

MOUNT HOLYOKE

Comparison of the College-Sponsored Health Insurance Plans July 1, 2009 - June 30, 2010

Conditions of Coverage	HMO Blue	Blue Choice New England Point of Service Plan In-Network	Blue Choice New England POS Out-of-Network Self Referred	Blue Care Elect Preferred PPO In-Network	Blue Care Elect Preferred PPO Out-of-Network
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 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.	Any nationwide BC/BS PPO participating provider.	Freedom of choice for any provider as out-of-network benefit.
Choice of Health Care Facility	Member's primary care facility must be a part of the HMO Blue network.	Member's primary care facility choices include: Blue Choice network.	Freedom of choice for any health care facility that participates with BC/BS indemnity network.	Any nationwide BC/BS PPO participating health care facility.	Freedom of choice for any health care facility as out-of-network benefit.
WAITING PERIODS	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 after a \$250 co-payment per admission	Covered at 80% after deductible.*	Covered in full after a \$250 co-payment per admission	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 after a \$250 co-payment per admission when medically necessary and authorized by plan physician.	Covered at 80% after deductible.*	Covered in full, up to semi-private room rate, after a \$250 co-payment per admission when medically necessary and authorized by plan physician.	Covered at 80% after deductible.*
3. Surgery	Covered in full after a \$250 co-payment per admission	Covered in full after a \$250 co-payment per admission.	Covered at 80% after deductible.*	Covered in full after a \$250 co-payment per admission.	Covered at 80% after deductible.*
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 after a \$250 co-payment per admission	Covered at 80% after deductible.*	Covered in full after a \$250 co-payment per admission	Covered at 80% after deductible.*
5. Physicians' and Consultants' Services	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 after a \$250 co-payment per admission	Covered in full after a \$250 co-payment per admission	Covered at 80% after deductible.*	Covered in full after a \$250 co-payment per admission	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 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 up to 100 days per calendar year	Covered at 80% after deductible up to a maximum of 100 days.*

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MATERNITY					
1. Pregnancy Complications	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.	Covered in full.	Covered at 80% after deductible.*	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 co-payment of \$250.00.	Covered at 80% after deductible.*	Covered in full after inpatient co-payment of \$250.00.	Covered at 80% after deductible.*
4. Newborn Checkups	\$15.00 per visit.	\$15.00 per visit.	Covered at 80% after deductible.*	\$15.00 per visit.	Covered at 80% after deductible.*
5. Childbirth Education	\$90.00 initial course. \$45.00 refresher.	\$90.00 initial course. \$45.00 refresher.	\$90.00 initial course. \$45.00 refresher.	\$90.00 initial course. \$45.00 refresher.	\$90.00 initial course. \$45.00 refresher.
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 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.*	\$15.00 per visit. (no costs for routine tests) Age based schedule followed: 1 visit/5 cal yrs age 19 thru 29 1 visit/3 cal yrs age 30 thru 39 1 visit/2 cal yrs age 40 thru 54 1 visit/cal yr age 55 and older	Covered at 80% after deductible. Age based schedule followed
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 PROVIDER.	Covered at 80% after deductible up to age six.* (Includes immunizations)	\$15.00 per visit. (no costs for routine tests) Age based schedule followed: 10 visits during 1st year 3 visits during 2nd year 1 visit/cal yr age 2 thru 11 1 visit/2 cal yrs age 12 thru 18	Covered at 80% after deductible. Age based schedule followed
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 – covered in full.	Covered at 80% after deductible.*	\$15.00 per visit. Allergy shots \$15.00 co-payment- separate from office visit co-payment	Covered at 80% after deductible.*
4. Diagnostic X-ray and Lab	Covered in full.	Covered in full.	Covered at 80% after deductible.*	Covered in full.	Covered at 80% after deductible.*

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5. Minor Surgery	<p>\$15.00/\$25.00 for office visit surgery.</p> <p>Covered in full in hospital surgical day care facility.</p> <p>Covered in full after \$250 co-payment when inpatient.</p>	<p>Covered in full in hospital surgical day care facility and providers office.</p> <p>Covered in full after \$250 co-payment when inpatient.</p>	Covered at 80% after deductible.*	<p>\$15.00 per visit in office setting.</p> <p>Covered in full in hospital surgical day care facility</p> <p>Covered in full after \$250.00 inpatient co-payment when inpatient</p>	Covered at 80% after deductible.*
6. Allergy Tests	<p>\$25.00 per visit.</p> <p>Injections only are covered in full</p>	<p>\$25.00 per visit.</p> <p>Injections only are covered in full</p>	Covered at 80% after deductible.*	<p>\$15.00 per visit</p> <p>\$15.00 for allergy injection per visit – separate from the office visit co-payment</p>	Covered at 80% after deductible.*
7. Eye and Refraction	<p>\$25.00 per visit</p> <p>Self-referral once every calendar year to any HMO Blue network provider.</p>	<p>\$25.00 per visit</p> <p>Self-referral once every calendar year to any Blue Choice network provider.</p>	Covered at 80% after deductible.*	<p>\$15.00 per visit. once every calendar year</p>	Covered at 80% after deductible.*
8. Routine Hearing Exams	<p>\$15.00 per visit by PCP \$25.00 per visit by other network providers.</p>	<p>\$15.00 per visit by PCP \$25.00 per visit by other network providers.</p>	Covered at 80% after deductible.*	\$15.00 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 at 80% after deductible when medically necessary.*	\$15.00 per visit	Covered at 80% after deductible.*
10. Radiation Therapy	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 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.*	\$15.00 per visit up to 100 visits per calendar year for each unrelated illness or injury.	Covered at 80% after deductible.*
12. Prescription Drugs	<p>\$10.00 generic \$20.00 brand \$35.00 non-preferred up to a 30 day supply.</p> <p><i>Mail order:</i> Up to a 90 day supply \$20 generic \$40 brand \$70 non-preferred</p>	<p>\$10.00 generic \$20.00 brand \$35.00 non-preferred up to a 30 day supply.</p> <p><i>Mail order:</i> Up to a 90 day supply \$20 generic \$40 brand \$70 non-preferred</p>	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.	<p>\$10.00 generic \$20.00 brand \$35.00 non-preferred up to a 30 day supply</p> <p><i>Mail order:</i> Up to 90 day supply \$20.00 generic \$40.00 brand name \$70.00 non-preferred</p>	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.

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13. Specialist Visits	\$25.00 per visit.	\$25.00 per visit.	Covered at 80% after deductible.*	\$15.00 per visit	Covered at 80% after deductible.*
14. Chiropractic Service	Not covered.	\$25.00 per visit.	Covered at 80% after deductible.*	\$15,00 per visit	Covered at 80% after deductible.*
15. Acupuncture and Homeopathy	Living Healthy Naturally program – offers discounts up to 30%.	Living Healthy Naturally program – offers discounts up to 30%.	Living Healthy Naturally program – offers discounts up to 30%.	Living Healthy Naturally program – offers discounts up to 30%.	Living Healthy Naturally program – offers discounts up to 30%.
FAMILY PLANNING					
1. Office Visit	\$15.00 per visit.	\$15.00 per visit.	Covered at 80% after deductible.*	\$15.00 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 facility.	Covered at 80% after deductible.*	\$15.00 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 facility.	Covered at 80% after deductible.*	\$15.00 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 facility.	Covered at 80% after deductible.*	\$15.00 per visit.	Covered at 80% after deductible.*
DENTAL					
1. Preventive Care	Full coverage for preventive 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.
2. Other Services	Coverage is provided for extraction of teeth imbedded in the bone. In the dentist office or surgical day care center by a network physician.	Coverage is provided for extraction of teeth imbedded in the bone. In the dentist office or surgical day care center by a network physician.	Covered at 80% after deductible.*	Not covered.	Not covered.
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 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.*	\$15.00 per office visit \$75.00 co-payment at emergency room, (waived if admitted or for observation stay) \$250 inpatient	\$75.00 co-payment at emergency room, (waived if admitted or for observation stay) no deductible - \$250 copayment if admitted.

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2. Out of the Area/ State /Country	\$75.00 co-payment when 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.	\$75.00 co-payment when 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.	Covered at 80% after deductible.*	\$75.00 co-payment when 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.	Covered at 80% after 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 at 80% after deductible.*	Covered in full	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 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.	Can see any PPO national provider	Member can see non PPO Provider. Benefits will be subject to deductible and coinsurance limits. Balance billing may occur.
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 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.	Can see any PPO national provider	Member can see non PPO Provider. Benefits will be subject to deductible and coinsurance limits. Balance billing may occur.
HEALTH EDUCATION					
1. Patient Education	Helping members stay informed, healthy: bcbsma.com Ahealthyme.com Drugstore.com	Helping members stay informed, healthy: bcbsma.com Ahealthyme.com Drugstore.com	Helping members stay informed, healthy: bcbsma.com Ahealthyme.com Drugstore.com	Helping members stay informed, healthy: bcbsma.com Ahealthyme.com Drugstore.com	Helping members stay informed, healthy: bcbsma.com Ahealthyme.com Drugstore.com

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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 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. 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.
2. 24-hour Crisis Counseling	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. 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. 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). Non-Biologically based conditions (Includes drug addiction and alcoholism) up to 24 visits per calendar year. Alcoholism treatment up to 8 additional visits per calendar year.	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. 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). Non-Biologically based conditions (Includes drug addiction and alcoholism) up to 24 visits per calendar year. Alcoholism treatment up to 8 additional visits per calendar year.
3. Psychotherapy	Same as above.	Same as above.	Same as above	Same as above.	Same as above.
ALCOHOL/DRUG TREATMENT					
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.	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.	Covered at 80% after deductible (less any benefits provided in-network). Up to 8 visits per member per calendar year.
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.	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.	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 in a facility designated by PPO 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.	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.

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	Non-Biologically – based conditions up to 24 visits per calendar year. \$15.00 per visit. An additional 8 visits for Alcoholism treatment.	Non Biologically based conditions up to 24 visits per calendar year. \$15.00 per visit. An additional 8 visits for Alcoholism treatment.		Non Biologically based conditions up to 24 visits per calendar year. \$15.00 per visit. An additional 8 visits for Alcoholism treatment.	
3. Rehabilitation	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.	Covered at 80% after deductible (less any benefits provided in-network). Up to 8 visits per member per calendar year.
HOME HEALTH CARE					
1. Visiting Nurse	Covered in full when arranged by HMO Blue.	Covered in full when arranged by PCP/Plan.	Covered at 80% after deductible.*	Covered in full	Covered at 80% after deductible.*
2. Home Health Aide	Covered in full when arranged by HMO Blue.	Covered in full when arranged by PCP/Plan.	Covered at 80% after deductible.*	Covered in full	Covered at 80% after deductible.*
MEDICAL PROSTHESES	Covered at 80% with no calendar year maximum.	Covered at 80% with no calendar year maximum.	Covered at 80% after deductible.*	Covered in full	Covered at 80% after deductible.*
MEDICAL APPLIANCES	Covered in full, up to \$1,500 per calendar year through HMO Blue provider.	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 in full, up to \$1,500 per calendar year	Covered at 80% after deductible* up to a maximum plan payment of \$1,500 per year.

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*DEDUCTIBLES AND CO-INSURANCE FOR OUT-OF-NETWORK SERVICES	None	None	<p>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.</p>	None	<p>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.</p>

***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.