BlueCross® BlueShield®

SUMMARY OF BENEFITS

Blue Choice New England®

Northeastern University - Core Plan

Northeastern University

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.

Your Care

Your Primary Care Provider (PCP)

When you enroll in Blue Choice New England, you choose a primary care provider (PCP) for you and each member of your family. There are a few ways to find a PCP: visit the Blue Cross Blue Shield of Massachusetts website at **www.bluecrossma.com**; consult the Provider Directory; or call the Physician Selection Service at **1-800-821-1388**. If you have trouble choosing a doctor, the Physician Selection Service can help. They can give you the doctor's gender, the medical school she or he attended, and whether there are languages other than English spoken in the office.

Your PCP is the first person you call when you need routine or sick care. If your PCP decides that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist who is likely affiliated with your PCP's hospital or medical group. Your provider may also work with Blue Cross Blue Shield of Massachusetts regarding Utilization Review Requirements, including Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. For detailed information about Utilization Review, see your subscriber certificate.

When your care is provided or arranged by your PCP or by a network provider, you must pay a calendar-year deductible before benefits are provided. The calendar-year deductible begins on January 1 and ends on December 31 of each year. The deductible is **$250** for each member (or **$500** per family).

You're protected by an out-of-pocket maximum. Your out-of-pocket maximum is the most that you could pay during a calendar year for deductible, copayments (including prescription drug copayments) and coinsurance for covered services. Your out-of-pocket maximum is **$2,500** per member (or **$5,000** per family).

When You Choose to Receive Care on Your Own (Self-Referred)

Your health care plan also allows you to seek most care without a referral from your primary care provider, at a lower level of coverage. When you choose to seek care on your own from a participating provider, your out-of-pocket cost will be greater. If you require hospitalization, you, or someone on your behalf, will need to call us before you're admitted to make sure that you're covered.

When you receive care without a referral from your PCP, you may have additional out-of-pocket expenses. You must pay a calendar-year deductible before benefits are provided. The deductible is **$500** per member (or **$1,000** per family).

You're protected by an out-of-pocket maximum of **$4,000** per member (or **$8,000** per family). Your out-of-pocket maximum is the most that you could pay during a calendar year for deductible, copayments, and coinsurance for covered services. This out-of-pocket maximum is separate from the PCP/plan-approved out-of-pocket maximum. Your PCP/plan-approved out-of-pocket maximum does not count toward your self-referred out-of-pocket maximum.

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 per visit for emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay. See the chart on the opposite page for your cost share.

Telehealth Services

You are covered for certain medical and behavioral health services for conditions that can be treated through video visits from an approved Telehealth provider. Telehealth services are available by using your computer or mobile device when you prefer not to make an in-person visit for any reason to a doctor or therapist. For a list of Telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at **www.bluecrossma.com**; consult the Provider Directory; or call the Physician Selection Service at **1-800-821-1388**.

Service Area

The plan's service area includes all cities and towns in the Commonwealth of Massachusetts, State of Rhode Island, State of Vermont, State of Connecticut, State of New Hampshire, and State of Maine.

When Outside the Service Area

If you're traveling outside the plan's service area and you need urgent or emergency care, you should go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. To receive the highest level of benefits, any additional follow-up care must be arranged by your PCP.

Dependent Benefits

This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. See your subscriber certificate (and riders, if any) for exact coverage details.

Domestic Partner Coverage

Domestic partner coverage may be available for eligible dependents. Contact your plan sponsor for more information.

Your Medical Benefits

Covered Services	Your Cost For PCP/Plan-Approved Benefits	Your Cost For Self-Referred Benefits
Preventive Care Well-child care visits	Nothing, no deductible	30% coinsurance after deductible
Routine adult physical exams, including related tests	Nothing, no deductible	30% coinsurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible	30% coinsurance after deductible
Routine hearing exams	Nothing, no deductible	30% coinsurance after deductible
Hearing aids (up to $2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum, no deductible	30% coinsurance after deductible and all charges beyond the maximum
Routine vision exams (one per calendar year)	Nothing, no deductible	30% coinsurance after deductible
Family planning services–office visits	Nothing, no deductible	30% coinsurance after deductible
Outpatient Care Emergency room visits	$100 per visit, no deductible (waived if admitted or for observation stay)	$100 per visit, no deductible (waived if admitted or for observation stay)
Office visits • When performed by your PCP, OB/GYN physician, network nurse practitioner, or nurse midwife • When performed by other network providers	$25 per visit, no deductible $35 per visit, no deductible	30% coinsurance after deductible 30% coinsurance after deductible
Chiropractors' office visits	$35 per visit, no deductible	30% coinsurance after deductible
Mental health or substance abuse treatment	$25 per visit, no deductible	30% coinsurance after deductible
Short-term rehabilitation therapy–physical and occupational (up to 100 visits per calendar year*)	$35 per visit, no deductible	30% coinsurance after deductible
Speech, hearing, and language disorder treatment–speech therapy	$35 per visit, no deductible	30% coinsurance after deductible
Diagnostic X-rays and lab tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	10% coinsurance after deductible	30% coinsurance after deductible
Home health care and hospice services	10% coinsurance after deductible	30% coinsurance after deductible
Oxygen and equipment for its administration	10% coinsurance after deductible	30% coinsurance after deductible
Durable medical equipment–such as wheelchairs, crutches, hospital beds	10% coinsurance after deductible**	30% coinsurance after deductible
Prosthetic devices	10% coinsurance after deductible	30% coinsurance after deductible
Surgery and related anesthesia • When performed by your PCP, OB/GYN physician, network nurse practitioner, or nurse midwife • When performed by other network providers • Ambulatory surgical facility, hospital, or surgical day care unit	$25 per visit***, no deductible $35 per visit***, no deductible 10% coinsurance after deductible	30% coinsurance after deductible 30% coinsurance after deductible 30% coinsurance after deductible
Inpatient Care (including maternity care) General or chronic disease hospital care (as many days as medically necessary)	10% coinsurance after deductible	30% coinsurance after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	10% coinsurance after deductible	30% coinsurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	10% coinsurance after deductible	30% coinsurance after deductible
Skilled nursing facility care	10% coinsurance after deductible (up to 100 days per calendar year)	30% coinsurance after deductible (up to 100 days per calendar year, less any PCP/plan-approved days used)

* 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.
*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

Prescription Drug Benefits*	Your Cost For PCP/Plan-Approved Benefits**	Your Cost For Self-Referred Benefits
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	No deductible $5 for Tier 1 $30 for Tier 2 $50 for Tier 3	Not covered
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	No deductible $10 for Tier 1 $60 for Tier 2 $100 for Tier 3	Not covered

* Tier 1 generally refers to generic drugs; Tier 2 generally refers to preferred brand-name drugs; Tier 3 refers to non-preferred drugs.
** Cost share may be waived for certain covered drugs and supplies.

Get the Most from Your Plan

Visit us at **www.bluecrossma.com** or call **1-888-543-8770** to learn about discounts, savings, resources,and special programs available to you, like those listed below.

Wellness Participation Program **Reimbursement for a membership at a health club or for fitness classes** This fitness program 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 subscriber certificate for details.)	$150 per calendar year per policy
Reimbursement for participation in a qualified weight loss program This weight loss program 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 subscriber certificate for details.)	$150 per calendar year per policy
Blue Care Line℠—A 24-hour nurse line to answer your health care questions—call **1-888-247-BLUE (2583)**	No additional charge

Questions?

For questions about Blue Cross Blue Shield of Massachusetts, call **1-888-543-8770**, or visit us online at **www.bluecrossma.com**. Interested in receiving information from us 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. Your subscriber certificate and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the subscriber certificate and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your subscriber certificate and riders.

164757BS (9/16) PDF LE

BlueCross® BlueShield®

MASSACHUSETTS

Nondiscrimination Notice

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**.

164264M 55-1487 (8/16)

MASSACHUSETTS

Translation Resources
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 Idantitifkasyon w lan (Sèvis pou Malantandan TTY: **711**).

Vietnamese/Tiếng Việt: LƯU Ý: Nếu quý vị nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cung cấp cho quý vị miễn phí. Gọi cho Dịch vụ Hội viên theo số trên thẻ ID của quý vị (TTY: **711**).

Russian/Русский: ВНИМАНИЕ: если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Позвоните в отдел обслуживания клиентов по номеру, указанному в Вашей идентификационной карте (телетайп: **711**).

Arabic/ةيبر:

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هُويتك (جهاز الهاتف النصي للصم والبكم "TTY": **711**).

Mon-Khmer, Cambodian/ខ្មែរ: ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខ នៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (TTY: **711**)។

French/Français: ATTENTION : si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le Service adhérents au numéro indiqué sur votre carte d'assuré (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**).

Korean/한국어: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드에 있는 전화번호(TTY: **711**)를 사용하여 회원 서비스에 전화하십시오.

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**).

Polish/Polski: UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej. Należy zadzwonić do Działu obsługi ubezpieczonych pod numer podany na identyfikatorze (TTY: **711**).

Hindi/हिंदी: ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए नि:शुल्क उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वाई.: **711**).

Gujarati/ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમને ભાષાકીય સહાયતા સેવાઓ વિના મૂલ્યે ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર આપેલા નંબર પર Member Service ને કૉલ કરો (TTY: **711**).

Tagalog/Tagalog: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tawagan ang Mga Serbisyo sa Miyembro sa numerong nasa iyong ID Card (TTY: **711**).

Japanese/日本語: お知らせ：日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。IDカードに記載の電話番号を使用してメンバーサービスまでお電話ください（TTY: **711**）。

German/Deutsch: ACHTUNG: Wenn Sie Deutsche sprechen, steht Ihnen kostenlos fremdsprachliche Unterstützung zur Verfügung. Rufen Sie den Mitgliederdienst unter der Nummer auf Ihrer ID-Karte an (TTY: **711**).

Persian/پارسیان:
توج: اگر زبان شما فارسی است، خدمات کمک زبانی ب صورت رایگان در اختیار شما قرار می گیرد. با شمار تلفن مندرج بر روی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: **711**).

Lao/ພາສາລາວ: ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: **711**).

Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'déé' nóomba biká'ígíiji' béésh bee hodíílnih (TTY: **711**).

164711MB 55-1493 (8/16)