SUMMARY OF BENEFITS

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
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 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.

How to Find a Preferred Provider
To find a preferred provider:
• Look up a provider on Find a Doctor at bluecrossma.com/findadoctor. 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.org/studentbluema

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.

You must pay a plan-year deductible before you can receive coverage for certain 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 $300 per member (or $600 per family).

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).

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 and prescription drug benefits is $8,700 per member (or $17,400 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. 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
Telehealth services are covered when the same in-person service would be covered by the health plan and the use of telehealth is appropriate. Your health care provider will work with you to determine if a telehealth visit is medically appropriate for your health care needs or if an in-person visit is required. For a list of telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at bluecrossma.org/studentbluema, consult Find a Doctor, or call the Member Service number on your ID card.

Your Virtual Care Team
Your health plan includes an option for a tech-enabled primary care delivery model where virtual care team covered providers furnish certain covered services. See your subscriber certificate (and riders, if any) for exact coverage details.

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.

Domestic Partner Coverage
Domestic partner coverage may be available for eligible dependents. Contact your plan sponsor for more information.
<table>
<thead>
<tr>
<th><strong>Preventive Care</strong></th>
<th><strong>Your Cost In-Network</strong></th>
<th><strong>Your Cost Out-of-Network</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive care **</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Well-child care exams, including routine tests, according to age-based schedule as follows:  
- Ten 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 | 20% coinsurance after deductible |
| Routine adult physical exams, including related tests (one per calendar year) | Nothing | 20% coinsurance after deductible |
| Routine GYN exams, including related lab tests (one per calendar year) | Nothing | 20% coinsurance after deductible |
| Mental health wellness exams (at least one per calendar year) | Nothing | Nothing, no deductible |
| Routine hearing exams, including routine tests | All charges beyond the maximum | 20% coinsurance after deductible and all charges beyond the maximum |
| Hearing aids (up to $2,000 per ear every 36 months for a member age 21 or younger) | Nothing | 20% coinsurance after deductible |
| Routine vision exams (one every 12 months) | 35% coinsurance | 55% 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) | Nothing | 20% coinsurance after deductible |
| Family planning services—office visits | Nothing | 20% coinsurance after deductible |
| **Outpatient Care** |  |  |
| Emergency room visits | $250 per visit  
(waived if admitted or for observation stay) | $250 per visit, no deductible  
(waived if admitted or for observation stay) |
| Office or health center visits | $10 per visit | 20% coinsurance after deductible |
| Mental health or substance use treatment | Nothing | 20% coinsurance after deductible |
| Outpatient telehealth services  
- With a covered provider  
- With the in-network designated telehealth vendor for simple medical conditions  
- With the in-network designated telehealth vendor for mental health services | Same as in-person visit  
Only applicable in-network | Same as in-person visit  
Only applicable in-network |
| Chiropractors’ office visits | $10 per visit | 20% coinsurance after deductible |
| Acupuncture visits (up to 12 visits per calendar year) | $10 per visit | 20% coinsurance after deductible |
| Short-term rehabilitation therapy—physical and occupational  
(up to 60 visits for rehabilitation services and 60 visits for habilitation services per calendar year*) | $10 per visit | 20% coinsurance after deductible |
| Speech, hearing, and language disorder treatment—speech therapy | Nothing | 20% coinsurance after deductible |
| Diagnostic X-rays and lab tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests | Nothing | 20% coinsurance after deductible |
| Home health care and hospice services | Nothing | 20% coinsurance after deductible |
| Oxygen and equipment for its administration | Nothing | 20% coinsurance after deductible |
| Durable medical equipment—such as wheelchairs, crutches, hospital beds | Nothing | 20% coinsurance after deductible |
| Prosthetic devices | Nothing | 20% coinsurance after deductible |
| Surgery and related anesthesia  
- Office or health center services  
- Ambulatory surgical facility, hospital outpatient department, or surgical day care unit | $10 per visit** | 20% coinsurance after deductible |
| **Inpatient Care (including maternity care)** |  |  |
| General or chronic disease hospital care (as many days as medically necessary) | $500 per admission | 20% coinsurance after deductible |
| Mental hospital or substance use facility care (as many days as medically necessary) | $500 per admission | 20% coinsurance after deductible |
| Rehabilitation hospital care (up to 60 days per calendar year) | $500 per admission | 20% coinsurance after deductible |
| Skilled nursing facility care (up to 100 days per calendar year) | $500 per admission | 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.
** 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

### Prescription Drug Benefits*  

<table>
<thead>
<tr>
<th>Service Description</th>
<th>In-Network Costs</th>
<th>Out-of-Network Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**</td>
<td>$15 for Tier 1, $30 for Tier 2, $50 for Tier 3, $100 for Tier 4</td>
<td>Not covered</td>
</tr>
<tr>
<td>Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)**</td>
<td>$30 for Tier 1, $60 for Tier 2, $100 for Tier 3, $200 for Tier 4</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

* 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 or reduced for certain covered drugs and supplies. Retail drugs are available in a 90-day supply at three times the standard retail cost share.

Get the Most from Your Plan: Visit us at bluecrossma.org/studentbluema 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 program that rewards participation in qualified fitness programs or equipment (See your subscriber certificate for details.)
  - $150 per calendar year per policy

- **Weight Loss Reimbursement:** a program that rewards participation in a qualified weight loss program (See your subscriber certificate for details.)
  - $150 per calendar year per policy

### Questions?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-888-753-6615, or visit us online at bluecrossma.org/studentbluema.
PEDIATRIC ESSENTIAL DENTAL BENEFITS

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

This separate dental policy 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.

### Pediatric Essential Dental Benefits*

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Your Cost In-Network**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1: Preventive and Diagnostic Services: oral exams, X-rays, and routine dental care</td>
<td>Nothing, no deductible</td>
</tr>
<tr>
<td>Group 2: Basic Restorative Services: fillings, root canals, stainless steel crowns, periodontal care, oral surgery, and dental prosthetic maintenance</td>
<td>25% coinsurance after deductible</td>
</tr>
<tr>
<td>Group 3: Major Restorative Services: tooth replacement, resin crowns, and occlusal guards</td>
<td>50% coinsurance after deductible</td>
</tr>
<tr>
<td>Orthodontic Services: medically necessary orthodontic care pre-authorized for a qualified member</td>
<td>50% coinsurance, no deductible</td>
</tr>
</tbody>
</table>

* 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.
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.
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 Idantitifikasyon w lan (Sèvis pou Malantandan TTY: 711).


Arabic/عربية: انتباه: إذا كنت تتحدث اللغة العربية، فتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هويتك (جهاز الهاتف TTY: 711).

Mon-Khmer, Cambodian/ខ្មែរ: ការជ្រុងជ្រុង ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ បានប្រើការជ្រុងជ្រុងសំរាប់អ្នក សូមបានធ្វើការជ្រុងជ្រុងដែលមានតំបន់ថ្មីមួយនៃការជ្រុងជ្រុងនេះបាន (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/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).