## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Blue Care Elect Preferred**  
**Amherst College**

**Coverage Period:** on or after 07/01/2015  
**Coverage for:** Individual and Family | **Plan Type:** PPO

---

### Important Questions | Answers | Why this Matters:
---|---|---
What is the overall **deductible**? | $0 in-network; $250 member / $500 family out-of-network. Does not apply to emergency room, emergency transportation. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.

Are there other **deductibles** for specific services? | No. | You don’t have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.

Is there an **out-of-pocket limit** on my expenses? | Yes. For medical benefits, $2,000 member / $4,000 family; and for prescription drug benefits, $1,000 member / $2,000 family. | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

What is not included in the **out-of-pocket limit**? | Premiums, balance-billed charges, and health care this plan doesn’t cover. | Even though you pay these expenses, they don’t count toward the **out-of-pocket limit**.

Does this plan use a network of **providers**? | Yes. See [www.bluecrossma.com/findadoctor](http://www.bluecrossma.com/findadoctor) or call 1-800-821-1388 for a list of preferred providers. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Do I need a referral to see a specialist? | No. | You can see the **specialist** you choose without permission from this plan.

Are there services this plan doesn’t cover? | Yes. | Some of the services this plan doesn’t cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

---

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bluecrossma.com](http://www.bluecrossma.com) or by calling 1-888-456-1351.
- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** (or provider’s charge if it is less than the **allowed amount**) for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is $1,000 (and it is less than the provider’s charge), your **coinsurance** payment of 20% would be $200. This may change if you haven’t met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network provider charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts. (If you are eligible to elect a Health Reimbursement Account (HRA), Flexible Spending Account (FSA) or you have elected a Health Savings Account (HSA), you may have access to additional funds to help cover certain **out-of-pocket** expenses such as **copayments**, **coinsurance**, **deductibles** and costs related to services not otherwise covered.)

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your cost if you use</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$15 / visit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$15 / visit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$15 / chiropractor visit</td>
<td>20% coinsurance / chiropractor visit</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Your cost if you use</td>
<td>Limitations &amp; Exceptions</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>----------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>$5 / retail supply or $10 / mail service supply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$25 / retail supply or $50 / mail service supply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$50 / retail supply or $100 / mail service supply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Applicable cost share (generic, preferred, non-preferred)</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$150 / admission</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room services</td>
<td>$75 / visit</td>
<td>$75 / visit</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$15 / visit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>$250 / admission</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Your cost if you use</td>
<td>Limitations &amp; Exceptions</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>---------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>$15 / visit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>$250 / admission</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$15 / visit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>$250 / admission</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>If you are pregnant</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prenatal and postnatal care</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>$250 / admission and no charge for delivery</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Deductible applies first for out-of-network</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Deductible applies first for out-of-network; pre-authorization required</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Deductible applies first for out-of-network</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Deductible applies first for out-of-network; pre-authorization required</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Your cost if you use</td>
<td>Limitations &amp; Exceptions</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>----------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Home health care</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>Deductible applies first for out-of-network; pre-authorization required</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$15 / visit</td>
<td>20% coinsurance</td>
<td>Deductible applies first for out-of-network; limited to 60 visits per calendar year (other than for autism, home health care, and speech therapy)</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>$15 / visit</td>
<td>20% coinsurance</td>
<td>Deductible applies first for out-of-network; rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>Deductible applies first for out-of-network; limited to 100 days per calendar year; pre-authorization required</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Deductible applies first for out-of-network; in-network cost share waived for one breast pump per birth (20% coinsurance for out-of-network)</td>
</tr>
<tr>
<td>Hospice service</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>Deductible applies first for out-of-network; pre-authorization required for certain services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye exam</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>Deductible applies first for out-of-network; limited to one exam per calendar year</td>
</tr>
<tr>
<td>Glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Dental check-up</td>
<td>No charge for members with a cleft palate / cleft lip condition</td>
<td>20% coinsurance for members with a cleft palate / cleft lip condition</td>
<td>Limited to members under age 18; deductible applies first for out-of-network</td>
</tr>
</tbody>
</table>
### Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
</tr>
<tr>
<td>Children's glasses</td>
</tr>
<tr>
<td>Cosmetic surgery</td>
</tr>
<tr>
<td>Dental care (adult)</td>
</tr>
<tr>
<td>Long-term care</td>
</tr>
<tr>
<td>Private-duty nursing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bariatric surgery</td>
</tr>
<tr>
<td>Chiropractic care</td>
</tr>
<tr>
<td>Hearing aids ($2,000 per ear every 36 months for members age 21 or younger)</td>
</tr>
<tr>
<td>Infertility treatment</td>
</tr>
<tr>
<td>Non-emergency care when traveling outside the U.S.</td>
</tr>
<tr>
<td>Routine eye care - adult (one exam per calendar year)</td>
</tr>
<tr>
<td>Routine foot care (only for patients with systemic circulatory disease)</td>
</tr>
<tr>
<td>Weight loss programs ($150 per calendar year per policy)</td>
</tr>
</tbody>
</table>
Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact your plan sponsor. Note: A plan sponsor is usually the member’s employer or organization that provides group health coverage to the member. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on your ID card or contact your plan sponsor. Note: 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/opb.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Assistance

To obtain language assistance, please call the toll-free Member Service number on your ID card.

SPANISH (Español): Para obtener asistencia en español, llame al número gratuito de Servicio de Atención al Miembro que figura en su tarjeta de identificación.

TAGALOG (Tagalog): Kung kailangan ninyo ng tulong sa Tagalog tumawag sa libreng numero ng telepono ng Serbisyo sa Miyembro na nakasulat sa inyong ID card.

CHINESE (中文): 如果您需要中文語言幫助，請撥打會員卡上的客戶服務免費電話號碼

NAVAJO (Dine): Dinek’ehji shika’a’dowoł ninizando, kwoji hodiihne t’áá jiikeh béésh bee’ hane’ji T’áá doolé’é bina’ishdiłkidgo yeeháá’adoojah éi binumber bee néého’dolzin biniiyé naanitinígíi bikáá’ doo.

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 page.
About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

---

This is not a cost estimator.

Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

---

### Having a baby (normal delivery)

<table>
<thead>
<tr>
<th>Sample care costs:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
</tr>
</tbody>
</table>

**Patient pays:**

| Deductibles                                             | $0    |
| Copays                                                  | $250  |
| Coinsurance                                             | $0    |
| Limits or exclusions                                    | $150  |
| **Total**                                               | **$400**|

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

<table>
<thead>
<tr>
<th>Sample care costs:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits and Procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,400</strong></td>
</tr>
</tbody>
</table>

**Patient pays:**

| Deductibles                                             | $0    |
| Copays                                                  | $1,120|
| Coinsurance                                             | $0    |
| Limits or exclusions                                    | $80   |
| **Total**                                               | **$1,200**|
Questions and answers about the Coverage Examples:

<table>
<thead>
<tr>
<th>What are some of the assumptions behind the Coverage Examples?</th>
<th>What does a Coverage Example show?</th>
<th>Can I use Coverage Examples to compare plans?</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Costs don’t include <strong>premiums</strong>.</td>
<td>For each treatment situation, the Coverage Example helps you see how <strong>deductibles</strong>, <strong>copayments</strong>, and <strong>coinsurance</strong> can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.</td>
<td>✓<strong>Yes.</strong> When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.</td>
</tr>
<tr>
<td>● Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.</td>
<td>● The patient’s condition was not an excluded or preexisting condition.</td>
<td></td>
</tr>
<tr>
<td>● All services and treatments started and ended in the same coverage period.</td>
<td>● Out-of-pocket expenses are based only on treating the condition in the example.</td>
<td></td>
</tr>
<tr>
<td>● There are no other medical expenses for any member covered under this plan.</td>
<td>● The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.</td>
<td></td>
</tr>
<tr>
<td>● Does the Coverage Example predict my own care needs?</td>
<td></td>
<td>✓<strong>Yes.</strong> Can I use Coverage Examples to compare plans?</td>
</tr>
<tr>
<td>✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.</td>
<td>✓<strong>Yes.</strong> When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Are there other costs I should consider when comparing plans?</strong></td>
<td></td>
</tr>
<tr>
<td>✗ No. Coverage Examples are <strong>not</strong> cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.</td>
<td>✓<strong>Yes.</strong> An important cost is the <strong>premium</strong> you pay. Generally, the lower your <strong>premium</strong>, the more you’ll pay in out-of-pocket costs, such as <strong>copayments</strong>, <strong>deductibles</strong>, and <strong>coinsurance</strong>. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.</td>
<td></td>
</tr>
</tbody>
</table>
MCC Compliance

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