MOUNT HOLYOKE

Comparison of the College-Sponsored Health Insurance Plans
July 1, 2008 - June 30, 2009

Conditions of Coverage	HMO Blue	TUFTS HMO	Blue Choice New England Point of Service Plan In-Network	Blue Choice New England Out-of-Network Self Referred	TUFTS PPO Premium In-Network	TUFTS PPO Premium Out-of-Network
Choice of Health Care Facility	Member's primary care physician choices include: HMO Blue community-based network, RiverBend Medical Group in Chicopee, Springfield, Agawam or Westfield and University Health Services affiliated physicians.	Members choose a primary care physician from the Tufts HMO provider list. Choices also include: RiverBend Medical Group in Chicopee, Springfield, Agawam or Westfield.	Member's primary care physician choices include: Blue Choice community-based network, RiverBend Medical Group in Chicopee, Springfield, Agawam, Westfield.	Freedom of choice for any health care facility that participates with BC/BS indemnity network.	**Do not need to designate a Primary Care Physician.** **In-Network, Refer to Tufts Health Plan (THP) PPO.**	**Freedom of choice for any health care facility as out-of-network benefit.**
Choice of Physician	Members choose a primary care physician from the HMO Blue participating physician listing. May change physicians at any time.	Members choose a primary care physician from the Tufts Health Plan participating physician listing. May change physicians at any time.	Members choose a primary care physician from the Blue Choice participating physician listing. May change physicians effective the first of the following month.	Freedom of choice for any physician that participates with any BC/BS indemnity network provider.	**Do not need to designate a Primary Care Physician. Member may utilize any provider in the Tufts Health Plan participating physician listing. May change physicians at any time.**	**Do not need to designate a Primary Care Physician.** **In and out-of-network benefits available.**
WAITING PERIODS	None.	None.	None.	None.	**None.**	**None.**
HOSPITAL/INPATIENT						
1. Semi-Private Room (medically necessary)	Covered in full **after a $250 co-payment per admission**	Covered in full unlimited days **after inpatient co-payment of $250 (capped at $250 for individuals & $500 for families)**	Covered in full **after a $250 co-payment per admission**	Covered at 80% after deductible.*	Covered in full unlimited days **after inpatient co-payment of $250 (capped at $250 for individuals & $500 for families)**	**Covered at 80% after deductible.**
2. Private Room	Covered in full **after a $250 co-payment per admission** when medically necessary and authorized by an HMO Blue physician.	Covered in full when medically necessary and authorized by a Tufts Health Plan physician **after inpatient co-payment of $250 (capped at $250 for individuals & $500 for families)**	Covered in full **after a $250 co-payment per admission** when medically necessary and authorized by plan physician.	Covered at 80% after deductible.*	Covered in full when medically necessary and authorized by a Tufts Health Plan physician **after inpatient co-payment of $250 (capped at $250 for individuals & $500 for families)**	**Covered at 80% after deductible.***
3. Surgery	Covered in full **after a $250 co-payment per admission**	Covered in full **for unlimited days after inpatient co-payment of $250 (capped at $250 for individuals & $500 for families)**	Covered in full **after a $250 co-payment per admission**.	Covered at 80% after deductible.*	Covered in full **for unlimited days after inpatient co-payment of $250 (capped at $250 for individuals & $500 for families)**	**Covered at 80% after deductible.***

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4. Hospital Services (including nursing care, operating room, anesthesia, drugs, and x-rays)	Covered in full **after a $250 co-payment per admission**	Covered in full **for unlimited days after inpatient copayment of $250 (capped at $250 for individuals & $500 for families)**	Covered in full **after a $250 co-payment per admission**	Covered at 80% after deductible.*	Covered in full **for unlimited days after inpatient copayment of $250 (capped at $250 for individuals & $500 for families)**	**Covered at 80% after deductible.***
5. Physicians' and Consultants' Services	Covered in full.	Covered in full.	Covered in full.	Covered at 80% after deductible.*	**Covered in full.**	**Covered at 80% after deductible.***
6. Intensive Care (Coronary, etc.)	Covered in full.	Covered in full.	Covered in full.	Covered at 80% after deductible.*	**Covered in full.**	**Covered at 80% after deductible.***
7. Extended Care Facility	Covered in full when arranged by an HMO Blue physician, up to 100 days per calendar year.	Covered in full when arranged by a Tufts Health Plan physician, up to 100 days per calendar year.	Covered in full when arranged by a Blue Choice physician, up to 100 days per calendar year.	Covered at 80% after deductible up to a maximum of 100 days.*	**Covered in full when arranged by a Tufts Health Plan physician, up to 100 days per calendar year.**	**Covered at 80% after deductible up to a maximum of 100 day annual maximum.**
MATERNITY						
1. Pregnancy Complications	Covered in full.	Covered in full.	Covered in full.	Covered at 80% after deductible.*	**Covered in full.**	**Covered at 80% after deductible.***
2. Prenatal and Post-Partum Checkups	Covered in full.	**$15.00 per visit for first 10 visits; then covered in full.**	Covered in full.	Covered at 80% after deductible.*	**$25.00 per visit for the first 10 visits, then covered in full.**	**Covered at 80% after deductible.***
3. Delivery and Nursery	Covered in full after inpatient co-payment of $250.00.	Covered in full **after inpatient copayment of $250 (capped at $250 for individuals & $500 for families)**	Covered in full.	Covered at 80% after deductible.*	Covered in full **after inpatient copayment of $250 (capped at $250 for individuals & $500 for families)**	**Covered at 80% after deductible.***
4. Newborn Checkups	$15.00 per visit.	$15.00 per visit.	$15.00 per visit.	Covered at 80% after deductible.*	**$25.00 per visit.**	**Covered at 80% after deductible.***
5. Childbirth Education	$90.00 initial course. $45.00 refresher.	30% discount on childbirth education program. Members are covered for a free home visit from a registered nurse specializing in maternal and child health after being discharged from the hospital.	$90.00 initial course. $45.00 refresher.	Not covered.	**30% discount on childbirth education program. Members are covered for a free home visit from a registered nurse specializing in maternal and child health after being discharged form the hospital.**	**N/A**

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OFFICE VISITS/OUTPATIENT						
1. Periodic Physical Exam	$15.00 per **PCP** visit. **$25.00 per Specialist visit.** **Difference in copayment Is based on PROVIDER.**	$15.00 per **PCP visit.** **$25.00 per Specialist visit.** **Difference in copayment is based on SERVICE provided.**	$15.00 per **PCP** visit. **$25.00 per Specialist visit.** **Difference in copayment Is based on PROVIDER.**	Routine physical exam covered at 80% after deductible. Mammograms covered at 80% after deductible. Annual gynecological exam including pap smear covered at 80% after deductible.*	**$25.00 per visit.**	**Covered at 80% after deductible.**
2. Well Baby Care	$15.00 per **PCP** visit. **$25.00 per Specialist visit.** **Difference in co-payment Is based on PROVIDER.**	$15.00 per **PCP visit.** **$25.00 per Specialist visit.** **Difference in co-payment is based on SERVICE provided.**	$15.00 per **PCP** visit. **$25.00 per Specialist visit.** **Difference in co-payment Is based on PROVIDER.**	Covered at 80% after deductible up to age six.* (Includes immunizations)	**$25.00 per visit.**	**Covered at 80% after deductible.**
3. Immunizations	**$15.00 per PCP visit.** **$25.00 per Specialist visit.** Allergy shots – covered in full.	**$15.00 per PCP visit.** **$25.00 per Specialist visit.** **Allergy shots $5.00 without visit.**	Covered in full.	Not covered out-of-network over age six.	**$25.00 per visit.** **$5.00 for Allergy shots**	**Covered at 80% after deductible.**
4. Diagnostic X-ray and Lab	Covered in full.	Covered in full.	Covered in full.	Covered at 80% after deductible.*	**Covered in full.**	**Covered at 80% after deductible.***
5. Minor Surgery	Covered in full in hospital surgical day care center. Covered in full **after $250 co-payment when inpatient.**	**Covered in full when done on an outpatient basis.** Covered in full **after $250 co-payment when inpatient (capped at $250 for individuals & $500 for families).**	Covered in full in hospital surgical day care center. Covered in full **after $250 co-payment when inpatient.**	Covered at 80% after deductible.*	**Covered in full when done on an outpatient basis.** Covered in full **after $250 co-payment when inpatient (capped at $250 for individuals & $500 for families).**	**Covered at 80% after deductible.***
6. Allergy Tests	**$25.00 per visit.** **Injections only are covered in full**	**$25.00 per visit** **Injections $5.00 per visit.**	**$25.00 per visit.** **Injections only are covered in full**	Covered at 80% after deductible.*	**$25.00 per visit** **Injections $5.00 per visit.**	**Covered at 80% after deductible.***
7. Eye and Refraction	**$25.00 per visit (self-referral once every calendar year.**	**$15.00 per visit (self-referral once every 24 months). Uses "EyeMed" as network.**	**$25.00 per visit (self-referral once every calendar year.**	Not covered.	**$25.00 per visit (self-referral once every 24 months). Uses "EyeMed" network**	**Covered at 80% after deductible.**

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8. Routine Hearing Exams	**$15.00 per visit by PCP $25.00 per visit by other network providers.**	$15.00 per visit	**$15.00 per visit by PCP $25.00 per visit by other network providers.**	Not covered.	**$25.00 per visit.**	**Covered at 80% after deductible.**
9. House Call	Covered in full when arranged by primary care physician.	Covered in full when arranged by primary care physician.	Covered in full when arranged by primary care physician.	Covered at 80% after deductible when medically necessary.*	**Covered in full when arranged by primary care physician.**	**Covered at 80% after deductible.**
10. Radiation Therapy	Covered in full.	Covered in full.	Covered in full.	Covered at 80% after deductible.*	**Covered in full.**	**Covered at 80% after deductible.***
11. Physical Therapy	**$25.00** per visit up to 60 visits per calendar year for each unrelated illness or injury.	**$25.00** per visit up to 60 consecutive days for each unrelated illness or injury.	$25.00 per visit up to 60 visits per calendar year for each unrelated illness or injury.	Covered at 80% after deductible up to 60 visits per calendar year for each unrelated illness or injury.*	**$25.00 per visit up to 60 consecutive days for each unrelated illness or injury.**	**Covered at 80% after deductible up to 60 consecutive days for each injury.**
12. Prescription Drugs	**$10.00 generic $20.00 brand $35.00 non-preferred up to a 30 day supply.** *Mail order:* Up to a 90 day supply **$20 generic $40 brand $70 non-preferred**	**$10.00 generic $20.00 brand $35.00 non-preferred up to a 30 day supply.** *Mail order:* Up to a 90 day supply **$20.00 generic $40.00 brand name $70.00 non preferred**	**$10.00 generic $20.00 brand $35.00 non-preferred up to a 30 day supply.** *Mail order:* Up to a 90 day supply **$20 generic $40 brand $70 non-preferred**	No coverage for use of non-participating pharmacies. (94% of pharmacies across United States participate with BC/BS). Reimbursement for out-of-country prescriptions by submitting claim forms.	**$10.00 generic $20.00 brand $35.00 non-preferred up to a 30 day supply** ***Mail order:*** **Up to 90 day supply $20.00 generic $40.00 brand name $70.00 non-preferred**	**No coverage for use of non-participating pharmacies. (95% of pharmacies across the United States participate with PCS/THP). Reimbursement for out of country prescriptions by submitting claim form.**
13. Specialist Visits	**$25.00 per visit.**	**$25.00 per visit.**	**$25.00 per visit.**	Covered at 80% after deductible.*	**$25.00 per visit.**	**Covered at 80% after deductible.***
14. Chiropractic Service	Not covered.	Not covered.	**$25.00** per visit.	Covered at 80% after deductible.*	**$25.00 per visit, 12 visit annual maximum.**	**Covered at 80% after deductible.**
15. Acupuncture and Homeopathy	Living Healthy Naturally program – offers discounts up to 30%.	Discounts available up to 30%.	Living Healthy Naturally program – offers discounts up to 30%.	Living Healthy Naturally program – offers discounts up to 30%.	**Discounts available up to 30%.**	**N/A**

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FAMILY PLANNING						
1. Office Visit	$15.00 per visit.	$15.00 per visit.	$15.00 per visit.	Covered at 80% after deductible.*	**$25.00 per visit.**	**Covered at 80% after deductible.**
2. Sterilization	$15.00 if done in office. Covered in full at facility.	$15.00 if done in office. Covered in full at outpatient facility.	$15.00 if done in office. Covered in full at facility.	Covered at 80% after deductible.*	**$25.00 if done in office. Covered in full at facility.**	**Covered at 80% after deductible.**
3. Termination of Pregnancy	$15.00 if done in office. Covered in full at facility.	$15.00 if done in office. Covered in full at outpatient facility.	$15.00 if done in office. Covered in full at facility.	Covered at 80% after deductible.*	**$25.00 if done in office. Covered in full at facility.**	**Covered at 80% after deductible.**
4. Infertility Services	$15.00 if done in office. Covered in full at facility.	$15.00 if done in office. Covered in full at outpatient facility	$15.00 if done in office. Covered in full at facility.	Covered at 80% after deductible.*	**$25.00 if done in office. Covered in full at facility.**	**Covered at 80% after deductible.***
DENTAL						
1. Preventive Care	Full coverage for preventative dental care for children through age 11. Includes cleaning, x-rays, and fluoride treatment 1 every 6 months.	Not covered.	Not covered.	Not covered.	**Not covered.**	**Not covered.**
2. Other Services	Coverage is provided for extraction of teeth imbedded in the bone.	Dental surgery limited to the initial treatment of an injury to sound natural teeth, reduction of a jaw fracture, or excision of a neoplasm of the jaw.	Coverage is provided for extraction of teeth imbedded in the bone.	Not Covered.	**Dental services limited to the initial treatment of an injury to sound natural teeth, reduction of a jaw fracture, or excision of a neoplasm of the jaw.**	**Covered at 80% after deductible for dental surgery limited to the initial treatment of an injury to sound natural teeth, reduction of a jze fracture, or excision of a neoplasm of the jaw.**
URGENT, EMERGENCY, AND OUT OF PLAN/AREA CARE						
1. In the Area	**$15.00 per office visit for PCP. $25.00 for specialist. $75.00 co-payment at emergency room, waived if admitted and a $250 inpatient co-payment applies. Plan must be notified within 48 hours.**	$15.00 per office visit. $25.00 for specialist. $75.00 co-payment at emergency room, waived if admitted and a $250 inpatient co-payment applies. Plan must be notified within 48 hours.	**$15.00 per office visit for PCP. $25.00 for specialist. $75.00 co-payment at emergency room, waived if admitted and a $250 inpatient co-payment applies. Plan must be notified within 48 hours.**	Covered at 80% after deductible.*	**$25.00 per office visit. $75.00 co-payment at emergency room, waived if admitted and a $250 inpatient co-payment applies.**	**Covered at 80% after deductible.***
2. Out of the Area/	**$75.00 co-payment when**	**$75.00 co-payment when**	**$75.00 co-payment when**	Covered at 80% after	**$75.00 co-payment when**	**Covered at 80% after**

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State /Country	**hospital emergency room is utilized for emergency or urgent care. The co-payment is waived if the emergency room visit results in an admission and a $250 inpatient co-payment applies. The plan must be notified within 48 hours.**	**hospital emergency room is utilized for emergency or urgent care. The co-payment is waived if the emergency room visit results in an admission and a $250 inpatient co-payment applies. The plan must be notified within 48 hours.**	**hospital emergency room is utilized for emergency or urgent care. The co-payment is waived if the emergency room visit results in an admission and a $250 inpatient co-payment applies. The plan must be notified within 48 hours.**	deductible.*	**hospital emergency room is utilized for emergency or urgent care. The co-payment is waived if the emergency room visit results in an admission and a $250 inpatient co-payment applies. The plan must be notified within 48 hours.**	**deductible.***
3. Ambulance	Covered in full when authorized by plan physician or life-threatening emergency.	Covered in full when authorized by plan physician or life-threatening emergency.	Covered in full when authorized by plan physician or life-threatening emergency.	Covered in full.	**Covered in full when authorized by plan physician or life-threatening emergency.**	**Covered at 80% after deductible.**
4. Out of Plan Care a. Non-Participating Physicians	(a and b) All medical services available on referral through primary care physician in HMO Blue medical group. Decision to use non-referred care will be at member's expense. Urgent care while outside of member's health center service area is covered same as out of state care.	(a and b) All medical services available on referral through a Tufts Health Plan primary care physician. Decision to use non-referred care will be at member's expense. Urgent care while outside of member's health center service area is covered the same as out of state coverage.	(a and b) All medical services available on referral through primary care physician in Blue Choice NE medical group. Urgent care while outside of member's health center service area is covered same as out of state care when PCP approved.	Member can self-refer to participating provider of their choice. Benefits will be subject to deductible and coinsurance limits. Participating physicians may not balance bill beyond the BCBSMA approved amount.	**Covered at 80% after deductible.**	**Covered at 80% after deductible.**
b. Non-Participating Facilities	(a and b) All medical services available on referral through primary care physician in HMO Blue medical group. Decision to use non-referred care will be at member's expense. Urgent care while outside of member's health center service area is covered same as out of state care.	(a and b) All medical services available on referral through a Tufts Health Plan primary care physician. Decision to use non-referred care will be at member's expense. Urgent care while outside of member's health center service area is covered the same as out of state coverage.	(a and b) All medical services available on referral through primary care physician in Blue Choice NE medical group. Urgent care while outside of member's health center service area is covered same as out of state care when PCP approved.	Benefits available only from participating facilities (Every hospital in Massachusetts participates with BC/BS.) Facilities outside of Massachusetts may balance bill the entire amount beyond BC/BS payment.	**Covered at 80% after deductible.**	**Covered at 80% after deductible.**
HEALTH EDUCATION						
1. Patient Education	Helping members stay	Discounts available	Helping members stay		**Discounts available**	**N/A**

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	informed, healthy: bcbsma.com Ahealthyme.com Drugstore.com	through Tufts' Member Rewards Program.	informed, healthy: bcbsma.com Ahealthyme.com Drugstore.com		**through Tufts Member Rewards Program.**	
2. Special Group Sessions		Discounts available.			**Discounts available.**	**N/A**
MENTAL HEALTH						
1. Hospitalization	Covered in full up to 60 days per calendar year in a psychiatric hospital, unlimited days in a general hospital. No limit for Biology based **conditions after a $250 co-payment per admission**	Covered in full **after $250 co-payment for** up to 60 days per calendar year in a psychiatric hospital, unlimited days in a general hospital. **Capped at $250 for individuals & $500 for families).**	Covered in full up to 60 days per calendar year in a psychiatric hospital, unlimited days in a general hospital. No limit for Biology based conditions **after a $250 co-payment per admission**	Covered at 80% after deductible* up to a maximum of 60 days (less any benefits provided in-network). In a licensed general hospital, covered as any other illness.	**Covered in full up to 60 days per calendar year in a psychiatric hospital, unlimited days in a general hospital.**	**Covered at 80% after deductible* up to 60 days per calendar year in a psychiatric hospital, unlimited days in a general hospital.**
2. 24-hour Crisis Counseling	Mental health care, alcohol / drug treatment care including crisis inter-vention and evaluation. Biologically – based conditions outpatient visits $15.00 per visit. Non-Biologically based conditions (Includes drug addition and alcoholism) up to 24 visits per calendar year. $15.00 per visit. Alcoholism treatment up to 8 additional visits per calendar year. $15.00 per visit.	Mental health care, alcohol/drug treatment care including crisis intervention and evaluation. Biologically – based conditions outpatient visits $15.00 per visit. Non-Biologically based conditions (Includes drug addiction and alcoholism) up to 24 visits per calendar year. $15.00 per visit.	Mental health care, alcohol / drug treatment care including crisis intervention and evaluation. Biologically – based conditions outpatient visits $15.00 per visit. Non-Biologically based conditions (Includes drug addition and alcoholism) up to 24 visits per calendar year. $15.00 per visit. Alcoholism treatment up to 8 additional visits per calendar year. $15.00 per visit.	Covered at 80% after deductible* (less any benefits provided in-network). Up to 24 visits per member per calendar year.	**Mental health care, alcohol / drug treatment care including crisis intervention and evaluation. Biologically – based conditions outpatient visits $25.00 per visit. Non-Biologically based conditions (Includes drug addition and alcoholism) up to 24 visits per calendar year. $25.00 per visit.**	**Mental health care, alcohol / drug treatment care including crisis intervention and evaluation. Biologically – based conditions outpatient visist 20% after deductible. Non-biologically based conditions (includes drug addition and alcoholism) 80% after deductible up to 24 visits.**
3. Psychotherapy	Same as above.	Same as above.	Same as above.	Covered at 80% after deductible (less any benefits provided in-network). Up to 8 visits per member per calendar year.	**Same as above.**	**Same as above.**
ALCOHOL/DRUG TREATMENT						

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1. Emergency Care	Mental health care, alcohol/drug treatment care including crisis intervention and evaluation.	Mental health care, alcohol/drug treatment care including crisis intervention and evaluation.	Mental health care, alcohol/drug treatment care including crisis intervention and evaluation.	Covered at 80% after deductible (less any benefits provided in-network).Up to 8 visits per member per calendar year.	**Mental health care, alcohol/drug treatment care including crisis intervention and evaluation.**	**Mental health care, alcohol/drug treatment care including crisis intervention and evaluation covered at 80% after deductible.**
2. Detoxification	Covered in full in a facility designated by HMO Blue for up to 30 days in a calendar year. Two days of outpatient treatment may be substituted for each inpatient day up to 60 days in a calendar year **after a $250 co-payment per admission.** Non-Biologically – based conditions up to 24 visits per calendar year. $15.00 per visit. An additional 8 visits for Alcoholism treatment.	Covered in full **after a $250 co-payment at a** facility designated by Tufts Health Plan for up to 30 days in a **calendar year**. **(capped at $250 for individuals & $500 for families).** Two days of outpatient treatment may be substituted for each inpatient day up to 60 days in a calendar year. Tufts Health Plan pays a maximum of $500 / **calendar year** for **outpatient** care. Non-Biologically – based conditions up to 24 visits per **calendar** year. $15.00 per visit.	Covered in full in a facility designated by Blue Choice for up to 30 days in a calendar year. Two days of outpatient treatment may be substituted for each inpatient day up to 60 days in a calendar year **after at $250 copayment per admission.** Non Biologically based conditions up to 24 visits per calendar year. $15.00 per visit. An additional 8 visits for Alcoholism treatment.	Covered at 80% after deductible less any benefits provided in-network.* In a licensed general hospital covered as for any other illness. Up to 8 visits per member per calendar year.	**Covered in full after a $250 co-payment at a facility designated by Tufts Health Plan for up to 30 days in a calendar year (capped at $250 for individuals & $500 for families). Two days or outpatient treatment may be substituted for each inpatient day up to 60 days in a calendar year.** **Tufts Health Plan pays a maximum of $500 per calendar year for outpatient care.** **Non-biologically-based conditions up to 24 visits per calendar year.** **$25.00 per visit.**	**Covered at 80% after deductible for up to 30 days in a calendar year. Two days of outpatient treatment may be substituted for each inpatient day up to 60 days in a calendar year.** **Tufts Health Plan pays a maximum of $500 per calendar year for outpatient care.**
3. Rehabilitation	Same as above.	Same as above.	Same as above.	Covered at 80% after deductible (less any benefits provided in-network). Up to 8 visits per member per calendar year.	**Same as above.**	**Same as above.**
HOME HEALTH CARE						
1. Visiting Nurse	Covered in full when arranged by HMO Blue.	Covered in full when arranged by Tufts Health Plan.	Covered in full when arranged by PCP/Plan.	Covered at 80% after deductible.*	**Covered in full when arranged by Tufts Health Plan.**	**Covered at 80% after deductible.***
2. Home Health Aide	Covered in full when arranged by HMO Blue.	Covered in full when arranged by Tufts Health Plan.	Covered in full when arranged by PCP/Plan.	Covered at 80% after deductible.*	**Covered in full when arranged by Tufts Health Plan.**	**Covered at 80% after deductible.***
MEDICAL PROSTHESES	Covered at 80% with no calendar year maximum.	Covered at **100%with no calendar year maximum.**	Covered at 80% with no calendar year maximum.	Covered at 80% after deductible.*	**Covered at 100% with no calendar year maximum**	**Covered at 100% with no calendar year maximum**

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MEDICAL APPLIANCES	Covered in full, up to $1,500 per calendar year through HMO Blue provider.	Covered at **100% up to $1,500/** calendar year maximum.	Covered in full, up to $1,500 per calendar year through Blue Choice provider.	Covered at 80% after deductible* up to a maximum plan payment of $1,500 per year.	**Covered at 100% up to $1,500 / calendar year maximum**	**Covered at 80% after deductible up to $1,500.**
*DEDUCTIBLES AND CO-INSURANCE FOR OUT-OF-NETWORK SERVICES				For out-of-network covered services, there is a calendar year deductible of $250 per individual ($500 per family) before benefits are paid. Then, the Plan pays 80% and the member 20% (called "co-insurance") up to an out-of-pocket maximum of $500 per individual in a calendar year ($1,000 per family.) After the maximum amount has been reached, the Plan pays 100% of approved charges for covered services for the rest of that calendar year. Calendar year limits for point-of-service plan apply to in-network and out-of-network benefits in the aggregate.		**For out-of-network covered services, annual out-of-network deductibles apply per calendar year. Deductibles are $250 for individuals and $500 for families, then the plan pays 80% / the member 20% up to an out-of-pocket maximum of $500 per individual and $1000 per family. Once maximum out-of-pocket amount is met, the plans pays out-of-network benefits at 100% of the maximum allowance.**

***Out-of-Network charges subject to annual deductible and reasonable and customary charge limitations.**

**NOTE: This summary of health insurance benefits is not a contract.
Please see the Individual Subscriber Certificates for details.**

Women's Health and Cancer Rights Act of 1998: All of the Mount Holyoke College group health insurance plans provide benefits for mastectomy related services including surgery, reconstruction, prostheses and treatment of physical complications. Please contact your health insurance provider for details.