BlueCross BlueShield

SUMMARY OF BENEFITS

Student Blue PPO

2015 - 2016

UMass Lowell

An Association of Independent Blue Cross and Blue Shield Plans

Your Choice

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. 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.

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. Your deductible is **$250** per member for in-network and out-of-network services combined.

When You Choose Preferred Providers.

After your deductible, you **20 percent** coinsurance for inpatient hospital, physician, and other provider covered services and some outpatient services. And, for some outpatient services, you pay a **$30** copayment for each covered visit. The **$30** copayment does not apply to preventive care services.

Please 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 several 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 our Physician Selection Service at **1-800-821-1388**

When You Choose Non-Preferred Providers.

After your deductible has been met, you pay **35 percent** coinsurance for most out-of-network covered services. **However, you pay 20 percent coinsurance after your deductible for covered out-of-network outpatient services when the corresponding in-network benefit is covered in full or just a copayment**. Payments for out-of-network benefits are based on the Blue Cross Blue Shield of Massachusetts 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 medical out-of-pocket maximum is **$4,000** per member (or **$8,000** per family) for in-network and out-of-network services combined. Your plan year out-of-pocket maximum for prescription drugs is **$1,000** per member (or **$2,000** per family).

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 **$150** 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. There is no deductible for these services.

Utilization Review Requirements.

You must follow the requirements of Utilization Review, which are Pre-Admission Review, Pre-Service Approval for certain outpatient services, Concurrent Review and Discharge Planning, and Individual Case Management. 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. Information concerning Utilization Review is detailed in your subscriber certificate and riders. If you do not notify Blue Cross Blue Shield and receive pre-approval, your benefits may be reduced or denied.

Dependent Benefits.

This plan covers dependents up to age 26, regardless of their financial dependency, student status, or employment status. Please see your subscriber certificate (and riders, if any) for exact coverage details.

Pediatric Dental Benefits.

Your medical plan coverage includes a separate dental policy that covers pediatric dental benefits for members under age 19 as required under the federal Patient Protection and Affordable Care Act.

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 under age 19 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 under age 19 enrolled under the same family membership).

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

Your Medical Benefits

Plan Specifics	Your Cost In-Network	Your Cost Out-of-Network
Plan-year deductible	$250 per member for in-network and out-of-network services combined	
Plan-year out-of-pocket maximum	$4,000 per member/$8,000 per family for in-network and out-of-network services combined	
Covered Services		
Preventive Care Well-child care exams, including related 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 from age 3 through age 18	Nothing, no deductible	20% coinsurance after deductible
Routine adult physical exams, including related tests, for members age 18 or older (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine hearing exams, including routine tests	Nothing, no deductible	20% coinsurance after deductible
Routine vision exams (one every 24 months)	Nothing, no deductible	20% coinsurance after deductible
Family planning services—office visits	Nothing, no deductible	20% coinsurance after deductible
Other Outpatient Care Emergency room visits	$150 per visit, no deductible (waived if admitted or for observation stay)	$150 per visit, no deductible (waived if admitted or for observation stay)
Clinic visits; physicians' and podiatrists' office visits	$30 per visit, no deductible	20% coinsurance after deductible
Mental health or substance abuse treatment	$30 per visit, no deductible	20% coinsurance after deductible
Chiropractors' office visits	$30 per visit, no deductible	20% coinsurance after deductible
Short-term rehabilitation therapy—physical and occupational (up to 100 visits per calendar year*)	$30 per visit, no deductible	20% coinsurance after deductible
Speech, hearing, and language disorder treatment—speech therapy	$30 per visit, no deductible	20% coinsurance after deductible
Diagnostic lab tests	Nothing, no deductible	20% coinsurance after deductible
Diagnostic X-rays and other tests, excluding MRIs, CT scans, PET scans and nuclear cardiac imaging tests	20% coinsurance after deductible	35% coinsurance after deductible
MRIs, CT scans, PET scans and nuclear cardiac imaging tests	$100 per category per date of service, no deductible	20% coinsurance after deductible
Oxygen and equipment for its administration	20% coinsurance after deductible	35% coinsurance after deductible
Home health care and hospice services	20% coinsurance after deductible	35% coinsurance after deductible
Prosthetic devices	20% coinsurance after deductible	35% coinsurance after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	20% coinsurance after deductible**	35% coinsurance after deductible**
Surgery and related anesthesia	20% coinsurance after deductible	35% coinsurance after deductible
Inpatient Care (including maternity care) General or chronic disease hospital care (as many days as medically necessary)	20% coinsurance after deductible	35% coinsurance after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	20% coinsurance after deductible	35% coinsurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	20% coinsurance after deductible	35% coinsurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	20% coinsurance after deductible	35% 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.
** In-network cost share waived for one breast pump per birth (20% coinsurance after deductible out-of-network).
*** 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 Benefit*	Your Cost In-Network	Your Cost Out-of-Network
Plan year out-of-pocket maximum	$1,000 per member $2,000 per family	None
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	$15 for Tier 1** $30 for Tier 2 $50 for Tier 3	Not covered
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	$30 for Tier 1** $60 for Tier 2 $150 for Tier 3	Not covered

* 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**
Plan-year deductible for Group 2 and Group 3 services	$50 per member $150 for three or more members
Plan-year out-of-pocket maximum	$350 per member $700 for two or more members
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 and/or frequency. For a complete list of covered services or additional information, refer to your subscriber certificate.

** Out-of-network benefits are not provided 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 like those listed below that are available to you.

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 of one annual family or individual membership at a health club or 10 fitness classes, per individual or family 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 individual or family per calendar year.
Blue Care Line[SM]—A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583)	No additional charge

Questions? Call 1-888-753-6615.

For questions about Blue Cross Blue Shield of Massachusetts, visit the website at **www.studentbluema.com**.
Interested in receiving information from Blue Cross Blue Shield of Massachusetts via e-mail?
Go to **www.bluecrossma.com/email** 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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