



## HEALTH PLAN FOR [Elon University Undergraduate Students](#)

Effective: 8/1/2024



# StudentBlue™

## A HEALTHY PLAN

for a successful future

Elon University has selected Student Blue to provide you with quality health insurance coverage from Blue Cross and Blue Shield of North Carolina (Blue Cross NC). With Student Blue, you have low out-of-pocket costs and worldwide coverage.<sup>1</sup>

All eligible students enrolled at Elon University are required to have health insurance coverage. Elon University endorses a cost-effective Student Health Insurance Plan (SHIP) that covers additional health care expenses not included in the Student Health Fee. This plan is administered by Blue Cross NC.

- **All full-time students** enrolled at Elon University are automatically enrolled in this Student Health Insurance Plan and the cost will be included on the Fall tuition bill.
- **Domestic students** may waive coverage by providing proof of comparable coverage. Students must complete an online waiver at [StudentBlueNC.com/Elon](https://StudentBlueNC.com/Elon) in order to opt out of the plan. Waivers must be submitted by Aug. 1, 2024, for the Fall and Feb. 1, 2025, for the Spring/Summer.
- **Student Health Center Benefits:** The deductible will be waived and the benefits will be paid at 100% of covered medical expenses incurred, based on the approved fee schedule when treatment is rendered at the Student Health Center.

MANDATORY HARD WAIVER <sup>2</sup>	Fall Semester Effective Dates 8/1/24 – 1/31/25	Spring Semester Effective Dates 2/1/25 – 7/31/25
<b>Student Rate</b>	\$1,322.64	\$1,322.64

DEPENDENT RATES Rates are additional to your student rate	Monthly
<b>Add Spouse</b>	\$220.44
<b>Add Child(ren)</b>	\$274.44
<b>Add Family</b>	\$494.88



## BENEFIT highlights

StudentBlue™	If you visit your Student Health Center or doctor in the Student Blue network (in-network provider):	If you visit a doctor NOT in the Student Blue network (out-of-network provider):
All dollar amounts and percentages are what you, as a plan member, would pay.		
<b>Student Health Services</b> (medical services)	No charge	Not applicable
<b>Office Visits</b> Includes office surgery, consultation, X-rays and labs and a benefit period maximum of four office visits for the evaluation and treatment of obesity in- and out-of-network. See "Inpatient and Hospital Services."	<b>Primary Care Provider and/or Specialist:</b> 20% after deductible	<b>Primary Care Provider and/or Specialist:</b> 50% after deductible
<b>Preventive Care</b> (primary preventive diagnosis only) For the most updated list of general preventive/screenings, immunizations, well-baby/well-child care and women's preventive care services mandated under federal law, see our website at <a href="https://BlueCrossNC.com/Preventive">BlueCrossNC.com/Preventive</a> . Nutritional counseling is covered and available only in-network.	<b>Primary Care Provider and/or Specialist:</b> No charge	<b>Primary Care Provider and/or Specialist:</b> Not available <sup>3</sup>
<b>Inpatient and Outpatient Hospital Services</b> Hospital and hospital-based services Hospital-based clinics (other than preventive services above) Professional services Outpatient diagnostic services Outpatient lab tests when performed alone (physician and hospital-based services) Outpatient lab tests when performed with another service Physician services Hospital and hospital-based services Outpatient mammography Outpatient X-rays, ultrasounds and other diagnostic tests, such as EEGs and EKGs CT scans, MRIs, MRAs and PET scans in any location, including physician's office	20% after deductible 20% after deductible 20% after deductible  20% after deductible  20% after deductible 20% after deductible 20% after deductible 20% after deductible 20% after deductible 20% after deductible 20% after deductible 20% after deductible 20% after deductible 20% after deductible	50% after deductible 50% after deductible 50% after deductible  50% after deductible  50% after deductible 50% after deductible 50% after deductible 30% after deductible 50% after deductible 50% after deductible

<sup>1</sup> This is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits and programs and does not constitute a contract. Covered medical expenses are subject to plan maximums, limitations and exclusions as described in the policy. The PPO network is Blue Options® PPO.

<h1>StudentBlue™</h1>	If you visit your Student Health Center or doctor in the Student Blue network (in-network provider):	If you visit a doctor NOT in the Student Blue network (out-of-network provider):
All dollar amounts and percentages are what you, as a plan member, would pay.		
<b>Urgent Care Centers and Emergency Room</b> Urgent care centers Emergency room visit  (If admitted from the ER, inpatient hospital benefits apply. If held for observation, outpatient benefits apply. See "Inpatient and Outpatient Hospital Services.")	20% after deductible 20% after deductible	50% after deductible 20% after deductible
<b>Ambulatory Surgical Center</b>	20% after deductible	50% after deductible
<b>Prescription Drugs</b> Up to 30-day supply. 31–60 day supply is two copayments and 61–90 day supply is three copayments. MAC B pricing, enhanced formulary. Prior plan approval, step therapy and quantity limits may apply. Preventive over-the-counter medications and contraceptive drugs and devices as listed at <a href="http://BlueCrossNC.com/Preventive">BlueCrossNC.com/Preventive</a> are available at no charge.  For each 30-day supply of a Tier 5 Drug, you will pay a minimum of \$100 in coinsurance, but not more than \$200.	<b>Tier 1:</b> \$4 copayment <b>Tier 2:</b> \$25 copayment <b>Tier 3:</b> \$35 copayment <b>Tier 4:</b> \$75 copayment <b>Tier 5:</b> 25% coinsurance	<b>Tier 1:</b> \$4 copayment <b>Tier 2:</b> \$25 copayment <b>Tier 3:</b> \$35 copayment <b>Tier 4:</b> \$75 copayment <b>Tiers 5:</b> 25% coinsurance
<b>Mental Health and Substance Use Disorders</b> Office visits Inpatient/outpatient	20% after deductible 20% after deductible	50% after deductible 50% after deductible
<b>Pediatric Dental Services*</b> Preventive services Basic and major services Orthodontic services (if medically necessary)  *Pediatric dental is only available for members up through the end of the month they become age 19.	No charge 20% after deductible 20% after deductible	30% after deductible 50% after deductible 50% after deductible
<b>Pediatric Vision Benefit*</b> Routine vision exam Frames and lenses or contact lenses  *Pediatric vision is only available for members up through the end of the month they become age 19. For more information, refer to your benefit booklet.	No charge 20% after deductible	Not covered 20% after deductible
<b>Other Services</b> Skilled nursing facility (60 days per benefit period) Home health care, durable medical equipment and hospice Ambulance Maternity (maternity delivery includes prenatal and post-delivery care) Hospital services (delivery) Professional services (delivery) Transplants Hospital services Professional services Infertility services (combined in-network and out-of-network lifetime maximum of three ovulation induction cycles, with or without insemination, per member for infertility services, provided in all places of service) Primary care provider Specialist Hospital services Inpatient and outpatient professional services	20% after deductible 20% after deductible 20% after deductible  20% after deductible 20% after deductible  20% after deductible 20% after deductible  20% after deductible 20% after deductible 20% after deductible 20% after deductible	50% after deductible 50% after deductible 20% after deductible  50% after deductible 50% after deductible  50% after deductible 50% after deductible
<b>Policy year deductible</b>	\$300 per insured member	\$600 per insured member
<b>Policy year out-of-pocket maximum</b>	\$4,000	\$8,000
<b>Therapies</b> Rehabilitative and habilitative therapies (maximums apply to home, office and outpatient settings): Physical/occupational, 30 visits per benefit period; speech therapy, 30 visits per benefit period; adaptive behavior treatment not covered for students.	<b>Primary Care Provider and/or Specialist:</b> 20% after deductible	<b>Primary Care Provider and/or Specialist:</b> 50% after deductible

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 **VISIT** [StudentBlueNC.com/Elon](https://StudentBlueNC.com/Elon)

 **CONNECT** @BCBSNCStudent

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides free aids to service people with disabilities as well as free language services for people whose primary language is not English. Please contact the Customer Service number on the back of your ID card for assistance.

*Blue Cross and Blue Shield of North Carolina (Blue Cross NC) proporciona asistencia gratuita a las personas con discapacidades, así como servicios lingüísticos gratuitos para las personas cuyo idioma principal no es el inglés. Comuníquese con el número para servicio al cliente que aparece en el reverso de su tarjeta del seguro para obtener ayuda.*

#### What is Not Covered?

The following are summaries of some of the coverage restrictions. A full explanation and listing of restrictions can be found in your benefit booklet. Your health benefit plan does not cover services, supplies, drugs or charges that are:

- Not medically necessary
- For injury or illness resulting from an act of war
- For personal hygiene and convenience items
- For inpatient admissions that are primarily for diagnostic studies
- For palliative or cosmetic foot care
- For investigative or experimental purposes
- For cosmetic services or cosmetic surgery except as specifically covered by your health benefit plan
- For custodial care, domiciliary care or rest cures
- For treatment of obesity, except for surgical treatment of morbid obesity, or as specifically covered by your health benefit plan
- For reversal of sterilization
- For treatment of sexual dysfunction not related to organic disease
- For conception by artificial means
- For self-injectable drugs in the provider's office

Deductibles, coinsurance, limitations and exclusions apply to this coverage. Further details of coverage, limitations and exclusions, and terms under which the policy can be continued in force will be provided in your benefit booklet.

Blue Cross NC offers several decision support tools to aid you in making decisions around your health care experience. These tools are offered for your convenience and should be used only as reference tools. You should consult your own legal counsel, tax advisor or personal physician as applicable throughout your health care experience.

Your actual expenses for covered services may exceed the stated coinsurance percentage or copayment amount because actual provider charges may not be used to determine the payment obligations for Blue Cross NC and its members.

\*Pediatric dental and vision are only available for members up through the end of the month they become age 19.

1 Covered in nearly 200 countries and territories worldwide through BlueCard® program. Blue Cross and Blue Shield Association Internal Data: [about.geo-blue.com/](https://about.geo-blue.com/) (Accessed July 2022). BlueCard coverage varies for each BCBS plan. For more complete details, including benefits, limitations and exclusions, please refer to your certificate of coverage.

2 Premium due for student coverage must be paid through the student's Elon University account.

3 Colorectal screening, bone mass measurement, newborn hearing screening, prostate-specific antigen tests (PSAs), gynecological exams, cervical cancer screening, ovarian cancer screening and screening mammograms are state-mandated and also covered out-of-network.

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