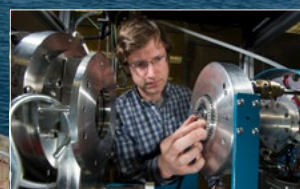
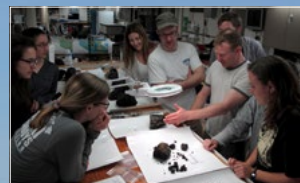
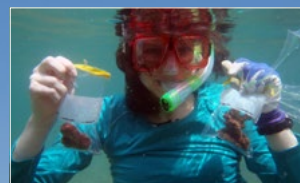


Woods Hole
Oceanographic
INSTITUTION

Medical Plan Comparison



2018

ATTENTION: This Medical Plan Comparison is considered a summary of material modifications (SMM) to one or more of the WHOI benefit plans. It contains a summary of important changes to the Plan. Please keep it with your Summary Plan Description, SMMs and other important plan documents. If there is any discrepancy between the terms of the Plan as amended, and this SMM, the provisions of the Plan, as amended, will control. If you have any questions, please contact BenefitsQA@whoi.edu. A copy of the Plan, including this modification, is available for your inspection.

Medical Plan Features	Blue Care Elect Saver Plan (with HSA - Health Savings Account)	Blue Care Elect Deductible Plan (with HRA - Health Reimbursement Account)	Advantage Blue Plan (Low Deductible Plan)
Annual Deductible Individual Coverage Family Coverage * *includes EE + child(ren), EE+ spouse, and family coverage	\$1,500	\$2,000	\$500
	\$3,000	\$4,000	\$1,000
	The <i>deductible</i> applies to in-network and out-of-network benefits combined.	The <i>deductible</i> applies to in-network and out-of-network benefits combined.	Coverage is provided for in-network benefits only, except for Emergency services
	The <i>deductible</i> applies to all covered services <u>except</u> preventive health services	The <i>deductible</i> applies to all covered services <u>except</u> in-network preventive health services, prescription drugs and supplies, and certain other covered services as noted in this chart.	The Deductible applies to covered services as noted in this chart
	The family <i>deductible</i> can be met by amounts paid by one family member or any combination of family members enrolled under the same family plan. Under a plan that includes the subscriber and eligible dependents, the entire amount of the family <i>deductible</i> must be met before benefits will be provided for any one member.	The family <i>deductible</i> can be met by eligible costs incurred by any combination of members enrolled under the same family plan. But, no one member will have to pay more than the \$2,000 per member <i>deductible</i> .	The family <i>deductible</i> can be met by eligible costs incurred by any combination of members enrolled under the same family plan. But, no one member will have to pay more than the \$500 per member <i>deductible</i> .
Annual Out-of-Pocket Max Individual Coverage Family Coverage * *includes EE + child(ren), EE+ spouse, and family coverage	\$6,000	\$6,000	\$6,000
	\$12,000	\$12,000	\$12,000
	The <i>out-of-pocket maximum</i> applies to in-network and out-of-network benefits combined.	The <i>out-of-pocket maximum</i> applies to in-network and out-of-network benefits combined.	The <i>out-of-pocket maximum</i> applies to all covered benefits.
	Includes member prescription drug cost share	Member Prescription Drug cost share applies towards the Out of Pocket Max	Member Prescription Drug cost share applies towards the Out of Pocket Max
	The <i>out-of-pocket maximum</i> is a total of your deductible, copayments, and coinsurance	The <i>out-of-pocket maximum</i> is a total of your deductible expenses, co-insurance, and all co-payments	The <i>out-of-pocket maximum</i> is a total of your deductible expenses, co-insurance, and all co-payments
Overall Benefit Maximum	The family out-of-pocket maximum can be met by eligible costs incurred by any combination of members enrolled under the same family plan. But, no one member will have to pay more than the \$6,000 per member out-of-pocket maximum.	The family <i>out-of-pocket maximum</i> can be met by eligible costs incurred by any combination of members enrolled under the same family plan. But, no one member will have to pay more than the \$6,000 per member <i>out-of-pocket maximum</i> .	The family <i>out-of-pocket maximum</i> can be met by eligible costs incurred by any combination of members enrolled under the same family plan. But, no one member will have to pay more than the \$6,000 per member <i>out-of-pocket maximum</i> .
	No dollar limit	No dollar limit	No dollar limit

Medical Plan Features	Blue Care Elect Saver Plan (with HSA - Health Savings Account)		Blue Care Elect Deductible Plan (with HRA - Health Reimbursement Account)		Advantage Blue Plan (Low Deductible Plan)
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
	Your Cost is:	Your Cost is:	Your Cost is:	Your Cost is:	Your Cost is:
Admissions for Inpatient Medical and Surgical Care					
In a General Hospital	\$0 AD	20% co-insurance AD	\$0 AD	20% co-insurance AD	\$0 AD
In a Chronic Disease Hospital	\$0 AD	20% co-insurance AD	\$0 AD	20% co-insurance AD	\$0 AD
In a Rehabilitation Hospital (60-day benefit limit per member per year)	\$0 AD	20% co-insurance AD	\$0 AD	20% co-insurance AD	\$0 AD
In a Skilled Nursing Facility (100-day benefit limit per member per year)	\$0 AD	20% co-insurance AD	\$0 AD	20% co-insurance AD	\$0 AD
Ambulance Services (ground or air ambulance transport)					
Emergency Ambulance	\$0 AD	\$0 AD	\$0 AD	\$0 AD	No charge
Other Ambulance	\$0 AD	20% co-insurance AD	\$0 AD	20% co-insurance AD	No charge
Cardiac Rehabilitation (Outpatient Services)	\$20 AD	20% co-insurance AD	\$20 AD	20% co-insurance AD	\$35 co-pay per visit
Chiropractor Services (Outpatient Services, including spinal manipulation)	\$20 AD	20% co-insurance AD	\$20 AD	20% co-insurance AD	\$35 co-pay per visit
Dialysis Services (Outpatient Services and home dialysis)	\$0 AD	20% co-insurance AD	\$0 AD	20% co-insurance AD	\$0 AD
Durable Medical Equipment	\$0 AD	20% co-insurance AD	\$0 AD	20% co-insurance AD	20% co-insurance AD
Early Intervention Services (for an eligible child through age two)	\$0 AD	\$0 AD	No charge	No charge	No charge
Emergency Room Services	\$100 AD Waived if admitted	\$100 AD Waived if admitted	\$100 AD Waived if admitted	\$100 AD Waived if admitted	\$150 co-pay per visit
Home Health Care	\$0 AD	20% co-insurance AD	\$0 AD	20% co-insurance AD	\$0 AD
Hospice Services (Inpatient or Outpatient Services)	\$0 AD	20% co-insurance AD	\$0 AD	20% co-insurance AD	\$0 AD
Lab Tests, X-Rays, Other Tests (Diagnostic Services not part of routine preventive visit)	\$0 AD	20% co-insurance AD	\$0 AD	20% co-insurance AD	\$0 AD

Medical Plan Features	Blue Care Elect Saver Plan (with HSA - Health Savings Account)		Blue Care Elect Deductible Plan (with HRA - Health Reimbursement Account)		Advantage Blue Plan (Low Deductible Plan)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only	
	Your Cost is:	Your Cost is:	Your Cost is:	Your Cost is:	Your Cost is:	
Maternity Services and Well Newborn Inpatient Care						
Maternity Services (includes delivery and postnatal care)	\$0 AD	20% co-insurance AD	\$0 AD	20% co-insurance AD	\$0 AD	
Prenatal Care	No charge	20% co-insurance AD	No charge	20% co-insurance AD	No charge	
Well Newborn Care during enrolled mother's maternity admission	No charge	20% co-insurance (deductible does not apply)	No charge	20% co-insurance (deductible does not apply)	No charge	
In a Skilled Nursing Facility (100-day benefit limit per member per year)	\$0 AD	20% co-insurance AD	\$0 AD	20% co-insurance AD	\$0 AD	
Medical Care Outpatient Visits (includes syringes and needles dispensed during a visit)	\$20 AD	20% co-insurance AD	\$20 AD	20% co-insurance AD	For services performed by a family or general practitioner, internist, nurse practitioner, nurse midwife, pediatrician, geriatric specialist, licensed dietitian nutritionist, and multi-specialty provider group services	\$20 co-pay per visit
					For services performed by other <i>covered providers</i> through a non-hospital or health center	\$35 co-pay per visit

Medical Plan Features	Blue Care Elect Saver Plan (with HSA - Health Savings Account)		Blue Care Elect Deductible Plan (with HRA - Health Reimbursement Account)		Advantage Blue Plan (Low Deductible Plan)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only	
	Your Cost is:	Your Cost is:	Your Cost is:	Your Cost is:	Your Cost is:	
Mental Health & Substance Abuse Treatment						
Inpatient Services	\$0 AD	20% co-insurance AD	\$0 AD	20% co-insurance AD	\$0 AD	
Outpatient Services	\$20 AD	20% co-insurance AD	\$20 AD	20% co-insurance AD	\$20 co-pay per visit, no deductible	
Oxygen & Respiratory Therapy						
Oxygen & Equipment for its administration	\$0 AD	20% co-insurance AD	\$0 AD	20% co-insurance AD	\$0 AD	
Outpatient Respiratory Therapy	\$0 AD	20% co-insurance AD	\$0 AD	20% co-insurance AD	For services performed by a family or general practitioner, internist, nurse practitioner, nurse midwife, pediatrician, geriatric specialist, licensed dietitian nutritionist, and multi-specialty provider group services	\$20 co-pay per visit
					For services performed by other <i>covered providers</i> through a non-hospital or health center	\$35 co-pay per visit
Prescriptions Drugs (Rx co-pay based on tier/brand) Rx Retail Pharmacy Tier 1 Tier 2 Tier 3 Note: CAD is Coronary Artery Disease.	\$10 AD \$25 AD \$45 AD \$0 AD for generic Diabetes & CAD drugs	\$20 AD \$50 AD \$90 AD \$0 AD for generic Diabetes & CAD drugs	\$15 \$30 \$50 \$0 for generic Diabetes & CAD drugs	N/A, not covered	\$15 \$30 \$50 \$0 for generic Diabetes & CAD drugs	

Medical Plan Features	Blue Care Elect Saver Plan (with HSA - Health Savings Account)		Blue Care Elect Deductible Plan (with HRA - Health Reimbursement Account)		Advantage Blue Plan (Low Deductible Plan)
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
	Your Cost is:	Your Cost is:	Your Cost is:	Your Cost is:	Your Cost is:
Rx Mail Order Tier 1 Tier 2 Tier 3 Note: CAD is Coronary Artery Disease.	\$20 AD \$50 AD \$135 AD \$0 AD for generic Diabetes & CAD drugs	N/A, not covered	\$30 \$60 \$150 \$0 for generic Diabetes & CAD drugs	N/A, not covered	\$30 \$60 \$150 \$0 for generic Diabetes & CAD drugs
Preventive Health Services					
Routine Pediatric Care	\$0	20% co-insurance AD	\$0	20% co-insurance AD	\$0
Routine Adult Exams & Tests (includes one routine exam per member per year, immunizations, routine lab tests and x-rays, routine mammograms once between age 35-39 and once per year for age 40+, blood tests to screen for lead poisoning, and routine colonoscopies)	\$0	20% co-insurance AD	\$0	20% co-insurance AD	\$0
Routine GYN exams (once per member per year)	\$0	20% co-insurance AD	\$0	20% co-insurance AD	\$0
Family Planning	\$0	20% co-insurance AD	\$0	20% co-insurance AD	\$0
Routine Hearing Exams & Tests	\$0	20% co-insurance AD	\$0	20% co-insurance AD	\$0
Routine Vision Exams (one exam per member every 24 months)	\$0	20% co-insurance AD	\$0	20% co-insurance AD	\$0
Prosthetic Devices	\$0 AD	20% co-insurance AD	\$0 AD	20% co-insurance AD	20% coinsurance AD
Radiation Therapy and Chemotherapy (Outpatient Services)	\$0 AD	20% co-insurance AD	\$0 AD	20% co-insurance AD	\$0 AD
Short-Term Rehabilitation Therapy Outpatient Services for physical, occupational, and speech therapy (100-visit benefit limit per member per year)	\$20 AD	20% co-insurance AD	\$20 AD	20% co-insurance AD	\$35 co-pay per visit
Surgery as an Outpatient	\$20 AD	20% co-insurance AD	\$20 AD	20% co-insurance AD	\$0 AD