Berklee College of Music Member Cost Summary – Deductible HMO

Effective: January 1, 2019

Description	Tufts Health Plan HMO
Deductible	
Deductible **Deductible is $500 per person up to family max of $1,000**	$500 Individual; $1,000 Family
Out-of-Pocket Maximum – $2,500 per person **(Includes all medical, pharmacy and mental health copayments, deductibles and coinsurance.)**	$2,500 Individual; $5,000 Family
Preventive Care	
Routine Physical	Covered in full
Well Child Visits	Covered in full
Routine Colonoscopy	Covered in full
Outpatient Medical Care	
Office Visit	$25 Copay applies (copay does not apply toward deductible)
Routine Maternity Care	Covered in full
Routine Eye Exam	$25 Copay applies; 1 visit every 12 months (copay does not apply toward deductible)
Hearing Exam	Charges apply toward the deductible
Allergy Injections	$5 Copay (copay does not apply toward deductible)
Speech Therapy	Charges apply toward the deductible
Physical and Occupational Therapy	Charges apply toward the deductible; up to 30 visits each per year
Spinal Manipulation	$25 Copay applies; up to 20 visits per year (copay does not apply toward deductible)
Non-Routine Colonoscopy- Generally Associated with Symptoms	Charges apply toward the deductible
Diagnostic Procedures	Charges apply toward the deductible
Diagnostic Imaging—General Imaging (xrays and ultrasounds)	Charges apply toward the deductible
Diagnostic Imaging—High Tech Imaging (MRI, CAT Scan, PET Scan)	$75 Copay applies per visit; 2x per year maximum (copay does not apply toward deductible)
Diagnostic Lab Test	Charges apply toward the deductible
Day Surgery	Charges apply toward the deductible then $250 Copay applies
Inpatient Medical Care	
All Hospital Care—Acute and Maternity	Charges apply toward the deductible then $500 Copay applies
Skilled Nursing in a Skilled Nursing Facility (up to 100 days per year)	Charges apply toward the deductible then $500 Copay applies
Emergency Care	
In Emergency Room	$100 Copay applies (copay does not apply toward deductible)
Mental Health/Substance Abuse	
Inpatient	Charges apply toward the deductible then $500 Copay applies
Outpatient	$25 Copay applies (copay does not apply toward deductible)

Other Healthcare Services	
Durable Medical Equipment	20% coinsurance, no benefit maximum (Charges do not apply toward deductible)
Ambulance Service	Charges apply toward the deductible
Prosthetics	20% coinsurance (Charges do not apply toward deductible)
Pediatric Dental	
Dental check-up (Covered through Delta Dental)	Coverage includes X-Rays (full mouth) once every 5 years. Bitewings, once every 6 months and periapicals, as needed. Periodic oral exam, oral prophylaxis, and fluoride treatment once every 6 months. Covered for children under age 12.
Pharmacy Benefit (Administered by OptumRx 855-546-3439)	
30 Day Supply	Tier 1 - $15 Tier 2 - $30 Tier 3 - $50 (copays do not apply toward deductible)
90 Day Supply	Tier 1 - $30 Tier 2 - $60 Tier 3 - $150 For prescriptions filled through our mail order service (copays do not apply toward deductible)

Group Numbers

Berklee: 17368-000

Conservatory: 17370-000