BlueCross® BlueShield®

SUMMARY OF BENEFITS

Blue Care® Elect Preferred 80

with Copay

Student Health Plan

2020 - 2021

This Plan Covers the Student Only.

Montserrat Col Of Art 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.

An Association of Independent Blue Cross and Blue Shield Plans

Your Choice

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 or help choosing a provider, 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 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 coinsurance).

Your Out-of-Pocket Maximum

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

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. This 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.

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**.

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**.

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 Routine adult physical exams, including related tests (one per calendar year)	Nothing	20% coinsurance
Routine GYN exams, including related lab tests (one per calendar year)	Nothing	20% coinsurance
Routine hearing exams, including routine tests	Nothing	20% coinsurance
Hearing aids (up to $2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum	20% coinsurance 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	20% coinsurance
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	55% coinsurance
Family planning services–office visits	Nothing	20% coinsurance
Outpatient Care Emergency room visits	$150 per visit (waived if admitted or for observation stay)	$150 per visit (waived if admitted or for observation stay)
Office or health center visits	$20 per visit	20% coinsurance
Mental health or substance use treatment	$20 per visit	20% coinsurance
Telehealth services for simple medical conditions or mental health	$20 per visit	20% coinsurance
Chiropractors' office visits	$20 per visit	20% coinsurance
Acupuncture visits (up to 12 visits per calendar year)	$20 per visit	20% coinsurance
Short-term rehabilitation therapy–physical and occupational (up to 100 visits for rehabilitation services and 100 visits for habilitation services per calendar year*)	$20 per visit	20% coinsurance
Speech, hearing, and language disorder treatment–speech therapy	$20 per visit	20% coinsurance
Diagnostic X-rays and lab tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing	20% coinsurance
Home health care and hospice services	20% coinsurance	40% coinsurance
Oxygen and equipment for its administration	20% coinsurance	40% coinsurance
Durable medical equipment–such as wheelchairs, crutches, hospital beds	20% coinsurance**	40% coinsurance**
Prosthetic devices	20% coinsurance	40% coinsurance
Surgery and related anesthesia • Office or health center services • Ambulatory surgical facility, hospital outpatient department, or surgical day care unit	$20 per visit*** $250 per admission	20% coinsurance 20% coinsurance
Inpatient Care (including maternity care) General or chronic disease hospital care (as many days as medically necessary)	20% coinsurance	40% coinsurance
Mental hospital or substance use facility care (as many days as medically necessary)	20% coinsurance	40% coinsurance
Rehabilitation hospital care (up to 60 days per calendar year)	20% coinsurance	40% coinsurance
Skilled nursing facility care (up to 100 days per calendar year)	20% coinsurance	40% coinsurance

* 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 for 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)	$15 for Tier 1 $30 for Tier 2 $60 for Tier 3 $120 for Tier 4	Not covered
Through the designated mail order pharmacy (up to a 90-day formulary supply for each prescription or refill)	$30 for Tier 1*** $60 for Tier 2*** $120 for Tier 3 $360 for Tier 4	Not covered

* Generally, Tier 1 refers to low-cost generic drugs; Tier 2 refers to other generic drugs; Tier 3 refers to preferred brand-name drugs; Tier 4 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.

Wellness Participation Program **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.)	$150 per calendar year per policy
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.)	$150 per calendar year per policy
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.

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BlueCross® BlueShield®

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**.

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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 Idantitifkasyon 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/ةيبر:

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

Mon-Khmer, Cambodian/ខ្មែរ: ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខនៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (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/Ελληνικά: 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**).

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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 नि:शुल्क 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 કૉલ 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 شمار تلفن مندرج بر روی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: **711**).

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

Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k'ehjí yáníłt'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'ígíiji' béésh bee hodíílnih (TTY: **711**).

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