Brandeis University

2022 Tufts Health Plan Comparison Chart

Covered Services	Tufts EPO Value Deductible (1)	Tufts EPO Premium (1)	Tufts PPO In-Network Benefit	Tufts PPO Out-of-Network (after deductible) (3)
Annual Deductible	$500 for Single (2) $1,000 for Family (2)	N/A	N/A	$500 for Single (3) $1,000 for Family (3)
Out of Pocket Maximum	$2,500 for single (1) $5,000 for family (1)	$2,500 for single (1) $5,000 for family (1)	$2,500 for single (1) $5,000 for family (1)	$2,500 for single (1)(3) $5,000 for family (1)(3)
Emergency Care (4) (6)	$150 / visit	$150 / visit	$150 / visit	$150 / visit
Outpatient Care				
Routine Physicals (8)	Covered in full	Covered in full	Covered in full	20% coinsurance
Doctor Office Visits	$25 / visit	$25 / visit	$25 / visit	20% coinsurance
Hospitalization	$500 / admission after ded.	Covered in full	$500 / admission	20% coinsurance
Room & Board (5)	Covered in full after ded. & copay	Covered in full	Covered in full after copay	20% coinsurance (6)
Physician/Surgeon Services	Covered in full after ded. & copay	Covered in full	Covered in full after copay	20% coinsurance
Day Surgery	$250 / surgery after ded.	Covered in full	$250 / surgery	20% coinsurance
Routine Colonoscopy (8)	Covered in full	Covered in full	Covered in full	20% coinsurance
Assisted Reproductive Technology	$250 / surgery	Covered in full	$250 / surgery	20% coinsurance
High Tech Imaging (10)	$75 / visit	$75 / visit	$75 / visit	20% coinsurance
Diagnostic Test, Lab work	Covered in full after ded	Covered in full	Covered in full	20% coinsurance
Maternity				
Prenatal/Postnatal Care (routine)	Covered in full	Covered in full	Covered in full	20% coinsurance
Hospitalization	$500 / admission after ded.	Covered in full	$500 / admission	20% coinsurance
Mental Health & Substance Abuse				
Inpatient – Non-Biological (5)				
• Mental Health	$500 / admission after ded.	Covered in full	$500 / admission	20% coinsurance
• Substance Abuse	$500 / admission after ded.	Covered in full	$500 / admission	20% coinsurance
Outpatient – Non-Biological				
• Mental Health	$25 / visit	$25 / visit	$25 / visit	20% coinsurance
• Substance Abuse	$25 / visit	$25 / visit	$25 / visit	20% coinsurance
Physical Therapy (12) *(short-term physical, occupational and speech therapy)*	Covered in full after ded.	$25 / visit	$25 / visit	20% coinsurance
Chiropractic/Acupuncture Care	$25 / visit, up to 30 visits per calendar year	$25 / visit, up to 30 visits per calendar year	$25 / visit, up to 30 visits per calendar year	20% coinsurance, up to 30 visits/ calendar year
Hearing Aid Benefit	First $2,000 covered per ear every 36 months. 20% coinsurance after limit has been reached.	First $2,000 covered per ear every 36 months. 20% coinsurance after limit has been reached	First $2,000 covered per ear every 36 months. 20% coinsurance after limit has been reached	First $2,000 covered per ear every 36 months. 20% coinsurance after limit has been reached
Prescription Drugs (11) *(up to a 30 day supply)*	$15, Tier I $30, Tier II $50, Tier III	$15, Tier I $30, Tier II $50, Tier III	$15, Tier I $30, Tier II $50, Tier III	
Mail Order Rx Drugs (11) *(up to a 90 day supply)*	$30, Tier I $60, Tier II $150, Tier III	$30, Tier I $60, Tier II $150, Tier III	$30, Tier I $60, Tier II $150, Tier III	
Weight Management & Fitness Reimbursement (9)	$150 weight management $150 fitness reimbursement	$150 weight management & $150 fitness reimbursement	$150 weight management $150 fitness reimbursement	

Note: The above is intended as a brief overview of covered services only. Please refer to the Evidence of Coverage booklet (EPO's) or the Certificate of Insurance (PPO) for more detailed benefit information.

Terms and Conditions

1. **All plans** include an **out of pocket maximum of $2,500 for an individual and $5,000 for a family** per calendar year. All copayments, deductibles and coinsurance (including prescription drug copayments) count towards this maximum.
2. **EPO Value Deductible** plan benefits includes a **$500 deductible** for single plans and a **$1,000 deductible** for family plans.
3. All covered **Out-of-Network PPO** benefits are **paid at 80% after satisfying $500 deductible for single plans and a $1,000 deductible for family plans**. The PPO plan out-of-pocket maximum for out-of-network services is $2,500 individual / $5,000 family per calendar year. There is a separate out of pocket maximum on in-network services of $2,500 individual /$5,000 family per calendar year.

4. Waived if immediately admitted to the hospital. If admitted to an in-network hospital, a $500 Inpatient copayment would apply on both the EPO Value Deductible and PPO plans. Members would be responsible for 20% coinsurance on the PPO plan if admitted to an out-of-network hospital.
5. A semi-private room is provided unless a private room is medically necessary.
6. If you receive outpatient Emergency care at an emergency facility, You or someone acting on your behalf should call your PCP or Tufts HP within 48 hours after receiving care. You are encouraged to contact your Primary Care Physician so your PCP can provide or arrange for any follow-up care that you may need.
7. If you receive inpatient services which are not provided by a Network Provider, you must pre-register these services. If you do not pre-register, you will be subject to a Pre-registration Penalty. Please refer to the Certificate of Insurance for additional information.
8. Cost sharing has been removed on preventive services as follows: Routine physical exams (including most preventive screenings), Well-Child Care, Preventive Immunizations, Preventive Pap Smears, Preventive Mammograms & Routine Colonoscopies (Colonoscopies which include any surgical removal will not be considered preventive, and will be subject to the copay, deductible and/or coinsurance).
9. The Weight Management reimbursement (up to $150 per family per year) and the Fitness Reimbursement (up to $150 per family per year) is available by submitting the applicable reimbursement form to Tufts Health Plan.
10. A maximum of two copayments apply per member per calendar year.
11. **Prescriptions are administered by OptumRx**. BIN: 610011, PCN: IXR, Group: EDHEALTH. More information available at www.Optumrx.com or 855-546-3439. Specialty Drugs limited to a 30-day supply at designated specialty pharmacy, may need prior authorization.