Blue Care® Elect Preferred

with Hospital Choice Cost Sharing

Student Health Plan

2020 - 2021

Wellesley College Students

This health plan option includes a tiered network feature called Hospital Choice Cost Sharing. As a member in this plan, you will pay different levels of in-network cost share (such as copayments and/or coinsurance) for certain services depending on the preferred general hospital you choose to furnish those covered services. For most preferred general hospitals, you will pay the lowest in-network cost sharing level. However, if you receive certain covered services from any of the preferred general hospitals listed in this Summary of Benefits, you pay the highest in-network cost sharing level. A preferred general hospital’s cost sharing level may change from time to time. Overall changes to add another preferred general hospital to the highest cost sharing level will happen no more than once each calendar year. For help in finding a preferred general hospital (not listed in this Summary of Benefits) for which you pay the lowest in-network cost sharing level, check the most current provider directory for your health plan option or visit the online provider search tool at blucrossma.com/hospitalchoice. Then click on the Planning Guide link on the left navigation to download a printable network hospital list or to access the provider search page.

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 blucrossma.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

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.

This plan has two levels of hospital benefits for preferred providers. You will pay a higher cost share when you receive certain services at or by “higher cost share hospitals,” including inpatient admissions, outpatient day surgery, and some other hospital outpatient services. See the charts for your cost share.

Note: If a preferred provider refers you to another provider for covered services (such as a specialist), make sure the provider is a preferred provider in order to receive benefits at the in-network level. If the provider you are referred to 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. It is also important to check whether the provider you are referred to is affiliated with one of the higher cost share hospitals listed below. Your cost will be greater when you receive certain services at or by these hospitals, even if your preferred provider refers you.

Higher Cost Share Hospitals
Your cost share will be higher at the hospitals listed below. Blue Cross Blue Shield of Massachusetts will let you know if this list changes.

- Baystate Medical Center
- Boston Children’s Hospital
- Brigham and Women’s Hospital
- Cape Cod Hospital
- Dana-Farber Cancer Institute
- Fairview Hospital
- Massachusetts General Hospital
- UMass Memorial Medical Center

Note: Some of the general hospitals listed above may have facilities in more than one location. At certain locations, the lowest cost sharing level may apply.

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 bluerossma.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.

You must pay a plan-year deductible before you can receive coverage for most out-of-network benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is $250 per member.

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 deductible and/or your coinsurance). See the charts for your cost share.

Your Out-of-Pocket Maximum
Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments (including prescription drug copayments), and coinsurance for covered services. Your out-of-pocket maximum is $4,000 per member (or $8,000 per family) for in-network and out-of-network services combined.

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 wellection.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 bluerossma.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 bluerossma.com/findadoctor or call the Member Service number on your ID card.
<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Your Cost In-Network</th>
<th>Your Cost Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well-child care exams, including related tests, according to age-based schedule as follows:</td>
<td>Nothing</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>• 10 visits during the first year of life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Three visits during the second year of life (age 1 to age 2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Two visits for age 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• One visit per calendar year age 3 and older</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine adult physical exams, including related tests (one per calendar year)</td>
<td>Nothing</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Routine GYN exams, including related lab tests (one per calendar year)</td>
<td>Nothing</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Routine hearing exams, including routine tests (one per calendar year)</td>
<td>Nothing</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Hearing aids (up to $2,000 per ear every 36 months for a member age 21 or younger)</td>
<td>All charges beyond the maximum</td>
<td>20% coinsurance after deductible and all charges beyond the maximum</td>
</tr>
<tr>
<td>Routine vision exams (one every 24 months, except one every 12 months until the end of the month a member turns age 19)</td>
<td>Nothing</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>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)</td>
<td>35% coinsurance</td>
<td>55% coinsurance after deductible</td>
</tr>
<tr>
<td>Family planning services--office visits</td>
<td>Nothing</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td><strong>Outpatient Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room visits</td>
<td>$50 per visit (waived if admitted or for observation stay)</td>
<td>$50 per visit, no deductible (waived if admitted or for observation stay)</td>
</tr>
<tr>
<td>Office or health center visits</td>
<td>$20 per visit</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Mental health or substance use treatment</td>
<td>$20 per visit</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Telehealth services for simple medical conditions or mental health</td>
<td>$20 per visit</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Chiropractors’ office visits</td>
<td>$20 per visit</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Acupuncture visits (up to 12 visits per calendar year)</td>
<td>$20 per visit</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Short-term rehabilitation therapy—physical and occupational (up to 100 visits for rehabilitation services and 100 visits for habilitation services per calendar year)*</td>
<td>$20 per visit $55 per visit</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>• At other hospitals or by other covered providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• At or by higher cost share hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech, hearing, and language disorder treatment—speech therapy</td>
<td>$20 per visit $55 per visit</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>• At other hospitals or by other covered providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• At or by higher cost share hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic X-rays</td>
<td>Nothing $100 per service date</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>• At other hospitals or by other covered providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• At or by higher cost share hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic lab tests</td>
<td>Nothing $35 per service date</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>• At other hospitals or by other covered providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• At or by higher cost share hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CT scans, MRIs, PET scans, and nuclear cardiac imaging tests</td>
<td>$100 per category per service date $550 per category per service date</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>• At other hospitals or by other covered providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• At or by higher cost share hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care and hospice services</td>
<td>Nothing</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Oxygen and equipment for its administration</td>
<td>Nothing</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Durable medical equipment—such as wheelchairs, crutches, hospital beds</td>
<td>20% coinsurance**</td>
<td>40% coinsurance after deductible**</td>
</tr>
<tr>
<td>Prosthetic devices</td>
<td>20% coinsurance</td>
<td>40% coinsurance after deductible</td>
</tr>
<tr>
<td>Surgery and related anesthesia, when performed in an office or health center</td>
<td>$20 per visit***</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Surgery in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit</td>
<td>Nothing $1,000 per admission</td>
<td>20% coinsurance after deductible</td>
</tr>
</tbody>
</table>

* 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.
Covered Services | Your Cost In-Network | Your Cost Out-of-Network
--- | --- | ---
**Inpatient Care (including maternity care)**
- In other general hospitals (as many days as medically necessary)
- In higher cost share hospitals (as many days as medically necessary)
  | Nothing | 20% coinsurance after deductible
  | $1,000 per admission | 20% coinsurance after deductible
**Chronic disease hospital care (as many days as medically necessary)**
  | Nothing | 20% coinsurance after deductible
**Mental hospital or substance use facility care (as many days as medically necessary)**
  | Nothing | 20% coinsurance after deductible
**Rehabilitation hospital care (up to 60 days per calendar year)**
  | Nothing | 20% coinsurance after deductible
**Skilled nursing facility care (up to 100 days per calendar year)**
  | Nothing | 20% coinsurance after deductible

**Prescription Drug Benefits**
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**
  | $20 for Tier 1
  | $35 for Tier 2
  | $55 for Tier 3
  | Not covered
Through the designated mail order pharmacy (up to a 90-day formulary supply for each prescription or refill)**
  | $40 for Tier 1***
  | $70 for Tier 2
  | $110 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 bluecrossma.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.)

**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.)

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**

| 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 bluecrossma.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.
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.
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 assistans nan lang disponib pou ou gratis. Rele nimewo Sèvis Mann nan ki sou kat Idantifikasyon w lan (Sèvis pou Malantandan TTY: 711).


Arabic/العربية: الاتصال إذا كنت تتحدث اللغة العربية، فتوفر خدمات المساعدة اللغوية مجانا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هويتك (جهاز الهاتف الفضائي للصم والبكم): TTY: 711.

Mon-Khmer, Cambodian/ម៉ូន-ខេម្ម្ស៍: នូវការជំនួសជាមួយភាសាមួយគ្នានៅក្នុងប្រទេសអាស៊ីពាណិជ្ជការ គ្រប់មនុស្សនៅក្នុងប្រទេសអាស៊ីពាណិជ្ជការនឹងផ្តល់ជំនួសជាមួយភាសាមួយគ្នានៅក្នុងប្រទេសអាស៊ីពាណិជ្ជការ (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).


Greek/λατινικά: 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 हिंदी बोलते हैं, तो भाषा सहायता सेवाएं, आप के लिए लिखित उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वाई: 711).

Gujarati/ગુજરાતી: ધ્યાન આપો: આપે ગુજરાતની ભાષા બોલતા છો, તો તમામ ભાષાસહેય સહાયક સેવાઓ તમારા મૂવમેન્ટ શીર્ષક હોય છે. તમારા આઇડીડ કાર્ડ પર આધિક્ય નંબર પર મેમ્બર સેવા ને કાઢ કરો (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ト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）。


Persian/پارسیان: توجه: اگر زبان شما فارسی است، خدمات کمک زبانی به صورت رایگان در انتظار شما قرار می‌گیرد. با شمار تلفن مندرج بر روی کارت شناسایی خود با پیام درخواست اطلاعات اعضای تماس بگیرید (TTY: 711).
