

# Berklee College of Music Member Cost Summary – Deductible HMO

Effective: January 1, 2021

Description	Tufts Health Plan HMO
<b>Deductible</b>	
<b>Deductible</b> Deductible is \$500 per person up to family max of \$1,000	\$500 Individual; \$1,000 Family
<b>Out-of-Pocket Maximum – \$2,500 per person</b> (Includes all medical, pharmacy and mental health copayments, deductibles and coinsurance.)	\$2,500 Individual; \$5,000 Family
<b>Preventive Care</b>	
<b>Routine Physical</b>	Covered in full
<b>Well Child Visits</b>	Covered in full
<b>Routine Colonoscopy</b>	Covered in full
<b>Outpatient Medical Care</b>	
<b>Office Visit</b>	\$25 Copay applies (copay does not apply toward deductible)
<b>Routine Maternity Care</b>	Covered in full
<b>Routine Eye Exam</b>	\$25 Copay applies; 1 visit every 12 months (copay does not apply toward deductible)
<b>Hearing Exam</b>	Covered in full
<b>Hearing Aids</b>	20% coinsurance; \$2000 maximum every 36 months
<b>Allergy Injections</b>	Charges apply toward the deductible
<b>Speech Therapy</b>	Charges apply toward the deductible
<b>Physical and Occupational Therapy</b>	Charges apply toward the deductible; up to 30 visits each per year
<b>Spinal Manipulation</b>	\$25 Copay applies; up to 20 visits per year (copay does not apply toward deductible)
<b>Acupuncture</b>	\$25 Copay applies; up to 20 visits per year (copay does not apply toward deductible)
<b>Non-Routine Colonoscopy- Generally Associated with Symptoms</b>	Charges apply toward the deductible
<b>Diagnostic Procedures</b>	Charges apply toward the deductible
<b>Diagnostic Imaging—General Imaging (xrays and ultrasounds)</b>	Charges apply toward the deductible
<b>Diagnostic Imaging—High Tech Imaging (MRI, CAT Scan, PET Scan)</b>	\$75 Copay applies per visit; 2x per year maximum (copay does not apply toward deductible)
<b>Diagnostic Lab Test</b>	Charges apply toward the deductible
<b>Day Surgery</b>	Charges apply toward the deductible then \$250 Copay applies
<b>Inpatient Medical Care</b>	
<b>All Hospital Care—Acute and Maternity</b>	Charges apply toward the deductible then \$500 Copay applies
<b>Skilled Nursing in a Skilled Nursing Facility (up to 100 days per year)</b>	Charges apply toward the deductible then \$500 Copay applies
<b>Emergency Care</b>	
<b>In Emergency Room</b>	\$100 Copay applies (copay does not apply toward deductible)

Mental Health/Substance Abuse	
<b>Inpatient</b>	Charges apply toward the deductible then \$500 Copay applies
<b>Outpatient</b>	\$25 Copay applies (copay does not apply toward deductible)
Other Healthcare Services	
<b>Durable Medical Equipment</b>	20% coinsurance, no benefit maximum (Charges do not apply toward deductible)
<b>Ambulance Service</b>	Charges apply toward the deductible
<b>Prosthetics</b>	20% coinsurance (Charges do not apply toward deductible)
Pediatric Dental	
<b>Dental check-up (Covered through Delta Dental)</b>	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)	
<i>30 Day Supply</i> <b>Low Cost Generic</b> <b>High Cost Generic</b> <b>Preferred Brand</b> <b>Non-Preferred Brand</b>	Tier 1 - \$5 Tier 2 - \$20 Tier 3 - \$30 Tier 4 - \$50 (copays do not apply toward deductible)
<i>90 Day Supply</i> <b>Low Cost Generic</b> <b>High Cost Generic</b> <b>Preferred Brand</b> <b>Non-Preferred Brand</b>	Tier 1 - \$10 Tier 2 - \$40 Tier 3 - \$60 Tier 4 - \$150 For prescriptions filled through our mail order service (copays do not apply toward deductible)

## Group Numbers

**Berklee:** 17368-000

**Conservatory:** 17370-000