Direct Bronze 2850

Schedule of Benefits

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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 Type. To see which Tufts Health Direct Plan Type 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* https://tuftshealthplan.com/documents/members/handbooks/direct-member-handbook-2024.

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).

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	$2,850	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	$5,700	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	$9,450	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	$18,900	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.
Acupuncture services	$65 Copayment per visit after Deductible	No Prior Authorization required. No visit limits.
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 visit 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 *Medical care Outpatient visits*	
Ambulance services		
Emergency	No charge after Deductible	No Prior Authorization required.
Other non-Emergency transportation	No charge after Deductible	Prior Authorization required.
Behavioral Health services - Mental Health & Substance Use Disorder		
Inpatient services		No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission 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.
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. Notification to the Plan is required within 48 hours of the Inpatient admission.
Outpatient services		
Individual therapy/Counseling	$30 Copayment per visit after Deductible	No Prior Authorization required. No visit limits.
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
Behavioral Health services - Mental Health & Substance Use Disorder, continued		
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.
Methadone treatment	No charge	No Prior Authorization required. Includes dosing, counseling, and lab services
Recovery Coaches and Peer Specialists	No charge	No Prior Authorization required.
Substance Use Treatment Programs	Cost sharing varies based on type and place of service.	
Autism Spectrum Disorder Services		
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
Habilitative and rehabilitative services	$65 Copayment per visit after Deductible	Physical, occupational, and speech therapy benefit limits do not apply.
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.
Clinical trials	Based on place of service	No Prior Authorization required. Routine patient care services covered for Members in a qualified clinical trial pursuant to state and federal mandates.
Dental care, accidental	Based on place of service	No Prior Authorization required. 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.

Covered Services	Cost Sharing	Benefit Limit & Notes
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 Good Measures program.
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.
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 *Medical care Outpatient visit* or *Inpatient medical care* 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.

Covered Services	Cost Sharing	Benefit Limit & Notes
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.
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 per visit after Deductible	No Prior Authorization required. Emergency Room Cost Share waived if held for *Observation services,* sent for *Outpatient surgery services* or admitted for *Inpatient medical or surgical care*. If admitted to the Hospital, Notification required within 48 hours.
Fitness center reimbursement	Covered for 3 months	Covered for 3 months of membership at a standard fitness center; excludes initiation fees. This benefit is available to Members once every Plan Year after being a Member for 4 months. See the *Tufts Health Direct Member Handbook* 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	$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.
Limits:		
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.
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	Cost Sharing varies based on type and place of service.	Prior Authorization required. Medically necessary services may include I*npatient medical and surgical care*, *Outpatient surgery*, *Diagnostic services*, *Medical care Outpatient services*, *Medical benefit drugs* and/or *Prescription drugs and supplies* among other services.
Inpatient medical and surgical care Hospital; Chronic Disease Hospital; Rehabilitation Hospital; or Skilled Nursing Facility (SNF)		No Prior Authorization required for Inpatient admissions from the Emergency room. Notification to the Plan is required within 48 hours of the admission 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
Limits:		
Chronic Disease or Rehabilitation Hospital		Maximum of 60 Days total per Member per Plan Year
Skilled Nursing Facility		Maximum of 100 Days total per Member per Plan Year

Covered Services	Cost Sharing	Benefit Limit & Notes
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	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 *Inpatient medical and surgical care*	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 benefit 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 *Preventive health services* for information about routine health care.		
Office and community health center visits		
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
Nutritional counseling	See *Medical care Outpatient visits*	Prior Authorization required.

Covered Services	Cost Sharing	Benefit Limit & Notes
Observation services	$400 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 *Inpatient medical and surgical care*	Prior Authorization required.
Outpatient surgery services		
Outpatient day surgery		
Outpatient Hospital or Ambulatory Surgery Center facility fee	$500 Copayment per visit after Deductible	Prior Authorization required for certain services.
Professional fee	No charge after Deductible	Includes physician and other covered professional Provider services
Office and community health center surgical services	See *Medical care Outpatient visits*	
Pain management	Cost Sharing varies based on type and place of service.	Certain services require Prior Authorization. Cost Sharing based on type of service, for example Acupuncture, Nutritional counseling, Physical therapy or Chiropractic care
Podiatry care	See *Medical care Outpatient visits*	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 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		
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		
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

Covered Services	Cost Sharing	Benefit Limit & Notes
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 Preventive Services Policy to review specific requirements.		
Routine pediatric care	No charge	Includes but is not limited to routine exams; 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 exams; 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 *Outpatient surgery* or *Inpatient medical and surgical care*	Certain services may require Prior Authorization.
Telehealth	See *Medical care Outpatient visits*	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 pediatric care (under 19 years of age)	$30 Copayment per visit after Deductible	Coverage for routine eye exams once every 12 months; Eyeglasses covered once every 12 months; Collection frames only or $150 allowance + 20% off expense beyond allowance. Members are eligible for pediatric services until the last Day of the month in which they turn 19 years old.
Routine adult care (age 19 or older)	$30 Copayment per visit after Deductible	Coverage for routine eye exams once every 12 months for diabetics and once every 24 months for non-diabetics.
Medical eye and vision care	See *Medical care Outpatient visits*	

Covered Services	Cost Sharing	Benefit Limit & Notes
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.