BlueCross® BlueShield®

SUMMARY OF BENEFITS

Blue Care Elect Preferred℠ (PPO)

Student Health Plan 2016-2017

This Plan Covers the Student Only.

Olin College Students

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

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. See charts on opposite and back pages 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

There are a few ways to find a preferred provider:

- Look up a provider in the Provider Directory. If you need a copy of your directory, call Member Service at the number on your ID card.
- Visit the Blue Cross Blue Shield of Massachusetts website at **www.bluecrossma.com/findadoctor**
- Call the Physician Selection Service at **1-800-821-1388**

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.

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 coinsurance). See the charts on opposite and back pages 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 copayments and coinsurance for covered services. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your out-of-pocket maximum for medical benefits is **$4,500** for in-network and out-of-network services combined. Your out-of-pocket maximum for prescription drug benefits is **$2,000**.

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. See the chart on opposite page for your cost share.

Utilization Review Requirements

You must follow the requirements of Utilization Review, including Pre-Admission Review, Pre-Service Approval for certain outpatient services, Concurrent Review and Discharge Planning, and Individual Case Management. For detailed information about Utilization Review, see your subscriber certificate. If you need non-emergency or non-maternity hospitalization, you, or someone on your behalf, must call the number on your ID card for pre-approval. If you do not notify Blue Cross Blue Shield of Massachusetts and receive pre-approval, your benefits may be reduced or denied.

Pediatric 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**.

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**.

To find participating dental providers, visit the Blue Cross Blue Shield of Massachusetts website at **www.bluecrossma.com/findadoctor** or call the Physician Selection Service at **1-800-821-1388**.

Your Medical Benefits

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Preventive Care Routine adult physical exams, including related tests (one per calendar year)	Nothing	20% coinsurance
Routine GYN exams, including related lab tests (one per calendar year)	Nothing	20% coinsurance
Routine hearing exams, including routine tests	Nothing	20% coinsurance
Routine vision exams (one every 24 months)	Nothing	20% coinsurance
Family planning services–office visits	Nothing	20% coinsurance
Outpatient Care Emergency room visits	$150 per visit (waived if admitted or for observation stay)	$150 per visit (waived if admitted or for observation stay)
Clinic visits; physicians' and podiatrists' office visits	$20 per visit	20% coinsurance
Mental health or substance abuse treatment	$20 per visit	20% coinsurance
Chiropractors' office visits	$20 per visit	20% coinsurance
Short-term rehabilitation therapy–physical and occupational (up to 100 visits per calendar year*)	$20 per visit	20% coinsurance
Speech, hearing, and language disorder treatment–speech therapy	$20 per visit	20% coinsurance
Diagnostic X-rays, lab tests, and other tests	Nothing	20% coinsurance
MRIs, CT scans, PET scans and nuclear cardiac imaging tests	$125 per category per date of service	20% coinsurance
Oxygen and equipment for its administration	Nothing	20% coinsurance
Home health care and hospice services	Nothing	20% coinsurance
Prosthetic devices	Nothing	20% coinsurance
Durable medical equipment–such as wheelchairs, crutches, hospital beds	Nothing	20% coinsurance
Surgery and related anesthesia: • Office and health center services • Hospital and other day surgical facility services	 $20 per visit** Nothing	 20% coinsurance 20% coinsurance
Inpatient care (including maternity care) General or chronic disease hospital care (as many days as medically necessary)	$250 per admission	20% coinsurance
Mental hospital or substance abuse facility care (as many days as medically necessary)	$250 per admission	20% coinsurance
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing	20% coinsurance
Skilled nursing facility care (up to 100 days per calendar year)	Nothing	20% coinsurance

* 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.

Prescription Drug Benefits*	Your Cost In-Network**	Your Cost Out-of-Network
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	$20 for Tier 1*** $40 for Tier 2 $60 for Tier 3	Not covered
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	$40 for Tier 1*** $80 for Tier 2 $120 for Tier 3	Not covered

* Tier 1 generally refers to generic drugs; Tier 2 generally refers to preferred drugs; Tier 3 refers to non-preferred drugs.

** Cost share waived for certain orally-administered anticancer drugs.

*** Cost share waived for birth control.

Pediatric Dental Benefits for Members under age 19*	Your Cost In-Network**
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 services are limited 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.

Get the Most from Your Plan

Visit us at **www.studentbluema.com** or call **1-888-753-6615** to learn about discounts, savings, resources, and special programs available to you, like those listed below.

A Fitness Benefit toward membership at a health club or for fitness classes This fitness benefit applies for fees paid to: privately-owned or privately-sponsored health clubs or fitness facilities, including individual health clubs and fitness centers; YMCAs; YWCAs; Jewish Community Centers; and municipal fitness centers. (See your subscriber certificate for details.)	Reimbursement for membership fees for up to 3 consecutive months at a health club or 10 fitness classes per calendar year.
A Weight Loss Program Benefit toward participation in a qualified weight loss program This weight loss program benefit applies for fees paid to: a qualified hospital-based weight loss program or a Blue Cross Blue Shield of Massachusetts designated weight loss program. (See your subscriber certificate for details.)	Reimbursement for up to 3 months participation fees per calendar year.
Blue Care Line℠—A 24-hour nurse line to answer your health care questions—call **1-888-247-BLUE (2583)**	No additional charge

Questions?

For questions about Blue Cross Blue Shield of Massachusetts, call **1-888-753-6615,** or visit us online at **www.studentbluema.com**.

Interested in receiving information from us via e-mail? Go to **www.studentbluema.com** to sign up.

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; hearing aids for members over age 21; 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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