

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.



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bluecrossma.com/coverage-info or by calling **1-888-753-6615**.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	\$300 member. Does not apply to in-network preventive and prenatal care, most office visits, therapy visits, mental health visits, prescription drugs, lab tests; x-rays, emergency room, emergency transportation.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$6,850 member / \$12,700 family.	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u>?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Does this plan use a <u>network of providers</u>?	Yes. See www.bluecrossma.com/findadoctor or call 1-800-821-1388 for a list of preferred providers.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <u>excluded services</u> .

Questions: Call **1-888-753-6615** or visit us at www.studentbluema.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.bluecrossma.com/sbcglossary or call **1-888-753-6615** to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** (or provider's charge if it is less than the **allowed amount**) for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000 (and it is less than the provider's charge), your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts. (If you are eligible to elect a Health Reimbursement Account (HRA), Flexible Spending Account (FSA) or you have elected a Health Savings Account (HSA), you may have access to additional funds to help cover certain **out-of-pocket** expenses such as **copayments**, **coinsurance**, **deductibles** and costs related to services not otherwise covered.)

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network	Out-of-Network	
If you visit a health care <u>provider's office or clinic</u>	Primary care visit to treat an injury or illness	\$35 / visit	20% coinsurance	Deductible applies first for out-of-network
	Specialist visit	\$35 / visit	20% coinsurance	Deductible applies first for out-of-network
	Other practitioner office visit	\$35 / chiropractor visit	20% coinsurance / chiropractor visit	Deductible applies first for out-of-network
	Preventive care/screening/immunization	No charge	20% coinsurance	Deductible applies first for out-of-network; limited to age-based schedule and / or frequency
If you have a test	Diagnostic test (x-ray, blood work)	\$5 for x-rays; no charge for all other tests	20% coinsurance	Deductible applies first for out-of-network except for x-rays; copayment applies per category of test / day
	Imaging (CT/PET scans, MRIs)	\$250	20% coinsurance	Deductible applies first; copayment applies per category of test / day

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network	Out-of-Network	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bluecrossma.com/medications .	Generic drugs	\$20 / retail supply or \$40 / mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	\$30 / retail supply or \$60 / mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs
	Non-preferred brand drugs	\$50 / retail supply or \$100 / mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Deductible applies first
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Deductible applies first
If you need immediate medical attention	Emergency room services	\$250 / visit	\$250 / visit	Copayment waived if admitted or for observation stay
	Emergency medical transportation	20% coinsurance	20% coinsurance	--- none ---
	Urgent care	\$35 / visit	20% coinsurance	Deductible applies first for out-of-network
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Deductible applies first; pre-authorization required
	Physician/surgeon fee	20% coinsurance	40% coinsurance	Deductible applies first; pre-authorization required

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network	Out-of-Network	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$35 / visit	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	Deductible applies first; pre-authorization required
	Substance use disorder outpatient services	\$35 / visit	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	Deductible applies first; pre-authorization required for certain services
If you are pregnant	Prenatal and postnatal care	No charge for prenatal care; 20% coinsurance for postnatal care	20% coinsurance for prenatal care; 40% coinsurance for postnatal care	Deductible applies first for in-network postnatal care and out-of-network prenatal and postnatal care
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Deductible applies first

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network	Out-of-Network	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Deductible applies first; pre-authorization required
	Rehabilitation services	\$35 / visit	20% coinsurance	Deductible applies first for out-of-network; limited to 100 visits per calendar year (other than for autism, home health care, and speech therapy)
	Habilitation services	\$35 / visit	20% coinsurance	Deductible applies first for out-of-network; rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children
	Skilled nursing care	20% coinsurance	40% coinsurance	Deductible applies first; limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	20% coinsurance	40% coinsurance	Deductible applies first; in-network cost share waived for one breast pump per birth (20% coinsurance for out-of-network)
	Hospice service	20% coinsurance	40% coinsurance	Deductible applies first; pre-authorization required for certain services
If your child needs dental or eye care	Eye exam	No charge	20% coinsurance	Deductible applies first for out-of-network; limited to one exam every 24 months
	Glasses	Not covered	Not covered	--- none ---
	Dental check-up	No charge	Not covered	Limited to members under age 19, twice in 12 months

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Children's glasses
- Cosmetic surgery
- Dental care (adult)
- Long-term care
- Private-duty nursing

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Hearing aids (\$2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine eye care - adult (one exam every 24 months)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs (three months in qualified program(s) per contract per calendar year)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact your plan sponsor. Note: A plan sponsor is usually the member's employer or organization that provides group health coverage to the member. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on your ID card or contact your plan sponsor. Note: A plan sponsor is usually the member's employer or organization that provides group health coverage to the member. You may also contact The Office of Patient Protection at 1-800-436-7757 or www.mass.gov/hpc/opp.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Assistance

To obtain language assistance, please call the toll-free Member Service number on your ID card.

SPANISH (Español): Para obtener asistencia en español, llame al número gratuito de Servicio de Atención al Miembro que figura en su tarjeta de identificación.

TAGALOG (Tagalog): Kung kailangan ninyo ng tulong sa Tagalog tumawag sa libreng numero ng telepono ng Serbisyo sa Miyembro na nakasulat sa inyong ID card.

CHINESE (中文): 如果您需要中文語言幫助，請撥打會員卡上的客戶服務免費電話號碼

NAVAJO (Dine): Dinek'ehjí shika' a'dowoł ninizingo, kwojí hodiíłné t'áá jííkeh béesh bee' hane'jí T'áá doolé'é bina'ishdiłkidgo yeeháka'adooljah éí binumber bee néého'dolzin biniiyé naanitinígíí bikáá' doo.

Disclaimer:

This document contains only a partial description of the benefits, limitations, exclusions and other provisions of this health care plan. It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$6,410
- Patient pays \$1,130

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$300
Copays	\$20
Coinsurance	\$660
Limits or exclusions	\$150
Total	\$1,130

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$2,510
- Patient pays \$2,890

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$0
Copays	\$2,810
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$2,890

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-888-753-6615 or visit us at www.studentbluema.com.

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MCC Compliance

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



MASSACHUSETTS

Pediatric Dental

Your health plan coverage includes a dental policy that covers pediatric dental services as required under the federal Patient Protection and Affordable Care Act.