Brandeis University

2023 Tufts Health Plan Comparison Chart

Covered Services	Tufts EPO Value Deductible	Tufts EPO Premium	Tufts PPO	
			In-Network Services	Out-of-Network (deductible applies first)
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)
Annual Deductible	$500 for Single (2) $1,000 for Family (2)	N/A	N/A	$500 for Single (3) $1,000 for Family (3)
Emergency Care (4) (6)	$150 / visit	$150 / visit	$150 / visit	$150 / visit
Urgent Care (13)	$25/visit	$25/visit	$25/visit	$25/ visit
Hospitalization	$500/admission after deductible	Covered in full	$500 / admission	20% coinsurance /ded
Outpatient Care				20% coinsurance /ded
Routine Physicals (8)	Covered in full	Covered in full	Covered in full	20% coinsurance /ded
Routine Colonoscopy screening (8)	Covered in full	Covered in full	Covered in full	20% coinsurance /ded
Doctor Office Visits	$25 / visit	$25 / visit	$25 / visit	20% coinsurance /ded
High Tech Imaging (10)	$75 / visit –2 payments max	$75 / visit – 2 pymt max	$75 / visit 2 pymt max	20% coinsurance /ded
Diagnostic Test, Lab work	Covered in full after deductible	Covered in full	Covered in full	20% coinsurance /ded
Day Surgery	$250/surgery after deductible	Covered in full	$250 / surgery	20% coinsurance /ded
Colonoscopy w/surgical removal	$250/surgery after deductible	Covered in Full	$250 / surgery	20% coinsurance /ded
Assisted Reproductive Technology	$250/surgery after deductible	Covered in full	$250 / surgery	20% coinsurance /ded
Maternity (14)				
Prenatal/Postnatal Care (routine)	Covered in full	Covered in full	Covered in full	20% coinsurance/ded
Office Visits	25 per visit	Covered in full	$25 /visit	20% coinsurance/ded
Hospitalization	$500/admission after deductible	Covered in full	$500 / admission	20% coinsurance/ded
Mental & Behavioral Health or Substance Abuse Services				
Inpatient	$500 /admission after deductible	Covered in full	$500 / admission	20% coinsurance/ded
Outpatient	$25 / visit	$25 / visit	$25 / visit	20% coinsurance/ded
Physical Therapy (12) *(short-term physical, occupational and speech therapy)*	$25/visit after deductible applied	$25 / visit	$25 / visit	20% coinsurance/ded
Eye Exam – EyeMed network	$25 once every 12 months	$25 once every 12 months	$25 once every 12 months	20% coinsurance /ded
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/ded, up to 30 visits/ calendar year
Durable Medical Equipment (DME)	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance /ded
Hearing Aid Benefit First $2,000 covered per ear every 36 months	20% coinsurance after limit has been reached.	20% coinsurance after limit has been reached	20% coinsurance after limit has been reached	20% coinsurance/ded 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	Reimbursable at In-Network level
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	Reimbursable at In-Network level
Weight Management **Fitness Reimbursement** (9)	$150 weight management $150 fitness reimbursement	$150 weight mgmt. $150 fitness reimburse	$150 weight management $150 fitness reimbursement	

Additional Information, Terms and Conditions

1. **All plans** include an **out of pocket maximum of $2,500 per individual and $5,000 per family** per calendar year. All copayments, deductibles and coinsurance (including prescription drug copayments for in-network services) count towards this maximum.
2. The deductible for EPO Value Deductible plan applies to **non-routine lab work & diagnostic tests**, which are paid in full **after deductible** is met. Day surgery & hospital admission includes co-payments and deductible.
3. All covered **PPO Out-of-Network** 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. Some drugs have quantity limitations.
12. Short-term physical and occupational therapy limited to 30 visits for each type of service per year. No set limit on speech therapy. Prior authorization may be required.
13. Services with out-of-network providers in MA, RI and NH are covered subject to deductible and coinsurance.
14. Depending on the type of services, copayment, coinsurance or deductible may apply. Maternity care may include tests and services described that may be subject to copay and/or deductible (i.e. ultrasound)