MOUNT HOLYOKE

Comparison of the College-Sponsored Health Insurance Plans
July 1, 2020 – June 30, 2021

Important Questions	HMO BLUE (Massachusetts Network)	VALUE HMO HMO Blue New England - $1000 deductible (New England Network)	PPO 90 Blue Care Elect Preferred 90 Copay (National Network)
What is the overall deductible	$0.00	**$1,000** member / **$2,000** family. Does not apply to preventive care, prenatal care, emergency room, prescription drugs, most office visits, mental health services, emergency transportation, home health care, and hospice services.	**$250** member -- **$500** family Does not apply to in-network preventive and prenatal care, most office visits, therapy visits, mental health visits; prescription drugs, emergency room, emergency transportation
Are there other deductibles for specific services?	No	No	No
Is there an out of pocket limit on my expenses?	Yes. For medical benefits, **$2,000** member / **$4,000** family; and for prescription drug benefits, **$1,000** member / **$2,000** family.	Yes. For medical benefits, $**2,000** member / **$4,000** family; and for prescription drug benefits, **$1,000** member / **$2,000** family.	Yes. For medical benefits, $**2,000** member / **$4,000** family; and for prescription drug benefits, **$1,000** member / **$2,000** family.
What is not included in the out of pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover. Even though you pay these expenses, they don't count toward the **out of pocket limit.**		
Does this plan use a network of providers?	Yes, for all plans, see www.bluecrossma.com/findadoctor or call **1-800-821-1388** for a list of network providers.		
	Uses a MASSACHUSETTS based network	Uses a NEW ENGLAND based network – ME, VT, NH, MA, CT, RI	Uses a NATIONAL network
Do I need a referral to see a specialist?	Yes	Yes	No
Are there services this plan **does not** cover?	Yes – Please see the complete "Summary of Benefits & Coverage" and the plan document for details This is not a complete list:		
	• Acupuncture • Children's glasses • Cosmetic Surgery • Dental Care (adult) • Long-term Care • Non-emergency care when traveling outside of the US • Private Duty nursing	• Acupuncture • Children's glasses • Cosmetic Surgery • Dental Care (adult) • Long-term Care • Non-emergency care when traveling outside of the US • Private Duty nursing	• Acupuncture • Children's glasses • Cosmetic Surgery • Dental Care (adult) • Long-term Care • Private Duty nursing

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Common Medical Event	Services You May Need	**HMO BLUE (Massachusetts Network)**			**VALUE HMO HMO Blue New England - $1000 deductible (New England Network)**			**PPO 90 Blue Care Elect Preferred 90 Copay (National Network)**		
		In Network	Out of Network	Limits/ Exceptions	In Network	Out of Network	Limits/ Exceptions	In Network	Out of Network	Limits/ Exceptions
If you visit a health care provider's office or clinic	PCP visit to treat an injury or illness	$30.00	Not covered	None	$30.00	Not covered	None	$20.00	20% co-insurance	Deductible applies first to out of network
	Specialist Visit	$40.00	Not covered	None	$40.00	Not covered	None	$20.00	20% co-insurance	Deductible applies first to out of network
	Other Practitioner office visit	$40/ chiropractor	Not covered	None	$40/ chiropractor	Not covered	None	$20/ chiropractor	20% co-insurance	Deductible applies first to out of network
	Preventive Care / screening / immunization	No charge	Not covered	GYN exam limited to 1 exam per calendar yr	No charge	Not covered	GYN exam limited to 1 exam per calendar yr	No charge	20% co-insurance	Deductible applies first for out of network; limited to age based frequency and/or schedule
If you have a test	Diagnostic Test (x-ray, blood work)	No charge	Not covered	None	No charge	Not covered	**Deductible applies first**	10% co-insurance	30% co-insurance	**Deductible applies first**
	Imaging (CT/PET scans, MRIs)	$75.00	Not covered	Copay applies per category of test/day; pre-authorization required for some services.	No charge	Not covered	**Deductible applies first; pre-authorization required for certain services**	10% co-insurance	30% co-insurance	**Deductible applies first**

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		In Network	Out of Network	Limits/ Exceptions	In Network	Out of Network	Limits/ Exceptions	In Network	Out of Network	Limits/ Exceptions
		$100/person; $200/family deductible for retail. No deductible for mail order			**$100/person; $200/family deductible for retail. No deductible for mail order**					
If you need drugs to treat your illness or condition More info about prescription drug coverage is available at www.bluecrossma.com	Generic drugs	**$15** – retail supply **$30** – mail service supply	Not covered	Up to 30 day retail (90 day mail service) supply; cost share waived for birth control and certain orally administered anti-cancer drugs; pre-authorization required for certain drugs.	**$15** – retail supply **$30** – mail service supply	Not covered	Up to 30 day retail (90 day mail service) supply; cost share waived for birth control and certain orally administered anti-cancer drugs; pre-authorization required for certain drugs.	**$10** – retail supply **$20** – mail service supply	Not covered	Up to 30 day retail (90 day mail service) supply; cost share waived for birth control and certain orally administered anti-cancer drugs; pre-authorization required for certain drugs.
	Preferred Brand Drugs	**$45 –** retail supply **$90 –** mail service supply	Not covered		**$45 –** retail supply **$60 –** mail service supply	Not covered		**$30 –** retail supply **$60 –** mail service supply	Not covered	
	Non-preferred Brand Drugs	**$60 –** retail supply **$180 –** mail service supply	Not covered		**$60 –** retail supply **$180 –** mail service supply	Not covered		**$50 –** retail supply **$100 –** mail service supply	Not covered	
	Specialty Drugs	Applicable cost share (generic, preferred, non preferred)	Not covered	When obtained from designated specialty pharmacy; pre-authorization required for certain drugs.	Applicable cost share (generic, preferred, non preferred)	Not covered	When obtained from designated specialty pharmacy; pre-authorization required for certain drugs.	Applicable cost share (generic, preferred, non preferred)	Not covered	When obtained from designated specialty pharmacy; pre-authorization required for certain drugs.

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		In Network	Out of Network	Limits/ Exceptions	In Network	Out of Network	Limits/ Exceptions	In Network	Out of Network	Limits/ Exceptions
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	$150 per admission (colono-scopies not subject to copay)	Not covered	Pre-authorization required for certain services	No charge (colono-scopies not subject to deductible)	Not covered	**Deductible applies first; pre-authorization required for certain services**	$250 per admission (colono-scopies not subject to copay)	20% co-insurance	**Deductible applies first**
	Physician / surgeon fees	No charge	Not covered	Pre-authorization required for certain services	No charge (colonoscopies not subject to deductible)	Not covered	**Deductible applies first; pre-authorization required for certain services**	No charge	20% co-insurance	**Deductible applies first**
If you need immediate medical attention	Emergency Room Services	$150.00 per visit	$150.00 per visit	Copayment waived if admitted or for observation stay	$150 per visit	$150.00 per visit	Copayment waived if admitted or for observation stay	$150.00 per visit	$150.00 per visit	Copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	None	No Charge	No Charge	None	10% coinsurance	10% coinsurance	None
	Urgent Care	$40 per visit	$40.00 per visit	Out of network coverage limited to out of service area	$40.00 per visit	$40.00 per visit	Out of network coverage limited to out of service area	$20.00 per visit	20% co-insurance	Deductible applies first for out of network

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		In Network	Out of Network	Limits/ Exceptions	In Network	Out of Network	Limits/ Exceptions	In Network	Out of Network	Limits/ Exceptions
If you have a hospital stay	Facility Fee (e.g. hospital room)	$250 per admission	Not covered	Pre-authorization required	No charge	Not covered	**Deductible applies first; pre-authorization required**	10% co-insurance	30% co-insurance	**Deductible applies first; pre-authorization required**
	Physician / surgeon fee	No charge	Not covered	Pre-authorization required	No charge	Not covered	**Deductible applies first; pre-authorization required**	10% co-insurance	30% co-insurance	**Deductible applies first; pre-authorization required**
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	$30.00 per visit	Not covered	Pre-authorization required for certain services	$30.00 per visit	Not covered	Pre-authorization required for certain services	$20.00 per visit	20% co-insurance	Deductible applies first for out of network
	Mental / Behavioral health inpatient services	$250 per admission	Not covered	Pre-authorization required	No charge	Not covered	Pre-authorization required	10% co-insurance	30% co-insurance	**Deductible applies first; pre-authorization required**
	Substance use disorder outpatient services	$30.00 per visit	Not covered	Pre-authorization required for certain services	$30.00 per visit	Not covered	Pre-authorization required for certain services	$20.00 per visit	20% co-insurance	Deductible applies first for out of network
	Substance use disorder inpatient services	$250.00 per admission	Not covered	Pre-authorization required	No charge	Not covered	Pre-authorization required	10% co-insurance	30% co-insurance	**Deductible applies first; pre-authorization required**

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Common Medical Event	Services You May Need	**HMO BLUE (Massachusetts Network)**			**VALUE HMO HMO Blue New England - $1000 deductible (New England Network)**			**PPO 90 Blue Care Elect Preferred 90 Copay (National Network)**		
		In Network	Out of Network	Limits/ Exceptions	In Network	Out of Network	Limits/ Exceptions	In Network	Out of Network	Limits/ Exceptions
If you are pregnant	Prenatal and Postnatal care	No charge	Not covered	None	No charge	Not covered	None	No charge for prenatal care; 10% coinsurance for postnatal care	20% coinsurance for prenatal care; 30% coinsurance for postnatal care	**Deductible applies first for in-network postnatal care and out-of-network prenatal and postnatal care**
	Delivery and all inpatient services	$250 per admission and no charge for delivery	Not covered	None	No charge	Not covered	**Deductible applies first**	10% co-insurance	30% co-insurance	**Deductible applies first**
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Pre-authorization required	No charge	Not covered	Pre-authorization required	10% co-insurance	30% co-insurance	**Deductible applies; pre-authorization required**
	Rehabilitation services	$40 per visit $30 per visit for speech therapy	Not covered	Limit 60 visits per calendar yr (other than for autism, home health care and speech therapy); pre-authorization required for certain services	$40 per visit $30 per visit for speech therapy	Not covered	**Deductible applies first; limited to 60 visits per calendar year (other than for autism, home health care, and speech therapy); pre-authorization required for certain services**	$20 per visit	20% co-insurance	Deductible applies first for out of network; limited to 100 visits per calendar year (other than for autism, home health care, and speech therapy)

Common Medical Event	Services You May Need	**HMO BLUE (Massachusetts Network)**			**VALUE HMO HMO Blue New England - $1000 deductible (New England Network)**			**PPO 90 Blue Care Elect Preferred 90 Copay (National Network)**		
		In Network	Out of Network	Limits/ Exceptions	In Network	Out of Network	Limits/ Exceptions	In Network	Out of Network	Limits/ Exceptions
If you need help recovering or have other special health needs	Habilitation services	$40 per visit $30 per visit for speech therapy	Not covered	Rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children; pre-authorization required for certain services.	$40 per visit $30 per visit for speech therapy	Not covered	**Deductible applies first, rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children; pre-authorization required for certain services**	$20 per visit	20% co-insurance	**Deductible applies first for out of network; rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children**
	Skilled Nursing care	No charge	Not covered	Limited to 100 days per calendar year; pre-authorization required	No charge	Not covered	**Deductible applies first; limited to 100 days per calendar year; pre-authorization required**	10% co-insurance	30% co-insurance	**Deductible applies first; limited to 100 days per calendar year; pre-authorization required**

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		In Network	Out of Network	Limits/ Exceptions	In Network	Out of Network	Limits/ Exceptions	In Network	Out of Network	Limits/ Exceptions
If you need help recovering or have other special health needs	Durable medical equipment	20% co-insurance	Not covered	Cost share waived for one breast pump per birth	20% co-insurance	Not covered	**Deductible applies first; cost share waived for one breast pump per birth**	20% co-insurance	40% co-insurance	**Deductible applies first; in-network cost share waived for one breast pump per birth (20% co-insurance for out of network**
	Hospice Service	No charge	Not covered	Pre-authorization required for certain services.	No charge	Not covered	Pre-authorization required for certain services	10% co-insurance	30% co-insurance	**Deductible applies; pre-authorization required for certain services.**
If your **child** needs dental or eye care	Eye exam	No charge	Not covered	Limited to one exam per calendar year	No charge	Not covered	Limited to one exam per calendar year	No charge	20% co-insurance	Deductible applies first for out of network; limited to one exam per calendar year.
	Glasses	Not covered	Not covered	None	Not covered	Not covered	None	Not covered	Not covered	None
	Dental Check up	No charge	Not covered	Limited to children under age **12 (one exam every 6 months)** and under age 18 with a cleft palate/ cleft lip condition.	No charge	Not covered	Limited to members under age **12 (one exam every 6 months)**; and members under age 18 with a cleft palate / cleft lip condition.	No charge for members with a cleft palate / cleft lip condition	20% co-insurance for members with a cleft palate / cleft lip condition	Limited to members under age 18; deductible applies first for out of network.

Common Medical Event		**HMO BLUE** **(Massachusetts Network)**	**VALUE HMO** **HMO Blue New England - $1000 deductible** **(New England Network)**	**PPO 90** **Blue Care Elect Preferred 90 Copay** **(National Network)**
Other covered services (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services		• Bariatric surgery • Chiropractic care • Hearing aids ($2,000 per ear every 36 months for members age 21 and younger) • Infertility treatment • Routine eye care (one exam per calendar year) • Routine foot care (only for patients with systemic circulatory disease) • Weight loss programs ($150 per calendar year per policy)	• Bariatric surgery • Chiropractic care • Hearing aids ($2,000 per ear every 36 months for members age 21 and younger) • Infertility treatment • Routine eye care (one exam per calendar year) • Routine foot care (only for patients with systemic circulatory disease) • Weight loss programs ($150 per calendar year per policy)	• Bariatric surgery • Chiropractic care • Hearing aids ($2,000 per ear every 36 months for members age 21 and younger) • Infertility treatment • Routine eye care (one exam per calendar year) • Routine foot care (only for patients with systemic circulatory disease) • Weight loss programs ($150 per calendar year per policy) • Non-emergency care when traveling outside the U.S.

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.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877- KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility –

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP	RHODE ISLAND – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEW HAMPSHIRE – Medicaid	**NEW YORK – Medicaid**	**VERMONT– Medicaid**
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Access to Exposure and Medical Records

The Occupational Health and Safety Administration (OSHA) have specific requirements regarding employee access to exposure and medical records. Exposure records include results of monitoring done to determine employee exposure to toxic substances or harmful physical agents, and records of toxic substances used in the workplace. Medical records include medical questionnaires, results of medical examinations, and other medical documents related to employment. Exposure records are maintained by the Environmental Health and Safety O□ice, and medical records by the Health Services. To access records, contact Environmental Health and Safety O□ice or the Health Services. If you have questions regarding OSHA requirements, contact the Environmental Health and Safety O□ice at x2529.