COMPARE YOUR CURRENT HEALTH INSURANCE PLAN TO THE STUDENT HEALTH INSURANCE PLAN OFFERED BY WHEATON COLLEGE

Complete this worksheet to help you make the best decision the best decision for student's healthcare needs. General provision below in blue text are those required by the Commonwealth of Massachusetts

Your Plan		**BCBS Student Blue** Effective 8/6/2022-8/5/2023
Annual Premium (Monthly x12) Individual: Family (if applicable):	$ ________ $ ________	$3,175 Student Only
Plan Type • **HMO** (Limited Provider Network) • **PPO** (Higher Benefits In-Network) • **Indemnity** (Can go to any licensed Provider)	__HMO __PPO __Indemnity __Other	PPO Plan
Deductible **Per Policy Year ____** **Per Condition _____**	In Network $______ Out of Network $________	$150 deductible/student $300 deductible/family (Combined In- and Out-of-network)
Annual Out-of-Pocket Maximum Individual: Family (if applicable):	$ ________ $ ________	$5,450 combined In/Out $10,900 combined In/Out
Service Area Coverage (coverage/care must be reasonably accessible to thestudent in the area in which the student attends college)	__National __Worldwide __Local Only __Other	Worldwide Coverage
Preferred Provider Network (National or Regional - network must be reasonablyaccessible to the student in the area in which the student attends college)	__National __Regional __Other	BCBS Preferred Elect PPO (in MA) & BCBS nationally
Travel Assistance, Medical Evacuation & Repatriation Coverage	Yes ___ No ___	Yes

Prepared by Gallagher Student Health
July 2022

	In-Network	Out-of-Network	In-Network	Out-of-Network
Coinsurance Share (What plan pays) (i.e., Plan pays 80%, insured person pays 20%)	________%	________%	90% of Preferred Allowance	70% of Usual & Customary
Annual Pharmacy Deductible:	$ ________	$ ________	None	No coverage
Annual Pharmacy Out-of-Pocket Maximum:	$ ________	$ ________	$1,000 Individual / $2,000 family	
Prescription Drug Copay Rx Tier 1 (Low costgenerics):	$ ________	$ ________	$15	No Coverage
Prescription Drug Copay Rx Tier 2 (Other generics):	$ ________	$ ________	$30	No Coverage
Prescription Drug Copay Rx Tier 3 (Preferred brand name)	$ ________	$ ________	$50	No Coverage
Prescription Drug Copay Rx Tier 4 (Non-preferred brand name	$ ________	$ ________	$75	No Coverage
Preventive Care Services (i.e., routine physical exam, GYN exams)	$ ________	$ ________	100%, no copay, no deductible	80% after deductible
Outpatient Medical Visits: office, health center, hospital outpatient services	$ ________	$ ________	$25/visit, then 100%, no deductible	80% after deductible
High-Cost Outpatient Testing (MRI, CT Scan, PET Scan)	$ ________	$ ________	$50/per category per date, after deductible	80% after deductible
Outpatient X-ray and Lab Tests	$ ________	$ ________	90% after deductible	70% after deductible
Emergency Room Visit	$ ________	$ ________	$150/visit, no deductible	$150/visit, no deductible
Emergency Ambulance Transportation	$ ________	$ ________	100% after deductible	100% after deductible
Outpatient Surgery: ambulatory surgical facility, surgical day care unit of a hospital, and hospital surgery services	$ ________	$ ________	90% after deductible	70% after deductible
Inpatient Hospitalization (medical and surgical care in a general hospital)	$ ________	$ ________	90% after deductible	70% after deductible
Inpatient mental Health and Substance Abuse Services	$ ________	$ ________	90% after deductible	70% after deductible
Outpatient Mental Health and Substance Abuse Services	$ ________	$ ________	$25 copay, then 100%, no deductible	80% after deductible

	In-Network	Out-of-Network	In-Network	Out-of-Network
Routine care (NMC, Student Health Center,visit is free regardless of insurance)	$ ________	$ ________	$25/visit, then 90% coinsurance	80%
Urgent care	$ ________	$ ________	$25/visit, then 90% coinsurance	80%
Vision (one exam every 24 months)	$ ________	$ ________	$0	80%