



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, see bluecrossma.com/coverage-info.

For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at bluecrossma.com/sbcglossary or call 1-888-753-6615 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall <u>deductible</u>? | \$150 member / \$300 family. | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. |
| Are there services covered before you meet your <u>deductible</u>? | Yes. In-network preventive and prenatal care, <u>prescription drugs</u> , most office visits, mental health visits, therapy visits; emergency room. | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u>? | For medical benefits, \$2,000 member / \$4,000 family; and for prescription drug benefits, \$1,000 member / \$2,000 family. | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the <u>out-of-pocket limit</u>? | <u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Will you pay less if you use a <u>network provider</u>? | Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u>? | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|---|--|---|
| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$25 / visit | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network |
| | <u>Specialist</u> visit | \$25 / visit; \$25 / chiropractor visit; \$25 / acupuncture visit | 20% <u>coinsurance</u> ; 20% <u>coinsurance</u> / chiropractor visit; 20% <u>coinsurance</u> / acupuncture visit | <u>Deductible</u> applies first for out-of-network; limited to 12 acupuncture visits per calendar year |
| | <u>Preventive care/screening/immunization</u> | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; limited to age-based schedule and / or frequency. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first; <u>pre-authorization</u> may be required |
| | Imaging (CT/PET scans, MRIs) | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first; <u>pre-authorization</u> may be required |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at bluecrossma.com/medications | Generic drugs | \$15 / retail supply or \$30 / mail order supply | Not covered | Up to 30-day retail (90-day mail order) supply; cost share may be waived for certain covered drugs and supplies; <u>pre-authorization</u> required for certain drugs |
| | Preferred brand drugs | \$30 / retail supply or \$60 / mail order supply | Not covered | |
| | Non-preferred brand drugs | \$50 / retail supply or \$100 / mail order supply | Not covered | |
| | <u>Specialty drugs</u> | Applicable cost share (generic, preferred, non-preferred) | Not covered | When obtained from a designated specialty pharmacy; <u>pre-authorization</u> required for certain drugs |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|-------------------------------------|--|--|
| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$250 / admission | 20% <u>coinsurance</u> | <u>Deductible</u> applies first |
| | Physician/surgeon fees | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first |
| If you need immediate medical attention | <u>Emergency room care</u> | \$150 / visit | \$150 / visit | <u>Copayment</u> waived if admitted or for observation stay |
| | <u>Emergency medical transportation</u> | No charge | No charge | <u>Deductible</u> applies first |
| | <u>Urgent care</u> | \$25 / visit | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$500 / admission | 20% <u>coinsurance</u> | <u>Deductible</u> applies first; <u>pre-authorization</u> required |
| | Physician/surgeon fees | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first; <u>pre-authorization</u> required |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; <u>pre-authorization</u> required for certain services |
| | Inpatient services | \$500 / admission | 20% <u>coinsurance</u> | <u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services |
| If you are pregnant | Office visits | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first except for in-network prenatal care; <u>cost sharing</u> does not apply for in-network preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) |
| | Childbirth/delivery professional services | No charge | 20% <u>coinsurance</u> | |
| | Childbirth/delivery facility services | \$500 / admission | 20% <u>coinsurance</u> | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|----------------------------------|-------------------------------------|--|---|
| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first; <u>pre-authorization</u> required |
| | <u>Rehabilitation services</u> | \$25 / visit | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; limited to 100 visits per calendar year (other than for autism, <u>home health care</u> , and speech therapy) |
| | <u>Habilitation services</u> | \$25 / visit | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; limited to 100 visits per calendar year (other than for autism, <u>home health care</u> , and speech therapy); cost share and coverage limits waived for early intervention services for eligible children; <u>pre-authorization</u> may be required for certain services |
| | <u>Skilled nursing care</u> | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first; limited to 100 days per calendar year; <u>pre-authorization</u> required |
| | <u>Durable medical equipment</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | <u>Deductible</u> applies first; in-network cost share waived for one breast pump per birth (20% <u>coinsurance</u> for out-of-network) |
| | <u>Hospice services</u> | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first; <u>pre-authorization</u> required for certain services |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|----------------------------|-------------------------------------|--|---|
| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| If your child needs dental or eye care | Children's eye exam | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> applies first for out-of-network; limited to one exam every 12 months until the end of the month a member turns age 19 |
| | Children's glasses | 35% <u>coinsurance</u> | 55% <u>coinsurance</u> | <u>Deductible</u> applies first; limited to one set of prescription lenses and / or frames or contact lenses per calendar year until the end of the month a member turns age 19 |
| | Children's dental check-up | No charge | Not covered | Limited to twice per calendar year until the end of the month a member turns age 19 |

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (12 visits per calendar year)
- Bariatric surgery
- Chiropractic care
- Hearing aids (\$2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine eye care - adult (one exam every 24 months)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs (\$150 per calendar year per policy)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through the state marketplace, please contact the Massachusetts Health Connector at www.mahealthconnector.org. For more information on your rights to continue coverage, you can contact the Member Service number listed on your ID card or call 1-800-262-BLUE (2583).

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, call 1-800-472-2689 or contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.) You may also contact The Office of Patient Protection at 1-800-436-7757 or www.mass.gov/hpc/opp.

Does this plan provide Minimum Essential Coverage? [Yes]

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? [Yes]

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Disclaimer: This document contains only a partial description of the benefits, limitations, exclusions and other provisions of this health care plan. It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$150 |
| ■ <u>Delivery fee copay</u> | \$0 |
| ■ <u>Facility fee copay</u> | \$500 |
| ■ <u>Diagnostic tests copay</u> | \$0 |

This EXAMPLE event includes services like:

Specialist office visits (*pre-natal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,800 |
|---------------------------|-----------------|

In this example, Peg would pay:

Cost Sharing

| | |
|-------------|-------|
| Deductibles | \$150 |
| Copayments | \$500 |
| Coinsurance | \$0 |

What isn't covered

| | |
|----------------------|------|
| Limits or exclusions | \$60 |
|----------------------|------|

| | |
|-----------------------------------|--------------|
| The total Peg would pay is | \$710 |
|-----------------------------------|--------------|

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|---|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$150 |
| ■ <u>Specialist visit copay</u> | \$25 |
| ■ <u>Primary care visit copay</u> | \$25 |
| ■ <u>Diagnostic tests copay</u> | \$0 |

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$7,400 |
|---------------------------|----------------|

In this example, Joe would pay:

Cost Sharing

| | |
|-------------|---------|
| Deductibles | \$100 |
| Copayments | \$1,200 |
| Coinsurance | \$0 |

What isn't covered

| | |
|----------------------|------|
| Limits or exclusions | \$60 |
|----------------------|------|

| | |
|-----------------------------------|----------------|
| The total Joe would pay is | \$1,360 |
|-----------------------------------|----------------|

Mia's Simple Fracture

(in-network emergency room visit and follow-up care)

| | |
|---|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$150 |
| ■ <u>Specialist visit copay</u> | \$25 |
| ■ <u>Emergency room copay</u> | \$150 |
| ■ <u>Ambulance services copay</u> | \$0 |

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$1,900 |
|---------------------------|----------------|

In this example, Mia would pay:

Cost Sharing

| | |
|-------------|-------|
| Deductibles | \$150 |
| Copayments | \$300 |
| Coinsurance | \$0 |

What isn't covered

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|-----------------------------------|--------------|
| The total Mia would pay is | \$450 |
|-----------------------------------|--------------|

The plan would be responsible for the other costs of these EXAMPLE covered services.

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MASSACHUSETTS

MCC Compliance



This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.



MASSACHUSETTS

Pediatric Dental

Your health plan coverage includes a dental policy that covers pediatric dental services as required under the federal Patient Protection and Affordable Care Act.



MASSACHUSETTS

Nondiscrimination Notice

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. It does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Blue Cross Blue Shield of Massachusetts provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print or other formats).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call Member Service at the number on your ID card.

If you believe that Blue Cross Blue Shield of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with the Civil Rights Coordinator by mail at Civil Rights Coordinator, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126; phone at 1-800-472-2689 (TTY: 711); fax at 1-617-246-3616; or email at civilrightscoordinator@bcbsma.com.

If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, online at ocrportal.hhs.gov; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, DC 20201; by phone at 1-800-368-1019 or 1-800-537-7697 (TDD).

Complaint forms are available at hhs.gov.



MASSACHUSETTS

Translation Resources

Proficiency of Language Assistance Services

Spanish/Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).

Portuguese/Português: ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

Chinese/简体中文: 注意: 如果您讲中文, 我们可向您免费提供语言协助服务。请拨打您 ID 卡上的号码联系会员服务部 (TTY 号码: **711**)。

Haitian Creole/Kreyòl Ayisyen: ATANSYON: Si ou pale kreyòl ayisyen, sèvis asistans nan lang disponib pou ou gratis. Rele nimewo Sèvis Manm nan ki sou kat Idantifikasyon w lan (Sèvis pou Malantandan TTY: **711**).

Vietnamese/Tiếng Việt: LƯU Ý: Nếu quý vị nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cung cấp cho quý vị miễn phí. Gọi cho Dịch vụ Hội viên theo số trên thẻ ID của quý vị (TTY: **711**).

Russian/Русский: ВНИМАНИЕ: если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Позвоните в отдел обслуживания клиентов по номеру, указанному в Вашей идентификационной карте (телетайп: **711**).

Arabic/عربي:

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجاناً بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هويتك (جهاز الهاتف النصي للصم والبكم "TTY": **711**).

Mon-Khmer, Cambodian/ខ្មែរ: ការជូនដំណឹង: ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខ នៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (TTY: **711**)។

French/Français: ATTENTION : si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le Service adhérents au numéro indiqué sur votre carte d'assuré (TTY : **711**).

Italian/Italiano: ATTENZIONE: se parlate italiano, sono disponibili per voi servizi gratuiti di assistenza linguistica. Chiamate il Servizio per i membri al numero riportato sulla vostra scheda identificativa (TTY: **711**).

Korean/한국어: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드에 있는 전화번호(TTY: **711**)를 사용하여 회원 서비스에 전화하십시오.

Greek/λληνικά: ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε την Υπηρεσία Εξυπηρέτησης Μελών στον αριθμό της κάρτας μέλους σας (ID Card) (TTY: **711**).

Polish/Polski: UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej. Należy zadzwonić do Działu obsługi ubezpieczonych pod numer podany na identyfikatorze (TTY: 711).

Hindi/हिंदी: ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए निःशुल्क उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वाई.: 711).

Gujarati/ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમને ભાષાકીય સહાયતા સેવાઓ વિના મૂલ્યે ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર આપેલા નંબર પર Member Service ને કોલ કરો (TTY: 711).

Tagalog/Tagalog: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tawagan ang Mga Serbisyo sa Miyembro sa numerong nasa iyong ID Card (TTY: 711).

Japanese/日本語: お知らせ:日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。IDカードに記載の電話番号を使用してメンバーサービスまでお電話ください (TTY: 711)。

German/Deutsch: ACHTUNG: Wenn Sie Deutsche sprechen, steht Ihnen kostenlos fremdsprachliche Unterstützung zur Verfügung. Rufen Sie den Mitgliederdienst unter der Nummer auf Ihrer ID-Karte an (TTY: 711).

Persian/پارسیان:

توج: اگر زبان شما فارسی است، خدمات کمک زبانی ب صورت رایگان در اختیار شما قرار می گیرد. با شماره تلفن مندرج بروی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: 711).

Lao/ພາສາລາວ: ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: 711).

Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k'ehjí yánílt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'déé' nóomba biká'ígíjij' béeesh bee hodíílnih (TTY: 711).



SUMMARY OF BENEFITS



Blue Care[®] Elect \$150 Deductible

Student Health Plan

2020 - 2021

Boston College Students

MyBlue is a personalized way to access and manage your health plan. Get secure access to key plan information, claims history, and recent medications. Download or email a copy of your digital ID card. View your spending dashboard, important updates, alerts and notifications. Register or log in at bluecrossma.com/myblue or download the app on iTunes[®] or Google Play[™].



This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.

Your Choice

Your Deductible

Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for most benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is **\$150** per member (or **\$300** per family) for in-network and out-of-network services combined.

When You Choose Preferred Providers

You receive the highest level of benefits under your health care plan when you obtain covered services from preferred providers. These are called your “in-network” benefits. See the charts for your cost share.

Note: If a preferred provider refers you to another provider for covered services (such as a lab or specialist), make sure the provider is a preferred provider in order to receive benefits at the in-network level. If the provider you use is not a preferred provider, you’re still covered, but your benefits, in most situations, will be covered at the out-of-network level, even if the preferred provider refers you.

How to Find a Preferred Provider

To find a preferred provider:

- Look up a provider in the Provider Directory. If you need a copy of your directory, call the Member Service number on your ID card.
- Visit the Blue Cross Blue Shield of Massachusetts website at bluecrossma.com/findadoctor

When You Choose Non-Preferred Providers

You can also obtain covered services from non-preferred providers, but your out-of-pocket costs are higher. These are called your “out-of-network” benefits. See the charts for your cost share.

Payments for out-of-network benefits are based on the Blue Cross Blue Shield of Massachusetts allowed charge as defined in your subscriber certificate. You may be responsible for any difference between the allowed charge and the provider’s actual billed charge (this is in addition to your deductible and/or your coinsurance).

Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical benefits is **\$2,000** per member (or **\$4,000** per family) for in-network and out-of-network services combined. Your out-of-pocket maximum for prescription drug benefits is **\$1,000** per member (or **\$2,000** per family).

Emergency Room Services

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call **911** (or the local emergency phone number). You pay a copayment per visit for in-network or out-of-network emergency room services. The copayment is waived if you are admitted to the hospital or for an observation stay. See the chart for your cost share.

Telehealth Services

You are covered for certain medical and mental health services for conditions that can be treated through video visits from an approved telehealth provider. Most telehealth services are available by using the Well Connection website at wellconnection.com on your computer, or the Well Connection app on your mobile device, when you prefer not to make an in-person visit for any reason to a doctor or therapist. Some providers offer telehealth services through their own video platforms. For a list of telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at bluecrossma.com, consult the Provider Directory, or call the Member Service number on your ID card.

Utilization Review Requirements

Certain services require **pre-approval/prior authorization** through Blue Cross Blue Shield of Massachusetts for you to have benefit coverage; this includes non-emergency and non-maternity hospitalization and may include certain outpatient services, therapies, procedures, and drugs. You should work with your health care provider to determine if pre-approval is required for any service your provider is suggesting. If your provider, or you, don’t get pre-approval when it’s required, your benefits will be denied, and you may be fully responsible for payment to the provider of the service. Refer to your subscriber certificate for requirements and the process you should follow for Utilization Review, including Pre-Admission Review, Pre-Service Approval, Concurrent Review and Discharge Planning, and Individual Case Management.

Dependent Benefits

This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. See your subscriber certificate (and riders, if any) for exact coverage details.

Pediatric Essential Dental Benefits

Your medical plan coverage includes a separate dental policy that covers pediatric essential dental benefits for members until the end of the calendar month in which they turn age 19 as required by federal law.

You must meet a plan-year deductible for certain covered dental services. Your deductible is **\$50** per member (no more than **\$150** for three or more members enrolled under the same family membership).

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible and coinsurance for covered dental services. Your out-of-pocket maximum is **\$350** per member (no more than **\$700** for two or more members enrolled under the same family membership).

To find participating dental providers, visit the Blue Cross Blue Shield of Massachusetts website at bluecrossma.com/findadoctor or call the Member Service number on your ID card.

Your Medical Benefits

| Covered Services | Your Cost In-Network | Your Cost Out-of-Network |
|--|--|--|
| Preventive Care Well-child care exams, including routine tests, according to age-based schedule as follows: <ul style="list-style-type: none"> • 10 visits during the first year of life • Three visits during the second year of life (age 1 to age 2) • Two visits for age 2 • One visit per calendar year for age 3 and older | Nothing, no deductible | 20% coinsurance after deductible |
| Routine adult physical exams, including related tests, (one per calendar year) | Nothing, no deductible | 20% coinsurance after deductible |
| Routine GYN exams, including related lab tests (one per calendar year) | Nothing, no deductible | 20% coinsurance after deductible |
| Routine hearing exams, including routine tests | Nothing, no deductible | 20% coinsurance after deductible |
| Hearing aids (up to \$2,000 per ear every 36 months for a member age 21 or younger) | All charges beyond the maximum, no deductible | 20% coinsurance after deductible and all charges beyond the maximum |
| Routine vision exams (one every 24 months, except one every 12 months until the end of the month a member turns age 19) | Nothing, no deductible | 20% coinsurance after deductible |
| Vision supplies (one set of prescription lenses and/or frames or contact lenses per calendar year until the end of the month a member turns age 19) | 35% coinsurance after deductible | 55% coinsurance after deductible |
| Family planning services—office visits | Nothing, no deductible | 20% coinsurance after deductible |
| Outpatient Care Emergency room visits | \$150 per visit, no deductible (waived if admitted or for an observation stay) | \$150 per visit, no deductible (waived if admitted or for an observation stay) |
| Office or health center visits | \$25 per visit, no deductible | 20% coinsurance after deductible |
| Mental health or substance use treatment | Nothing, no deductible | 20% coinsurance after deductible |
| Telehealth services for simple medical conditions or mental health | \$25 per visit, no deductible | 20% coinsurance after deductible |
| Chiropractors' office visits | \$25 per visit, no deductible | 20% coinsurance after deductible |
| Acupuncture visits (up to 12 visits per calendar year) | \$25 per visit, no deductible | 20% coinsurance after deductible |
| Short-term rehabilitation therapy—physical and occupational (up to 100 visits for rehabilitation services and 100 visits for habilitation services per calendar year*) | \$25 per visit, no deductible | 20% coinsurance after deductible |
| Speech, hearing, and language disorder treatment—speech therapy | \$25 per visit, no deductible | 20% coinsurance after deductible |
| Diagnostic X-rays and lab tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests | Nothing after deductible | 20% coinsurance after deductible |
| Home health care and hospice services | Nothing after deductible | 20% coinsurance after deductible |
| Oxygen and equipment for its administration | Nothing after deductible | 20% coinsurance after deductible |
| Durable medical equipment—such as wheelchairs, crutches, hospital beds | 20% coinsurance after deductible** | 40% coinsurance after deductible** |
| Prosthetic devices | 20% coinsurance after deductible | 40% coinsurance after deductible |
| Surgery and related anesthesia <ul style="list-style-type: none"> • Office or health center services • Ambulatory surgical facility, hospital outpatient department, or surgical day care unit | \$25 per visit***, no deductible \$250 per admission after deductible | 20% coinsurance after deductible 20% coinsurance after deductible |
| Inpatient Care (including maternity care) General or chronic disease hospital care (as many days as medically necessary) | \$500 per admission after deductible | 20% coinsurance after deductible |
| Mental hospital or substance use facility care (as many days as medically necessary) | \$500 per admission after deductible | 20% coinsurance after deductible |
| Rehabilitation hospital care (up to 60 days per calendar year) | Nothing after deductible | 20% coinsurance after deductible |
| Skilled nursing facility care (up to 100 days per calendar year) | Nothing after deductible | 20% coinsurance after deductible |

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.

** In-network cost share waived for one breast pump per birth (20% coinsurance after deductible out-of-network).

*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

| Prescription Drug Benefits* | Your Cost In-Network** | Your Cost Out-of-Network |
|---|--|--------------------------|
| At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill) | No deductible \$15 for Tier 1 \$30 for Tier 2 \$50 for Tier 3 | Not covered |
| Through the designated mail order pharmacy (up to a 90-day formulary supply for each prescription or refill) | No deductible \$30 for Tier 1*** \$60 for Tier 2 \$100 for Tier 3 | Not covered |

* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred brand-name drugs.

** Cost share may be waived for certain covered drugs and supplies.

*** Certain generic medications are available through the mail order pharmacy at \$9. For more information, go to bluecrossma.com/mail-order-pharmacy.

Get the Most from Your Plan

Visit us at studentbluema.com or call 1-888-753-6615 to learn about discounts, savings, resources, and special programs available to you, like those listed below.

| | |
|--|---|
| <p>Wellness Participation Program</p> <p>Fitness Reimbursement: a benefit that rewards participation in qualified fitness programs This fitness benefit applies for fees paid to: a health club with cardiovascular and strength-training equipment; or a fitness studio offering instructor-led group classes for certain cardiovascular and strength-training programs. (See your subscriber certificate for details.)</p> <p>Weight Loss Reimbursement: a benefit that rewards participation in a qualified weight loss program This weight loss program benefit applies for fees paid to: hospital-based or non-hospital-based weight loss programs that focus on eating and physical activity habits and behavioral/lifestyle counseling with certified health professionals. (See your subscriber certificate for details.)</p> | <p>\$150 per calendar year per policy</p> <p>\$150 per calendar year per policy</p> |
| 24/7 Nurse Care Line—A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583) | No additional charge |

| Pediatric Essential Dental Benefits* | Your Cost In-Network** |
|---|----------------------------------|
| Group 1—Preventive and Diagnostic Services: oral exams, X-rays, and routine dental care | Nothing, no deductible |
| Group 2—Basic Restorative Services: fillings, root canals, stainless steel crowns, periodontal care, oral surgery, and dental prosthetic maintenance | 25% coinsurance after deductible |
| Group 3—Major Restorative Services: tooth replacement, resin crowns, and occlusal guards | 50% coinsurance after deductible |
| Orthodontic Services: medically necessary orthodontic care pre-authorized for a qualified member | 50% coinsurance, no deductible |

* All covered services are limited to members until the end of the month they turn age 19, and may be subject to an age-based schedule or frequency. For a complete list of covered services or additional information, refer to your subscriber certificate.

** There are no out-of-network benefits for dental services.

Questions?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-888-753-6615, or visit us online at studentbluema.com.

Register for or log in to MyBlue, a personalized way to access your health care information, claims, and more, at bluecrossma.com/myblue.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your subscriber certificate and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the subscriber certificate and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your subscriber certificate and riders.



MASSACHUSETTS

Nondiscrimination Notice

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. It does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Blue Cross Blue Shield of Massachusetts provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print or other formats).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call Member Service at the number on your ID card.

If you believe that Blue Cross Blue Shield of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with the Civil Rights Coordinator by mail at Civil Rights Coordinator, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126; phone at 1-800-472-2689 (TTY: 711); fax at 1-617-246-3616; or email at civilrightscordinator@bcbsma.com.

If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, online at ocrportal.hhs.gov; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, DC 20201; by phone at 1-800-368-1019 or 1-800-537-7697 (TDD).

Complaint forms are available at hhs.gov.



MASSACHUSETTS

Translation Resources

Proficiency of Language Assistance Services

Spanish/Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

Portuguese/Português: ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).

Chinese/简体中文: 注意: 如果您讲中文, 我们可向您免费提供语言协助服务。请拨打您 ID 卡上的号码联系会员服务部 (TTY 号码: 711)。

Haitian Creole/Kreyòl Ayisyen: ATANSYON: Si ou pale kreyòl ayisyen, sèvis asistans nan lang disponib pou ou gratis. Rele nimewo Sèvis Manm nan ki sou kat Idantifikasyon w lan (Sèvis pou Malantandan TTY: 711).

Vietnamese/Tiếng Việt: LƯU Ý: Nếu quý vị nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cung cấp cho quý vị miễn phí. Gọi cho Dịch vụ Hội viên theo số trên thẻ ID của quý vị (TTY: 711).

Russian/Русский: ВНИМАНИЕ: если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Позвоните в отдел обслуживания клиентов по номеру, указанному в Вашей идентификационной карте (телетайп: 711).

Arabic/عربي:

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجاناً بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هويتك (جهاز الهاتف النصي للصم والبكم "TTY": 711).

Mon-Khmer, Cambodian/ខ្មែរ: ការជូនដំណឹង: ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខ នៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (TTY: 711)។

French/Français: ATTENTION : si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le Service adhérents au numéro indiqué sur votre carte d'assuré (TTY : 711).

Italian/Italiano: ATTENZIONE: se parlate italiano, sono disponibili per voi servizi gratuiti di assistenza linguistica. Chiamate il Servizio per i membri al numero riportato sulla vostra scheda identificativa (TTY: 711).

Korean/한국어: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드에 있는 전화번호(TTY: 711)를 사용하여 회원 서비스에 전화하십시오.

Greek/λληνικά: ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε την Υπηρεσία Εξυπηρέτησης Μελών στον αριθμό της κάρτας μέλους σας (ID Card) (TTY: 711).

Polish/Polski: UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej. Należy zadzwonić do Działu obsługi ubezpieczonych pod numer podany na identyfikatorze (TTY: 711).

Hindi/हिंदी: ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए निःशुल्क उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वाई.: 711).

Gujarati/ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમને ભાષાકીય સહાયતા સેવાઓ વિના મૂલ્યે ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર આપેલા નંબર પર Member Service ને કોલ કરો (TTY: 711).

Tagalog/Tagalog: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tawagan ang Mga Serbisyo sa Miyembro sa numerong nasa iyong ID Card (TTY: 711).

Japanese/日本語: お知らせ:日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。IDカードに記載の電話番号を使用してメンバーサービスまでお電話ください (TTY: 711)。

German/Deutsch: ACHTUNG: Wenn Sie Deutsche sprechen, steht Ihnen kostenlos fremdsprachliche Unterstützung zur Verfügung. Rufen Sie den Mitgliederdienst unter der Nummer auf Ihrer ID-Karte an (TTY: 711).

Persian/پارسیان:

توج: اگر زبان شما فارسی است، خدمات کمک زبانی ب صورت رایگان در اختیار شما قرار می گیرد. با شماره تلفن مندرج بروی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: 711).

Lao/ພາສາລາວ: ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: 711).

Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k'ehjí yánílt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'déé' nóomba biká'ígíjij' béeesh bee hodíílnih (TTY: 711).