BlueCross® BlueShield®

SUMMARY OF BENEFITS

PPO Student Health Plan

2017- 2018 Academic Year

Northeastern University Student Health Plan

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.

NUshp
Northeastern University
Student Health Plan

Northeastern University

This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect as of January 1, 2014, as part of the Massachusetts Health Care Reform Law.

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 coinsurance for most inpatient hospital, physician, and other provider-covered services. You also pay 10 percent coinsurance 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).

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.

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 coinsurance for most out-of-network covered services 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 out-of-pocket maximum for medical benefits is $3,500 per member (or $7,000 per family) for in-network services and $7,000 per member (or $14,000 per family) for out-of-network services. Your out-of-pocket maximum for prescription drug benefits 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 $50 copayment, plus 10 percent coinsurance, for in-network or out-of-network emergency room services. 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 Benefit Description and riders. If you do not notify Blue Cross Blue Shield and receive pre-approval, your benefits may be reduced or denied.

Dependent Benefits.

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

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.

- For more information about UHCS, visit the website at www.northeastern.edu/uhcs or call 617-373-2772. For benefit questions regarding NUSHP, please email NUSHP@northeastern.edu.
- For more information about enrollment in or waiver of NUSHP, visit the website at www.northeastern.edu/nushp.
- For more information about BCBSMA coverage, call 1-888-648-0825 or visit the website at www.bluecrossma.com/nushp.

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

* 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.

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	None	$250 per member
Plan-year out-of-pocket maximum	$3,500 per member $7,000 per family	$7,000 per member $14,000 per family
Preventive Care Well-child care visits, including related tests, according to age-based schedule as follows: • 6 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	20% coinsurance after deductible
Routine adult physical exams, including related tests, for members age 19 or older (one per plan year)	Nothing	20% coinsurance after deductible
Routine GYN exam (one per plan year), including related lab tests	Nothing	20% coinsurance after deductible
Routine hearing exam	Nothing	20% coinsurance after deductible
Family planning services–office visits	Nothing	20% coinsurance after deductible
Other Outpatient Care Emergency room visits	$50 per visit (waived if admitted or for observation stay), plus 10% coinsurance	$50 per visit (waived if admitted or for observation stay), plus 10% coinsurance, no deductible
Medical care visits for infertility services	$25 per visit*	20% coinsurance after deductible
Clinic visits; physicians', podiatrists', and office visits for medical care services	$25 per visit*	20% coinsurance after deductible
Chiropractic medical care services (up to 12 visits per plan year)	$25 per visit	20% coinsurance after deductible
Short-term rehabilitation therapy - physical & occupational (up to 60 visits per plan year**)	$25 per visit	20% coinsurance after deductible
Allergy injections	$25 per visit	20% coinsurance after deductible
Speech, hearing, and language disorder treatment (see below for benefits for diagnostic X-rays and lab tests)	$25 per visit	20% coinsurance after deductible
Diagnostic X-rays, lab tests, and other tests	10% coinsurance	20% coinsurance after deductible
Home health care, including hospice care	10% coinsurance	20% coinsurance after deductible
Durable medical equipment (such as wheelchairs, crutches, hospital beds) and repairs	10% coinsurance***	20% coinsurance after deductible
Prosthetic devices and repairs	10% coinsurance	20% coinsurance after deductible
Oxygen and equipment for its administration	10% coinsurance	20% coinsurance after deductible
Surgery and related anesthesia (including infertility services) • Ambulatory surgical facility • Office setting	$50 per admission, plus 10% coinsurance†	20% coinsurance after deductible 20% coinsurance after deductible
Mental Health and Substance Abuse Treatment Biologically based conditions • Inpatient admissions in a general or mental hospital, or substance abuse facility • Outpatient visits	$250 per admission, plus 10% coinsurance $25 per visit*	20% coinsurance after deductible 20% coinsurance after deductible
Non-biologically based mental conditions • Inpatient admissions in a general hospital • Inpatient admissions in a mental hospital • Outpatient visits	$250 per admission, plus 10% coinsurance $250 per admission, plus 10% coinsurance $25 per visit*	20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible
Vision Care Benefits at Fenway Health†† Routine vision exam (one per plan year)	Nothing	
Contact lens fitting (one per plan year)	$40 per visit	

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

** 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

† You pay a $100 copayment for surgeon fees plus 10% coinsurance for removal of impacted teeth (except in an office setting you pay only the10% coinsurance).

†† No coverage is provided when these services are performed at a facility other than Fenway Health.

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Inpatient care (including maternity care) General or chronic disease hospital care (as many days as medically necessary)	$250 per admission, plus 10% coinsurance	20% coinsurance after deductible
Surgical services	$200 copayment, plus 10% coinsurance*	20% coinsurance after deductible
Care in a skilled nursing facility (up to 100 days per plan year)	$250 per admission, plus 10% coinsurance	20% coinsurance after deductible
Care in a rehabilitation hospital (up to 60 days per plan year)	$250 per admission, plus 10% coinsurance	20% coinsurance after deductible
Prescription Drug Benefits**		
Plan-year out-of-pocket maximum	$1,000 per member $2,000 per family	
At designated retail pharmacies (up to a 30-day formulary supply for each prescription/refill or supply)	$10 for Tier 1*** $20 for Tier 2 $30 for Tier 3	Not covered
At Fenway Health retail pharmacy (up to a 30-day formulary supply for each prescription/refill or supply)	$5 for Tier 1*** $10 for Tier 2 $15 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 $90 for Tier 3	Not covered

* You pay a $100 copayment for surgeon fees plus 10% coinsurance for removal of impacted teeth.
** Cost share waived for certain orally-administered anticancer drugs.
*** You pay nothing for Tier 1 oral contraceptives and contraceptive devices from a designated retail pharmacy or Fenway Health retail pharmacy.

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 benefit description. ** Out-of-network benefits are not provided for dental services.

Get the Most from Your Plan.

Visit us at www.bluecrossma.com/membercentral or call 1-888-648-0825 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 benefit description 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 benefit description for	Reimbursement for up to 3 months participation fees per individual or family per calendar year
Blue Care Line℠—A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE	No additional charge

Questions? Call 1-888-648-0825.

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. The benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; hearing aids; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders.

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