

# Berklee College of Music Member Cost Summary – High Deductible PPO

Effective: January 1, 2025

Description	Harvard Pilgrim Health Care Access America PPO	
	In Network	Out of Network (after deductible)
Deductible		
Deductible	\$1,650 Individual; \$3,300 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 60 visits each per year	20% coinsurance
Spinal Manipulation	Deductible; no visit limit	20% coinsurance
Acupuncture	Deductible; no visit limit	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

Description	Harvard Pilgrim Health Care Access America PPO	
	In Network	Out of Network (after deductible)
<b>Emergency Care</b>		
<b>In Emergency Room</b>	Deductible	Deductible
<b>Mental Health/Substance Abuse</b>		
<b>Inpatient</b>	Deductible	20% coinsurance
<b>Outpatient</b>	Deductible	20% coinsurance
<b>Pharmacy Benefit</b>		
<b>Durable Medical Equipment</b>	20% coinsurance after deductible, no benefit maximum	20% coinsurance, no benefit maximum
<b>Ambulance Service</b>	Deductible	Deductible
<b>Home Health Care</b>	Deductible	20% coinsurance
<b>Hospice Care</b>	Deductible	20% coinsurance
<b>Prosthetics</b>	20% coinsurance after deductible	20% coinsurance
<b>Pharmacy Benefit (Administered by OptumRx 855-546-3439)</b>		
<b>30 Day Supply</b>  <b>Generic</b> <b>Preferred Brand</b> <b>Non-Preferred Brand</b> <b>Specialty*</b>	Deductible, then copay applies:  Tier 1 - \$15 Tier 2 - \$30 Tier 3 - \$50 Tier 4 - \$75	Not Covered
<b>90 Day Supply</b> <b>Generic</b> <b>Preferred Brand</b> <b>Non-Preferred Brand</b>	Deductible, then copay applies: Tier 1 - \$30 Tier 2 - \$60 Tier 3 - \$100	Not Covered
<i>*Only 30 day supply available for Specialty Rx</i>	For prescriptions filled through our mail order service	

## Group Numbers

**Berklee:** 176052

**Conservatory:** 176058