BLUE CARE® ELECT
Northeastern University Student Health Plan

2021 – 2022 Academic Year

UNLOCK THE POWER OF YOUR PLAN
MyBlue gives you an instant snapshot of your plan:

- COVERAGE AND BENEFITS
- CLAIMS AND BALANCES
- DIGITAL ID CARD

Sign in
Download the app, or create an account at bluecrossma.com.

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.

This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.
When You Choose Preferred Providers
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. See the charts for your cost share.

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 are referred to 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
To find a preferred provider:

• Look up a provider in the Provider Directory. If you need a copy of your directory or help choosing a provider, call the Member Service number on your ID card.

• Visit the Blue Cross Blue Shield of Massachusetts website at bluecrossma.com/findadoctor

When You Choose Non-Preferred Providers
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. See the charts for your cost share.

You must pay a plan-year deductible before you can receive coverage for most out-of-network benefits under this plan. Your plan year begins on September 1 and ends on August 31 of each year. Your deductible is $250 per member.

Payments for out-of-network benefits are based on the Blue Cross Blue Shield allowed charge as defined in your benefit description. 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 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 maximums for medical benefits are $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. Any amount applied toward the in-network medical out-of-pocket maximum will also be applied toward the out-of-network medical out-of-pocket maximum (and vice versa). 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 copayment and coinsurance per visit for in-network or out-of-network emergency room services. The copayment is waived if you are admitted to the hospital or for an observation stay. See the chart for your cost share.

Telehealth Services
You are covered for certain medical and mental health services for conditions that can be treated through video visits from an approved telehealth provider. Most telehealth services are available by using the Wel Connection website at wellconnection.com on your computer, or the Well Connection app on your mobile device, when you prefer not to make an in-person visit for any reason to a doctor or therapist. Some providers offer telehealth services through their own video platforms. For a list of telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at bluecrossma.com, consult the Provider Directory, or call the Member Service number on your ID card.

Utilization Review Requirements
Certain services require pre-approval/prior authorization through Blue Cross Blue Shield of Massachusetts for you to have benefit coverage; this includes non-emergency and non-maternity hospitalization and may include certain outpatient services, therapies, procedures, and drugs. You should work with your health care provider to determine if pre-approval is required for any service your provider is suggesting. If your provider, or you, don’t get pre-approval when it’s required, your benefits will be denied, and you may be fully responsible for payment to the provider of the service. Refer to your benefit description for requirements and the process you should follow for Utilization Review, including Pre-Admission Review, Pre-Service Approval, Concurrent Review and Discharge Planning, and Individual Case Management.

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@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@neu.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 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 Essential Dental Benefits
Your medical plan coverage includes a separate dental policy that covers pediatric essential dental benefits for members until the end of the calendar month in which they turn age 19 as required by federal law.

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 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 enrolled under the same family membership).

To find participating dental providers, visit the Blue Cross Blue Shield of Massachusetts website at bluecrossma.com/findadoctor or call the Member Service number on your ID card.
### Preventive Care

<table>
<thead>
<tr>
<th>Service</th>
<th>Your Cost In-Network</th>
<th>Your Cost Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive care</td>
<td>Nothing</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Six visits during the first year of life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Three visits during the second year of life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two visits for age 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One visit per plan year for age 3 and older</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine physical exams, including related tests (one per plan year)</td>
<td>Nothing</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Routine GYN exams, including related tests</td>
<td>Nothing</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Routine hearing exams, including related tests</td>
<td>Nothing</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Vision supplies (one set of prescription lenses and/or frames or contact lenses per plan year until the end of the month a member turns age 19)</td>
<td>35% coinsurance</td>
<td>55% coinsurance after deductible</td>
</tr>
<tr>
<td>Family planning services–office visits</td>
<td>Nothing</td>
<td>20% coinsurance after deductible</td>
</tr>
</tbody>
</table>

### Outpatient Care

<table>
<thead>
<tr>
<th>Service</th>
<th>Your Cost In-Network</th>
<th>Your Cost Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room visits</td>
<td>$50 per visit (waived if admitted or for observation stay), then 10% coinsurance</td>
<td>$50 per visit (waived if admitted or for observation stay), then 10% coinsurance, no deductible</td>
</tr>
<tr>
<td>Clinic visits, physicians’, podiatrists’, and office visits for medical care services</td>
<td>$25 per visit*</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Medical care visits for infertility services</td>
<td>$25 per visit*</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Telehealth services for simple medical conditions or mental health</td>
<td>$10 per visit</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Chiropractic medical care services</td>
<td>$25 per visit</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Acupuncture visits (up to 12 visits per plan year)</td>
<td>$25 per visit</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Allergy injections</td>
<td>$25 per visit</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Short-term rehabilitation therapy–physical and occupational (up to 60 visits for rehabilitation services and 60 visits for habilitation services per plan year**)</td>
<td>$25 per visit</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Speech, hearing, and language disorder treatment–speech therapy (see below for benefits for diagnostic X-rays and lab tests)</td>
<td>$25 per visit</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Diagnostic X-rays and lab tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests</td>
<td>10% coinsurance</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Home health care and hospice services</td>
<td>10% coinsurance</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Oxygen and equipment for its administration</td>
<td>10% coinsurance</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Durable medical equipment–such as wheelchairs, crutches, and hospital beds</td>
<td>10% coinsurance****</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Prosthetic devices</td>
<td>10% coinsurance</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Surgery and related anesthesia</td>
<td>10% coinsurance</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Biologically based conditions</td>
<td>$25 per visit*</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Non-biologically based mental conditions</td>
<td>$25 per visit*</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Vision Care Benefits at Fenway Health††</td>
<td>Nothing</td>
<td>Not covered</td>
</tr>
<tr>
<td>Routine vision exams (one per plan year)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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* 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.

*** 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 the 10% coinsurance). There is a $2,500 plan-year benefit maximum for removal of impacted teeth (inpatient and outpatient combined).

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

<table>
<thead>
<tr>
<th>Inpatient Care (including maternity care)</th>
<th>Your Cost In-Network</th>
<th>Your Cost Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>General or chronic disease hospital care (as many days as medically necessary)</td>
<td>$250 per admission, then 10% coinsurance</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Surgical services</td>
<td>$250 per admission, then 10% coinsurance*</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Rehabilitation hospital care (up to 60 days per plan year)</td>
<td>$250 per admission, then 10% coinsurance</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Skilled nursing facility care (up to 100 days per plan year)</td>
<td>$250 per admission, then 10% coinsurance</td>
<td>20% coinsurance after deductible</td>
</tr>
</tbody>
</table>

### Prescription Drug Benefits**

- **At designated retail pharmacies** *(up to a 30-day formulary supply for each prescription or refill)***
  - $10 for Tier 1
  - $20 for Tier 2
  - $30 for Tier 3
- **At Fenway Health retail pharmacy** *(up to a 30-day formulary supply for each prescription or refill)***
  - $5 for Tier 1
  - $10 for Tier 2
  - $15 for Tier 3
- **Through the designated mail order or designated retail 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

* You pay a $100 copayment for surgeon fees plus 10% coinsurance for removal of impacted teeth. There is a $2,500 plan-year benefit maximum for removal of impacted teeth (inpatient and outpatient combined).
* * Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred brand-name drugs.
** Cost share may be waived for certain covered drugs and supplies.
† Certain generic medications are available through the mail order pharmacy at $9. For more information, go to bluecrossma.com/mail-order-pharmacy.

### Get the Most from Your Plan

- **Wellness Participation Program**
  - **Fitness Reimbursement**: a program that rewards participation in qualified fitness programs. This fitness program applies for fees paid to: a health club with cardiovascular and strength-training equipment; a fitness studio offering instructor-led group classes for cardiovascular and strength-training; or virtual fitness memberships or classes. (See your benefit description for details.)
  - **Weight Loss Reimbursement**: a program that rewards participation in a qualified weight loss program. This weight loss program applies for fees paid to: hospital-based or non-hospital-based weight loss programs that focus on eating and physical activity habits and behavioral/lifestyle counseling with certified health professionals. (See your benefit description for details.)

- **24/7 Nurse Line**: A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583). No additional charge.

### Pediatric Essential Dental Benefits*

- **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 covered services are limited to members until the end of the month they turn age 19, and may be subject to an age-based schedule or frequency. For a complete list of covered services or additional information, refer to your benefit description.
** There are no out-of-network benefits for dental services.

### QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-888-648-0825, or visit us online at bluecrossma.org/studentbluema.
Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. It does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

**BLUE CROSS BLUE SHIELD OF MASSACHUSETTS PROVIDES:**

- Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print or other formats).

- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call Member Service at the number on your ID card.

If you believe that Blue Cross Blue Shield of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with the Civil Rights Coordinator by mail at Civil Rights Coordinator, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126; phone at 1-800-472-2689 (TTY: 711); fax at 1-617-246-3616; or email at civilrightscoordinator@bcbsma.com.

If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, online at ocrportal.hhs.gov; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, DC 20201; by phone at 1-800-368-1019 or 1-800-537-7697 (TDD).

Complaint forms are available at hhs.gov.
PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES

Spanish/Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

Portuguese/Português: ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).

Chinese/简体中文: 注意：如果您讲中文，我们可向您免费提供语言协助服务。请拨打您 ID 卡上的号码联系会员服务部（TTY 号码：711）。

Haitian Creole/Kreyòl Ayisyen: ATANSYON: Si ou pale kreyòl ayisyen, sèvis asistans nan lang disponib pou ou gratis. Rele nimewo Sèvis Manm nan ki sou kat Idantitifikasyon w lan (Sèvis pou Malantandan TTY: 711).


Arabic/العربية: احتذار: إذا كنت تتحدث اللغة العربية، فتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هوية (جهاز الهاتف التصني للصم والبكم) 711.

Mon-Khmer, Cambodian/ខ្មែរ: ការជំនួយ៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ បានក្លាយជាអត្ថបស់ដុះនៅក្នុងសេដ្ឋកិច្ច អ្នកអាចទទួលបានសេវាកម្មនេះល្អប្រសើរដោយប្រើសេវាកម្មនេះក្នុងការប្រើការសម្រាប់អត្ថបស់អ្នក។ សូមទូរស័ព្ទបៅខ្្នកបសវាសរាជិកតាមបេ្ (TTY: 711)។


Italian/Italiano: ATTENZIONE: se parlate italiano, sono disponibili per voi servizi gratuiti di assistenza linguistica. Chiamate il Servizio per i membri al numero riportato sulla vostra scheda identificativa (TTY: 711).


Greek/Ελληνικά: ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε την Υπηρεσία Εξυπηρέτησης Μελών στον αριθμό της κάρτας μέλους σας (ID Card) (TTY: 711).