

NUSHP BENEFIT DESCRIPTION

Blue Care Elect Preferred 90 with Copay

A preferred provider organization (PPO) health plan administered by

Blue Cross and Blue Shield of Massachusetts, Inc.

Northeastern University Student Health Plan (NUSHP)

Web-Site References:

NUSHP: www.bluecrossma.com/nushp

University Health and Counseling Services: www.uhcs.neu.edu

Key terms

Note that the words in this booklet in italics have special meanings and are defined in Part 2.

Welcome to the NUSHP!

This booklet provides you with a description of benefits that are available while you are enrolled under the Northeastern University Student Health Plan (NUSHP). The NUSHP is offered by Northeastern University and administered by *Blue Cross and Blue Shield*. You should read this booklet to familiarize yourself with the NUSHP's main provisions and keep it for future reference.

Understanding your NUSHP coverage is the best way to minimize your *out-of-pocket expenses*. In this regard, students are encouraged to use the University Health and Counseling Service (UHCS) for first-line care for any medical or behavioral health problem, or for acute injury. UHCS serves as a primary care office where the student develops an ongoing relationship with a physician, nurse practitioner, or mental health clinician. Just as in clinical practices in the community, many problems are managed in the office, including the initial evaluation of sports injuries. Other issues may require referral to outside specialists. In either case, the UHCS clinician ensures that the care is of the highest quality. We are fortunate in the Boston area to have an array of world-class clinicians to whom we can refer when needed. We welcome your questions and encourage you to come in to choose a primary care clinician.

Our website, www.uhcs.neu.edu, has additional information that may be helpful to you. For questions about your benefits administered by *Blue Cross and Blue Shield*, you can visit www.bluecrossma.com/nushp.

Regards,

Roberta Berrien, M.D., Executive Director,
University Health and Counseling Services

Northeastern University's Relationship with *Blue Cross and Blue Shield*

Northeastern University retained *Blue Cross and Blue Shield* to provide administrative services for the NUSHP, such as claims processing, individual case management, *utilization review*, quality assurance programs, disease monitoring and management services as selected by Northeastern University, claim review and other related services, and to arrange for a network of health care providers whose services are covered by the NUSHP. The *Blue Cross and Blue Shield* customer service office can help you understand the terms of the NUSHP and what you need to do to get your maximum benefits.

Blue Cross and Blue Shield has entered into a contract with Northeastern University to provide these administrative services for the NUSHP. This contract, including this benefit booklet and any applicable *amendments*, will be governed by and construed according to the laws of the Commonwealth of Massachusetts, except as preempted by federal law.

Blue Cross and Blue Shield of Massachusetts, Inc. (*Blue Cross and Blue Shield*) is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting *Blue Cross and Blue Shield* to use the Blue Cross and Blue Shield Service Marks in the Commonwealth of Massachusetts. *Blue Cross and Blue Shield* has entered into a contract with Northeastern University on its own behalf and not as the agent of the Association.

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Introduction

The Northeastern University Student Health Plan is a self-funded health plan and is financed largely by student and dependent coverage cost contributions. *Blue Cross and Blue Shield* has been retained by Northeastern University to provide administrative services to the NUSHP, such as claims processing, individual case management, *utilization review*, quality assurance programs, disease monitoring and management services as selected by the *group*, claim review and other related services, and to arrange for a network of health care providers whose services are covered by the NUSHP. The name and address of this organization is: **Blue Cross and Blue Shield of Massachusetts, Inc., Landmark Center, 401 Park Drive, Boston, Massachusetts 02215-3326**. These benefits are provided by your *group* on a self-funded basis. *Blue Cross and Blue Shield* is not an underwriter or insurer of the benefits provided by the NUSHP but is providing stop-loss insurance to limit Northeastern University's financial liability.

This Blue Care Elect booklet provides you with a complete description of your benefits while you are enrolled in the NUSHP. You should read this booklet to familiarize yourself with the main provisions and keep it retain it for future reference. The words in italics have special meanings and are described in Part 2. Northeastern University or *Blue Cross and Blue Shield* may change the terms of the NUSHP. If this is the case, the change is described in a *amendment*. Northeastern University can supply you with any *amendments* that apply to your benefits under the NUSHP. Keep any *amendments* with this booklet for easy reference.

Blue Care Elect is a preferred provider organization (PPO) health care plan. This means that you determine the amount of your benefits each time you obtain a health care service. You will receive the highest level of benefits provided by the NUSHP when you use providers in your *preferred provider* network to furnish *covered services*. These are called your “in-network benefits.” When you obtain *covered services* from a covered *non-preferred provider*, you will usually receive a lower level of benefits. If this is the case, your *out-of-pocket expenses* will be more. These are called your “out-of-network benefits.”

Before using your benefits, you should remember there are limitations and exclusions. Limitations and exclusions on your benefits may be found in Parts 3, 4, 5, 6 and 7.

(In this Benefit Description, the term “you” refers to any *member* who has the right to the benefits provided by the NUSHP—the enrolled student or the enrolled spouse or any other enrolled dependent.)

Part 1

Member Services

Network of Health Care Providers

Under the NUSHP, you will receive the highest level of benefits when you use providers in your designated *preferred provider* health care network to furnish *covered services*. When you obtain *covered services* from a covered health care provider that is not in the designated *preferred provider* health care network, you will usually receive a lower level of benefits. If this is the case, your *out-of-pocket expenses* will be more.

Finding a Preferred Provider

Finding a Preferred Provider in Massachusetts. To find a *preferred provider* in Massachusetts, you may use one of the following options to find a *preferred provider*:

- You may call the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your health plan identification card.
- You may call the Physician Selection Service at **1-800-821-1388**.
- You may access the online provider directory on the *Blue Cross and Blue Shield* internet website at **www.bluecrossma.com**.

A copy of the *preferred provider* directory is also available at the University Health and Counseling Service (UHCS), although neither Northeastern University nor *Blue Cross and Blue Shield* warrants that this directory will show current status for all listed providers.

Finding a Preferred Provider Outside of Massachusetts. If you live or are traveling outside of Massachusetts and need health care services, you can check the status of an out-of-state provider or obtain help in finding a *preferred provider* by calling **1-800-810-BLUE**. You can call this telephone number for help finding a provider 24 hours a day. Or, you may access the BlueCard[®] Doctor & Hospital Finder on the internet at **www.bcbs.com**. When you call, you should have your health plan identification card ready. Be sure to let the representative know that you are looking for health care providers in the “BlueCard[®] PPO” program.

Note: For some types of covered health care providers, *Blue Cross and Blue Shield* or the local Blue Cross and/or Blue Shield Plan may not have (in the opinion of *Blue Cross and Blue Shield*) established an adequate *preferred provider* network. If this is the case and you obtain *covered services* from that type of *non-preferred provider*, the NUSHP will provide “in-network benefits” for these *covered services*.

NUSHP Identification Cards

After you enroll in the NUSHP, you will receive a health plan identification card. This card is for identification purposes only. While you are a *member*, you must show your identification card to the health care provider before you receive *covered services*. If your health plan identification card is lost or stolen, you should contact the *Blue Cross and Blue Shield* customer service office. They will send you a new health plan identification card. Or, you may also use the online Member Self Service option that is located on the *Blue Cross and Blue Shield* internet website at www.bluecrossma.com.

Copayment, Deductible and Out-of-Pocket Maximum Features

The NUSHP includes *copayments* for almost all in-network services, a *plan year deductible* applicable to out-of-network services, and *coinsurance*. *Coinsurance* is usually applicable to both in-network and out-of-network services up to an *out-of-pocket maximum* for each *plan year*. You should familiarize yourself with these overall health plan features since they affect the costs that you will pay for services and supplies covered by the NUSHP. For information about the *deductible* feature, including the specific amount, see page 8. For information about *copayments*, see page 7, but for *copayment* amounts and which *covered services* are subject to a *copayment*, see Part 5, “*Covered Services*” of this booklet. Or, for information about the *out-of-pocket maximum* feature, including the specific amount, see page 12.

Making Inquiries and/or Resolving Claim Problems

Calling Member Services. For help to understand your benefits or to resolve a problem or concern, you may call the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your health plan identification card. (Or, to use the Telecommunications Device for the Deaf, call 1-800-522-1254.) A customer service representative will work with you to help you understand your benefits or resolve your problem or concern as quickly as possible.

You can call the *Blue Cross and Blue Shield* customer service office Monday through Friday from 8:00 a.m. to 8:00 p.m. (Eastern Time). Or, you can write to:

Blue Cross and Blue Shield of Massachusetts, Inc.
Member Services
P.O. Box 9134
North Quincy, Massachusetts 02171-9134

Appeals and Formal Grievance Review. See Part 9 for more information about the claim appeals and formal grievance review process.

Requesting Medical Policy Information. To receive the benefits described in this Benefit Description, your treatment must conform to *Blue Cross and Blue Shield* medical policy guidelines that are in effect at the time the services or supplies are furnished. If you have access to a FAX machine, you may request medical policy information by calling the Medical Policy on Demand toll-free service at **1-888-MED-POLI**. Or, you may call the *Blue Cross and Blue Shield* customer service office to request a copy of the information.

Translation Services

Need a Language Translator? A language translator service is available when you call the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your health plan identification card. This service provides you with access to interpreters who are able to translate over 140 different languages. If you need these translation services, just tell the customer service representative when you call. Then during your call, *Blue Cross and Blue Shield* will use the language line service to access an interpreter who will assist in answering your questions or helping you to understand *Blue Cross and Blue Shield* procedures. (This interpreter is not an employee or designee of *Blue Cross and Blue Shield*.)

Part 2

Definitions

The following terms are shown in italics in this Benefit Description and in any *amendments* that apply to your benefits under the NUSHP. These terms will give you a better understanding of your benefits.

Allowed Charge

The charge that is used to calculate payment of your benefits. The *allowed charge* depends on the type of health care provider that furnishes a *covered service* to you.

- ***Preferred Providers.*** For providers that have a preferred payment agreement with *Blue Cross and Blue Shield* or with the local Blue Cross and/or Blue Shield Plan, the *allowed charge* is based on the provisions of that provider's preferred payment agreement. (Blue Cross and/or Blue Shield Plan means an independent corporation or affiliate operating under a license from the Blue Cross and Blue Shield Association.) In general, when you share in the cost for *covered services* (such as a *deductible, copayment* and/or *coinsurance*), the calculation for the amount that you pay is based on the initial full *allowed charge* for the *preferred provider*. This amount that you pay is generally not subject to future adjustments—up or down—even though the *preferred provider's* payment may be subject to future adjustments for such things as provider contractual settlements, risk-sharing settlements and fraud or other operations.
- ***Non-preferred providers with a Local Payment Agreement.*** For *non-preferred providers* outside Massachusetts that have a payment agreement with the local Blue Cross and/or Blue Shield Plan, the *allowed charge* is the “negotiated price” that the local Blue Cross and/or Blue Shield Plan passes on to *Blue Cross and Blue Shield*. In many cases, the negotiated price paid by *Blue Cross and Blue Shield* to the local Blue Cross and/or Blue Shield Plan is a discount from the provider's billed charges. However, a number of local Blue Cross and/or Blue Shield Plans can determine only an estimated price at the time your claim is paid. Any such estimated price is based on expected settlements, withholds, any other contingent payment arrangements and non-claims transactions, such as provider advances, with the provider (or with a specific group of providers) of the local Blue Cross and/or Blue Shield Plan in the area where services are received. In addition, some local Blue Cross and/or Blue Shield Plans' payment agreements with providers do not give a comparable discount for all claims. These local Blue Cross and/or Blue Shield Plans elect to smooth out the effect of their payment agreements with providers by applying an average discount to claims. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. Local Blue Cross and/or Blue Shield Plans that use these estimated or averaging methods to calculate the negotiated price may prospectively adjust their estimated or average prices to correct for overestimating or underestimating past prices. **In**

most cases for *covered services*, you pay only your *copayment, deductible and/or coinsurance*, whichever applies. However, the amount you pay is considered a final price.

- ***Non-preferred providers without a Local Payment Agreement.*** For non-preferred physicians and other professional providers who do not have a payment agreement with *Blue Cross and Blue Shield* or with the local Blue Cross and/or Blue Shield Plan, the *allowed charge* that is used to calculate your benefits is based on the 90th percentile of the Health Insurance Association of America’s (HIAA) schedule of allowed charges. This amount may be less than the provider’s actual charge. **If this is the case, you must pay the amount of the actual charge that is in excess of the *allowed charge*. This is in addition to your *deductible, copayment and/or coinsurance, whichever is applicable*.** For this reason, you may wish to discuss charges with your provider before you receive *covered services*.

For other *non-preferred providers* that do not have a payment agreement with *Blue Cross and Blue Shield* or with the local Blue Cross and/or Blue Shield Plan, the provider’s actual charges are used to calculate your benefits. **For *covered services*, you pay only your *copayment, deductible and/or coinsurance, whichever applies*.**

Pharmacy Providers. *Blue Cross and Blue Shield* may have payment arrangements with pharmacy providers that may result in rebates on covered drugs and supplies. The amount that you pay for a covered drug or supply is determined at the time you buy the drug or supply. The amount that you pay will not be adjusted for any later rebates, settlements or other monies paid to *Blue Cross and Blue Shield* from pharmacy providers or vendors.

Amendment (Rider)

A change to the terms described in this Benefit Description. Northeastern University or *Blue Cross and Blue Shield* may change the terms of the NUSHP. For example, an *amendment* may change the amount you must pay for certain services such as the amount of your *deductible* or *copayment*, or it may add or limit the benefits provided by the NUSHP. An *amendment* describes the change that is made to this Benefit Description. Northeastern University will supply you with any *amendments* that apply to your benefits under the NUSHP. You should keep any *amendments* with this booklet.

Benefit Limit

The day, visit or dollar benefit maximum that applies to certain *covered services*. **See Part 5, “Covered Services” of this Benefit Description for the *benefit limit (if any) that applies for a covered service*.** Once your benefits have reached the *benefit limit* described in your Benefit Description for specific *covered services*, no further benefits are provided by the NUSHP for those health care services or supplies. When this is the case, you must pay all charges that are in excess of the *benefit limit* for those health care services or supplies. For certain benefits, such as outpatient mental health care services, the benefit limit renews each *plan year*.

Blue Cross and Blue Shield

Blue Cross and Blue Shield of Massachusetts, Inc., the organization that has been designated by Northeastern University to provide administrative services to the NUSHP, such as claims processing, individual case management, *utilization review*, quality assurance programs, disease monitoring and

management services as selected by the *group*, claim review and other related services, and to arrange for a network of health care providers whose services are covered by the NUSHP. This includes an employee or designee of *Blue Cross and Blue Shield* (including a Blue Cross and/or Blue Shield Plan) who is authorized to make decisions or take action called for as described in this Benefit Description.

Coinsurance

The amount that you must pay for a certain *covered service* that is calculated as a percentage. See **Part 5, “Covered Services” of this Benefit Description for the percentage amount of your coinsurance and which covered services are subject to coinsurance.** Your *coinsurance* is a percentage of:

- The provider’s actual charge or the *allowed charge*, whichever is less (unless otherwise required by law) when you receive *covered services* from: a *preferred provider*; a *non-preferred provider* who has a payment agreement with a local Blue Cross and/or Blue Shield Plan; or a non-preferred physician and other professional provider who does not have a payment agreement with *Blue Cross and Blue Shield* or with the local Blue Cross and/or Blue Shield Plan.
- The provider’s actual charge when you receive *covered services* from a *non-preferred provider* who does not have a payment agreement with *Blue Cross and Blue Shield* or the local Blue Cross and/or Blue Shield Plan except for physicians and other professional providers (see above).

Copayment

The amount that you must pay for a certain *covered service* which is a fixed dollar amount. (Note that *copayments* do not apply to all in-network services.) In most cases, a *preferred provider* will collect the *copayment* from you at the time he or she furnishes the *covered service*. However, when the provider’s actual charge at the time of providing the *covered service* is less than your *copayment*, you pay only that provider’s actual charge or the *allowed charge*, whichever is less. Any later charge adjustment—up or down—will not affect your *copayment* (or the amount you were charged at the time of the service if it was less than the *copayment*). See **Part 5, “Covered Services” of this Benefit Description for the copayment amount and which covered services are subject to the copayment.** At certain times when a *copayment* would normally apply, your *copayment* may be waived. Your *copayment* will be waived when:

- Your hospital emergency room visit results in your being held for an overnight observation stay or being admitted for *inpatient* care within 24 hours. In this case, any emergency room *copayment* will be waived.
- Your *outpatient* visit is only for: lab tests and/or x-rays; and hearing tests. In this case, any *outpatient* visit *copayment* will be waived.
- You receive certain approved “intermediate” mental health care services such as day treatment program services in lieu of an *inpatient* admission (see page 38 for more information). In this case, any *inpatient copayment* will be waived.

Covered Services

Health care services or supplies for which the NUSHP provides benefits as described in this Benefit Description. In order to receive the highest level of benefits provided by the NUSHP (referred to as

“in-network benefits”), *covered services* must be furnished by *preferred providers*. A lower level of benefits (referred to as “out-of-network benefits”) will usually be provided when you obtain *covered services* from a covered *non-preferred provider*. (See Part 10 for situations when in-network benefits may be provided for *covered services* furnished by *non-preferred providers*.)

Custodial Care

A type of care that is not covered by the NUSHP. *Custodial care* means **any of the following**:

- Care that is given primarily by medically-trained personnel for a *member* who shows no significant improvement response despite extended or repeated treatment, or
- Care that is given for a condition that is not likely to improve, even if the *member* receives attention of medically-trained personnel, or
- Care that is given for the maintenance and monitoring of an established treatment program, when no other aspects of treatment require an acute level of care, or
- Care that is given for the purpose of meeting personal needs which could be provided by persons without medical training, such as assistance with mobility, dressing, bathing, eating and preparation of special diets and taking medications, or
- Care that is given to maintain the *member’s* or anyone else’s safety. (*Custodial care* does not mean care that is given to maintain the *member’s* or anyone else’s safety when that *member* is an *inpatient* in a psychiatric unit.)

Deductible

The amount that you must pay before out-of-network benefits are provided for certain *covered services*. The amount that is put toward your *deductible* is calculated based on:

- The provider’s actual charge or the *allowed charge*, whichever is less (unless otherwise required by law) when you receive *covered services* from: a *preferred provider*; a *non-preferred provider* who has a payment agreement with the local Blue Cross and/or Blue Shield Plan; or a non-preferred physician and other professional provider who does not have a payment agreement with *Blue Cross and Blue Shield* or with the local Blue Cross and/or Blue Shield Plan.
- The provider’s actual charge when you receive *covered services* from a *non-preferred provider* who does not have a payment agreement with *Blue Cross and Blue Shield* or the local Blue Cross and/or Blue Shield Plan except for physicians and other professional providers (see above).

Note: Separate expenses from *covered services* may be combined during the *plan year* to satisfy the *deductible*.

Your Overall Deductible Amount

See Part 5, “*Covered Services*,” for a description of *covered services* that are subject to the *deductible*.

In-Network Benefits	Out-of-Network Benefits
<i>Deductible</i> (per <i>plan year</i>)	<i>Deductible</i> (per <i>plan year</i>)
None	\$250 per <i>member</i>

Amounts Not Counting Toward the *Deductible*. There are amounts you pay that do not count toward your *deductible*. These include:

- Any *copayments* and/or *coinsurance* amounts.
- Any amount you pay when your benefits are reduced or denied because you did not follow the requirements of the *utilization review* program (see Part 4).
- Any amount you pay that is more than the *allowed charge*.
- Any amounts you pay when your benefits under the NUSHP have been exhausted for a specific service or supply.

Diagnostic Lab Tests

The examination or analysis of tissues, liquids or wastes from the body. This also includes: the taking and interpretation of 12-lead electrocardiograms; all standard electroencephalograms; and glycosylated hemoglobin (HgbA1C) tests, urinary protein/microalbumin tests and lipid profiles to diagnose and treat diabetes.

Diagnostic X-Ray and Other Imaging Tests

Fluoroscopic tests and their interpretation; and the taking and interpretation of roentgenograms and other imaging studies that are recorded as a permanent picture, such as film. Some examples of imaging tests include magnetic resonance imaging (MRI) and computerized axial tomography (CT scans). These types of tests also include diagnostic tests that require the use of radioactive drugs.

Effective Date

The date on which your membership in the NUSHP begins.

Emergency Medical Care

Medical, surgical or psychiatric care that you need immediately due to the sudden onset of a condition manifesting itself by acute symptoms, including severe pain, which are severe enough that the lack of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing your health or the health of another (including an unborn child) in serious jeopardy or serious impairment of bodily functions or serious dysfunction of any bodily organ or part or, as determined by a provider with knowledge of your condition, result in severe pain that cannot be managed without such care. Some examples of conditions that require *emergency medical care* are suspected heart attacks, strokes, poisoning, loss of consciousness, convulsions and suicide attempts. This also includes treatment of *mental conditions* when: you are admitted as an *inpatient* as required under Massachusetts General Laws, Chapter 123, Section 12; you seem very likely to endanger yourself as shown by a serious suicide attempt, a plan to commit suicide or behavior that shows that you are not able to care for yourself; or you seem very likely to endanger others as shown by an action against another person that could cause serious physical injury or death or by a plan to harm another person.

Group

The corporation, partnership, individual proprietorship or other organization that has entered into an agreement under which *Blue Cross and Blue Shield* provides administrative services for the *group's* self-insured benefits plan.

Inpatient

A patient who is a registered bed patient in a facility. This also includes a patient who is receiving approved intensive services such as partial hospital programs or covered residential care. (A patient who is kept overnight in a hospital solely for observation is **not** considered a registered *inpatient*. This is true even though the patient uses a bed. In this case, the patient is considered an *outpatient*. This is important for you to know since *member* cost sharing and *benefit limits* may differ for *inpatient* and *outpatient* benefits.)

Medical Technology Assessment Guidelines

The guidelines that *Blue Cross and Blue Shield* uses to assess whether a technology improves health outcomes such as length of life or ability to function. These guidelines include the following five criteria:

- The technology must have final approval from the appropriate government regulatory bodies. This criterion applies to drugs, biological products, devices (such as durable medical equipment) and diagnostic services. A drug, biological product or device must have final approval from the Food and Drug Administration (FDA). Any approval granted as an interim step in the FDA regulatory process is not sufficient. Except as required by law, the NUSHP may limit benefits for drugs, biological products and devices to those specific indications, conditions and methods of use approved by the FDA.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed English-language journals. The qualities of the body of studies and the consistency of the results are considered in evaluating the evidence. The evidence should demonstrate that the technology can measurably alter the physiological changes related to a disease, injury, illness or condition. In addition, there should be evidence or a convincing argument based on established medical facts that the measured alterations affect health outcomes. Opinions and evaluations by national medical associations, consensus panels and other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence upon which they are based.
- The technology must improve the net health outcome. The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
- The technology must be as beneficial as any established alternatives. The technology should improve the net outcome as much as or more than established alternatives. The technology must be as cost effective as any established alternatives that achieve a similar health outcome.
- The improvement must be attainable outside the investigational setting. When used under the usual conditions of medical practice, the technology should be reasonably expected to improve health outcomes to a degree comparable to that published in the medical literature.

Medically Necessary

All *covered services*, except routine circumcision, voluntary termination of pregnancy, voluntary sterilization procedures, stem cell (“bone marrow”) transplant donor suitability testing and preventive health services, must be *medically necessary* and appropriate for your specific health care needs. This means that all *covered services* must be consistent with generally accepted principals of professional medical practice. *Blue Cross and Blue Shield* decides which *covered services* are *medically necessary* and appropriate for you by using the following guidelines. All health care services must be required to diagnose or treat your illness, injury, symptom, complaint or condition and they must also be:

- Consistent with the diagnosis and treatment of your condition and in accordance with *Blue Cross and Blue Shield* medical policy and *medical technology assessment guidelines*.
- Essential to improve your net health outcome and as beneficial as any established alternatives covered by the NUSHP.

(This means that if *Blue Cross and Blue Shield* determines that your treatment is more costly than an alternative treatment, benefits are provided for the amount that would have been provided for the least expensive alternative treatment that meets your needs. In this case, you pay the difference between the claim payment and the actual charge.)

- As cost effective as any established alternatives and consistent with the level of skilled services that are furnished.
- Furnished in the least intensive type of medical care setting required by your medical condition.

It is not a service that: is furnished solely for your convenience or religious preference or the convenience of your family or health care provider; promotes athletic achievements or a desired lifestyle; improves your appearance or how you feel about your appearance; or increases or enhances your environmental or personal comfort.

Member

You, the person who has the right to NUSHP benefits described in this Benefit Description. A *member* may be the eligible, enrolled student (*subscriber*) or his or her enrolled spouse (or former spouse, if applicable) or any other enrolled dependent.

Mental Conditions

Psychiatric illnesses or diseases. (These include drug addiction and alcoholism.) The illnesses or diseases that qualify as *mental conditions* are listed in the latest edition, at the time you receive treatment, of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders.

Mental Health Provider

A provider that may furnish *covered services* to *members* for the treatment of *mental conditions*. These providers include:

- Alcohol and drug treatment facilities.
- Clinical specialists in psychiatric and mental health nursing.

- Community health centers (that are a part of a general hospital).
- Day care centers.
- Detoxification facilities.
- General hospitals.
- Licensed independent clinical social workers.
- Licensed mental health counselors.
- Mental health centers.
- Mental hospitals.
- Physicians.
- Psychologists.
- Any other mental health provider designated by *Blue Cross and Blue Shield*.

Non-Preferred Provider

A covered health care provider that does not have a written preferred provider payment agreement with *Blue Cross and Blue Shield* or with a local Blue Cross and/or Blue Shield Plan. (See page 13 for the kinds of health care providers that are covered under the NUSHP.)

Out-of-Pocket Expenses

Copayment, deductible and coinsurance amounts you pay.

Note: *Coinsurance* amounts you pay are used to satisfy the *out-of-pocket maximum* you must meet each *plan year* before the NUSHP will begin reimbursing most out-of-network *covered services* at the full benefit level. (See “*Out-of-Pocket Maximum*” below.)

Out-of-Pocket Maximum

The maximum *coinsurance* amount you pay for *covered services* in each *plan year*. When the total *coinsurance* amount you have paid in a *plan year* reaches your *out-of-pocket maximum* amount, the NUSHP provides full benefits based on the *allowed charge* for those *covered services* for which you normally pay a *coinsurance* if you continue to receive these *covered services* during the rest of that *plan year*.

Your Out-of-Pocket Maximum Amount

Your *out-of-pocket maximum* includes *coinsurance* amounts only. (Any *deductible* and/or *copayment* amounts do not count toward the *out-of-pocket maximum*.)

In-Network Benefits	Out-of-Network Benefits
<i>Out-of-Pocket Maximum</i> (per <i>plan year</i>)	<i>Out-of-Pocket Maximum</i> (per <i>plan year</i>)
\$3,500 per <i>member</i>	\$7,000 per <i>member</i>

Amounts Not Counting Toward the *Out-of-Pocket Maximum*. There are amounts you pay that do not count toward your *out-of-pocket maximum*. These include:

- Any *deductible* and/or *copayment* amounts.

- Any amount you pay when your benefits are reduced or denied because you did not follow the requirements of the *utilization review* program (see Part 4).
- Any amount you pay that is more than the *allowed charge*.
- Any amounts you pay when your benefits under the NUSHP have been exhausted for a specific service or supply.

Outpatient

A patient who is not a registered bed patient in a facility. For example, a patient at a health center, provider's office, surgical day care unit or ambulatory surgical facility is considered an *outpatient*. A patient who is kept overnight in a hospital solely for observation is also considered an *outpatient*. This is true even though the patient uses a bed. (This does not include a patient who is receiving approved intensive services such as day treatment or partial hospital programs or covered residential care—see the definition of “Inpatient.”)

Plan Year

The period of time beginning on September 1 and continuing for 12 consecutive months and ending on August 31. A new *plan year* begins each 12-month period thereafter.

Preferred Provider

A health care provider that has a written preferred provider payment agreement with *Blue Cross and Blue Shield* or with a local Blue Cross and/or Blue Shield Plan. For each *covered service*, this Benefit Description specifies the kinds of health care providers that are covered under the NUSHP. (A covered health care provider that does not have a written preferred provider payment agreement with *Blue Cross and Blue Shield* or with a local Blue Cross and/or Blue Shield Plan is referred to as a “*non-preferred provider*” in this Benefit Description.) The kinds of health care providers that are covered under the NUSHP include:

- **Hospital and Other Covered Facilities.** Alcohol and drug treatment facilities; ambulatory surgical facilities; Christian Science sanatoriums; chronic disease hospitals; community health centers; day care centers; detoxification facilities; free-standing diagnostic imaging facilities; free-standing dialysis facilities; free-standing radiation therapy and chemotherapy facilities; general hospitals; independent labs; mental health centers; mental hospitals; rehabilitation hospitals; and skilled nursing facilities.
- **Physician and Other Covered Professional Providers.** Certified registered nurse anesthetists; chiropractors; Christian Science practitioners; clinical specialists in psychiatric and mental health nursing; dentists; licensed audiologists; licensed dietitian nutritionists; licensed independent clinical social workers; licensed mental health counselors; licensed speech-language pathologists; nurse midwives; nurse practitioners; occupational therapists; optometrists; physical therapists; physicians; podiatrists; and psychologists.
- **Other Covered Health Care Providers.** Ambulance services; appliance companies; cardiac rehabilitation centers; Christian Science nurses; Christian Science nursing homes; coordinated home health agencies; early intervention providers; home infusion therapy providers; hospice providers; oxygen suppliers; retail pharmacies; and visiting nurse associations.

Note: To find out if a covered health care provider is a *preferred provider*, you may look in your Directory of Preferred Providers. Or, you may call the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your health plan identification card.

Room and Board

Your room, meals and general nursing services while you are an *inpatient*. This includes hospital services furnished in an intensive care or similar unit.

Special Services

The services and supplies that a facility ordinarily furnishes to its patients for diagnosis or treatment while the patient is in the facility. *Special services* include such things as:

- The use of special rooms. These include: operating rooms; and treatment rooms.
- Tests and exams.
- The use of special equipment in the facility. Also, the services of the people hired by the facility to run the equipment.
- Drugs, medications, solutions, biological preparations and medical and surgical supplies used while you are in the facility.
- Administration of infusions and transfusions and blood processing fees. These do not include the cost of: whole blood; packed red blood cells; blood donor fees; or blood storage fees.
- Internal prostheses (artificial replacements of parts of the body) that are part of an operation. These include things such as: hip joints; skull plates; intraocular lenses; and pacemakers. They do not include things such as: ostomy bags; artificial limbs or eyes; hearing aids; or air-plane splints.

Subscriber

The eligible student who signs the enrollment form at the time of enrollment in the NUSHP.

Utilization Review

The approach that *Blue Cross and Blue Shield* uses to evaluate the necessity and appropriateness of many different services. This approach employs a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. These techniques include pre-admission review, concurrent review, discharge planning, pre-authorization of selected *outpatient* services, post-payment review and individual case management. *Blue Cross and Blue Shield's* utilization management policies are designed to encourage appropriate care and services (not less care). *Blue Cross and Blue Shield* understands the need for special concern about underutilization, and shares this concern with *members* and providers. *Blue Cross and Blue Shield* does not compensate individuals who conduct *utilization review* activities based on denials. It also does not offer incentives to providers to encourage inappropriate denials of care and services.

Blue Cross and Blue Shield applies *medical technology assessment guidelines* to develop its clinical guidelines and *utilization review* criteria. In developing these, *Blue Cross and Blue Shield* carefully assesses a treatment to determine that it is:

- Consistent with generally accepted principals of professional medical practice; and
- Required to diagnose or treat your illness, injury, symptom, complaint or condition; and
- Essential to improve your net health outcome and as beneficial as any established alternatives covered by the NUSHP; and
- As cost effective as any established alternatives and consistent with the level of skilled services that are furnished; and
- Furnished in the least intensive type of medical care setting required by your medical condition.

Blue Cross and Blue Shield reviews clinical guidelines and *utilization review* criteria periodically to reflect new treatments, applications and technologies. As new drugs are approved by the Food and Drug Administration (FDA), *Blue Cross and Blue Shield* reviews their safety, effectiveness and overall value on an ongoing basis. While a new drug is being reviewed, it will not be covered by the NUSHP.

Part 3

Emergency Medical Services

Obtaining Emergency Medical Services

The NUSHP provides benefits for worldwide emergency medical services. These emergency medical services may include *inpatient* or *outpatient* services by providers qualified to furnish *emergency medical care* and that are needed to evaluate or stabilize your emergency medical condition. Additional special medical evacuation and repatriation coverage is provided to NUSHP members through a separate insurance program purchased by Northeastern University. Refer to the UHCS web site for more details: www.uhcs.neu.edu.

Call 911. At the onset of an emergency medical condition that in your judgment requires *emergency medical care*, you should go to the nearest emergency room. For assistance, call your local emergency medical service system by dialing the emergency telephone access number 911, or the local emergency telephone number. You will not be denied benefits for medical and transportation services described in this Benefit Description that you incur as a result of your emergency medical condition.

You usually need emergency medical services because of the sudden onset of a condition with acute symptoms, including severe pain, which are severe enough that the lack of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing your health or the health of another (including an unborn child) in serious jeopardy or serious impairment of bodily functions or serious dysfunction of any bodily organ or part or, as determined by a provider with knowledge of your condition, result in severe pain that cannot be managed without such care. Some examples of conditions that require *emergency medical care* are suspected heart attacks, strokes, poisoning, loss of consciousness, convulsions and suicide attempts.

Note: When you receive emergency medical services from an emergency room at a non-preferred hospital, the NUSHP will provide the same benefits that you would normally receive if a preferred hospital had furnished the services.

Post-Stabilization Care

After your emergency medical condition has been evaluated and stabilized in the hospital emergency room, you may be ready to go home or you may require further care.

Admission From the Emergency Room. Your condition may require that you be admitted directly from the emergency room for *inpatient emergency medical care* in that hospital. If this is the case, you, the facility or someone on your behalf must notify *Blue Cross and Blue Shield* within 48 hours of the admission. (In Massachusetts, the preferred hospital will call *Blue Cross and Blue Shield* for you.)

This notification to *Blue Cross and Blue Shield* must include the patient's name, the patient's identification number, the name of the facility, the date of admission and the condition for which the patient is receiving treatment. *Blue Cross and Blue Shield* will monitor and evaluate the clinical necessity and appropriateness of the health care services you are receiving in order to make sure you continue to need *inpatient* coverage in that facility. (For more information about Concurrent Review, see Part 4, "Utilization Review Requirements.")

Transfer to another *Inpatient* Facility. Your emergency room provider may recommend transfer for *inpatient* care to another facility. If this is the case, you or the admitting facility must call *Blue Cross and Blue Shield* within 48 hours of the admission so that *Blue Cross and Blue Shield* can evaluate the appropriateness of the health care services you are receiving in order to make sure you need *inpatient* coverage in that facility. (In Massachusetts, the preferred facility will call *Blue Cross and Blue Shield* for you.)

Outpatient Follow-up Care. Your emergency room provider may recommend *outpatient* follow-up care. If this is the case, the NUSHP will provide benefits for *covered services*.

Filing an Emergency Care Claim

You do not have to file a claim when you receive *covered services* from a *preferred provider* or a provider outside of Massachusetts who has a payment agreement with the local Blue Cross and/or Blue Shield Plan. The provider will file the claim for you. Just tell the provider that you are a *member* and show him or her your health plan identification card. *Blue Cross and Blue Shield* will pay the provider directly for *covered services*. But, you may have to file your claim when you receive *covered services* from a *non-preferred provider* in Massachusetts or a *non-preferred provider* outside of Massachusetts who does **not** have a payment agreement with the local Blue Cross and/or Blue Shield Plan. The provider may ask you to pay the entire charge at the time of the visit or at a later time. It is up to you to pay your provider. After you have filed your claim, you will be repaid less the amount you normally pay for *covered services*. See Part 8 for more information about filing a claim for repayment of *covered services*.

Part 4

Utilization Review Requirements

To receive all the in-network and out-of-network benefits described in this Benefit Description, you must follow the requirements of this *utilization review* program. This program applies anywhere in the United States. Your benefits may be reduced or denied if you do not follow the requirements of this program. This section describes how the *utilization review* process works. You may check on the status or outcome of a request for prior approval for proposed health care services or supplies at any time. To check, you may call the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your health plan identification card. (The requirements of this program do not apply to *covered services* when Medicare is the primary coverage.)

Note: Your provider will be considered your authorized representative for the prior approval process. *Blue Cross and Blue Shield* will tell your provider if a proposed service has been approved or may ask your provider for more information if it is needed to make a decision. (See Part 10 for more information about authorized representatives.)

Prior Authorization Requirements

Pre-Admission Review

Important Note: All *inpatient* admissions must be approved in advance by *Blue Cross and Blue Shield* to receive in-network benefits or out-of-network benefits. In some situations, you will need to start the process described in this section for obtaining approval from *Blue Cross and Blue Shield*.

Before you enter a facility for *inpatient* care, prior approval must be obtained from *Blue Cross and Blue Shield* in order for the care to be covered by the NUSHP. Within two working days of receiving all necessary information, *Blue Cross and Blue Shield* will determine if the health care setting is suitable to treat your condition. (This pre-approval is **not** required when your *inpatient* admission is for *emergency medical care* or maternity services.) For proposed admissions in a preferred facility, the facility may start this pre-admission review process for you. A *preferred provider* can tell you if you must start this process. **You must start the pre-admission review process if the preferred facility does not start this process or if your proposed admission is to a non-preferred facility.** To start the pre-admission review process, you must call the *Blue Cross and Blue Shield utilization review* unit at the toll-free telephone number shown on your health plan identification card.

Missing Information. *Blue Cross and Blue Shield* will get in touch with your physician about the proposed admission if more information is needed. In some situations, *Blue Cross and Blue Shield* may arrange an evaluation (usually face to face) with an assessment provider who will assess your specific need and determine if the health care setting is suitable to treat your condition. If necessary informa-

tion is missing or more information is needed, *Blue Cross and Blue Shield* will request the necessary information or records within 15 calendar days of receiving the pre-admission review request. The requested information or records must be provided within 45 calendar days of *Blue Cross and Blue Shield's* request. If the requested information or records are not provided to *Blue Cross and Blue Shield* within 45 calendar days of the request, the proposed *inpatient* coverage will be denied. Within two working days of receiving all necessary information, *Blue Cross and Blue Shield* will determine if the health care setting is suitable to treat your condition.

Coverage Approval. If *Blue Cross and Blue Shield* determines that the proposed setting for your care is suitable, *Blue Cross and Blue Shield* will call the facility within 24 hours of the determination to let the facility know the status of the pre-admission review. *Blue Cross and Blue Shield* will also send a written (or electronic) confirmation of the coverage approval to you and the facility within two working days of the phone call to the facility.

Coverage Denial. If *Blue Cross and Blue Shield* determines that the proposed setting is not *medically necessary* for your condition, *Blue Cross and Blue Shield* will call the facility within 24 hours of the determination to let the facility know of the denial of coverage and to recommend alternative treatment. *Blue Cross and Blue Shield* will also send a written (or electronic) explanation of the coverage decision to you and the facility within one working day of the phone call to the facility. (This explanation will describe the reasons for the denial, the applicable terms of your *group* benefits as described in this Benefit Description, any applicable *Blue Cross and Blue Shield* medical policy guidelines used and how to obtain a free copy, any additional information needed, the review process and your right to pursue legal action.)

Reconsideration of Adverse Determination. When *Blue Cross and Blue Shield* determines that *inpatient* coverage is not *medically necessary* for your condition, your health care provider may ask that *Blue Cross and Blue Shield* arrange a reconsideration of that decision from a clinical peer reviewer. This reconsideration will be conducted between your provider and the clinical peer reviewer within one working day of the request for a reconsideration. If the initial determination is not reversed, you (or the health care provider on your behalf) may request a formal review as described in Part 9 of this Benefit Description. (You may request a formal review even though your health care provider has not followed this reconsideration process.)

If Pre-Approval Requirements Are Not Followed. If you (or the provider on your behalf) do not call for pre-admission review prior to being admitted as an *inpatient*, you must pay the first \$1,000 of otherwise covered facility charges for each admission that *Blue Cross and Blue Shield* determines is *medically necessary*. You must pay this amount as well as any costs that you would normally be required to pay for *covered services*.

Note: If you do not call for pre-admission review and *Blue Cross and Blue Shield* determines your admission is not *medically necessary* (or if you choose to be admitted after the pre-admission review determined that *inpatient* coverage was not *medically necessary*), you must pay the entire amount for facility and physician (or other professional provider) services for the admission.

Concurrent Review and Discharge Planning

Concurrent Review means that while you are an *inpatient*, *Blue Cross and Blue Shield* will monitor and evaluate the clinical necessity and appropriateness of the health care services you are receiving and to make sure you still need *inpatient* coverage in that facility. In some cases, *Blue Cross and Blue Shield* may determine that you will need to continue *inpatient* coverage in that facility beyond the number of days initially thought to be required for your condition. *Blue Cross and Blue Shield* will make this determination within one working day of receiving all necessary information. When this is the case, *Blue Cross and Blue Shield* will call the facility within one working day of the coverage determination to let the facility know the approval status of the review. *Blue Cross and Blue Shield* will also send a written (or electronic) explanation of the decision to you and the facility within one working day of the phone call to the facility. This written (or electronic) explanation will include the number of additional days that are being approved for coverage (or the next review date), the new total number of approved days or services and the date the approved services will begin.

In other cases, based on *medical necessity* determination, *Blue Cross and Blue Shield* may determine that you no longer need *inpatient* coverage in that facility. Or, you may no longer need *inpatient* coverage at all. *Blue Cross and Blue Shield* will make this coverage determination within one working day of receiving all necessary information. When this is the case, *Blue Cross and Blue Shield* will call the facility within 24 hours of the coverage determination to let the facility know of the decision and to discuss plans for continued coverage in a health care setting that better meets your needs. For example, your condition may no longer require *inpatient* coverage in a hospital, but still may require skilled nursing coverage. If this is the case, your physician may decide to transfer you to an appropriate skilled nursing facility. Any proposed plans will be discussed with you by your physician. All arrangements for discharge planning will be confirmed in writing with you.

If you choose to stay in the facility after you have been notified by your provider or *Blue Cross and Blue Shield* that *inpatient* coverage is no longer *medically necessary*, no further benefits will be provided by the NUSHP. You must pay all charges for the rest of that *inpatient* stay, starting from the date the written notification is sent to you.

Reconsideration of Adverse Determination. When *Blue Cross and Blue Shield* determines that continued *inpatient* coverage is not *medically necessary* for your condition, your health care provider may ask that *Blue Cross and Blue Shield* arrange a reconsideration of that decision from a clinical peer reviewer. This reconsideration will be conducted between your health care provider and the clinical peer reviewer within one working day of the request for a reconsideration. If the initial determination is not reversed, you (or the health care provider on your behalf) may request a formal review as described in Part 9 of this Benefit Description. (You may request a formal review even though your health care provider has not followed this reconsideration process.)

Prior Approval for Home Health Care Services

Before you receive home health care, approval must be obtained from *Blue Cross and Blue Shield* in order for the care to be covered by the NUSHP. Within two working days of receiving all necessary information, *Blue Cross and Blue Shield* will determine if the proposed services should be covered as *medically necessary* for your condition. (If you have been receiving *inpatient* care, *Blue Cross and Blue Shield* may approve these services through Discharge Planning.) If you are planning to obtain home health care from a *preferred provider*, the provider may start the approval process for you. A *preferred provider* can tell you if you must start this process. **You must start the pre-approval process if the *preferred provider* does not start this process or if you are planning to obtain these services from a *non-preferred provider*.** To start this pre-approval process, you must call the *Blue Cross and Blue Shield utilization review* unit at the toll-free telephone number shown on your health plan identification card.

Missing Information. If necessary information is missing or more information is needed, *Blue Cross and Blue Shield* will request the necessary information or records within 15 calendar days of receiving the request. The requested information or records must be provided within 45 calendar days of *Blue Cross and Blue Shield's* request. If the requested information or records are not provided to *Blue Cross and Blue Shield* within 45 calendar days of the request, the proposed *outpatient* coverage will be denied. Within two working days of receiving all necessary information, *Blue Cross and Blue Shield* will determine if the proposed services should be covered as *medically necessary* for your condition.

Coverage Approval. If *Blue Cross and Blue Shield* determines that the proposed course of treatment should be covered as *medically necessary* for your condition, *Blue Cross and Blue Shield* will call the health care provider within 24 hours of the determination to let the provider know the approval status of the review. *Blue Cross and Blue Shield* will also send a written (or electronic) confirmation of the approval to you and the provider within two working days of the phone call to the provider.

Coverage Denial. If *Blue Cross and Blue Shield* determines that the proposed course of treatment should not be covered as *medically necessary* for your condition, *Blue Cross and Blue Shield* will call the health care provider within 24 hours of the determination to let the provider know of the denial of coverage and to recommend alternative treatment. *Blue Cross and Blue Shield* will also send a written (or electronic) explanation of the decision to you and the provider within one working day of the phone call to the provider. (This explanation will describe the reasons for the denial, the applicable terms of your *group* benefits as described in this Benefit Description, any applicable *Blue Cross and Blue Shield* medical policy guidelines used and how to obtain a free copy, any additional information needed, the review process and your right to pursue legal action.)

Reconsideration of Adverse Determination. When *Blue Cross and Blue Shield* determines that the proposed course of treatment will not be covered as *medically necessary* for your condition, your health care provider may ask that *Blue Cross and Blue Shield* arrange a reconsideration of that decision from a clinical peer reviewer. This reconsideration will be conducted between your provider and the clinical peer reviewer within one working day of the request for a reconsideration. If the initial review determination is not reversed, you (or the health care provider on your behalf) may request a formal review as described in Part 9 of this Benefit Description. (You may request a formal review even though your health care provider has not followed this reconsideration process.)

If Pre-Approval Requirements Are Not Followed. If you (or the provider on your behalf) do not call for pre-approval prior to obtaining home health care services, you must pay the first \$1,000 of otherwise covered charges for each course of treatment that *Blue Cross and Blue Shield* determines is *medically necessary*. You must pay this amount as well as any costs that you would normally be required to pay for *covered services*.

Individual Case Management

Individual Case Management is a flexible program for managing your benefits in some situations. Through this program, *Blue Cross and Blue Shield* works with your health care providers to make sure that you get *medically necessary* services in the least intensive setting that meets your needs. Individual Case Management is for a *member* whose condition may otherwise require *inpatient* hospital care. Under Individual Case Management, coverage for services in addition to those described in this Benefit Description may be approved to:

- Shorten an *inpatient* stay by sending a *member* home or to a less intensive setting to continue treatment;
- Direct a *member* to a less costly setting when an *inpatient* admission has been proposed; or
- Prevent future *inpatient* stays by providing *outpatient* benefits instead.

Blue Cross and Blue Shield may, in some situations, present a specific alternative treatment plan to you and your attending physician. This treatment plan will be one that is *medically necessary* for you. *Blue Cross and Blue Shield* will need the full cooperation of everyone involved: the patient (or guardian); the hospital; the attending physician; and the proposed setting or health care provider. Also, there must be a written agreement between the patient (or family or guardian) and *Blue Cross and Blue Shield*, and between the provider and *Blue Cross and Blue Shield* to furnish the services approved through this alternative treatment plan.

Part 5

Covered Services

You have the right to the benefits described in this section, except as limited or excluded in other sections of this Benefit Description. **There are two levels of benefits under the NUSHP.** You will receive the highest level of benefits when you obtain *covered services* from a *preferred provider*. These are called your “in-network benefits.” When you obtain *covered services* from a covered health care provider that is not a *preferred provider*, you will usually receive a lower level of benefits. If this is the case, your *out-of-pocket expenses* will be more. These are called your “out-of-network benefits.” **Be sure to read this section along with Parts 3 and 4 for the requirements you must follow to receive benefits and the limitations and exclusions in Part 6, as well as all provisions of this Benefit Description. Pay close attention to all *benefit limits* described in this section. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply. When this occurs, you must pay all charges.**

Admissions for *Inpatient Medical and Surgical Care*

Inpatient Medical and Surgical Services

In-Network Benefits	Out-of-Network Benefits
<ul style="list-style-type: none"> For general or chronic disease hospital or Christian Science sanatorium admissions, YOU PAY: 	20% <i>coinsurance</i> after <i>deductible</i> .
\$250 <i>copayment</i> * per admission; then 10% <i>coinsurance</i> .	
*For covered surgery, you must also pay a \$200 <i>copayment</i> for the surgeon’s charges (or a \$100 <i>copayment</i> when the surgery is for removal of impacted wisdom teeth). This is in addition to your <i>inpatient copayment</i> and 10% <i>coinsurance</i> .	
<ul style="list-style-type: none"> For rehabilitation hospital admissions (up to a 60-day <i>benefit limit</i> each <i>plan year</i>) or skilled nursing facility or Christian Science nursing home admissions (up to a 100-day <i>benefit limit</i> each <i>plan year</i>), YOU PAY: 	20% <i>coinsurance</i> after <i>deductible</i> up to the <i>benefit limit</i> .
\$250 <i>copayment</i> per admission and 10% <i>coinsurance</i> for balance up to the <i>benefit limit</i> .	

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

The NUSHP provides benefits based on the *allowed charge* for *medically necessary inpatient* admissions in a general, chronic disease or rehabilitation hospital, skilled nursing facility or Christian Science sanatorium (or Christian Science nursing home). These benefits include:

- Semiprivate *room and board* and *special services*.
- Surgery furnished by a physician, podiatrist, nurse practitioner or dentist and services of an assistant surgeon (physician) when *Blue Cross and Blue Shield* decides an assistant is needed. These surgical services include (but are not limited to):
 - Reconstructive surgery. This non-dental surgery is meant to improve or give back bodily function or correct a functional physical impairment that was caused by a birth defect, a prior surgical procedure or disease or an accidental injury. This also includes surgery to correct a deformity or disfigurement that was caused by an accidental injury.

Women’s Health and Cancer Rights: These benefits include reconstructive surgery for a *member* who is receiving benefits for a mastectomy and who elects breast reconstruction in connection with the mastectomy. The NUSHP provides benefits for: all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas. These services will be furnished in a manner determined in consultation with the attending physician and the patient.

- Human organ and stem cell (“bone marrow”) transplants furnished in accordance with *Blue Cross and Blue Shield* medical policy and *medical technology assessment guidelines*. This includes one or more stem cell transplants for a *member* who has been diagnosed with breast cancer that has spread. For covered transplants, benefits also include the harvesting of the donor’s organ or stem cells when the recipient is a *member* (“harvesting” includes the surgical removal of the donor’s organ or stem cells and related *medically necessary* services and/or tests that are required to perform the transplant itself) and drug therapy during the transplant procedure to prevent rejection of the transplanted organ/tissue or stem cells. (See “Lab Tests, X-Rays and Other Tests” for benefits for transplant donor suitability testing.) No benefits are provided for the harvesting of the donor’s organ or stem cells when the recipient is not a *member*.
- Oral surgery. This includes: reduction of a dislocation or fracture of the jaw or facial bone; excision of a benign or malignant tumor of the jaw; and orthognathic surgery that you need to correct a significant functional impairment that cannot be adequately corrected with orthodontic services but only if you have a serious medical condition that requires that you be admitted to a hospital as an *inpatient* in order for the surgery to be safely performed. (No benefits are provided for orthognathic surgery when it is performed primarily for cosmetic reasons. This surgery must be performed along with orthodontic services. If it is not, the oral surgeon must send a letter to *Blue Cross and Blue*

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

Shield asking for approval for the surgery. But, no benefits are provided for the orthodontic services.)

Covered oral surgery includes removal of impacted wisdom teeth that are fully or partially imbedded in the bone. **However, benefits for *inpatient* and/or *outpatient* removal of impacted wisdom teeth are limited to a total of \$2,500 for each *member* in each *plan year*.**

- Voluntary termination of pregnancy and voluntary sterilization procedures.
- Anesthesia services furnished by a physician other than the attending physician or by a certified registered nurse anesthetist, when the anesthesia is related to covered surgery.
- Radiation and x-ray therapy furnished by a physician. This includes: radiation therapy using isotopes, radium, radon or other ionizing radiation; and x-ray therapy for cancer or when used in place of surgery.
- Chemotherapy (drug therapy for cancer) furnished by a physician.
- Interpretation of *diagnostic x-ray and other imaging tests, diagnostic lab tests* and diagnostic machine tests furnished by a physician or podiatrist, when these tests are not furnished by a hospital-based radiologist or pathologist.
- Medical care furnished by a physician, nurse practitioner, podiatrist or Christian Science practitioner and medical care by a physician other than the attending physician to treat an uncommon aspect or complication of your illness or injury. The NUSHP provides benefits for medical care by two or more physicians at the same time only when *Blue Cross and Blue Shield* decides that the care is needed to treat a critically ill patient. The second physician must be an expert in a different medical sub-specialty than the attending physician. If the second physician is an expert in the same medical sub-specialty as the attending physician, the NUSHP provides benefits only for the services of the attending physician.
- Monitoring services related to dialysis when furnished by a covered health care provider.
- Consultations furnished by a physician other than the attending physician. The consultation must be needed to diagnose or treat the condition for which you were admitted. Or, it must be for a complication that develops after you are an *inpatient*. The attending physician must order the consultation. The physician who furnishes it must send a written report to *Blue Cross and Blue Shield* if it asks for one. The physician who furnishes this consultation for you must be an expert in a different medical sub-specialty than the attending physician. If the consultant is an expert in the same medical sub-specialty as the attending physician, the NUSHP provides benefits only for the services of the attending physician.
- Intensive care services furnished by a physician other than the attending physician or by a nurse practitioner. This means services that are needed for only a limited number of hours to treat an uncommon aspect or complication of your illness or injury.
- Emergency admission services furnished by a physician or nurse practitioner. This means a complete history and physical exam of a *member* who is admitted as an *inpatient* for *emergency medical care*, when the treatment is taken over immediately by another physician.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

- Pediatric specialty care furnished by covered health care providers with recognized expertise in specialty pediatrics.
- Second surgical opinions furnished by a physician. This includes a third surgical opinion when the second surgical opinion differs from the first.

Ambulance Services

Emergency and Other Medically Necessary Ambulance Transport

In-Network Benefits	Out-of-Network Benefits
<ul style="list-style-type: none"> • For emergency ambulance transport, YOU PAY: 	
\$200 <i>copayment</i> per day.	20% <i>coinsurance</i> (<i>deductible</i> does not apply).
<ul style="list-style-type: none"> • For other <i>medically necessary</i> ambulance transport, YOU PAY: 	
10% <i>coinsurance</i> .	20% <i>coinsurance</i> after <i>deductible</i> .

The NUSHP provides benefits based on the *allowed charge* for:

- **Emergency Ambulance Transport.** These benefits include ambulance transport to an emergency medical facility for *emergency medical care*. For example, covered ambulance services include transport from an accident scene or to a hospital due to symptoms of a heart attack. These benefits include air ambulance transport to take you to a hospital when your emergency medical condition requires the use of an air ambulance rather than a ground ambulance. **If you need assistance at the onset of an emergency medical condition that in your judgment requires *emergency medical care*, call your local emergency medical service system by dialing the emergency telephone access number 911, or the local emergency telephone number.**
- **Other *Medically Necessary* Ambulance Transport.** These benefits include other *medically necessary* ambulance transport furnished by an ambulance service to take you to or from the nearest hospital (or another covered facility). This includes ambulance transport that is needed for a *mental condition*.

No benefits are provided for taxi or chair car service or to transport the *member* to or from medical appointments.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

Cardiac Rehabilitation

Outpatient Cardiac Rehabilitation Visits

In-Network Benefits	Out-of-Network Benefits
YOU PAY: \$15 <i>copayment</i> per visit.	YOU PAY: 20% <i>coinsurance</i> after <i>deductible</i> .

The NUSHP provides benefits based on the *allowed charge* for *medically necessary outpatient* cardiac rehabilitation furnished by a general or chronic disease hospital or cardiac rehabilitation center. Your first visit must be within 26 weeks of the date you were first diagnosed with cardiovascular disease or after a cardiac event. *Blue Cross and Blue Shield* must determine through medical documentation that you have cardiovascular disease, angina pectoris or have had a myocardial infarction, angioplasty or cardiovascular surgery. (This type of surgery includes a heart transplant, coronary bypass graft surgery or valve repair or replacement.) For angina pectoris, only one course of cardiac rehabilitation is covered for each *member*.

No benefits are provided for: club membership fees; counseling services that are not part of the cardiac rehabilitation program (for example, educational, vocational and psychosocial counseling); medical or exercise equipment used in your home; services provided to your family; and additional services after you complete a cardiac rehabilitation program.

Chiropractor Services

Outpatient Chiropractor Services

Important Note: This \$1,500 *benefit limit* also includes any benefits that are paid for short-term rehabilitation therapy.

In-Network Benefits	Out-of-Network Benefits
<ul style="list-style-type: none"> For <i>outpatient</i> lab tests and x-rays, YOU PAY: 	
10% <i>coinsurance</i> .	20% <i>coinsurance</i> after <i>deductible</i> .
<ul style="list-style-type: none"> For <i>outpatient</i> medical care services (includes spinal manipulation) up to a \$1,500 <i>benefit limit</i> per <i>member</i> per <i>plan year</i>, YOU PAY: 	
\$15 <i>copayment</i> per visit up to the <i>benefit limit</i> .	20% <i>coinsurance</i> after <i>deductible</i> up to the <i>benefit limit</i> .

The NUSHP provides benefits based on the *allowed charge* for chiropractic services furnished by a chiropractor when the chiropractor is licensed to furnish the specific *covered service*. These benefits include:

- *Diagnostic lab tests*, such as blood tests.
- Diagnostic x-rays, other than magnetic resonance imaging (MRI), computerized axial tomography (CT scans) and other imaging tests.
- *Outpatient* medical care services, including spinal manipulation.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

Dialysis Services

Outpatient and Home Dialysis Services

In-Network Benefits	Out-of-Network Benefits
YOU PAY: 10% <i>coinsurance</i> .	YOU PAY: 20% <i>coinsurance</i> after <i>deductible</i> .

The NUSHP provides benefits based on the *allowed charge* for *outpatient* dialysis furnished by a general or chronic disease hospital, community health center, free-standing dialysis facility or physician. These benefits are also provided for home dialysis that is under the direction of a general or chronic disease hospital or free-standing dialysis facility. These home dialysis benefits include: non-durable medical supplies such as dialysis membrane and solution, tubing and drugs needed during dialysis; the cost to install dialysis equipment for up to a \$300 *benefit limit*; and the cost to maintain or fix dialysis equipment. *Blue Cross and Blue Shield* will decide whether to rent or to buy the dialysis equipment. If the dialysis equipment is bought, the NUSHP keeps ownership rights to this equipment. It does not become your property. No home dialysis benefits are provided for: costs to get or supply power, water or waste disposal systems; costs of a person to help with the dialysis procedure; and costs not needed to run the dialysis equipment.

Durable Medical Equipment

Durable Medical Equipment Bought or Rented for Home Use

These benefits are limited to \$3,000 per *member* per *plan year*.

In-Network Benefits	Out-of-Network Benefits
YOU PAY: 10% <i>coinsurance</i> up to the <i>benefit limit</i> .	YOU PAY: 20% <i>coinsurance</i> after <i>deductible</i> up to the <i>benefit limit</i> .
(This <i>benefit limit</i> does not apply when durable medical equipment is furnished as part of covered home dialysis, home health care or hospice services.)	

The NUSHP provides benefits based on the *allowed charge* for durable medical equipment you buy or rent from an appliance company (or another provider who is designated by *Blue Cross and Blue Shield* to furnish the specific covered appliance). These benefits include equipment that: can stand repeated use; serves a medical purpose; is *medically necessary* for you; is not useful if you are not ill or injured; and can be used in the home. Examples of covered durable medical equipment include (but are not limited to):

- Knee and back braces.
- Orthopedic and corrective shoes that are part of a leg brace.
- Hospital beds; wheelchairs; crutches; and walkers.
- Glucometers that are *medically necessary* due to the patient’s type of diabetic condition.
- Visual magnifying aids and voice-synthesizers for a legally blind *member* who has insulin dependent, insulin using, gestational or non-insulin dependent diabetes.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

- Insulin injection pens.

From time to time, the equipment that is covered by the NUSHP may change. This change will be based on the *Blue Cross and Blue Shield's* periodic review of medical policy and *medical technology assessment guidelines* to reflect new applications and technologies. For more information about covered equipment, you may call the *Blue Cross and Blue Shield* customer service office.

Blue Cross and Blue Shield will decide whether to rent or buy the durable medical equipment. If *Blue Cross and Blue Shield* decides to rent the equipment, benefits will not be more than the amount that would have been paid if the equipment were bought. If the equipment is bought, the NUSHP keeps ownership rights to the equipment. It does not become your property.

The NUSHP provides these benefits for the least expensive equipment of its type that meets your needs. If *Blue Cross and Blue Shield* determines that you chose durable medical equipment that costs more than what you need for your medical condition, the NUSHP will provide benefits only for those charges that would have been paid for the least expensive equipment that meets your needs. In this case, you pay the provider's charges that are more than the claim payment.

Early Intervention Services

Outpatient Early Intervention Services

These benefits are limited to \$5,200 per eligible child per *plan year*; \$15,600 lifetime.

In-Network Benefits	Out-of-Network Benefits
YOU PAY: \$15 <i>copayment</i> per visit up to the <i>benefit limit</i> .	YOU PAY: 20% <i>coinsurance</i> after <i>deductible</i> up to the <i>benefit limit</i> .

The NUSHP provides benefits based on the *allowed charge* for early intervention services furnished by an early intervention provider for enrolled dependent children from birth through age two (until the child turns three years old). These benefits include: physical, speech/language and occupational therapy; nursing care; and psychological counseling.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

Emergency Medical Outpatient Services

Outpatient Emergency and Accident Medical Treatment

In-Network Benefits	Out-of-Network Benefits
<ul style="list-style-type: none"> For emergency room visits, YOU PAY: 	
\$50 <i>copayment</i> per visit; then, 10% <i>coinsurance</i> .	\$50 <i>copayment</i> per visit; then, 10% <i>coinsurance</i> (<i>deductible</i> does not apply).
The emergency room <i>copayment</i> is waived when your visit is for an overnight observation stay or if you are admitted as an <i>inpatient</i> .	
<ul style="list-style-type: none"> For office, health center and hospital <i>outpatient</i> visits, YOU PAY: 	
\$15 <i>copayment</i> per visit.	20% <i>coinsurance</i> after <i>deductible</i> .
<ul style="list-style-type: none"> For repair and replacement of sound, natural teeth damaged due to accidental injury, YOU PAY: 	
\$100 <i>copayment</i> per <i>plan year</i> ; then, 10% <i>coinsurance</i> .	20% <i>coinsurance</i> after <i>deductible</i> .

The NUSHP provides benefits based on the *allowed charge* for *outpatient emergency medical care* furnished at an emergency room of a general hospital. **At the onset of an emergency medical condition that in your judgment requires *emergency medical care*, you should go to the nearest emergency room. For assistance, call your local emergency medical service system by dialing the emergency telephone access number 911, or the local emergency telephone number.** (See Part 3 for more information about your benefits for emergency medical services.)

The NUSHP also provides benefits for:

- Emergency medical services furnished by a hospital outpatient department, community health center, physician or nurse practitioner.
- Repair and replacement of sound, natural teeth damaged due to accidental injury. This includes accident treatment to repair damaged teeth and any necessary follow-up medical care services furnished by a general, chronic disease or rehabilitation hospital, surgical day care unit, ambulatory surgical facility, community health center, physician or dentist. No benefits are provided for: dental care required following an injury caused by biting or chewing; and dental prosthetics (such as dentures, bridges, braces and other such dental appliances).

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Home Health Care

Medically Necessary Home Health Care

In-Network Benefits	Out-of-Network Benefits
YOU PAY: 10% <i>coinsurance</i> .	YOU PAY: 20% <i>coinsurance</i> after <i>deductible</i> .
The <i>benefit limit</i> that applies to short-term rehabilitation therapy does not apply when physical, speech and/or occupational therapy services are furnished as part of covered home health care.	

The NUSHP provides benefits based on the *allowed charge* for *medically necessary* home health care. These benefits include:

- Part-time skilled nursing visits and physical therapy furnished by a visiting nurse association or Christian Science nurse.
- Part-time skilled nursing visits, physical therapy, speech/language therapy, occupational therapy, medical social work, nutrition counseling, home health aide services, medical supplies, durable medical equipment, enteral infusion therapy and basic hydration therapy furnished by a coordinated home health agency.
- Home infusion therapy, including the infusion solution, preparation of the solution and equipment for its administration and necessary part-time nursing furnished by a home infusion therapy provider.

The NUSHP provides these benefits only when you are expected to reach a defined medical goal set by your attending physician and, for medical reasons, you are not reasonably able to travel to another treatment site where medically appropriate care can be furnished for your condition.

No benefits are provided for: meals, personal comfort items and housekeeping services; *custodial care*; treatment of *mental conditions*; and home infusion therapy, including the infusion solution, when furnished by a pharmacy or other provider that is not a home infusion therapy provider (except for enteral infusion therapy and basic hydration therapy by a coordinated home health agency).

Hospice Services

Hospice Services for Terminally Ill

In-Network Benefits	Out-of-Network Benefits
YOU PAY: 10% <i>coinsurance</i> .	YOU PAY: 20% <i>coinsurance</i> after <i>deductible</i> .

The NUSHP provides benefits based on the *allowed charge* for hospice services furnished by (or arranged and billed by) a hospice provider. “Hospice services” means pain control and symptom relief and supportive and other care for a *member* who is terminally ill (the patient is expected to live six

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months or less). These services are furnished to meet the needs of the *member* and of his or her family during the illness and death of the *member*. These services may be furnished at home, in the community and in facilities. These hospice benefits include:

- Services furnished and/or arranged by the hospice provider. These may include services such as: physician, nursing, social, volunteer and counseling services, *inpatient* care, home health aide visits, drugs; and durable medical equipment.
- Respite care. This care is furnished to the hospice patient in order to relieve the family or primary care person from care giving functions.
- Bereavement services. These services are provided to the family or primary care person after the death of the hospice patient. They can include contacts, counseling, communication and correspondence.

Infertility Services

Services to Diagnose and/or Treat Infertility

These benefits are limited to *covered services* furnished by infertility providers designated by *Blue Cross and Blue Shield*.

(See also “Admissions for *Inpatient* Medical and Surgical Care.”)

In-Network Benefits	Out-of-Network Benefits
<ul style="list-style-type: none"> • For <i>outpatient</i> lab tests and x-rays and office or health center surgical services, YOU PAY: 	
10% <i>coinsurance</i> .	20% <i>coinsurance</i> after <i>deductible</i> .
<ul style="list-style-type: none"> • For <i>outpatient</i> medical care services, YOU PAY: 	
\$15 <i>copayment</i> per visit.	20% <i>coinsurance</i> after <i>deductible</i> .
<ul style="list-style-type: none"> • For <i>outpatient</i> day surgical services by a hospital, surgical day care unit or ambulatory surgical facility, YOU PAY: 	
\$50 <i>copayment</i> per admission; then, 10% <i>coinsurance</i> .	20% <i>coinsurance</i> after <i>deductible</i> .

The NUSHHP provides benefits based on the *allowed charge* for services to diagnose and treat infertility for a healthy *member* who is unable to conceive or produce conception during a period of one year. These benefits include: artificial insemination; sperm, egg and/or inseminated egg procurement and processing; banking of sperm or inseminated eggs (provided these charges are not covered by the donor’s health plan); and infertility technologies (such as in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer, natural oocyte retrieval intravaginal fertilization, intracytoplasmic sperm injection and assisted embryo hatching). **All services must be furnished in accordance with *Blue Cross and Blue Shield* medical policy and *medical technology assessment guidelines*.**

All *covered services* must be *medically necessary* for you and furnished by an infertility provider designated by *Blue Cross and Blue Shield*. If *Blue Cross and Blue Shield* determines that infertility services are not *medically necessary* for you or you receive services from an infertility provider not designated by *Blue Cross and Blue Shield*, no benefits will be provided for these services.

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No benefits are provided for: long term sperm or egg preservation or long term cryopreservation not associated with active infertility treatment; costs that are associated with achieving pregnancy through surrogacy (gestational carrier); and infertility treatment that is needed as a result of a prior sterilization or unsuccessful sterilization reversal procedure. (The NUSHP will provide benefits for *medically necessary* infertility treatment that is needed after a sterilization reversal procedure that is successful as determined by appropriate diagnostic tests.)

Lab Tests, X-Rays and Other Tests

Outpatient Diagnostic Tests, Including Preoperative Tests

In-Network Benefits	Out-of-Network Benefits
YOU PAY: 10% <i>coinsurance</i> .	YOU PAY: 20% <i>coinsurance</i> after <i>deductible</i> .

The NUSHP provides benefits based on the *allowed charge* for:

- *Diagnostic lab tests* furnished by a general, chronic disease, rehabilitation or mental hospital, surgical day care unit, ambulatory surgical facility, community health center, independent lab, physician or nurse practitioner. These tests also include diagnostic machine tests (such as pulmonary function tests and holter monitoring).
- *Diagnostic x-ray and other imaging tests* furnished by a general, chronic disease, rehabilitation or mental hospital, surgical day care unit, ambulatory surgical facility, community health center or physician. These tests also include diagnostic imaging tests by a free-standing diagnostic imaging facility.
- Preoperative tests furnished by a general hospital or community health center (that is part of a hospital). These tests must be performed before a scheduled *inpatient* or surgical day care unit admission for surgery. And, they must not be repeated during the admission. These tests include: *diagnostic lab tests*; *diagnostic x-ray and other imaging tests*; and diagnostic machine tests (such as pulmonary function tests).
- Human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to establish stem cell (“bone marrow”) transplant donor suitability when the tests are furnished to a *member* by a covered health care provider. This includes testing for A, B or DR antigens or any combination.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

Maternity Services and Well Newborn *Inpatient* Care

Maternity Services

Obstetrical Care

These benefits include *inpatient* and *outpatient* services related to pregnancy and childbirth for any female *member*.

In-Network Benefits	Out-of-Network Benefits
<ul style="list-style-type: none"> For <i>inpatient</i> admissions, YOU PAY: 	
\$250 <i>copayment</i> per admission; then, 10% <i>coinsurance</i> .	20% <i>coinsurance</i> after <i>deductible</i> .
<ul style="list-style-type: none"> For <i>outpatient</i> services (includes prenatal and postnatal care), YOU PAY: 	
10% <i>coinsurance</i> .	20% <i>coinsurance</i> after <i>deductible</i> .

The NUSHP provides benefits based on the *allowed charge* for all medical care related to pregnancy and childbirth (or miscarriage) for any female *member*. These benefits include:

- Semiprivate *room and board* and *special services* when the enrolled mother is an *inpatient* in a general hospital. Nursery charges for a well newborn are included with the benefits for the mother’s maternity admission.

The mother’s (and newborn child’s) *inpatient* stay will be no less than 48 hours following a vaginal delivery or 96 hours following a Caesarian section unless the mother and her attending physician decide otherwise as provided by law. If the mother chooses to be discharged earlier, the NUSHP provides benefits for one home visit by a physician, registered nurse, nurse midwife or nurse practitioner within 48 hours of discharge. This visit may include: parent education; assistance and training in breast or bottle feeding; and appropriate tests. The NUSHP will provide benefits for more visits by a covered health care provider only if *Blue Cross and Blue Shield* determines they are clinically necessary.

- Delivery of one or more than one baby, including prenatal and postnatal medical care furnished by a physician or nurse midwife. Your benefits for prenatal and postnatal medical care furnished by a physician or nurse midwife are included in the payment for the delivery. The benefits that are available for these obstetrical services will be those that are in effect on the date of delivery. But, when a physician or nurse midwife furnishes only prenatal and/or postnatal care, benefits are those that are available on the date the care is received.

These benefits also include prenatal and postnatal medical care exams and lab tests furnished by a general hospital or community health center. The benefits that are available for these services are those that are available on the date the care is received.

- Standby attendance furnished by a pediatrician, when a known or suspected complication threatening the health of the mother or child requires the presence of a pediatrician during the delivery.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

- Childbirth classes for up to \$90 for one childbirth course for each covered expectant mother and up to \$45 for each refresher childbirth course. The expectant mother is encouraged to attend the childbirth course recommended by her physician, health care facility or nurse midwife. You must pay the full cost of the childbirth course. After you complete the course, call the *Blue Cross and Blue Shield* customer service office for a claim form to file your claim. You will not be reimbursed unless you complete the course. There is one exception. You will be reimbursed if your delivery occurs before the course ends.

All expectant mothers enrolled in the NUSHP may take part in a program that provides support and education for expectant mothers. Through this program, *members* receive outreach and education that add to the care the *member* gets from her obstetrician or nurse midwife. You may call the *Blue Cross and Blue Shield* customer service office for more information.

Well Newborn *Inpatient* Care

Well Newborn Care During the Mother’s Maternity Admission
 (See “Maternity Services” for nursery room benefits.)

In-Network Benefits	Out-of-Network Benefits
YOU PAY: 10% <i>coinsurance</i> .	YOU PAY: 20% <i>coinsurance</i> (newborn’s <i>deductible</i> does not apply).

The NUSHP provides benefits based on the *allowed charge* for well newborn care furnished during the enrolled mother’s *inpatient* maternity stay. These benefits include:

- Pediatric care furnished by a physician (who is a pediatrician) or nurse practitioner for a well newborn. (These visits are counted toward any *benefit limit* that may apply for subsequent visits for *outpatient* routine pediatric care received during the first year of life.)
- Routine circumcision furnished by a physician.
- Newborn hearing screening tests performed by a covered health care provider before the newborn child (an infant under three months of age) is discharged from the hospital to the care of the parent or guardian.

Note: See “Admissions for *Inpatient* Medical and Surgical Care” for benefits when an enrolled newborn child requires *medically necessary inpatient* care.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

Medical Care Outpatient Visits

Outpatient Medical Care Services to Diagnose and/or Treat a Medical Condition

In-Network Benefits	Out-of-Network Benefits
YOU PAY: \$15 <i>copayment</i> per visit.	YOU PAY: 20% <i>coinsurance</i> after <i>deductible</i> .

The NUSHP provides benefits based on the *allowed charge* for *outpatient* medical care services furnished by a general, chronic disease or rehabilitation hospital, community health center, physician, nurse practitioner, nurse midwife, optometrist or licensed dietitian nutritionist or by a Christian Science sanatorium or practitioner. These benefits include:

- Medical care services to diagnose and/or treat a medical condition, illness or injury.

Women’s Health and Cancer Rights: These benefits include medical care services to treat physical complications at all stages of mastectomy, including lymphedemas, for a *member* who is receiving benefits for a mastectomy and who elects breast reconstruction in connection with the mastectomy. These services will be furnished in a manner determined in consultation with the attending physician and the patient.

- Medical exams and contact lenses (plus the fitting of these contact lenses) that are needed to treat keratoconus.
- Nutrition counseling services.
- Hormone replacement therapy for peri- and post-menopausal women.
- Follow-up care related to an accidental injury or emergency medical condition.
- Allergy testing (such as PRIST, RAST and scratch tests).
- Injections (such as allergy shots).
- Diabetes self-management training and education, including medical nutrition therapy when provided by a certified diabetes health care professional who is a covered health care provider or who is affiliated with a covered health care provider.
- Pediatric specialty care furnished by covered health care providers with recognized expertise in specialty pediatrics.
- Non-dental services furnished by a dentist only if the services would normally be covered when furnished by a physician (see Part 6, “Dental Care”).
- Monitoring and medication management for *members* taking psychiatric drugs. This also includes neuropsychological assessment services. (These services may also be furnished by a *mental health provider*.)

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

Mental Health and Substance Abuse Treatment

Mental Health and/or Substance Abuse Treatment	In-Network Benefits	Out-of-Network Benefits
	<ul style="list-style-type: none"> For <i>inpatient</i> admissions in a general or mental hospital or substance abuse facility, YOU PAY: 	
	\$250 <i>copayment</i> per admission and 10% <i>coinsurance</i> for balance up to the applicable <i>benefit limit</i> (if any).	20% <i>coinsurance</i> after <i>deductible</i> up to the applicable <i>benefit limit</i> (if any).
	<ul style="list-style-type: none"> For <i>outpatient</i> visits, YOU PAY: 	
	\$15 <i>copayment</i> per visit up to the applicable <i>benefit limit</i> (if any).	20% <i>coinsurance</i> after <i>deductible</i> up to the applicable <i>benefit limit</i> (if any).
	<p><i>Benefit Limits:</i> For non-biologically-based <i>mental conditions</i> (other than rape-related mental or emotional conditions and all conditions for enrolled children under age 19), these benefits are limited to: 60 <i>inpatient</i> days per <i>plan year</i> in a mental hospital or substance abuse facility plus 30 more days for alcoholism; and 24 <i>outpatient</i> visits per <i>member</i> per <i>plan year</i> plus 8 more visits for alcoholism.</p>	

The NUSHP covers *medically necessary* services to diagnose and/or treat *mental conditions*. This includes drug addiction and alcoholism. These benefits are provided for:

- Biologically-based *mental conditions*. “Biologically-based *mental conditions*” means:
 - Schizophrenia;
 - schizoaffective disorder;
 - major depressive disorder;
 - bipolar disorder;
 - paranoia and other psychotic disorders;
 - obsessive-compulsive disorder; panic disorder;
 - delirium and dementia;
 - affective disorders; and
 - any biologically-based *mental conditions* appearing in the most recent edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders that are scientifically recognized and approved by the Commissioner of the Department of Mental Health in consultation with the Commissioner of the Division of Insurance.
- Rape-related mental or emotional disorders for victims of a rape or victims of an assault with intent to rape.
- Non-biologically-based mental, behavior or emotional disorders of enrolled dependent children who are under age 19. This includes pediatric specialty mental health care furnished by *mental health providers* with recognized expertise in specialty pediatrics. (If a child under age 19

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is receiving an ongoing course of treatment, these benefits will continue to be provided after the child's 19th birthday until that ongoing course of treatment is completed, provided that the child or someone acting on behalf of the child continues to pay for coverage under the NUSHP or a subsequent *Blue Cross and Blue Shield* plan.)

- All other non-biologically-based *mental conditions* (including drug addiction and alcoholism) not described above.

No benefits are provided for: psychiatric services for a condition that is not a *mental condition*; residential or other care that is *custodial care*; or services and/or programs that are not *medically necessary* to treat the *member's mental condition*. Some examples of services and programs that are not covered include (but are not limited to): “outward bound-type,” “wilderness” or “ranch” programs; and services that are performed in educational, vocational or recreational settings.

Inpatient Services

The NUSHP provides benefits based on the *allowed charge* for admissions in a general or mental hospital or substance abuse treatment facility. These benefits are provided for as many days as are *medically necessary* for the *member's mental condition*, except as may be limited for certain non-biologically-based *mental conditions*. For non-biologically-based *mental conditions* (other than treatment of rape-related conditions and treatment of children who are under age 19), these benefits are limited to 60 days for each *member* in each *plan year* when the admission is in a mental hospital or substance abuse treatment facility. An additional 30 days each *plan year* is available for alcohol treatment. For *covered services*, benefits include: semiprivate *room and board*; facility *special services*; and psychiatric care furnished by a physician (who is a specialist in psychiatry), psychologist or clinical specialist in psychiatric and mental health nursing.

All services must be approved in advance. During the pre-approval process (see Part 4), *Blue Cross and Blue Shield* will assess the *member's* specific mental health needs. The least intensive type of setting that is required for the *member's* condition will be approved by *Blue Cross and Blue Shield*. There are times when a *member* will require *covered services* that are more intensive than the typical *outpatient* services. But, these services may not require that the *member* be admitted for 24-hour hospital care. These “intermediate” mental health care services that may be approved by *Blue Cross and Blue Shield* include (but are not limited to): acute residential treatment; partial hospital programs; or intensive outpatient programs. *Blue Cross and Blue Shield* will arrange for treatment with the appropriate *mental health provider*.

If an *inpatient day benefit limit* applies for the *mental condition* (see above), these treatments will be counted as part of the day limit as follows:

- One acute residential treatment day will count as one day of your *inpatient day limit*.
- Two partial hospital treatment days will count as one day of your *inpatient day limit*.
- Two intensive outpatient treatment days will count as one day of your *inpatient day limit*.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

(Since *Blue Cross and Blue Shield* considers benefits for these intermediate mental health care services to be an *inpatient* benefit, any *benefit limits* or *member* cost sharing for *outpatient* mental health services will **not** apply.)

Outpatient Services

The NUSHP provides benefits based on the *allowed charge* for *outpatient* services furnished by a *mental health provider*. These benefits are provided for as many visits as are *medically necessary* for the *member's mental condition*, except as may be limited for certain non-biologically-based *mental conditions*. For non-biologically-based *mental conditions* (other than treatment of rape-related conditions and treatment of children who are under age 19), these benefits are limited to 24 visits for each *member* in each *plan year*. An additional 8 visits each *plan year* are available for alcohol treatment. These *outpatient benefit limits* do not apply to electric shock therapy.

Oxygen and Respiratory Therapy

Oxygen for Home Use and Outpatient Respiratory Therapy

In-Network Benefits	Out-of-Network Benefits
<ul style="list-style-type: none"> For oxygen and equipment for its administration, YOU PAY: 	
10% <i>coinsurance</i> .	20% <i>coinsurance</i> after <i>deductible</i> .
<ul style="list-style-type: none"> For <i>outpatient</i> respiratory therapy, YOU PAY: 	
\$15 <i>copayment</i> per visit.	20% <i>coinsurance</i> after <i>deductible</i> .

The NUSHP provides benefits based on the *allowed charge* for:

- Oxygen and the equipment to administer it for use in the home when obtained from an oxygen supplier. This includes oxygen concentrators.
- Respiratory therapy services furnished by a general, chronic disease or rehabilitation hospital or community health center. Some examples include postural drainage and chest percussion.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

Pharmacy Services and Supplies

Prescription Drugs and Other Covered Supplies Obtained From a Pharmacy

Note: The overall *deductible* does not apply to these *covered services*.

In-Network Benefits	Out-of-Network Benefits
<ul style="list-style-type: none"> Retail Pharmacy Benefit (<i>copayment</i> applies for up to a 30-day supply), YOU PAY: 	
<p>Generic: \$5 <i>copayment</i>. Brand-name: \$15 <i>copayment</i>.</p>	Not covered except while living or traveling out of Massachusetts; otherwise, you pay all costs.
<ul style="list-style-type: none"> Mail Service Pharmacy 	
Not covered.	Not covered.

The NUSHHP provides these prescription drug benefits for covered drugs and supplies you obtain from a pharmacy **only** when all of the following criteria are met:

- The drug or supply is listed on the *Blue Cross and Blue Shield* Drug Formulary as a covered drug or supply. For certain drugs (such as growth hormones), prior approval is required from *Blue Cross and Blue Shield* in order for you to receive these benefits. (The pharmacy will tell you if your drug needs prior approval and how to request this approval.)
- The drug or supply is prescribed for use out of the hospital or another health care facility.
- The drug or supply is purchased from a pharmacy that is approved by *Blue Cross and Blue Shield* for payment for the specific covered drug and/or supply. This means that for most covered drugs and supplies, you may buy your drug or supply from any retail pharmacy. However, for a select number of covered drugs and supplies, you may need to buy your drug or supply from certain pharmacies that specialize in treating specific diseases and that have been approved by *Blue Cross and Blue Shield* for payment for that specific covered drug or supply.

The Drug Formulary. The *Blue Cross and Blue Shield* Drug Formulary is a list of *Blue Cross and Blue Shield* approved drugs and supplies. Under its agreement with the *group*, *Blue Cross and Blue Shield* has the right to update its Drug Formulary from time to time. In this case, your benefits for certain drugs and supplies may change. (For example, a drug may be added to or excluded from the Drug Formulary.) **If you have any questions about this Drug Formulary or about which drugs are not included on the Drug Formulary, you may call the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your health plan identification card. Or, you may look on the *Blue Cross and Blue Shield* internet website at www.bluecrossma.com.** (For the current list of drugs not included on the Drug Formulary, you may also refer to the current version of the *Blue Cross and Blue Shield* Pharmacy Program booklet.)

Drug Formulary Exception Process. These drug benefits include a drug formulary exception process. This process allows your prescribing physician to request an exception from *Blue Cross and Blue Shield* to obtain benefits for a drug (or supply) that is not included on the *Blue Cross and Blue*

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

Shield formulary. *Blue Cross and Blue Shield* will consider a drug formulary exception request if there is a medical basis for your not being able to take any of the covered drugs from the same therapeutic class. If the drug formulary exception request is approved, benefits for the drug (or supply) that is not included on the *Blue Cross and Blue Shield* formulary will be provided to the same extent as benefits are provided for a covered drug (or supply) at the highest *member* cost-share level.

Buying Covered Drugs and Supplies. For help to obtain your pharmacy benefits, you may call the *Blue Cross and Blue Shield* customer service office. The toll-free telephone number is shown on your health plan identification card. A customer service representative can help you find a covered pharmacy where you may buy a specific drug or supply. They can also help you find out which *member* cost-share level you will pay for a specific covered drug or supply. Or, you may also look on the internet website at www.bluecrossma.com.

(Remember: When you buy your drugs or supplies, the pharmacist may give you a generic equivalent of the prescribed drug when allowed.)

Covered Drugs and Supplies. These pharmacy benefits are provided for:

- Drugs that require a prescription by law and are furnished in accordance with *Blue Cross and Blue Shield medical technology assessment guidelines*. These include: birth control drugs; oral diabetes medication that influences blood sugar levels; hormone replacement therapy drugs for peri- and post-menopausal women; and certain drugs used on an off-label basis (such as drugs used to treat cancer and drugs used to treat HIV/AIDS).
- Injectable insulin and disposable syringes and needles needed for its administration and/or insulin injection pens, whether or not a prescription is required. (If insulin, syringes and needles are bought at the same time, when a *copayment* applies, you pay two *copayments*: one for the insulin; and one for the syringes and needles.)
- Materials to test for the presence of sugar, including blood glucose monitoring strips, ketone strips, lancets, urine glucose testing strips, normal, low and high calibrator solution/chips and dextrostik or glucose test strips when ordered by a physician for home use. (For your benefits for glucometers see “Durable Medical Equipment.”)
- Insulin infusion pumps and related pump supplies. (You will obtain the insulin infusion pump from an appliance company instead of a pharmacy. For the insulin infusion pump itself, the cost you would normally pay for covered drugs and supplies will be waived.)
- Drugs that do not require a prescription by law (“over-the-counter” drugs), if any, that are listed on the *Blue Cross and Blue Shield* drug formulary as a covered drug. The *Blue Cross and Blue Shield* Pharmacy Program booklet will list the over-the-counter drugs that are covered by the NUSHP, if there are any. Or, you may look on the *Blue Cross and Blue Shield* internet website at www.bluecrossma.com.
- Special medical formulas that are *medically necessary* to treat: homocystinuria; maple syrup urine disease; phenylketonuria; propionic acidemia; methylmalonic acidemia; and tyrosinemia.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

- Enteral formulas for home use that are *medically necessary* to treat malabsorption caused by: Crohn's disease; chronic intestinal pseudo-obstruction; gastroesophageal reflux; gastrointestinal motility; ulcerative colitis; and inherited diseases of amino acids and organic acids.
- Food products modified to be low protein that are *medically necessary* to treat inherited diseases of amino acids and organic acids for up to a \$2,500 *benefit limit* for each *member* in each *plan year*. You may buy these food products directly from a distributor.
- Diaphragms (when a *copayment* applies, you pay the same *copayment* as for generic drugs) and other prescription birth control devices that have been approved by the U.S. Food and Drug Administration (FDA).
- Prescription prenatal vitamins and pediatric vitamins with fluoride.
- Nicotine gum or nicotine patches (or other smoking cessation aids that require a prescription by law) when prescribed by a physician for up to a 90-day supply *benefit limit* for each *member* in each *plan year*.

Non-Covered Drugs and Supplies. No benefits are provided for:

- Anorexiant.
- Pharmaceuticals that you can buy without a prescription, except as described above.
- Medical supplies such as dressings and antiseptics.
- The cost of delivering drugs to you.
- Combination vitamins that require a prescription, except for prescription prenatal vitamins and pediatric vitamins with fluoride.
- Dental topical fluoride, rinses and gels that require a prescription.
- Immunizing agents, toxoids, blood and blood products.
- Drugs and supplies that you buy from a non-designated mail service pharmacy or a drug or supply that you buy from a pharmacy other than a pharmacy that has been approved by *Blue Cross and Blue Shield* for payment for that specific covered drug or supply.
- Drugs and supplies dispensed or administered by providers such as physician assistants, home health care providers and visiting nurses when supplied by the provider during the visit.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

Podiatry Care

Outpatient Medically Necessary Foot Care

(See also “Admissions for Inpatient Medical and Surgical Care.”)

In-Network Benefits	Out-of-Network Benefits
<ul style="list-style-type: none"> For <i>outpatient</i> lab tests and x-rays and office or health center surgical services, YOU PAY: 	
10% <i>coinsurance</i> .	20% <i>coinsurance</i> after <i>deductible</i> .
<ul style="list-style-type: none"> For <i>outpatient</i> medical care services, YOU PAY: 	
\$15 <i>copayment</i> per visit.	20% <i>coinsurance</i> after <i>deductible</i> .
<ul style="list-style-type: none"> For <i>outpatient</i> day surgical services by a hospital, surgical day care unit or ambulatory surgical facility, YOU PAY: 	
\$50 <i>copayment</i> per admission; then, 10% <i>coinsurance</i> .	20% <i>coinsurance</i> after <i>deductible</i> .

The NUSHHP provides benefits based on the *allowed charge* for non-routine podiatry (foot) care furnished by a general hospital, surgical day care unit, ambulatory surgical facility, community health center, physician or podiatrist. These benefits include:

- *Diagnostic lab tests*.
- Diagnostic x-rays.
- Surgical services (including related anesthesia) and necessary postoperative care.
- Other *medically necessary* medical care services (such as foot care treatment for hammertoe and osteoarthritis).
- Routine foot care (such as trimming of corns, trimming of toenails and other hygienic care) when the care is *medically necessary* because you have systemic circulatory disease (such as diabetes).

No benefits are provided for: routine foot care, except when the care is *medically necessary* because the *member* has systemic circulatory disease; and certain foot care services and supplies such as foot orthotics, arch supports, shoe (foot) inserts, orthopedic and corrective shoes that are not part of a leg brace (except as described in this Benefit Description for “Prosthetic Devices”) and fittings, castings and other services related to devices for the feet.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

Preventive Health Services

Routine Pediatric Care

Routine Pediatric Care Through Age 18

These benefits are limited to an age-based schedule: six visits during first year of life; three visits during second year of life; and one visit per *plan year* from age 2 through age 18.

In-Network Benefits	Out-of-Network Benefits
<ul style="list-style-type: none"> For covered routine pediatric exams, YOU PAY: 	
\$15 <i>copayment</i> per visit for <i>covered services</i> ; otherwise, you pay all costs.	20% <i>coinsurance</i> after <i>deductible</i> for <i>covered services</i> ; otherwise, you pay all costs.
<ul style="list-style-type: none"> For immunizations, YOU PAY: 	
\$15 <i>copayment</i> per visit.	20% <i>coinsurance</i> after <i>deductible</i> .
<ul style="list-style-type: none"> For covered routine lab tests and x-rays, YOU PAY: 	
Nothing for <i>covered services</i> ; otherwise, you pay all costs.	20% <i>coinsurance</i> after <i>deductible</i> for <i>covered services</i> ; otherwise, you pay all costs.

The NUSHP provides benefits based on the *allowed charge* for routine pediatric care furnished by a general hospital, community health center, independent lab, physician or nurse practitioner. These benefits include:

- Routine medical exams, history, measurements, sensory screening, neuropsychiatric evaluation and development screening and assessment and related routine services furnished in accordance with *Blue Cross and Blue Shield* medical policy guidelines.
- Hereditary and metabolic screening at birth.
- Appropriate immunizations (including flu shots and travel immunizations).
- Tuberculin tests.
- Hematocrit, hemoglobin and other appropriate blood tests.
- Urinalysis.
- Blood tests to screen for lead poisoning.

For an enrolled dependent child who gets benefits for hepatitis B vaccine from a state agency, the NUSHP provides benefits only to administer the vaccine. Otherwise, the NUSHP also provides benefits for the hepatitis B vaccine when the child is at high risk for getting the disease.

No benefits are provided for exams that are needed: to take part in school, camp and sports activities; or by third parties. The only exception to this is when these exams are furnished as part of a covered routine exam.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

Routine Adult Physical Exams

Routine Medical Exams and Routine Tests for Members Age 19 and Older

These benefits are limited to an age-based schedule: once every five years for age 19 through 29; once every three years for age 30 through 39; once every two years for age 40 through 54; and once per *plan year* for age 55 or older.

In-Network Benefits	Out-of-Network Benefits
<ul style="list-style-type: none"> For covered routine medical exams, YOU PAY: 	
\$15 <i>copayment</i> per visit for covered visits; otherwise, you pay all costs.	20% <i>coinsurance</i> after <i>deductible</i> for covered visits; otherwise, you pay all costs.
<ul style="list-style-type: none"> For routine lab tests and x-rays related to covered medical exams, YOU PAY: 	
Nothing for <i>covered services</i> ; otherwise, you pay all costs.	20% <i>coinsurance</i> after <i>deductible</i> for <i>covered services</i> ; otherwise, you pay all costs.
<ul style="list-style-type: none"> For immunizations, YOU PAY: 	
\$15 <i>copayment</i> per visit	20% <i>coinsurance</i> after <i>deductible</i>

The NUSHHP provides benefits based on the *allowed charge* for routine adult physical exams furnished by a general hospital, community health center, independent lab, physician, nurse practitioner or nurse midwife. These benefits include:

- Routine medical exams, including related routine lab tests and x-rays furnished in accordance with *Blue Cross and Blue Shield* medical policy guidelines.
- Immunizations (such as flu shots and travel immunizations).
- Routine mammograms once between age 35 through 39 and once in each *plan year* for a *member* age 40 or older.
- Routine prostate-specific antigen (PSA) blood tests once in each *plan year* for a *member* age 40 or older.
- Routine sigmoidoscopies or barium enemas once every three *plan years* for a *member* age 50 or older.
- Routine colonoscopies once every ten *plan years* for a *member* age 50 or older.

No benefits are provided for exams that are needed: to take part in school, camp and sports activities; or by employers or third parties. The only exception to this is when these exams are furnished as part of a covered routine exam.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

Routine Gynecological (GYN) Exams

Yearly Routine GYN Exams and Pap Smear Tests	In-Network Benefits	Out-of-Network Benefits
	<ul style="list-style-type: none"> For routine GYN exam once per <i>member per plan year</i>, YOU PAY: \$15 <i>copayment</i> per covered exam; otherwise, you pay all costs. 	20% <i>coinsurance</i> after <i>deductible</i> for covered exam; otherwise, you pay all costs.
<ul style="list-style-type: none"> For routine Pap smear tests and other related routine lab tests once per <i>member per plan year</i>, YOU PAY: 	20% <i>coinsurance</i> after <i>deductible</i> for <i>covered services</i> ; otherwise, you pay all costs.	
<ul style="list-style-type: none"> Nothing for <i>covered services</i>; otherwise, you pay all costs. 	20% <i>coinsurance</i> after <i>deductible</i> for <i>covered services</i> ; otherwise, you pay all costs.	

The NUSHHP provides benefits based on the *allowed charge* for yearly routine GYN exams, including routine Pap smear tests and other related routine lab tests, furnished by a general hospital, community health center, physician, nurse practitioner, nurse midwife or independent lab.

Family Planning

Medical Services Related to the Use of FDA Approved Contraceptive Methods	In-Network Benefits	Out-of-Network Benefits
	YOU PAY: \$15 <i>copayment</i> per visit.	YOU PAY: 20% <i>coinsurance</i> after <i>deductible</i> .

The NUSHHP provides benefits based on the *allowed charge* for family planning services furnished by a general hospital, community health center, physician, nurse practitioner or nurse midwife. These benefits include:

- Consultations, exams, procedures and medical services related to the use of all contraceptive methods to prevent pregnancy that have been approved by the U.S. Food and Drug Administration (FDA).
- Injection of birth control drugs, including the prescription drug when supplied by the health care provider during the visit.
- Insertion of a levonorgestrel implant system, including the implant system itself.
- IUDs, diaphragms and other prescription contraceptive methods that have been approved by the U.S. Food and Drug Administration (FDA), when the items are supplied by the health care provider during the visit.
- Genetic counseling.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

No benefits are provided for: services related to achieving pregnancy through a surrogate (gestational carrier); and non-prescription birth control preparations (for example, condoms, birth control foams, jellies and sponges).

Routine Hearing Exams

Routine Hearing Exams and Tests	In-Network Benefits	Out-of-Network Benefits
	<ul style="list-style-type: none"> For routine hearing exams, YOU PAY: 	
	\$15 <i>copayment</i> per visit.	20% <i>coinsurance</i> after <i>deductible</i> .
	<ul style="list-style-type: none"> For routine hearing tests (includes newborn hearing screening tests), YOU PAY: 	
	Nothing	20% <i>coinsurance</i> after <i>deductible</i>

The NUSHP provides benefits based on the *allowed charge* for:

- Routine hearing exams (including hearing tests that are part of a covered hearing exam) furnished by a general hospital, community health center or physician.
- Newborn hearing screening tests for a newborn child (an infant under three months of age) when furnished by a covered health care provider. (See “Maternity Services and Well Newborn *Inpatient Care*” for your *inpatient* benefits.)

Prosthetic Devices

Prosthetic Devices (See below for the <i>benefit limit</i> that applies to scalp hair prostheses.)	In-Network Benefits	Out-of-Network Benefits
	YOU PAY: 10% <i>coinsurance</i> (for covered wigs, up to the <i>benefit limit</i>).	YOU PAY: 20% <i>coinsurance</i> after <i>deductible</i> (for covered wigs, up to the <i>benefit limit</i>).

The NUSHP provides benefits based on the *allowed charge* for prosthetic devices you get from an appliance company (or another provider who is designated by *Blue Cross and Blue Shield* to furnish the covered prosthetic device). These benefits include devices that are: used to replace the function of a missing body part; made to be fitted to your body as an external substitute; and not useful when you are not ill or injured. Examples of prosthetic devices include (but are not limited to):

- Artificial arms, legs and eyes.
- Ostomy supplies.
- Urinary catheters.
- Breast prostheses, including mastectomy bras.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

- Wigs (scalp hair prostheses) for up to a *benefit limit* of \$500 for each *member* in each *plan year* when hair loss is due to chemotherapy, radiation therapy, infections, burns, traumatic injury, congenital baldness and medical conditions resulting in alopecia areata or alopecia totalis (capitus). (No benefits are provided for wigs when hair loss is due to: male pattern baldness; female pattern baldness; or natural or premature aging.)
- Therapeutic/molded shoes and shoe inserts for a *member* with severe diabetic foot disease.

Note: See “Pharmacy Services and Supplies” for your benefits for insulin infusion pumps and related pump supplies that are *medically necessary* for *members* with insulin dependent diabetes.

The NUSHP provides these benefits for the least expensive prosthesis of its type that meets your needs. If *Blue Cross and Blue Shield* determines that you chose a prosthesis that costs more than what you need for your medical condition, the NUSHP will provide benefits only for those charges that would have been paid for the least expensive prosthesis that meets your needs. In this case, you pay the provider’s charges that are more than the claim payment.

Qualified Clinical Trials for Treatment of Cancer

Covered Services Furnished in a Qualified Clinical Trial

(For *inpatient* admissions, see “Admissions for *Inpatient* Medical and Surgical Care.”)

In-Network Benefits

Out-of-Network Benefits

These benefits are provided to the same extent as they would have been provided if the patient did not participate in a trial. (For your cost, see the applicable *covered services* sections in Part 5.)

The NUSHP provides benefits for health care services received by a *member* who is enrolled in a qualified clinical trial (for treatment of cancer). These benefits are provided for health care services that are consistent with the standard of care for someone with the patient’s diagnosis, consistent with the study protocol, and that would be covered if the patient did not participate in the trial. This includes investigational drugs and devices that have been approved for use as part of the trial. These benefits are provided to the same extent as they would have been provided if the patient did not participate in a trial.

No benefits are provided for:

- Investigational drugs and devices that have not been approved for use in the trial.
- Investigational drugs and devices that are paid for by the manufacturer, distributor or provider of the drug or device, whether or not the drug or device has been approved for use in the trial.
- Non-*covered services* under the NUSHP.
- Costs associated with managing the research for the trial.
- Items, services or costs that are reimbursed or otherwise furnished by the sponsor of the trial.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

- Costs that are inconsistent with widely accepted and established national and regional standards of care.
- Costs for clinical trials that are not “qualified trials” as defined by law.

Radiation Therapy and Chemotherapy

Outpatient Radiation Therapy and/or Chemotherapy Services

In-Network Benefits	Out-of-Network Benefits
<ul style="list-style-type: none"> • For <i>outpatient</i> hospital and free-standing radiation therapy and chemotherapy facility services, YOU PAY: 	
10% <i>coinsurance</i> .	20% <i>coinsurance</i> after <i>deductible</i> .
<ul style="list-style-type: none"> • For office and health center visits, YOU PAY: 	
10% <i>coinsurance</i> .	20% <i>coinsurance</i> after <i>deductible</i> .

The NUSHHP provides benefits based on the *allowed charge* for radiation and x-ray therapy and chemotherapy furnished by a general, chronic disease or rehabilitation hospital, community health center, free-standing radiation therapy and chemotherapy facility, physician, nurse practitioner or other covered health care provider with a recognized expertise in specialty pediatrics. These benefits include:

- Radiation therapy using isotopes, radium, radon or other ionizing radiation.
- X-ray therapy for cancer or when used in place of surgery.
- Drug therapy for cancer (chemotherapy).

Second Opinions

Outpatient Second and Third Surgical Opinions

In-Network Benefits	Out-of-Network Benefits
YOU PAY: \$15 <i>copayment</i> per visit.	YOU PAY: 20% <i>coinsurance</i> after <i>deductible</i> .

When your physician recommends that you have non-emergency surgery, the NUSHHP provides benefits based on the *allowed charge* for an *outpatient* second surgical opinion by a consulting physician. This includes a third opinion when the second opinion differs from the first. (See “Lab Tests, X-Rays and Other Tests” for your benefits for related diagnostic tests.)

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

Short-Term Rehabilitation Therapy

Outpatient Short-Term Rehabilitation Therapy (Physical, Speech and Occupational Therapy)

These benefits are limited to \$1,500 per *member* per *plan year*. (This *benefit limit* also includes benefits that are paid for chiropractors' medical care services.)

In-Network Benefits	Out-of-Network Benefits
YOU PAY: \$15 <i>copayment</i> per visit up to the <i>benefit limit</i> .	YOU PAY: 20% <i>coinsurance</i> after <i>deductible</i> up to the <i>benefit limit</i> .
This <i>benefit limit</i> does not apply when <i>covered services</i> are furnished as part of approved home health care or speech therapy to diagnose and/or treat speech, hearing and language disorders.	

The NUSHHP provides benefits based on the *allowed charge* for *medically necessary* short-term rehabilitation therapy furnished by a general, chronic disease or rehabilitation hospital, skilled nursing facility, community health center, physical therapist, licensed speech-language pathologist, occupational therapist or other covered health care provider with a recognized expertise in specialty pediatrics. These benefits include: physical therapy; speech/language therapy; occupational therapy; or an organized program of these combined services.

Speech, Hearing and Language Disorder Treatment

Outpatient Services to Diagnose and/or Treat Speech, Hearing and Language Disorders

In-Network Benefits	Out-of-Network Benefits
• For <i>outpatient</i> diagnostic tests, YOU PAY:	
10% <i>coinsurance</i> .	20% <i>coinsurance</i> after <i>deductible</i> .
• For <i>outpatient</i> medical care services and speech therapy, YOU PAY:	
\$15 <i>copayment</i> per visit.	20% <i>coinsurance</i> after <i>deductible</i> .

The NUSHHP provides benefits based on the *allowed charge* for *medically necessary* services to diagnose and treat speech, hearing and language disorders when the services are furnished by a general, chronic disease or rehabilitation hospital, skilled nursing facility, community health center, physician, nurse practitioner, licensed audiologist, licensed speech-language pathologist or other covered health care provider with a recognized expertise in specialty pediatrics. These benefits include:

- Medical care services to diagnose or treat speech, hearing and language disorders.
- Diagnostic tests.
- Speech/language therapy.

No benefits are provided when these services are furnished in a school-based setting.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

Surgery as an Outpatient

Outpatient Surgical Services, Including Related Anesthesia

In-Network Benefits	Out-of-Network Benefits
<ul style="list-style-type: none"> For <i>outpatient</i> day hospital, surgical day care unit and ambulatory surgical facility services, YOU PAY: 	
\$50 <i>copayment*</i> per admission; then, 10% <i>coinsurance</i> .	
*You must also pay a \$100 <i>copayment</i> for the surgeon's charges when the surgery is for removal of impacted wisdom teeth. This is in addition to your day surgery <i>copayment</i> and 10% <i>coinsurance</i> .	20% <i>coinsurance</i> after <i>deductible</i> .
<ul style="list-style-type: none"> For office and health center visits, YOU PAY: 	
10% <i>coinsurance</i> .	20% <i>coinsurance</i> after <i>deductible</i> .

The NUSHP provides benefits based on the *allowed charge* for *outpatient* surgical services by a surgical day care unit, ambulatory surgical facility, general, chronic disease or rehabilitation hospital, community health center, physician, dentist, nurse practitioner or other covered health care provider with a recognized expertise in specialty pediatrics. These benefits include:

- Routine circumcision.
- Voluntary termination of pregnancy and voluntary sterilization procedures.
- Endoscopic procedures.
- Surgical procedures (including emergency and scheduled surgery). These surgical services include (but are not limited to):
 - Reconstructive surgery. This non-dental surgery is meant to improve or give back bodily function or correct a functional physical impairment that was caused by a birth defect, a prior surgical procedure or disease or an accidental injury. This also includes surgery to correct a deformity or disfigurement that was caused by an accidental injury.

Women's Health and Cancer Rights: These benefits include reconstructive surgery for a *member* who is receiving benefits for a mastectomy and who elects breast reconstruction in connection with the mastectomy. The NUSHP provides benefits for: all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas. These services will be furnished in a manner determined in consultation with the attending physician and the patient.

REMEMBER: Pay close attention to all *benefit limits*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for the specific service or supply.

- Human organ and stem cell (“bone marrow”) transplants furnished in accordance with *Blue Cross and Blue Shield* medical policy and *medical technology assessment guidelines*. This includes one or more stem cell transplants for a *member* who has been diagnosed with breast cancer that has spread. For covered transplants, benefits also include the harvesting of the donor’s organ or stem cells when the recipient is a *member* (“harvesting” includes the surgical removal of the donor’s organ or stem cells and related *medically necessary* services and/or tests that are required to perform the transplant itself) and drug therapy during the transplant procedure to prevent rejection of the transplanted organ/tissue or stem cells. (See “Lab Tests, X-Rays and Other Tests” for benefits for transplant donor suitability testing.) No benefits are provided for harvesting of the donor’s organ or stem cells when the recipient is not a *member*.
- Oral surgery. This includes: reduction of a dislocation or fracture of the jaw or facial bone; excision of a benign or malignant tumor of the jaw; and orthognathic surgery that you need to correct a significant functional impairment that cannot be adequately corrected with orthodontic services when the surgery is furnished at a hospital provided that you have a serious medical condition that requires that you be admitted to a surgical day care unit of a hospital or to an ambulatory surgical facility in order for the surgery to be safely performed. These benefits are also provided when the surgery is furnished at an oral surgeon’s office. (Orthognathic surgery is not covered when it is performed primarily for cosmetic reasons. This surgery must be performed along with orthodontic services. If it is not, the oral surgeon must send a letter to *Blue Cross* and *Blue Shield* asking for approval for the surgery. No benefits are provided for the orthodontic services.)

Covered oral surgery includes removal of impacted wisdom teeth that are fully or partially imbedded in the bone. **However, benefits for *inpatient* and/or *outpatient* removal of impacted wisdom teeth are limited to a total of \$2,500 for each *member* in each *plan year*.**

- Non-dental surgery and necessary postoperative care furnished by a dentist (see Part 6, “Dental Care”).
 - Necessary postoperative care after covered *inpatient* or *outpatient* surgery.
 - Anesthesia services related to covered surgery, including anesthesia administered by a physician other than the attending physician or by a certified registered nurse anesthetist.

Part 6

Limitations and Exclusions

The benefits described in this Benefit Description are limited or excluded as described in this section. (Other limitations or restrictions and exclusions on your benefits may be found in Parts 3, 4, 5 and 7. You should be sure to read all provisions described in this Benefit Description.)

Admissions before *Effective Date*

The benefits described in this Benefit Description are provided only for *covered services* furnished on or after your *effective date*. If you are already an *inpatient* in a hospital (or another covered health care facility) on your *effective date*, the NUSHP will provide benefits starting on your *effective date*. But, these benefits are subject to all the provisions described in this Benefit Description.

Benefits from Other Sources

No benefits are provided for health care services and supplies to treat an illness or injury for which you have the right to benefits under government programs. These include the Veterans Administration for an illness or injury connected to military service. They also include programs set up by other local, state, federal or foreign laws or regulations that provide or pay for health care services and supplies or that require care or treatment to be furnished in a public facility. No benefits are provided if you could have received governmental benefits by applying for them on time. (This exclusion does not include Medicaid or Medicare. See Part 7 for more information if you are eligible for Medicare benefits.)

Birth Control

No benefits are provided for over-the-counter birth control preparations (for example, condoms, birth control foams, jellies and sponges). See Part 5 for your benefits for family planning and prescription drugs and devices obtained from a pharmacy.

Blood and Related Fees

No benefits are provided for: whole blood; packed red blood cells; blood donor fees; and blood storage fees.

Cosmetic Services and Procedures

No benefits are provided for cosmetic services that are performed solely for the purpose of making you look better, whether or not these services are meant to make you feel better about yourself or treat a *mental condition*. For example, no benefits are provided for: acne related services such as the removal of acne cysts, injections to raise acne scars, cosmetic surgery and dermabrasion or other procedures to plane the skin; electrolysis; hair removal or restoration (except as described in Part 5 for scalp hair prostheses); and liposuction. (See Part 5 for your benefits for reconstructive surgery.)

Custodial Care

No benefits are provided for *custodial care*. This type of care may be furnished with or without routine nursing or other medical care and the supervision or care of a physician.

Dental Care

Unless otherwise described in Part 5, no benefits are provided for services that *Blue Cross and Blue Shield* determines to be for dental care, even when the dental condition is related to or caused by a medical condition or medical treatment. However, benefits are provided for facility charges when you have a serious medical condition that requires that you be admitted to a hospital as an *inpatient* or to a surgical day care unit of a hospital or to an ambulatory surgical facility in order for dental care to be safely performed. Some examples of serious medical conditions are hemophilia and heart disease.

Educational Testing and Evaluations

No benefits are provided for exams, evaluations or services that are performed solely for educational or developmental purposes. The only exceptions are for: early intervention services when covered by the NUSHP; treatment of *mental conditions* for children with serious behavioral or emotional disorders when covered by the NUSHP; and *covered services* to diagnose and/or treat speech, hearing and language disorders. (See Part 5.)

Exams/Treatment Required by a Third Party

No benefits are provided for physical, psychiatric and psychological exams, treatments and related services that are required by third parties. Some examples of *non-covered services* are: exams and tests required for recreational activities, employment, insurance and school; and court-ordered exams and services, except for *medically necessary* services. (But, certain exams may be covered when they are furnished as part of a covered routine physical exam.)

Experimental Services and Procedures

The benefits described in this Benefit Description are provided only when *covered services* are furnished in accordance with *Blue Cross and Blue Shield medical technology assessment guidelines*. No benefits are provided for health care charges that are received for or related to care that *Blue Cross and Blue Shield* considers to be experimental services or procedures. The fact that a treatment is offered as a last resort does not mean that benefits will be provided for it. There are two exceptions to this exclusion. The NUSHP does provide benefits for:

- One or more stem cell (“bone marrow”) transplants for a *member* who has been diagnosed with breast cancer that has spread.
- Certain drugs used on an off-label basis. Some examples are: drugs used to treat cancer; and drugs used to treat HIV/AIDS.

Eye Exams and Eyewear

No benefits are provided for routine vision exams and eyeglasses and contact lenses or exams to prescribe, fit or change them. There are two exceptions to this exclusion. The NUSHP does provide benefits for:

- Contact lenses when they are needed to treat keratoconus (including the fitting of these contact lenses).
- Intraocular lenses that are implanted after covered corneal transplant, cataract surgery or other covered eye surgery when the natural eye lens is replaced.

Hearing Aids

No benefits are provided for hearing aids or exams to prescribe, fit or change them.

Medical Devices, Appliances, Materials and Supplies

No benefits are provided for medical devices, appliances, materials and supplies, except as otherwise described in Part 5. Some examples of non-covered items are:

- Devices such as: air conditioners; air purifiers; arch supports; bath seats; bed pans; bath tub grip bars; chair lifts; computers; computerized communication devices; computer software; dehumidifiers; dentures; elevators; foot orthotics; heating pads; hot water bottles; humidifiers; orthopedic and corrective shoes that are not part of a leg brace; raised toilet seats; and shoe (foot) inserts.
- Special clothing, except for gradient pressure support aids for lymphedema or venous disease and clothing needed to wear a covered device (for example, mastectomy bras and stump socks).
- Self-monitoring devices, except for certain devices that *Blue Cross and Blue Shield* decides would give a *member* having particular symptoms the ability to detect or stop the onset of a sudden life-threatening condition.

Missed Appointments

No benefits are provided for charges for appointments that you do not keep. Physicians and other providers may charge you for failing to keep your scheduled appointments. They may do so if you do not give reasonable notice to the office. You must pay for these charges. Appointments that you do not keep are not counted against any *benefit limits* described in this Benefit Description.

Non-Covered Providers

No benefits are provided for any services and supplies furnished by the kinds of health care providers that are not covered by the NUSHP. For each *covered service*, this Benefit Description specifies the kinds of health care providers that are covered. (See Part 2, “Definitions.” The definition of “*preferred provider*” describes those types of health care providers that are covered by the NUSHP.)

Non-Covered Services

No benefits are provided for:

- A service or supply that is not described as a *covered service* in this Benefit Description. Some examples of *non-covered services* are: acupuncture; private duty nursing; weight loss programs; and fitness benefits.

There is one exception to this exclusion. As other services and supplies are approved by the U.S. Food and Drug Administration (FDA) for the diagnosis and treatment of insulin dependent, insulin using, gestational or non-insulin dependent diabetes, your benefits will be changed to include those services and supplies as long as they can be classified under categories of services or supplies that are already covered under this Benefit Description and are in accordance with *Blue Cross and Blue Shield medical technology assessment guidelines*.

- Services and supplies that do not conform to *Blue Cross and Blue Shield* medical policy guidelines.
- Services or supplies that you received when you were not enrolled in the NUSHP. There is one exception to this exclusion. The NUSHP does provide benefits for routine nursery charges and may provide benefits for other well newborn care. But, to ensure benefits for all *covered services* (including circumcision) for the newborn child, you must remember to enroll the newborn under the *subscriber's* membership within the time period required to make family status changes (see Part 11).
- Any service or supply furnished along with a *non-covered service*.
- Any service or supply furnished by a provider who has not been approved by *Blue Cross and Blue Shield* for payment for the specific service or supply.
- Services and supplies that are not considered *medically necessary* by *Blue Cross and Blue Shield*, except as otherwise described in this Benefit Description.
- Services that are furnished to someone other than the patient, except as described in this Benefit Description for: hospice services; and harvesting of a donor's organ or stem cells (which includes the surgical removal of the donor's organ or stem cells and related *medically necessary* services and/or tests that are required to perform the transplant itself) when the recipient is a *member*.
- Services that are furnished to all patients due to a facility's routine admission requirements.

- Services and supplies that are related to sex change surgery or to the reversal of a sex change.
- A provider’s charge for shipping and handling, taxes or interest (finance charges).
- A provider’s charge to file a claim. Also, a provider’s charge to transcribe or copy your medical records.
- A separate fee for services by interns, residents, fellows or other physicians who are salaried employees of the hospital or other facility.
- Expenses that you have when you choose to stay in a hospital or other health care facility beyond the discharge time determined by *Blue Cross and Blue Shield*.

Overall Benefit Maximum

When the benefits described in this Benefit Description are subject to an overall benefit maximum, no further benefits are provided by the NUSHHP once this overall benefit maximum has been reached. (There may also be *benefit limits* or restrictions that apply for certain *covered services*. See Part 5, “*Covered Services*” for information about *benefit limits* for specific services and supplies.)

Your Overall Benefit Maximum	In-Network Benefits	Out-of-Network Benefits
	None	None

If you reach your overall benefit maximum, this amount may be restored. This is the case if *Blue Cross and Blue Shield* finds that your health condition and complications of that condition that caused the maximum to be reached are no longer present or no longer need care or treatment. *Blue Cross and Blue Shield* will review your request to restore your overall benefit maximum. When *Blue Cross and Blue Shield* does this, it will use medical data such as recent claims history. *Blue Cross and Blue Shield* will also ask for a statement from your physician.

Personal Comfort Items

No benefits are provided for items or services that are furnished for your personal care or convenience or for the convenience of your family. Some examples of non-covered items or services are: telephones; radios; televisions; and personal care services.

Private Room Charges

For covered *room and board*, the benefits described in this Benefit Description are provided based on the semiprivate room rate. If a private room is used, you must pay for any charges that are more than the semiprivate room rate.

Refractive Eye Surgery

No benefits are provided for refractive eye surgery for conditions that can be corrected by means other than surgery. This type of surgery includes radial keratotomy.

Reversal of Voluntary Sterilization

No benefits are provided for the reversal of sterilization.

Services and Supplies After Termination Date

No benefits are provided for services and supplies furnished after your termination date in the NUSHP. There is one exception to this exclusion. The benefits described in this Benefit Description will continue to be provided for *inpatient* services, **but only** if you are receiving covered *inpatient* care on your termination date. In this case, benefits will continue to be provided until all the benefits allowed by the NUSHP have been used up or the date of discharge, whichever comes first. This does not apply if your membership in the NUSHP is canceled for misrepresentation or fraud.

Services Furnished to Immediate Family

No benefits are provided for a *covered service* furnished by a provider to himself or herself or to a member of his or her immediate family. An exception is for drugs for which the NUSHP provides benefits when used by a physician, dentist or podiatrist while furnishing a *covered service*. “Immediate family” means any of the following members of a provider’s family:

- Spouse or spousal equivalent.
- Parent, child, brother or sister (by birth or adoption).
- Stepparent, stepchild, stepbrother or stepsister.
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law or sister-in-law. (For purposes of providing *covered services*, an in-law relationship does not exist between the provider and the spouse of his or her wife’s (or husband’s) brother or sister.)
- Grandparent or grandchild.

Note: For the purposes of this exclusion, the immediate family members listed above will still be considered immediate family after the marriage which created the relationship is ended (by divorce or death).

Surrogate Pregnancy

No benefits are provided for services related to achieving pregnancy through a surrogate (gestational carrier).

TMJ Disorders

No benefits are provided for services and supplies to diagnose and/or treat temporomandibular joint (TMJ) disorders. This includes physical therapy, splint therapy, appliances (such as a mandibular orthopedic repositioning appliance) and services, supplies or procedures to change the height of teeth or otherwise restore occlusion (such as bridges, crowns or braces).

Part 7

Other Party Liability

Coordination of Benefits (COB)

If you are covered under other hospital, medical, dental, health or other plans, the benefits provided by this Northeastern University student health plan will be reduced by the benefits provided by those plan(s). This means that the benefits available under the NUSHP are secondary to or in excess of the benefits provided by other plan(s). Other plans include: personal injury insurance; automobile insurance, including medical payments coverage; homeowner's insurance; or other plans that cover hospital or medical expenses.

You must include information on your enrollment forms about other health plans under which you are covered. Once you are enrolled in the NUSHP, you must notify *Blue Cross and Blue Shield* if you add or change health plan coverage. Upon request, you must also supply *Blue Cross and Blue Shield* with information about other plans that may provide you with coverage for health care services.

Important Note: If you fail to comply with the provisions of this COB section, payment of your claim may be denied.

Medicare Program

When you are eligible for the Medicare program and Medicare is allowed by federal law to be the primary payor, the benefits provided by this Northeastern University student health plan will be reduced by the amount of benefits allowed under Medicare for the same *covered services*. This reduction will be made whether or not you actually receive the benefits from Medicare

Plan Rights to Recover Benefit Payments

Subrogation and Reimbursement of Benefit Payments

If you are injured by any act or omission of another person, the benefits under the NUSHP will be subrogated. This means that the NUSHP and *Blue Cross and Blue Shield*, as the NUSHP's representative, may use your right to recover money from the person(s) who caused the injury or from any insurance company or other party. If you recover money, the NUSHP is entitled to recover up to the amount of the benefit payments that it has made. This is true no matter where or by whom the recovered money is held or how it is designated and even if you do not recover the total amount of your claim against the other person(s). This is also true if the payment you receive is described as payment for other than health care expenses. The amount you must reimburse the NUSHP will not be reduced by any attorney's fees or expenses you incur.

Member Cooperation

You must give *Blue Cross and Blue Shield*, as the NUSHP's representative, information and help. This means you must complete and sign all necessary documents to help *Blue Cross and Blue Shield* get this money back on behalf of the NUSHP. This also means that you must give *Blue Cross and Blue Shield* timely notice of all significant steps during the negotiation, litigation or settlement with any third party (such as filing a claim or lawsuit, initiation of settlement discussions, agreement to a settlement in principle, etc.) and before settling any claim arising out of injuries you sustained by an act or omission of another person(s) for which the NUSHP paid benefits. You must not do anything that might limit the NUSHP's right to full reimbursement.

Workers' Compensation

No benefits are provided for health care services and supplies to treat an illness or injury for which you have the right to benefits under any workers' compensation act or equivalent employer liability or indemnification law. All employers provide their employees with workers' compensation insurance. This is done to protect employees in case of work related illness or injury. All medical claims related to the illness or injury must be billed to the employer's workers' compensation carrier. It is up to you to use workers' compensation insurance. If the NUSHP provides or pays for *covered services* that are covered by workers' compensation, *Blue Cross and Blue Shield* on behalf of the NUSHP has the right to get paid back from the party that legally must pay for the health care services.

If you have recovered the value of services from workers' compensation or another employer liability program, you will have to pay the amount recovered for medical services that were paid by the NUSHP. If *Blue Cross and Blue Shield* is billed in error for these services, you must promptly call or write the *Blue Cross and Blue Shield* customer service office.

Part 8

Filing a Claim

When the Provider Files a Claim

Your provider will file a claim for you when you receive a *covered service* from a *preferred provider* or a provider outside of Massachusetts that has a payment agreement with the local Blue Cross and/or Blue Shield Plan. Just tell the provider that you are a *member* and show him or her your health plan identification card. Also, be sure to give the provider any other information that is needed to file your claim. You must properly inform your provider within 30 days after you receive the *covered service*. (If you do not, benefits will not have to be provided.) The provider will be paid directly for *covered services*.

When a Member Files a Claim

You may have to file your claim when you receive a *covered service* from a *non-preferred provider* in Massachusetts or a *non-preferred provider* outside of Massachusetts that does not have a payment agreement with the local Blue Cross and/or Blue Shield Plan. The provider may ask you to pay the entire charge at the time of the visit or at a later time. It is up to you to pay your provider. To file a claim for repayment, you must:

- Fill out a claim form;
- Attach your original itemized bills; and
- Mail the claim to the *Blue Cross and Blue Shield* customer service office.

You can get claim forms from the *Blue Cross and Blue Shield* customer service office. *Blue Cross and Blue Shield* will mail to you all applicable forms within 15 days after receiving notice that you obtained some service or supply for which you may be paid.

Note: When you receive *covered services* outside the United States, you must file your claim to the BlueCard[®] Worldwide Service Center. (The BlueCard Worldwide International Claim Form you receive from *Blue Cross and Blue Shield* will include the address to mail your claim.) The service center will prepare your claim, including the conversion to U.S. currency and forward it to *Blue Cross and Blue Shield* for repayment to you.

You must file a claim within two years of the date you received the *covered service*. The NUSHP does not have to provide benefits for services and/or supplies for which a claim is submitted after this two-year period.

Timeliness of Claim Payments

Within 30 calendar days after *Blue Cross and Blue Shield* receives a completed request for benefits or payment, a decision will be made and, where appropriate, payment will be made to the provider (or to you if you sent in the claim) for your claim to the extent of your benefits described in this Benefit Description. Or, you and/or the provider will be sent a notice in writing of why your claim is not being paid in full or in part.

Missing Information. If the request for benefits or payment is not complete or if more information is needed to make a final determination for the claim, *Blue Cross and Blue Shield* will ask for the information or records it needs within 30 calendar days of receiving the request for benefits or payment. This additional information must be provided to *Blue Cross and Blue Shield* within 45 calendar days of this request.

Missing Information Received Within 45 Days. If the additional information is provided to *Blue Cross and Blue Shield* within 45 calendar days of the request, a decision will be made within the time remaining in the original 30-day claim determination period or within 15 calendar days of the date the additional information is received, whichever is later.

Missing Information Not Received Within 45 Days. If the additional information is not provided to *Blue Cross and Blue Shield* within 45 calendar days of the request, the claim for benefits or payment will be denied. If the additional information is submitted after this 45 days, then it may be viewed as a new claim for benefits or payment. In this case, a decision will be made within 30 days as described previously in this section.

Part 9

Grievance Program

You have the right to a review when you disagree with a decision by *Blue Cross and Blue Shield* to deny payment for services, or if you have a complaint about the care or service you received from *Blue Cross and Blue Shield* or a *preferred provider*.

Making an Inquiry or Resolving Claim Problems

Most problems or concerns can be handled with just one phone call. (See page 3 for more information about *Member Services*.) For help resolving a problem or concern, you should first call the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your health plan identification card. A customer service representative will work with you to help you understand your benefits or resolve your problem or concern as quickly as possible.

When resolving a problem or concern, *Blue Cross and Blue Shield* will consider all aspects of the particular case, including the terms of your *group* benefits as described in this Benefit Description, *Blue Cross and Blue Shield* policies and procedures that support the administration of these benefits, the provider's input, as well as your understanding and expectation of benefits. *Blue Cross and Blue Shield* will use every opportunity to be reasonable in finding a solution that makes sense for all parties and may use an individual case management approach when it is judged to be appropriate. *Blue Cross and Blue Shield* will follow its standard business practices guidelines when resolving your problem or concern.

If you disagree with the decision given to you by the customer service representative, you may request a review through the formal internal grievance program as described below. The formal grievance review process described below will be followed when your request for a review is because *Blue Cross and Blue Shield* has determined that a service or supply is not *medically necessary* for your condition.

Internal Formal Grievance Review

How to Request a Grievance Review

To request a formal review from the internal Grievance Program, you (or your authorized representative) have three options.

- **Write or Fax.** The preferred option is for you to send your grievance in writing to: **Grievance Program, Blue Cross and Blue Shield of Massachusetts, Inc., Landmark Center, 401 Park Drive, Boston, Massachusetts 02215-3326; or Fax to: 1-617-246-3616.** *Blue Cross and Blue Shield* will let you know that your request was received by sending you a written confirmation within 15 calendar days.

- **E-mail.** Or, you may send your grievance to the Grievance Program internet address **grievances@bcbsma.com**. *Blue Cross and Blue Shield* will let you know that your request was received by sending you a confirmation immediately by e-mail.
- **Telephone Call.** Or, you may call the *Blue Cross and Blue Shield* Grievance Program at **1-800-462-5601** (extension 63605) to request a formal grievance review.

Once your request is received, *Blue Cross and Blue Shield* will research the case in detail and ask for more information as needed. When the review is completed, *Blue Cross and Blue Shield* will let you know in writing of the decision or the outcome of the review.

All grievances must be received by *Blue Cross and Blue Shield* within one year of the date of treatment, event or circumstance, such as the date you were told of the service denial or claim denial.

What to Include in a Grievance Review Request

Your request for a formal grievance review should include: the name and health plan identification number of the *member* asking for the review; a description of the problem; all relevant dates; names of health care providers or administrative staff involved; details of the attempt that has been made to resolve the problem; and any comments, documents, records and other information to support your grievance. If *Blue Cross and Blue Shield* needs to review the medical records and treatment information that relate to your grievance, *Blue Cross and Blue Shield* will promptly send you an authorization form to sign if needed. You must return this signed form to *Blue Cross and Blue Shield*. It will allow for the release of your medical records. You also have the right to look at and get copies (free of charge) of records and criteria that *Blue Cross and Blue Shield* has and that are relevant to your grievance, including the identity of any experts who may have been consulted.

Authorized Representative

You may choose to have another person act on your behalf during the grievance review process. You must designate this person in writing to *Blue Cross and Blue Shield*. Or, if you are not able to do this, a person such as a conservator, a person with power of attorney or a family member may be your authorized representative.

Who Handles the Grievance Review

All grievances are reviewed by individuals who are knowledgeable about *Blue Cross and Blue Shield* and the issues involved in the grievance. The individuals who will review your grievance will be those who did not participate in any of *Blue Cross and Blue Shield's* prior decisions regarding the subject of your grievance, nor do they work for anyone who did. When a grievance is related to a *medical necessity* denial, at least one grievance reviewer is an individual who is an actively practicing health care professional in the same or similar specialty that usually treats the medical condition, performs the procedure or provides treatment that is the subject of your grievance.

Response Time

The review and response for *Blue Cross and Blue Shield's* formal internal grievance review will be completed within 30 calendar days. Every reasonable effort will be made to speed up the review of grievances that involve health care services that are soon to be obtained by the *member*. (When the grievance review is for services you have already obtained and it requires a review of your medical records, the 30-day response time will not include the days from when *Blue Cross and Blue Shield* sends

you the authorization form to sign until it receives your signed authorization form if needed. If *Blue Cross and Blue Shield* does not receive your authorization within 30 calendar days after you are asked for it, *Blue Cross and Blue Shield* may make a final decision about your grievance without that medical information.)

Note: If your grievance review began after an inquiry, the 30-day response time will begin on the day you tell *Blue Cross and Blue Shield* that you disagree with *Blue Cross and Blue Shield's* answer and would like a formal grievance review.

Blue Cross and Blue Shield may extend the time frame to complete a grievance review, with your permission, in cases when *Blue Cross and Blue Shield* and the *member* agree that additional time is required to fully investigate and respond to the grievance.

Response

Once the grievance review is completed, *Blue Cross and Blue Shield* will let you know of the decision or the outcome of the review. If *Blue Cross and Blue Shield* continues to deny coverage for all or part of a health care service or supply, *Blue Cross and Blue Shield's* response will explain the reasons. It will give you the specific medical and scientific reasons for the denial and a description of alternative treatment, health care services and supplies that would be covered and information about requesting an external review.

Grievance Records

Blue Cross and Blue Shield will maintain a record of all formal grievances, including the response for each grievance review, for up to seven years.

Expedited Review for Immediate or Urgently-Needed Services

In place of the formal grievance review described above, you have the right to request an “expedited” review right away when your grievance review concerns medical care or treatment for which waiting for a response under the grievance review timeframes described above would seriously jeopardize your life or health or your ability to regain maximum function as determined by *Blue Cross and Blue Shield* or your physician, or if your physician says that you will have severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance review. If you request an expedited review, *Blue Cross and Blue Shield* will review your grievance and notify you of the decision within 72 hours after your request is received.

External Review

For all grievances, you must first go through the formal internal grievance process as described above. In some cases, you are then entitled to a voluntary external review. *Blue Cross and Blue Shield's* grievance review may deny coverage for all or part of a health care service or supply. When the denial is because *Blue Cross and Blue Shield* has determined that the service or supply is not *medically necessary*, you have the right to an external review. You are not required to pursue an external review and your decision whether to pursue it will not affect your other benefits. If you receive a denial letter from *Blue Cross and Blue Shield* for this reason, the letter will tell you what steps you should take to file a request for an external review. A decision will be provided within ten days of the date the external reviewer receives your request for a review.

You also have the right to an expedited external review. You may request an expedited external review by contacting *Blue Cross and Blue Shield* at the telephone number shown in your denial letter. A final decision will be provided within 72 hours after the external reviewer receives your request for a review.

You must file your request for an external review or expedited external review within 30 days of receiving the denial letter sent to you by *Blue Cross and Blue Shield* following the formal internal grievance process. *Blue Cross and Blue Shield* will work closely with you to guide you through the external review or expedited external review process.

Appeals for Rhode Island Residents or Services

The following provisions apply only to:

- A *member* who lives in Rhode Island and is planning to obtain services that *Blue Cross and Blue Shield* has determined are not *medically necessary*.
- A *member* who lives outside Rhode Island and is planning to obtain services in Rhode Island that *Blue Cross and Blue Shield* has determined are not *medically necessary*.

Blue Cross and Blue Shield decides which services are *medically necessary* by using its *medical necessity* guidelines. Some of the services that are described in this Benefit Description may not be *medically necessary* for you. If *Blue Cross and Blue Shield* has determined that services are not *medically necessary* for you, you have the right to the following appeals process:

Reconsideration

Reconsideration is the first step in this appeals process. If you receive a letter denying payment for your health care services, you may request that *Blue Cross and Blue Shield* reconsider its decision by writing to: Grievance Program, Blue Cross and Blue Shield of Massachusetts, Inc., Landmark Center, 401 Park Drive, Boston, Massachusetts 02215-3326. You must submit your reconsideration request within 180 days of the adverse decision. Along with your letter, you should include any information that supports your request. *Blue Cross and Blue Shield* will review your request and let you know the outcome of your reconsideration request within 15 calendar days after receipt of all necessary information.

Appeal

An appeal is the second step in this process. If *Blue Cross and Blue Shield* continues to deny benefits for all or part of the original service, you may request an appeal within 60 days of receiving the reconsideration denial letter. Your appeal request should include any information that supports your appeal. You may also inspect and add information to your *Blue Cross and Blue Shield* case file to prepare your appeal. In accordance with Rhode Island state law, if you wish to review the information in your *Blue Cross and Blue Shield* case file, you must make your request in writing and include the name of a physician who may review your file on your behalf. Your physician may review, interpret and disclose any or all of that information to you. Once received by *Blue Cross and Blue Shield*, your appeal will be reviewed by a provider in the same specialty as your attending provider. *Blue Cross and Blue Shield* will notify you of the outcome of your appeal within 15 calendar days of receiving all necessary information.

External Appeal

If your appeal is denied, you have the right to present your case to an appeals agency that is designated by Rhode Island and not affiliated with *Blue Cross and Blue Shield*. If you request this voluntary external appeal, Rhode Island requires you be responsible for half of the cost of the appeal. Your *group* will be responsible for the remaining half. To file an external appeal, you must make your request in writing to Grievance Program, Blue Cross and Blue Shield of Massachusetts, Inc., Landmark Center, 401 Park Drive, Boston, Massachusetts 02215-3326. Along with your request, you must state your reason(s) for your disagreement with *Blue Cross and Blue Shield's* decision and enclose a check payable to one of the following external appeals agencies: MassPRO (your fee is \$147.50) or The MAXIMUS Center for Health Dispute Resolution (your fee is \$144.20). (If your service denial is for treatment of *mental conditions*, your fee is: \$237.50 for MassPRO and \$144.20 for The MAXIMUS Center for Health Dispute Resolution.)

Within five working days after the receipt of your written request and payment for the appeal, *Blue Cross and Blue Shield* will forward your request to the external appeals agency along with your *group's* portion of the fee and your entire *Blue Cross and Blue Shield* case file. The external appeals agency will notify you in writing of the decision within ten working days of receiving all necessary information.

Expedited Appeal

If your situation is an emergency, you have the right to an expedited appeal at all three levels of appeal as stated above. An emergency is defined as the sudden onset of a medical or *mental condition* that in the absence of immediate medical attention could reasonably be expected to result in placing your health or your ability to regain maximum function in serious jeopardy or, in your physician's opinion, would result in severe pain. You may request an expedited reconsideration or appeal by contacting *Blue Cross and Blue Shield* at the telephone number shown in your letter. *Blue Cross and Blue Shield* will notify you of the result of your expedited appeal within 72 hours of its receipt. To request an expedited voluntary external appeal, you must send your request in writing to: Grievance Program, Blue Cross and Blue Shield of Massachusetts, Inc., Landmark Center, 401 Park Drive, Boston, Massachusetts 02215-3326. Your request should state your reason(s) for your disagreement with the decision and include signed documentation from your provider that describes the emergency nature of your treatment. In addition, Rhode Island requires you be responsible for half of the cost of the appeal. Your request for an expedited appeal must also include a check payable to one of the following external appeals agencies: MassPRO (your fee is \$172.50) or The MAXIMUS Center for Health Dispute Resolution (your fee is \$144.20). (If your service denial is for treatment of *mental conditions*, your fee is: \$237.50 for MassPRO and \$144.20 for The MAXIMUS Center for Health Dispute Resolution.)

Within two working days after the receipt of your written request and payment for the appeal, *Blue Cross and Blue Shield* will forward your request to the external appeals agency along with your *group's* portion of the fee and your entire *Blue Cross and Blue Shield* case file. The external appeals agency will notify you in writing of the decision within 72 hours of receiving your request for a review.

External Appeal Final Decision

If the external appeals agency upholds the original decision of *Blue Cross and Blue Shield*, this completes the appeals process for your case. But, if the external appeals agency reverses *Blue Cross and Blue Shield's* decision, the claim in dispute will be reprocessed by *Blue Cross and Blue Shield* upon receipt of the notice of the final appeal decision. In addition, *Blue Cross and Blue Shield* will repay you for your share of the cost for the external appeal within 60 days of the receipt of the notice of the final appeal decision.

Part 10

Other Plan Provisions

Access to and Confidentiality of Medical Records

Blue Cross and Blue Shield and *preferred providers* may, in accordance with applicable law, have access to all medical records and related information needed by *Blue Cross and Blue Shield* or *preferred providers*. *Blue Cross and Blue Shield* may collect information from health care providers, other insurance companies or the *plan sponsor* to help them administer the benefits described in this Benefit Description and to get facts on the quality of care provided under this and other health care contracts. In accordance with law, *Blue Cross and Blue Shield* and *preferred providers* may use this information, and may disclose it to necessary persons and entities as follows:

- For administering benefits (including coordination of benefits with other insurance plans); disease management programs; managing care; quality assurance; utilization management; the prescription drug history program; grievance and claims review activities; or other specific business, professional or insurance functions for *Blue Cross and Blue Shield*.
- For bona fide medical research according to the regulations of the U.S. Department of Health and Human Services and the Food and Drug Administration for the protection of human subjects.
- As required by law or valid court order.
- As required by government or regulatory agencies.
- As required by the *subscriber's group* or its auditors.
- For the purpose of processing a claim, medical information may be released to your *group's* reinsurance carrier.

To obtain a copy of *Blue Cross and Blue Shield's* Commitment to Confidentiality statement, call the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your health plan identification card.

Blue Cross and Blue Shield will not share information about you with the Medical Information Bureau (MIB). Except as described above, *Blue Cross and Blue Shield* will keep all information confidential and not disclose it without your consent.

You have the right to get the information *Blue Cross and Blue Shield* collects about you. You may also ask *Blue Cross and Blue Shield* to correct any information that you believe is not correct. *Blue Cross and Blue Shield* may charge a reasonable fee for copying records.

Acts of Providers

Blue Cross and Blue Shield is not liable for the acts or omissions by any individuals or institutions that furnish care or services to you. In addition, *Blue Cross and Blue Shield* will not interfere with the relationship between providers and their patients. You are free to select or discharge any provider. It is not up to *Blue Cross and Blue Shield* to find a provider for you. In addition, a *preferred provider* or other health care provider does **not** act as an agent on behalf of or for *Blue Cross and Blue Shield*. And, *Blue Cross and Blue Shield* does not act as an agent for *preferred providers* or other health care providers.

Blue Cross and Blue Shield is not responsible if a provider refuses to furnish services to you. *Blue Cross and Blue Shield* does not guarantee that you will be admitted to any facility or that you will get a special type of room or service. If you are admitted to a facility, you will be subject to all of its requirements. This includes its requirements on admission, discharge and the availability of services.

Assignment of Benefits

You cannot assign any benefit or monies due under the NUSHP to any person, corporation or other organization without the *plan sponsor's* and *Blue Cross and Blue Shield's* written consent. Any assignment by you will be void. Assignment means the transfer of your rights to the benefits provided under the NUSHP to another person or organization. There is one exception to this rule. If Medicaid has already paid the provider, you can assign your benefits to Medicaid.

Authorized Representative

You may choose to have another person act on your behalf concerning your benefits under this health care plan. You must designate this person in writing to *Blue Cross and Blue Shield*. Or, if you are not able to do this, a person such as a conservator, a person with power of attorney or a family member may be your authorized representative. You can get a form to designate an authorized representative from the *Blue Cross and Blue Shield* customer service office.

In certain situations, *Blue Cross and Blue Shield* may consider your health care facility or your physician to be your authorized representative. For example, *Blue Cross and Blue Shield* may tell your hospital that a proposed *inpatient* admission has been approved or may ask your physician for more information if more is needed to make a decision. Or, *Blue Cross and Blue Shield* will consider the provider to be your authorized representative for *emergency medical care* services. *Blue Cross and Blue Shield* will continue to send benefit payments and written communications regarding health care coverage in accordance with *Blue Cross and Blue Shield's* standard practices, unless specifically requested to do otherwise.

Changes to the NUSHP

Northeastern University or *Blue Cross and Blue Shield* may change the benefits described in this Benefit Description. For example, a change may be made to the amount you must pay for certain services. Northeastern University is responsible for sending you a notice of any change. The notice will describe the change being made. It will also give the effective date of the change. When a change is made to your benefits, you can get the actual language of the change from Northeastern University. The change will apply to all benefits for services you receive on or after its effective date.

Services Furnished by Non-Preferred Providers

There are two levels of benefits under the NUSHP. You will usually receive the highest level of benefits (“in-network benefits”) provided by the NUSHP **only** when you obtain *covered services* from a *preferred provider*. But, the NUSHP will provide “in-network benefits” for *covered services* furnished by *non-preferred providers* in the following situations:

- You receive inpatient emergency medical care as described in Parts 3 and 5.
- You receive covered services in an emergency room of a hospital.
- You receive *covered services* that are not reasonably available from a *preferred provider* and you had prior approval from *Blue Cross and Blue Shield* to obtain those services.
- You receive *covered services* from a covered type of provider for which *Blue Cross and Blue Shield* or the local Blue Cross and/or Blue Shield Plan has not, in the opinion of *Blue Cross and Blue Shield*, established an adequate *preferred provider* network.

Otherwise, when you obtain *covered services* from a *non-preferred provider*, the NUSHP will provide a lower level of benefits. **If this is the case, your *out-of-pocket expenses* will be more.** These are called your out-of-network benefits.

Time Limit for Legal Action

Before pursuing a legal action against *Blue Cross and Blue Shield* for any claim under the NUSHP, you must complete a formal internal grievance review as described in Part 9 of this Benefit Description. You may, but do not need to, pursue an external review prior to pursuing a legal action.

If, after completing the grievance review, you choose to bring legal action against *Blue Cross and Blue Shield*, this action must be brought within two years after the cause of action arises. For example, if you are filing a legal action because you were denied a service or a claim for benefits under the NUSHP, you will lose your right to bring a legal action against *Blue Cross and Blue Shield* unless you file your action within two years after the date you were first sent a notice of the service or claim denial. Going through the internal formal grievance process does not extend the two-year limit for filing a lawsuit. However, if you choose to pursue a voluntary external review, the days from the date your request is received by the external reviewer until the date you receive the response are not counted toward the two-year limit.

Part 11

Eligibility for Coverage

Who Is Eligible to Enroll

Student Enrollment

A regular, registered student (or a student taking 27 or more units) at Northeastern University is eligible for enrollment as a *subscriber* in this Northeastern University student health plan. For details about enrollment in the NUSHP or details about waiving coverage, contact Northeastern University.

Eligible Dependents

A student may enroll eligible dependents under his or her membership in the NUSHP. “Eligible dependents” include the *subscriber’s*:

- Legal spouse.

Note: A legal civil union spouse, where applicable, is eligible to enroll under the NUSHP to the extent that a legal civil union spouse is determined eligible by the *group*. For more details, contact Northeastern University.

- Unmarried dependent children under age 19. These include the *subscriber’s* or legal spouse’s dependent children who: live with the *subscriber* or the spouse on a regular basis; or qualify as dependents for federal tax purposes; or are the subjects of a court order that requires the *subscriber* to provide health insurance for the children.

Note: Eligibility for membership under the NUSHP also includes the *subscriber’s* children who are recognized under a Qualified Medical Child Support Order as having the right to enroll for *group* coverage.

- Newborn dependent children. The *effective date* of coverage for a newborn child will be the date of birth provided that the child is enrolled under the *subscriber’s* membership within the time period required to make family status changes (refer to page 74). (A claim for the enrolled mother’s maternity admission may be considered this notice when the *subscriber’s* membership under the NUSHP is a family plan.)
- Unmarried adoptive dependent children under age 19. The *effective date* of coverage for an adoptive child will be the date of placement with the *subscriber* for the purpose of adoption. The *effective date* of coverage for an adoptive child who has been living with the *subscriber* and for whom the *subscriber* has been getting foster care payments will be the date the petition to adopt is filed.

Note: If the adoptive parent is enrolled under a family membership as of the date he or she assumes custody of a child for the purpose of adoption, the child's health care services will be covered from the date of custody (without a waiting period or pre-existing condition restriction). But, benefits for these services are subject to all the provisions described in this Benefit Description.

- Unmarried disabled dependent children age 19 or older. An unmarried disabled dependent child may continue coverage under the *subscriber's* membership. But, the child must be either mentally or physically handicapped so as not to be able to earn his or her own living on the date he or she would normally lose eligibility under the *subscriber's* membership. In this case, the *subscriber* must make arrangements with *Blue Cross and Blue Shield* through the *plan sponsor* within the time period required to make family status changes (refer to page 74). Also, *Blue Cross and Blue Shield* must be given any medical or other information that it may need to determine if the child can maintain coverage under the *subscriber's* membership. From time to time, *Blue Cross and Blue Shield* may conduct reviews that will require a statement from the attending physician. This is to confirm that the child is still an eligible disabled dependent.
- Unmarried children of enrolled dependent children.

Important Note: The eligibility provisions described in this section may differ from the federal tax laws that define who may qualify as a dependent.

Former Spouse

In the event of divorce or legal separation, the person who was the spouse of the *subscriber* prior to the divorce or legal separation will remain eligible for coverage under the *subscriber's* membership, whether or not the judgment was entered prior to the *effective date* of the NUSHP. This coverage is provided with no additional cost. The former spouse will remain eligible for this coverage only until the *subscriber* is no longer required by the judgment to provide health insurance for the former spouse or the *subscriber* or former spouse remarries, whichever comes first. (In these situations, *Blue Cross and Blue Shield* must be notified within 30 days of a change to the former spouse's address. Otherwise, *Blue Cross and Blue Shield* will not be liable for any acts or omissions due to having the former spouse's incorrect address on file.)

In the event the *subscriber* remarries, the former spouse may continue coverage under a separate membership with the *subscriber's group*, provided the divorce judgment requires that the *subscriber* provide health insurance for the former spouse. This is true even if the *subscriber's* new spouse is not enrolled under the *subscriber's* membership.

Note: When the *subscriber's* coverage in the NUSHP ends, the former spouse's coverage in the NUSHP will also end, even if the divorce judgment requires that the *subscriber* provide health insurance for the former spouse.

Enrolling in the Northeastern University Student Plan

An eligible student will automatically be enrolled in the Northeastern University Student Plan. However, certain students can waive this coverage. For more enrollment information or details about waiving coverage, contact Northeastern University.

Making Other Membership Changes

Generally, you may make membership changes (for example, change from an individual membership to a family membership) only if you have a change in family status such as:

- Marriage or divorce.
- Birth, adoption, placement for adoption or change in custody of a child.
- Death of an enrolled spouse or dependent child.
- The loss of an enrolled dependent's eligibility under the *subscriber's* membership. For example, when an unmarried dependent child reaches the maximum dependent age to be covered under the NUSHP, his or her coverage ends under the *subscriber's* membership.

If you want to ask for a membership change or you need to change your name or mailing address, you should call or write Northeastern University. Northeastern University will send you any special forms you may need. You must request the membership change within the time period required by Northeastern University. If you do not make the change within the required time period, you will have to wait until the *group's* next enrollment period to make the change. All membership changes or any additions are allowed only when they comply with the eligibility and enrollment rules set by Northeastern University for your *group* health care benefits and the conditions outlined in this Benefit Description.

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