Northeastern University: Student Health Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 09/01/2016 -08/31/2017

Coverage for: Individual and Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bluecrossma.com or by calling **1-888-648-0825**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0** in-network; **$250** per member out-of-network. Does not apply to in- network prenatal care; emergency room, emergency transportation.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. For Pediatric Dental Benefits **$50** in-network per member / **$150** for three or more members. There are no other specific deductibles.	Some specific services have their own **deductible** you must pay before the plan begins to pay. See the Northeastern University Student Health Plan Schedule of Benefits chart.
Is there an out-of-pocket limit on my expenses?	Yes. For medical benefits **$3,500** member/**$7,000** family in-network, **$7,000** member/$**14,000** family out- of-network; for prescription drug benefits **$1,000** member/**$2,000** family; and for pediatric dental benefits **$350** per member/**$700** or two or more members.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.bluecrossma.com/findadoctor or call **1-800-821-1388** for a list of network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-888-648-0825** or visit us at www.studentbluema.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.bluecrossma.com/sbcglossary or call **1-888-648-0825** to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20/visit at Fenway Health Center; $25 / visit for other covered providers	20% coinsurance	Deductible applies first for out-of-network
	Specialist visit	$20/visit at Fenway Health Center; $25 / visit for other covered providers	20% coinsurance	Deductible applies first for out-of-network
	Other practitioner office visit	$25/chiropractor visit	20% coinsurance/chiropractor visit	Deductible applies first for out-of-network; limited to 12 visits per plan year
	Preventive care/screening/ immunization	No charge	20% coinsurance	Deductible applies first for out-of-network; limited to age-based schedule and / or frequency
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	20% coinsurance	Deductible applies first for out-of-network
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	Deductible applies first for out-of-network

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bluecrossma.com.	Preferred brand drugs	$10/retail supply at Fenway Health Center; $20/retail supply at other covered pharmacies; or $60 mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs. Coverage may be denied without pre-authorization
	Non-preferred brand drugs	$15/retail supply at Fenway Health Center; $30/retail supply at other covered pharmacies; or $90 mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs. Coverage may be denied without pre-authorization
	Specialty drugs	Tier 1: $5 copayment at Fenway Health Center, otherwise $10 copayment; $30 mail service Tier 2: $10 copayment at Fenway Health Center, otherwise $20 copayment; $60 mail service supply Tier 3: $15 copayment at Fenway Health Center, otherwise $30 copayment; $90 mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply. When obtained from a designated specialty pharmacy; pre-authorization required for certain drugs. Coverage may be denied without pre-authorization
If you have outpatient surgery.	Facility fee (e.g., ambulatory surgery center)	$50/admission, then 10% coinsurance	20% coinsurance	Deductible applies first for out-of-network
	Physician/surgeon fees	10% coinsurance	20% coinsurance	Deductible applies first for out-of-network
If you need immediate medical attention	Emergency room services	$50/admission, then 10% coinsurance	$50/admission, then 10% coinsurance	Copayment waived if admitted or for observation stay
	Emergency medical transportation	$200 copayment per day	$200 copayment per day	—— none ——
	Urgent care	$20/visit at Fenway Health Center; $25/visit for other covered providers	20% coinsurance	Deductible applies first for out-of-network

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	$250/admission, then 10% coinsurance	20% coinsurance	Deductible applies first for out-of-network. Coverage may be denied without pre-authorization
	Physician/surgeon fee	$200/admission, then 10% coinsurance; $100/admission then 10% coinsurance for removal of impacted wisdom teeth	20% coinsurance	Deductible applies first for out-of-network. Coverage may be denied without pre-authorization
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20/visit at Fenway Health Center; $25/ visit for other covered providers	20% coinsurance	Deductible applies first for out-of-network. Coverage may be denied without pre-authorization
	Mental/Behavioral health inpatient services	$250/admission, then 10% coinsurance	20% coinsurance	Deductible applies first for out-of-network. Coverage may be denied without pre-authorization
	Substance use disorder outpatient services	$20/visit at Fenway Health Center; $25 visit for other covered providers	20% coinsurance	Deductible applies first for out-of-network; pre-authorization is not required at a hospital or other certified or licensed facility by the Massachusetts Department of Public Health
	Substance use disorder inpatient services	$250 admission, then 10% coinsurance	20% coinsurance	Deductible applies first for out-of-network; pre-authorization is not required at a hospital or other certified or licensed facility by the Massachusetts Department of Public Health
If you are pregnant	Prenatal and postnatal care	No charge for prenatal care; 10% coinsurance for postnatal care	20% coinsurance	Deductible applies first for out-of-network
	Delivery and all inpatient services	$250/admission, then 10% coinsurance	20% coinsurance	Deductible applies first for out-of-network

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	Deductible applies first for out-of-network
	Rehabilitation services	$25/visit	20% coinsurance	Deductible applies first for out-of-network; limited to 60 visits per plan year (other than for home health care, autism and speech therapy)
	Habilitation services	$25/visit	20% coinsurance	Deductible applies first for out-of-network; rehabilitation therapy coverage limits apply; coverage limit waived for early intervention services for eligible children
	Skilled nursing care	$250 admission, then 10% coinsurance	20% coinsurance	Deductible applies first for out-of-network; limited to 100 days per plan year
	Durable medical equipment	10% coinsurance	20% coinsurance	Deductible applies first for out-of-network; in-network cost share waived for one breast pump per birth
	Hospice service	10% coinsurance	20% coinsurance	Deductible applies first for out-of-network
If your child needs dental or eye care	Eye exam	No charge at Fenway Health Center; not covered for other providers	Not covered	Limited to one exam per plan year
	Glasses	1 pair per plan year. $40 for contact lens fitting at Fenway Health center; not covered for other providers	Not covered	—— none ——
	Dental check-up	No charge	Not covered	Limited to members under age 19, twice in 12 months

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Private-duty nursing

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care (12 visits per plan year)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)- covered at Fenway Health Center only (one exam per plan year)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs (three months in qualified program(s) per contract per calendar year)

Your Rights to Continue Coverage:

You are eligible for coverage under this qualified Student Health Plan as long as you are a regular, registered student (or a student taking 27 or more units) at Northeastern University. If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-888-648-0825. You may also contact your state insurance department at 1-888-444-3272.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. To request an internal formal appeal or grievance review, you (or your authorized representative) have three options. The preferred option is for you to send your request for an appeal or a grievance review in writing to: Member Appeal and Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Or, you may fax your request to 1-617-249-3616 or contact by email or a toll free telephone call. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on your ID card or contact your plan sponsor at 1-888-648-0825.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-648-0825.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-648-0825.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-648-0825.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-648-0825.

----------To see examples of how this plan might cover costs for a sample medical situation, see the next page.----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,340
- **Patient pays** $1,200

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$300
Coinsurance	$800
Limits or exclusions	$100
Total	**$1,200**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,100
- **Patient pays** $1,300

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$1,200
Coinsurance	$20
Limits or exclusions	$80
Total	**$1,300**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums.**
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers** If the patient had received care from out-of-network **providers** costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles, copayments,** and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium,** the more you'll pay in out-of-pocket costs, such as **copayments., deductibles,** and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expense.