Berklee College of Music Member Cost Summary – PPO

Effective: January 1, 2021

Description	Tufts Health Plan CareLink PPO	
	In Network	Out of Network (after deductible)
Deductible and Out-of-Pocket Maximums		
Deductible	None	$250 Individual; $500 Family
Out-of-Pocket Maximum (Includes all medical, pharmacy and mental health copayments, deductibles and coinsurance.)	$2,500 Individual; $5,000 Family	$2,500 Individual; $5,000 Family
Preventive Care		
Routine Physical	Covered in full	20% coinsurance
Well Child Visits	Covered in full	20% coinsurance
Routine Colonoscopy	Covered in full	20% coinsurance
Outpatient Medical Care		
Office Visit	$25 per visit	20% coinsurance
Routine Maternity Care	Covered in Full	20% coinsurance
Routine Eye Exam	$25 per visit; 1 exam covered every 12 months	20% coinsurance
Hearing Exam	Covered in full	20% coinsurance
Hearing Aids	20% coinsurance;$2000 maximum every 36 months	20% coinsurance
Allergy Injections	$5 per visit	20% coinsurance
Speech Therapy	$25 per visit	20% coinsurance
Physical and Occupational Therapy	$25 per visit, up to 30 visits each per year	20% coinsurance
Spinal Manipulation	$25 per visit; up to 20 visits per year	20% coinsurance
Acupuncture	$25 per visit; up to 20 visits per year	20% coinsurance
Non-Routine Colonoscopy- Generally Associated with Symptoms	Covered in full	20% coinsurance
Diagnostic Procedures	Covered in full	20% coinsurance
Diagnostic Imaging—General Imaging (xrays and ultrasounds)	Covered in full	20% coinsurance
Diagnostic Imaging—High Tech Imaging (MRI, CAT Scan, PET Scan)	$75 per visit	20% coinsurance
Diagnostic Lab Test	Covered in full	20% coinsurance
Day Surgery	Covered in full	20% coinsurance
Inpatient Medical Care		
All Hospital Care—Acute and Maternity	Covered in full	20% coinsurance
Skilled Nursing in a Skilled Nursing Facility (up to 100 days per year)	Covered in full	20% coinsurance

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Description	Tufts Health Plan CareLink PPO	
	In Network	Out of Network (after deductible)
Emergency Care		
In Emergency Room	$100 per visit	$100 per visit
Mental Health/Substance Abuse		
Inpatient	Inpatient	Inpatient
Outpatient	$25 per visit	20% coinsurance
Other Healthcare Services		
Durable Medical Equipment	20% coinsurance, no benefit maximum	20% coinsurance, no benefit maximum
Ambulance Service	Covered in full	20% coinsurance
Home Health Care	Covered in full	20% coinsurance
Hospice Care	Covered in full	20% coinsurance
Prosthetics	20% coinsurance	20% coinsurance
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.	Not covered
Pharmacy Benefit (Administered by OptumRx 855-546-3439)		
30 Day Supply **Low Cost Generic** **High Cost Generic** **Preferred Brand** **Non-Preferred Brand**	 Tier 1 - $5 Tier 2 - $20 Tier 3 - $30 Tier 4 - $50	Not Covered
90 Day Supply **Low Cost Generic** **High Cost Generic** **Preferred Brand** **Non-Preferred Brand**	 Tier 1 - $10 Tier 2 - $40 Tier 3 - $60 Tier 4 - $150 For prescriptions filled through our mail order service	Not Covered

Group Numbers

Berklee: 46264-000

Conservatory: 48854-000