Direct Gold 1000

Schedule of Benefits

TUFTS Health Plan
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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. 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-2027.

You must go to Providers who are part of the Tufts Health Direct Provider Network to get services. Services from Non-Plan Providers require Prior Authorization, except for Emergency care and Urgent Care outside of the Service Area. 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 a Plan 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	$7,500	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	$15,000	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	$45 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 *Medical care Outpatient visits*	
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		
Inpatient services		Behavioral Health Urgent and Emergent levels of care do not require Prior Authorization.
Facility Fee	$500 Copayment per stay after Deductible	Includes room and board and services supplied by the facility during the inpatient stay.
Professional fee	$20 Copayment per visit	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.
Outpatient services		
Individual therapy/Counseling	$20 Copayment per visit	No Prior Authorization required. No visit limits.
Applied Behavior Analysis (ABA) services	$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	$75 Copayment per visit	Certain services require Prior Authorization.
Chiropractic care	$45 Copayment per visit	No Prior Authorization required.
Cleft palate and cleft lip care	No charge after Deductible	Covered for Members under the age of 18. Includes medical, dental, oral, and facial surgery, follow-up, and related services. See *Outpatient surgery services*; *Dental care*; *Medical care Outpatient visits*; *Speech, hearing, and language therapy*; and *Nutritional counseling* for related Cost Share.
COVID-19 Testing/Treatment	No charge	
Dental care, accidental	$250 Copayment per visit after Deductible	No Prior Authorization required. See *Emergency Room care*, *Outpatient surgery services*, or *Urgent care* 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.

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	See *Durable Medical Equipment; Prescription drugs and supplies; Medical care Outpatient visits;* or *Nutritional Counseling* for related Cost Share	Prior Authorization required for certain services. No charge for the NationsNutrition™ program.
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.
X-rays	$35 Copayment after Deductible	No Prior Authorization required.
Advanced imaging (MRI, CT, PET scans)	$200 Copayment after Deductible	Prior Authorization required.
Sleep studies	See *Medical care Outpatient visit* or *Inpatient medical care* for related Cost Share	Prior Authorization required.
Other diagnostic testing	$25 Copayment after Deductible	Certain services require Prior Authorization. See *Allergy Testing* under *Allergy Services.*
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.
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 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*.
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 *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.
Habilitative and rehabilitative services	$45 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. 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.

Covered Services	Cost Sharing	Benefit Limit & Notes
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 *Inpatient 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		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 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	$500 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 one childbirth class per pregnancy	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	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	$75 Copayment 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 Plan Providers. You are not covered for services from Non-Plan 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 a Plan Provider. See *Preventive health services* for information about routine health care.

Covered Services	Cost Sharing	Benefit Limit & Notes
Office and community health center visits		
Primary Care Provider (PCP)	$20 Copayment per visit	No Prior Authorization required.
Specialist	$45 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 *Medical care Outpatient visits*	Prior Authorization required.
Observation services	$500 Copayment per visit 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	$250 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.	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 *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 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

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 in the *Patient Protection and Affordable Care Act* chapter of our Provider Manual at 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 *Outpatient surgery* or *Inpatient medical and surgical care*	Certain services may require Prior Authorization.
Skilled Nursing Facility	$500 Copayment per stay after Deductible	Maximum of 100 Days total per Member per Plan Year
Telehealth	See *Medical care Outpatient visits*	Please ask your Providers' office for information on Telehealth availability and access.
Urgent care	$45 Copayment per visit	No Prior Authorization required. Outside of our Service Area, free-standing Urgent Care Centers (UCCs) are covered at Non-Plan 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	$45 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 *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 cover.