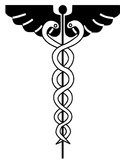
SMITH COLLEGE



Health Care Program

2021 Comparison Chart

This chart outlines the health coverage, which is available to eligible faculty and staff during the 2021 plan year. The college offers you the option of joining an HMO, a Value HMO, a HDHP with HAS, or a POS plan.

- **Health Maintenance Organization (HMO):** In an HMO, your Primary Care Physician coordinates all of your care within a specific network of doctors and hospitals. You generally pay a fee, called a co-payment, for office visits, prescriptions, and hospitalization. If you receive medical care without Primary Care Physician or Plan referrals, the HMO usually will ***not*** cover the cost, unless the services are for a medical emergency.

- **Value Health Maintenance Organization (Value HMO):** In a Value HMO, your Primary Care Physician coordinates all of your care within a specific network of doctors and hospitals. For some services you will pay a copayment, for other services you must first satisfy a deductible. Certain tests and screenings are covered at no charge. If you receive medical care without Primary Care Physician or Plan referrals, the HMO usually will ***not*** cover the cost, unless the services are for a medical emergency.

- **Point of Service Plan (POS):** A POS plan works similar to an HMO if you use Blue Cross Blue Shield of Massachusetts providers but has an out-of-network option and the out-of-pocket costs and the premiums tend to be significantly higher than the HMO. At the point of electing any medical service, you decide whether or not to use in-network or out-of-network services. If you go in-network you need to get a Primary Care Physician referral. With a referral, services are typically covered in full after you pay a co-payment. Without a referral, the services will be considered out-of-network and you will pay initial charges (a “deductible”) and then a percentage of the following charges (“coinsurance”) before the plan begins paying fully. You and your providers must fill out claim forms. The option to bypass the referral is thus more expensive, but does provide you with freedom of choice.

- **High Deductible Health Plan with Health Savings Account (HDHP with HSA):** In a HDHP with HSA, for most services you must first satisfy a deductible. After the deductible is met, you pay a percentage of the following charges (“coinsurance”) before the plan begins paying fully. You may use the HSA to assist in paying out of pocket costs. Certain tests and screenings are covered at no charge. If you go in-network you need to get a Primary Care Physician referral. Without a referral, the services will be considered out-of-network.

SMITH COLLEGE offers these health plans for 2021:

- **Blue Cross Blue Shield of Massachusetts HMO (Group # 004068736)**
- **Blue Cross Blue Shield of Massachusetts Value HMO (Group # 004068739)**
- **Blue Cross Blue Shield of Massachusetts HDHP (Group # 002373452)**
- **Blue Cross Blue Shield of Massachusetts POS (Group # 004068742)**

For complete information, please consult the appropriate plan booklet or subscriber certificate.

While every attempt has been made to ensure the accuracy of this summary, the Blue Cross Blue Shield of Massachusetts plan legal documents; policies or certificates prevail in the event of any discrepancy. This summary does not constitute a legal document. The policies summarized here are not conditions of employment and are subject to change. Smith College reserves the right to amend, modify or withdraw in its sole discretion any provision contained in this summary. Neither this document nor any of its terms or provisions constitutes a contractual obligation of Smith College.

Revised as of: 10/06/2017

	Blue Cross Blue Shield Health Plan HMO	Blue Cross Blue Shield Health Plan Value HMO
Services and Costs	**In Network only**	**In Network only**
Annual Deductible:	None	$500 per member, embedded $1000 for double/family plans
Annual Coinsurance:	None	None
Annual Out-of-Pocket Maximum:	$2,500 per member, embedded $5,000 for double/family plans This is the total amount in co-pays (office visits, emergency room, inpatient or day surgery) you are required to pay each year for services, not including prescription drugs.	$2,500 per member, embedded (Co-payments and Deductible) $5,000 for double/family plans (Co-payments and Deductible)
Hospital Services and Surgery:	Covered in full, after co-pay, with referral from Primary Care Physician (PCP)	Covered in full, after deductible, with referral from PCP
Outpatient Co-pay:	$250 co-pay	Covered in full, after deductible, with referral from PCP
Inpatient Co-pay:	$350 co-pay per admission, up to a maximum of $1,000 per calendar year	Covered in full, after deductible, with referral from PCP
Office visits:	$25 co-pay	$25 co-pay
Maternity office visits, pap tests, mammograms, preventative services*:	Covered in full	Covered in full
Allergy injections, lab tests (diagnostic)	Covered in full	Covered in full
Office visits to specialists:	$35 co-pay; Referral from PCP is required	$35 co-pay; Referral from PCP is required
Chiropractic Care:	$25 co-pay; Twelve visits (spinal manipulations only) per year, Must use chiropractors in BCBS network, No referral necessary	$25 co-pay; Twelve visits (spinal manipulations only) per year, Must use chiropractors in BCBS network, No referral necessary
Physical Therapy/Occupational Therapy	$25 co-pay; 60 visits per year	60 visits per year; covered in full after deductible
OB/Gyn visits:	$25 co-pay; No referral necessary, Must use BCBS provider	$25 co-pay; No referral necessary, Must use BCBS provider
Vision Care:	$25 co-pay; No referral necessary for one annual exam from a BCBS provider	$25 co-pay; No referral necessary for one annual exam from a BCBS provider
Mental Health/Substance Abuse:		
Inpatient Care:	Covered in full, after $350 co-pay.	Covered in full, after deductible
Outpatient Care:	$25 co-pay/visit individual therapy, $10 co-pay group therapy.	$25 co-pay/visit individual therapy, $10 co-pay group therapy.
Emergency Care:		
In-Network:	$150 co-pay for emergency room, waived if admitted. Notify BCBS or your PCP within 48 hrs. after receiving emergency care. For non-life-threatening conditions, call your PCP before going to the emergency room, or coverage may be denied.	$150 co-pay for emergency room, waived if admitted. Notify BCBS or your PCP within 48 hrs. after receiving emergency care. For non-life-threatening conditions, call your PCP before going to the emergency room, or coverage may be denied.
Out-of-Area Health Care:	For urgent or emergency care, seek attention at nearest facility. You must call BCBS within 48 hours of the event. BCBS will cover charges less the $100 emergency co-pay. Non-urgent care and follow-up care are not covered out of the BCBS network.	For urgent or emergency care, seek attention at nearest facility. You must call BCBS within 48 hours of the event. BCBS will cover charges less the $100 emergency co-pay. Non-urgent care and follow-up care are not covered out of the BCBS network.
Pediatric Dental Care:	Two preventive visits per year for children through the age of 12, Covered in full; Must use a BCBS dentist or services will not be covered.	Two preventive visits per year for children through the age of 12, $25 co-pay; Must use a BCBS dentist or services will not be covered.
Prescription Drug Coverage: Prescription drug benefits managed by: OptumRx 1-888-374-8127 Preferred & non-preferred brand name deductible: $100 per member, embedded $200 for double/family plan	$10 co-pay for generic drugs $30 co-pay for preferred brand name drugs after deductible $50 co-pay for non-preferred brand name drugs after deductible Pharmacy Network: All participating pharmacies Mail Order: 90-day supply for two co-payments: $20 co-pay generic $60 co-pay preferred brand name after deductible $100 co-pay non-preferred brand name after deductible	$10 co-pay for generic drugs $30 co-pay for preferred brand name drugs after deductible $50 co-pay for non-preferred brand name drugs after deductible Pharmacy Network: All participating pharmacies Mail Order: 90-day supply for two co-payments: $20 co-pay generic $60 co-pay preferred brand name after deductible $100 co-pay non-preferred brand name after deductible

*Preventative services may include, but are not limited to: routine exams, screenings and tests, immunizations, certain family planning services, and routine GYN exams. Please see the Schedule of Benefits for a detailed list of covered services.

	Blue Cross Blue Shield Health Plan POS	
Services and Costs	**In Network**	**Out of Network**
Annual Deductible:	None	$400 per member, embedded $800 for double/family plans
Annual Coinsurance:	None	20% co-insurance after deductible
Annual Out-of-Pocket Maximum:	$2,500 per member, embedded $5,000 for double/family plans This is the total amount in co-pays (office visits, emergency room, inpatient or day surgery) you are required to pay each year for services, not including prescription drugs.	$2,000 per member, embedded (Deductible and Coinsurance) $4,000 for double/family plans (Deductible and Coinsurance)
Hospital Services and Surgery:	Covered in full, after co-pay, with referral from Primary Care Physician	20% co-insurance after deductible; pre-authorization is required
Outpatient Co-pay:	$300 co-pay	20% co-insurance after deductible
Inpatient Co-pay:	$350 co-pay per admission, up to a maximum of $1,000 per calendar year	20% co-insurance after deductible
Office visits:	$30 co-pay	20% co-insurance after deductible
Maternity office visits, pap tests, mammograms, preventative services*:	Covered in full	20% co-insurance after deductible
Allergy injections, lab tests (diagnostic)	Covered in full	20% co-insurance after deductible
Office visits to specialists:	$40 co-pay; Referral from PCP required	20% co-insurance after deductible
Chiropractic Care:	$40 co-pay; Twelve visits (spinal manipulations only) per year; Must use chiropractors in BCBS network	20% co-insurance after deductible; Twelve visits (spinal manipulations only) per year
Physical Therapy/Occupational Therapy	$30 co-pay; 60 visits per year	20% co-insurance after deductible; 60 visits per year
OB/Gyn visits:	$30 co-pay; No referral necessary; Must use a BCBS provider	20% co-insurance after deductible
Vision Care:	$30 co-pay; No referral necessary; Must use a BCBS provider	20% co-insurance after deductible
Mental Health/Substance Abuse: Inpatient Care:	Covered in full, after $350 co-pay.	20% co-insurance after deductible
Outpatient Care:	$30 co-pay/visit individual therapy, $10 co-pay group therapy.	20% co-insurance after deductible
Emergency Care: In-Network:	$200 co-pay for emergency room, waived if admitted. Notify BCBS or your PCP after receiving emergency care. For non-life-threatening conditions, call your PCP before going to the emergency room, or coverage may be denied.	$200 co-pay for emergency room, waived if admitted. Notify BCBS or your PCP after receiving emergency care. For non-life-threatening conditions, call your PCP before going to the emergency room, or coverage may be denied.
Out-of-Area Health Care:	For urgent or emergency care, seek attention at nearest facility. You must call BCBS within 48 hours of the event. BCBS will cover charges less the $150 emergency co-pay. Non-urgent care and follow-up care are not covered out of the BCBS network.	For urgent or emergency care, seek attention at nearest facility. You must call BCBS within 48 hours of the event. BCBS will cover charges less the $150 emergency co-pay. Non-urgent care and follow-up care are not covered out of the BCBS network.
Pediatric Dental Care:	Two preventive visits per year for children through the age of 12, Covered in full; Must use a BCBS dentist or services will not be covered.	20% co-insurance after deductible
Prescription Drug Coverage: Prescription drug benefits managed by: OptumRx 1-888-374-8127 Preferred & non-preferred brand name deductible: $100 per member, embedded $200 for double/family plan	$10 co-pay for generic drugs $30 co-pay for preferred brand name drugs after deductible $50 co-pay for non-preferred brand name drugs after deductible Pharmacy Network: All participating pharmacies Mail Order: 90-day supply for two co-payments: $20 co-pay generic $60 co-pay preferred brand name after deductible $100 co-pay non-preferred brand name after deductible	

	Blue Cross Blue Shield Health Plan High Deductible Health Plan	
Services and Costs	**In Network**	**Out of Network****
Annual Deductible (not embedded per individual)	$1500 individual plans only $3000 double and family plans	$3000 individual plans only $6000 double and family plans
Smith HSA Seed: (Pro-rated by half on or after 7/1/20.)	$500 individual plans $1,000 double and family plans	$500 individual plans $1,000 double and family plans
Annual Coinsurance:	10% co-insurance after deductible	30% co-insurance after deductible
Annual Out-of-Pocket Maximum:	$3,000 individual plans only $6,000 double and family plans This is the total amount in co-pay, deductible and co-insurance (including presciption drugs) you are required to pay each year for services.	$6,000 individual plans only $12,000 double and family plans This is the total amount in deductible and co-insurance (including presciption drugs) you are required to pay each year for services.
Hospital Services and Surgery:	10% co-insurance after deductible	30% co-insurance after deductible
Outpatient Co-pay:	10% co-insurance after deductible	30% co-insurance after deductible
Inpatient Co-pay:	10% co-insurance after deductible	30% co-insurance after deductible
Office visits:	10% co-insurance after deductible	30% co-insurance after deductible
Maternity office visits, pap tests, mammograms, preventative services*:	Covered in full	Covered in full
Allergy injections, lab tests (diagnostic)	10% co-insurance after deductible	30% co-insurance after deductible
Office visits to specialists:	10% co-insurance after deductible	30% co-insurance after deductible
Chiropractic Care: Limited to 12 visits per year	10% co-insurance after deductible	30% co-insurance after deductible
Physical Therapy/Occupational Therapy	10% co-insurance after deductible	30% co-insurance after deductible
OB/Gyn visits:	10% co-insurance after deductible	30% co-insurance after deductible
Vision Care: Routine Eye Exam	$25 co-pay	20% co-insurance after deductible
Mental Health/Substance Abuse: Inpatient Care:	10% co-insurance after deductible	30% co-insurance after deductible
Outpatient Care:	10% co-insurance after deductible	30% co-insurance after deductible
Emergency Care: In-Network:	10% co-insurance after deductible	10% co-insurance after deductible
Out-of-Area Health Care:	10% co-insurance after deductible	10% co-insurance after deductible
Pediatric Dental Care:	10% co-insurance after deductible	30% co-insurance after deductible
Prescription Drug Coverage: Prescription drug benefits managed by: OptumRx 1-888-374-8127 Preferred & non-preferred brand name deductible not a separate deductible from medical services	$10 co-pay for generic drugs after deductible $30 co-pay for preferred brand name drugs after deductible $50 co-pay for non-preferred brand name drugs after deductible Pharmacy Network: All participating pharmacies Mail Order: 90-day supply for two co-payments: $20 co-pay generic after deductible $60 co-pay preferred brand name after deductible $100 co-pay non-preferred brand name after deductible	$10 co-pay for generic drugs after deductible $30 co-pay for preferred brand name drugs after deductible $50 co-pay for non-preferred brand name drugs after deductible Pharmacy Network: All participating pharmacies Mail Order: 90-day supply for two co-payments: $20 co-pay generic after deductible $60 co-pay preferred brand name after deductible $100 co-pay non-preferred brand name after deductible

*Preventative services may include, but are not limited to: routine exams, screenings and tests, immunizations, certain family planning services, and routine GYN exams. Please see the Schedule of Benefits for a detailed list of covered services.

**Prior Approval is required for certain Out-of-Network benefits. Before you receive services from a Non-Plan Provider, refer to Blue Cross Blue Shield for the complete listing of Out-of-Network services that require Prior Approval.