# Direct ConnectorCare III

## 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** | $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<br>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<br>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. |
| **Acupuncture services** | $22 Copayment per visit | No Prior Authorization required. No visit limits. |
| **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) | $7 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 *Medical care outpatient visits* | |
| **Ambulance services** | | |
| Emergency | No charge | No Prior Authorization required. |
| Other non-Emergency transportation | No charge | 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 | $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 | 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 | No charge | 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) | 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. |
| Habilitative and rehabilitative services | $20 Copayment per visit | Physical, occupational, and speech therapy benefit limits do not apply. |
| **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. |
| **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 | 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 Good Measures program. |
| **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. |
| Advanced imaging (MRI, CT, PET scans) | $60 Copayment | 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 | 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. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|---|---|---|
| **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. |
| **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 *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** | $20 Copayment per visit | 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 | Prior Authorization is required for all home care services and disciplines. |
| **Hospice services** | No charge | 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 | $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 |
| Limits: | | |
| Chronic Disease or Rehabilitation Hospital | | Maximum of 60 Days total per Member per Plan Year |
| Skilled Nursing Facility | No charge | 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 | 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 | 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) | 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 |
| **Nutritional counseling** | See *Medical care Outpatient visits* | Prior Authorization required. |

| Covered Services | Cost Sharing | Benefit Limit & Notes |
|---|---|---|
| **Observation services** | $100 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 *Inpatient medical and surgical care* | Prior Authorization required. |
| **Outpatient surgery services** | | |
| Outpatient day surgery | | |
| 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 |
| 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 | $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 | | |
| 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 |

| 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** | $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 pediatric care (under 19 years of age) | No charge | 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) | No charge | 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.