Berklee College of Music Member Cost Summary – High Deductible PPO

Effective: January 1, 2021

Description	Tufts Health Plan CareLink PPO	
	In Network	Out of Network (after deductible)
Deductible		
Deductible	$1,500 Individual; $3,000 Family	
Out-of-Pocket Maximum (Includes all medical, pharmacy and mental health copayments, deductibles and coinsurance.)	$5,000 Individual; $10,000 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	Deductible	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; $2,000 maximum every 36 months	20% coinsurance
Allergy Injections	Deductible	20% coinsurance
Speech Therapy	Deductible	20% coinsurance
Physical and Occupational Therapy	Deductible, up to 30 visits each per year	20% coinsurance
Spinal Manipulation	Deductible; up to 20 visits per year	20% coinsurance
Acupuncture	Deductible; up to 20 visits per year	20% coinsurance
Non-Routine Colonoscopy- Generally Associated with Symptoms	Deductible	20% coinsurance
Diagnostic Procedures	Deductible	20% coinsurance
Diagnostic Imaging—General Imaging (xrays and ultrasounds)	Deductible	20% coinsurance
Diagnostic Imaging—High Tech Imaging (MRI, CAT Scan, PET Scan)	Deductible	20% coinsurance
Diagnostic Lab Test	Deductible	20% coinsurance
Day Surgery	Deductible	20% coinsurance
Inpatient Medical Care		
All Hospital Care—Acute and Maternity	Deductible	20% coinsurance
Skilled Nursing in a Skilled Nursing Facility (up to 100 days per year)	Deductible	20% coinsurance

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Description	Tufts Health Plan CareLink PPO	
	In Network	Out of Network (after deductible)
Emergency Care		
In Emergency Room	Deductible	Deductible
Mental Health/Substance Abuse		
Inpatient	Deductible	20% coinsurance
Outpatient	Deductible	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		
Durable Medical Equipment	20% coinsurance after deductible, no benefit maximum	20% coinsurance, no benefit maximum
Ambulance Service	Deductible	Deductible
Home Health Care	Deductible	20% coinsurance
Hospice Care	Deductible	20% coinsurance
Prosthetics	20% coinsurance after deductible	20% coinsurance
Pharmacy Benefit (Administered by OptumRx 855-546-3439)		
30 Day Supply **Low Cost Generic** **High Cost Generic** **Preferred Brand** **Non-Preferred Brand**	Deductible, then copay applies: Tier 1 - $5 Tier 2 - $20 Tier 3 - $30 Tier 4 - $50	Reimbursable at the in-network level
90 Day Supply **Low Cost Generic** **High Cost Generic** **Preferred Brand** **Non-Preferred Brand**	Deductible, then copay applies: 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: 48400-000

Conservatory: 48853-000