Be advised that you may be eligible for coverage under a group health plan of a parent’s employer or under a parent’s individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent’s employer plan or the parent’s individual health insurance issuer for more information.

Self-funded student health plans, such as the NUSHP, are not subject to regulation under the Patient Protection and Affordable Care Act (ACA). NUSHP is voluntarily including in its program benefits that are designed to meet or exceed requirements that would otherwise apply to fully insured student health insurance programs.
Your Choice

Know How to Receive the Highest Level of Coverage.

You receive the highest level of benefits under this plan when you choose preferred providers. These are called your “in-network” benefits. You can also choose a non-preferred provider, usually at a lower level of benefits. These are called your “out-of-network” benefits. With this health care plan, you can go almost anywhere for health care. However, your costs are lower if you use the services of preferred providers in our network.

When You Choose Preferred Providers.

After a $250 per-admission copayment, you pay 10 percent co-insurance for most inpatient hospital, physician, and other provider-covered services. You also pay 10 percent co-insurance for some outpatient services, and for some outpatient services you pay a $25 copayment for each visit. You pay a $20 copayment for services received at Fenway Health. The copayment does not apply to preventive care services (see chart on opposite and back pages).

When the money paid for the 10 percent co-insurance reaches $3,500 for a member in a plan year, benefits for that member will be provided in full, based on the allowed charge, for the rest of that plan year. (If you are not sure when your plan year begins, contact your plan sponsor.) Your in-network copayments do not count toward your co-insurance maximum. If you reach your co-insurance maximum, you must still pay your copayment when it applies.

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 benefit, in most situations, will be covered at the out-of-network level, even if the preferred provider refers you.

When You Choose Non-Preferred Providers.

You must meet a deductible for all out-of-network services each plan year before you can receive coverage for benefits under this plan. Your deductible is calculated on a plan-year basis. Your plan year begins on September 1 and ends on August 31 of each year. Your deductible is the first $250 of covered charges per member each plan year. After your deductible has been met, you pay 20 percent co-insurance for most out-of-network covered services.

When the money paid for the 20 percent co-insurance reaches $7,000 for a member in a plan year, benefits for that member will be provided in full, based on the allowed charge, for the rest of that plan year.

Your Benefit Description describes your deductible, co-insurance maximum, and allowed charges.

How to Find a Preferred Provider.

There are several ways to find a preferred provider:

- Look up a provider in the preferred provider directory. If you need a copy of your provider directory, call Member Service at the number on your ID card.
- Visit the Blue Cross Blue Shield of Massachusetts website at www.bluecrossma.com for Massachusetts providers.
- Call the BlueCard® Program at 1-800-810-BLUE (2583), 24 hours a day, 7 days a week.

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 Benefit Description and riders. If you do not notify Blue Cross Blue Shield and receive pre-approval, your benefits may be reduced or denied.

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 $50 copayment, plus 10 percent co-insurance, for in-network or out-of-network emergency room services. There is no deductible for these services.

Dependent Benefits.

You may purchase this health care plan for your spouse and/or unmarried dependent children until age 26. Please visit www.northeastern.edu/nushp or e-mail NUSHP@neu.edu for additional information. Enrollment forms are available on our website.

The BlueCard® Program.

The BlueCard Program gives you access to in-network benefits throughout the United States. You need only use a BlueCard PPO-participating doctor or hospital and show your ID card when you seek care. There are no claims to submit, no paperwork, and no up-front costs. You simply pay your copayment, co-insurance, and/or deductibles as usual. If you choose to see non-participating providers, you may have to file the claim yourself and benefits will be provided at the out-of-network level.
# Your Medical Benefits

## Plan Specifics

<table>
<thead>
<tr>
<th>Plan Specifics</th>
<th>Your Cost In-Network</th>
<th>Your Cost Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan-year deductible</td>
<td>None</td>
<td>$250 per member</td>
</tr>
<tr>
<td>Plan-year co-insurance maximum</td>
<td>$3,500 per member</td>
<td>$7,000 per member</td>
</tr>
</tbody>
</table>

## Covered Services

### Preventive Care

Well-child care visits, including related tests, according to age-based schedule as follows:
- Six visits during the first year of life
- Three visits during the second year of life
- One visit per plan year from age 2 through age 18

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine adult physical exams, including related tests, for members age 19 or older (one per plan year)</td>
<td>No cost</td>
<td>20% co-insurance after deductible</td>
</tr>
<tr>
<td>Routine GYN exam (one per plan year), including related lab tests</td>
<td>No cost</td>
<td>20% co-insurance after deductible</td>
</tr>
<tr>
<td>Routine hearing exam</td>
<td>No cost</td>
<td>20% co-insurance after deductible</td>
</tr>
<tr>
<td>Family planning services—office visits</td>
<td>No cost</td>
<td>20% co-insurance after deductible</td>
</tr>
</tbody>
</table>

### Other Outpatient Care

- Emergency room visits: $50 per visit (waived if admitted or for observation stay), plus 10% co-insurance.

### Other Outpatient Care (continued)

- Medical care visits for infertility services: $25 per visit*.
- Clinic visits; physicians’, podiatrists’, and office visits for medical care services: $25 per visit*.
- Chiropractic medical care services: Covered up to $1,500 benefit limit per plan year, combined with short-term rehabilitation therapy: $25 per visit and all charges beyond the plan-year maximum.
- Short-term rehabilitation therapy (physical and occupational): Covered up to $1,500 benefit limit per plan year, combined with chiropractic services: $25 per visit and all charges beyond the plan-year maximum.
- Allergy injections: $25 per visit.
- Speech, hearing, and language disorder treatment: $25 per visit.
- Diagnostic X-rays, lab tests, and other tests: 10% co-insurance.
- Home health care, including hospice care: 10% co-insurance.
- Durable medical equipment (such as wheelchairs, crutches, hospital beds) and repairs: Covered up to $3,000 benefit limit per plan year: 10% co-insurance and all charges beyond the plan-year maximum.
- Prosthetic devices and repairs: 10% co-insurance.
- Oxygen and equipment for its administration: 10% co-insurance.
- Surgery and related anesthesia (including infertility services):
  - Ambulatory surgical facility: $50 per admission, plus 10% co-insurance***.
  - Office setting: 10% co-insurance***.
- Vision Care Benefits at Fenway Health**
  - Routine vision exam (one per plan year): No cost.
  - Contact lens fitting (one per plan year): $40 per visit.

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* You pay a $20 copayment when this service is performed at Fenway Health.
** No coverage is provided when these services are performed at a facility other than Fenway Health.
*** You pay a $100 copayment for surgeon fees plus 10% co-insurance for removal of impacted teeth (except in an office setting you pay only the 10% coinsurance). There is $2,500 plan-year benefit maximum for removal of impacted teeth (inpatient and outpatient combined).
### Your Medical Benefits (continued)

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Your Cost In-Network</th>
<th>Your Cost Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Care (including maternity care)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital care in general or chronic disease hospital</td>
<td>$250 per admission, plus 10% co-insurance</td>
<td>20% co-insurance after deductible</td>
</tr>
<tr>
<td><strong>Surgical services</strong></td>
<td>$200 copayment, plus 10% co-insurance*</td>
<td>20% co-insurance after deductible</td>
</tr>
<tr>
<td><strong>Care in a skilled nursing facility (up to 100 days per plan year)</strong></td>
<td>$250 per admission, plus 10% co-insurance</td>
<td>20% co-insurance after deductible</td>
</tr>
<tr>
<td><strong>Care in a rehabilitation hospital (up to 60 days per plan year)</strong></td>
<td>$250 per admission, plus 10% co-insurance</td>
<td>20% co-insurance after deductible</td>
</tr>
<tr>
<td><strong>Mental Health and Substance Abuse Treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Biologically based conditions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Inpatient admissions in a general or mental hospital, or substance abuse facility</td>
<td>$250 per admission, plus 10% co-insurance</td>
<td>20% co-insurance after deductible</td>
</tr>
<tr>
<td>- Outpatient visits</td>
<td>$25 per visit***</td>
<td>20% co-insurance after deductible</td>
</tr>
<tr>
<td><strong>Non-biologically based mental conditions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Inpatient admissions in a general hospital</td>
<td>$250 per admission, plus 10% co-insurance</td>
<td>20% co-insurance after deductible</td>
</tr>
<tr>
<td>(up to 60 days per plan year)</td>
<td>$250 per admission, plus 10% co-insurance</td>
<td>20% co-insurance after deductible</td>
</tr>
<tr>
<td>- Outpatient visits (up to 24 visits per plan year)</td>
<td>$25 per visit***</td>
<td>20% co-insurance after deductible</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At designated retail pharmacies</td>
<td>$10 for Tier 1 †</td>
<td>Not covered</td>
</tr>
<tr>
<td>(up to a 30-day formulary supply for each prescription/refill or supply)</td>
<td>$20 for Tier 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$30 for Tier 3</td>
<td></td>
</tr>
<tr>
<td>At Fenway Health retail pharmacy</td>
<td>$5 for Tier 1 †</td>
<td>Not covered</td>
</tr>
<tr>
<td>(up to a 30-day formulary supply for each prescription/refill or supply)</td>
<td>$10 for Tier 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$15 for Tier 3</td>
<td></td>
</tr>
</tbody>
</table>

* You pay a $100 copayment for surgeon fees plus 10% co-insurance for removal of impacted teeth. There is a $2,500 plan-year benefit maximum for removal of impacted teeth (inpatient and outpatient combined).

** Treatment of rape-related mental or emotional disorders and treatment for children under age 19 are covered to the same extent as biologically based conditions.

*** You pay a $20 copayment when the service is performed at Fenway Health Center.

† You pay nothing for Tier 1 oral contraceptives and contraceptive devices from a designated retail pharmacy or Fenway Health retail pharmacy.

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### Northeastern University Health and Counseling Services (UHCS)-Forsyth Building

Eligible* students have full use of the services offered at Northeastern University’s Health and Counseling Services (UHCS) whether they waive or enroll in NUSHP. There is no charge for office visits at UHCS for eligible students.

* undergraduate day and law students (with no additional fee); eligible graduate and College of Professional Studies students who pay the annual UHCS fee of $225.

For more information about UHCS, visit the website at [www.northeastern.edu/uhcs](http://www.northeastern.edu/uhcs) or call 617-373-2772. For benefit questions regarding NUSHP, please email NUSHP@neu.edu.

For more information about enrollment in or waiver of NUSHP, visit the website at [www.northeastern.edu/nushp](http://www.northeastern.edu/nushp).

For more information about BCBSMA coverage, call 1-888-648-0825 or visit the website at [www.bluecrossma.com/nushp](http://www.bluecrossma.com/nushp).

Disclaimer: UHCS is not affiliated with Blue Cross Blue Shield of Massachusetts. Information regarding UHCS was provided by Northeastern University for UHCS.

Limitations and Exclusions. These pages highlight some of the benefits of your health care plan. The Benefit Description, along with any riders, defines the full terms and conditions of your coverage. Should any questions arise concerning benefits, the Benefit Description and riders will govern. Some of the services we don’t cover are: custodial care; cosmetic surgery; hearing aids; most dental care; vision care services; and any services covered by workers’ compensation. For a complete listing of limitations and exclusions, refer to your Benefit Description. Please note: Blue Cross and Blue Shield of Massachusetts, Inc., administers claims payment only and does not assume financial risk for claims.

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