

MCPHS University Health Insurance Program Information

Beginning September 1, 2016

Health Services

MCPHS University students on the Boston campus have access to the Massachusetts College of Art and Design Student Health Services, second floor of the new Mass Art Residence Hall, 578 Huntington Avenue (617-879-5220) by utilizing their personal health insurance and scheduling appointments. Blue Cross and Blue Shield is accepted at the Mass Art Student Health Services.

Health services for Worcester, Manchester, and Newton campus students are available through the many providers in the local area.

Health Insurance Waiver and Enrollment Information:

According to the Commonwealth of Massachusetts and MCPHS University policy, all Boston, Worcester, Manchester, and Newton matriculated students (regardless of enrollment) must be covered by a comprehensive health insurance program. MCPHS University is obligated by law to ensure that students meet this requirement. Any student who does not meet this obligation may obtain coverage through the Blue Cross and Blue Shield Student Health Insurance Plan, an alternative program arranged by the college and administered through University Health Plans, Inc.

All Boston, Worcester, Manchester, and Newton matriculated students (regardless of enrollment) will be charged \$2,288 for the annual student insurance plan. If you have a comprehensive health insurance plan for the 2016-2017 academic year, you may complete the online waiver at www.universityhealthplans.com under the MCPHS University tab. The charge will be removed from your student account only after a valid, completed waiver has been submitted.

Any Boston, Worcester, or Manchester student who does not submit proof of enrollment in a qualifying program before **September 25, 2016** will automatically be enrolled in and charged for the Student Health Insurance Plan. Once enrolled, waiving the insurance is not an option. **No exceptions or refunds will be granted.** Please note that international students must enroll in the Plan with the exceptions of: 1) Those international students whose sponsoring institutions have a signed agreement with MCPHS University that complies with the University's health insurance waiver requirements or 2) International students with a plan for which their health insurance company's primary office is based in the United States AND the policy provides comparable coverage to the University Student Health Insurance Plan. Travel Insurance Plans and Short-Term Limited Duration Plans are not comparable. International students who do not fall under conditions 1 or 2 above MUST purchase the University's Student Health Insurance Plan.

For questions addressing BCBS general information, or if you do not have internet access, please contact University Health Plans at (800) 437-6448. If you have questions regarding the benefits please feel free to contact Blue Cross and Blue Shield of Massachusetts at (888) 753-6615. If you have questions about the \$2,288 premium that has been charged to your bill, please contact MCPHS University at (617) 732-2864.

Student Health Insurance Policy Periods and Premium Rates

	Annual (9/1/16-8/31/17)	Fall (9/1/16-12/31/17)	Spring (1/1/17-8/31/17)	Summer (5/1/17-8/31/17)
Student	\$2,288	\$766	\$1,527	\$766

If you are interested in insurance for dependents, then coverage for Insured Dependents will become effective on the same date the insured student's coverage becomes effective, or the day after the postmarked date when the completed application and premium are sent, if later.

Dependent Enrollment Forms will be available online at www.universityhealthplans.com for you to print, fill out, and submit to University Health Plans.



Blue Care Elect PreferredSM (PPO)

80 With Copayment

Student Health Plan 2016-2017

MCPHS

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

Your Choice

Your Deductible

Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for most benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is **\$300** per member for in-network and out-of-network services combined.

When You Choose Preferred Providers

You receive the highest level of benefits under your health care plan when you obtain covered services from preferred providers. These are called your “in-network” benefits. See charts on opposite and back pages for your cost share.

Note: If a preferred provider refers you to another provider for covered services (such as a lab or specialist), make sure the provider is a preferred provider in order to receive benefits at the in-network level. If the provider you use is not a preferred provider, you’re still covered, but your benefits, in most situations, will be covered at the out-of-network level, even if the preferred provider refers you.

How to Find a Preferred Provider

There are a few ways to find a preferred provider:

- Look up a provider in the Provider Directory. If you need a copy of your directory, call Member Service at the number on your ID card.
- Visit the Blue Cross Blue Shield of Massachusetts website at www.bluecrossma.com/findadoctor
- Call the Physician Selection Service at **1-800-821-1388**

When You Choose Non-Preferred Providers

You can also obtain covered services from non-preferred providers, but your out-of-pocket costs are higher. These are called your “out-of-network” benefits. See charts on opposite and back pages for your cost share.

Payments for out-of-network benefits are based on the Blue Cross Blue Shield allowed charge as defined in your subscriber certificate. You may be responsible for any difference between the allowed charge and the provider’s actual billed charge (this is in addition to your deductible and/or your coinsurance).

Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments (including prescription drug copayments), and coinsurance for covered services. Your out-of-pocket maximum is **\$6,850** per member (or **\$12,700** per family) for in-network and out-of-network services combined.

Emergency Room Services

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call **911** (or the local emergency phone number). You pay a copayment per visit for in-network or out-of-network emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay. See chart on the opposite page for your cost share.

Utilization Review Requirements

You must follow the requirements of Utilization Review, including Pre-Admission Review, Pre-Service Approval for certain outpatient services, Concurrent Review and Discharge Planning, and Individual Case Management. For detailed information about Utilization Review, see your subscriber certificate. If you need non-emergency or non-maternity hospitalization, you or someone on your behalf must call the number on your ID card for pre-approval. If you do not notify Blue Cross Blue Shield of Massachusetts and receive pre-approval, your benefits may be reduced or denied.

Dependent Benefits

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

Pediatric Dental Benefits

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

You must meet a plan-year deductible for certain covered dental services. Your deductible is **\$50** per member (no more than **\$150** for three or more members enrolled under the same family membership).

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible and coinsurance for covered dental services. Your out-of-pocket maximum is **\$350** per member (no more than **\$700** for two or more members enrolled under the same family membership).

To find participating dental providers, visit the Blue Cross Blue Shield of Massachusetts website at www.bluecrossma.com/findadoctor or call the Physician Selection Service at **1-800-821-1388**.

Your Medical Benefits

Covered Specifics	Your Cost In-Network	Your Cost Out-of-Network
Preventive Care Well-child care exams, including related tests, according to age-based schedule as follows: <ul style="list-style-type: none"> • 10 visits during the first year of life • Three visits during the second year of life (age 1 to age 2) • Two visits for age 2 • One visit per calendar year for age 3 and older 	Nothing, no deductible	20% coinsurance after deductible
Routine adult physical exams, including related tests (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine hearing exams, including routine tests	Nothing, no deductible	20% coinsurance after deductible
Routine vision exams (one every 24 months)	Nothing, no deductible	20% coinsurance after deductible
Family planning services—office visits	Nothing, no deductible	20% coinsurance after deductible
Outpatient Care Emergency room visits	\$250 per visit, no deductible (waived if admitted or for observation stay)	\$250 per visit, no deductible (waived if admitted or for observation stay)
Clinic visits; physicians' and podiatrists' office visits	\$35 per visit, no deductible	20% coinsurance after deductible
Mental health or substance abuse treatment	\$35 per visit, no deductible	20% coinsurance after deductible
Chiropractors' office visits	\$35 per visit, no deductible	20% coinsurance after deductible
Short-term rehabilitation therapy—physical and occupational (up to 100 visits per calendar year*)	\$35 per visit, no deductible	20% coinsurance after deductible
Speech, hearing, and language disorder treatment—speech therapy	\$35 per visit, no deductible	20% coinsurance after deductible
Diagnostic lab tests, and other tests, excluding X-rays, CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing, no deductible	40% coinsurance after deductible
Diagnostic X-rays	\$5 per category per date of service after deductible	20% coinsurance after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	\$250 per category per date of service after deductible	20% coinsurance after deductible
Oxygen and equipment for its administration	20% coinsurance after deductible	40% coinsurance after deductible
Home health care and hospice services	20% coinsurance after deductible	40% coinsurance after deductible
Prosthetic devices	20% coinsurance after deductible	40% coinsurance after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	20% coinsurance after deductible**	40% coinsurance after deductible**
Surgery and related anesthesia <ul style="list-style-type: none"> • Office and health center services • Hospital and other day surgical facility services 	\$35 per visit***, no deductible 20% coinsurance after deductible	20% coinsurance after deductible 40% coinsurance after deductible
Inpatient Care (including maternity care) General or chronic disease hospital care (as many days as medically necessary)	20% coinsurance after deductible	40% coinsurance after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	20% coinsurance after deductible	40% coinsurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	20% coinsurance after deductible	40% coinsurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	20% coinsurance after deductible	40% coinsurance after deductible

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

** In-network cost share waived for one breast pump per birth (20% coinsurance after deductible out-of-network).

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

Prescription Drug Benefits*	Your Cost In-Network**	Your Cost Out-of-Network
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	No deductible \$20 for Tier 1*** \$30 for Tier 2 \$50 for Tier 3	Not covered
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	No deductible \$40 for Tier 1*** \$60 for Tier 2 \$100 for Tier 3	Not covered

* Tier 1 generally refers to generic drugs; Tier 2 generally refers to preferred drugs; Tier 3 refers to non-preferred drugs.

** Cost share waived for certain orally-administered anticancer drugs.

*** Cost share waived for birth control.

Pediatric Dental Benefits for Members under age 19*	Your Cost In-Network**
Group 1—Preventive and Diagnostic Services: oral exams, X-rays, and routine dental care	Nothing, no deductible
Group 2—Basic Restorative Services: fillings, root canals, stainless steel crowns, periodontal care, oral surgery, and dental prosthetic maintenance	25% coinsurance after deductible
Group 3—Major Restorative Services: tooth replacement, resin crowns, and occlusal guards	50% coinsurance after deductible
Orthodontic Services: medically necessary orthodontic care pre-authorized for a qualified member	50% coinsurance, no deductible

* All services are limited to an age-based schedule or frequency. For a complete list of covered services or additional information, refer to your subscriber certificate.

** There are no out-of-network benefits for dental services.

Get the Most from Your Plan

Visit us at www.studentbluema.com or call 1-888-753-6615 to learn about discounts, savings, resources, and special programs available to you, like those listed below.

A Fitness Benefit toward membership at a health club or for fitness classes This fitness benefit applies for fees paid to: privately-owned or privately-sponsored health clubs or fitness facilities, including individual health clubs and fitness centers; YMCAs; YWCAs; Jewish Community Centers; and municipal fitness centers. (See your subscriber certificate for details.)	Reimbursement for membership fees for up to 3 consecutive months of one annual family or individual membership at a health club or 10 fitness classes, per individual or family per calendar year
A Weight Loss Program Benefit toward participation in a qualified weight loss program This weight loss program benefit applies for fees paid to: a qualified hospital-based weight loss program or a Blue Cross Blue Shield of Massachusetts designated weight loss program. (See your subscriber certificate for details.)	Reimbursement for up to 3 months participation fees per individual or family per calendar year .
Blue Care Line SM —A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583)	No additional charge

Questions?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-888-753-6615, or visit us online at www.studentbluema.com.

Interested in receiving information from us via e-mail? Go to www.studentbluema.com to sign up.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your subscriber certificate and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the subscriber certificate and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; hearing aids for members over age 21; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your subscriber certificate and riders.