SUMMARY OF BENEFITS

Amherst College – Students

BLUE CARE ELECT
PREFERRED

Student Health Plan
2023 – 2024

UNLOCK THE POWER OF YOUR PLAN
MyBlue gives you an instant snapshot of your plan:

Coverage and Benefits
Claims and Balances
Digital ID Card

Sign in
Download the app, or create an account at bluecrossma.org.

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 (including prescription drug copayments), and coinsurance for covered services. Your out-of-pocket maximum 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 the option for a tech-enabled delivery model where virtual care team covered providers furnish certain covered services, including primary care with integrated mental health and/or substance use care within the patient care team, via traditional and/or digital platforms (such as: mobile app; web portal; telephone; and/or text message). This care delivery model offers a comprehensive and coordinated primary care experience with virtual engagement and seamless navigation to in-person care with network providers when applicable. For in-network outpatient covered services furnished by a designated virtual care team primary care or mental health care provider type, you will pay nothing (any deductible, copayment, and/or coinsurance does not apply). For in-network outpatient covered services furnished by a virtual care team covered provider that is not a virtual care team primary care or mental health care provider type, you will pay your applicable cost share (deductible, copayment, and/or coinsurance). To find a virtual care team covered provider or to learn more about this care delivery model, visit MyBlue online or see “When You Need Help to Find a Health Care Provider” in your subscriber certificate, 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.

Domestic Partner Coverage

Domestic partner coverage may be available for eligible dependents. Contact your plan sponsor for more information.
### Covered Services

#### Preventive Care
- **Well-child care exams**, including routine tests, according to age-based schedule as follows:
  - 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
  - **Your Cost In-Network**: Nothing
  - **Your Cost Out-of-Network**: 20% coinsurance after deductible
- **Routine adult physical exams**, including related tests (one per calendar year)
  - **Your Cost In-Network**: Nothing
  - **Your Cost Out-of-Network**: 20% coinsurance after deductible
- **Routine GYN exams**, including related lab tests (one per calendar year)
  - **Your Cost In-Network**: Nothing
  - **Your Cost Out-of-Network**: 20% coinsurance after deductible
- **Hearing aids** (up to $2,000 per ear every 36 months for a member age 21 or younger)
  - **Your Cost In-Network**: All charges beyond the maximum
  - **Your Cost Out-of-Network**: 20% coinsurance after deductible
- **Routine vision exams** (one every 12 months)
  - **Your Cost In-Network**: Nothing
  - **Your Cost Out-of-Network**: 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)
  - **Your Cost In-Network**: 35% coinsurance
  - **Your Cost Out-of-Network**: 55% coinsurance after deductible
- **Family planning services—office visits**
  - **Your Cost In-Network**: Nothing
  - **Your Cost Out-of-Network**: 20% coinsurance after deductible

#### Outpatient Care
- **Emergency room visits**
  - **Your Cost In-Network**: $250 per visit
    - (waived if admitted or for observation stay)
  - **Your Cost Out-of-Network**: $250 per visit, no deductible
    - (waived if admitted or for observation stay)
- **Office or health center visits**
  - **Your Cost In-Network**: $10 per visit
  - **Your Cost Out-of-Network**: 20% coinsurance after deductible
- **Mental health or substance use treatment**
  - **Your Cost In-Network**: Nothing
  - **Your Cost Out-of-Network**: 20% coinsurance after deductible
- **Outpatient telehealth services**
  - With a covered provider
    - **Your Cost In-Network**: Same as in-person visit
  - With the in-network designated telehealth vendor for simple medical conditions
    - **Your Cost In-Network**: Same as in-person visit
  - With the in-network designated telehealth vendor for mental health services
    - **Your Cost In-Network**: Only applicable in-network
- **Chiropractors’ office visits**
  - **Your Cost In-Network**: $10 per visit
  - **Your Cost Out-of-Network**: 20% coinsurance after deductible
- **Acupuncture visits** (up to 12 visits per calendar year)
  - **Your Cost In-Network**: $10 per visit
  - **Your Cost Out-of-Network**: 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*)
  - **Your Cost In-Network**: $10 per visit
  - **Your Cost Out-of-Network**: 20% coinsurance after deductible
- **Speech, hearing, and language disorder treatment—speech therapy**
  - **Your Cost In-Network**: $10 per visit
  - **Your Cost Out-of-Network**: 20% coinsurance after deductible
- **Diagnostic X-rays and lab tests**, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests
  - **Your Cost In-Network**: Nothing
  - **Your Cost Out-of-Network**: 20% coinsurance after deductible
- **Home health care and hospice services**
  - **Your Cost In-Network**: Nothing
  - **Your Cost Out-of-Network**: 20% coinsurance after deductible
- **Oxygen and equipment for its administration**
  - **Your Cost In-Network**: Nothing
  - **Your Cost Out-of-Network**: 20% coinsurance after deductible
- **Durable medical equipment—such as wheelchairs, crutches, hospital beds**
  - **Your Cost In-Network**: Nothing
  - **Your Cost Out-of-Network**: 20% coinsurance after deductible
- **Prosthetic devices**
  - **Your Cost In-Network**: Nothing
  - **Your Cost Out-of-Network**: 20% coinsurance after deductible
- **Surgery and related anesthesia**
  - Office or health center services
    - **Your Cost In-Network**: $10 per visit
  - Ambulatory surgical facility, hospital outpatient department, or surgical day care unit
    - **Your Cost In-Network**: $10 per visit
    - **Your Cost out-of-network**: $150 per admission
  - **Your Cost Out-of-Network**: 20% coinsurance after deductible

#### Inpatient Care (including maternity care)
- **General or chronic disease hospital care** (as many days as medically necessary)
  - **Your Cost In-Network**: $500 per admission
  - **Your Cost Out-of-Network**: 20% coinsurance after deductible
- **Mental hospital or substance use facility care** (as many days as medically necessary)
  - **Your Cost In-Network**: $500 per admission
  - **Your Cost Out-of-Network**: 20% coinsurance after deductible
- **Rehabilitation hospital care** (up to 60 days per calendar year)
  - **Your Cost In-Network**: $500 per admission
  - **Your Cost Out-of-Network**: 20% coinsurance after deductible
- **Skilled nursing facility care** (up to 100 days per calendar year)
  - **Your Cost In-Network**: $500 per admission
  - **Your Cost Out-of-Network**: 20% coinsurance after deductible

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*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.
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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Questions?
For questions about Blue Cross Blue Shield of Massachusetts, call 1-888-753-6615, or visit us online at bluecrossma.org/studentbluema.
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.

<table>
<thead>
<tr>
<th>Pediatric Essential Dental Benefits*</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).


Mon-Khmer, Cambodian/ខ្មែរ: ការជនដណង៖ ប្រសនប្រអ្នកនយាយភាសាខ្មែរបានសវាជនយភាសាឥតគតថ្លៃ គអាចរកបានសបរាជាសកពីហ្គេមតព៊ះនរ្រសអ្នក (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).
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 सेवाएँ, आप के लिए निःशल्क 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 ભાષાફ્રેમાં સહાયતા સેવાઓ વિના મૂક્યે ઉપલબ્ધ છે. નમાજ આઈ.ડી.ગુડ જે ભાષા સભ્ય નંબર પર અપલોડ કરે (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 ب صورت رایگان در اختیار شما قرار می‌گیرد. با شمار تلفن مندرج بر روی کارت شناسایی خود با بخش "خدمات اعضا" تماس بگیرید (TTY: 711).
