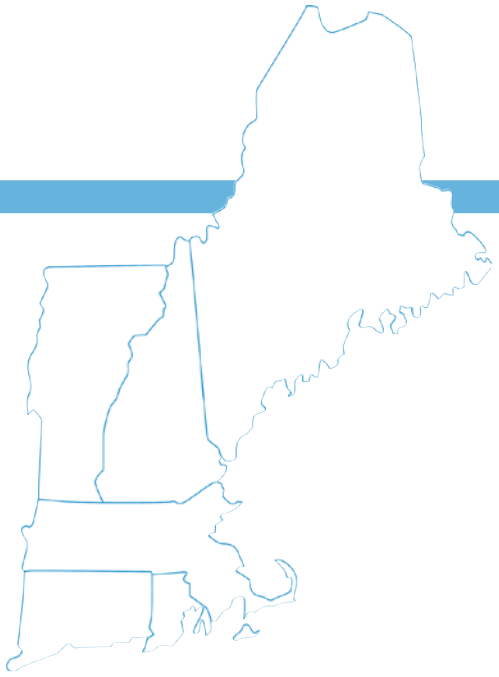
BlueCross®
BlueShield®



Blue Choice New England℠

Summary of Benefits



Northeastern University

This plan is intended to be a "grandfathered" plan under the Patient Protection and Affordable Care Act. For more information, please see the notice included with your Evidence of Coverage package.

This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect as of January 1, 2011, as part of the Massachusetts Health Care Reform Law.

An Association of Independent Blue Cross and Blue Shield Plans

Your Care

Your Primary Care Provider.

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 several ways to find a PCP: visit the Blue Cross Blue Shield of Massachusetts website at **www.bluecrossma.com**; consult the Provider Directory; or call our Physician Selection Service at **1-800-821-1388.** If you have trouble choosing a doctor, the Physician Selection Service can help. We can tell you whether a doctor is male or female, the medical school(s) he or she attended, and if any languages other than English are spoken in the office.

Your PCP is the first person you call when you need routine or sick care (see *Emergency Care–Wherever You Are* for emergency care services). If you and your PCP decide that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist. The specialist will usually be one your PCP knows, probably someone affiliated with your PCP's hospital or medical group. Your provider may also work with Blue Cross Blue Shield concerning the Utilization Review Requirements, which are Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. Information concerning Utilization Review is detailed in your subscriber certificates.

When You Choose to Receive Care on Your Own.

You also have the freedom to seek care without seeing your PCP first. When you 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.

You may have additional out-of-pocket expenses when you receive care without a referral from your PCP. These expenses include the following:

- For self-referred services, 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 **$500** for each member (or **$1,000** per family). After you have met your deductible, you pay **20 percent** co-insurance for covered services.
- When the money you've paid for your 20 percent co-insurance equals **$1,000** for each member in a calendar year (or **$2,000** per family), then your benefits (or your family's benefits) are provided in full, based on the allowed charge, up to any benefit maximums, for the rest of that calendar year. Your PCP/plan-approved copayments do not count toward your co-insurance maximum. You must still pay your copayment when it applies.

Emergency Care–Wherever You Are.

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 **$100** copayment per visit for emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay.

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, 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 up to age 26, regardless of the dependent's financial dependency, student status, or employment status. Please see your subscriber certificate (and riders, if any) for exact coverage details.

Your Medical Benefits

Covered Services	Your Cost For PCP/Plan-Approved Benefits	Your Cost For Self-Referred Major Medical Benefits (after your deductible)
Outpatient Care Emergency room visits	$100 per visit (waived if admitted or for observation stay)	20% co-insurance*
Mental health and substance abuse treatment	$20 per visit	20% co-insurance
Well-child care visits	$20 per visit (no cost for immunizations and routine tests)	20% co-insurance
Routine adult physical exams, including related tests	$20 per visit (no cost for immunizations and routine tests)	20% co-insurance
Routine GYN exams, including related lab tests (one per calendar year)	$20 per visit (no cost for routine tests)	20% co-insurance
Routine hearing exams	$20 per visit	20% co-insurance
Routine vision exams (one per calendar year)	$20 per visit	20% co-insurance
Family planning services–office visits	$20 per visit	20% co-insurance
Office visits	$20 per visit	20% co-insurance
Chiropractor services	$20 per visit	20% co-insurance
Short-term rehabilitation therapy–physical and occupational (up to 60 visits per calendar year**)	$20 per visit	20% co-insurance
Speech, hearing, and language disorder treatment–speech therapy	$20 per visit	20% co-insurance
Allergy injections only	Nothing	20% co-insurance
Diagnostic X-rays, lab tests, and other tests	Nothing	20% co-insurance
Home health care and hospice services	Nothing	20% co-insurance
Oxygen and equipment for its administration	Nothing	20% co-insurance
Prosthetic devices	Nothing	20% co-insurance
Durable medical equipment–such as wheelchairs, crutches, hospital beds (up to $3,000 per calendar year***)	All charges beyond the calendar-year benefit maximum	20% co-insurance and all charges beyond the calendar-year benefit maximum
Surgery and related anesthesia • Office setting • Ambulatory surgical facility, hospital, or surgical day care unit	 Nothing Nothing	 20% co-insurance 20% co-insurance
Inpatient Care (including maternity care) General or chronic disease hospital care (as many days as medically necessary)	Nothing	20% co-insurance
Mental hospital or substance abuse facility care (as many days as medically necessary)	Nothing	20% co-insurance
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing	20% co-insurance
Skilled nursing facility care	Nothing (up to 100 days per calendar year)	20% co-insurance (up to 100 days per calendar year, less any PCP/plan-approved days used)

* If this visit is for emergency care, you will have to pay a $100 copayment per visit only.

** No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care and for the treatment of autism spectrum disorders.

*** No dollar limit applies when durable medical equipment is furnished as part of covered home dialysis, home health care, or hospice services.

Your Medical Benefits (continued)

Covered Services	Your Cost
Prescription Drug Benefits At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	$5 for Tier 1 $25 for Tier 2 $40 for Tier 3
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	$10 for Tier 1 $45 for Tier 2 $75 for Tier 3

Get the Most from Your Plan.

Visit us at **www.bluecrossma.com/membercentral** or call **1-888-543-8770** 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 (see your subscriber certificate for details)	$150 per year, per individual/family
Reimbursement for a Blue Cross Blue Shield of Massachusetts designated weight loss program	$150 per year, per individual/family
Blue Care Line℠ to answer your health care questions 24 hours a day–call **1-888-247-BLUE (2583)**	No additional charge
Healthy You Concierge Care Center—For answers to claims, benefits as well as any health or wellness-related questions call Member Services at **1–888-543-8770**. The nurses in the Care Center are available to support your health care needs, whether that means choosing a doctor or hospital, understanding a diagnosis, medication, or upcoming surgery or procedure, or taking advantage of benefits available through your plan to help you lead a healthier life.	No additional charge

Questions? Call 1-888-543-8770.

For questions about Blue Cross Blue Shield of Massachusetts, visit the website at **www.bluecrossma.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. Your subscriber certificates and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the subscriber certificates 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 subscriber certificates and riders.

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