BlueCross® BlueShield®

SUMMARY OF BENEFITS

BLUE CARE ELECT SAVER 90

Simmons University

Plan-Year Deductible: $2,000/$4,000

Benefits effective July 1, 2022

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.

YOUR CHOICE

Your Deductible
Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for most benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductibles are **$2,000** per individual membership (or **$4,000** per family membership) for in-network services and **$3,000** per individual membership (or **$6,000** per family membership) for out-of-network services. **The entire amount of the family deductible must be met before benefits will be provided for any one member.** Any amount applied toward the in-network deductible will also be applied toward the out-of-network deductible (and vice versa).

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 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**

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 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 maximums are **$3,000** per member (or **$6,000** per family) for in-network services and **$4,000** per member (or **$8,000** per family) for out-of-network services. Any amount applied toward the in-network out-of-pocket maximum will also be applied toward the out-of-network out-of-pocket maximum (and vice versa).

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). After meeting your in-network deductible, 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
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**, consult Find a Doctor, 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	Your Cost In-Network	Your Cost Out-of-Network
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	Nothing, no deductible	20% coinsurance, no deductible
Routine adult physical exams, including related tests (one per calendar year)	Nothing, no deductible	20% coinsurance, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible	20% coinsurance, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible	20% coinsurance, no deductible
Hearing aids (up to $2,000 per ear every 36 months)	All charges beyond the maximum after deductible	20% coinsurance after deductible and all charges beyond the maximum
Routine vision exams (one every 24 months)	Nothing, no deductible	20% coinsurance, no deductible
Family planning services—office visits	Nothing, no deductible	20% coinsurance, no deductible
Outpatient Care		
Emergency room visits	$150 per visit after deductible (copayment waived if admitted or for observation stay)	$150 per visit after in-network deductible (copayment waived if admitted or for observation stay)
Office or health center visits	10% coinsurance after deductible	30% coinsurance after deductible
Mental health or substance use treatment	10% coinsurance after deductible	30% coinsurance after deductible
Outpatient telehealth services • With a covered provider • With the designated telehealth vendor	 10% coinsurance after deductible 10% coinsurance after deductible	 30% coinsurance after deductible Not applicable
Diabetic management services (first two visits per calendar year*)	Nothing, no deductible	20% coinsurance after deductible
Chiropractors' office visits	10% coinsurance after deductible	30% coinsurance after deductible
Acupuncture visits (up to 12 visits per calendar year)	10% coinsurance after deductible	30% coinsurance after deductible
Short-term rehabilitation therapy—physical and occupational (up to 100 visits per calendar year**)	10% coinsurance after deductible	30% coinsurance after deductible
Speech, hearing, and language disorder treatment—speech therapy	10% coinsurance after deductible	30% coinsurance after deductible
Diagnostic X-rays and lab tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	10% coinsurance after deductible***	30% coinsurance after deductible
Home health care and hospice services	10% coinsurance after deductible	30% coinsurance after deductible
Oxygen and equipment for its administration	10% coinsurance after deductible	30% coinsurance after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	10% coinsurance after deductible†	30% coinsurance after deductible†
Prosthetic devices	10% coinsurance after deductible	30% coinsurance after deductible
Surgery and related anesthesia	10% coinsurance after deductible	30% coinsurance after deductible
Inpatient Care (including maternity care)		
General or chronic disease hospital care (as many days as medically necessary)	10% coinsurance after deductible	30% coinsurance after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	10% coinsurance after deductible	30% coinsurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	10% coinsurance after deductible	30% coinsurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	10% coinsurance after deductible	30% coinsurance after deductible

* These diabetic services are for diabetes evaluation and management services, diabetic eye exams, or diabetic foot care.
** 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.
*** The overall deductible does not apply to the following outpatient covered services when they are furnished for members who are diagnosed with certain chronic conditions: blood pressure monitors with the diagnosis of hypertension; glucometers with the diagnosis of diabetes; International Normalized Ratio (INR) testing with the diagnosis of liver disease and/or a bleeding disorder; and retinopathy screenings with the diagnosis of diabetes.
† In-network cost share waived for one breast pump per birth (20% coinsurance after deductible out-of-network).

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Prescription Drug Benefits*		
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**		
• Covered smoking cessation drugs***	**Nothing**, no deductible for Tier 1 **Nothing**, no deductible for Tier 2 **$45** after deductible for Tier 3	**Nothing**, no deductible for Tier 1 **Nothing**, no deductible for Tier 2 **$90** after deductible for Tier 3
• All other covered drugs and supplies	**$10** after deductible for Tier 1 **$25** after deductible for Tier 2 **$45** after deductible for Tier 3	**$20** after deductible for Tier 1 **$50** after deductible for Tier 2 **$90** after deductible for Tier 3
Through the designated mail order pharmacy (up to a 90-day formulary supply for each prescription or refill)**		Not covered
• Covered smoking cessation drugs***	**Nothing**, no deductible for Tier 1 **Nothing**, no deductible for Tier 2 **$135** after deductible for Tier 3	
• Certain covered drugs for: asthma, diabetes, coronary artery disease or risk for cardiovascular disease (concurrently taking high blood pressure medications and high cholesterol medications), and depression associated with any of these conditions***	**$10**, no deductible for Tier 1† **$25**, no deductible for Tier 2 **$135**, no deductible for Tier 3	
• All other covered drugs and supplies	**$20** after deductible for Tier 1† **$50** after deductible for Tier 2 **$135** after deductible for Tier 3	

* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred brand-name drugs. Your pharmacy coverage includes the Select Home Delivery Program. For a complete description of the program refer to your subscriber certificate and riders. To find out which maintenance drugs are on the Select Home Delivery Pharmacy drug list, call the Member Service number on your ID card, or visit our website at bluecrossma.org/90daymeds.

** Cost share may be waived for certain covered drugs and supplies. Retail drugs are available in a 90-day supply at three times the standard retail cost share. Deductible is waived for medications on the HSA preventive drug list.

*** For a list of these drugs, contact Blue Cross Blue Shield of Massachusetts or visit the Value-Based Benefits page in the Pharmacy Coverage section at bluecrossma.org.

† Certain generic medications are available through the mail order pharmacy at $9, no deductible. For more information, go to bluecrossma.org/mail-order-pharmacy.

Get the Most from Your Plan: Visit us at bluecrossma.org or call 1-800-358-2227 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 This fitness program applies for fees paid to: a health club with cardiovascular and strength-training equipment; a fitness studio offering instructor-led group classes for cardiovascular and strength-training; or virtual fitness memberships or classes. (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 This weight loss program 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
Mind and Body Wellness Program Reimbursement for participation in the Mind and Body Wellness Program The Mind and Body Wellness Program applies for fees paid for services from a licensed or certified practitioner who participates in the Blue Cross Blue Shield of Massachusetts Living Healthy Naturally℠ program. Services include: acupuncture, massage therapy, hypnosis mind and body therapy, meditation mind and body therapy, Tai Chi or Qi Gong. (See your subscriber certificate for details.)	**$300** per calendar year per policy

24/7 Nurse Line: Speak to a registered nurse, day or night, to get immediate guidance and advice. Call 1-888-247-BLUE (2583). No additional charge.

QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-358-2227, or visit us online at bluecrossma.org.

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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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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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។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខ នៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (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**).

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'dééʼ nóomba biká'ígíiji' béésh bee hodíílnih (TTY: **711**).

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