, they and their family members may extend COBRA coverage for up to 11 more months. During this extended period, they may need to pay up to 150% of the COBRA coverage cost.

Continuation of Group coverage under Massachusetts law

A Member's Group coverage under the Group Contract may end because the Member experiences a qualifying event. A qualifying event is defined as:

- The Subscriber's death
- Termination of the Subscriber's employment for any reason other than gross misconduct
- Reduction in the Subscriber's work hours
- The Subscriber's divorce or legal separation

- The Subscriber's entitlement to Medicare
- The Subscriber's or Spouse's enrolled Dependent ceases to be a Dependent Child

If a Member experiences a qualifying event, the Member may be eligible to continue Group coverage as a Subscriber or an enrolled Dependent under Massachusetts continuation coverage as described below.

Note: Continuation provisions apply to same-sex Spouses. Contact your employer for more information.

When coverage begins

Massachusetts continuation coverage is effective on the date following the Day Group coverage ends, in most cases.

When coverage ends

Massachusetts continuation coverage would end, in most cases, 18 or 36 months from the date of the Qualifying Event, depending on the type of Qualifying Event.

Payment of Premium

In most cases, you pay 102% of the Group Premium for Massachusetts continuation coverage.

Rules for Massachusetts continuation

Under a Massachusetts law like COBRA, you may be eligible for continuing coverage if you:

- Were enrolled in Tufts Health Direct Plan through a Massachusetts Group with 2-19 eligible employees
- Experience a qualifying event that would cause you to lose Group coverage
- Choose this continuation coverage following the described procedure

A Member who is eligible for Massachusetts continuation of coverage is a "qualified beneficiary." This Member must be given an election period of 60 Days to choose whether to elect Massachusetts continuation of coverage. This period is measured from the later of the date the qualified beneficiary's coverage under the Group Contract ends, or the date the Group provides the qualified beneficiary with an election notice. To elect this coverage, you must complete a Massachusetts continuation of coverage election form and return it to your Group with the 60-Day period. Contact your Group for more information.

Coverage under an individual contract

When your coverage under federal COBRA continuation or Massachusetts continuation ends, you and your enrolled Dependents may be eligible to apply for coverage under an Individual Contract.

Plant closing

Description of continuation available under a Group Contract

Under Massachusetts law, Subscribers whose employment is ended due to a state-certified plant closing or covered partial closing may be eligible, along with their enrolled Dependents, for continuation of coverage for a period of 90 Days. The Group must notify Subscribers of their eligibility. Call your Group or Member Services for more information.

Coverage under an individual contract

If your Group coverage ends, you may be eligible to enroll in coverage under an individual contract. 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 1-877-MA-ENROLL (1-877-623-6765), or TTY: 711 for people who are deaf, hard of hearing, or speech disabled.

Covered Services

We cover Medically Necessary Covered Services listed in this Handbook. Covered Services must be consistent with Tufts Health Plan Medical Necessity Guidelines (MNGs) in effect at the time the services or supplies are provided. Please review our MNGs at point32health.org/provider/medical-necessity-guidelines. We do not impose any restrictions, limitations or exclusions related to pre-existing conditions on your Covered Benefits. Products and services to treat a mental health condition will be classified as a mental health benefit where consistent with generally recognized independent standards of current medical practice.

You must receive Covered Services from Tufts Health Direct In-Network Providers. The only Out-of-Network services we cover are Emergency and Urgent Care. If a service is not specifically listed as covered, then it is not covered under this agreement. See also “Services not covered” on page 49.

If a proposed Covered Service is not available In-Network, we may cover it Out-of-Network with Prior Authorization. If so, your Cost Sharing amounts still apply. See also “Prior Authorization – Out-of-Network Services” on page 15.

The following sections list services we cover for Tufts Health Direct Members. The Cost Sharing responsibility for your Plan is listed in the Schedule of Benefits section in Appendix B.

In addition to limitations listed in the Schedule of Benefits, we may limit or require Prior Authorization for Covered Services based on Medical Necessity. See also “Utilization Management” on page 13.

Covered medical benefits

Abortion services

We cover surgical or medication-based abortion and related care without Prior Authorization. The following services are covered when provided with an abortion procedure:

- Pre-abortion evaluation and examination
- Pre-operative counseling
- Ultrasounds
- Laboratory services, including pregnancy testing, blood type, and Rh factor
- Rh (D) immune globulin (human)
- Anesthesia (general or local)
- Post-abortion care

- Follow-up
- Advice on contraception or referral to Family Planning Services

Note: Care related to a pregnancy or miscarriage is not covered under this benefit.

Allergy services

We cover allergy testing and allergy immunotherapy (allergy injections); coverage limits apply.

Ambulance services

In an Emergency, we cover ground, sea, and air transportation services without Prior Authorization. Non-Emergency, basic or advanced life support, ground ambulance transportation may be covered with Prior Authorization. Services to and from medical appointments, transport by taxi, public transportation, and the use of chair cars are not covered.

Chemotherapy and Radiation Oncology services

We cover chemotherapy and radiation oncology services for cancer treatment. Prior Authorization is required for some services.

Chiropractic care

We cover spinal manipulation, therapeutic exercise, and electrical muscle stimulation.

Cleft palate/cleft lip care

We cover surgery for Members under 18 years of age with a cleft palate and/or cleft lip, including:

- Outpatient Surgery: Surgery and care by oral and plastic surgeons
- Dental Care: Preventive, restorative and/or orthodontic dentistry for related treatment
- Speech therapy
- Audiology services
- Nutrition services

Prior Authorization may be required.

Clinical trials

We cover routine costs for qualified individuals in approved clinical trials per Massachusetts and federal law without Prior Authorization.

COVID-19 Vaccines, Testing and Treatment

We cover COVID-19 vaccines, tests administered by providers, and COVID-19 related telemedicine and treatment; over-the-counter, at-home tests are not covered. Prior Authorization may be required.

Dental – accidental

We cover Emergency treatment of accidental injury to sound, natural, and permanent teeth caused by an external source to the mouth.

Dental care, non-Emergency (Pediatric only, Delta Dental)

Delta Dental covers pediatric dental care services for Members under 19 years of age. Dental care includes preventive, basic, and restorative services. Orthodontia is covered when Medically Necessary and with Prior Authorization. Please visit the Delta Dental website for more information: deltadentalma.com/epo-find-a-dentist

Note: "Under 19 years of age" means the last Day of the month in which a Member turns 19 years old.

Diabetes treatment

We cover the following services to diagnose or treat various types of diabetes:

- Diabetes Outpatient self-management training and educational services, including medical nutrition therapy
- Podiatry services for Members diagnosed with diabetes
- Diabetes lab tests, such as glycosylated hemoglobin (HbA1c) tests, urinary protein/microalbumin, and lipid profiles
- Insulin pumps and insulin pump supplies, voice synthesizers, and visual magnifying aids for home use for the legally blind
- Therapeutic and molded shoes and shoe inserts for Members with severe diabetic foot disease
- Prescribed diabetes medications, including insulin, insulin pens, insulin needles and syringes, lancets, blood glucose, urine glucose, and ketone monitoring strips, and oral diabetes medications

Some services require Prior Authorization.

Diagnostic Services (Outpatient lab tests, X-rays, Imaging, and other diagnostic tests)

We cover Outpatient laboratory, radiology imaging, and other diagnostic tests. This includes Diagnostic screenings and tests as required by law including: hereditary and metabolic screening at birth; newborn screening for Duchenne Muscular Dystrophy; tuberculin tests; lead screenings; hematocrit, hemoglobin or other appropriate blood tests, human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish bone marrow transplant donor suitability, and urinalysis.

Laboratory services

We cover laboratory services ordered by a Physician, Physician Assistant, or Advanced Practice Registered Nurse and performed at a licensed laboratory. Certain laboratory tests, such as genetic testing, may require Prior Authorization.

Please note that certain laboratory tests are routine Preventive Care and covered with no Cost Share. If a laboratory service is not billed according to this policy, it is subject to Cost Share.

Imaging services (Radiology)

We cover radiology imaging services, including X-rays, Mammograms, MRIs, PET, and CT scans. Prior Authorization may be required. This includes digital breast tomosynthesis screening and Medically Necessary and appropriate screening with breast magnetic resonance imaging (MRI) or breast ultrasound.

Other diagnostic tests

Other diagnostic tests, such as EKGs and pulmonary function testing, may be covered. Prior Authorization may be required.

Dialysis

We cover dialysis services.

Durable Medical Equipment (DME)

Durable Medical Equipment (DME) is medical equipment that is ordered by a Provider for use in the home. These items must be reusable, such as walkers, wheelchairs, or hospital beds. We provide coverage for certain DME, including the rental or purchase of medical equipment, some replacement parts, and repairs. Some DME requires Prior Authorization. Below are examples of the DME benefits we cover:

Hearing aids

For Members aged 21 and younger, we cover hearing aids, including one hearing aid per hearing-impaired ear, up to \$2,000 per ear every 36 months. This coverage includes both payment by the Plan and the Member's Cost Share. Additionally, related services like hearing aid evaluations, fitting and adjustment of hearing aids, and supplies such as ear molds are also covered.

Medical supplies

We cover prescribed disposable medical supplies for treating specific medical conditions. Examples of covered medical supplies include ostomy, tracheostomy, and catheter supplies.

Orthotics

Coverage includes nondental braces and other mechanical or molded devices, excluding oral devices. For Members with diabetes, shoe inserts are covered without Prior Authorization.

Oxygen and respiratory therapy equipment services

We cover oxygen and respiratory therapy equipment with Prior Authorization.

Prosthetic Devices

We cover the cost of breast prostheses and prosthetic arms and legs, including the cost of repairs. The coverage includes the most appropriate model that adequately meets the Member's needs. Prior Authorization is required, except for breast prostheses when provided in connection with a mastectomy.

Scalp hair prostheses or wigs

We cover scalp hair prostheses made specifically for an individual. We cover wigs when needed for hair loss suffered as a result of the treatment for any form of cancer or leukemia or a certain pathological condition such as alopecia areata, alopecia totalis or alopecia medicamentosa, or permanent loss of scalp hair due to injury. There is a limit of one wig per Plan Year. No benefits are provided for wigs when hair loss is due to: male pattern baldness; female pattern baldness; or natural or premature aging.

Early Intervention (EI) services

We cover Early Intervention services. A certified EI Provider must provide EI services. These services must be part of an EI program meeting the standards of the Department of Public Health. This benefit is only for

Members from birth up to age three (3) who meet set criteria. There is no Cost Share responsibility for these services.

Fitness center reimbursement

After being an enrolled member for four consecutive months and participating with a standard fitness center in the current Plan Year, we cover up to \$200 of membership fees incurred in the Plan Year. The reimbursement excludes initiation fees.

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 cover any fees for country clubs, gymnastics facilities, martial arts centers, social clubs, independent yoga or Pilates studios, tennis-only or pool-only facilities, personal training, sports teams or leagues, or the purchase of personal or at-home exercise machines.

Submit a reimbursement form by mail with itemized receipts attached. We will reimburse once per Plan Year for individual- or family-level fitness center membership fees. The reimbursement will be paid to the Plan Subscriber.

Call us at 888-257-1985, and we will send you a reimbursement form to complete. You can also get the form at tuftshealthplan.com/documents/members/forms/direct-fitness-reimbursement.

Gender affirming services

We cover all Medically Necessary gender affirming services including reconstruction surgeries, hair removal, vocal cord surgery for voice feminization, and Speech Therapy. Prior Authorization is required.

Habilitative and Rehabilitative services: Physical, Occupational, and Speech Therapy

Physical and Occupational therapies

We cover therapies for evaluation and short-term restorative treatments to help you achieve your highest level of independent functioning. Care is provided promptly, with a focus on achieving significant, sustained, and measurable improvements in your condition.

Prior Authorization is required after the initial evaluation and 11 visits. You can have up to 60 combined visits of Physical and Occupational Therapies per Member per Plan Year. Please note that these limits do not apply when the services are for treating autism spectrum disorders.

Cardiac rehabilitation

We cover specialized cardiac Rehabilitation services.

Speech, hearing, and language disorders

We cover the diagnosis and treatment of speech, hearing, and language disorders. Services must be provided by 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 Hospitals, clinics, or private offices. Prior Authorization is required after 30 visits.

Home health care

We cover certain home health services offered by a home health agency. To be eligible for home health care services, your home cannot be a Hospital or Skilled Nursing or Rehabilitation institution, and you must be homebound*.

The services covered 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/psychiatric social work services
- Nutritional consults

*To be considered homebound, you do not have to be bedridden. However, your condition should make it difficult to leave home without considerable effort. If you do leave home, you may still be considered homebound if absences are infrequent or short, or for medical treatment. This homebound requirement does not apply to palliative care.

Hospice

We cover hospice and palliative care for Terminally Ill Members who choose not to pursue curative treatments. Prior Authorization is required. Services must meet the standards set by a Medicare-certified hospice Provider regulated by the Massachusetts Department of Public Health.

We cover a package of services, including biological supplies, counseling, drugs, homemaker/home health aide services, institutional care services, medical and social services, medical supplies, nursing, physical, Occupational, and speech-language therapies, Provider care, and short-term Inpatient care services for respite.

The 100-Day limit for care at a Skilled Nursing Facility and Rehabilitation Hospital does not apply to hospice services.

Immunizations and Vaccinations

We cover routine preventive and Medically Necessary immunizations. More information is available in the Preventive Health Care Services section. Please note that some vaccines and immunizations are covered under your Pharmacy benefit and others you must receive as a medical benefit.

Infertility Services and Treatment

Infertility is defined as the inability to conceive or produce conception with exposure to sperm during a period of six months for Members over 35 years of age and a period of one year for Members age 35 or younger.

The Plan covers the following diagnostic services for infertility:

- Consultation
- Evaluation
- Laboratory tests
- Preimplantation genetic testing (PGT) (Requires Prior Authorization)

When the Member meets Medical Necessity Guidelines, the Plan covers the following infertility treatment:

- Therapeutic artificial insemination (AI), including related sperm procurement and banking
- Donor egg procedures, including related egg and inseminated egg procurement, processing and banking
- Donor oocyte (DO/IVF)
- Donor embryo/frozen embryo transfer (DO/FET)
- Frozen embryo transfer (FET)
- Assisted hatching
- Gamete intrafallopian transfer (GIFT)
- Intra-cytoplasmic sperm injection (ICSI)
- Intra-uterine insemination (IUI)
- In-vitro fertilization and embryo transfer (IVF)
- Zygote intrafallopian transfer (ZIFT)
- Microsurgical epididymal sperm aspiration (MESA)
- Testicular sperm extraction (TESE)
- Sperm collection, freezing and up to 24 months of storage is also covered for male Members in association with ongoing infertility care, or when the member is undergoing medical treatment that may result in infertility
- Procurement, cryopreservation and storage of eggs, sperm, gametes, embryos, or other reproductive tissue

Note: We use evidence based clinical criteria to evaluate whether the use of infertility treatment is Medically Necessary. Infertility treatments evolve and new treatments may be developed. If you are planning to receive infertility treatment we recommend that you review with your Provider the *Assisted Reproductive Technology Services* MNG online at point32health.org/provider/medical-necessity-guidelines.

Inpatient medical and surgical care

We cover 24-hour Inpatient medical services delivered in a licensed Hospital setting, including room and board, professional Provider services, preadmission testing, anesthesia, diagnostic services, and medication and supplies.

We cover donor human milk and donor human milk-derived products provided when a covered infant under the age of 6 months is undergoing treatment in an inpatient setting for a congenital or acquired condition as required by law. Prior Authorization is required.

Inpatient admissions for elective procedures may require Prior Authorization. However, for Emergency services, Prior Authorization is not required, and Emergency services are available In-Network or Out-of-Network. If admitted from an Emergency room, please contact us within 48 hours of your Emergency admission.

Inpatient Surgery: Organ transplant

We cover human organ transplants, including bone marrow transplants. Prior Authorization is required. To qualify, members must meet criteria set by the Massachusetts Department of Public Health. Transplants must be non-Experimental surgical procedures. Coverage includes costs for cadaver donors and living donors if not covered by the donor's own insurance. We do not cover donor charges for members donating organs to non-members or recipients who are not Tufts Health Direct members. Personal searches for solid organs or stem cell donation outside of the organ bank are also not covered.

Long Term Acute Care Hospital or Acute Rehabilitation Hospital

We cover daily rehabilitative services provided in an inpatient setting for a maximum of 60 Days per Member per Plan Year. Prior Authorization is required.

Maternity Services and Well Newborn Care

Inpatient

We cover Hospital and delivery services for the mother at an In-Network facility. Home birth is not covered. The mother's inpatient stay is covered for at least 48 hours following a vaginal delivery or 96 hours after a Caesarean delivery. Decisions to reduce the stay are made by attending obstetricians, pediatricians, or certified nurse midwives, along with the mother.

Routine nursery charges and well-newborn care for a healthy newborn are covered, including pediatric care, routine circumcision by a Provider, and newborn hearing screening tests for infants under three months of age.

We cover parent education, assistance, and training in breast or bottle feeding and necessary and appropriate clinical tests. These Covered Services will be available to a mother and newborn Child regardless of whether or not there is an early discharge (Hospital discharge less than 48 hours following a vaginal delivery or 96 hours following a Caesarean delivery)

Care that could have been foreseen before leaving the Service Area is not covered. There is no coverage outside of the Service Area for delivery or problems with pregnancy after the 36th week of pregnancy; or within 4 weeks of the due date; or if your Provider has told you that you are at risk for early delivery. This includes postpartum care as well as care provided to the newborn Child.

Outpatient

We cover Outpatient maternity services including routine prenatal exams, breastfeeding classes, and breast pumps. Additional services include:

- Routine outpatient postpartum care, including postpartum depression and major depressive disorder screenings for the mother up to six weeks after delivery.
- Universal Postpartum Home Visiting Services including at least 1 visit at the patient's home or other mutually agreed upon location with no Member Cost Sharing as required by law.

For childbirth classes and more information about this benefit, please contact Member Services.

Medical care Outpatient visits

Medical Care includes services to diagnose, treat, and maintain health conditions, including routine gynecological examination, examinations for breast cancer, and annual cytological screenings. We cover community health center and office visits to Tufts Health Direct Providers for Primary Care or specialty services. These services are provided by Providers within the Tufts Health Direct Network. Please note that services from Providers outside our Network are not covered, and you will be responsible for full payment. To find an In-Network Provider, contact Member Services at 888-257-1985 or visit tuftshealthplan.com/memberlogin.

Medical Drugs

A Medical Drug is a drug prescribed to treat a medical, mental health or substance use disorder condition. We cover practitioner-administered, FDA-approved drugs and biologicals and the associated administration services during Outpatient or home care. Prior Authorization may be required.

Medical formulas

We cover medical formulas and low protein foods to treat certain conditions, which may require Prior Authorization, including:

- Special medical formulas approved by the Massachusetts Department of Public Health and Medically Necessary for treating conditions like homocystinuria, maple syrup urine disease, phenylketonuria, propionic acidemia, methylmalonic acidemia, or tyrosinemia.
- Enteral formulas needed for home use and Medically Necessary for treating malabsorption caused by conditions like Crohn's disease, chronic intestinal pseudo-obstruction, gastroesophageal reflux, gastrointestinal motility issues, ulcerative colitis, or inherited amino acid and organic acid disorders.
- Medically Necessary low protein food products for treating inherited amino acid and organic acid disorders (available for purchase directly from a distributor) to the extent required by Massachusetts law.

Nutritional counseling

We cover nutritional counseling, which may require Prior Authorization. This includes diagnostic, therapeutic, and counseling services provided by a registered dietitian or nutrition professional for disease management. Nutritional counseling involves an initial nutritional status assessment followed by planned visits for dietary interventions to treat medical illnesses.

Outpatient Surgery

We cover surgical procedures and related anesthesia services performed in an Outpatient surgical center; Hospital operating room; or Provider's office. Some procedures may require Prior Authorization.

Reconstructive procedures, mastectomy surgeries, and surgeries to treat functional deformity or impairment

Coverage is provided for services required to relieve pain or restore bodily function impaired due to congenital defects, birth abnormalities, traumatic injuries, or covered surgical procedures. This includes treatment of cleft lip or cleft palate for children under 18, as required by Massachusetts law.

For mastectomy, coverage includes reconstruction of the affected breast, surgery for the other breast to create symmetry, prostheses, and treatment of physical complications (including lymphedema) at all stages of mastectomy.

Breast implant removal is covered under specific conditions, such as post-mastectomy placement, documented rupture of a silicone implant, or evidence of auto-immune disease or infection.

Note: Cosmetic surgery is not covered, except for Medically Necessary gender affirming services

Pain Management

In compliance with Massachusetts law, we cover services and medications for pain management as alternatives to opioids.

Services include, but are not limited to:

- Nutrition counseling
- Physical Therapy
- Spinal manipulation and Chiropractic medicine

Medications include, but are not limited to:

- Cyclooxygenase-2 (Cox-2) inhibitors, such as celecoxib
- Non-steroidal anti-inflammatory agents, such as ibuprofen

Prior Authorization is not required to begin care.

Podiatry

We cover non-routine podiatry services provided by a licensed Podiatrist. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot.

Preventive Health Care Services

Preventive Health Care includes routine screenings, check-ups, and counseling to prevent illnesses and other health problems. We cover these services without any cost share as required by the Affordable Care Act.

Below are some common Preventive Health Care Services. For a complete and up-to-date list, review with your Provider the *Preventive Services* policy in the *Patient Protection and Affordable Care Act* chapter of our Provider Manual at <https://point32health.org/provider/provider-manuals/tufts-health-public-plans-provider-manual/>.

Please note that some Preventive vaccines and immunizations are covered under your Pharmacy benefit, and others you must receive as a medical benefit.

Note: Some testing or lab screening ordered by a Provider during a routine visit may not qualify as Preventive Services and could be subject to Cost Sharing. Any follow-up care deemed Medically Necessary after a routine physical exam may be subject to Cost Sharing.

For Children

- Hereditary and metabolic screening at birth
- Immunizations, blood tests, urinalysis, and other recommended screenings
- Newborn hearing screening before discharge
- Care for newborns and Adoptive Children with congenital defects or premature birth
- Regular physical exams and developmental screenings at specific intervals
- Yearly physical exams and Mental Health screenings for children aged 6 and older, including vision and auditory screening

For adults

- Nutritional counseling and health education for medical, mental health or substance use disorder conditions
- Routine medical exams and related lab tests and X-rays (once per Plan Year)
- Recommended preventive immunizations
- Routine preventive screenings and procedures (e.g., screening colonoscopies)

For women, including pregnant women

- Baseline mammograms for women between 35 and 40, and annual screening mammograms for women 40 and older
- Laboratory tests for routine maternity care
- Voluntary sterilization procedures
- Breastfeeding services, breast pumps, and related supplies
- Lactation counseling and support
- Prescription and nonprescription contraceptives listed on our Formulary
- Prenatal care
- Routine gynecological exams, including pap smears once per Plan Year

Some testing or lab screening ordered by a Provider during a Preventive examination may not qualify as Preventive Services. That additional diagnostic testing and lab screening may be subject to Cost Share.

Family-planning Services

We cover Family-planning Services, including:

- Birth control counseling
- Diagnostic tests
- Medical consults
- Pregnancy testing
- Prescription and nonprescription contraceptives approved by the FDA
- Routine medical exams

Smoking Cessation Counseling Services

We cover Smoking/Tobacco Cessation Counseling Services, including individual, group, and telephonic counseling as per current guidelines by the US Department of Health and Human Services. Tufts Health Direct also covers prescription and generic over-the-counter smoking cessation agents prescribed by your PCP.

Skilled Nursing Facility

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

Telehealth

We cover Covered Services that are appropriate to be provided via telephone, video, or other technology. Common examples include, but are not limited to, seeing your PCP, Mental Health or Substance Use Disorder Provider through a video portal provided by the Provider.

Vision care

We offer coverage for routine eye exams once every 12 months. To get coverage for these services, you must visit a Provider in the EyeMed Vision Care Select Network. You can find EyeMed Select Providers by calling EyeMed at 866-504-5908 or visiting eyedoclocator.eyemedvisioncare.com/tuftsac/en/.

Additionally, eyeglasses are covered for Members under 19 years of age. For more detailed information on vision coverage, please refer to your Schedule of Benefits in Appendix B.

Note: "Under 19 years of age" refers to the last Day of the month in which a Member turns 19 years old.

Weight loss program reimbursement

You may request reimbursement for three months of membership fees for a qualified weight loss program.

A qualified weight loss program is one that is either Hospital-based or non-Hospital-based and focuses on weight loss by modifying habits. The program requires participation in behavioral and lifestyle counseling with certified health professionals like nutritionists, registered dietitians, or exercise physiologists. Counseling sessions can be conducted in-person, over the phone, or online.

We do not cover individual nutrition counseling sessions, one-time initiation fees, pre-packaged meals, books, videos, scales, or other weight loss related items or supplies.

To be eligible for reimbursement, you must be a Tufts Health Direct Member for three months and actively 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 Plan Year.

To request a reimbursement form, please call us at 888-257-1985. Or go to tuftshealthplan.com/documents/members/forms/direct-weight-loss-reimbursement.

Covered Mental Health and Substance Use Disorder services

Some services may require Prior Authorization. Intermediate and Inpatient services require notification and we will conduct a concurrent UM review. See page 16 for details. No Prior Authorization is required for:

- Emergency services
- Inpatient services
- Partial Hospitalization Program
- Outpatient therapy
- Outpatient substance use disorder services

Please also see the “Autism Spectrum Disorders Treatment” and “Gender Affirming Services” benefits for more information. For more information about the services available under this benefit, please call Member Services at 888-257-1985. You may also review the Medical Necessity Guidelines on our website at point32health.org/provider/medical-necessity-guidelines.

Outpatient Mental Health and Substance Use Disorder services

We cover Mental health and Substance Use Disorder services with Licensed Mental Health Professionals. These services may be provided in-person or via Telehealth in:

- A licensed Hospital
- A mental health or substance use clinic licensed by the Massachusetts Department of Public Health
- A public community mental health center
- A Community Behavioral Health Center (CBHC)
- An office of a Licensed Mental Health Professional
- Home-based services by licensed professionals acting within the scope of their license

Biologically and non-biologically based Outpatient services are provided without annual, lifetime, or visit/unit/Day limits.

Outpatient Mental health and Substance Use Disorder services include:

- Annual mental health wellness examination performed by a Licensed Mental Health Professional or by a PCP during a routine physical exam
- Applied Behavior Analysis (ABA) services for the treatment of Autism and Down Syndrome

- Community Behavioral Health Centers (CBHC) services
- Community crisis counseling
- Diagnostic evaluation
- Electroconvulsive therapy
- Family and case consultation
- Individual, group, and family counseling
- Medication management services
- Narcotic treatment services
- Neuropsychological assessment and psychological testing
- Psychiatric collaborative care by a Primary Care team under the direction of a treating physician or other qualified health care professional
- Recovery coaches and peer specialists if part of a licensed Mental Health treatment program
- Transcranial Magnetic Stimulation (rTMS)

Intermediate Mental Health services

We cover Intermediate services for Mental Health and Substance Use Disorders as defined by Massachusetts law. These services are more intensive than Outpatient services but less intensive than Inpatient services.

Examples include:

- Acute residential treatment
- Clinically managed detoxification services
- Community Crisis Stabilization (CCS)
- Adult and Youth Mobile Crisis Intervention (AMCI and YMCI)
- Day treatment programs
- Partial Hospital programs
- Intensive Outpatient Programs
- Level 3 community-based detoxification services

Inpatient Mental Health services

We cover 24-hour clinical intervention services for Mental Health and Substance Use Disorder diagnoses delivered in:

- A facility under the direction and supervision of the Department of Mental Health
- A licensed Hospital

- A private mental health Hospital licensed by the Department of Mental Health
- A substance use facility licensed by the Massachusetts Department of Public Health

Biologically based and non-biologically based Inpatient Services are provided on a nondiscriminatory basis.

Inpatient and intermediate services for Child-Adolescent Mental Health Disorders

In addition to the services mentioned above, additional services are available to Children and adolescents until age 19, and their parents/caregivers when Medically Necessary.

Community-based acute treatment (CBAT)

CBAT services are provided in a staff-secure setting on a 24-hour basis. Clinical staffing ensures the safety for the Child or adolescent and provides intensive therapeutic services. These services may be used as an alternative to or transition from Inpatient Services.

Intensive community-based acute treatment (ICBAT)

ICBAT services are the same as CBAT, but with higher frequency and more intensive staffing. ICBAT programs can treat Members with clinical presentations similar Inpatient Mental Health services, but who are able to be cared for safely in an unlocked setting. ICBAT is not used as a step-down placement following discharge from a locked, 24-hour setting.

Youth Mobile crisis intervention (YMCI)

YMCI is a short-term, mobile, on-site, face-to-face therapeutic response service that is available 24 hours a Day, 7 Days a week to a Child experiencing a Mental Health crisis.

In-home behavioral services

Services provide a combination of behavior management therapy and behavior management monitoring. Behavior management therapy may include short-term counseling and assistance. Services are provided where the Child resides.*

In-home therapy services

Services provide therapeutic clinical intervention or ongoing training, as well as therapeutic support. Services are provided where the Child resides.*

Intensive care coordination (ICC)

ICC is targeted case management services to Children and adolescents with a serious emotional disturbance, including co-occurring conditions. ICC services work to meet the medical, Mental Health, and psychosocial needs of the Member and the Member's family. ICC is delivered in office, home, or other setting.

Family support and training

Services provided to a parent or other caregiver of a Child to improve their capacity to work with the Child's emotional or behavioral needs. Services are provided where the Child resides.*

Therapeutic mentoring services

Services provided to support a Child's age-appropriate social functioning. Services are provided where the Child resides.*

*Note: This includes the Child's home, a foster home, a therapeutic foster home, or another community setting.

Autism spectrum disorder (ASD) services

We cover the diagnosis and treatment of Autism Spectrum Disorders. This includes:

- Assessments, evaluations, genetic testing, or other tests to diagnose whether an individual has one of the Autism spectrum disorders
- Professional services by In-Network Providers
- Rehabilitation and Habilitation Services, including, but not limited to, applied behavior analysis
- Prescription drug coverage

There is no coverage for services related to autism spectrum disorders provided under an individualized education program (IEP) or that are conducted in a school setting.

Additional Mental Health services

We cover Medically Necessary Outpatient, Intermediate, and Inpatient Mental Health services to diagnose and treat mental disorders. These include:

- Applied Behavioral Analysis (ABA) services for the treatment of Autism and Down Syndrome
- Biologically based mental disorders
- Rape-related mental or emotional disorders
- All other non-biologically based mental disorders

In addition to the coverage discussed above, the Plan will provide coverage for the care of all other conditions listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders or International Classification of Diseases (ICD). Services for all other conditions not identified above will be covered to the extent Medically Necessary. Please also see the "Autism Spectrum Disorders Treatment" and "Gender Affirming Services" benefits for more information.

Mental health parity law

We comply with Massachusetts and federal laws on mental health parity. This means that Copayments, Coinsurance, Deductibles, and/or unit of service limits are not greater for Mental Health and Substance Use Disorder services than those required for medical or surgical services.

Prescription drugs and supplies

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. To fill a prescription, make sure an In-Network Provider writes the prescription, except in cases of Emergency care.

Our pharmacy program does not cover all drugs and prescriptions. Some drugs or products must meet certain Medical Necessity Guidelines before we can cover them. Your Provider must ask us for Prior Authorization before we will cover these drugs.

If you want more information about our pharmacy program, visit tuftshealthplan.com/member/tufts-health-direct-plans/pharmacy or call us at 888-257-1985.

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. We require Prior Authorization for such drugs. Our Formulary states whether a drug requires Prior Authorization.

If we do not approve the request for Prior Authorization, you or your Designated Representative can appeal the decision. For more information, please see the section “How to resolve concerns” starting on page 59.

Formulary

We use a Formulary, also known as the Preferred Drug List, as our list of covered drugs. The Formulary applies only to drugs you get at retail, mail-order, and specialty pharmacies. The Formulary does not apply to drugs you get if you are in the Hospital. For the most current Formulary information, please visit tuftshealthplan.com/member/tufts-health-direct-plans/pharmacy or call us at 888-257-1985.

Step-therapy program

Step therapy is a type of Prior Authorization program that uses a stepwise approach. It requires 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. If your Provider advises that the medications on lower step(s) is not right for your health condition and that the medication on higher step is Medically Necessary, your Provider can submit a request for approval. If we do not approve it, you or your Designated Representative can appeal the decision.

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 will cover the drug according to our Medical Necessity Guidelines if there is a medical reason you need this amount.

If you fill a lesser quantity than is prescribed of a Schedule II opioid controlled substance and then decide to fill the remainder of the original prescription at the same pharmacy within 30 Days of the original prescription date, no additional Copayment or other Cost Sharing will be applied.

Medication Synchronization (Med Sync)

This program permits and applies a prorated daily Cost Sharing rate to covered maintenance prescription drugs that are:

- Dispensed by a Tufts Health Plan Network pharmacy
- In a quantity less than a thirty (30) Days' supply

- Used for the management or treatment of a chronic, long-term condition

Limitation: Medication synchronization is limited to one per Plan Year per maintenance prescription drug.

Excluded prescription drugs: Prescription drugs excluded from this program include, but are not limited to, controlled substances, pain medications, and antibiotics.

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 Copayment savings do not apply to these designated specialty drugs unless specified on the formulary. Some medications may be required to be dispensed for a 60-Day supply. In these circumstances, Members have the option to decline the 60-Day supply and obtain a 30-Day supply of the medication by contacting Member Services at the number on their Member ID card. To find out if your medication needs to be obtained at a specialty pharmacy, please visit tuftshealthplan.com/member/tufts-health-direct-plans/pharmacy.

Limited distribution drugs

Limited distribution drugs treat complex conditions and are only available through certain pharmacies. Select limited distribution drugs will be limited to a 30-Day supply. The Prescription Drug List will indicate when a limited distribution drug is limited to a 30-Day supply.

Generic drugs

Generic drugs have the same active ingredients and work the same as brand-name drugs. When generic drugs are available, we may not cover the brand-name drug without granting approval. 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.

90-Day prescription drug benefit at a pharmacy

You may purchase up to a 90-Day supply of maintenance medications from a participating pharmacy. Although most maintenance medications are available for a 90-Day supply, we may limit drugs for clinical reasons or to prevent potential waste. In addition, drugs included in the Specialty Pharmacy Program, discussed above, are not available for a 90-Day supply.

New-to-market drugs

We review new drugs for safety and effectiveness before we add them to our Formulary. A Provider who feels a new-to-market drug is Medically Necessary for you before we have reviewed it can submit a request for approval. One of our clinicians will review this request. If we approve the request, we will cover the drug according to our Medical Necessity Guidelines. If we do not approve it, you or your Designated Representative can appeal the decision.

Manufacturer Drug Assistance Programs

You may be eligible to participate in our prescription drug copay card program that is designed to help you manage your prescriptions and save on costs. Copay cards offer financial assistance to help pay for certain

high-cost medications. By participating in this program, you can access the benefits of drug manufacturer-provided copay cards to lower certain out-of-pocket costs, such as copayments and coinsurance. When using a copay card, you will pay the lower of a discounted price or your copay or coinsurance. While these copay cards provide financial assistance, the dollar value they cover will not contribute towards your deductible or Out-of-pocket Maximum. Medications on this list are subject to change and inclusion on this list does not guarantee coverage nor eligibility under the program.

Covered prescription drugs and supplies

In addition to the covered prescription drugs and supplies listed in the Formulary, we may cover:

- Off-label use of U.S. Food and Drug Administration (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” starting on page 33.)
- Compounded medications: (1) If the Member is under the age of 18, (2) the active ingredients are listed in the Prescription Drug List and cost \$500 or less (3) and one or more agents within the compound is FDA approved and requires a prescription. Compounded medications are covered for Members over the age of 18 when determined to be Medically Necessary. 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 us at 888-257-1985.

Included in the Formulary are:

- Hormone replacement therapy (HRT) for perimenopausal and postmenopausal individuals
- Hypodermic syringes or needles when Medically Necessary
- At least one generic drug and one brand name drug used to treat each of the following chronic conditions: (i) diabetes; (ii) asthma; (iii) hypertension and iv) chronic ischemic heart disease. The generic drug is covered with no Cost Share and the brand name drug cannot have Cost Share more than \$25.00. Note: Insulin is the drug used to treat diabetes.

In compliance with Massachusetts law, opioid medications listed as Schedule II or Schedule III controlled substances will be filled at a lesser quantity than prescribed if the Member requests it. If the Member requests the lesser quantity, no additional cost or penalty will be enforced on the Member. If the Member fills a lesser quantity than is prescribed of a Schedule II opioid controlled substance, and then decides to fill the remainder of the original prescription at the same pharmacy within 30 Days of the original prescription date, no additional Copayment or other Cost Sharing will be applied. Please see Appendix C, “Schedule II and III Opioid Medications,” for a list of these medications.

Non-Formulary drugs

There are thousands of drugs listed on the Tufts Health Plan covered drug list. In fact, most drugs are covered. There are however, select drugs that Tufts Health Plan does not include on the Formulary. In many cases,

these drugs are not on the Tufts Health Plan Formulary because there are safe, comparably effective, and cost-effective alternatives available. Our goal is to keep pharmacy benefits as affordable as possible. If your doctor feels that one of the non-Formulary drugs is needed, your doctor can submit a request for coverage under the Formulary Exception Process.

Note: Drug approved through the Formulary Exception Process may be subject to the highest Cost Sharing Amount.

Exclusions

We do not cover certain drugs and prescription medications. See the *Services not covered* list on page 51 for details.

Exception requests

An exception request may be submitted for the following pharmacy programs: Prior Authorization, Step Therapy Prior Authorization, Quantity Limitations, New-to-market, or Non-Formulary drugs.

Exception requests are reviewed on a case-by-case basis. Your Provider will be asked to provide medical reasons and any other important information about why you need an exception.

We will act on exception requests according to the timelines below:

- Drugs not subject to step therapy: Within 48 hours of receiving your prescribing Provider's statement of the reasons an exception is Medically Necessary
 - In accordance with state law, when a new Tufts Health Direct Member has already been prescribed and is stable on a drug to treat a chronic heart condition, diabetes (insulin), or asthma, Tufts Health Plan will provide continuation of coverage. We will cover a 30-Day fill of an FDA approved drug and will not apply any greater Member Cost Share than would otherwise apply to other drugs covered by the Plan.
- Step therapy drugs: Within three (3) business days following the receipt of all Necessary Information needed to make a medical necessity determination
 - In accordance with state law, when a Tufts Health Direct Member has already been prescribed and is stable on a drug subject to step therapy requirements, Tufts Health Plan will allow a one-time transition fill for up to 30-Day supply of the requested drug while the step therapy exception request is being reviewed. Please contact Tufts Health Direct Member Services at 888-257-1985 to request the one-time transition fill.
- Expedited exception requests: Within 24 hours of receiving the expedited request

We will notify you and your Provider about our decision. Please note:

- If the request for a Non-Formulary Drug is approved, the medication will be covered on the highest Tier (e.g., Tier-3 on a 3-Tier Formulary)
- If the request for coverage of a Formulary drug that is restricted under another pharmacy management program is approved, the medication will be covered with the Tier Cost Sharing Amount applicable to that drug's current tier on the Formulary

- If the request is denied, you and your Provider have the right to appeal

Your Appeal can be submitted in one of the following ways:

- By phone, call a Member Services Representative
- By fax, send it to us at 617-972-9509
- By mail, submit your Appeal in writing to:

Tufts Health Plan
Attn: Appeals and Grievances Department
1 Wellness Way
Canton, MA 02021

Please see “How to resolve concerns” for information regarding Member Appeals, including Expedited Appeals.

You may have questions about your Prescription Drug Benefit. You may want to know the Tier of a particular drug. You might like to know if your medication is part of a Pharmacy Management Program. For these issues, visit tuftshealthplan.com/member/tufts-health-direct-plans/pharmacy or call us at 888-257-1985.

The Tufts Health Plan website has a list of covered drugs with their Tiers. The Formulary is updated regularly so please review the website for the most current information.

Important note: There may be limited circumstances when we may change a drug’s Tier which can happen at any time throughout the year. For example, a brand drug’s patent may expire. In this case, we may change the drug's status by either (a) moving the brand drug from Tier-2 to Tier-3 or (b) no longer covering the brand drug when a generic alternative becomes available. In such cases, we will make the generic available at the same Tier (i.e., Tier-2) or a lower Tier (i.e., Tier-1).

If you get a bill for a Covered Service

Certain services you receive from Out-of-Network Providers may be reimbursable. Some examples include:

- Emergency ambulance transportation
- Emergency rooms Specialists
- Radiologists, pathologists, and anesthesiologists who work at In-Network Hospitals

You are not responsible to pay more than your In-Network Cost Share amount for Covered Services. Before paying the bill, contact the Member Services at 888-257-1985.

If you do pay the bill, send us the following information:

- a completed, signed Member Reimbursement Medical Claim Form. Click on the link below or contact Member Services to get the form
- the documents listed on the Member Reimbursement Medical Claim Form that are required for proof of service and payment

- Medical Reimbursement Medical Claim Form: tuftshhealthplan.com/documents/members/forms/thpp-member-reimbursement

The address for the Member Reimbursement Medical Claims Department is listed on the Member Reimbursement Medical Claims Form.

You must contact us or send us your medical bill(s) within one year of the date of service. If you do not, the bill cannot be considered for payment.

Most completed reimbursement requests are processed within 30 Days. Incomplete requests and requests for services rendered outside of the United States may take longer.

Reimbursements are sent to the Subscriber at the address we have on file.

Note: Requests for reimbursement for drugs must be submitted directly to OptumRx within one year of the date of service. Find the request form at tuftshhealthplan.com/member/tufts-health-direct-plans/pharmacy.

Note: Send vision care reimbursement requests for Covered Services to EyeMed. Call Member Services at 888-257-1985 for assistance.

Services not covered

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

| Category | List of excluded services |
|--|---|
| General rules | <ul style="list-style-type: none"> • Any service, supply, or medication that is not a Covered Service. • Services for which we did not give required Prior Authorization • Services from Out-of-Network Providers, unless we give Prior Authorization (except Emergency and Urgent Care services, which never require Prior Authorization) • A service or supply that is not covered by or at the direction of a Tufts Health Direct Provider, except for Emergency services • Any service, supply, or medication that is not Medically Necessary • Medications, devices, treatments, and procedures that have not been demonstrated to be medically effective • Routine care, including routine prenatal care, when you are outside of our Service Area • Services for which there would be no charge in the absence of insurance • A Provider's charge for shipping and handling or copying of records |
| Durable Medical Equipment (DME) | <p><i>DME – general exclusion rules</i></p> <ul style="list-style-type: none"> • Hygienic equipment that does not serve a primary medical purpose • Nonmedical equipment otherwise available to Members that does not serve a primary medical purpose • Replacement of Durable Medical Equipment or prosthetics due to loss, intentional damage or negligence • “Back-up” equipment <p><i>DME – home modification exclusions</i></p> <ul style="list-style-type: none"> • Fixtures to real property: Examples are ceiling lifts, elevators, ramps, stair lifts, or stair climbers • Elevators, ramps, and home modifications • Bath and toilet aids, including but not limited to, tub seats/benches/stools, raised toilet seats, commodes, and rails |

| Category | List of excluded services |
|----------|--|
| | <p><i>DME – personal comfort exclusions</i></p> <ul style="list-style-type: none"> • Personal comfort items, such as air conditioners, air purifiers, chair lifts, dehumidifiers, radios, telephones, and televisions • Comfort or convenience devices • Air conditioners, dehumidifiers, HEPA filters and other filters, and portable nebulizers • Cooling devices • Heat and cold therapy devices, including but not limited to, hot packs, cold packs, and water pumps with or without compression wrap • Heating or cooling pads, caps or devices, hot water bottles, and paraffin bath units • Heating pads, hot water bottles, and paraffin bath units • Weighted blankets • Massage devices, including Theraguns • Exercise equipment and saunas • Hot tubs, jacuzzis, swimming pools, or whirlpools • Whirlpool equipment used for soothing/comfort • Sensory equipment, including noise machines and light machines <p><i>DME – bed-related exclusions</i></p> <ul style="list-style-type: none"> • Hospital-type beds in full, queen, and king sizes • Hospital-type beds requiring installation in a home • Non-hospital beds and mattresses • Mattresses, except for mattresses used in conjunction with a hospital bed and ordered by a Provider. Commercially available standard mattresses not used primarily to treat an illness or injury (e.g., Tempur-Pedic® and Posturepedic® mattresses), even if used in conjunction with a hospital bed, are not covered • Articles of special clothing, mattress and pillow covers, including hypo-allergenic versions • Bed-related items, including bed trays, bed pans, bed rails, over-the-bed tables, and bed wedges • Bed lifters that are not primarily medical • Cushions, pads and pillows, except when Medically Necessary and we give Prior Authorization <p><i>DME- other exclusions</i></p> <ul style="list-style-type: none"> • Bluetooth cameras • Car seats • Car/van modifications • Certain wearable devices (e.g., smartwatches, bracelets, patches) used for physiological monitoring and fitness tracking (e.g., Fitbit, Biostamp, Embrace, Smartwatch, Smartmonitor smartwatch, Garmin Vivofit 4, Garmin Vivosmart 3, Samsung Galaxy Fit) • Dentures • Ear plugs • Emergency response systems (e.g., LifeAlert) • Externally powered exoskeleton assistive devices and orthoses • Hearing aids for Members more than 21 years old (see Schedule of Benefits for more information) • Home blood pressure monitors and cuffs • Incontinence supplies/Absorbent products • Neuromuscular stimulators, and related supplies • Pulse tachometers • Special equipment needed for sports or job purposes |

| Category | List of excluded services |
|--|--|
| | <ul style="list-style-type: none"> • Wagons • Wheelchair trays |
| Prescription drugs and supplies | <ul style="list-style-type: none"> • Drugs not listed on the Formulary • Drugs listed as non-Formulary on the Formulary except when approved through the Formulary Exception Process • Drugs that are not Medically Necessary for Preventive Care or for treating illness, injury or pregnancy • Drugs in excess of coverage limitations imposed by the Plan. (Limitations may be placed on the quantity of a drug covered; the medical conditions for which a drug may be prescribed; and/or whether another drug must be tried first.) • Any drug products used exclusively for cosmetic purposes, except for Medically Necessary gender affirming services • Experimental or Investigational drugs, which are 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 • Prescription drugs that are not approved by the FDA for both safety and effectiveness (This does not include off-label uses of FDA approved drugs where use is recognized by established research documentation.) • Immunization agents: These may be provided under Preventive Health Care earlier in this chapter. Other select vaccines may be accessible at the pharmacy at no Cost Share and covered under the medical benefit • Non-prescription items or medical supplies other than those listed as covered in the “Covered medications and pharmacy” section or listed on the Formulary as covered. Drugs packaged for institutional use will be excluded from the pharmacy benefit coverage unless otherwise noted on the Formulary as covered • Drugs provided to you anywhere other than an Outpatient pharmacy. Certain drugs may be covered as a non-pharmacy benefit, e.g., infused or injected drugs, which are covered under your medical benefits • Drugs prescribed as part of a course of treatment that we do not cover • 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) or listed on the Formulary as covered • Vitamins and dietary supplements (except those listed on the Formulary as covered.) • Topical and oral fluorides for adults • Medications for the treatment of idiopathic short stature • GLP-1 drugs for non-diabetic patients to treat weight loss and associated comorbidities. • 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 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 that 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 |

| Category | List of excluded services |
|----------------|--|
| Other services | <ul style="list-style-type: none"> • Prescription medications when co-packaged with non-prescription products <ul style="list-style-type: none"> • Any non-Emergency dental services for Members 19 years or older • Biofeedback, except for the treatment of urinary incontinence • With respect to Child-adolescent mental health intermediate care and Outpatient services, the following programs: <ul style="list-style-type: none"> ○ Programs in which the patient has a pre-defined duration of care without the Plan's ability to conduct concurrent determinations of continued Medical Necessity for an individual ○ Programs that only provide meetings or activities that are not based on individualized treatment planning ○ Programs that focus solely on improvement in interpersonal or other skills rather than services directed toward symptom reduction and functional recovery related to specific mental health disorders • Cosmetic (meaning to change or improve appearance) services and procedures, unless required to restore bodily function ; correct a functional physical impairment after an accidental injury, prior surgical procedure or congenital/birth defect; or as a Medically Necessary gender affirming service • Costs associated with home births; and/or cost associated with services provided by a doula • Custodial Care • Educational testing and evaluations • Exams required or ordered by a third party (e.g., physical, psychiatric and psychological examinations or testing ordered by a third party, such as an employer, court or school) • A drug, device, medical treatment or procedure (collectively "treatment") that is Experimental or Investigational treatment. This exclusion does not apply to the following services which meet the requirements of Massachusetts and federal law: <ul style="list-style-type: none"> ○ Long-term antibiotic treatment of chronic Lyme disease ○ Bone marrow transplants for breast cancer ○ Patient care services provided as part of a qualified clinical trial conducted to prevent, detect or treat cancer or other life-threatening diseases or conditions ○ Off-label uses of prescription drugs for the treatment of cancer or HIV/AIDS. Note: If the treatment is Experimental or investigative, we will not pay for any related treatments that are provided to the Member for the purpose of furnishing the Experimental or investigative treatment. • We do not cover the cost of services (including tuition-based programs) that offer educational, vocational, recreational or personal development activities, including but not limited to therapeutic schools, camps, wilderness or ranch programs, sports or performance enhancement programs, spas/resorts, leadership or behavioral coaching or Outward Bound. <ul style="list-style-type: none"> ○ We will provide coverage for Medically Necessary Outpatient or intermediate Mental Health and Substance Use Disorder services provided by Licensed Mental Health Professionals while the Member is in a tuition-based program, subject to Plan rules including any Network requirements or Cost Share. • Massage therapy • Private duty nursing (block or non-intermittent nursing) • Reversal of voluntary sterilization • Routine podiatry/foot care, except as noted in the Podiatry Benefit on page 37 • Services of a chair car |

Tufts Health Direct EXTRAS

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

\$25 gift card for completing your annual wellness visit

Members can earn a \$25 gift card for having an annual wellness visit.

How to get it

1. Call us at 888-257-1985. We will send you a form to complete or you can download the form at tuftshealthplan.com/documents/members/forms/direct-extras-reward-form.
2. Fill out the Member Information section of the form.
 - If you are filling out the form for a Child, use the Child's name and Tufts Health Plan Member ID #.
 - Fill out one form for each Member.
3. Make a copy of the form to keep for yourself.
4. Mail or fax us the completed form:

Tufts Health Plan
Attn: Claims Department
P.O. Box 524
Canton, MA 02021

Fax 857-304-6300

We will begin processing your request when we receive the completed form. You should get your reward 6–8 weeks later.

Note: You must be a Tufts Health Direct Member when you get your annual wellness visit and when we process your form.

\$25 gift card for diabetes screenings

If you have diabetes, we want to help you manage it. We will give you a \$25 gift card for completing 5 routine diabetes screenings in 1 calendar year:

- 1 eye exam
- 2 blood sugar (HbA1c) tests
- 1 protein test and
- 1 cholesterol (LDL) test

How to get it

1. Call us at 888-257-1985. We will send you a form to complete or you can download the form at tuftshealthplan.com/documents/members/forms/direct-extras-reward-form.
2. Fill out the Member Information section of the form.
 - If you are filling out the form for a Child, use the Child's name and Tufts Health Plan Member ID #.
 - Fill out one form for each Member.
3. Make a copy of the form to keep for yourself.
4. Mail or fax us the completed form:

Tufts Health Plan
Attn: Claims Department
P.O. Box 524
Canton, MA 02021

Fax 857-304-6300

We will begin processing your request when we receive the completed form. You should get your reward 6–8 weeks later.

Note: You must be a Tufts Health Direct Member when you get your diabetes screenings and when we process your form.

Car and booster seats gift cards

Members may be eligible to get one \$25 gift card to use to buy a booster seat and one \$50 gift card to use towards a purchase of a convertible car seat, one year later as long as your Child is a Tufts Health Plan Member. You can get up to two gift cards during their membership. You can get the reward if you are:

- 28 or more weeks pregnant
- A Child 0–8 years old

How to get it

1. Call us at 888-257-1985. We will send you a form to complete or you can download the form at tuftshealthplan.com/documents/members/forms/direct-extras-car-seat-form
2. Fill out the Member Information section of the form.
 - If you are filling out the form for a Child, use the Child's name and Tufts Health Plan Member ID #.
 - Fill out one form for each Member.
3. Make a copy of the form to keep for yourself.

4. Mail or fax us the completed form:

Tufts Health Plan
Attn: Claims Department
P.O. Box 524
Canton, MA 02021

Fax 857-304-6300

We will begin processing your request when we receive the completed form. You should get your reward 6–8 weeks later.

Note: You must be a Tufts Health Direct Member when we process your form.

Care Management

Care Management (CM) helps you stay healthy and improve your health. Our CM services may include assisting with appointments, giving health information, and arranging care with your Providers. While Care Management aids, it doesn't replace care from your PCP or other Providers.

We or providers affiliated with the care management program may contact Members that may benefit from participating in one of these programs. We may reach out if you had a recent diagnosis or service that makes you a candidate for its programs. If interested in Care Management and want to self-refer, call us at 888-257-1985 to talk to our Care Management team, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays.

Maternal and Child health program

We collaborate closely with you and your Providers to ensure you receive care during pregnancy. We can also assist in coordinating the care you need after childbirth. To learn more about Covered Services available to expecting Members, please refer to page 35.

Integrated Care Management

Integrated Care Management (ICM) is a model of care with a focus on your specific needs. Our Behavioral Health (mental health and/or substance use) and medical care managers along with Community Health Workers (CHWs) collaborate closely to provide the care you need. Our team can help with health care, social, and financial matters.

ICM is helpful for complex situations, like mental health, substance use, physical disabilities, or special health conditions (e.g., high-risk pregnancy, cancer, HIV/AIDS).

Behavioral Health Care Management

We offer a wide range of Behavioral Health (mental health and/or substance use disorder) services to support your well-being. Our licensed clinicians can:

- Inform you about community-based services
- Monitor your treatment progress

- Collaborate with your Providers for discharge planning
- Review your ongoing care needs

We help make sure you get the best care as we work to

- Enhance your health and your family's well-being
- Coordinate care among your Providers
- Engage you in treatment planning
- Ensure seamless care during Provider or Plan changes
- Facilitate timely access to the correct level of Behavioral Health care

We also provide Behavioral Health Care Management if you

- Need help after a new mental health or substance use diagnosis
- Struggle with managing a Behavioral Health condition
- Have multiple admissions for Behavioral Health concerns
- Face challenges in getting community-based services
- Experience a catastrophic event
- Need multi-agency coordination for diverse needs or cultural considerations

Transition of Care (ToC)

When you leave a 24-hour care facility, our care team may help you with your transition of care needs. This is the care you need to keep getting better at home. Our care team can work with Providers to make sure you get the services you need when you need them.

The ToC plan includes:

- Coordinating your care needs with your Providers, such as making timely follow-up appointments
- Reviewing your medications
- Developing a plan to help you get the services you need
- Providing you with educational information about your condition, your medications, and managing your disease

Complex Care Management (CCM)

Our Complex Care Management program is for Members with complex health care concerns. If you have one or more health care conditions that are difficult to manage, we can help. These may be medical and/or Behavioral Health in nature. We have a team of dedicated health care professionals who can help you get and stay healthy. They can also help you remove barriers to getting care.

Members with the following conditions may benefit from our CCM services:

- AIDS or other immune system diseases
- Bipolar disorder
- Cancer
- Certain neurological diseases
- High-risk pregnancy and newborn Children in Neonatal Intensive Care Unit (NICU)
- Intensive-care needs
- Major depressive disorder
- Multiple health conditions that are hard to manage
- Organ transplantation
- Complex pediatric care needs
- Schizophrenia
- Serious heart or lung disease
- Severe disability or impairment
- Severe traumatic injury
- Substance use disorders

Disease Management

Our Care Managers can assist you with Disease Management for asthma, diabetes, chronic obstructive pulmonary disease (COPD), heart failure, or chronic kidney disease (CKD).

We offer information and tools to help you understand your disease better. Working with your Providers, we can help you avoid trips to the Emergency room. We explain why certain tests are important and may call you to remind you about yearly lab work and PCP appointments.

Community Health Services

Community Health Workers (CHWs) are certified frontline public health workers. CHWs have unique understanding of the populations they serve. CHWs help with safety net services. Safety net services are for basic needs such as education, housing, healthcare, health harming legal issues, transportation, and counseling.

CHWs stand out because they:

- Understand the communities they serve
- Spend much of their time on outreach in the community
- Bridge the gap between communities and health and human services

- Help Members find and apply for state and federal benefits
- Offer culturally competent health education to Members and care givers
- Refer Members to community-based resources
- Visit Members at home and in the community

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.

We produce our Quality Management and Improvement Program Description (QMIPD) annually. The QMIPD includes:

- A description of our Quality Management programs
- The 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 satisfaction with access to services
- Clear goals focused on our diverse membership and those 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:

- Deeply grasp the social, linguistic, moral, intellectual, and behavioral traits of a community or population
- Use this understanding to enhance the effectiveness of health care delivery to diverse groups

Our commitment to providing affordable, high-quality health care is clear in our NCQA rating. We stand among the top health Plans, recognized for our quality and Member satisfaction.

We have been NCQA accredited since 1994. From 1999-2019, our products achieved “Excellent” accreditation status from NCQA, which is the highest possible achievement. With a change of criteria in 2020, “Excellent” accreditation has become “Accredited.” Our HMO/POS and PPO products now carry the “Accredited” Level.

The present accreditation has been valid since 2022. Our next NCQA accreditation review is in 2025.

If you have a concern about the quality of care you get from a Network Provider or the services we provide, please contact us at 888-257-1985, Monday through Friday, 8 a.m. to 5 p.m., excluding holidays.

How to resolve concerns

Inquiries

An Inquiry is any question or request you may have about how we work. You can make an Inquiry anytime. We will resolve your Inquiry right away or within three business days of receiving it. We will inform you of the result on the same Day we resolve it.

Grievances

You have the right to file a Grievance if you are unhappy with something we have done or not done. We will research the situation and resolve it. Note: You may file an Appeal for any denial of coverage. See the next section for details.

You may file a Grievance at any time. Reasons may include:

- Poor quality of care or services
- Rudeness by a Provider or one of our employees
- Lack of respect for your rights by a Provider or one of our employees
- Extension for us to decide about an Authorization or Appeal
- Decision not to expedite a Standard Internal Appeal request

Your Designated Representative (or simply, Representative) can file a Grievance for you. You can appoint a Representative by sending us a signed Tufts Health Plan Designated Representative Form. You can get a form online or by calling Member Services. See details below.

You have 30 days between when a Representative may file a Grievance for you and when we receive the form. Otherwise, we will dismiss the Grievance.

How to file a Grievance

You or your 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., excluding holidays.
- **TTY/TTD:** People with partial or total hearing loss can call our TTY line at 711, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays.
- **Mail:** mail a Grievance to:

Tufts Health Plan
Attn: Appeals and Grievances
1 Wellness Way
Canton, MA 02021
- **Email:** Email a Grievance via the “Contact us” section of our website at tuftshealthplan.com and tuftshealthplan.com/memberlogin.
- **Fax:** Fax a Grievance to us at 617-972-9509.

- **In person:** Visit our office at 1 Wellness Way; Canton, Mass.), Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays.
- **Secure online Member portal:** Log into your secure online portal at tuftshealthplan.com/memberlogin to file a Grievance electronically.

Once you file a Grievance, we will:

- Tell you or your Representative that we got your Grievance by sending you a written notice
- Provide you or your Representative a written response to your Grievance by certified or registered mail within 30 Days of the date the Grievance was received. This response will include the information we considered and will explain our decision
- Provide interpreter services, if necessary

Appeals

You, your Provider, or your Representative all have the right to request a Standard Internal Appeal if you disagree with any denial based on your benefits or Medical Necessity (Adverse Determination). You have 180 Days to request a Standard Internal Appeal. We encourage you to act as soon as possible.

How to request a Standard Internal Appeal

You or your Representative may request a Standard Internal Appeal within 180 Days of a denial or Adverse Determination in the following ways:

- **Telephone:** Call us at 888-257-1985, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays
- **TTY/TTD:** People with partial or total hearing loss can call 711, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays
- **Mail:** Mail a request for a Standard Internal Appeal, along with a copy of any relevant notices and any additional information about the Standard Internal Appeal, to:

Tufts Health Plan
Attn: Appeals and Grievances
1 Wellness Way
Canton, MA 02021

- **Email:** Request a Standard Internal Appeal by email via the “Contact us” section of our website at tuftshealthplan.com and tuftshealthplan.com/memberlogin
- **Fax:** Request a Standard Internal Appeal by faxing us at 857-304-6321
- **In person:** Visit our office at 1 Wellness Way (Canton, Mass), Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays
- **Secure online Member portal:** Log into your secure online portal at tuftshealthplan.com/memberlogin to file an Appeal electronically

We will let you know we got your Standard Internal Appeal request by sending you a written notice within 15 Days of receiving it.

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

You can appoint a Representative by sending us a signed Tufts Health Plan Designated Representative Form. You can get a Form by calling Member Services at 888-257-1985. You can also find this form online.

If someone tries to submit a Standard Internal Appeal for you without us having a Designated Representative Form on file, we will tell you in writing that a request has been made. We will include the form for you to sign and return. We will not take further action until we get the signed form. If we do not receive the form, we will dismiss the request.

Continuation of services during the Appeal process

If your Appeal concerns the termination of ongoing Covered Services, we will continue coverage through the completion of the Internal Appeal Process. You or your Representative must request the Appeal in a timely manner. You are responsible for related Cost Sharing. 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 will review and decide about your Standard Internal Appeal request within 30 Days from the date we receive your request. We may ask to extend the time frame if we need more information. We will call to discuss the extension and send an extension letter. The extra time will not be more than 30 Days from the date we discuss an extension.

Any Medical Necessity (Adverse Determination) Appeal that we do not properly act on within the time limits specified will be decided in your favor.

There are situations where we may review an Appeal quickly. Each situation has a certain time requirement in which we must decide:

- If you are a patient in a Hospital: We must issue a decision before you are discharged
- If you are requesting Durable Medical Equipment: We must issue a decision within 48 hours or in less time when the Provider specifies a reasonable time
- If you are Terminally Ill: We must issue a decision within five business days of receipt of the Appeal

Reviewing medical records as part of the Standard Internal Appeal

You may send us written comments, documents or other information relating to your Appeal. You have the right to review your case file. Your case file includes the documents we considered during the Appeal process.

Expedited Internal Appeal

You or your Representative may request an Expedited Internal Appeal of an Adverse Determination if you or your Provider think 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

You, your Provider, or your Representative may request an Expedited Internal Appeal from us orally, in writing, or in person. You may request this instead of asking for a Standard Internal Appeal.

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 will reverse the decision within forty-eight (48) hours after the review is started pending outcome of the Expedited Appeal decision.

If you or your Representative submit the request, a Physician will review the request to decide if the criteria for an Expedited Appeal have been met. You will be notified of the decision within 72 hours after the review has begun.

You or your Representative may also request an Expedited External Review from the Office of Patient Protection (OPP). You may ask for this at the same time you ask us for an Expedited Internal Appeal. For more information, please see the sections on Expedited External Reviews, starting on page 63.

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 are restricted under any of the Tufts Health Plan pharmacy management programs, the Provider may submit a request for coverage. We will review the request and let you know of our decision within 72 hours after receiving the request.

You or your prescribing Provider may request an expedited exception process for a prescription drug based on Exigent Circumstances. We will let you and your prescribing Provider know of our decision no later than 24 hours after receiving the request.

Written notice of Appeal decisions

We will tell you our Appeal decisions in writing.

- For Standard Internal Appeals, we will send you a decision letter via certified or registered mail within thirty (30) calendar Days of the date the Appeal was received
- For Expedited Internal Appeals, we will send you a decision letter via certified or registered mail within two (2) business days of the decision

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 given does not meet the relevant medical review criteria
- Specify alternative treatment options we cover
- Reference and include applicable clinical review criteria
- Let you or your 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 can 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 Representative must start the External Review process. We will enclose an External Review Form anytime we issue a Final Adverse Determination. To start the review, send the required Form to the OPP within four months of getting our Final Adverse Determination:

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

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

- Meet the requirements of the External Review process
- Do not involve a service or benefit we specify in this Member Handbook as excluded from coverage
- Result from our issuing a Final Adverse Determination. You will not 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.

Payment disputes are not eligible for External Review, except when the Appeal is filed to decide if Surprise Billing protections are applicable.

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 send you a written decision.

Expedited External Reviews

You may request an Expedited External Review if your Provider tells the OPP in writing that a delay in 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 receiving the service because there could be substantial harm to you if the service ends, we will 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 website: mass.gov/orgs/office-of-patient-protection.

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

Limitation on actions

You cannot file a lawsuit against Tufts Health Plan for failing to pay or arrange for Covered Services unless you have completed the Tufts Health Plan Appeals and any applicable External Review processes and file the lawsuit within two years from initial denial of benefits. Going through the appeals and applicable External Review process does not extend the time limit for filing a lawsuit beyond two years after the date you were first denied coverage. However, if you choose to pursue available External Review by the Office of Patient Protection, the Days from the date your request is received by the Office of Patient Protection until the date you receive the response are not counted toward the two-year limit.

Questions or concerns

If you have questions or concerns about the Grievance and/or Appeal process, call Member Services at 888-257-1985, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays.

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 beliefs, 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 Mental Health and/or Substance Use Disorder Provider's office 24 hours a Day, seven Days a week
- Expect that your Protected Health Information is private, and that we abide by state and federal (HIPAA) privacy laws regarding confidentiality of your health 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
- 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

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 will 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 do not 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 have agreed to with your Providers
- Understand that refusing treatment may have serious effects on your health
- Contact your PCP or Mental health or Substance Use Disorder Provider within 48 hours after you visit the Emergency room, for follow-up care
- Change your PCP or Mental Health or Substance Use Disorder Provider if you are not 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 about any PCP changes
- Tell us and the Health Connector about any address or phone
- Tell us if you are pregnant

More information available to you

You can learn about your rights and responsibilities with Tufts Health Plan by calling us at 888-257-1985 (TTY: 711, for people with partial or total hearing loss), Monday through Friday, 8 a.m. to 5 p.m., excluding holidays.

You can also get information about us from:

- The Massachusetts Board of Registration in Medicine at [mass.gov/orgs/board-of-registration-in-medicine](https://www.mass.gov/orgs/board-of-registration-in-medicine), 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 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, Waste, and Abuse. Examples include:

- Receiving bills or explanations of benefits for Health Care Services you never got
- Misuse of a Member's health insurance ID Card for the purpose of getting Health Care Services or prescription drugs
- Being asked to provide false or misleading health care information, for example: submitting an inaccurate diagnosis within a reimbursement request
- Individuals reselling supplies, equipment, or prescriptions provided to them as Covered Services
- Offering or receiving something of value in exchange for agreeing to receive Covered Services

To report potential health care Fraud, Waste, 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@point32health.org. We do not need

your name or Member information. You can also call our anonymous hotline anytime at 877-824-7123 or send an anonymous letter to us at:

Tufts Health Plan
Attn: Special Investigations Unit
1 Wellness Way
Canton, MA 02021

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 to your other insurance coverage. The types of other 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 a nongroup insurance contract
- Coverage under Workers' Compensation because of a job-related illness or injury
- Coverage from Medicare or other public insurance
- Coverage for an accident wherein no-fault insurance or liability insurance is involved
- Coverage you have through Veterans Benefits Administration
- "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 starting on page 25 for more information.

Coordination of Benefits

You may have benefits from another Plan to cover health care expenses. Our Coordination of Benefits (COB) program prevents duplication of payment for the same Health Care Services. We ensure benefits for Covered Services are coordinated with other plans. We determine which Plan must pay first when you make a Claim, and which Plan must pay second. We coordinate benefits for prescription drug Claims pursuant to our secondary payer Allowed Amount in all cases. Our COB program follows Massachusetts law, 211 CMR 38.00 et seq.

If you have additional 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

Right of Subrogation

You may have a legal right to recover some or all the costs of your health care from someone else (a "Third Party"). "Third Party" means any person or company that is, could be or is claimed to be responsible for the costs of injuries or illness to you. This includes such costs to any Dependent covered under this Plan.

Tufts Health Direct may cover health care costs for which a Third Party is responsible. In this case, we may require that Third Party to repay us the full cost of all such benefits provided by this Plan. Our rights of recovery apply to any recoveries made by you or on your behalf from any source.

This includes, but is not limited to:

- Payments made by a Third Party
- Payments made by any insurance company on behalf of the Third Party
- Any payments or rewards under an uninsured or underinsured motorist coverage policy
- Any disability award or settlement
- No-fault, personal injury protection (“PIP”) or medical payments coverage (“MedPay”) under any automobile policy to the extent permissible by law
- Premises’ or homeowners’ medical payments coverage
- Premises’ or homeowners’ insurance coverage
- Any other payments from a source intended to compensate you for Third Party injuries

We have the right to recover those costs in your name. We can do this with or without your consent, directly from that person or company. Our right has priority, except as otherwise provided by law. We can recover against the total amount of any recovery, regardless of whether:

- All or part of the recovery is for medical expenses or
- The recovery is less than the amount needed to reimburse you fully for the illness or injury

Right of reimbursement

This provision applies in addition to the rights described above. You may recover money by suit, settlement or otherwise. If this happens, you are required to reimburse us for the cost of Health Care Services, supplies, medications, and expenses for which we paid or will pay. This right of reimbursement attaches when we have provided health care benefits for expenses for which a Third Party is responsible, and you have recovered any amounts from any sources. This includes, but is not limited to:

- Payments made by a Third Party
- Payments made by any insurance company on behalf of the Third Party
- Any payments or awards under an uninsured or underinsured motorist coverage policy
- Any disability award or settlement
- No-fault PIP or MedPay under any automobile policy to the extent permissible by law
- Premises’ or homeowners’ medical payments coverage

- Premises' or homeowners' insurance coverage
- Any other payments from a source intended to compensate you and for which a Third Party is responsible

We have the right to be reimbursed up to the amount of any payment received by you to the extent permissible by law, regardless of whether (a) all or part of the payment to you was designated, allocated or characterized as payment for medical expenses; or (b) the payment is for an amount less than that necessary to compensate you fully for the illness or injury.

Member cooperation

You further agree:

- To notify Tufts Health Direct promptly and in writing when notice is given to any Third Party or representative of a Third Party of the intention to investigate or pursue a Claim to recover damages or obtain compensation
- To cooperate with us and provide us with requested information
- To do whatever is necessary to secure our rights of Subrogation and reimbursement under this Plan
- To assign us any benefits you may be entitled to receive from a Third Party. Your assignment is up to the cost of Health Care Services and supplies and expenses that we paid or will pay for your illness or injury
- To give us a first priority lien on any recovery, settlement or judgment or other source of compensation which may be had by any Third Party. You agree to do this to the extent of the full cost of all benefits associated with Third Party responsibility
- To do nothing to prejudice our rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by this Plan
- To serve as a constructive trustee for the benefit of this Plan over any settlement or recovery funds received as a result of Third Party responsibility
- That we may recover the full cost of all benefits provided by this Plan without regard to any Claim of fault on your part, whether by comparative negligence or otherwise
- That no court costs or attorney fees may be deducted from our recovery
- That we are not required to pay or contribute to paying court costs or attorney's fees for the
- Attorney hired by you to pursue your Claim or lawsuit against any Third Party
- That in the event you or your representative fail to cooperate with Tufts Health Direct, you shall be responsible for all benefits provided by this Plan in addition to costs and attorney's fees incurred by Tufts Health Direct in obtaining repayment

Workers' Compensation

Employers provide Workers' Compensation insurance for their employees to protect them in case of work-related illness or injury.

If you have a work-related illness or injury, you and your employer must ensure that all medical Claims related to the illness or injury are billed to your employer's Workers' Compensation insurer. We will not provide coverage for any injury or illness for which it is determined that the Member is entitled to benefits pursuant to any Workers' Compensation statute or equivalent employer liability or indemnification law (whether or not the employer has obtained Workers' Compensation coverage as required by law).

If we pay for the costs of Health Care Services or medications for any work-related illness or injury, we have the right to recover those costs from you, the person or company legally obligated to pay for such services or from the Provider. If your Provider bills services or medications to us for any work-related illness or injury, Members should please call Member Services: 888-257-1985.

Constructive trust

By accepting benefits from Tufts Health Direct (whether the payment of such benefits is made to you directly or made on your behalf, for example, to a Provider), you hereby agree that if you receive any payment from any responsible party as a result of an injury, illness, or condition, you will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to Tufts Health Direct.

Subrogation agent

We may contract with a third party to administer Subrogation recoveries. In such case, that subcontractor will act as our agent.

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

If you are 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 pay 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.

Other Provisions

Use and disclosure of medical information

Tufts Health Plan mails a separate Notice of Privacy Practice to all Subscribers to explain how we use and disclose your medical information. If you have questions or would like another copy of our Notice of Privacy

Practices, call Member Services at 888-257-1985. Information is also available on our website at tuftshealthplan.com.

Relationships between Tufts Health Plan and Providers

Tufts Health Plan and Providers

We arrange Health Care Services. We do not provide Health Care Services. We have agreements with Providers practicing in their own private offices throughout the Service Area. These Providers are independent. They are not Tufts Health Plan employees, agents, or representatives. Providers are not authorized to:

- Change this Evidence of Coverage or
- Assume or create any obligation for Tufts Health Plan

We are not liable for acts, omissions, representations, or other conduct of any Provider.

Circumstances beyond reasonable control

Tufts Health Plan shall not be responsible for a failure or delay in arranging for the provision of services in cases of circumstances beyond our reasonable control. Such circumstances include but are not limited to: Major disaster, epidemic, strike, war, riot, and civil insurrection. In such circumstances, we will make a good faith effort to arrange for the provision of services. In doing so, we consider the impact of the event and the availability of Network Providers.

Appendix A: Glossary

24/7 NurseLine for Tufts Health Direct: Call 888-MY-RN-LINE (888-697-6546) for our free helpline with caring health professionals. Get info and support on symptoms, diagnoses, treatments, and tests ordered by your Provider. Note: NurseLine doesn't provide medical advice or replace your Provider.

Adoptive Child: A Child who is legally adopted by the Subscriber or placed for adoption with them. "Placed for adoption" means the Subscriber has taken a legal obligation to support the Child partially or fully in preparation for adoption. If the legal obligation ends, the Child is no longer considered placed for adoption. A foster Child is also considered an Adoptive Child from the date of the adoption petition filing, as required by state law. See also Dependent.

Advance Premium Tax Credit (APTC): A tax credit you can use to lower your monthly Premium. The APTC is based on your income and household information. To qualify, you must apply for and purchase your insurance through the Health Connector

Adverse Determination: Our decision 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.

Affordable Care Act (ACA): A US healthcare reform law. The goal of the ACA is to increase access to healthcare. It aims to help reduce costs and improve quality. It also ends pre-existing condition exclusions.

Allowed Amount: The price that we negotiate with In-Network Providers to render Covered Services for Members of Tufts Health Direct. Deductible and Coinsurance responsibilities are based on the Allowed Amount.

Annual Wellness Visit: A yearly appointment with your PCP that includes:

- A review of your medical history, family history, and health risks
- Checks on your vitals like blood pressure, weight, and height
- Screenings and immunizations
- Counseling to prevent future health problems

Appeal: see Standard Internal Appeal or Expedited Internal Appeal.

Authorization: see Prior Authorization.

Behavioral Health Help Line (BHHL): A 24/7 clinical hotline. It is staffed by trained Mental Health and Substance Use Disorder Providers and peer coaches. The BHHL offers clinical assessment, treatment referrals, and crisis triage services. The Help Line is available in more than 200 languages, 24/7, 365 Days a year.

Billed Amount: The amount a Provider charges for a drug or service. This amount is usually different than the Allowed Amount we contract with our Providers.

Child: One of the following individuals, until the last Day of the month of the individual's 26th birthday:

- The Subscriber or Spouse's biological Child, stepchild, or Adoptive Child
- The Dependent Child of an enrolled Child
- A Subscriber or Spouse's or domestic partner's Disabled adult Child, who is currently disabled and remains financially dependent on the Subscriber.
- A Child for whom the Subscriber or Spouse or domestic partner is the court-appointed legal guardian

Claim: A bill your Provider sends us to ask us to pay for services you get.

Coinsurance: A type of Cost Sharing. It is a fixed percentage of the Allowed Amount that you must pay for a Covered Service.

ConnectorCare Plan: A subsidized non-Group Plan available individuals 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: How we make sure you keep getting the care you need when your doctor is not In-Network. This can be if you are getting active care when you first become a Member. It may also be when one of our Providers leaves our Network for reasons other than quality or Fraud.

Coordination of Benefits: A program that prevents duplication of payment for the same services when you have more than one insurance Plan.

Copayment: A type of Cost Sharing. It is a fixed amount you may have to pay for a Covered Service.

Cost Sharing: The amount you pay for certain Covered Services. Cost Sharing includes Deductibles, Copayments, and/or Coinsurance.

Covered Services: The services Tufts Health Direct covers. The Schedule of Benefits we include in this Member Handbook includes all your Covered Services.

Covering Provider: The Provider named by your PCP to provide or authorize services in your PCP's absence, e.g., after hours. A Covering Provider is a Provider who can help you when your PCP is not available.

Custodial Care:

- Care provided primarily to assist in the activities of daily living, such as bathing, dressing, eating, and maintaining personal hygiene and safety
- Care, other than Behavioral Health (mental health and/or substance use) care, provided primarily for maintaining the Member's or anyone else's safety, when no other aspects of treatment require an acute Hospital level of care
- Services that could be provided by people without professional skills or training

- Routine maintenance of colostomies, ileostomies, and urinary catheters
- Adult and pediatric day care

Note: Custodial Care is not covered by Tufts Health Plan.

Day: A calendar day, unless “business day” is specified.

Deductible: A type of Cost Sharing. It is the amount you pay for certain Covered Services in a Plan Year before we will begin to pay.

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

Dependent: The Subscriber’s Spouse, Child, or Disabled Dependent.

Designated Representative (or, Representative): Someone you choose in writing to make decisions related to your benefit Plan and receive information related to your healthcare.

Designated Representative Form: A form to choose a Representative to act your behalf and authorize Tufts Health Plan to disclose your Protected Health Information.

Disabled Dependent: The Subscriber’s Child who:

- Is currently physically or mentally disabled; and
- Remains financially dependent on the Subscriber due to disability;

Durable Medical Equipment (DME): Devices or instruments of a durable nature that:

- Are reasonable and necessary to sustain a minimum threshold of independent daily living;
- Are made primarily to serve a medical purpose;
- Are not useful in the absence of illness or injury;
- Can withstand repeated use; and
- Can be used in the home.

Effective Date: The date on which you become a Member of Tufts Health Direct and are eligible to get Covered Services from Tufts Health Direct Providers.

Emergency: A medical or Behavioral Health (mental health and/or substance use) condition with severe symptoms that require immediate medical attention. If not addressed promptly, your health could be seriously jeopardized. In the case of a pregnant individual, the health of the individual and/or unborn Child is at risk. This danger may lead to significant damage to bodily functions or affect any body organ or part.

Some examples of conditions that need Emergency care include severe pain, a broken leg, loss of consciousness, vomiting blood, chest pain, difficulty breathing, uncontrollable urges to harm oneself or others, or a medical condition that is rapidly deteriorating.

Enrollment Administrator: A benefits marketplace that is not part of the state health insurance exchange. Tufts Health Direct is offered through the Enrollment Administrators, HSA Insurance and Small Business Service Bureau (SBSB). This also may refer to your Human Resources department if you are enrolled on a Small Group plan.

Evidence of Coverage (EOC), also referred to as the Member Handbook or Handbook: This document and any future amendments. The EOC also includes the Schedule of Benefits for your Plan, Formulary, and any amendments we may send you.

Exigent Circumstances: When someone is suffering from a health condition that may seriously jeopardize life, health, or ability to regain maximum function. For pharmacy services, it applies to when a person is undergoing a current course of treatment using a non-Formulary drug.

Expedited External Review: 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.

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

Experimental or Investigational services: Services that do not have approval for use in mainstream healthcare. These services are often part of medical research and not yet established as standard practice. As a result, they may not be Medically Necessary. The definition is fully explained in the *Noncovered Investigational Services* MNG which you can review at point32health.org/provider/medical-necessity-guidelines.

External Review: A request for an External Review Agency to review the Plan's final Standard Internal Appeal decision.

External Review Agency: An accredited company under contract with the Office of Patient Protection and separate from Tufts Health Plan that looks at our coverage decisions. Providers 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.

Facility Fee: A fee that clinics, Hospitals, or Free-standing facilities may charge to cover the costs of maintaining those facilities. For certain Outpatient services, you may be billed both a Facility Fee and a separate physician fee for a single episode of care.

Family Planning Services: Services that help Members make decisions about having children. Services may include contraceptives, counseling, and medical support.

Federal Poverty Level (FPL): The minimum income needed to cover basic living expenses. It is set each year by the U.S. government. The FPL varies by household size and address.

Final Adverse Determination: An Adverse Determination made after you have exhausted all remedies available through our formal Appeal process.

Formulary: Our list of covered drugs. See list at tuftshealthplan.com/member/tufts-health-direct-plans/pharmacy.

Fraud, Waste, and Abuse: Fraud includes knowingly making or allowing someone else to make false statements to obtain unauthorized services, items, or payments. Waste includes the overutilization of services or other practices that result in unnecessary costs to the Plan. Abuse involves payment for items or service when there is no legal entitlement to that payment. This may include misrepresentation without intent..

Free-standing Urgent Care Center (UCC): A medical facility that offers treatment for non-life-threatening injuries and illnesses requiring immediate care. It provides an alternative to visiting the Emergency room for members who cannot see their PCP promptly. A UCC is not part of a Hospital or Hospital system and are not a Limited Service Medical Clinic. A UCC does not handle life-threatening conditions. If you have a severe or life-threatening condition, go to the Emergency room instead.

Grievance: Any expression of dissatisfaction by you or Designated Representative about an action or inaction by Tufts Health Plan.

Group Contract: The agreement between Tufts Health Plan and the Group under which we agree to provide Group coverage and the Group agrees to pay a Premium on your behalf. The Group Contract includes this Member Handbook, also called Evidence of Coverage.

Group Plan: The Plan of an employer or other legal entity with which Tufts Health Plan has an agreement to provide Group coverage. An employer Group subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended, is the ERISA Plan sponsor. If you are covered under a Group Plan, the Group is your agent and is not the Plan's agent.

Habilitative Services: Services that help people with disabilities learn or improve life skills. They prevent skill deterioration and can be provided Inpatient and Outpatient. Services include Physical Therapy, Occupational Therapy, and Speech-language pathology. These services address skills never learned or acquired due to the disabling condition.

Handbook: Another term for the Member Handbook or Evidence of Coverage (EOC).

Health Benefit Plan (or Plan): An individual or Group health maintenance contract issued by a health maintenance organization.

Health Care Services: Services that include diagnosis, prevention, treatment, cure, or relief of a health care condition.

Health Connector: A state-based health insurance marketplace established under the ACA. It helps Massachusetts Residents find affordable health insurance plans, offering subsidies and easy enrollment. Additionally, the Health Connector reviews and approves Qualified Health Plans (QHPs) to ensure they meet quality and coverage standards for consumers.

Health Savings Account (HSA): A special savings account for medical expenses. It lets you set aside pre-tax money from your paycheck. The funds in the HSA can be used for healthcare expenses like doctor visits, prescriptions, and medical treatments. Funds may not be used to pay Premiums. To qualify for an HSA, you must have a high-Deductible health insurance Plan.

High Deductible Health Plan (HDHP): A plan that is subject to IRS rules requiring that a minimum Deductible be satisfied before the health Plan provides coverage for non-Preventive Care. For additional information on the rules governing HDHP Plans, please refer to [irs.gov/publications/p969](https://www.irs.gov/publications/p969).

Hospital: A licensed facility that offers medical and surgical care to patients with acute illnesses or injuries. It must be listed with the American Hospital Association (AHA) or accredited by The Joint Commission.

HSA Insurance: An Enrollment Administrator. It offers Tufts Health Direct Plans in a benefits marketplace that is not part of the state health insurance exchange.

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

Mental Health and Substance Use Disorder: Emergency, Inpatient, intermediate, and Outpatient services for the treatment of behavioral health, mental health, and substance use disorders.

In-Network: Covered Services that a member obtains through an In-Network Provider.

In-Network Provider: A Provider who Tufts Health Direct contracts to provide Covered Services to Members.

Inpatient Services: 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.

Inquiry: Any question or request you have for us.

Licensed Mental Health Professional: A licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed certified social worker, a licensed mental health counselor, a licensed supervised mental health counselor, a licensed psychiatric nurse mental health clinical specialist, a licensed psychiatric mental health Nurse Practitioner, a licensed Physician Assistant who practices in the area of psychiatry, a licensed alcohol and drug counselor I, as defined in Massachusetts General Law chapter 111J, section 1, or a licensed marriage and family therapist within the lawful scope of practice for such therapist.

Limited Service Medical Clinic: A walk-in retail-based clinic with licensed Nurse Practitioners or Physician Assistants providing care. For instance, CVS MinuteClinic® offers an alternative to certain Emergency room visits for non-emergency cases or when patients can't see their PCP promptly. It treats common illnesses like strep throat, eye, ear, sinus, or bronchial infections for patients aged 24 months or older. It is not suitable for emergencies, wounds, injuries, x-rays, stitches, or life-threatening conditions. Such cases should be directed to an Emergency room.

Medical Drugs: A prescription drug prescribed to treat a medical, mental health or substance use disorder condition that is administered to you either (1) in a doctor's office or other outpatient medical facility, or (2) at home while you are receiving home health care services or receiving drugs administered by home infusion services. Medical Drugs cannot be self-administered. The words "cannot be self-administered" mean that the active participation of skilled medical personnel is always required to take the drug. When a Member is receiving drugs in the home, the words "cannot be self-administered" will also include circumstances in which a family member or friend is trained to administer the drug and ongoing supervision by skilled medical personnel is required.

Medically Necessary: Services that aim to prevent, diagnose, stop worsening, improve, correct, or cure life-threatening, painful, disabling, or sickness-inducing conditions. They align with accepted medical practices based on appropriateness, proven effectiveness, and scientific evidence. Our Medical Necessity Guidelines (MNGs) are available on our website at point32health.org/provider/medical-necessity-guidelines.

Member: A person enrolled in Tufts Health Plan Direct under an individual or Group Plan. Also referred to as “you.”

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

Member Services: Our team that handles all your questions about policies, procedures, requests, and concerns. You can reach them at 888-257-1985; TTY line: 711 for people with partial or total hearing loss. We are available Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays.

Necessary Information: Information that includes, but is not limited to, the results of any face-to-face clinical evaluation, consults, second opinion, labs, imaging, and/or previous therapies

Network: The collective group of health care Providers who have contracted with Tufts Health Direct to provide Covered Services. Network Providers are located throughout the Service Area

Notice of Privacy Practices: A document that tells you about how we may use and disclose your Protected Health Information (PHI) and your privacy rights. We send you our Notice of Privacy Practices upon enrollment.

Nurse Practitioner (NP): A registered nurse with advanced training. NPs may diagnose and treat illnesses, prescribe medications, and provide healthcare services.

Observation: Services that involve using Hospital services for treatment and evaluation. The goal is either discharge within 48 hours or diagnosis and treatment plan. In some cases, an Observation stay may lead to an Inpatient admission for further treatment.

Occupational Therapy: Services that help people gain the knowledge and skills necessary to perform activities of daily life.

Out-of-Network: Covered Services that a Member obtains through an Out-of-Network Provider.

Out-of-Network Provider: A Provider that we do not contract with to provide Covered Services to Members.

Out-of-pocket Maximum (MOOP): The maximum amount of Cost Sharing you are required to pay in a Plan Year for Covered Services. All Tufts Health Direct Plans have an Out-of-pocket Maximum.

Outpatient Care: Services provided in a Provider’s office, a Day Surgery or ambulatory care unit, an Emergency room, Outpatient clinic or other location. Outpatient Services include all services that are not Inpatient Services.

Outpatient Surgery: Surgical procedures when the patient is expected to leave on the same Day or within twenty-four hours. It is also known as Day Surgery, Ambulatory Surgery or Surgical Day Care.

Physical Therapy: Services for the treatment of disease or injury by physical and mechanical means. Examples include massage, regulated exercise or water, light, heat or electrical therapy.

Physician Assistant (PA): A medical professional with advanced training. PAs may diagnose and treat illnesses, prescribe medications, and provide healthcare services.

Plan: The specific Tufts Health Direct Plan you enrolled in. Each Plan has different Premiums and Cost Sharing structures. Your Member ID Card lists the name of your Plan.

Plan Year: The consecutive 12-month period during which health Plan benefits are purchased and administered. Cost Sharing responsibilities and benefit limits apply to each Plan Year. In some cases, first Plan Year will not be a full 12 months. Also called Benefit Year.

Podiatrist: A Specialist who provides medical and surgical foot care services.

Premium: The monthly bill paid to the Health Connector or your Enrollment Administrator for your Tufts Health Direct benefits.

Preventive Care: Routine health care that includes screenings, check-ups, and counseling to prevent illnesses, disease, or other health problems. Preventive Care services must be covered without Cost Share under the Affordable Care Act.

Primary Care: Services that include basic medical help, preventive services, and ongoing management of common health issues. Your PCP provides these services, aiming to keep you healthy and address non-Emergency medical needs.

Primary Care Provider (PCP): A Tufts Health Direct Provider that you choose from our Provider Directory or we assign to you. Your PCP offers general medical care for common health issues and coordinate Covered Services. They serve as the starting point for all medical care and can refer you to Specialists if needed. PCPs must be doctors in family practice, internal medicine, general practice, adolescent and pediatric medicine, or obstetrics/gynecology, board-certified or eligible for certification. You may also choose a licensed Nurse Practitioner or Physician Assistant as your PCP. People with disabilities, including those with HIV/AIDS, may have PCPs from other specialties.

Prior Authorization: Permission from Tufts Health Plan before a proposed treatment begins. There are two reasons you may require Prior Authorization. One is based on the specific Covered Service. The other is if the Provider is not part of the Tufts Health Direct Network. Your Providers know when and how to ask us for Prior Authorization. If Prior Authorization is not approved before you receive care, coverage will be denied. You will need to pay for the services you received.

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

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

Provider Directory: A list of Tufts Health Direct contracted health care facilities and professionals, including all PCPs, Specialists listed by specialty, Hospitals, Emergency rooms and Community Behavioral Health Centers (CBHCs), pharmacies, Ancillary Services, and Behavioral Health (mental health and/or substance use) services. The Provider Directory is available online or hardcopy.

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

Reconsideration of a Standard Internal Appeal: A request by you or your Designated Representative for us to review our Standard Internal Appeal decision a second time. We will review and decide within 30 Days of the date we receive the request.

Rehabilitation Hospital: 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.

Resident: 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.

Schedule of Benefits (SOB): A document that provides a general description of your Covered Services. It lists benefits, Cost Sharing amounts, Prior Authorization requirements, and any limits on the benefits your policy covers. It is in Appendix B at the end of this Member Handbook.

Serious and Complex Condition:

- An acute illness or condition that requires specialized medical treatment to avoid possibility of death or permanent harm; or
- A chronic illness or condition that (i) is life-threatening, degenerative, potentially disabling, or congenital; and (ii) requires specialized medical care over a prolonged period of time.

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

The Tufts Health Direct Service Area includes all of mainland Massachusetts; Dukes and Nantucket counties are not included.

Skilled Nursing Facility: A licensed inpatient facility providing specialized nursing care to individuals who do not need acute care Hospital services.

Small Business Service Bureau (SBSB): An Enrollment Administrator. It offers Tufts Health Direct Plans in a benefits marketplace that is not part of the state health insurance exchange.

Small Group: An employer or other legal entity with which Tufts Health Plan has an agreement to provide Group coverage. An employer Group subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended, is the ERISA Plan sponsor. If you are covered under a Group Contract, the Group is your agent and is not the Plan's agent.

Specialist: A doctor who is trained to provide specialty services. Examples include cardiologists, psychologists, obstetricians, and dermatologists.

Speech Therapy: Services that evaluate and treat speech, language, voice, hearing and fluency disorders.

Spouse: The Subscriber's legal Spouse, according to the law of the state in which you reside. This includes a divorced Spouse as required by Massachusetts law. Spouse also includes the spousal equivalent of the Subscriber. This refers to someone who is registered as a domestic partner, civil union partner, or any other legally recognized partner of the Subscriber. The person must reside in a state or municipal jurisdiction that grants such legal recognition or equivalent spousal rights.

Standard Internal Appeal: An oral or written request for Tufts Health Plan to review any Adverse Determination. We will review and decide about a Standard Internal Appeal request within 30 Days of the date we get the request.

Subrogation: The procedure under which Tufts Health Plan can recover the full or partial cost of benefits paid from a third person (“Third Party”) or entity, such as an insurer.

Subscriber: The person who enrolls in Tufts Health Direct and in whose name the Premium is paid in accordance with either a Group Contract or an individual contract. For an individual contract, a Subscriber must live in Massachusetts. For a Group Contract, a Subscriber is an employee of a Group.

Surprise Bill: An unexpected bill you may receive if you obtain services from an Out-of-Network provider: (1) in an emergency or (2) while you were receiving a service from an In-Network Provider or facility, and you did not knowingly select the Out-of-Network Provider.

Telehealth: The use of synchronous or asynchronous audio, video, electronic media, or other telecommunications technology, including, but not limited to: (i) interactive audio-video technology; (ii) remote patient monitoring devices; (iii) audio-only telephone; and (iv) online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating, or monitoring of a patient's physical health, oral health, mental health or substance use disorder condition.

Terminally Ill: Having a life expectancy of six months or less, as certified by an In-Network Provider.

Tufts Health Plan: In this Handbook refers to Tufts Health Direct.

Tufts Health Direct: Tufts Health Public Plans, Inc., a Massachusetts corporation. Tufts Health Direct is licensed by Massachusetts as a health maintenance organization (HMO). Also referred to as “we,” “us,” “our,” and “Tufts Health Plan.”

Urgent Care: Care provided when your health is not in danger, but you need immediate medical attention. Examples for which Urgent Care might be needed are a broken or dislocated toe, a cut that needs stitches but is not actively bleeding, sudden extreme anxiety or symptoms of a urinary tract infection. Care that is rendered after the urgent condition has been treated and stabilized and the Member is safe for transport is not considered Urgent Care.

Utilization Management: Our process that evaluates whether Health Care Services provided to Members are: (1) Medically Necessary; and (2) provided in the most appropriate and efficient manner.

Utilization Review: 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 evaluate the clinical necessity, appropriateness, or efficiency of Covered Services and settings. Review methods may include but are not limited to ambulatory review, prospective review, second opinion, certification, concurrent review, Care Management, discharge planning or retrospective review.

Waiting Period: 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: Insurance coverage employers maintain under state and federal law to cover employees’ injuries and illnesses under certain conditions.

Appendix B: Schedule of Benefits

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Direct ConnectorCare II



a Point32Health company

Schedule of Benefits

This Schedule of Benefits gives you information about your Tufts Health Direct Covered Services and costs you may have to pay. Make sure you review the services you are eligible for under the Schedule of Benefits for your specific Plan. To see which Tufts Health Direct Plan you have, check your Tufts Health Plan Member ID Card.

If you want more information about your benefits and capitalized terms, see your Tufts Health Direct Member Handbook tuftshealthplan.com/documents/members/handbooks/direct-member-handbook-2026.

You must go to Providers who are part of the Tufts Health Direct Provider Network to get services. Out-of-Network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal.

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 (TTY: 711, for people with partial or total hearing loss).

You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document. Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The amounts of the Annual Deductible and Annual Out-of-pocket Maximum which apply to you and the enrolled Members of your family each Plan Year are:

| ANNUAL DEDUCTIBLE | AMOUNT | NOTES |
|-------------------|--------|---|
| Individual | \$0 | The Individual Deductible applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Deductible even if other Members on the family Plan have not. |
| Family | \$0 | Once two or more Members on a family Plan meet the Family Annual Deductible, the entire family is considered to have met the Deductible for the Plan Year. |

| ANNUAL OUT-OF-POCKET MAXIMUM | AMOUNT | NOTES |
|------------------------------|---------------------------------------|---|
| Individual | Medical: \$750 Pharmacy: \$500 | The Individual Out-of-pocket Maximum applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Out-of-pocket Maximum even if other Members on the family Plan have not. |
| Family | Medical: \$1,500 Pharmacy: \$1,000 | Once two or more Members on a family Plan meet the Family Annual Out-of-pocket Maximum amount, the entire family is considered to have met the Out-of-pocket Maximum for the Plan Year. |

Notice for American Indian and Alaskan Native (AI/AN) Members: All American Indian/Alaskan Native Members, regardless of income, can enroll in a limited Cost Sharing Plan at any metal level, which means no Copayments, Deductibles, or Coinsurance when receiving care from Indian health care Providers. The Massachusetts Health Connector determines your eligibility to enroll in this Plan variation as part of your application process.

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|---|---|---|
| Abortion services | No charge | No Prior Authorization required. |
| Allergy services | | |
| Allergy testing | \$18 Copayment per visit | No Prior Authorization required. Covered for up to 200 allergy tests per Plan Year. |
| Allergy treatments (injections) | \$10 Copayment per injection | Note: Allergy immunotherapy covered as part of the pharmacy prescription benefit may require Prior Authorization and have separate pharmacy Cost Sharing responsibility. |
| Outpatient medical office visits | See <i>Medical care Outpatient visits</i> | |
| Ambulance services | No charge | No Prior Authorization required for Emergency transportation. Non-emergency basic or advanced life support, ground ambulance transportation may be covered with Prior Authorization. Services to and from medical appointments, transport by taxi, public transportation, and the use of chair cars are not covered |
| Behavioral Health services - Mental Health & Substance Use Disorder | | |
| <u>Inpatient services</u> | | Behavioral Health Urgent and Emergent levels of care do not require Prior Authorization. |
| Facility Fee | \$50 Copayment per stay | Includes room and board and services supplied by the facility during the inpatient stay. |
| Professional fee | No charge | Includes physician and other covered professional Provider services |
| Intensive community based acute treatment (ICBAT) for Children and adolescents | \$50 Copayment per stay | No Prior Authorization required for admission. |
| <u>Outpatient services</u> | | |
| Individual therapy/Counseling | No charge | No Prior Authorization required. No visit limits. |
| Applied Behavioral Analysis (ABA) | No charge | Prior Authorization required. Includes assessments, evaluations, testing, and treatment; covered in home, Outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst for treatment of Autism Spectrum Disorder or Down Syndrome |
| Intermediate care, including Behavioral Health (mental health and/or substance use) services for children and adolescents | No charge | Prior Authorization is required for certain Behavioral Health (mental health and/or substance use) services for children and adolescents. Please see the "Covered Services" section of the Tufts Health Direct Member Handbook for more information about these services. |
| Medication-Assisted Treatment services | No charge | Certain medication may require Prior Authorization. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|--|---|
| Mental Health Wellness Exam | No charge | Annual mental health wellness examination performed by a Licensed Mental Health Professional. Please Note: Your annual mental health wellness examination may also be provided by a PCP during your annual routine physical exam. |
| Recovery Coaches and Peer Specialists | No charge | No Prior Authorization required. |
| Chemotherapy and radiation oncology services | No charge | Certain services require Prior Authorization. |
| Chiropractic care | \$18 Copayment per visit | No Prior Authorization required. |
| Cleft palate and cleft lip care | No charge. Additional Cost Sharing may apply based on place of service | Covered for Members under the age of 18. Includes medical, dental, oral, and facial surgery, follow-up, and related services. See <i>Outpatient surgery services; Dental care; Medical care Outpatient visits; Speech, hearing, and language therapy; and Nutritional counseling</i> for related Cost Share. |
| Clinical trials | Based on place of service | No Prior Authorization required. Includes services that are Medically Necessary for the treatment of your condition and the reasonable cost of investigational drug or device approved for use in the trial but not otherwise paid for by its manufacturer, distributor, or Provider. |
| COVID-19 Testing/Treatment | No charge | |
| Dental care, accidental | Based on place of service | No Prior Authorization required. See <i>Emergency Room care, Outpatient surgery services, or Urgent care</i> for related Cost Share. Coverage for services related to teeth is limited to the Emergency treatment of accidental injury to sound, natural and permanent teeth when caused by a source external to the mouth. |
| Dental care, non-Emergency (Pediatric only, Delta Dental) | | |
| Members are eligible for services until the last Day of the month in which they turn 19 years old. Please call Delta Dental at 800-872-0500 for more information and for Prior Authorization requirements. | | |
| Type I: Preventive & Diagnostic | No charge | Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age. |
| Type II: Basic Covered Services | No charge | |
| Type III: Major restorative services | No charge | |
| Type IV: Orthodontia | No charge | Medically Necessary orthodontia requires Prior Authorization. |
| Diabetes education and treatment | Cost Sharing varies based on type and place of service. | Prior Authorization required for certain services. No charge for the NationsNutrition™ program. See <i>Durable Medical Equipment; Prescription drugs and supplies; Medical care Outpatient visits; and Nutritional Counseling</i> for related Cost Share. |
| Diagnostic services (Outpatient laboratory services, imaging, radiology, and other diagnostic testing) | | |
| Laboratory services | No charge | Includes blood tests, urinalysis, and throat cultures to maintain health and to test, diagnose, and treat disease. Genetic testing requires Prior Authorization. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|--|--|
| X-rays | No charge | No Prior Authorization required. |
| Advanced imaging (MRI, CT, PET scans) | \$30 Copayment | Prior Authorization required. |
| Sleep studies | Related <i>Medical care</i> <i>Outpatient visit</i> or <i>Inpatient medical care</i> Cost Sharing may be required | Prior Authorization required. |
| Other diagnostic testing | No charge | Certain services require Prior Authorization . |
| Dialysis services | No charge | No Prior Authorization required. |
| Disease Management Programs | No charge | For Members with asthma, diabetes, chronic obstructive pulmonary disease (COPD) or congestive heart failure. If you have any of these conditions, please contact us at 888-257-1985 to discuss our disease management programs. |
| Durable Medical Equipment (DME) | | |
| Covered medical equipment rented or purchased for home use | No charge | Prior Authorization is required for certain services, including prosthetic orthotics. Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs. |
| Hearing aids | No charge | Covered for Members 21 and younger. This includes the cost of one hearing aid per hearing-impaired ear up to \$2,000 per ear every 36 months. This includes both the amount Tufts Health Direct pays and the applicable Member Cost Share as listed in this document. Related services and supplies do not count toward the \$2,000 limit. |
| Wigs | No charge | Limit of 1 wig per Plan Year. |
| Early Intervention services | No charge | No Prior Authorization required. Covered for Members up to age 3; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention Specialist. |
| Emergency Room care | \$50 Copayment per visit | No Prior Authorization required. Emergency Room Cost Share waived if held for <i>Observation services</i> , sent for <i>Outpatient Surgery services</i> or admitted for <i>Inpatient medical or surgical care</i> . |
| Fitness center reimbursement | Covered for 3 months | After being an enrolled Member for four consecutive months and participating with a standard fitness center in the current Plan Year, we cover up to \$200 of membership fees incurred in the Plan Year. See the <i>Tufts Health Direct Member Handbook</i> for more information on limitations. Must complete a Fitness Center Reimbursement Form . |
| Gender affirming services | Cost Sharing varies based on type and place of service. | Prior Authorization required. Medically necessary services may include Inpatient medical and surgical care, Outpatient Surgery, Diagnostic services, Speech therapy, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies among other services. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---|--|
| Habilitative and rehabilitative services | \$10 Copayment per visit | Includes cardiac rehabilitation; physical therapy; Occupational Therapy; and speech, hearing, and language therapy services. See below for specific details. |
| <u>Limits:</u> | | |
| Cardiac rehabilitation | | |
| Physical and Occupational Therapy | | Prior Authorization required after initial evaluation and 11 visits. Maximum of 60 visits total Physical and Occupational Therapy per Member per Plan Year. Limits do not apply for Autism Spectrum Disorder services. |
| Speech, hearing, and language therapy | | Prior Authorization required after visit 30. No visit limits. |
| Home health care | No charge | Prior Authorization is required for all home care services and disciplines. |
| Hospice services | No charge | Prior Authorization required. |
| Infertility services & treatment | Cost Sharing varies based on type and place of service. | Prior Authorization required. Medically necessary services may include <i>Inpatient medical and surgical care, Outpatient Surgery, Diagnostic services, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies</i> among other services. |
| Inpatient medical and surgical care | | |
| No Prior Authorization required for Inpatient admissions from the Emergency room. Planned admissions require Prior Authorization 5 business days before admission. | | |
| Facility Fee | \$50 Copayment per stay | Includes room and board and services supplied by the facility during the inpatient stay, including preadmission testing, anesthesia, diagnostic services, and medication and supplies |
| Professional Fee | No charge | Includes physician and other covered professional Provider services |
| Long Term Acute Care Hospital or Acute Rehabilitation Hospital | \$50 Copayment per stay | Maximum of 60 Days total per Member per Plan Year |
| Maternity services and Well Newborn care | | |
| Childbirth classes | Covered for cost of childbirth education course | Complete a Member Reimbursement Medical Claim Form and submit by mail with proof of payment. |
| Routine prenatal and postpartum care | No charge | All Outpatient routine prenatal and postpartum office visits are covered as well as breastfeeding services and supports. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|---|---|--|
| Non-routine prenatal care | Cost Sharing varies based on type and place of service. | Any Outpatient maternity services not considered routine or those related to complications or risks with a pregnancy, may be subject to Cost Sharing. Some examples of services not considered routine include, but are not limited to, amniocentesis, fetal stress testing, and OB ultrasounds. |
| Hospital and delivery services | See <i>Inpatient medical and surgical care</i> | Well newborn care is included as part of covered maternity admission. |
| Breast pumps | No charge | No Prior Authorization required. One breast pump per birth including related parts and supplies. Covered for the purchase of a manual or electric pump or the rental of a hospital-grade pump when deemed appropriate by the ordering Provider. Pump must be obtained from contracting DME Provider. |
| Medical drugs | No charge | Prior Authorization required for certain drugs. Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit. |
| Medical care Outpatient visits | | |
| Medical Care includes services to diagnose, treat, and maintain a health condition. Medical care services are covered by Providers in the Tufts Health Direct Network. You are not covered for services from Providers outside of our Network and will be responsible for payment in full. Contact Member Services at 888-257-1985 or visit tuftshealthplan.com/memberlogin to find an In-Network Provider. See <i>Preventive health services</i> for information about routine health care. | | |
| <u>Office and community health center visits</u> | | |
| Primary Care Provider (PCP) | No charge | No Prior Authorization required. |
| Specialist | \$18 Copayment per visit | Prior Authorization required for certain specialist visits. |
| MinuteClinic | No charge | No Prior Authorization required. A walk-in clinic accessible at select CVS locations in our Service Area. |
| Nutritional counseling | See <i>Medical care Outpatient visits</i> | Prior Authorization required. |
| Observation services | \$50 Copayment per visit | No Prior Authorization required. Hospital services to treat and/or evaluate a condition that should result in either a discharge within 48 hours or a verified diagnosis and concurrent treatment plan. |
| Organ or bone marrow transplant | See <i>Inpatient medical and surgical care</i> | Prior Authorization required. |
| Outpatient surgery services | | |
| <u>Outpatient Day Surgery</u> | | |
| Outpatient Hospital or Ambulatory Surgery Center Facility Fee | \$50 Copayment per visit | Prior Authorization required for certain services. |
| Professional fee | No charge | Includes physician and other covered professional Provider services |
| <u>Office and community health center surgical services</u> | See <i>Medical care Outpatient visits</i> | |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|--|--|
| Pain management | Cost Sharing varies based on type and place of service. | Prior Authorization is not required to begin care. Cost Sharing based on type of service, for example , Nutritional counseling, Physical therapy or Chiropractic care |
| Podiatry care | See <i>Medical care Outpatient visits</i> | No Prior Authorization required. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot. |
| Prescription drugs and supplies | | See the Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost Share. Refer to Formulary for a complete list. |
| <u>Retail pharmacy</u> (up to 30-Day supply) | | |
| Tier 1 | \$10 Copayment | Primarily generic drugs |
| Tier 2 | \$20 Copayment | Includes some non-preferred generics and preferred brands |
| Tier 3 | \$40 Copayment | Includes high-cost generics, non-preferred brands, and Specialty drugs |
| <u>Mail order pharmacy</u> (up to 90-Day supply) | | |
| Tier 1 | \$20 Copayment | Primarily generic drugs |
| Tier 2 | \$40 Copayment | Includes some non-preferred generics and preferred brands |
| Tier 3 | \$80 Copayment | Includes high-cost generics, non-preferred brands, and Specialty drugs |
| Preventive health services | | |
| Preventive Health services are routine health care that include screenings, check-ups, and counseling to prevent illnesses, disease, or other health problems. Certain Preventive health services may require Prior Authorization. Work with your PCP to use the <i>Preventive Services</i> policy in the <i>Patient Protection and Affordable Care Act</i> chapter of our Provider Manual at https://point32health.org/provider/provider-manuals/tufts-health-public-plans-provider-manual/ to review specific requirements. | | |
| Routine pediatric care | No charge | Includes but is not limited to routine annual physical exams; screenings, immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning |
| Routine adult care | No charge | Includes but is not limited to routine annual physical exams; screenings; immunizations; routine lab tests and x-rays; routine mammograms; and routine colonoscopies |
| Routine gynecological (GYN) care | No charge | Includes but is not limited to routine exams and cervical cancer screenings (Pap smear tests) |
| Family planning | No charge | |
| Smoking Cessation Counseling Services | No charge | |
| Reconstructive surgery and procedures | See <i>Outpatient surgery or Inpatient medical and surgical care</i> | Certain services may require Prior Authorization. |
| Skilled Nursing Facility | No charge | Maximum of 100 Days total per Member per Plan Year |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---|--|
| Telehealth | See <i>Medical care Outpatient visits</i> | Please ask your Providers' office for information on Telehealth availability and access. |
| Urgent care | \$18 Copayment per visit | No Prior Authorization required. In our Service Area, you must visit a UCC that is in our Network to be covered for services. Outside of our Service Area, free-standing Urgent Care Centers (UCCs) are covered at Out-of-Network Provider sites, including Hospitals and clinics. |
| Vision care | | |
| You must receive routine eye examinations from a Provider in the EyeMed Vision Care Select network in order to obtain coverage for these services. Call EyeMed at 866-504-5908 for the names of EyeMed Select Providers. | | |
| Routine care | \$18 Copayment per visit | Coverage for routine eye exams once every 12 months; |
| Eyeglasses for children (under 19 years of age) | No charge | Eyeglasses covered once every 12 months; \$150 allowance + 20% off expense beyond allowance. |
| Medical eye care | See <i>Medical care Outpatient visits</i> | |
| Weight loss programs | No charge for 3 months of membership fees for a qualified program | 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 Plan Year. Must complete a Weight Loss Program Reimbursement Form . See the Tufts Health Direct Member Handbook for more information on limitations. |

Services not covered

See the section "Services not covered" in the *Tufts Health Direct Member Handbook* for the list of services not covered.

Direct ConnectorCare III



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Schedule of Benefits

This Schedule of Benefits gives you information about your Tufts Health Direct Covered Services and costs you may have to pay. Make sure you review the services you are eligible for under the Schedule of Benefits for your specific Plan. To see which Tufts Health Direct Plan you have, check your Tufts Health Plan Member ID Card.

If you want more information about your benefits and capitalized terms, see your Tufts Health Direct Member Handbook tuftshealthplan.com/documents/members/handbooks/direct-member-handbook-2026.

You must go to Providers who are part of the Tufts Health Direct Provider Network to get services. Out-of-Network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal.

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 (TTY: 711, for people with partial or total hearing loss).

You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document. Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The amounts of the Annual Deductible and Annual Out-of-pocket Maximum which apply to you and the enrolled Members of your family each Plan Year are:

| ANNUAL DEDUCTIBLE | AMOUNT | NOTES |
|-------------------|--------|---|
| Individual | \$0 | The Individual Deductible applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Deductible even if other Members on the family Plan have not. |
| Family | \$0 | Once two or more Members on a family Plan meet the Family Annual Deductible, the entire family is considered to have met the Deductible for the Plan Year. |

| ANNUAL OUT-OF-POCKET MAXIMUM | AMOUNT | NOTES |
|------------------------------|---------------------------------------|---|
| Individual | Medical: \$1,500 Pharmacy: \$750 | The Individual Out-of-pocket Maximum applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Out-of-pocket Maximum even if other Members on the family Plan have not. |
| Family | Medical: \$3,000 Pharmacy: \$1,500 | Once two or more Members on a family Plan meet the Family Annual Out-of-pocket Maximum amount, the entire family is considered to have met the Out-of-pocket Maximum for the Plan Year. |

Notice for American Indian and Alaskan Native (AI/AN) Members: All American Indian/Alaskan Native Members, regardless of income, can enroll in a limited Cost Sharing Plan at any metal level, which means no Copayments, Deductibles, or Coinsurance when receiving care from Indian health care Providers. The Massachusetts Health Connector determines your eligibility to enroll in this Plan variation as part of your application process.

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|---|---|---|
| Abortion services | No charge | No Prior Authorization required. |
| Allergy services | | |
| Allergy testing | \$22 Copayment per visit | No Prior Authorization required. Covered for up to 200 allergy tests per Plan Year. |
| Allergy treatments (injections) | \$10 Copayment per injection | Note: Allergy immunotherapy covered as part of the pharmacy prescription benefit may require Prior Authorization and have separate pharmacy Cost Sharing responsibility. |
| Outpatient medical office visits | See <i>Medical care Outpatient visits</i> | |
| Ambulance services | No charge | No Prior Authorization required for Emergency transportation. Non-emergency basic or advanced life support, ground ambulance transportation may be covered with Prior Authorization. Services to and from medical appointments, transport by taxi, public transportation, and the use of chair cars are not covered |
| Behavioral Health services - Mental Health & Substance Use Disorder | | |
| <u>Inpatient services</u> | | Behavioral Health Urgent and Emergent levels of care do not require Prior Authorization. |
| Facility Fee | \$250 Copayment per stay | Includes room and board and services supplied by the facility during the inpatient stay. |
| Professional fee | No charge | Includes physician and other covered professional Provider services |
| Intensive community based acute treatment (ICBAT) for Children and adolescents | \$250 Copayment per stay | No Prior Authorization required for admission. |
| <u>Outpatient services</u> | | |
| Individual therapy/Counseling | No charge | No Prior Authorization required. No visit limits. |
| Applied Behavioral Analysis (ABA) | No charge | Prior Authorization required. Includes assessments, evaluations, testing, and treatment; covered in home, Outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst for treatment of Autism Spectrum Disorder or Down Syndrome |
| Intermediate care, including Behavioral Health (mental health and/or substance use) services for children and adolescents | No charge | Prior Authorization is required for certain Behavioral Health (mental health and/or substance use) services for children and adolescents. Please see the "Covered Services" section of the Tufts Health Direct Member Handbook for more information about these services. |
| Medication-Assisted Treatment services | No charge | Certain medication may require Prior Authorization. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|--|---|
| Mental Health Wellness Exam | No charge | Annual mental health wellness examination performed by a Licensed Mental Health Professional. Please Note: Your annual mental health wellness examination may also be provided by a PCP during your annual routine physical exam. |
| Recovery Coaches and Peer Specialists | No charge | No Prior Authorization required. |
| Chemotherapy and radiation oncology services | No charge | Certain services require Prior Authorization. |
| Chiropractic care | \$22 Copayment per visit | No Prior Authorization required. |
| Cleft palate and cleft lip care | No charge. Additional Cost Sharing may apply based on place of service | Covered for Members under the age of 18. Includes medical, dental, oral, and facial surgery, follow-up, and related services. See <i>Outpatient surgery services; Dental care; Medical care Outpatient visits; Speech, hearing, and language therapy; and Nutritional counseling</i> for related Cost Share. |
| Clinical trials | Based on place of service | No Prior Authorization required. Includes services that are Medically Necessary for the treatment of your condition and the reasonable cost of investigational drug or device approved for use in the trial but not otherwise paid for by its manufacturer, distributor, or Provider. |
| COVID-19 Testing/Treatment | No charge | |
| Dental care, accidental | Based on place of service | No Prior Authorization required. See <i>Emergency Room care, Outpatient surgery services, or Urgent care</i> for related Cost Share. Coverage for services related to teeth is limited to the Emergency treatment of accidental injury to sound, natural and permanent teeth when caused by a source external to the mouth. |
| Dental care, non-Emergency (Pediatric only, Delta Dental) | | |
| Members are eligible for services until the last Day of the month in which they turn 19 years old. Please call Delta Dental at 800-872-0500 for more information and for Prior Authorization requirements. | | |
| Type I: Preventive & Diagnostic | No charge | Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age. |
| Type II: Basic Covered Services | No charge | |
| Type III: Major restorative services | No charge | |
| Type IV: Orthodontia | No charge | Medically Necessary orthodontia requires Prior Authorization. |
| Diabetes education and treatment | Cost Sharing varies based on type and place of service. | Prior Authorization required for certain services. No charge for the NationsNutrition™ program. See <i>Durable Medical Equipment; Prescription drugs and supplies; Medical care Outpatient visits; and Nutritional Counseling</i> for related Cost Share. |
| Diagnostic services (Outpatient laboratory services, imaging, radiology, and other diagnostic testing) | | |
| Laboratory services | No charge | Includes blood tests, urinalysis, and throat cultures to maintain health and to test, diagnose, and treat disease. Genetic testing requires Prior Authorization. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|--|--|
| X-rays | No charge | No Prior Authorization required. |
| Advanced imaging (MRI, CT, PET scans) | \$60 Copayment | Prior Authorization required. |
| Sleep studies | Related <i>Medical care</i> <i>Outpatient visit</i> or <i>Inpatient medical care</i> Cost Sharing may be required | Prior Authorization required. |
| Other diagnostic testing | No charge | Certain services require Prior Authorization . |
| Dialysis services | No charge | No Prior Authorization required. |
| Disease Management Programs | No charge | For Members with asthma, diabetes, chronic obstructive pulmonary disease (COPD) or congestive heart failure. If you have any of these conditions, please contact us at 888-257-1985 to discuss our disease management programs. |
| Durable Medical Equipment (DME) | | |
| Covered medical equipment rented or purchased for home use | No charge | Prior Authorization is required for certain services, including prosthetic orthotics. Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs. |
| Hearing aids | No charge | Covered for Members 21 and younger. This includes the cost of one hearing aid per hearing-impaired ear up to \$2,000 per ear every 36 months. This includes both the amount Tufts Health Direct pays and the applicable Member Cost Share as listed in this document. Related services and supplies do not count toward the \$2,000 limit. |
| Wigs | No charge | Limit of 1 wig per Plan Year. |
| Early Intervention services | No charge | No Prior Authorization required. Covered for Members up to age 3; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention Specialist. |
| Emergency Room care | \$100 Copayment per visit | No Prior Authorization required. Emergency Room Cost Share waived if held for <i>Observation services</i> , sent for <i>Outpatient Surgery services</i> or admitted for <i>Inpatient medical or surgical care</i> . |
| Fitness center reimbursement | Covered for 3 months | After being an enrolled Member for four consecutive months and participating with a standard fitness center in the current Plan Year, we cover up to \$200 of membership fees incurred in the Plan Year. See the <i>Tufts Health Direct Member Handbook</i> for more information on limitations. Must complete a Fitness Center Reimbursement Form . |
| Gender affirming services | Cost Sharing varies based on type and place of service. | Prior Authorization required. Medically necessary services may include Inpatient medical and surgical care, Outpatient Surgery, Diagnostic services, Speech therapy, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies among other services. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|---|---|--|
| Habilitative and rehabilitative services | \$20 Copayment per visit | Includes cardiac rehabilitation; physical therapy; Occupational Therapy; and speech, hearing, and language therapy services. See below for specific details. |
| <u>Limits:</u> | | |
| Cardiac rehabilitation | | |
| Physical and Occupational Therapy | | Prior Authorization required after initial evaluation and 11 visits. Maximum of 60 visits total Physical and Occupational Therapy per Member per Plan Year. Limits do not apply for Autism Spectrum Disorder services. |
| Speech, hearing, and language therapy | | Prior Authorization required after visit 30. No visit limits. |
| Home health care | No charge | Prior Authorization is required for all home care services and disciplines. |
| Hospice services | No charge | Prior Authorization required. |
| Infertility services & treatment | Cost Sharing varies based on type and place of service. | Prior Authorization required. Medically necessary services may include <i>Inpatient medical and surgical care, Outpatient Surgery, Diagnostic services, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies</i> among other services. |
| Inpatient medical and surgical care | | |
| | | No Prior Authorization required for Inpatient admissions from the Emergency room. Planned admissions require Prior Authorization 5 business days before admission. |
| Facility Fee | \$250 Copayment per stay | Includes room and board and services supplied by the facility during the inpatient stay, including preadmission testing, anesthesia, diagnostic services, and medication and supplies |
| Professional Fee | No charge | Includes physician and other covered professional Provider services |
| Long Term Acute Care Hospital or Acute Rehabilitation Hospital | \$250 Copayment per stay | Maximum of 60 Days total per Member per Plan Year |
| Maternity services and Well Newborn care | | |
| Childbirth classes | Covered for cost of childbirth education course | Complete a Member Reimbursement Medical Claim Form and submit by mail with proof of payment. |
| Routine prenatal and postpartum care | No charge | All Outpatient routine prenatal and postpartum office visits are covered as well as breastfeeding services and supports. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|---|---|--|
| Non-routine prenatal care | Cost Sharing varies based on type and place of service. | Any Outpatient maternity services not considered routine or those related to complications or risks with a pregnancy, may be subject to Cost Sharing. Some examples of services not considered routine include, but are not limited to, amniocentesis, fetal stress testing, and OB ultrasounds. |
| Hospital and delivery services | See <i>Inpatient medical and surgical care</i> | Well newborn care is included as part of covered maternity admission. |
| Breast pumps | No charge | No Prior Authorization required. One breast pump per birth including related parts and supplies. Covered for the purchase of a manual or electric pump or the rental of a hospital-grade pump when deemed appropriate by the ordering Provider. Pump must be obtained from contracting DME Provider. |
| Medical drugs | No charge | Prior Authorization required for certain drugs. Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit. |
| Medical care Outpatient visits | | |
| Medical Care includes services to diagnose, treat, and maintain a health condition. Medical care services are covered by Providers in the Tufts Health Direct Network. You are not covered for services from Providers outside of our Network and will be responsible for payment in full. Contact Member Services at 888-257-1985 or visit tuftshealthplan.com/memberlogin to find an In-Network Provider. See <i>Preventive health services</i> for information about routine health care. | | |
| <u>Office and community health center visits</u> | | |
| Primary Care Provider (PCP) | No charge | No Prior Authorization required. |
| Specialist | \$22 Copayment per visit | Prior Authorization required for certain specialist visits. |
| MinuteClinic | No charge | No Prior Authorization required. A walk-in clinic accessible at select CVS locations in our Service Area. |
| Nutritional counseling | See <i>Medical care Outpatient visits</i> | Prior Authorization required. |
| Observation services | \$250 Copayment per visit | No Prior Authorization required. Hospital services to treat and/or evaluate a condition that should result in either a discharge within 48 hours or a verified diagnosis and concurrent treatment plan. |
| Organ or bone marrow transplant | See <i>Inpatient medical and surgical care</i> | Prior Authorization required. |
| Outpatient surgery services | | |
| <u>Outpatient Day Surgery</u> | | |
| Outpatient Hospital or Ambulatory Surgery Center Facility Fee | \$125 Copayment per visit | Prior Authorization required for certain services. |
| Professional fee | No charge | Includes physician and other covered professional Provider services |
| <u>Office and community health center surgical services</u> | See <i>Medical care Outpatient visits</i> | |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|--|--|
| Pain management | Cost Sharing varies based on type and place of service. | Prior Authorization is not required to begin care. Cost Sharing based on type of service, for example , Nutritional counseling, Physical therapy or Chiropractic care |
| Podiatry care | See <i>Medical care Outpatient visits</i> | No Prior Authorization required. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot. |
| Prescription drugs and supplies | | See the Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost Share. Refer to Formulary for a complete list. |
| Retail pharmacy (up to 30-Day supply) | | |
| Tier 1 | \$12.50 Copayment | Primarily generic drugs |
| Tier 2 | \$25 Copayment | Includes some non-preferred generics and preferred brands |
| Tier 3 | \$50 Copayment | Includes high-cost generics, non-preferred brands, and Specialty drugs |
| Mail order pharmacy (up to 90-Day supply) | | |
| Tier 1 | \$25 Copayment | Primarily generic drugs |
| Tier 2 | \$50 Copayment | Includes some non-preferred generics and preferred brands |
| Tier 3 | \$100 Copayment | Includes high-cost generics, non-preferred brands, and Specialty drugs |
| Preventive health services | | |
| Preventive Health services are routine health care that include screenings, check-ups, and counseling to prevent illnesses, disease, or other health problems. Certain Preventive health services may require Prior Authorization. Work with your PCP to use the <i>Preventive Services</i> policy in the <i>Patient Protection and Affordable Care Act</i> chapter of our Provider Manual at https://point32health.org/provider/provider-manuals/tufts-health-public-plans-provider-manual/ to review specific requirements. | | |
| Routine pediatric care | No charge | Includes but is not limited to routine annual physical exams; screenings, immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning |
| Routine adult care | No charge | Includes but is not limited to routine annual physical exams; screenings; immunizations; routine lab tests and x-rays; routine mammograms; and routine colonoscopies |
| Routine gynecological (GYN) care | No charge | Includes but is not limited to routine exams and cervical cancer screenings (Pap smear tests) |
| Family planning | No charge | |
| Smoking Cessation Counseling Services | No charge | |
| Reconstructive surgery and procedures | See <i>Outpatient surgery or Inpatient medical and surgical care</i> | Certain services may require Prior Authorization. |
| Skilled Nursing Facility | No charge | Maximum of 100 Days total per Member per Plan Year |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---|--|
| Telehealth | See <i>Medical care Outpatient visits</i> | Please ask your Providers' office for information on Telehealth availability and access. |
| Urgent care | \$22 Copayment per visit | No Prior Authorization required. In our Service Area, you must visit a UCC that is in our Network to be covered for services. Outside of our Service Area, free-standing Urgent Care Centers (UCCs) are covered at Out-of-Network Provider sites, including Hospitals and clinics. |
| Vision care | | |
| You must receive routine eye examinations from a Provider in the EyeMed Vision Care Select network in order to obtain coverage for these services. Call EyeMed at 866-504-5908 for the names of EyeMed Select Providers. | | |
| Routine care | \$22 Copayment per visit | Coverage for routine eye exams once every 12 months; |
| Eyeglasses for children (under 19 years of age) | No charge | Eyeglasses covered once every 12 months; \$150 allowance + 20% off expense beyond allowance. |
| Medical eye care | See <i>Medical care Outpatient visits</i> | |
| Weight loss programs | No charge for 3 months of membership fees for a qualified program | 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 Plan Year. Must complete a Weight Loss Program Reimbursement Form . See the Tufts Health Direct Member Handbook for more information on limitations. |

Services not covered

See the section "Services not covered" in the *Tufts Health Direct Member Handbook* for the list of services not covered.

Direct ConnectorCare AIAN



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Schedule of Benefits

This Schedule of Benefits gives you information about your Tufts Health Direct Covered Services and costs you may have to pay. Make sure you review the services you are eligible for under the Schedule of Benefits for your specific Plan. To see which Tufts Health Direct Plan you have, check your Tufts Health Plan Member ID Card.

If you want more information about your benefits and capitalized terms, see your Tufts Health Direct Member Handbook tuftshealthplan.com/documents/members/handbooks/direct-member-handbook-2026.

You must go to Providers who are part of the Tufts Health Direct Provider Network to get services. Out-of-Network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal.

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 (TTY: 711, for people with partial or total hearing loss).

This zero Cost Sharing Plan is made available by the Massachusetts Health Connector for all American Indian/Alaskan Natives with incomes below 300% FPL that are eligible for Federal APTC. The amounts of the Annual Deductible and Annual Out-of-pocket Maximum which apply to you and the enrolled Members of your family each Plan Year are:

| ANNUAL DEDUCTIBLE | AMOUNT |
|--------------------------|---------------|
| Individual | \$0 |
| Family | \$0 |

| ANNUAL OUT-OF-POCKET MAXIMUM | AMOUNT |
|-------------------------------------|---------------|
| Individual | \$0 |
| Family | \$0 |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|---|---------------------|---|
| Abortion services | No charge | No Prior Authorization required. |
| Allergy services | | |
| Allergy testing | No charge | No Prior Authorization required. Covered for up to 200 allergy tests per Plan Year. |
| Allergy treatments (injections) | No charge | Note: Allergy immunotherapy covered as part of the pharmacy prescription benefit may require Prior Authorization and have separate pharmacy Cost Sharing responsibility. |
| Outpatient medical office visits | No charge | |
| Ambulance services | No charge | No Prior Authorization required for Emergency transportation. Non-emergency basic or advanced life support, ground ambulance transportation may be covered with Prior Authorization. Services to and from medical appointments, transport by taxi, public transportation, and the use of chair cars are not covered |
| Behavioral Health services - Mental Health & Substance Use Disorder | | |
| <u>Inpatient services</u> | | Behavioral Health Urgent and Emergent levels of care do not require Prior Authorization. |
| Facility Fee | No charge | Includes room and board and services supplied by the facility during the inpatient stay. |
| Professional fee | No charge | Includes physician and other covered professional Provider services |
| Intensive community based acute treatment (ICBAT) for Children and adolescents | No charge | No Prior Authorization required for admission. |
| <u>Outpatient services</u> | | |
| Individual therapy/Counseling | No charge | No Prior Authorization required. No visit limits. |
| Applied Behavioral Analysis (ABA) | No charge | Prior Authorization required. Includes assessments, evaluations, testing, and treatment; covered in home, Outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst for treatment of Autism Spectrum Disorder or Down Syndrome |
| Intermediate care, including Behavioral Health (mental health and/or substance use) services for children and adolescents | No charge | Prior Authorization is required for certain Behavioral Health (mental health and/or substance use) services for children and adolescents. Please see the "Covered Services" section of the Tufts Health Direct Member Handbook for more information about these services. |
| Medication-Assisted Treatment services | No charge | Certain medication may require Prior Authorization. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---------------------|---|
| Mental Health Wellness Exam | No charge | Annual mental health wellness examination performed by a Licensed Mental Health Professional. Please Note: Your annual mental health wellness examination may also be provided by a PCP during your annual routine physical exam. |
| Recovery Coaches and Peer Specialists | No charge | No Prior Authorization required. |
| Chemotherapy and radiation oncology services | No charge | Certain services require Prior Authorization. |
| Chiropractic care | No charge | No Prior Authorization required. |
| Cleft palate and cleft lip care | No charge | Covered for Members under the age of 18. Includes medical, dental, oral, and facial surgery, follow-up, and related services. See <i>Outpatient surgery services; Dental care; Medical care Outpatient visits; Speech, hearing, and language therapy; and Nutritional counseling</i> for related Cost Share. |
| Clinical trials | No charge | No Prior Authorization required. Includes services that are Medically Necessary for the treatment of your condition and the reasonable cost of investigational drug or device approved for use in the trial but not otherwise paid for by its manufacturer, distributor, or Provider. |
| COVID-19 Testing/Treatment | No charge | |
| Dental care, accidental | No charge | No Prior Authorization required. See <i>Emergency Room care, Outpatient surgery services, or Urgent care</i> for related Cost Share. Coverage for services related to teeth is limited to the Emergency treatment of accidental injury to sound, natural and permanent teeth when caused by a source external to the mouth. |
| Dental care, non-Emergency (Pediatric only, Delta Dental) | | |
| Members are eligible for services until the last Day of the month in which they turn 19 years old. Please call Delta Dental at 800-872-0500 for more information and for Prior Authorization requirements. | | |
| Type I: Preventive & Diagnostic | No charge | Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age. |
| Type II: Basic Covered Services | No charge | |
| Type III: Major restorative services | No charge | |
| Type IV: Orthodontia | No charge | Medically Necessary orthodontia requires Prior Authorization. |
| Diabetes education and treatment | No charge | Prior Authorization required for certain services. No charge for the NationsNutrition™ program. See <i>Durable Medical Equipment; Prescription drugs and supplies; Medical care Outpatient visits; and Nutritional Counseling</i> for related Cost Share. |
| Diagnostic services (Outpatient laboratory services, imaging, radiology, and other diagnostic testing) | | |
| Laboratory services | No charge | Includes blood tests, urinalysis, and throat cultures to maintain health and to test, diagnose, and treat disease. Genetic testing requires Prior Authorization. |
| X-rays | No charge | No Prior Authorization required. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|----------------------|--|
| Advanced imaging (MRI, CT, PET scans) | No charge | Prior Authorization required. |
| Sleep studies | No charge | Prior Authorization required. |
| Other diagnostic testing | No charge | Certain services require Prior Authorization . |
| Dialysis services | No charge | No Prior Authorization required. |
| Disease Management Programs | No charge | For Members with asthma, diabetes, chronic obstructive pulmonary disease (COPD) or congestive heart failure. If you have any of these conditions, please contact us at 888-257-1985 to discuss our disease management programs. |
| Durable Medical Equipment (DME) | | |
| Covered medical equipment rented or purchased for home use | No charge | Prior Authorization is required for certain services, including prosthetic orthotics. Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs. |
| Hearing aids | No charge | Covered for Members 21 and younger. This includes the cost of one hearing aid per hearing-impaired ear up to \$2,000 per ear every 36 months. This includes both the amount Tufts Health Direct pays and the applicable Member Cost Share as listed in this document. Related services and supplies do not count toward the \$2,000 limit. |
| Wigs | No charge | Limit of 1 wig per Plan Year. |
| Early Intervention services | No charge | No Prior Authorization required. Covered for Members up to age 3; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention Specialist. |
| Emergency Room care | No charge | No Prior Authorization required. Emergency Room Cost Share waived if held for <i>Observation services</i> , sent for <i>Outpatient Surgery services</i> or admitted for <i>Inpatient medical or surgical care</i> . |
| Fitness center reimbursement | Covered for 3 months | After being an enrolled Member for four consecutive months and participating with a standard fitness center in the current Plan Year, we cover up to \$200 of membership fees incurred in the Plan Year. See the <i>Tufts Health Direct Member Handbook</i> for more information on limitations. Must complete a Fitness Center Reimbursement Form . |
| Gender affirming services | No charge | Prior Authorization required. Medically necessary services may include Inpatient medical and surgical care, Outpatient Surgery, Diagnostic services, Speech therapy, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies among other services. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|---|---|--|
| Habilitative and rehabilitative services | No charge | Includes cardiac rehabilitation; physical therapy; Occupational Therapy; and speech, hearing, and language therapy services. See below for specific details. |
| <u>Limits:</u> | | |
| Cardiac rehabilitation | | |
| Physical and Occupational Therapy | | Prior Authorization required after initial evaluation and 11 visits. Maximum of 60 visits total Physical and Occupational Therapy per Member per Plan Year. Limits do not apply for Autism Spectrum Disorder services. |
| Speech, hearing, and language therapy | | Prior Authorization required after visit 30. No visit limits. |
| Home health care | No charge | Prior Authorization is required for all home care services and disciplines. |
| Hospice services | No charge | Prior Authorization required. |
| Infertility services & treatment | No charge | Prior Authorization required. Medically necessary services may include <i>Inpatient medical and surgical care, Outpatient Surgery, Diagnostic services, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies</i> among other services. |
| Inpatient medical and surgical care | | |
| | | No Prior Authorization required for Inpatient admissions from the Emergency room. Planned admissions require Prior Authorization 5 business days before admission. |
| Facility Fee | No charge | Includes room and board and services supplied by the facility during the inpatient stay, including preadmission testing, anesthesia, diagnostic services, and medication and supplies |
| Professional Fee | No charge | Includes physician and other covered professional Provider services |
| Long Term Acute Care Hospital or Acute Rehabilitation Hospital | No charge | Maximum of 60 Days total per Member per Plan Year |
| Maternity services and Well Newborn care | | |
| Childbirth classes | Covered for cost of childbirth education course | Complete a Member Reimbursement Medical Claim Form and submit by mail with proof of payment. |
| Routine prenatal and postpartum care | No charge | All Outpatient routine prenatal and postpartum office visits are covered as well as breastfeeding services and supports. |
| Non-routine prenatal care | No charge | Any Outpatient maternity services not considered routine or those related to complications or risks with a pregnancy, may be subject to Cost Sharing. Some examples of services not considered routine include, but are not limited to, amniocentesis, fetal stress testing, and OB ultrasounds. |
| Hospital and delivery services | No charge | Well newborn care is included as part of covered maternity admission. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---------------------|--|
| Breast pumps | No charge | No Prior Authorization required. One breast pump per birth including related parts and supplies. Covered for the purchase of a manual or electric pump or the rental of a hospital-grade pump when deemed appropriate by the ordering Provider. Pump must be obtained from contracting DME Provider. |
| Medical drugs | No charge | Prior Authorization required for certain drugs. Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit. |
| Medical care Outpatient visits | | |
| Medical Care includes services to diagnose, treat, and maintain a health condition. Medical care services are covered by Providers in the Tufts Health Direct Network. You are not covered for services from Providers outside of our Network and will be responsible for payment in full. Contact Member Services at 888-257-1985 or visit tuftshealthplan.com/memberlogin to find an In-Network Provider. See <i>Preventive health services</i> for information about routine health care. | | |
| <u>Office and community health center visits</u> | | |
| Primary Care Provider (PCP) | No charge | No Prior Authorization required. |
| Specialist | No charge | Prior Authorization required for certain specialist visits. |
| MinuteClinic | No charge | No Prior Authorization required. A walk-in clinic accessible at select CVS locations in our Service Area. |
| Nutritional counseling | No charge | Prior Authorization required. |
| Observation services | No charge | No Prior Authorization required. Hospital services to treat and/or evaluate a condition that should result in either a discharge within 48 hours or a verified diagnosis and concurrent treatment plan. |
| Organ or bone marrow transplant | No charge | Prior Authorization required. |
| Outpatient surgery services | | |
| <u>Outpatient Day Surgery</u> | | |
| Outpatient Hospital or Ambulatory Surgery Center Facility Fee | No charge | Prior Authorization required for certain services. |
| Professional fee | No charge | Includes physician and other covered professional Provider services |
| <u>Office and community health center surgical services</u> | | |
| Pain management | No charge | Prior Authorization is not required to begin care. Cost Sharing based on type of service, for example , Nutritional counseling, Physical therapy or Chiropractic care |
| Podiatry care | No charge | No Prior Authorization required. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|--------------|--|
| Prescription drugs and supplies | | See the Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost Share. Refer to Formulary for a complete list. |
| <u>Retail pharmacy</u> (up to 30-Day supply) | | |
| Tier 1 | No charge | Primarily generic drugs |
| Tier 2 | No charge | Includes some non-preferred generics and preferred brands |
| Tier 3 | No charge | Includes high-cost generics, non-preferred brands, and Specialty drugs |
| <u>Mail order pharmacy</u> (up to 90-Day supply) | | |
| Tier 1 | No charge | Primarily generic drugs |
| Tier 2 | No charge | Includes some non-preferred generics and preferred brands |
| Tier 3 | No charge | Includes high-cost generics, non-preferred brands, and Specialty drugs |
| Preventive health services | | |
| Preventive Health services are routine health care that include screenings, check-ups, and counseling to prevent illnesses, disease, or other health problems. Certain Preventive health services may require Prior Authorization. Work with your PCP to use the <i>Preventive Services</i> policy in the <i>Patient Protection and Affordable Care Act</i> chapter of our Provider Manual at https://point32health.org/provider/provider-manuals/tufts-health-public-plans-provider-manual/ to review specific requirements. | | |
| Routine pediatric care | No charge | Includes but is not limited to routine annual physical exams; screenings, immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning |
| Routine adult care | No charge | Includes but is not limited to routine annual physical exams; screenings; immunizations; routine lab tests and x-rays; routine mammograms; and routine colonoscopies |
| Routine gynecological (GYN) care | No charge | Includes but is not limited to routine exams and cervical cancer screenings (Pap smear tests) |
| Family planning | No charge | |
| Smoking Cessation Counseling Services | No charge | |
| Reconstructive surgery and procedures | No charge | Certain services may require Prior Authorization. |
| Skilled Nursing Facility | No charge | Maximum of 100 Days total per Member per Plan Year |
| Telehealth | No charge | Please ask your Providers' office for information on Telehealth availability and access. |
| Urgent care | No charge | No Prior Authorization required. In our Service Area, you must visit a UCC that is in our Network to be covered for services. Outside of our Service Area, free-standing Urgent Care Centers (UCCs) are covered at Out-of-Network Provider sites, including Hospitals and clinics. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---|--|
| Vision care | | |
| You must receive routine eye examinations from a Provider in the EyeMed Vision Care Select network in order to obtain coverage for these services. Call EyeMed at 866-504-5908 for the names of EyeMed Select Providers. | | |
| Routine care | No charge | Coverage for routine eye exams once every 12 months; |
| Eyeglasses for children (under 19 years of age) | No charge | Eyeglasses covered once every 12 months; \$150 allowance + 20% off expense beyond allowance. |
| Medical eye care | No charge | |
| Weight loss programs | No charge for 3 months of membership fees for a qualified program | 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 Plan Year. Must complete a Weight Loss Program Reimbursement Form . See the Tufts Health Direct Member Handbook for more information on limitations. |

Services not covered

See the section “Services not covered” in the *Tufts Health Direct Member Handbook* for the list of services not covered.

Direct Platinum

Schedule of Benefits

This Schedule of Benefits gives you information about your Tufts Health Direct Covered Services and costs you may have to pay. Make sure you review the services you are eligible for under the Schedule of Benefits for your specific Plan. To see which Tufts Health Direct Plan you have, check your Tufts Health Plan Member ID Card.

If you want more information about your benefits and capitalized terms, see your Tufts Health Direct Member Handbook tuftshealthplan.com/documents/members/handbooks/direct-member-handbook-2026.

You must go to Providers who are part of the Tufts Health Direct Provider Network to get services. Out-of-Network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal.

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 (TTY: 711, for people with partial or total hearing loss).

You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document. Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The amounts of the Annual Deductible and Annual Out-of-pocket Maximum which apply to you and the enrolled Members of your family each Plan Year are:

| ANNUAL DEDUCTIBLE | AMOUNT | NOTES |
|-------------------|--------|---|
| Individual | \$0 | The Individual Deductible applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Deductible even if other Members on the family Plan have not. |
| Family | \$0 | Once two or more Members on a family Plan meet the Family Annual Deductible, the entire family is considered to have met the Deductible for the Plan Year. |

| ANNUAL OUT-OF-POCKET MAXIMUM | AMOUNT | NOTES |
|------------------------------|---------|---|
| Individual | \$3,000 | The Individual Out-of-pocket Maximum applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Out-of-pocket Maximum even if other Members on the family Plan have not. |
| Family | \$6,000 | Once two or more Members on a family Plan meet the Family Annual Out-of-pocket Maximum amount, the entire family is considered to have met the Out-of-pocket Maximum for the Plan Year. |

Notice for American Indian and Alaskan Native (AI/AN) Members: All American Indian/Alaskan Native Members, regardless of income, can enroll in a limited Cost Sharing Plan at any metal level, which means no Copayments, Deductibles, or Coinsurance when receiving care from Indian health care Providers. The Massachusetts Health Connector determines your eligibility to enroll in this Plan variation as part of your application process.

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|---|---|---|
| Abortion services | No charge | No Prior Authorization required. |
| Allergy services | | |
| Allergy testing | \$40 Copayment per visit | No Prior Authorization required. Covered for up to 200 allergy tests per Plan Year. |
| Allergy treatments (injections) | \$10 Copayment per injection | Note: Allergy immunotherapy covered as part of the pharmacy prescription benefit may require Prior Authorization and have separate pharmacy Cost Sharing responsibility. |
| Outpatient medical office visits | See <i>Medical care Outpatient visits</i> | |
| Ambulance services | No charge | No Prior Authorization required for Emergency transportation. Non-emergency basic or advanced life support, ground ambulance transportation may be covered with Prior Authorization. Services to and from medical appointments, transport by taxi, public transportation, and the use of chair cars are not covered |
| Behavioral Health services - Mental Health & Substance Use Disorder | | |
| <u>Inpatient services</u> | | Behavioral Health Urgent and Emergent levels of care do not require Prior Authorization. |
| Facility Fee | \$500 Copayment per stay | Includes room and board and services supplied by the facility during the inpatient stay. |
| Professional fee | No charge | Includes physician and other covered professional Provider services |
| Intensive community based acute treatment (ICBAT) for Children and adolescents | No charge | No Prior Authorization required for admission. |
| <u>Outpatient services</u> | | |
| Individual therapy/Counseling | \$20 Copayment per visit | No Prior Authorization required. No visit limits. |
| Applied Behavioral Analysis (ABA) | \$20 Copayment per visit | Prior Authorization required. Includes assessments, evaluations, testing, and treatment; covered in home, Outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst for treatment of Autism Spectrum Disorder or Down Syndrome |
| Intermediate care, including Behavioral Health (mental health and/or substance use) services for children and adolescents | No charge | Prior Authorization is required for certain Behavioral Health (mental health and/or substance use) services for children and adolescents. Please see the "Covered Services" section of the Tufts Health Direct Member Handbook for more information about these services. |
| Medication-Assisted Treatment services | No charge | Certain medication may require Prior Authorization. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|--|---|
| Mental Health Wellness Exam | No charge | Annual mental health wellness examination performed by a Licensed Mental Health Professional. Please Note: Your annual mental health wellness examination may also be provided by a PCP during your annual routine physical exam. |
| Recovery Coaches and Peer Specialists | No charge | No Prior Authorization required. |
| Chemotherapy and radiation oncology services | No charge | Certain services require Prior Authorization. |
| Chiropractic care | \$40 Copayment per visit | No Prior Authorization required. |
| Cleft palate and cleft lip care | No charge. Additional Cost Sharing may apply based on place of service | Covered for Members under the age of 18. Includes medical, dental, oral, and facial surgery, follow-up, and related services. See <i>Outpatient surgery services; Dental care; Medical care Outpatient visits; Speech, hearing, and language therapy; and Nutritional counseling</i> for related Cost Share. |
| Clinical trials | Based on place of service | No Prior Authorization required. Includes services that are Medically Necessary for the treatment of your condition and the reasonable cost of investigational drug or device approved for use in the trial but not otherwise paid for by its manufacturer, distributor, or Provider. |
| COVID-19 Testing/Treatment | No charge | |
| Dental care, accidental | Based on place of service | No Prior Authorization required. See <i>Emergency Room care, Outpatient surgery services, or Urgent care</i> for related Cost Share. Coverage for services related to teeth is limited to the Emergency treatment of accidental injury to sound, natural and permanent teeth when caused by a source external to the mouth. |
| Dental care, non-Emergency (Pediatric only, Delta Dental) | | |
| Members are eligible for services until the last Day of the month in which they turn 19 years old. Please call Delta Dental at 800-872-0500 for more information and for Prior Authorization requirements. | | |
| Type I: Preventive & Diagnostic | No charge | Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age. |
| Type II: Basic Covered Services | 25% Coinsurance | |
| Type III: Major restorative services | 50% Coinsurance | |
| Type IV: Orthodontia | 50% Coinsurance | Medically Necessary orthodontia requires Prior Authorization. |
| Diabetes education and treatment | Cost Sharing varies based on type and place of service. | Prior Authorization required for certain services. No charge for the NationsNutrition™ program. See <i>Durable Medical Equipment; Prescription drugs and supplies; Medical care Outpatient visits; and Nutritional Counseling</i> for related Cost Share. |
| Diagnostic services (Outpatient laboratory services, imaging, radiology, and other diagnostic testing) | | |
| Laboratory services | No charge | Includes blood tests, urinalysis, and throat cultures to maintain health and to test, diagnose, and treat disease. Genetic testing requires Prior Authorization. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|--|--|
| X-rays | No charge | No Prior Authorization required. |
| Advanced imaging (MRI, CT, PET scans) | \$150 Copayment | Prior Authorization required. |
| Sleep studies | Related <i>Medical care</i> <i>Outpatient visit</i> or <i>Inpatient medical care</i> Cost Sharing may be required | Prior Authorization required. |
| Other diagnostic testing | No charge | Certain services require Prior Authorization . |
| Dialysis services | No charge | No Prior Authorization required. |
| Disease Management Programs | No charge | For Members with asthma, diabetes, chronic obstructive pulmonary disease (COPD) or congestive heart failure. If you have any of these conditions, please contact us at 888-257-1985 to discuss our disease management programs. |
| Durable Medical Equipment (DME) | | |
| Covered medical equipment rented or purchased for home use | 20% Coinsurance | Prior Authorization is required for certain services, including prosthetic orthotics. Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs. |
| Hearing aids | 20% Coinsurance | Covered for Members 21 and younger. This includes the cost of one hearing aid per hearing-impaired ear up to \$2,000 per ear every 36 months. This includes both the amount Tufts Health Direct pays and the applicable Member Cost Share as listed in this document. Related services and supplies do not count toward the \$2,000 limit. |
| Wigs | 20% Coinsurance | Limit of 1 wig per Plan Year. |
| Early Intervention services | No charge | No Prior Authorization required. Covered for Members up to age 3; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention Specialist. |
| Emergency Room care | \$150 Copayment per visit | No Prior Authorization required. Emergency Room Cost Share waived if held for <i>Observation services</i> , sent for <i>Outpatient Surgery services</i> or admitted for <i>Inpatient medical or surgical care</i> . |
| Fitness center reimbursement | Covered for 3 months | After being an enrolled Member for four consecutive months and participating with a standard fitness center in the current Plan Year, we cover up to \$200 of membership fees incurred in the Plan Year. See the <i>Tufts Health Direct Member Handbook</i> for more information on limitations. Must complete a Fitness Center Reimbursement Form . |
| Gender affirming services | Cost Sharing varies based on type and place of service. | Prior Authorization required. Medically necessary services may include Inpatient medical and surgical care, Outpatient Surgery, Diagnostic services, Speech therapy, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies among other services. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|---|---|--|
| Habilitative and rehabilitative services | \$40 Copayment per visit | Includes cardiac rehabilitation; physical therapy; Occupational Therapy; and speech, hearing, and language therapy services. See below for specific details. |
| <u>Limits:</u> | | |
| Cardiac rehabilitation | | |
| Physical and Occupational Therapy | | Prior Authorization required after initial evaluation and 11 visits. Maximum of 60 visits total Physical and Occupational Therapy per Member per Plan Year. Limits do not apply for Autism Spectrum Disorder services. |
| Speech, hearing, and language therapy | | Prior Authorization required after visit 30. No visit limits. |
| Home health care | No charge | Prior Authorization is required for all home care services and disciplines. |
| Hospice services | No charge | Prior Authorization required. |
| Infertility services & treatment | Cost Sharing varies based on type and place of service. | Prior Authorization required. Medically necessary services may include <i>Inpatient medical and surgical care, Outpatient Surgery, Diagnostic services, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies</i> among other services. |
| Inpatient medical and surgical care | | |
| | | No Prior Authorization required for Inpatient admissions from the Emergency room. Planned admissions require Prior Authorization 5 business days before admission. |
| Facility Fee | \$500 Copayment per stay | Includes room and board and services supplied by the facility during the inpatient stay, including preadmission testing, anesthesia, diagnostic services, and medication and supplies |
| Professional Fee | No charge | Includes physician and other covered professional Provider services |
| Long Term Acute Care Hospital or Acute Rehabilitation Hospital | \$500 Copayment per stay | Maximum of 60 Days total per Member per Plan Year |
| Maternity services and Well Newborn care | | |
| Childbirth classes | Covered for cost of childbirth education course | Complete a Member Reimbursement Medical Claim Form and submit by mail with proof of payment. |
| Routine prenatal and postpartum care | No charge | All Outpatient routine prenatal and postpartum office visits are covered as well as breastfeeding services and supports. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|---|--|--|
| Non-routine prenatal care | Cost Sharing varies based on type and place of service. | Any Outpatient maternity services not considered routine or those related to complications or risks with a pregnancy, may be subject to Cost Sharing. Some examples of services not considered routine include, but are not limited to, amniocentesis, fetal stress testing, and OB ultrasounds. |
| Hospital and delivery services | See <i>Inpatient medical and surgical care</i> | Well newborn care is included as part of covered maternity admission. |
| Breast pumps | No charge if billed per Preventive Services Policy; Otherwise, 20% Coinsurance | No Prior Authorization required. One breast pump per birth including related parts and supplies. Covered for the purchase of a manual or electric pump or the rental of a hospital-grade pump when deemed appropriate by the ordering Provider. Pump must be obtained from contracting DME Provider. |
| Medical drugs | No charge | Prior Authorization required for certain drugs. Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit. |
| Medical care Outpatient visits | | |
| Medical Care includes services to diagnose, treat, and maintain a health condition. Medical care services are covered by Providers in the Tufts Health Direct Network. You are not covered for services from Providers outside of our Network and will be responsible for payment in full. Contact Member Services at 888-257-1985 or visit tuftshealthplan.com/memberlogin to find an In-Network Provider. See <i>Preventive health services</i> for information about routine health care. | | |
| <u>Office and community health center visits</u> | | |
| Primary Care Provider (PCP) | \$20 Copayment per visit | No Prior Authorization required. |
| Specialist | \$40 Copayment per visit | Prior Authorization required for certain specialist visits. |
| MinuteClinic | \$20 Copayment per visit | No Prior Authorization required. A walk-in clinic accessible at select CVS locations in our Service Area. |
| Nutritional counseling | See <i>Medical care Outpatient visits</i> | Prior Authorization required. |
| Observation services | \$500 Copayment per visit | No Prior Authorization required. Hospital services to treat and/or evaluate a condition that should result in either a discharge within 48 hours or a verified diagnosis and concurrent treatment plan. |
| Organ or bone marrow transplant | See <i>Inpatient medical and surgical care</i> | Prior Authorization required. |
| Outpatient surgery services | | |
| <u>Outpatient Day Surgery</u> | | |
| Outpatient Hospital or Ambulatory Surgery Center Facility Fee | \$250 Copayment per visit | Prior Authorization required for certain services. |
| Professional fee | No charge | Includes physician and other covered professional Provider services |
| <u>Office and community health center surgical services</u> | See <i>Medical care Outpatient visits</i> | |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|--|--|
| Pain management | Cost Sharing varies based on type and place of service. | Prior Authorization is not required to begin care. Cost Sharing based on type of service, for example , Nutritional counseling, Physical therapy or Chiropractic care |
| Podiatry care | See <i>Medical care Outpatient visits</i> | No Prior Authorization required. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot. |
| Prescription drugs and supplies | | See the Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost Share. Refer to Formulary for a complete list. |
| Retail pharmacy (up to 30-Day supply) | | |
| Tier 1 | \$10 Copayment | Primarily generic drugs |
| Tier 2 | \$25 Copayment | Includes some non-preferred generics and preferred brands |
| Tier 3 | \$50 Copayment | Includes high-cost generics, non-preferred brands, and Specialty drugs |
| Mail order pharmacy (up to 90-Day supply) | | |
| Tier 1 | \$20 Copayment | Primarily generic drugs |
| Tier 2 | \$50 Copayment | Includes some non-preferred generics and preferred brands |
| Tier 3 | \$150 Copayment | Includes high-cost generics, non-preferred brands, and Specialty drugs |
| Preventive health services | | |
| Preventive Health services are routine health care that include screenings, check-ups, and counseling to prevent illnesses, disease, or other health problems. Certain Preventive health services may require Prior Authorization. Work with your PCP to use the <i>Preventive Services</i> policy in the <i>Patient Protection and Affordable Care Act</i> chapter of our Provider Manual at https://point32health.org/provider/provider-manuals/tufts-health-public-plans-provider-manual/ to review specific requirements. | | |
| Routine pediatric care | No charge | Includes but is not limited to routine annual physical exams; screenings, immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning |
| Routine adult care | No charge | Includes but is not limited to routine annual physical exams; screenings; immunizations; routine lab tests and x-rays; routine mammograms; and routine colonoscopies |
| Routine gynecological (GYN) care | No charge | Includes but is not limited to routine exams and cervical cancer screenings (Pap smear tests) |
| Family planning | No charge | |
| Smoking Cessation Counseling Services | No charge | |
| Reconstructive surgery and procedures | See <i>Outpatient surgery or Inpatient medical and surgical care</i> | Certain services may require Prior Authorization. |
| Skilled Nursing Facility | \$500 Copayment per stay | Maximum of 100 Days total per Member per Plan Year |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---|--|
| Telehealth | See <i>Medical care Outpatient visits</i> | Please ask your Providers' office for information on Telehealth availability and access. |
| Urgent care | \$40 Copayment per visit | No Prior Authorization required. In our Service Area, you must visit a UCC that is in our Network to be covered for services. Outside of our Service Area, free-standing Urgent Care Centers (UCCs) are covered at Out-of-Network Provider sites, including Hospitals and clinics. |
| Vision care | | |
| You must receive routine eye examinations from a Provider in the EyeMed Vision Care Select network in order to obtain coverage for these services. Call EyeMed at 866-504-5908 for the names of EyeMed Select Providers. | | |
| Routine care | \$40 Copayment per visit | Coverage for routine eye exams once every 12 months; |
| Eyeglasses for children (under 19 years of age) | 20% Coinsurance | Eyeglasses covered once every 12 months; \$150 allowance + 20% off expense beyond allowance. |
| Medical eye care | See <i>Medical care Outpatient visits</i> | |
| Weight loss programs | No charge for 3 months of membership fees for a qualified program | 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 Plan Year. Must complete a Weight Loss Program Reimbursement Form . See the Tufts Health Direct Member Handbook for more information on limitations. |

Services not covered

See the section "Services not covered" in the *Tufts Health Direct Member Handbook* for the list of services not covered.

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Schedule of Benefits

This Schedule of Benefits gives you information about your Tufts Health Direct Covered Services and costs you may have to pay. Make sure you review the services you are eligible for under the Schedule of Benefits for your specific Plan. To see which Tufts Health Direct Plan you have, check your Tufts Health Plan Member ID Card.

If you want more information about your benefits and capitalized terms, see your Tufts Health Direct Member Handbook tuftshealthplan.com/documents/members/handbooks/direct-member-handbook-2026.

You must go to Providers who are part of the Tufts Health Direct Provider Network to get services. Out-of-Network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal.

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 (TTY: 711, for people with partial or total hearing loss).

You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document. Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The amounts of the Annual Deductible and Annual Out-of-pocket Maximum which apply to you and the enrolled Members of your family each Plan Year are:

| ANNUAL DEDUCTIBLE | AMOUNT | NOTES |
|-------------------|---------|---|
| Individual | \$1,000 | The Individual Deductible applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Deductible even if other Members on the family Plan have not. |
| Family | \$2,000 | Once two or more Members on a family Plan meet the Family Annual Deductible, the entire family is considered to have met the Deductible for the Plan Year. |

| ANNUAL OUT-OF-POCKET MAXIMUM | AMOUNT | NOTES |
|------------------------------|----------|---|
| Individual | \$7,000 | The Individual Out-of-pocket Maximum applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Out-of-pocket Maximum even if other Members on the family Plan have not. |
| Family | \$14,000 | Once two or more Members on a family Plan meet the Family Annual Out-of-pocket Maximum amount, the entire family is considered to have met the Out-of-pocket Maximum for the Plan Year. |

Notice for American Indian and Alaskan Native (AI/AN) Members: All American Indian/Alaskan Native Members, regardless of income, can enroll in a limited Cost Sharing Plan at any metal level, which means no Copayments, Deductibles, or Coinsurance when receiving care from Indian health care Providers. The Massachusetts Health Connector determines your eligibility to enroll in this Plan variation as part of your application process.

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|---|---|---|
| Abortion services | No charge | No Prior Authorization required. |
| Allergy services | | |
| Allergy testing | \$40 Copayment per visit | No Prior Authorization required. Covered for up to 200 allergy tests per Plan Year. |
| Allergy treatments (injections) | \$10 Copayment per injection | Note: Allergy immunotherapy covered as part of the pharmacy prescription benefit may require Prior Authorization and have separate pharmacy Cost Sharing responsibility. |
| Outpatient medical office visits | See <i>Medical care Outpatient visits</i> | |
| Ambulance services | No charge | No Prior Authorization required for Emergency transportation. Non-emergency basic or advanced life support, ground ambulance transportation may be covered with Prior Authorization. Services to and from medical appointments, transport by taxi, public transportation, and the use of chair cars are not covered |
| Behavioral Health services - Mental Health & Substance Use Disorder | | |
| <u>Inpatient services</u> | | Behavioral Health Urgent and Emergent levels of care do not require Prior Authorization. |
| Facility Fee | \$300 Copayment per stay after Deductible | Includes room and board and services supplied by the facility during the inpatient stay. |
| Professional fee | No charge after Deductible | Includes physician and other covered professional Provider services |
| Intensive community based acute treatment (ICBAT) for Children and adolescents | No charge | No Prior Authorization required for admission. |
| <u>Outpatient services</u> | | |
| Individual therapy/Counseling | \$20 Copayment per visit | No Prior Authorization required. No visit limits. |
| Applied Behavioral Analysis (ABA) | \$20 Copayment per visit | Prior Authorization required. Includes assessments, evaluations, testing, and treatment; covered in home, Outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst for treatment of Autism Spectrum Disorder or Down Syndrome |
| Intermediate care, including Behavioral Health (mental health and/or substance use) services for children and adolescents | No charge | Prior Authorization is required for certain Behavioral Health (mental health and/or substance use) services for children and adolescents. Please see the "Covered Services" section of the Tufts Health Direct Member Handbook for more information about these services. |
| Medication-Assisted Treatment services | No charge | Certain medication may require Prior Authorization. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---|---|
| Mental Health Wellness Exam | No charge | Annual mental health wellness examination performed by a Licensed Mental Health Professional. Please Note: Your annual mental health wellness examination may also be provided by a PCP during your annual routine physical exam. |
| Recovery Coaches and Peer Specialists | No charge | No Prior Authorization required. |
| Chemotherapy and radiation oncology services | No charge after Deductible | Certain services require Prior Authorization. |
| Chiropractic care | \$40 Copayment per visit | No Prior Authorization required. |
| Cleft palate and cleft lip care | No charge after Deductible. Additional Cost Sharing may apply based on place of service | Covered for Members under the age of 18. Includes medical, dental, oral, and facial surgery, follow-up, and related services. See <i>Outpatient surgery services; Dental care; Medical care Outpatient visits; Speech, hearing, and language therapy; and Nutritional counseling</i> for related Cost Share. |
| Clinical trials | Based on place of service | No Prior Authorization required. Includes services that are Medically Necessary for the treatment of your condition and the reasonable cost of investigational drug or device approved for use in the trial but not otherwise paid for by its manufacturer, distributor, or Provider. |
| COVID-19 Testing/Treatment | No charge | |
| Dental care, accidental | Based on place of service | No Prior Authorization required. See <i>Emergency Room care, Outpatient surgery services, or Urgent care</i> for related Cost Share. Coverage for services related to teeth is limited to the Emergency treatment of accidental injury to sound, natural and permanent teeth when caused by a source external to the mouth. |
| Dental care, non-Emergency (Pediatric only, Delta Dental) | | |
| Members are eligible for services until the last Day of the month in which they turn 19 years old. Please call Delta Dental at 800-872-0500 for more information and for Prior Authorization requirements. | | |
| Type I: Preventive & Diagnostic | No charge | Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age. |
| Type II: Basic Covered Services | 25% Coinsurance | |
| Type III: Major restorative services | 50% Coinsurance | |
| Type IV: Orthodontia | 50% Coinsurance | Medically Necessary orthodontia requires Prior Authorization. |
| Diabetes education and treatment | Cost Sharing varies based on type and place of service. | Prior Authorization required for certain services. No charge for the NationsNutrition™ program. See <i>Durable Medical Equipment; Prescription drugs and supplies; Medical care Outpatient visits; and Nutritional Counseling</i> for related Cost Share. |
| Diagnostic services (Outpatient laboratory services, imaging, radiology, and other diagnostic testing) | | |
| Laboratory services | \$25 Copayment after Deductible | Includes blood tests, urinalysis, and throat cultures to maintain health and to test, diagnose, and treat disease. Genetic testing requires Prior Authorization. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|--|--|
| X-rays | \$35 Copayment after Deductible | No Prior Authorization required. |
| Advanced imaging (MRI, CT, PET scans) | \$150 Copayment after Deductible | Prior Authorization required. |
| Sleep studies | Related <i>Medical care</i> <i>Outpatient visit</i> or <i>Inpatient medical care</i> Cost Sharing may be required | Prior Authorization required. |
| Other diagnostic testing | \$25 Copayment after Deductible | Certain services require Prior Authorization . |
| Dialysis services | No charge after Deductible | No Prior Authorization required. |
| Disease Management Programs | No charge | For Members with asthma, diabetes, chronic obstructive pulmonary disease (COPD) or congestive heart failure. If you have any of these conditions, please contact us at 888-257-1985 to discuss our disease management programs. |
| Durable Medical Equipment (DME) | | |
| Covered medical equipment rented or purchased for home use | 20% Coinsurance after Deductible | Prior Authorization is required for certain services, including prosthetic orthotics. Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs. |
| Hearing aids | 20% Coinsurance after Deductible | Covered for Members 21 and younger. This includes the cost of one hearing aid per hearing-impaired ear up to \$2,000 per ear every 36 months. This includes both the amount Tufts Health Direct pays and the applicable Member Cost Share as listed in this document. Related services and supplies do not count toward the \$2,000 limit. |
| Wigs | 20% Coinsurance after Deductible | Limit of 1 wig per Plan Year. |
| Early Intervention services | No charge | No Prior Authorization required. Covered for Members up to age 3; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention Specialist. |
| Emergency Room care | \$250 Copayment per visit | No Prior Authorization required. Emergency Room Cost Share waived if held for <i>Observation services</i> , sent for <i>Outpatient Surgery services</i> or admitted for <i>Inpatient medical or surgical care</i> . |
| Fitness center reimbursement | Covered for 3 months | After being an enrolled Member for four consecutive months and participating with a standard fitness center in the current Plan Year, we cover up to \$200 of membership fees incurred in the Plan Year. See the <i>Tufts Health Direct Member Handbook</i> for more information on limitations. Must complete a Fitness Center Reimbursement Form . |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|---|---|---|
| Gender affirming services | Cost Sharing varies based on type and place of service. | Prior Authorization required. Medically necessary services may include Inpatient medical and surgical care, Outpatient Surgery, Diagnostic services, Speech therapy, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies among other services. |
| Habilitative and rehabilitative services | \$40 Copayment per visit | Includes cardiac rehabilitation; physical therapy; Occupational Therapy; and speech, hearing, and language therapy services. See below for specific details. |
| <u>Limits:</u> | | |
| Cardiac rehabilitation | | |
| Physical and Occupational Therapy | | Prior Authorization required after initial evaluation and 11 visits. Maximum of 60 visits total Physical and Occupational Therapy per Member per Plan Year. Limits do not apply for Autism Spectrum Disorder services. |
| Speech, hearing, and language therapy | | Prior Authorization required after visit 30. No visit limits. |
| Home health care | No charge after Deductible | Prior Authorization is required for all home care services and disciplines. |
| Hospice services | No charge after Deductible | Prior Authorization required. |
| Infertility services & treatment | Cost Sharing varies based on type and place of service. | Prior Authorization required. Medically necessary services may include <i>Inpatient medical and surgical care, Outpatient Surgery, Diagnostic services, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies</i> among other services. |
| Inpatient medical and surgical care | | |
| | | No Prior Authorization required for Inpatient admissions from the Emergency room. Planned admissions require Prior Authorization 5 business days before admission. |
| Facility Fee | \$300 Copayment per stay after Deductible | Includes room and board and services supplied by the facility during the inpatient stay, including preadmission testing, anesthesia, diagnostic services, and medication and supplies |
| Professional Fee | No charge after Deductible | Includes physician and other covered professional Provider services |
| Long Term Acute Care Hospital or Acute Rehabilitation Hospital | \$300 Copayment per stay after Deductible | Maximum of 60 Days total per Member per Plan Year |
| Maternity services and Well Newborn care | | |
| Childbirth classes | Covered for cost of childbirth education course | Complete a Member Reimbursement Medical Claim Form and submit by mail with proof of payment. |
| Routine prenatal and postpartum care | No charge | All Outpatient routine prenatal and postpartum office visits are covered as well as breastfeeding services and supports. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---|--|
| Non-routine prenatal care | Cost Sharing varies based on type and place of service. | Any Outpatient maternity services not considered routine or those related to complications or risks with a pregnancy, may be subject to Cost Sharing. Some examples of services not considered routine include, but are not limited to, amniocentesis, fetal stress testing, and OB ultrasounds. |
| Hospital and delivery services | See <i>Inpatient medical and surgical care</i> | Well newborn care is included as part of covered maternity admission. |
| Breast pumps | No charge if billed per Preventive Services Policy; Otherwise, 20% Coinsurance after Deductible | No Prior Authorization required. One breast pump per birth including related parts and supplies. Covered for the purchase of a manual or electric pump or the rental of a hospital-grade pump when deemed appropriate by the ordering Provider. Pump must be obtained from contracting DME Provider. |
| Medical drugs | No charge after Deductible | Prior Authorization required for certain drugs. Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit. |
| Medical care Outpatient visits | | |
| Medical Care includes services to diagnose, treat, and maintain a health condition. Medical care services are covered by Providers in the Tufts Health Direct Network. You are not covered for services from Providers outside of our Network and will be responsible for payment in full. Contact Member Services at 888-257-1985 or visit tuftshealthplan.com/memberlogin to find an In-Network Provider. See <i>Preventive health services</i> for information about routine health care. | | |
| <u>Office and community health center visits</u> | | |
| Primary Care Provider (PCP) | \$20 Copayment per visit | No Prior Authorization required. |
| Specialist | \$40 Copayment per visit | Prior Authorization required for certain specialist visits. |
| MinuteClinic | \$20 Copayment per visit | No Prior Authorization required. A walk-in clinic accessible at select CVS locations in our Service Area. |
| Nutritional counseling | See <i>Medical care Outpatient visits</i> | Prior Authorization required. |
| Observation services | \$300 Copayment after Deductible | No Prior Authorization required. Hospital services to treat and/or evaluate a condition that should result in either a discharge within 48 hours or a verified diagnosis and concurrent treatment plan. |
| Organ or bone marrow transplant | See <i>Inpatient medical and surgical care</i> | Prior Authorization required. |
| Outpatient surgery services | | |
| <u>Outpatient Day Surgery</u> | | |
| Outpatient Hospital or Ambulatory Surgery Center Facility Fee | \$150 Copayment after Deductible | Prior Authorization required for certain services. |
| Professional fee | No charge after Deductible | Includes physician and other covered professional Provider services |
| <u>Office and community health center surgical services</u> | See <i>Medical care Outpatient visits</i> | |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|--|--|
| Pain management | Cost Sharing varies based on type and place of service. | Prior Authorization is not required to begin care. Cost Sharing based on type of service, for example , Nutritional counseling, Physical therapy or Chiropractic care |
| Podiatry care | See <i>Medical care Outpatient visits</i> | No Prior Authorization required. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot. |
| Prescription drugs and supplies | | See the Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost Share. Refer to Formulary for a complete list. |
| Retail pharmacy (up to 30-Day supply) | | |
| Tier 1 | \$25 Copayment | Primarily generic drugs |
| Tier 2 | \$45 Copayment | Includes some non-preferred generics and preferred brands |
| Tier 3 | \$75 Copayment after Deductible | Includes high-cost generics, non-preferred brands, and Specialty drugs |
| Mail order pharmacy (up to 90-Day supply) | | |
| Tier 1 | \$50 Copayment | Primarily generic drugs |
| Tier 2 | \$90 Copayment | Includes some non-preferred generics and preferred brands |
| Tier 3 | \$225 Copayment after Deductible | Includes high-cost generics, non-preferred brands, and Specialty drugs |
| Preventive health services | | |
| Preventive Health services are routine health care that include screenings, check-ups, and counseling to prevent illnesses, disease, or other health problems. Certain Preventive health services may require Prior Authorization. Work with your PCP to use the <i>Preventive Services</i> policy in the <i>Patient Protection and Affordable Care Act</i> chapter of our Provider Manual at https://point32health.org/provider/provider-manuals/tufts-health-public-plans-provider-manual/ to review specific requirements. | | |
| Routine pediatric care | No charge | Includes but is not limited to routine annual physical exams; screenings, immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning |
| Routine adult care | No charge | Includes but is not limited to routine annual physical exams; screenings; immunizations; routine lab tests and x-rays; routine mammograms; and routine colonoscopies |
| Routine gynecological (GYN) care | No charge | Includes but is not limited to routine exams and cervical cancer screenings (Pap smear tests) |
| Family planning | No charge | |
| Smoking Cessation Counseling Services | No charge | |
| Reconstructive surgery and procedures | See <i>Outpatient surgery or Inpatient medical and surgical care</i> | Certain services may require Prior Authorization. |
| Skilled Nursing Facility | \$300 Copayment per stay after Deductible | Maximum of 100 Days total per Member per Plan Year |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---|--|
| Telehealth | See <i>Medical care Outpatient visits</i> | Please ask your Providers' office for information on Telehealth availability and access. |
| Urgent care | \$40 Copayment per visit | No Prior Authorization required. In our Service Area, you must visit a UCC that is in our Network to be covered for services. Outside of our Service Area, free-standing Urgent Care Centers (UCCs) are covered at Out-of-Network Provider sites, including Hospitals and clinics. |
| Vision care | | |
| You must receive routine eye examinations from a Provider in the EyeMed Vision Care Select network in order to obtain coverage for these services. Call EyeMed at 866-504-5908 for the names of EyeMed Select Providers. | | |
| Routine care | \$40 Copayment per visit | Coverage for routine eye exams once every 12 months; |
| Eyeglasses for children (under 19 years of age) | 20% Coinsurance after deductible | Eyeglasses covered once every 12 months; \$150 allowance + 20% off expense beyond allowance. |
| Medical eye care | See <i>Medical care Outpatient visits</i> | |
| Weight loss programs | No charge for 3 months of membership fees for a qualified program | 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 Plan Year. Must complete a Weight Loss Program Reimbursement Form . See the Tufts Health Direct Member Handbook for more information on limitations. |

Services not covered

See the section "Services not covered" in the *Tufts Health Direct Member Handbook* for the list of services not covered.

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Schedule of Benefits

This Schedule of Benefits gives you information about your Tufts Health Direct Covered Services and costs you may have to pay. Make sure you review the services you are eligible for under the Schedule of Benefits for your specific Plan. To see which Tufts Health Direct Plan you have, check your Tufts Health Plan Member ID Card.

If you want more information about your benefits and capitalized terms, see your Tufts Health Direct Member Handbook tuftshealthplan.com/documents/members/handbooks/direct-member-handbook-2026.

You must go to Providers who are part of the Tufts Health Direct Provider Network to get services. Out-of-Network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal.

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 (TTY: 711, for people with partial or total hearing loss).

You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document. Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The amounts of the Annual Deductible and Annual Out-of-pocket Maximum which apply to you and the enrolled Members of your family each Plan Year are:

| ANNUAL DEDUCTIBLE | AMOUNT | NOTES |
|-------------------|-------------------------------------|---|
| Individual | Medical: \$1,600 Pharmacy: \$180 | The Individual Deductible applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Deductible even if other Members on the family Plan have not. |
| Family | Medical: \$3,200 Pharmacy: \$360 | Once two or more Members on a family Plan meet the Family Annual Deductible, the entire family is considered to have met the Deductible for the Plan Year. |

| ANNUAL OUT-OF-POCKET MAXIMUM | AMOUNT | NOTES |
|------------------------------|----------|---|
| Individual | \$5,900 | The Individual Out-of-pocket Maximum applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Out-of-pocket Maximum even if other Members on the family Plan have not. |
| Family | \$11,800 | Once two or more Members on a family Plan meet the Family Annual Out-of-pocket Maximum amount, the entire family is considered to have met the Out-of-pocket Maximum for the Plan Year. |

Notice for American Indian and Alaskan Native (AI/AN) Members: All American Indian/Alaskan Native Members, regardless of income, can enroll in a limited Cost Sharing Plan at any metal level, which means no Copayments, Deductibles, or Coinsurance when receiving care from Indian health care Providers. The Massachusetts Health Connector determines your eligibility to enroll in this Plan variation as part of your application process.

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|---|---|---|
| Abortion services | No charge | No Prior Authorization required. |
| Allergy services | | |
| Allergy testing | \$55 Copayment per visit | No Prior Authorization required. Covered for up to 200 allergy tests per Plan Year. |
| Allergy treatments (injections) | \$10 Copayment per injection after Deductible | Note: Allergy immunotherapy covered as part of the pharmacy prescription benefit may require Prior Authorization and have separate pharmacy Cost Sharing responsibility. |
| Outpatient medical office visits | See <i>Medical care Outpatient visits</i> | |
| Ambulance services | No charge after Deductible | No Prior Authorization required for Emergency transportation. Non-emergency basic or advanced life support, ground ambulance transportation may be covered with Prior Authorization. Services to and from medical appointments, transport by taxi, public transportation, and the use of chair cars are not covered |
| Behavioral Health services - Mental Health & Substance Use Disorder | | |
| <u>Inpatient services</u> | | Behavioral Health Urgent and Emergent levels of care do not require Prior Authorization. |
| Facility Fee | \$750 Copayment per stay after Deductible | Includes room and board and services supplied by the facility during the inpatient stay. |
| Professional fee | No charge after Deductible | Includes physician and other covered professional Provider services |
| Intensive community based acute treatment (ICBAT) for Children and adolescents | No charge | No Prior Authorization required for admission. |
| <u>Outpatient services</u> | | |
| Individual therapy/Counseling | \$35 Copayment per visit | No Prior Authorization required. No visit limits. |
| Applied Behavioral Analysis (ABA) | \$35 Copayment per visit | Prior Authorization required. Includes assessments, evaluations, testing, and treatment; covered in home, Outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst for treatment of Autism Spectrum Disorder or Down Syndrome |
| Intermediate care, including Behavioral Health (mental health and/or substance use) services for children and adolescents | No charge | Prior Authorization is required for certain Behavioral Health (mental health and/or substance use) services for children and adolescents. Please see the "Covered Services" section of the Tufts Health Direct Member Handbook for more information about these services. |
| Medication-Assisted Treatment services | No charge | Certain medication may require Prior Authorization. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---|---|
| Mental Health Wellness Exam | No charge | Annual mental health wellness examination performed by a Licensed Mental Health Professional. Please Note: Your annual mental health wellness examination may also be provided by a PCP during your annual routine physical exam. |
| Recovery Coaches and Peer Specialists | No charge | No Prior Authorization required. |
| Chemotherapy and radiation oncology services | No charge after Deductible | Certain services require Prior Authorization. |
| Chiropractic care | \$55 Copayment per visit | No Prior Authorization required. |
| Cleft palate and cleft lip care | No charge after Deductible. Additional Cost Sharing may apply based on place of service | Covered for Members under the age of 18. Includes medical, dental, oral, and facial surgery, follow-up, and related services. See <i>Outpatient surgery services; Dental care; Medical care Outpatient visits; Speech, hearing, and language therapy; and Nutritional counseling</i> for related Cost Share. |
| Clinical trials | Based on place of service | No Prior Authorization required. Includes services that are Medically Necessary for the treatment of your condition and the reasonable cost of investigational drug or device approved for use in the trial but not otherwise paid for by its manufacturer, distributor, or Provider. |
| COVID-19 Testing/Treatment | No charge | |
| Dental care, accidental | Based on place of service | No Prior Authorization required. See <i>Emergency Room care, Outpatient surgery services, or Urgent care</i> for related Cost Share. Coverage for services related to teeth is limited to the Emergency treatment of accidental injury to sound, natural and permanent teeth when caused by a source external to the mouth. |
| Dental care, non-Emergency (Pediatric only, Delta Dental) | | |
| Members are eligible for services until the last Day of the month in which they turn 19 years old. Please call Delta Dental at 800-872-0500 for more information and for Prior Authorization requirements. | | |
| Type I: Preventive & Diagnostic | No charge | Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age. |
| Type II: Basic Covered Services | 25% Coinsurance after Deductible | |
| Type III: Major restorative services | 50% Coinsurance after Deductible | |
| Type IV: Orthodontia | 50% Coinsurance after Deductible | Medically Necessary orthodontia requires Prior Authorization. |
| Diabetes education and treatment | Cost Sharing varies based on type and place of service. | Prior Authorization required for certain services. No charge for the NationsNutrition™ program. See <i>Durable Medical Equipment; Prescription drugs and supplies; Medical care Outpatient visits; and Nutritional Counseling</i> for related Cost Share. |
| Diagnostic services (Outpatient laboratory services, imaging, radiology, and other diagnostic testing) | | |
| Laboratory services | \$50 Copayment after Deductible | Includes blood tests, urinalysis, and throat cultures to maintain health and to test, diagnose, and treat disease. Genetic testing requires Prior Authorization. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|--|--|
| X-rays | \$75 Copayment after Deductible | No Prior Authorization required. |
| Advanced imaging (MRI, CT, PET scans) | \$300 Copayment after Deductible | Prior Authorization required. |
| Sleep studies | Related <i>Medical care</i> <i>Outpatient visit</i> or <i>Inpatient medical care</i> Cost Sharing may be required | Prior Authorization required. |
| Other diagnostic testing | \$50 Copayment after Deductible | Certain services require Prior Authorization . |
| Dialysis services | No charge after Deductible | No Prior Authorization required. |
| Disease Management Programs | No charge | For Members with asthma, diabetes, chronic obstructive pulmonary disease (COPD) or congestive heart failure. If you have any of these conditions, please contact us at 888-257-1985 to discuss our disease management programs. |
| Durable Medical Equipment (DME) | | |
| Covered medical equipment rented or purchased for home use | 20% Coinsurance after Deductible | Prior Authorization is required for certain services, including prosthetic orthotics. Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs. |
| Hearing aids | 20% Coinsurance after Deductible | Covered for Members 21 and younger. This includes the cost of one hearing aid per hearing-impaired ear up to \$2,000 per ear every 36 months. This includes both the amount Tufts Health Direct pays and the applicable Member Cost Share as listed in this document. Related services and supplies do not count toward the \$2,000 limit. |
| Wigs | 20% Coinsurance after Deductible | Limit of 1 wig per Plan Year. |
| Early Intervention services | No charge | No Prior Authorization required. Covered for Members up to age 3; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention Specialist. |
| Emergency Room care | \$400 Copayment after Deductible | No Prior Authorization required. Emergency Room Cost Share waived if held for <i>Observation services</i> , sent for <i>Outpatient Surgery services</i> or admitted for <i>Inpatient medical or surgical care</i> . |
| Fitness center reimbursement | Covered for 3 months | After being an enrolled Member for four consecutive months and participating with a standard fitness center in the current Plan Year, we cover up to \$200 of membership fees incurred in the Plan Year. See the <i>Tufts Health Direct Member Handbook</i> for more information on limitations. Must complete a Fitness Center Reimbursement Form . |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|---|---|---|
| Gender affirming services | Cost Sharing varies based on type and place of service. | Prior Authorization required. Medically necessary services may include Inpatient medical and surgical care, Outpatient Surgery, Diagnostic services, Speech therapy, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies among other services. |
| Habilitative and rehabilitative services | \$55 Copayment per visit | Includes cardiac rehabilitation; physical therapy; Occupational Therapy; and speech, hearing, and language therapy services. See below for specific details. |
| <u>Limits:</u> | | |
| Cardiac rehabilitation | | |
| Physical and Occupational Therapy | | Prior Authorization required after initial evaluation and 11 visits. Maximum of 60 visits total Physical and Occupational Therapy per Member per Plan Year. Limits do not apply for Autism Spectrum Disorder services. |
| Speech, hearing, and language therapy | | Prior Authorization required after visit 30. No visit limits. |
| Home health care | No charge after Deductible | Prior Authorization is required for all home care services and disciplines. |
| Hospice services | No charge after Deductible | Prior Authorization required. |
| Infertility services & treatment | Cost Sharing varies based on type and place of service. | Prior Authorization required. Medically necessary services may include <i>Inpatient medical and surgical care, Outpatient Surgery, Diagnostic services, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies</i> among other services. |
| Inpatient medical and surgical care | | |
| | | No Prior Authorization required for Inpatient admissions from the Emergency room. Planned admissions require Prior Authorization 5 business days before admission. |
| Facility Fee | \$750 Copayment per stay after Deductible | Includes room and board and services supplied by the facility during the inpatient stay, including preadmission testing, anesthesia, diagnostic services, and medication and supplies |
| Professional Fee | No charge after Deductible | Includes physician and other covered professional Provider services |
| Long Term Acute Care Hospital or Acute Rehabilitation Hospital | \$750 Copayment per stay after Deductible | Maximum of 60 Days total per Member per Plan Year |
| Maternity services and Well Newborn care | | |
| Childbirth classes | Covered for cost of childbirth education course | Complete a Member Reimbursement Medical Claim Form and submit by mail with proof of payment. |
| Routine prenatal and postpartum care | No charge | All Outpatient routine prenatal and postpartum office visits are covered as well as breastfeeding services and supports. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---|--|
| Non-routine prenatal care | Cost Sharing varies based on type and place of service. | Any Outpatient maternity services not considered routine or those related to complications or risks with a pregnancy, may be subject to Cost Sharing. Some examples of services not considered routine include, but are not limited to, amniocentesis, fetal stress testing, and OB ultrasounds. |
| Hospital and delivery services | See <i>Inpatient medical and surgical care</i> | Well newborn care is included as part of covered maternity admission. |
| Breast pumps | No charge if billed per Preventive Services Policy; Otherwise, 20% Coinsurance after Deductible | No Prior Authorization required. One breast pump per birth including related parts and supplies. Covered for the purchase of a manual or electric pump or the rental of a hospital-grade pump when deemed appropriate by the ordering Provider. Pump must be obtained from contracting DME Provider. |
| Medical drugs | No charge after Deductible | Prior Authorization required for certain drugs. Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit. |
| Medical care Outpatient visits | | |
| Medical Care includes services to diagnose, treat, and maintain a health condition. Medical care services are covered by Providers in the Tufts Health Direct Network. You are not covered for services from Providers outside of our Network and will be responsible for payment in full. Contact Member Services at 888-257-1985 or visit tuftshealthplan.com/memberlogin to find an In-Network Provider. See <i>Preventive health services</i> for information about routine health care. | | |
| <u>Office and community health center visits</u> | | |
| Primary Care Provider (PCP) | \$35 Copayment per visit | No Prior Authorization required. |
| Specialist | \$55 Copayment per visit | Prior Authorization required for certain specialist visits. |
| MinuteClinic | \$35 Copayment per visit | No Prior Authorization required. A walk-in clinic accessible at select CVS locations in our Service Area. |
| Nutritional counseling | See <i>Medical care Outpatient visits</i> | Prior Authorization required. |
| Observation services | \$750 Copayment after Deductible | No Prior Authorization required. Hospital services to treat and/or evaluate a condition that should result in either a discharge within 48 hours or a verified diagnosis and concurrent treatment plan. |
| Organ or bone marrow transplant | See <i>Inpatient medical and surgical care</i> | Prior Authorization required. |
| Outpatient surgery services | | |
| <u>Outpatient Day Surgery</u> | | |
| Outpatient Hospital or Ambulatory Surgery Center Facility Fee | \$500 Copayment after Deductible | Prior Authorization required for certain services. |
| Professional fee | No charge after Deductible | Includes physician and other covered professional Provider services |
| <u>Office and community health center surgical services</u> | See <i>Medical care Outpatient visits</i> | |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|--|--|
| Pain management | Cost Sharing varies based on type and place of service. | Prior Authorization is not required to begin care. Cost Sharing based on type of service, for example , Nutritional counseling, Physical therapy or Chiropractic care |
| Podiatry care | See <i>Medical care Outpatient visits</i> | No Prior Authorization required. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot. |
| Prescription drugs and supplies | | See the Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost Share. Refer to Formulary for a complete list. |
| Retail pharmacy (up to 30-Day supply) | | |
| Tier 1 | \$25 Copayment | Primarily generic drugs |
| Tier 2 | \$50 Copayment after Deductible | Includes some non-preferred generics and preferred brands |
| Tier 3 | \$125 Copayment after Deductible | Includes high-cost generics, non-preferred brands, and Specialty drugs |
| Mail order pharmacy (up to 90-Day supply) | | |
| Tier 1 | \$50 Copayment | Primarily generic drugs |
| Tier 2 | \$100 Copayment after Deductible | Includes some non-preferred generics and preferred brands |
| Tier 3 | \$375 Copayment after Deductible | Includes high-cost generics, non-preferred brands, and Specialty drugs |
| Preventive health services | | |
| Preventive Health services are routine health care that include screenings, check-ups, and counseling to prevent illnesses, disease, or other health problems. Certain Preventive health services may require Prior Authorization. Work with your PCP to use the <i>Preventive Services</i> policy in the <i>Patient Protection and Affordable Care Act</i> chapter of our Provider Manual at https://point32health.org/provider/provider-manuals/tufts-health-public-plans-provider-manual/ to review specific requirements. | | |
| Routine pediatric care | No charge | Includes but is not limited to routine annual physical exams; screenings, immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning |
| Routine adult care | No charge | Includes but is not limited to routine annual physical exams; screenings; immunizations; routine lab tests and x-rays; routine mammograms; and routine colonoscopies |
| Routine gynecological (GYN) care | No charge | Includes but is not limited to routine exams and cervical cancer screenings (Pap smear tests) |
| Family planning | No charge | |
| Smoking Cessation Counseling Services | No charge | |
| Reconstructive surgery and procedures | See <i>Outpatient surgery or Inpatient medical and surgical care</i> | Certain services may require Prior Authorization. |
| Skilled Nursing Facility | \$750 Copayment per stay after Deductible | Maximum of 100 Days total per Member per Plan Year |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---|--|
| Telehealth | See <i>Medical care Outpatient visits</i> | Please ask your Providers' office for information on Telehealth availability and access. |
| Urgent care | \$55 Copayment per visit | No Prior Authorization required. In our Service Area, you must visit a UCC that is in our Network to be covered for services. Outside of our Service Area, free-standing Urgent Care Centers (UCCs) are covered at Out-of-Network Provider sites, including Hospitals and clinics. |
| Vision care | | |
| You must receive routine eye examinations from a Provider in the EyeMed Vision Care Select network in order to obtain coverage for these services. Call EyeMed at 866-504-5908 for the names of EyeMed Select Providers. | | |
| Routine care | \$55 Copayment per visit | Coverage for routine eye exams once every 12 months; |
| Eyeglasses for children (under 19 years of age) | 20% Coinsurance after deductible | Eyeglasses covered once every 12 months; \$150 allowance + 20% off expense beyond allowance. |
| Medical eye care | See <i>Medical care Outpatient visits</i> | |
| Weight loss programs | No charge for 3 months of membership fees for a qualified program | 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 Plan Year. Must complete a Weight Loss Program Reimbursement Form . See the Tufts Health Direct Member Handbook for more information on limitations. |

Services not covered

See the section "Services not covered" in the *Tufts Health Direct Member Handbook* for the list of services not covered.

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Schedule of Benefits

This Schedule of Benefits gives you information about your Tufts Health Direct Covered Services and costs you may have to pay. Make sure you review the services you are eligible for under the Schedule of Benefits for your specific Plan. To see which Tufts Health Direct Plan you have, check your Tufts Health Plan Member ID Card.

If you want more information about your benefits and capitalized terms, see your Tufts Health Direct Member Handbook tuftshealthplan.com/documents/members/handbooks/direct-member-handbook-2026.

You must go to Providers who are part of the Tufts Health Direct Provider Network to get services. Out-of-Network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal.

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 (TTY: 711, for people with partial or total hearing loss).

You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document. Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The amounts of the Annual Deductible and Annual Out-of-pocket Maximum which apply to you and the enrolled Members of your family each Plan Year are:

| ANNUAL DEDUCTIBLE | AMOUNT | NOTES |
|-------------------|---------|---|
| Individual | \$2,000 | The Individual Deductible applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Deductible even if other Members on the family Plan have not. |
| Family | \$4,000 | Once two or more Members on a family Plan meet the Family Annual Deductible, the entire family is considered to have met the Deductible for the Plan Year. |

| ANNUAL OUT-OF-POCKET MAXIMUM | AMOUNT | NOTES |
|------------------------------|----------|---|
| Individual | \$10,150 | The Individual Out-of-pocket Maximum applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Out-of-pocket Maximum even if other Members on the family Plan have not. |
| Family | \$20,300 | Once two or more Members on a family Plan meet the Family Annual Out-of-pocket Maximum amount, the entire family is considered to have met the Out-of-pocket Maximum for the Plan Year. |

Notice for American Indian and Alaskan Native (AI/AN) Members: All American Indian/Alaskan Native Members, regardless of income, can enroll in a limited Cost Sharing Plan at any metal level, which means no Copayments, Deductibles, or Coinsurance when receiving care from Indian health care Providers. The Massachusetts Health Connector determines your eligibility to enroll in this Plan variation as part of your application process.

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|---|---|---|
| Abortion services | No charge | No Prior Authorization required. |
| Allergy services | | |
| Allergy testing | \$60 Copayment per visit | No Prior Authorization required. Covered for up to 200 allergy tests per Plan Year. |
| Allergy treatments (injections) | \$10 Copayment per injection after Deductible | Note: Allergy immunotherapy covered as part of the pharmacy prescription benefit may require Prior Authorization and have separate pharmacy Cost Sharing responsibility. |
| Outpatient medical office visits | See <i>Medical care Outpatient visits</i> | |
| Ambulance services | No charge after Deductible | No Prior Authorization required for Emergency transportation. Non-emergency basic or advanced life support, ground ambulance transportation may be covered with Prior Authorization. Services to and from medical appointments, transport by taxi, public transportation, and the use of chair cars are not covered |
| Behavioral Health services - Mental Health & Substance Use Disorder | | |
| <u>Inpatient services</u> | | Behavioral Health Urgent and Emergent levels of care do not require Prior Authorization. |
| Facility Fee | \$1,000 Copayment per stay after Deductible | Includes room and board and services supplied by the facility during the inpatient stay. |
| Professional fee | No charge after Deductible | Includes physician and other covered professional Provider services |
| Intensive community based acute treatment (ICBAT) for Children and adolescents | \$1,000 Copayment per stay after Deductible | No Prior Authorization required for admission. |
| <u>Outpatient services</u> | | |
| Individual therapy/Counseling | \$25 Copayment per visit | No Prior Authorization required. No visit limits. |
| Applied Behavioral Analysis (ABA) | \$25 Copayment per visit | Prior Authorization required. Includes assessments, evaluations, testing, and treatment; covered in home, Outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst for treatment of Autism Spectrum Disorder or Down Syndrome |
| Intermediate care, including Behavioral Health (mental health and/or substance use) services for children and adolescents | \$25 Copayment per visit | Prior Authorization is required for certain Behavioral Health (mental health and/or substance use) services for children and adolescents. Please see the "Covered Services" section of the Tufts Health Direct Member Handbook for more information about these services. |
| Medication-Assisted Treatment services | \$25 Copayment per visit | Certain medication may require Prior Authorization. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---|---|
| Mental Health Wellness Exam | No charge | Annual mental health wellness examination performed by a Licensed Mental Health Professional. Please Note: Your annual mental health wellness examination may also be provided by a PCP during your annual routine physical exam. |
| Recovery Coaches and Peer Specialists | No charge | No Prior Authorization required. |
| Chemotherapy and radiation oncology services | No charge after Deductible | Certain services require Prior Authorization. |
| Chiropractic care | \$60 Copayment per visit | No Prior Authorization required. |
| Cleft palate and cleft lip care | No charge after Deductible. Additional Cost Sharing may apply based on place of service | Covered for Members under the age of 18. Includes medical, dental, oral, and facial surgery, follow-up, and related services. See <i>Outpatient surgery services; Dental care; Medical care Outpatient visits; Speech, hearing, and language therapy; and Nutritional counseling</i> for related Cost Share. |
| Clinical trials | Based on place of service | No Prior Authorization required. Includes services that are Medically Necessary for the treatment of your condition and the reasonable cost of investigational drug or device approved for use in the trial but not otherwise paid for by its manufacturer, distributor, or Provider. |
| COVID-19 Testing/Treatment | No charge | |
| Dental care, accidental | Based on place of service | No Prior Authorization required. See <i>Emergency Room care, Outpatient surgery services, or Urgent care</i> for related Cost Share. Coverage for services related to teeth is limited to the Emergency treatment of accidental injury to sound, natural and permanent teeth when caused by a source external to the mouth. |
| Dental care, non-Emergency (Pediatric only, Delta Dental) | | |
| Members are eligible for services until the last Day of the month in which they turn 19 years old. Please call Delta Dental at 800-872-0500 for more information and for Prior Authorization requirements. | | |
| Type I: Preventive & Diagnostic | No charge | Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age. |
| Type II: Basic Covered Services | 25% Coinsurance after Deductible | |
| Type III: Major restorative services | 50% Coinsurance after Deductible | |
| Type IV: Orthodontia | 50% Coinsurance after Deductible | Medically Necessary orthodontia requires Prior Authorization. |
| Diabetes education and treatment | Cost Sharing varies based on type and place of service. | Prior Authorization required for certain services. No charge for the NationsNutrition™ program. See <i>Durable Medical Equipment; Prescription drugs and supplies; Medical care Outpatient visits; and Nutritional Counseling</i> for related Cost Share. |
| Diagnostic services (Outpatient laboratory services, imaging, radiology, and other diagnostic testing) | | |
| Laboratory services | \$30 Copayment after Deductible | Includes blood tests, urinalysis, and throat cultures to maintain health and to test, diagnose, and treat disease. Genetic testing requires Prior Authorization. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|--|--|
| X-rays | \$60 Copayment after Deductible | No Prior Authorization required. |
| Advanced imaging (MRI, CT, PET scans) | \$350 Copayment after Deductible | Prior Authorization required. |
| Sleep studies | Related <i>Medical care</i> <i>Outpatient visit</i> or <i>Inpatient medical care</i> Cost Sharing may be required | Prior Authorization required. |
| Other diagnostic testing | \$30 Copayment after Deductible | Certain services require Prior Authorization . |
| Dialysis services | No charge after Deductible | No Prior Authorization required. |
| Disease Management Programs | No charge | For Members with asthma, diabetes, chronic obstructive pulmonary disease (COPD) or congestive heart failure. If you have any of these conditions, please contact us at 888-257-1985 to discuss our disease management programs. |
| Durable Medical Equipment (DME) | | |
| Covered medical equipment rented or purchased for home use | 20% Coinsurance after Deductible | Prior Authorization is required for certain services, including prosthetic orthotics. Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs. |
| Hearing aids | 20% Coinsurance after Deductible | Covered for Members 21 and younger. This includes the cost of one hearing aid per hearing-impaired ear up to \$2,000 per ear every 36 months. This includes both the amount Tufts Health Direct pays and the applicable Member Cost Share as listed in this document. Related services and supplies do not count toward the \$2,000 limit. |
| Wigs | 20% Coinsurance after Deductible | Limit of 1 wig per Plan Year. |
| Early Intervention services | No charge | No Prior Authorization required. Covered for Members up to age 3; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention Specialist. |
| Emergency Room care | \$350 Copayment after Deductible | No Prior Authorization required. Emergency Room Cost Share waived if held for <i>Observation services</i> , sent for <i>Outpatient Surgery services</i> or admitted for <i>Inpatient medical or surgical care</i> . |
| Fitness center reimbursement | Covered for 3 months | After being an enrolled Member for four consecutive months and participating with a standard fitness center in the current Plan Year, we cover up to \$200 of membership fees incurred in the Plan Year. See the <i>Tufts Health Direct Member Handbook</i> for more information on limitations. Must complete a Fitness Center Reimbursement Form . |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---|---|
| Gender affirming services | Cost Sharing varies based on type and place of service. | Prior Authorization required. Medically necessary services may include Inpatient medical and surgical care, Outpatient Surgery, Diagnostic services, Speech therapy, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies among other services. |
| Habilitative and rehabilitative services | \$60 Copayment per visit | Includes cardiac rehabilitation; physical therapy; Occupational Therapy; and speech, hearing, and language therapy services. See below for specific details. |
| <u>Limits:</u> | | |
| Cardiac rehabilitation | | |
| Physical and Occupational Therapy | | Prior Authorization required after initial evaluation and 11 visits. Maximum of 60 visits total Physical and Occupational Therapy per Member per Plan Year. Limits do not apply for Autism Spectrum Disorder services. |
| Speech, hearing, and language therapy | | Prior Authorization required after visit 30. No visit limits. |
| Home health care | No charge after Deductible | Prior Authorization is required for all home care services and disciplines. |
| Hospice services | No charge after Deductible | Prior Authorization required. |
| Infertility services & treatment | Cost Sharing varies based on type and place of service. | Prior Authorization required. Medically necessary services may include <i>Inpatient medical and surgical care, Outpatient Surgery, Diagnostic services, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies</i> among other services. |
| Inpatient medical and surgical care | | |
| No Prior Authorization required for Inpatient admissions from the Emergency room. Planned admissions require Prior Authorization 5 business days before admission. | | |
| Facility Fee | \$1,000 Copayment per stay after Deductible | Includes room and board and services supplied by the facility during the inpatient stay, including preadmission testing, anesthesia, diagnostic services, and medication and supplies |
| Professional Fee | No charge after Deductible | Includes physician and other covered professional Provider services |
| Long Term Acute Care Hospital or Acute Rehabilitation Hospital | \$1,000 Copayment per stay after Deductible | Maximum of 60 Days total per Member per Plan Year |
| Maternity services and Well Newborn care | | |
| Childbirth classes | Covered for cost of childbirth education course | Complete a Member Reimbursement Medical Claim Form and submit by mail with proof of payment. |
| Routine prenatal and postpartum care | No charge | All Outpatient routine prenatal and postpartum office visits are covered as well as breastfeeding services and supports. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---|--|
| Non-routine prenatal care | Cost Sharing varies based on type and place of service. | Any Outpatient maternity services not considered routine or those related to complications or risks with a pregnancy, may be subject to Cost Sharing. Some examples of services not considered routine include, but are not limited to, amniocentesis, fetal stress testing, and OB ultrasounds. |
| Hospital and delivery services | See <i>Inpatient medical and surgical care</i> | Well newborn care is included as part of covered maternity admission. |
| Breast pumps | No charge if billed per Preventive Services Policy; Otherwise, 20% Coinsurance after Deductible | No Prior Authorization required. One breast pump per birth including related parts and supplies. Covered for the purchase of a manual or electric pump or the rental of a hospital-grade pump when deemed appropriate by the ordering Provider. Pump must be obtained from contracting DME Provider. |
| Medical drugs | No charge after Deductible | Prior Authorization required for certain drugs. Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit. |
| Medical care Outpatient visits | | |
| Medical Care includes services to diagnose, treat, and maintain a health condition. Medical care services are covered by Providers in the Tufts Health Direct Network. You are not covered for services from Providers outside of our Network and will be responsible for payment in full. Contact Member Services at 888-257-1985 or visit tuftshealthplan.com/memberlogin to find an In-Network Provider. See <i>Preventive health services</i> for information about routine health care. | | |
| <u>Office and community health center visits</u> | | |
| Primary Care Provider (PCP) | \$25 Copayment per visit | No Prior Authorization required. |
| Specialist | \$60 Copayment per visit | Prior Authorization required for certain specialist visits. |
| MinuteClinic | \$25 Copayment per visit | No Prior Authorization required. A walk-in clinic accessible at select CVS locations in our Service Area. |
| Nutritional counseling | See <i>Medical care Outpatient visits</i> | Prior Authorization required. |
| Observation services | \$1,000 Copayment after Deductible | No Prior Authorization required. Hospital services to treat and/or evaluate a condition that should result in either a discharge within 48 hours or a verified diagnosis and concurrent treatment plan. |
| Organ or bone marrow transplant | See <i>Inpatient medical and surgical care</i> | Prior Authorization required. |
| Outpatient surgery services | | |
| <u>Outpatient Day Surgery</u> | | |
| Outpatient Hospital or Ambulatory Surgery Center Facility Fee | \$500 Copayment after Deductible | Prior Authorization required for certain services. |
| Professional fee | No charge after Deductible | Includes physician and other covered professional Provider services |
| <u>Office and community health center surgical services</u> | See <i>Medical care Outpatient visits</i> | |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|--|--|
| Pain management | Cost Sharing varies based on type and place of service. | Prior Authorization is not required to begin care. Cost Sharing based on type of service, for example , Nutritional counseling, Physical therapy or Chiropractic care |
| Podiatry care | See <i>Medical care Outpatient visits</i> | No Prior Authorization required. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot. |
| Prescription drugs and supplies | | See the Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost Share. Refer to Formulary for a complete list. |
| Retail pharmacy (up to 30-Day supply) | | |
| Tier 1 | \$30 Copayment | Primarily generic drugs |
| Tier 2 | \$55 Copayment | Includes some non-preferred generics and preferred brands |
| Tier 3 | \$75 Copayment after Deductible | Includes high-cost generics, non-preferred brands, and Specialty drugs |
| Mail order pharmacy (up to 90-Day supply) | | |
| Tier 1 | \$60 Copayment | Primarily generic drugs |
| Tier 2 | \$110 Copayment | Includes some non-preferred generics and preferred brands |
| Tier 3 | \$225 Copayment after Deductible | Includes high-cost generics, non-preferred brands, and Specialty drugs |
| Preventive health services | | |
| Preventive Health services are routine health care that include screenings, check-ups, and counseling to prevent illnesses, disease, or other health problems. Certain Preventive health services may require Prior Authorization. Work with your PCP to use the <i>Preventive Services</i> policy in the <i>Patient Protection and Affordable Care Act</i> chapter of our Provider Manual at https://point32health.org/provider/provider-manuals/tufts-health-public-plans-provider-manual/ to review specific requirements. | | |
| Routine pediatric care | No charge | Includes but is not limited to routine annual physical exams; screenings, immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning |
| Routine adult care | No charge | Includes but is not limited to routine annual physical exams; screenings; immunizations; routine lab tests and x-rays; routine mammograms; and routine colonoscopies |
| Routine gynecological (GYN) care | No charge | Includes but is not limited to routine exams and cervical cancer screenings (Pap smear tests) |
| Family planning | No charge | |
| Smoking Cessation Counseling Services | No charge | |
| Reconstructive surgery and procedures | See <i>Outpatient surgery or Inpatient medical and surgical care</i> | Certain services may require Prior Authorization. |
| Skilled Nursing Facility | \$1,000 Copayment per stay after Deductible | Maximum of 100 Days total per Member per Plan Year |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---|--|
| Telehealth | See <i>Medical care Outpatient visits</i> | Please ask your Providers' office for information on Telehealth availability and access. |
| Urgent care | \$60 Copayment per visit | No Prior Authorization required. In our Service Area, you must visit a UCC that is in our Network to be covered for services. Outside of our Service Area, free-standing Urgent Care Centers (UCCs) are covered at Out-of-Network Provider sites, including Hospitals and clinics. |
| Vision care | | |
| You must receive routine eye examinations from a Provider in the EyeMed Vision Care Select network in order to obtain coverage for these services. Call EyeMed at 866-504-5908 for the names of EyeMed Select Providers. | | |
| Routine care | \$60 Copayment per visit | Coverage for routine eye exams once every 12 months; |
| Eyeglasses for children (under 19 years of age) | 20% Coinsurance after deductible | Eyeglasses covered once every 12 months; \$150 allowance + 20% off expense beyond allowance. |
| Medical eye care | See <i>Medical care Outpatient visits</i> | |
| Weight loss programs | No charge for 3 months of membership fees for a qualified program | 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 Plan Year. Must complete a Weight Loss Program Reimbursement Form . See the Tufts Health Direct Member Handbook for more information on limitations. |

Services not covered

See the section "Services not covered" in the *Tufts Health Direct Member Handbook* for the list of services not covered.

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Schedule of Benefits

This Schedule of Benefits gives you information about your Tufts Health Direct Covered Services and costs you may have to pay. Make sure you review the services you are eligible for under the Schedule of Benefits for your specific Plan. To see which Tufts Health Direct Plan you have, check your Tufts Health Plan Member ID Card.

If you want more information about your benefits and capitalized terms, see your Tufts Health Direct Member Handbook tuftshealthplan.com/documents/members/handbooks/direct-member-handbook-2026.

You must go to Providers who are part of the Tufts Health Direct Provider Network to get services. Out-of-Network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal.

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 (TTY: 711, for people with partial or total hearing loss).

You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document. Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The amounts of the Annual Deductible and Annual Out-of-pocket Maximum which apply to you and the enrolled Members of your family each Plan Year are:

| ANNUAL DEDUCTIBLE | AMOUNT | NOTES |
|-------------------|---------|---|
| Individual | \$2,000 | The Individual Deductible applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Deductible even if other Members on the family Plan have not. |
| Family | \$4,000 | Once two or more Members on a family Plan meet the Family Annual Deductible, the entire family is considered to have met the Deductible for the Plan Year. |

| ANNUAL OUT-OF-POCKET MAXIMUM | AMOUNT | NOTES |
|------------------------------|----------|---|
| Individual | \$10,150 | The Individual Out-of-pocket Maximum applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Out-of-pocket Maximum even if other Members on the family Plan have not. |
| Family | \$20,300 | Once two or more Members on a family Plan meet the Family Annual Out-of-pocket Maximum amount, the entire family is considered to have met the Out-of-pocket Maximum for the Plan Year. |

Notice for American Indian and Alaskan Native (AI/AN) Members: All American Indian/Alaskan Native Members, regardless of income, can enroll in a limited Cost Sharing Plan at any metal level, which means no Copayments, Deductibles, or Coinsurance when receiving care from Indian health care Providers. The Massachusetts Health Connector determines your eligibility to enroll in this Plan variation as part of your application process.

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|---|---|---|
| Abortion services | No charge | No Prior Authorization required. |
| Allergy services | | |
| Allergy testing | \$60 Copayment per visit | No Prior Authorization required. Covered for up to 200 allergy tests per Plan Year. |
| Allergy treatments (injections) | \$10 Copayment per injection after Deductible | Note: Allergy immunotherapy covered as part of the pharmacy prescription benefit may require Prior Authorization and have separate pharmacy Cost Sharing responsibility. |
| Outpatient medical office visits | See <i>Medical care Outpatient visits</i> | |
| Ambulance services | No charge after Deductible | No Prior Authorization required for Emergency transportation. Non-emergency basic or advanced life support, ground ambulance transportation may be covered with Prior Authorization. Services to and from medical appointments, transport by taxi, public transportation, and the use of chair cars are not covered |
| Behavioral Health services - Mental Health & Substance Use Disorder | | |
| <u>Inpatient services</u> | | Behavioral Health Urgent and Emergent levels of care do not require Prior Authorization. |
| Facility Fee | \$1,000 Copayment per stay after Deductible | Includes room and board and services supplied by the facility during the inpatient stay. |
| Professional fee | No charge after Deductible | Includes physician and other covered professional Provider services |
| Intensive community based acute treatment (ICBAT) for Children and adolescents | \$1,000 Copayment per stay after Deductible | No Prior Authorization required for admission. |
| <u>Outpatient services</u> | | |
| Individual therapy/Counseling | \$25 Copayment per visit | No Prior Authorization required. No visit limits. |
| Applied Behavioral Analysis (ABA) | \$25 Copayment per visit | Prior Authorization required. Includes assessments, evaluations, testing, and treatment; covered in home, Outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst for treatment of Autism Spectrum Disorder or Down Syndrome |
| Intermediate care, including Behavioral Health (mental health and/or substance use) services for children and adolescents | \$25 Copayment per visit | Prior Authorization is required for certain Behavioral Health (mental health and/or substance use) services for children and adolescents. Please see the "Covered Services" section of the Tufts Health Direct Member Handbook for more information about these services. |
| Medication-Assisted Treatment services | \$25 Copayment per visit | Certain medication may require Prior Authorization. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---|---|
| Mental Health Wellness Exam | No charge | Annual mental health wellness examination performed by a Licensed Mental Health Professional. Please Note: Your annual mental health wellness examination may also be provided by a PCP during your annual routine physical exam. |
| Recovery Coaches and Peer Specialists | No charge | No Prior Authorization required. |
| Chemotherapy and radiation oncology services | No charge after Deductible | Certain services require Prior Authorization. |
| Chiropractic care | \$60 Copayment per visit | No Prior Authorization required. |
| Cleft palate and cleft lip care | No charge after Deductible. Additional Cost Sharing may apply based on place of service | Covered for Members under the age of 18. Includes medical, dental, oral, and facial surgery, follow-up, and related services. See <i>Outpatient surgery services; Dental care; Medical care Outpatient visits; Speech, hearing, and language therapy; and Nutritional counseling</i> for related Cost Share. |
| Clinical trials | Based on place of service | No Prior Authorization required. Includes services that are Medically Necessary for the treatment of your condition and the reasonable cost of investigational drug or device approved for use in the trial but not otherwise paid for by its manufacturer, distributor, or Provider. |
| COVID-19 Testing/Treatment | No charge | |
| Dental care, accidental | Based on place of service | No Prior Authorization required. See <i>Emergency Room care, Outpatient surgery services, or Urgent care</i> for related Cost Share. Coverage for services related to teeth is limited to the Emergency treatment of accidental injury to sound, natural and permanent teeth when caused by a source external to the mouth. |
| Dental care, non-Emergency (Pediatric only, Delta Dental) | | |
| Members are eligible for services until the last Day of the month in which they turn 19 years old. Please call Delta Dental at 800-872-0500 for more information and for Prior Authorization requirements. | | |
| Type I: Preventive & Diagnostic | No charge | Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age. |
| Type II: Basic Covered Services | 25% Coinsurance after Deductible | |
| Type III: Major restorative services | 50% Coinsurance after Deductible | |
| Type IV: Orthodontia | 50% Coinsurance after Deductible | Medically Necessary orthodontia requires Prior Authorization. |
| Diabetes education and treatment | Cost Sharing varies based on type and place of service. | Prior Authorization required for certain services. No charge for the NationsNutrition™ program. See <i>Durable Medical Equipment; Prescription drugs and supplies; Medical care Outpatient visits; and Nutritional Counseling</i> for related Cost Share. |
| Diagnostic services (Outpatient laboratory services, imaging, radiology, and other diagnostic testing) | | |
| Laboratory services | \$30 Copayment after Deductible | Includes blood tests, urinalysis, and throat cultures to maintain health and to test, diagnose, and treat disease. Genetic testing requires Prior Authorization. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|--|--|
| X-rays | \$60 Copayment after Deductible | No Prior Authorization required. |
| Advanced imaging (MRI, CT, PET scans) | \$350 Copayment after Deductible | Prior Authorization required. |
| Sleep studies | Related <i>Medical care</i> <i>Outpatient visit</i> or <i>Inpatient medical care</i> Cost Sharing may be required | Prior Authorization required. |
| Other diagnostic testing | \$30 Copayment after Deductible | Certain services require Prior Authorization . |
| Dialysis services | No charge after Deductible | No Prior Authorization required. |
| Disease Management Programs | No charge | For Members with asthma, diabetes, chronic obstructive pulmonary disease (COPD) or congestive heart failure. If you have any of these conditions, please contact us at 888-257-1985 to discuss our disease management programs. |
| Durable Medical Equipment (DME) | | |
| Covered medical equipment rented or purchased for home use | 20% Coinsurance after Deductible | Prior Authorization is required for certain services, including prosthetic orthotics. Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs. |
| Hearing aids | 20% Coinsurance after Deductible | Covered for Members 21 and younger. This includes the cost of one hearing aid per hearing-impaired ear up to \$2,000 per ear every 36 months. This includes both the amount Tufts Health Direct pays and the applicable Member Cost Share as listed in this document. Related services and supplies do not count toward the \$2,000 limit. |
| Wigs | 20% Coinsurance after Deductible | Limit of 1 wig per Plan Year. |
| Early Intervention services | No charge | No Prior Authorization required. Covered for Members up to age 3; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention Specialist. |
| Emergency Room care | \$350 Copayment after Deductible | No Prior Authorization required. Emergency Room Cost Share waived if held for <i>Observation services</i> , sent for <i>Outpatient Surgery services</i> or admitted for <i>Inpatient medical or surgical care</i> . |
| Fitness center reimbursement | Covered for 3 months | After being an enrolled Member for four consecutive months and participating with a standard fitness center in the current Plan Year, we cover up to \$200 of membership fees incurred in the Plan Year. See the <i>Tufts Health Direct Member Handbook</i> for more information on limitations. Must complete a Fitness Center Reimbursement Form . |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---|---|
| Gender affirming services | Cost Sharing varies based on type and place of service. | Prior Authorization required. Medically necessary services may include Inpatient medical and surgical care, Outpatient Surgery, Diagnostic services, Speech therapy, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies among other services. |
| Habilitative and rehabilitative services | \$60 Copayment per visit | Includes cardiac rehabilitation; physical therapy; Occupational Therapy; and speech, hearing, and language therapy services. See below for specific details. |
| <u>Limits:</u> | | |
| Cardiac rehabilitation | | |
| Physical and Occupational Therapy | | Prior Authorization required after initial evaluation and 11 visits. Maximum of 60 visits total Physical and Occupational Therapy per Member per Plan Year. Limits do not apply for Autism Spectrum Disorder services. |
| Speech, hearing, and language therapy | | Prior Authorization required after visit 30. No visit limits. |
| Home health care | \$5 Copayment per visit after Deductible | Prior Authorization is required for all home care services and disciplines. |
| Hospice services | No charge after Deductible | Prior Authorization required. |
| Infertility services & treatment | Cost Sharing varies based on type and place of service. | Prior Authorization required. Medically necessary services may include <i>Inpatient medical and surgical care, Outpatient Surgery, Diagnostic services, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies</i> among other services. |
| Inpatient medical and surgical care | | |
| No Prior Authorization required for Inpatient admissions from the Emergency room. Planned admissions require Prior Authorization 5 business days before admission. | | |
| Facility Fee | \$1,000 Copayment per stay after Deductible | Includes room and board and services supplied by the facility during the inpatient stay, including preadmission testing, anesthesia, diagnostic services, and medication and supplies |
| Professional Fee | No charge after Deductible | Includes physician and other covered professional Provider services |
| Long Term Acute Care Hospital or Acute Rehabilitation Hospital | \$1,000 Copayment per stay after Deductible | Maximum of 60 Days total per Member per Plan Year |
| Maternity services and Well Newborn care | | |
| Childbirth classes | Covered for cost of childbirth education course | Complete a Member Reimbursement Medical Claim Form and submit by mail with proof of payment. |
| Routine prenatal and postpartum care | No charge | All Outpatient routine prenatal and postpartum office visits are covered as well as breastfeeding services and supports. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---|--|
| Non-routine prenatal care | Cost Sharing varies based on type and place of service. | Any Outpatient maternity services not considered routine or those related to complications or risks with a pregnancy, may be subject to Cost Sharing. Some examples of services not considered routine include, but are not limited to, amniocentesis, fetal stress testing, and OB ultrasounds. |
| Hospital and delivery services | See <i>Inpatient medical and surgical care</i> | Well newborn care is included as part of covered maternity admission. |
| Breast pumps | No charge if billed per Preventive Services Policy; Otherwise, 20% Coinsurance after Deductible | No Prior Authorization required. One breast pump per birth including related parts and supplies. Covered for the purchase of a manual or electric pump or the rental of a hospital-grade pump when deemed appropriate by the ordering Provider. Pump must be obtained from contracting DME Provider. |
| Medical drugs | No charge after Deductible | Prior Authorization required for certain drugs. Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit. |
| Medical care Outpatient visits | | |
| Medical Care includes services to diagnose, treat, and maintain a health condition. Medical care services are covered by Providers in the Tufts Health Direct Network. You are not covered for services from Providers outside of our Network and will be responsible for payment in full. Contact Member Services at 888-257-1985 or visit tuftshealthplan.com/memberlogin to find an In-Network Provider. See <i>Preventive health services</i> for information about routine health care. | | |
| <u>Office and community health center visits</u> | | |
| Primary Care Provider (PCP) | \$25 Copayment per visit | No Prior Authorization required. |
| Specialist | \$60 Copayment per visit | Prior Authorization required for certain specialist visits. |
| MinuteClinic | \$25 Copayment per visit | No Prior Authorization required. A walk-in clinic accessible at select CVS locations in our Service Area. |
| Nutritional counseling | See <i>Medical care Outpatient visits</i> | Prior Authorization required. |
| Observation services | \$1,000 Copayment after Deductible | No Prior Authorization required. Hospital services to treat and/or evaluate a condition that should result in either a discharge within 48 hours or a verified diagnosis and concurrent treatment plan. |
| Organ or bone marrow transplant | See <i>Inpatient medical and surgical care</i> | Prior Authorization required. |
| Outpatient surgery services | | |
| <u>Outpatient Day Surgery</u> | | |
| Outpatient Hospital or Ambulatory Surgery Center Facility Fee | \$500 Copayment after Deductible | Prior Authorization required for certain services. |
| Professional fee | No charge after Deductible | Includes physician and other covered professional Provider services |
| <u>Office and community health center surgical services</u> | See <i>Medical care Outpatient visits</i> | |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|--|--|
| Pain management | Cost Sharing varies based on type and place of service. | Prior Authorization is not required to begin care. Cost Sharing based on type of service, for example , Nutritional counseling, Physical therapy or Chiropractic care |
| Podiatry care | See <i>Medical care Outpatient visits</i> | No Prior Authorization required. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot. |
| Prescription drugs and supplies | | See the Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost Share. Refer to Formulary for a complete list. |
| Retail pharmacy (up to 30-Day supply) | | |
| Tier 1 | \$30 Copayment | Primarily generic drugs |
| Tier 2 | \$55 Copayment | Includes some non-preferred generics and preferred brands |
| Tier 3 | \$75 Copayment after Deductible | Includes high-cost generics, non-preferred brands, and Specialty drugs |
| Mail order pharmacy (up to 90-Day supply) | | |
| Tier 1 | \$60 Copayment | Primarily generic drugs |
| Tier 2 | \$110 Copayment | Includes some non-preferred generics and preferred brands |
| Tier 3 | \$225 Copayment after Deductible | Includes high-cost generics, non-preferred brands, and Specialty drugs |
| Preventive health services | | |
| Preventive Health services are routine health care that include screenings, check-ups, and counseling to prevent illnesses, disease, or other health problems. Certain Preventive health services may require Prior Authorization. Work with your PCP to use the <i>Preventive Services</i> policy in the <i>Patient Protection and Affordable Care Act</i> chapter of our Provider Manual at https://point32health.org/provider/provider-manuals/tufts-health-public-plans-provider-manual/ to review specific requirements. | | |
| Routine pediatric care | No charge | Includes but is not limited to routine annual physical exams; screenings, immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning |
| Routine adult care | No charge | Includes but is not limited to routine annual physical exams; screenings; immunizations; routine lab tests and x-rays; routine mammograms; and routine colonoscopies |
| Routine gynecological (GYN) care | No charge | Includes but is not limited to routine exams and cervical cancer screenings (Pap smear tests) |
| Family planning | No charge | |
| Smoking Cessation Counseling Services | No charge | |
| Reconstructive surgery and procedures | See <i>Outpatient surgery or Inpatient medical and surgical care</i> | Certain services may require Prior Authorization. |
| Skilled Nursing Facility | \$1,000 Copayment per stay after Deductible | Maximum of 100 Days total per Member per Plan Year |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---|--|
| Telehealth | See <i>Medical care Outpatient visits</i> | Please ask your Providers' office for information on Telehealth availability and access. |
| Urgent care | \$60 Copayment per visit | No Prior Authorization required. In our Service Area, you must visit a UCC that is in our Network to be covered for services. Outside of our Service Area, free-standing Urgent Care Centers (UCCs) are covered at Out-of-Network Provider sites, including Hospitals and clinics. |
| Vision care | | |
| You must receive routine eye examinations from a Provider in the EyeMed Vision Care Select network in order to obtain coverage for these services. Call EyeMed at 866-504-5908 for the names of EyeMed Select Providers. | | |
| Routine care | \$60 Copayment per visit | Coverage for routine eye exams once every 12 months; |
| Eyeglasses for children (under 19 years of age) | 20% Coinsurance after deductible | Eyeglasses covered once every 12 months; \$150 allowance + 20% off expense beyond allowance. |
| Medical eye care | See <i>Medical care Outpatient visits</i> | |
| Weight loss programs | No charge for 3 months of membership fees for a qualified program | 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 Plan Year. Must complete a Weight Loss Program Reimbursement Form . See the Tufts Health Direct Member Handbook for more information on limitations. |

Services not covered

See the section "Services not covered" in the *Tufts Health Direct Member Handbook* for the list of services not covered.

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Schedule of Benefits

This Schedule of Benefits gives you information about your Tufts Health Direct Covered Services and costs you may have to pay. Make sure you review the services you're eligible for under the Schedule of Benefits for your specific Plan. To see which Tufts Health Direct Plan you have, check your Tufts Health Direct Plan Member ID Card.

If you want more information about your benefits and capitalized terms, see your Tufts Health Direct Member Handbook tuftshealthplan.com/documents/members/handbooks/direct-member-handbook-2026.

You must go to Providers who are part of the Tufts Health Direct Provider Network to get services. Out-of-Network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal.

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 (TTY: 711, for people with partial or total hearing loss).

This Plan is a Health Savings Account (HSA)-compatible High Deductible Health Plan (HDHP) as defined by the Internal Revenue Service (IRS). High Deductible Health Plans are subject to IRS rules requiring that a minimum Deductible is satisfied before the health Plan provides coverage for Non-Preventive Care. The minimum Deductible dollar amount is adjusted each year to meet IRS requirements. For additional information on the rules governing HDHPs, please refer to irs.gov/publications/p969.

You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document. Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The amounts of the Annual Deductible and Annual Out-of-pocket Maximum which apply to you and the enrolled Members of your family each Plan Year are:

| ANNUAL DEDUCTIBLE | AMOUNT | NOTES |
|---|---------|---|
| Individual (Self-only Plan) | \$2,500 | Individual Annual Deductible amount applies when there is only one Member enrolled on the Plan. |
| Family (two Members or more) | \$5,000 | Family Annual Deductible amount applies if there are two or more Members enrolled on the Plan. The Family Deductible is met when a total of \$5,000 has been paid toward the Deductible by one or more Members on the Plan. |

| ANNUAL OUT-OF-POCKET MAXIMUM | AMOUNT | NOTES |
|------------------------------|----------|---|
| Individual | \$8,450 | A Member can meet the Individual Annual Out of Pocket Maximum on a self-only or a family Plan and then does not have additional Cost Sharing for Covered Services for the remainder of the Plan Year. |
| Family | \$16,900 | Two or more Members on a family Plan can meet the Family Out-of-pocket Maximum and then no Member of the family has additional Cost Sharing for Covered Services for the remainder of the Plan Year. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|---|---|---|
| Abortion services | No charge after Deductible | No Prior Authorization required. |
| Allergy services | | |
| Allergy testing | \$60 Copayment per visit after Deductible | No Prior Authorization required. Covered for up to 200 allergy tests per Plan Year. |
| Allergy treatments (injections) | \$10 Copayment per injection after Deductible | Note: Allergy immunotherapy covered as part of the pharmacy prescription benefit may require Prior Authorization and have separate pharmacy Cost Sharing responsibility. |
| Outpatient medical office visits | See <i>Medical care Outpatient visits</i> | |
| Ambulance services | No charge after Deductible | No Prior Authorization required for Emergency transportation. Non-emergency basic or advanced life support, ground ambulance transportation may be covered with Prior Authorization. Services to and from medical appointments, transport by taxi, public transportation, and the use of chair cars are not covered |
| Behavioral Health services - Mental Health & Substance Use Disorder | | |
| <u>Inpatient services</u> | | Behavioral Health Urgent and Emergent levels of care do not require Prior Authorization. |
| Facility Fee | \$750 Copayment per stay after Deductible | Includes room and board and services supplied by the facility during the inpatient stay. |
| Professional fee | No charge after Deductible | Includes physician and other covered professional Provider services |
| Intensive community based acute treatment (ICBAT) for Children and adolescents | \$750 Copayment per stay after Deductible | No Prior Authorization required for admission. |
| <u>Outpatient services</u> | | |
| Individual therapy/Counseling | \$30 Copayment per visit after Deductible | No Prior Authorization required. No visit limits. |
| Applied Behavioral Analysis (ABA) | \$30 Copayment per visit after Deductible | Prior Authorization required. Includes assessments, evaluations, testing, and treatment; covered in home, Outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst for treatment of Autism Spectrum Disorder or Down Syndrome |
| Intermediate care, including Behavioral Health (mental health and/or substance use) services for children and adolescents | \$30 Copayment per visit after Deductible | Prior Authorization is required for certain Behavioral Health (mental health and/or substance use) services for children and adolescents. Please see the "Covered Services" section of the Tufts Health Direct Member Handbook for more information about these services. |
| Medication-Assisted Treatment services | \$30 Copayment per visit after Deductible | Certain medication may require Prior Authorization. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---|---|
| Mental Health Wellness Exam | No charge | Annual mental health wellness examination performed by a Licensed Mental Health Professional. Please Note: Your annual mental health wellness examination may also be provided by a PCP during your annual routine physical exam. |
| Recovery Coaches and Peer Specialists | No charge after Deductible | No Prior Authorization required. |
| Chemotherapy and radiation oncology services | No charge after Deductible | Certain services require Prior Authorization. |
| Chiropractic care | \$60 Copayment per visit after Deductible | No Prior Authorization required. |
| Cleft palate and cleft lip care | No charge after Deductible. Additional Cost Sharing may apply based on place of service | Covered for Members under the age of 18. Includes medical, dental, oral, and facial surgery, follow-up, and related services. See <i>Outpatient surgery services; Dental care; Medical care Outpatient visits; Speech, hearing, and language therapy; and Nutritional counseling</i> for related Cost Share. |
| Clinical trials | Based on place of service | No Prior Authorization required. Includes services that are Medically Necessary for the treatment of your condition and the reasonable cost of investigational drug or device approved for use in the trial but not otherwise paid for by its manufacturer, distributor, or Provider. |
| COVID-19 Testing/Treatment | No charge after Deductible | |
| Dental care, accidental | Based on place of service | No Prior Authorization required. See <i>Emergency Room care, Outpatient surgery services, or Urgent care</i> for related Cost Share. Coverage for services related to teeth is limited to the Emergency treatment of accidental injury to sound, natural and permanent teeth when caused by a source external to the mouth. |
| Dental care, non-Emergency (Pediatric only, Delta Dental) | | |
| Members are eligible for services until the last Day of the month in which they turn 19 years old. Please call Delta Dental at 800-872-0500 for more information and for Prior Authorization requirements. | | |
| Type I: Preventive & Diagnostic | No charge | Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age. |
| Type II: Basic Covered Services | 25% Coinsurance after Deductible | |
| Type III: Major restorative services | 50% Coinsurance after Deductible | |
| Type IV: Orthodontia | 50% Coinsurance after Deductible | Medically Necessary orthodontia requires Prior Authorization. |
| Diabetes education and treatment | Cost Sharing varies based on type and place of service. | Prior Authorization required for certain services. No charge for the NationsNutrition™ program. See <i>Durable Medical Equipment; Prescription drugs and supplies; Medical care Outpatient visits; and Nutritional Counseling</i> for related Cost Share. |
| Diagnostic services (Outpatient laboratory services, imaging, radiology, and other diagnostic testing) | | |
| Laboratory services | \$60 Copayment after Deductible | Includes blood tests, urinalysis, and throat cultures to maintain health and to test, diagnose, and treat disease. Genetic testing requires Prior Authorization. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|--|--|
| X-rays | \$75 Copayment after Deductible | No Prior Authorization required. |
| Advanced imaging (MRI, CT, PET scans) | \$500 Copayment after Deductible | Prior Authorization required. |
| Sleep studies | Related <i>Medical care</i> <i>Outpatient visit</i> or <i>Inpatient medical care</i> Cost Sharing may be required | Prior Authorization required. |
| Other diagnostic testing | \$60 Copayment after Deductible | Certain services require Prior Authorization . |
| Dialysis services | No charge after Deductible | No Prior Authorization required. |
| Disease Management Programs | No charge | For Members with asthma, diabetes, chronic obstructive pulmonary disease (COPD) or congestive heart failure. If you have any of these conditions, please contact us at 888-257-1985 to discuss our disease management programs. |
| Durable Medical Equipment (DME) | | |
| Covered medical equipment rented or purchased for home use | 20% Coinsurance after Deductible | Prior Authorization is required for certain services, including prosthetic orthotics. Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs. |
| Hearing aids | 20% Coinsurance after Deductible | Covered for Members 21 and younger. This includes the cost of one hearing aid per hearing-impaired ear up to \$2,000 per ear every 36 months. This includes both the amount Tufts Health Direct pays and the applicable Member Cost Share as listed in this document. Related services and supplies do not count toward the \$2,000 limit. |
| Wigs | 20% Coinsurance after Deductible | Limit of 1 wig per Plan Year. |
| Early Intervention services | No charge | No Prior Authorization required. Covered for Members up to age 3; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention Specialist. |
| Emergency Room care | \$300 Copayment after Deductible | No Prior Authorization required. Emergency Room Cost Share waived if held for <i>Observation services</i> , sent for <i>Outpatient Surgery services</i> or admitted for <i>Inpatient medical or surgical care</i> . |
| Fitness center reimbursement | Covered for 3 months | After being an enrolled Member for four consecutive months and participating with a standard fitness center in the current Plan Year, we cover up to \$200 of membership fees incurred in the Plan Year. See the <i>Tufts Health Direct Member Handbook</i> for more information on limitations. Must complete a Fitness Center Reimbursement Form . |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|---|---|---|
| Gender affirming services | Cost Sharing varies based on type and place of service. | Prior Authorization required. Medically necessary services may include Inpatient medical and surgical care, Outpatient Surgery, Diagnostic services, Speech therapy, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies among other services. |
| Habilitative and rehabilitative services | \$60 Copayment per visit after Deductible | Includes cardiac rehabilitation; physical therapy; Occupational Therapy; and speech, hearing, and language therapy services. See below for specific details. |
| <u>Limits:</u> | | |
| Cardiac rehabilitation | | |
| Physical and Occupational Therapy | | Prior Authorization required after initial evaluation and 11 visits. Maximum of 60 visits total Physical and Occupational Therapy per Member per Plan Year. Limits do not apply for Autism Spectrum Disorder services. |
| Speech, hearing, and language therapy | | Prior Authorization required after visit 30. No visit limits. |
| Home health care | No charge after Deductible | Prior Authorization is required for all home care services and disciplines. |
| Hospice services | No charge after Deductible | Prior Authorization required. |
| Infertility services & treatment | Cost Sharing varies based on type and place of service. | Prior Authorization required. Medically necessary services may include <i>Inpatient medical and surgical care, Outpatient Surgery, Diagnostic services, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies</i> among other services. |
| Inpatient medical and surgical care | | |
| | | No Prior Authorization required for Inpatient admissions from the Emergency room. Planned admissions require Prior Authorization 5 business days before admission. |
| Facility Fee | \$750 Copayment per stay after Deductible | Includes room and board and services supplied by the facility during the inpatient stay, including preadmission testing, anesthesia, diagnostic services, and medication and supplies |
| Professional Fee | No charge after Deductible | Includes physician and other covered professional Provider services |
| Long Term Acute Care Hospital or Acute Rehabilitation Hospital | \$750 Copayment per stay after Deductible | Maximum of 60 Days total per Member per Plan Year |
| Maternity services and Well Newborn care | | |
| Childbirth classes | Covered for cost of childbirth education course | Complete a Member Reimbursement Medical Claim Form and submit by mail with proof of payment. |
| Routine prenatal and postpartum care | No charge | All Outpatient routine prenatal and postpartum office visits are covered as well as breastfeeding services and supports. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---|--|
| Non-routine prenatal care | Cost Sharing varies based on type and place of service. | Any Outpatient maternity services not considered routine or those related to complications or risks with a pregnancy, may be subject to Cost Sharing. Some examples of services not considered routine include, but are not limited to, amniocentesis, fetal stress testing, and OB ultrasounds. |
| Hospital and delivery services | See <i>Inpatient medical and surgical care</i> | Well newborn care is included as part of covered maternity admission. |
| Breast pumps | No charge if billed per Preventive Services Policy; Otherwise, 20% Coinsurance after Deductible | No Prior Authorization required. One breast pump per birth including related parts and supplies. Covered for the purchase of a manual or electric pump or the rental of a hospital-grade pump when deemed appropriate by the ordering Provider. Pump must be obtained from contracting DME Provider. |
| Medical drugs | No charge after Deductible | Prior Authorization required for certain drugs. Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit. |
| Medical care Outpatient visits | | |
| Medical Care includes services to diagnose, treat, and maintain a health condition. Medical care services are covered by Providers in the Tufts Health Direct Network. You are not covered for services from Providers outside of our Network and will be responsible for payment in full. Contact Member Services at 888-257-1985 or visit tuftshealthplan.com/memberlogin to find an In-Network Provider. See <i>Preventive health services</i> for information about routine health care. | | |
| <u>Office and community health center visits</u> | | |
| Primary Care Provider (PCP) | \$30 Copayment per visit after Deductible | No Prior Authorization required. |
| Specialist | \$60 Copayment per visit after Deductible | Prior Authorization required for certain specialist visits. |
| MinuteClinic | \$30 Copayment per visit after Deductible | No Prior Authorization required. A walk-in clinic accessible at select CVS locations in our Service Area. |
| Nutritional counseling | See <i>Medical care Outpatient visits</i> | Prior Authorization required. |
| Observation services | \$750 Copayment after Deductible | No Prior Authorization required. Hospital services to treat and/or evaluate a condition that should result in either a discharge within 48 hours or a verified diagnosis and concurrent treatment plan. |
| Organ or bone marrow transplant | See <i>Inpatient medical and surgical care</i> | Prior Authorization required. |
| Outpatient surgery services | | |
| <u>Outpatient Day Surgery</u> | | |
| Outpatient Hospital or Ambulatory Surgery Center Facility Fee | \$500 Copayment after Deductible | Prior Authorization required for certain services. |
| Professional fee | No charge after Deductible | Includes physician and other covered professional Provider services |
| <u>Office and community health center surgical services</u> | See <i>Medical care Outpatient visits</i> | |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|--|--|
| Pain management | Cost Sharing varies based on type and place of service. | Prior Authorization is not required to begin care. Cost Sharing based on type of service, for example , Nutritional counseling, Physical therapy or Chiropractic care |
| Podiatry care | See <i>Medical care Outpatient visits</i> | No Prior Authorization required. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot. |
| Prescription drugs and supplies | | See the Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost Share. Refer to Formulary for a complete list. |
| Retail pharmacy (up to 30-Day supply) | | |
| Tier 1 | \$30 Copayment after Deductible | Primarily generic drugs |
| Tier 2 | \$60 Copayment after Deductible | Includes some non-preferred generics and preferred brands |
| Tier 3 | \$105 Copayment after Deductible | Includes high-cost generics, non-preferred brands, and Specialty drugs |
| Mail order pharmacy (up to 90-Day supply) | | |
| Tier 1 | \$60 Copayment after Deductible | Primarily generic drugs |
| Tier 2 | \$120 Copayment after Deductible | Includes some non-preferred generics and preferred brands |
| Tier 3 | \$315 Copayment after Deductible | Includes high-cost generics, non-preferred brands, and Specialty drugs |
| Preventive health services | | |
| Preventive Health services are routine health care that include screenings, check-ups, and counseling to prevent illnesses, disease, or other health problems. Certain Preventive health services may require Prior Authorization. Work with your PCP to use the <i>Preventive Services</i> policy in the <i>Patient Protection and Affordable Care Act</i> chapter of our Provider Manual at https://point32health.org/provider/provider-manuals/tufts-health-public-plans-provider-manual/ to review specific requirements. | | |
| Routine pediatric care | No charge | Includes but is not limited to routine annual physical exams; screenings, immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning |
| Routine adult care | No charge | Includes but is not limited to routine annual physical exams; screenings; immunizations; routine lab tests and x-rays; routine mammograms; and routine colonoscopies |
| Routine gynecological (GYN) care | No charge | Includes but is not limited to routine exams and cervical cancer screenings (Pap smear tests) |
| Family planning | No charge | |
| Smoking Cessation Counseling Services | No charge | |
| Reconstructive surgery and procedures | See <i>Outpatient surgery or Inpatient medical and surgical care</i> | Certain services may require Prior Authorization. |
| Skilled Nursing Facility | \$750 Copayment per stay after Deductible | Maximum of 100 Days total per Member per Plan Year |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---|--|
| Telehealth | See <i>Medical care Outpatient visits</i> | Please ask your Providers' office for information on Telehealth availability and access. |
| Urgent care | \$60 Copayment per visit after Deductible | No Prior Authorization required. In our Service Area, you must visit a UCC that is in our Network to be covered for services. Outside of our Service Area, free-standing Urgent Care Centers (UCCs) are covered at Out-of-Network Provider sites, including Hospitals and clinics. |
| Vision care | | |
| You must receive routine eye examinations from a Provider in the EyeMed Vision Care Select network in order to obtain coverage for these services. Call EyeMed at 866-504-5908 for the names of EyeMed Select Providers. | | |
| Routine care | \$60 Copayment per visit after Deductible | Coverage for routine eye exams once every 12 months; |
| Eyeglasses for children (under 19 years of age) | 20% Coinsurance after deductible | Eyeglasses covered once every 12 months; \$150 allowance + 20% off expense beyond allowance. |
| Medical eye care | See <i>Medical care Outpatient visits</i> | |
| Weight loss programs | No charge for 3 months of membership fees for a qualified program | 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 Plan Year. Must complete a Weight Loss Program Reimbursement Form . See the Tufts Health Direct Member Handbook for more information on limitations. |

Services not covered

See the section "Services not covered" in the *Tufts Health Direct Member Handbook* for the list of services not covered.

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Schedule of Benefits

This Schedule of Benefits gives you information about your Tufts Health Direct Covered Services and costs you may have to pay. Make sure you review the services you are eligible for under the Schedule of Benefits for your specific Plan. To see which Tufts Health Direct Plan you have, check your Tufts Health Plan Member ID Card.

If you want more information about your benefits and capitalized terms, see your Tufts Health Direct Member Handbook tuftshealthplan.com/documents/members/handbooks/direct-member-handbook-2026.

You must go to Providers who are part of the Tufts Health Direct Provider Network to get services. Out-of-Network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal.

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 (TTY: 711, for people with partial or total hearing loss).

You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document. Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The amounts of the Annual Deductible and Annual Out-of-pocket Maximum which apply to you and the enrolled Members of your family each Plan Year are:

| ANNUAL DEDUCTIBLE | AMOUNT | NOTES |
|-------------------|---------|---|
| Individual | \$2,900 | The Individual Deductible applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Deductible even if other Members on the family Plan have not. |
| Family | \$5,800 | Once two or more Members on a family Plan meet the Family Annual Deductible, the entire family is considered to have met the Deductible for the Plan Year. |

| ANNUAL OUT-OF-POCKET MAXIMUM | AMOUNT | NOTES |
|------------------------------|----------|---|
| Individual | \$10,150 | The Individual Out-of-pocket Maximum applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Out-of-pocket Maximum even if other Members on the family Plan have not. |
| Family | \$20,300 | Once two or more Members on a family Plan meet the Family Annual Out-of-pocket Maximum amount, the entire family is considered to have met the Out-of-pocket Maximum for the Plan Year. |

Notice for American Indian and Alaskan Native (AI/AN) Members: All American Indian/Alaskan Native Members, regardless of income, can enroll in a limited Cost Sharing Plan at any metal level, which means no Copayments, Deductibles, or Coinsurance when receiving care from Indian health care Providers. The Massachusetts Health Connector determines your eligibility to enroll in this Plan variation as part of your application process.

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|---|---|---|
| Abortion services | No charge | No Prior Authorization required. |
| Allergy services | | |
| Allergy testing | \$65 Copayment per visit after Deductible | No Prior Authorization required. Covered for up to 200 allergy tests per Plan Year. |
| Allergy treatments (injections) | \$10 Copayment per injection after Deductible | Note: Allergy immunotherapy covered as part of the pharmacy prescription benefit may require Prior Authorization and have separate pharmacy Cost Sharing responsibility. |
| Outpatient medical office visits | See <i>Medical care Outpatient visits</i> | |
| Ambulance services | No charge after Deductible | No Prior Authorization required for Emergency transportation. Non-emergency basic or advanced life support, ground ambulance transportation may be covered with Prior Authorization. Services to and from medical appointments, transport by taxi, public transportation, and the use of chair cars are not covered |
| Behavioral Health services - Mental Health & Substance Use Disorder | | |
| <u>Inpatient services</u> | | Behavioral Health Urgent and Emergent levels of care do not require Prior Authorization. |
| Facility Fee | \$1,000 Copayment per stay after Deductible | Includes room and board and services supplied by the facility during the inpatient stay. |
| Professional fee | No charge after Deductible | Includes physician and other covered professional Provider services |
| Intensive community based acute treatment (ICBAT) for Children and adolescents | \$1,000 Copayment per stay after Deductible | No Prior Authorization required for admission. |
| <u>Outpatient services</u> | | |
| Individual therapy/Counseling | \$30 Copayment per visit after Deductible | No Prior Authorization required. No visit limits. |
| Applied Behavioral Analysis (ABA) | \$30 Copayment per visit after Deductible | Prior Authorization required. Includes assessments, evaluations, testing, and treatment; covered in home, Outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst for treatment of Autism Spectrum Disorder or Down Syndrome |
| Intermediate care, including Behavioral Health (mental health and/or substance use) services for children and adolescents | \$30 Copayment per visit after Deductible | Prior Authorization is required for certain Behavioral Health (mental health and/or substance use) services for children and adolescents. Please see the "Covered Services" section of the Tufts Health Direct Member Handbook for more information about these services. |
| Medication-Assisted Treatment services | \$30 Copayment per visit after Deductible | Certain medication may require Prior Authorization. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---|---|
| Mental Health Wellness Exam | No charge | Annual mental health wellness examination performed by a Licensed Mental Health Professional. Please Note: Your annual mental health wellness examination may also be provided by a PCP during your annual routine physical exam. |
| Recovery Coaches and Peer Specialists | No charge | No Prior Authorization required. |
| Chemotherapy and radiation oncology services | No charge after Deductible | Certain services require Prior Authorization. |
| Chiropractic care | \$65 Copayment per visit after Deductible | No Prior Authorization required. |
| Cleft palate and cleft lip care | No charge after Deductible. Additional Cost Sharing may apply based on place of service | Covered for Members under the age of 18. Includes medical, dental, oral, and facial surgery, follow-up, and related services. See <i>Outpatient surgery services; Dental care; Medical care Outpatient visits; Speech, hearing, and language therapy; and Nutritional counseling</i> for related Cost Share. |
| Clinical trials | Based on place of service | No Prior Authorization required. Includes services that are Medically Necessary for the treatment of your condition and the reasonable cost of investigational drug or device approved for use in the trial but not otherwise paid for by its manufacturer, distributor, or Provider. |
| COVID-19 Testing/Treatment | No charge | |
| Dental care, accidental | Based on place of service | No Prior Authorization required. See <i>Emergency Room care, Outpatient surgery services, or Urgent care</i> for related Cost Share. Coverage for services related to teeth is limited to the Emergency treatment of accidental injury to sound, natural and permanent teeth when caused by a source external to the mouth. |
| Dental care, non-Emergency (Pediatric only, Delta Dental) | | |
| Members are eligible for services until the last Day of the month in which they turn 19 years old. Please call Delta Dental at 800-872-0500 for more information and for Prior Authorization requirements. | | |
| Type I: Preventive & Diagnostic | No charge | Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age. |
| Type II: Basic Covered Services | 25% Coinsurance after Deductible | |
| Type III: Major restorative services | 50% Coinsurance after Deductible | |
| Type IV: Orthodontia | 50% Coinsurance after Deductible | Medically Necessary orthodontia requires Prior Authorization. |
| Diabetes education and treatment | Cost Sharing varies based on type and place of service. | Prior Authorization required for certain services. No charge for the NationsNutrition™ program. See <i>Durable Medical Equipment; Prescription drugs and supplies; Medical care Outpatient visits; and Nutritional Counseling</i> for related Cost Share. |
| Diagnostic services (Outpatient laboratory services, imaging, radiology, and other diagnostic testing) | | |
| Laboratory services | \$50 Copayment after Deductible | Includes blood tests, urinalysis, and throat cultures to maintain health and to test, diagnose, and treat disease. Genetic testing requires Prior Authorization. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|--|--|
| X-rays | \$100 Copayment after Deductible | No Prior Authorization required. |
| Advanced imaging (MRI, CT, PET scans) | \$350 Copayment after Deductible | Prior Authorization required. |
| Sleep studies | Related <i>Medical care</i> <i>Outpatient visit</i> or <i>Inpatient medical care</i> Cost Sharing may be required | Prior Authorization required. |
| Other diagnostic testing | \$50 Copayment after Deductible | Certain services require Prior Authorization . |
| Dialysis services | No charge after Deductible | No Prior Authorization required. |
| Disease Management Programs | No charge | For Members with asthma, diabetes, chronic obstructive pulmonary disease (COPD) or congestive heart failure. If you have any of these conditions, please contact us at 888-257-1985 to discuss our disease management programs. |
| Durable Medical Equipment (DME) | | |
| Covered medical equipment rented or purchased for home use | 20% Coinsurance after Deductible | Prior Authorization is required for certain services, including prosthetic orthotics. Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs. |
| Hearing aids | 20% Coinsurance after Deductible | Covered for Members 21 and younger. This includes the cost of one hearing aid per hearing-impaired ear up to \$2,000 per ear every 36 months. This includes both the amount Tufts Health Direct pays and the applicable Member Cost Share as listed in this document. Related services and supplies do not count toward the \$2,000 limit. |
| Wigs | 20% Coinsurance after Deductible | Limit of 1 wig per Plan Year. |
| Early Intervention services | No charge | No Prior Authorization required. Covered for Members up to age 3; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention Specialist. |
| Emergency Room care | \$400 Copayment after Deductible | No Prior Authorization required. Emergency Room Cost Share waived if held for <i>Observation services</i> , sent for <i>Outpatient Surgery services</i> or admitted for <i>Inpatient medical or surgical care</i> . |
| Fitness center reimbursement | Covered for 3 months | After being an enrolled Member for four consecutive months and participating with a standard fitness center in the current Plan Year, we cover up to \$200 of membership fees incurred in the Plan Year. See the <i>Tufts Health Direct Member Handbook</i> for more information on limitations. Must complete a Fitness Center Reimbursement Form . |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---|---|
| Gender affirming services | Cost Sharing varies based on type and place of service. | Prior Authorization required. Medically necessary services may include Inpatient medical and surgical care, Outpatient Surgery, Diagnostic services, Speech therapy, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies among other services. |
| Habilitative and rehabilitative services | \$65 Copayment per visit after Deductible | Includes cardiac rehabilitation; physical therapy; Occupational Therapy; and speech, hearing, and language therapy services. See below for specific details. |
| <u>Limits:</u> | | |
| Cardiac rehabilitation | | |
| Physical and Occupational Therapy | | Prior Authorization required after initial evaluation and 11 visits. Maximum of 60 visits total Physical and Occupational Therapy per Member per Plan Year. Limits do not apply for Autism Spectrum Disorder services. |
| Speech, hearing, and language therapy | | Prior Authorization required after visit 30. No visit limits. |
| Home health care | No charge after Deductible | Prior Authorization is required for all home care services and disciplines. |
| Hospice services | No charge after Deductible | Prior Authorization required. |
| Infertility services & treatment | Cost Sharing varies based on type and place of service. | Prior Authorization required. Medically necessary services may include <i>Inpatient medical and surgical care, Outpatient Surgery, Diagnostic services, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies</i> among other services. |
| Inpatient medical and surgical care | | |
| No Prior Authorization required for Inpatient admissions from the Emergency room. Planned admissions require Prior Authorization 5 business days before admission. | | |
| Facility Fee | \$1,000 Copayment per stay after Deductible | Includes room and board and services supplied by the facility during the inpatient stay, including preadmission testing, anesthesia, diagnostic services, and medication and supplies |
| Professional Fee | No charge after Deductible | Includes physician and other covered professional Provider services |
| Long Term Acute Care Hospital or Acute Rehabilitation Hospital | \$1,000 Copayment per stay after Deductible | Maximum of 60 Days total per Member per Plan Year |
| Maternity services and Well Newborn care | | |
| Childbirth classes | Covered for cost of childbirth education course | Complete a Member Reimbursement Medical Claim Form and submit by mail with proof of payment. |
| Routine prenatal and postpartum care | No charge | All Outpatient routine prenatal and postpartum office visits are covered as well as breastfeeding services and supports. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|---|---|--|
| Non-routine prenatal care | Cost Sharing varies based on type and place of service. | Any Outpatient maternity services not considered routine or those related to complications or risks with a pregnancy, may be subject to Cost Sharing. Some examples of services not considered routine include, but are not limited to, amniocentesis, fetal stress testing, and OB ultrasounds. |
| Hospital and delivery services | See <i>Inpatient medical and surgical care</i> | Well newborn care is included as part of covered maternity admission. |
| Breast pumps | No charge if billed per Preventive Services Policy; Otherwise, 20% Coinsurance after Deductible | No Prior Authorization required. One breast pump per birth including related parts and supplies. Covered for the purchase of a manual or electric pump or the rental of a hospital-grade pump when deemed appropriate by the ordering Provider. Pump must be obtained from contracting DME Provider. |
| Medical drugs | No charge after Deductible | Prior Authorization required for certain drugs. Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit. |
| Medical care Outpatient visits | | |
| Medical Care includes services to diagnose, treat, and maintain a health condition. Medical care services are covered by Providers in the Tufts Health Direct Network. You are not covered for services from Providers outside of our Network and will be responsible for payment in full. Contact Member Services at 888-257-1985 or visit tuftshealthplan.com/memberlogin to find an In-Network Provider. See <i>Preventive health services</i> for information about routine health care. | | |
| <u>Office and community health center visits</u> | | |
| Primary Care Provider (PCP) | \$30 Copayment per visit after Deductible | No Prior Authorization required. |
| Specialist | \$65 Copayment per visit after Deductible | Prior Authorization required for certain specialist visits. |
| MinuteClinic | \$30 Copayment per visit after Deductible | No Prior Authorization required. A walk-in clinic accessible at select CVS locations in our Service Area. |
| Nutritional counseling | See <i>Medical care Outpatient visits</i> | Prior Authorization required. |
| Observation services | \$1,000 Copayment after Deductible | No Prior Authorization required. Hospital services to treat and/or evaluate a condition that should result in either a discharge within 48 hours or a verified diagnosis and concurrent treatment plan. |
| Organ or bone marrow transplant | See <i>Inpatient medical and surgical care</i> | Prior Authorization required. |
| Outpatient surgery services | | |
| <u>Outpatient Day Surgery</u> | | |
| Outpatient Hospital or Ambulatory Surgery Center Facility Fee | \$500 Copayment after Deductible | Prior Authorization required for certain services. |
| Professional fee | No charge after Deductible | Includes physician and other covered professional Provider services |
| <u>Office and community health center surgical services</u> | See <i>Medical care Outpatient visits</i> | |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|--|--|
| Pain management | Cost Sharing varies based on type and place of service. | Prior Authorization is not required to begin care. Cost Sharing based on type of service, for example , Nutritional counseling, Physical therapy or Chiropractic care |
| Podiatry care | See <i>Medical care Outpatient visits</i> | No Prior Authorization required. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot. |
| Prescription drugs and supplies | | See the Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost Share. Refer to Formulary for a complete list. |
| Retail pharmacy (up to 30-Day supply) | | |
| Tier 1 | \$30 Copayment | Primarily generic drugs |
| Tier 2 | \$65 Copayment after Deductible | Includes some non-preferred generics and preferred brands |
| Tier 3 | \$100 Copayment after Deductible | Includes high-cost generics, non-preferred brands, and Specialty drugs |
| Mail order pharmacy (up to 90-Day supply) | | |
| Tier 1 | \$60 Copayment | Primarily generic drugs |
| Tier 2 | \$130 Copayment after Deductible | Includes some non-preferred generics and preferred brands |
| Tier 3 | \$300 Copayment after Deductible | Includes high-cost generics, non-preferred brands, and Specialty drugs |
| Preventive health services | | |
| Preventive Health services are routine health care that include screenings, check-ups, and counseling to prevent illnesses, disease, or other health problems. Certain Preventive health services may require Prior Authorization. Work with your PCP to use the <i>Preventive Services</i> policy in the <i>Patient Protection and Affordable Care Act</i> chapter of our Provider Manual at https://point32health.org/provider/provider-manuals/tufts-health-public-plans-provider-manual/ to review specific requirements. | | |
| Routine pediatric care | No charge | Includes but is not limited to routine annual physical exams; screenings, immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning |
| Routine adult care | No charge | Includes but is not limited to routine annual physical exams; screenings; immunizations; routine lab tests and x-rays; routine mammograms; and routine colonoscopies |
| Routine gynecological (GYN) care | No charge | Includes but is not limited to routine exams and cervical cancer screenings (Pap smear tests) |
| Family planning | No charge | |
| Smoking Cessation Counseling Services | No charge | |
| Reconstructive surgery and procedures | See <i>Outpatient surgery or Inpatient medical and surgical care</i> | Certain services may require Prior Authorization. |
| Skilled Nursing Facility | \$1,000 Copayment per stay after Deductible | Maximum of 100 Days total per Member per Plan Year |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---|--|
| Telehealth | See <i>Medical care Outpatient visits</i> | Please ask your Providers' office for information on Telehealth availability and access. |
| Urgent care | \$65 Copayment per visit after Deductible | No Prior Authorization required. In our Service Area, you must visit a UCC that is in our Network to be covered for services. Outside of our Service Area, free-standing Urgent Care Centers (UCCs) are covered at Out-of-Network Provider sites, including Hospitals and clinics. |
| Vision care | | |
| You must receive routine eye examinations from a Provider in the EyeMed Vision Care Select network in order to obtain coverage for these services. Call EyeMed at 866-504-5908 for the names of EyeMed Select Providers. | | |
| Routine care | \$65 Copayment per visit after Deductible | Coverage for routine eye exams once every 12 months; |
| Eyeglasses for children (under 19 years of age) | 20% Coinsurance after deductible | Eyeglasses covered once every 12 months; \$150 allowance + 20% off expense beyond allowance. |
| Medical eye care | See <i>Medical care Outpatient visits</i> | |
| Weight loss programs | No charge for 3 months of membership fees for a qualified program | 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 Plan Year. Must complete a Weight Loss Program Reimbursement Form . See the Tufts Health Direct Member Handbook for more information on limitations. |

Services not covered

See the section "Services not covered" in the *Tufts Health Direct Member Handbook* for the list of services not covered.

Direct Catastrophic

Schedule of Benefits

This Schedule of Benefits gives you information about your Tufts Health Direct Covered Services and costs you may have to pay. Make sure you review the services you are eligible for under the Schedule of Benefits for your specific Plan. To see which Tufts Health Direct Plan you have, check your Tufts Health Plan Member ID Card.

If you want more information about your benefits and capitalized terms, see your Tufts Health Direct Member Handbook tuftshealthplan.com/documents/members/handbooks/direct-member-handbook-2026.

You must go to Providers who are part of the Tufts Health Direct Provider Network to get services. Out-of-Network services require Prior Authorization, except for Emergency care and out of the Service Area Urgent Care. For Primary Care, you must see the Primary Care Provider (PCP) you have on record in the Member Portal.

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 (TTY: 711, for people with partial or total hearing loss).

You are responsible for paying the Deductible, Copayment, and/or Coinsurance amounts listed in this document. Deductible, Coinsurance and Copayments apply toward your Out-of-pocket Maximum. The amounts of the Annual Deductible and Annual Out-of-pocket Maximum which apply to you and the enrolled Members of your family each Plan Year are:

| ANNUAL DEDUCTIBLE | AMOUNT | NOTES |
|-------------------|----------|---|
| Individual | \$10,600 | The Individual Deductible applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Deductible even if other Members on the family Plan have not. |
| Family | \$21,200 | Once two or more Members on a family Plan meet the Family Annual Deductible, the entire family is considered to have met the Deductible for the Plan Year. |

| ANNUAL OUT-OF-POCKET MAXIMUM | AMOUNT | NOTES |
|------------------------------|----------|---|
| Individual | \$10,600 | The Individual Out-of-pocket Maximum applies to a single Member enrolled on either an individual or family Plan. This means a Member enrolled on a family Plan can meet the Individual Out-of-pocket Maximum even if other Members on the family Plan have not. |
| Family | \$21,200 | Once two or more Members on a family Plan meet the Family Annual Out-of-pocket Maximum amount, the entire family is considered to have met the Out-of-pocket Maximum for the Plan Year. |

Notice for American Indian and Alaskan Native (AI/AN) Members: All American Indian/Alaskan Native Members, regardless of income, can enroll in a limited Cost Sharing Plan at any metal level, which means no Copayments, Deductibles, or Coinsurance when receiving care from Indian health care Providers. The Massachusetts Health Connector determines your eligibility to enroll in this Plan variation as part of your application process.

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|---|---|---|
| Abortion services | No charge | No Prior Authorization required. |
| Allergy services | | |
| Allergy testing | No charge after Deductible | No Prior Authorization required. Covered for up to 200 allergy tests per Plan Year. |
| Allergy treatments (injections) | No charge after Deductible | Note: Allergy immunotherapy covered as part of the pharmacy prescription benefit may require Prior Authorization and have separate pharmacy Cost Sharing responsibility. |
| Outpatient medical office visits | See <i>Medical care Outpatient visits</i> | |
| Ambulance services | No charge after Deductible | No Prior Authorization required for Emergency transportation. Non-emergency basic or advanced life support, ground ambulance transportation may be covered with Prior Authorization. Services to and from medical appointments, transport by taxi, public transportation, and the use of chair cars are not covered |
| Behavioral Health services - Mental Health & Substance Use Disorder | | |
| <u>Inpatient services</u> | | Behavioral Health Urgent and Emergent levels of care do not require Prior Authorization. |
| Facility Fee | No charge after Deductible | Includes room and board and services supplied by the facility during the inpatient stay. |
| Professional fee | No charge after Deductible | Includes physician and other covered professional Provider services |
| Intensive community based acute treatment (ICBAT) for Children and adolescents | No charge after Deductible | No Prior Authorization required for admission. |
| <u>Outpatient services</u> | | |
| Individual therapy/Counseling | No charge after Deductible | No Prior Authorization required. No visit limits. |
| Applied Behavioral Analysis (ABA) | No charge after Deductible | Prior Authorization required. Includes assessments, evaluations, testing, and treatment; covered in home, Outpatient, or office setting by board-certified behavior analyst or board-certified assistant behavior analyst for treatment of Autism Spectrum Disorder or Down Syndrome |
| Intermediate care, including Behavioral Health (mental health and/or substance use) services for children and adolescents | No charge after Deductible | Prior Authorization is required for certain Behavioral Health (mental health and/or substance use) services for children and adolescents. Please see the "Covered Services" section of the Tufts Health Direct Member Handbook for more information about these services. |
| Medication-Assisted Treatment services | No charge after Deductible | Certain medication may require Prior Authorization. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---|---|
| Mental Health Wellness Exam | No charge | Annual mental health wellness examination performed by a Licensed Mental Health Professional. Please Note: Your annual mental health wellness examination may also be provided by a PCP during your annual routine physical exam. |
| Recovery Coaches and Peer Specialists | No charge | No Prior Authorization required. |
| Chemotherapy and radiation oncology services | No charge after Deductible | Certain services require Prior Authorization. |
| Chiropractic care | No charge after Deductible | No Prior Authorization required. |
| Cleft palate and cleft lip care | No charge after Deductible. Additional Cost Sharing may apply based on place of service | Covered for Members under the age of 18. Includes medical, dental, oral, and facial surgery, follow-up, and related services. See <i>Outpatient surgery services; Dental care; Medical care Outpatient visits; Speech, hearing, and language therapy; and Nutritional counseling</i> for related Cost Share. |
| Clinical trials | Based on place of service | No Prior Authorization required. Includes services that are Medically Necessary for the treatment of your condition and the reasonable cost of investigational drug or device approved for use in the trial but not otherwise paid for by its manufacturer, distributor, or Provider. |
| COVID-19 Testing/Treatment | No charge | |
| Dental care, accidental | Based on place of service | No Prior Authorization required. See <i>Emergency Room care, Outpatient surgery services, or Urgent care</i> for related Cost Share. Coverage for services related to teeth is limited to the Emergency treatment of accidental injury to sound, natural and permanent teeth when caused by a source external to the mouth. |
| Dental care, non-Emergency (Pediatric only, Delta Dental) | | |
| Members are eligible for services until the last Day of the month in which they turn 19 years old. Please call Delta Dental at 800-872-0500 for more information and for Prior Authorization requirements. | | |
| Type I: Preventive & Diagnostic | No charge | Covered 2 exams per year for pediatric dental checkup for Members under 19 years of age. |
| Type II: Basic Covered Services | No charge after Deductible | |
| Type III: Major restorative services | No charge after Deductible | |
| Type IV: Orthodontia | No charge after Deductible | Medically Necessary orthodontia requires Prior Authorization. |
| Diabetes education and treatment | Cost Sharing varies based on type and place of service. | Prior Authorization required for certain services. No charge for the NationsNutrition™ program. See <i>Durable Medical Equipment; Prescription drugs and supplies; Medical care Outpatient visits; and Nutritional Counseling</i> for related Cost Share. |
| Diagnostic services (Outpatient laboratory services, imaging, radiology, and other diagnostic testing) | | |
| Laboratory services | No charge after Deductible | Includes blood tests, urinalysis, and throat cultures to maintain health and to test, diagnose, and treat disease. Genetic testing requires Prior Authorization. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|----------------------------|--|
| X-rays | No charge after Deductible | No Prior Authorization required. |
| Advanced imaging (MRI, CT, PET scans) | No charge after Deductible | Prior Authorization required. |
| Sleep studies | No charge after Deductible | Prior Authorization required. |
| Other diagnostic testing | No charge after Deductible | Certain services require Prior Authorization . |
| Dialysis services | No charge after Deductible | No Prior Authorization required. |
| Disease Management Programs | No charge | For Members with asthma, diabetes, chronic obstructive pulmonary disease (COPD) or congestive heart failure. If you have any of these conditions, please contact us at 888-257-1985 to discuss our disease management programs. |
| Durable Medical Equipment (DME) | | |
| Covered medical equipment rented or purchased for home use | No charge after Deductible | Prior Authorization is required for certain services, including prosthetic orthotics. Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs. |
| Hearing aids | No charge after Deductible | Covered for Members 21 and younger. This includes the cost of one hearing aid per hearing-impaired ear up to \$2,000 per ear every 36 months. This includes both the amount Tufts Health Direct pays and the applicable Member Cost Share as listed in this document. Related services and supplies do not count toward the \$2,000 limit. |
| Wigs | No charge after Deductible | Limit of 1 wig per Plan Year. |
| Early Intervention services | No charge | No Prior Authorization required. Covered for Members up to age 3; includes intake screenings, evaluations and assessments, individual visits, and group sessions. Services must be provided by a certified early intervention Specialist. |
| Emergency Room care | No charge after Deductible | No Prior Authorization required. Emergency Room Cost Share waived if held for <i>Observation services</i> , sent for <i>Outpatient Surgery services</i> or admitted for <i>Inpatient medical or surgical care</i> . |
| Fitness center reimbursement | Covered for 3 months | After being an enrolled Member for four consecutive months and participating with a standard fitness center in the current Plan Year, we cover up to \$200 of membership fees incurred in the Plan Year. See the <i>Tufts Health Direct Member Handbook</i> for more information on limitations. Must complete a Fitness Center Reimbursement Form . |
| Gender affirming services | No charge after Deductible | Prior Authorization required. Medically necessary services may include Inpatient medical and surgical care, Outpatient Surgery, Diagnostic services, Speech therapy, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies among other services. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---|--|
| Habilitative and rehabilitative services | No charge after Deductible | Includes cardiac rehabilitation; physical therapy; Occupational Therapy; and speech, hearing, and language therapy services. See below for specific details. |
| <u>Limits:</u> | | |
| Cardiac rehabilitation | | |
| Physical and Occupational Therapy | | Prior Authorization required after initial evaluation and 11 visits. Maximum of 60 visits total Physical and Occupational Therapy per Member per Plan Year. Limits do not apply for Autism Spectrum Disorder services. |
| Speech, hearing, and language therapy | | Prior Authorization required after visit 30. No visit limits. |
| Home health care | No charge after Deductible | Prior Authorization is required for all home care services and disciplines. |
| Hospice services | No charge after Deductible | Prior Authorization required. |
| Infertility services & treatment | No charge after Deductible | Prior Authorization required. Medically necessary services may include <i>Inpatient medical and surgical care, Outpatient Surgery, Diagnostic services, Medical care Outpatient services, Medical benefit drugs and/or Prescription drugs and supplies</i> among other services. |
| Inpatient medical and surgical care | | |
| No Prior Authorization required for Inpatient admissions from the Emergency room. Planned admissions require Prior Authorization 5 business days before admission. | | |
| Facility Fee | No charge after Deductible | Includes room and board and services supplied by the facility during the inpatient stay, including preadmission testing, anesthesia, diagnostic services, and medication and supplies |
| Professional Fee | No charge after Deductible | Includes physician and other covered professional Provider services |
| Long Term Acute Care Hospital or Acute Rehabilitation Hospital | No charge after Deductible | Maximum of 60 Days total per Member per Plan Year |
| Maternity services and Well Newborn care | | |
| Childbirth classes | Covered for cost of childbirth education course | Complete a Member Reimbursement Medical Claim Form and submit by mail with proof of payment. |
| Routine prenatal and postpartum care | No charge | All Outpatient routine prenatal and postpartum office visits are covered as well as breastfeeding services and supports. |
| Non-routine prenatal care | No charge after Deductible | Any Outpatient maternity services not considered routine or those related to complications or risks with a pregnancy, may be subject to Cost Sharing. Some examples of services not considered routine include, but are not limited to, amniocentesis, fetal stress testing, and OB ultrasounds. |
| Hospital and delivery services | No charge after Deductible | Well newborn care is included as part of covered maternity admission. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---|--|
| Breast pumps | No charge if billed per Preventive Services Policy; Otherwise, no charge after Deductible | No Prior Authorization required. One breast pump per birth including related parts and supplies. Covered for the purchase of a manual or electric pump or the rental of a hospital-grade pump when deemed appropriate by the ordering Provider. Pump must be obtained from contracting DME Provider. |
| Medical drugs | No charge after Deductible | Prior Authorization required for certain drugs. Medical benefit drugs are practitioner-administered, FDA-approved drugs and biologicals that are not a part of the pharmacy benefit. |
| Medical care Outpatient visits | | |
| Medical Care includes services to diagnose, treat, and maintain a health condition. Medical care services are covered by Providers in the Tufts Health Direct Network. You are not covered for services from Providers outside of our Network and will be responsible for payment in full. Contact Member Services at 888-257-1985 or visit tuftshealthplan.com/memberlogin to find an In-Network Provider. See <i>Preventive health services</i> for information about routine health care. | | |
| <u>Office and community health center visits</u> | | |
| Primary Care Provider (PCP) | \$35 Copayment for first 3 non-Preventive PCP visits, then no charge after Deductible | No Prior Authorization required. |
| Specialist | No charge after Deductible | Prior Authorization required for certain specialist visits. |
| MinuteClinic | No charge after Deductible | No Prior Authorization required. A walk-in clinic accessible at select CVS locations in our Service Area. |
| Nutritional counseling | See <i>Medical care Outpatient visits</i> | Prior Authorization required. |
| Observation services | No charge after Deductible | No Prior Authorization required. Hospital services to treat and/or evaluate a condition that should result in either a discharge within 48 hours or a verified diagnosis and concurrent treatment plan. |
| Organ or bone marrow transplant | No charge after Deductible | Prior Authorization required. |
| Outpatient surgery services | | |
| <u>Outpatient Day Surgery</u> | | |
| Outpatient Hospital or Ambulatory Surgery Center Facility Fee | No charge after Deductible | Prior Authorization required for certain services. |
| Professional fee | No charge after Deductible | Includes physician and other covered professional Provider services |
| <u>Office and community health center surgical services</u> | See <i>Medical care Outpatient visits</i> | |
| Pain management | Cost Sharing varies based on type and place of service. | Prior Authorization is not required to begin care. Cost Sharing based on type of service, for example , Nutritional counseling, Physical therapy or Chiropractic care |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---|--|
| Podiatry care | See <i>Medical care</i> <i>Outpatient visits</i> | No Prior Authorization required. Routine foot care is covered only for Members with diabetes and other systemic illnesses that compromise the blood supply to the foot. |
| Prescription drugs and supplies | | See the Formulary for specific Prior Authorization requirements. Some drugs included in Preventive Services mandates are covered with no Cost Share. Refer to Formulary for a complete list. |
| <u>Retail pharmacy</u> (up to 30-Day supply) | | |
| Tier 1 | No charge after Deductible | Primarily generic drugs |
| Tier 2 | No charge after Deductible | Includes some non-preferred generics and preferred brands |
| Tier 3 | No charge after Deductible | Includes high-cost generics, non-preferred brands, and Specialty drugs |
| <u>Mail order pharmacy</u> (up to 90-Day supply) | | |
| Tier 1 | No charge after Deductible | Primarily generic drugs |
| Tier 2 | No charge after Deductible | Includes some non-preferred generics and preferred brands |
| Tier 3 | No charge after Deductible | Includes high-cost generics, non-preferred brands, and Specialty drugs |
| Preventive health services | | |
| Preventive Health services are routine health care that include screenings, check-ups, and counseling to prevent illnesses, disease, or other health problems. Certain Preventive health services may require Prior Authorization. Work with your PCP to use the <i>Preventive Services</i> policy in the <i>Patient Protection and Affordable Care Act</i> chapter of our Provider Manual at https://point32health.org/provider/provider-manuals/tufts-health-public-plans-provider-manual/ to review specific requirements. | | |
| Routine pediatric care | No charge | Includes but is not limited to routine annual physical exams; screenings, immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning |
| Routine adult care | No charge | Includes but is not limited to routine annual physical exams; screenings; immunizations; routine lab tests and x-rays; routine mammograms; and routine colonoscopies |
| Routine gynecological (GYN) care | No charge | Includes but is not limited to routine exams and cervical cancer screenings (Pap smear tests) |
| Family planning | No charge | |
| Smoking Cessation Counseling Services | No charge | |
| Reconstructive surgery and procedures | See <i>Outpatient surgery</i> or <i>Inpatient medical and surgical care</i> | Certain services may require Prior Authorization. |
| Skilled Nursing Facility | No charge after Deductible | Maximum of 100 Days total per Member per Plan Year |
| Telehealth | See <i>Medical care</i> <i>Outpatient visits</i> | Please ask your Providers' office for information on Telehealth availability and access. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|--|---|--|
| Urgent care | No charge after Deductible | No Prior Authorization required. In our Service Area, you must visit a UCC that is in our Network to be covered for services. Outside of our Service Area, free-standing Urgent Care Centers (UCCs) are covered at Out-of-Network Provider sites, including Hospitals and clinics. |
| Vision care | | |
| You must receive routine eye examinations from a Provider in the EyeMed Vision Care Select network in order to obtain coverage for these services. Call EyeMed at 866-504-5908 for the names of EyeMed Select Providers. | | |
| Routine care | No charge after Deductible | Coverage for routine eye exams once every 12 months; |
| Eyeglasses for children (under 19 years of age) | No charge after Deductible | Eyeglasses covered once every 12 months; \$150 allowance + 20% off expense beyond allowance. |
| Medical eye care | See <i>Medical care Outpatient visits</i> | |
| Weight loss programs | No charge for 3 months of membership fees for a qualified program | 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 Plan Year. Must complete a Weight Loss Program Reimbursement Form . See the Tufts Health Direct Member Handbook for more information on limitations. |

Services not covered

See the section “Services not covered” in the *Tufts Health Direct Member Handbook* for the list of services not covered

Appendix C: Schedule II and III Opioid Drug List

Schedule II and Schedule III drugs are defined under Massachusetts law. Please see www.mass.gov for those definitions. In accordance with Massachusetts law, if you are prescribed any of these medications and wish to have a quantity less than what was prescribed, no additional cost or penalty will be imposed on you. If you fill a lesser quantity than is prescribed of a Schedule II opioid controlled substance and then decide to fill the remainder of the original prescription at the same pharmacy within 30 Days of the original prescription date, no additional Copayment or other Cost Sharing will be applied. This list is subject to change throughout the year. Please call a Member Services Representative at 888-257-1985 (TTY: 711, for people with partial or total hearing loss) for the most current information about Schedule II and III medications covered by Tufts Health Plan.

Schedule II medications

- [acetaminophen/hydrocodone]
- [acetaminophen/oxycodone]
- [aspirin/oxycodone]
- [belladonna/opium suppositories]
- [brompheniramine/hydrocodone/phenylephrine]
- [brompheniramine/hydrocodone/pseudoephedrine]
- [chlorpheniramine polistirex/hydrocodone polistirex]
- [chlorpheniramine/hydrocodone]
- [chlorpheniramine/hydrocodone/phenylephrine]
- [chlorpheniramine/hydrocodone/pseudoephedrine]
- [codeine sulfate]
- [dextbrompheniramine/hydrocodone/phenylephrine]
- [dexchlorpheniramine/hydrocodone/phenylephrine]
- [diphenhydramine/hydrocodone/phenylephrine]
- [fentanyl]
- [guaifenesin/hydrocodone/phenylephrine]
- [guaifenesin/hydrocodone/pseudoephedrine]
- [hydrocodone]
- [hydrocodone ER]
- [hydrocodone/homatropine]

- [hydrocodone/ibuprofen]
- [hydrocodone/phenylephrine/pyrilamine]
- [hydrocodone/potassium guaiacolsulfonate]
- [hydrocodone/pseudoephedrine]
- [hydromorphone]
- [hydromorphone ER]
- [ibuprofen/oxycodone]
- [levorphanol tartrate]
- [meperidine]
- [meperidine/promethazine]
- [methadone]
- [morphine]
- [morphine ER]
- [morphine sulfate ER]
- [morphine/naltrexone]
- [naltrexone/oxycodone]
- [opium tincture]
- [oxycodone]
- [oxycodone ER]
- [oxymorphone]
- [oxymorphone ER]
- [tapentadol]

Schedule III medications

- [acetaminophen/butalbital/caffeine/codeine]
- [acetaminophen/caffeine/dihydrocodeine]
- [acetaminophen/chlorpheniramine/codeine]
- [acetaminophen/codeine]
- [aspirin/butalbital/caffeine/codeine]

- [aspirin/caffeine/dihydrocodeine]
- [aspirin/carisoprodol/codeine]
- [aspirin/codeine]
- [brompheniramine/dihydrocodeine/pseudoephedrine]
- [chlorpheniramine/codeine]
- [codeine/guaifenesin]
- [codeine/guaifenesin/pseudoephedrine]
- [dihydrocodeine/guaifenesin]
- [dihydrocodeine/guaifenesin/phenylephrine]
- [dihydrocodeine/phenylephrine/pyrilamine]

Appendix D: Service Area Map

Tufts Health Direct coverage area includes mainland Massachusetts. Martha's Vineyard and Nantucket are not included.

