MASSACHUSETTS

HARVARD UNIVERSITY
Student Health Program

LEARN ABOUT YOUR HEALTH CARE COVERAGE

Discover the difference between the Harvard University Student Health Fee, and your Blue Cross Blue Shield of Massachusetts Student Health Insurance Plan. See what's covered, and where to get care.

WHAT'S COVERED BY THE STUDENT HEALTH FEE, AND YOUR BLUE CROSS BLUE SHIELD OF MASSACHUSETTS HEALTH PLAN

The Harvard University Student Health Program (HUSHP) has two parts that work together to offer comprehensive medical coverage: the Student Health Fee and the Student Health Insurance Plan. The Student Health Fee covers most care at Harvard University Health Services (HUHS). The Student Health Insurance Plan covers certain care nationwide and abroad. Find out what's covered by each, and where to get care when you're sick or injured.

Questions?

If you have any questions about the Harvard University Student Health Program, please call **1-617-495-2008** or email **mservices@huhs.harvard.edu**.

SERVICES COVERED BY THE STUDENT HEALTH FEE

The Student Health Fee is required for all registered students who are enrolled as more than half-time at Harvard. Most of the care, including telemedicine visits, is covered at no cost when administered by Harvard University Health Services, meaning you won't have to pay a copay, co-insurance, or deductible (see page 3 for more information). Covered services include:

- Allergy and Asthma
- Counseling and Mental Health
- Dermatology
- Gastroenterology
- Neurology
- Nutrition
- Ophthalmology
- Orthopedics
- Physical Therapy
- Podiatry
- Primary Care
- Surgery
- Urgent Care
- X-ray/Ultrasound

SERVICES NOT COVERED BY THE STUDENT HEALTH FEE

The services below are available at HUHS, but will be billed directly to the student, or their private health insurance plan if the student has waived the Student Health Insurance Plan. Students should confirm coverage of these services with their private insurance plan.

Type of Service	Billed to Student	Billed to Student's Private Insurance Plan
ALLERGY SERUM	✓	
IMMUNIZATIONS	✓	
ROUTINE EYE EXAM	✓	
AMBULANCE TRANSPORT		✓
LABORATORY SERVICES (QUEST OR OTHER)		✓
OBSTETRICS/GYNECOLOGY SERVICES WITH ON-SITE OB/GYN GROUP		✓
PRESCRIPTION MEDICATIONS		✓
REFERRALS FROM HUHS TO OUTSIDE CARE OR EVALUATION (SPECIALISTS/IMAGING/CONSULTATION)		✓

DID YOU KNOW?

Students who waive the Student Health Insurance Plan still have coverage for many services at HUHS.

UNDERSTANDING YOUR BLUE CROSS PLAN

When you get care anywhere other than HUHS, your coverage will be determined by your Blue Cross Student Health Insurance Plan. This plan covers hospital visits, specialty care, and prescription medications, nationwide and abroad. Before you get care, it's important to understand the difference between in-network and out-of-network care, when you'll have to pay for care, what services are covered, and if you have any visit limitations (see pages 5-6).

You Have a PPO Plan

With this plan:

1. You can visit any doctor or hospital for covered services.
2. In-network care will typically cost less than out-of-network care.
3. You don't need a referral to see a specialist.

What's the difference between in-network and out-of-network care?

When you get care from an in-network doctor or hospital, you'll pay less for care because these providers have agreed to participate in your network.

If you see an out-of-network doctor or provider, you'll pay the most out-of-pocket costs because these providers don't participate in your network, and will charge you their full fee for services.

What is prior authorization?

Certain services and medications must be approved as medically necessary before coverage begins. This ensures that you don't pay more than you have to for unnecessary care. If a service or medication requires prior authorization, your doctor must request it before the service is performed or the medication is prescribed.

Some services that require prior authorization include sleep management programs, hospital stays, MRIs, CT scans, genetic testing, and certain medications.

Important Terms to Know

Copayment—Also called a copay, this is the fixed amount you pay at the time of service.

Deductible—The amount you pay for out-of-network health care services before your plan covers eligible expenses. Each plan year, your deductible resets on August 1 and runs through July 31.

Co-insurance—The percentage of the cost you're responsible for paying for covered services out-of-network, usually after the deductible has been met. Your plan pays the rest, excluding balance billing.*

You Don't Pay for Preventive Care

Getting preventive care is one of the most important steps you can take to stay healthy. Adult preventive care is covered only at HUHS, and provided at no cost to you. Other screenings, such as mammograms and colonoscopies, are completely covered by your Student Health Insurance Plan, which means you won't have to pay any out-of-pocket costs.

You Pay for Diagnostic Care

Diagnostic care includes services you receive when you're experiencing symptoms, or are monitoring a specific condition. You're responsible for paying any out-of-pocket costs associated with the service, such as a copayment, co-insurance, or deductible.

* Balance billing occurs when an out-of-network provider sends a bill for the difference between their cost of service, and the amount that your Student Health Insurance Plan pays for that service.

YOUR CHOICE

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.

This plan has two levels of hospital benefits for preferred providers. You will pay a higher cost share when you receive certain services at or by "higher-cost-share hospitals," including inpatient admissions, outpatient day surgery, and some other hospital outpatient services. See the charts on pages 5–6 for your cost share.

Note: If a preferred provider refers you to another provider for covered services (such as a specialist), make sure the provider is a preferred provider so you can receive benefits at the in-network level. If the provider you're referred to 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. It's also important to check whether the provider you're referred to is affiliated with one of the higher-cost-share hospitals listed below. Your cost will be greater when you receive certain services at or by these hospitals, even if your preferred provider refers you.

Higher-cost-share Hospitals

Your cost share will be higher at the hospitals listed below. Blue Cross Blue Shield of Massachusetts will let you know if this list changes.

- **Baystate Medical Center**
- **Boston Children's Hospital**
- **Brigham and Women's Hospital**
- **Cape Cod HospitaL**
- **Dana-Farber Cancer Institute**
- **Fairview Hospital**
- **Massachusetts General Hospital**
- **UMass Memorial Medical Center**

Note: Some of the general hospitals listed above may have facilities in more than one location. At certain locations, the lowest cost-sharing level may apply.

To Find a Preferred Provider:

- Look up a provider in the Provider Directory. If you need a copy of the directory or help choosing a provider, call the Member Service number on your ID card.
- Visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.com/findadoctor**.

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. You must pay a plan-year deductible before you can receive coverage for most out-of-network benefits under this plan. A "plan year" means the 12-month period of time that starts on the original effective date of the group's coverage under this health plan (August 1) and continues for 12 consecutive months. A new plan year begins each 12-month period thereafter. Your deductible is **$250** per member (or **$500** per family).

Payments for out-of-network benefits are based on the Blue Cross Blue Shield allowed charge as defined in your benefit description. 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 co-insurance). See the charts on pages 5–6 for your cost share.

Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and co-insurance for covered services. Your out-of-pocket maximums for medical benefits are **$1,700** per member (or **$3,400** per family) for in-network services and **$7,500** per member (or **$15,000** per family) for out-of-network services. Your out-of-pocket maximum for prescription drug benefits is **$1,300** per member (or **$2,600** per family).

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 the chart on page 6 for your cost share.

Telehealth Services

You're covered for certain medical and mental health services, for conditions that can be treated through video visits from an approved telehealth provider. Most telehealth services are available by using the Well Connection website at **wellconnection.com** on your computer, or the Well Connection app on your mobile device, when you prefer not to make an in-person visit for any reason to a doctor or therapist. Some providers offer telehealth services through their own video platforms. For a list of telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.com**, consult the Provider Directory, or call the Member Service number on your ID card.

Utilization Review Requirements

Certain services require **pre-approval/prior authorization** through Blue Cross Blue Shield of Massachusetts for you to have benefit coverage; this includes non-emergency and non-maternity hospitalization and may include certain outpatient services, therapies, procedures, and drugs. You should work with your health care provider to determine if pre-approval is required for any service your provider is suggesting. If your provider, or you, don't get pre-approval when it's required, your benefits will be denied, and you may be fully responsible for payment to the provider of the service. Refer to your benefit description for requirements and the process you should follow for Utilization Review, including Pre-Admission Review, Pre-Service Approval, Concurrent Review and Discharge Planning, and Individual Case Management.

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 benefit description (and riders, if any) for exact coverage details. Call HUSHP Member Services at **617-495-2008** for more information.

Pediatric Essential 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 co-insurance 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 **bluecrossma.com/findadoctor** or call the Member Service number on your ID card.

MEDICAL BENEFITS SUMMARY

AUGUST 1, 2021–JULY 31, 2022

Academic Year 2021–2022

Plan Specifics	Student Health Fee (What You Pay)	Student Health Insurance Plan: Blue Cross Blue Shield PPO	
		Your Cost In-Network	Your Cost Out-of-Network
Plan-Year Deductible	None	None	$250 per member/ $500 per family
Out-of-Pocket Maximum	None	$3,000 per member/ $6,000 per family (Combined medical and prescription)	$7,500 per member/ $15,000 per family You may also be responsible for any difference between the allowed charge and the provider's actual charge.

Medical Benefits	Your Out-of-Pocket Cost (What You Pay)		
	Student Health Fee	Student Health Insurance Plan: Blue Cross Blue Shield PPO	
	At Harvard University Health Services (HUHS)	In-PPO-Network	Out-of-Network (after deductible is met)
Chiropractic Care	Not available	$35 copayment	30% co-insurance
Clinic and Physicians' Office Visits Diagnostic/Specialist/Sick— Pediatric (through age 17)	Not available	$0 copayment with Harvard Vanguard providers $35 copayment with other in-network providers	30% co-insurance
Clinic and Physicians' Office Visits Diagnostic/Specialist/Sick— Adult (18 and older)	Covered in full	$35 copayment	30% co-insurance
		12-visit limit (combined in- and out-of-network)	
Dermatology	Covered in full	$35 copayment	30% co-insurance
		Subject to clinic's and physicians' office visit limit	
Diagnostic Lab Tests	Not covered Available at HUHS	Covered in full	30% co-insurance
Diagnostic Outpatient High-Tech Radiology (CT scans, MRI, PET scans, and nuclear cardiac imaging)	Not available	$50 copayment at lower-cost-share hospitals or other facilities* $125 copayment at higher-cost-share hospitals*	30% co-insurance
Durable Medical Equipment	Not available	Covered in full	30% co-insurance
Routine Eye Exams: for eyeglasses (eyeglasses, contact lens exam, and contact lenses excluded)	Not covered Available at HUHS	$0 copayment at HUHS $35 copayment at other providers	30% co-insurance
		One routine eye exam covered per plan year	
Immunizations (no coverage for travel-related vaccines or those required by another party)	Not covered Available at HUHS	Covered at HUHS only for preventive immunizations	Not available
Routine Exams and Preventive Care including immunizations Pediatric (through age 17)	Not available	$0 copayment	30% co-insurance Visit limits apply—see Handbook
Routine Exams and Preventive Care Adult (18 and older)	Covered in full	Not covered Routine care is only covered under the Student Health Fee at HUHS	
Short-Term Rehabilitation Therapy Occupational Therapy (OT) Physical Therapy (PT) Speech Therapy (ST)	OT: Not available PT: Covered in full ST: Not available	$35 copayment	30% co-insurance
		60-visit limit (Combined in- and out-of-network. No visit limit for autism or ST.)	
Surgery (Outpatient)	Not available	$75 copayment at lower-cost-share hospitals or other facilities* $250 copayment at higher-cost-share hospitals*	30% co-insurance
X-ray Services	Covered in full	Covered in full	30% co-insurance

(continued)

Medical Benefits	Your Out-of-Pocket Cost (What You Pay)		
	Student Health Fee	Student Health Insurance Plan: Blue Cross Blue Shield PPO	
	At Harvard University Health Services (HUHS)	In-PPO-Network	Out-of-Network (after deductible is met)
Inpatient Care			
Inpatient Admission in an acute care, chronic disease hospital	Not available	$100 copayment at lower-cost-share hospitals* $500 copayment at higher-cost-share hospitals*	30% co-insurance
Inpatient Admission in a skilled nursing facility or rehabilitation hospital	Not available	Covered in full	30% co-insurance
Mental Health			
Inpatient Admission in a psychiatric hospital or substance abuse facility	Not available	$100 copayment per admission	30% co-insurance
Outpatient Visits for mental health therapy and psychopharmacology	As medically necessary	$0 copayment (visits 1-8) $35 copayment (visits 9-52)	30% co-insurance
		52-visit limit (combined in- and out-of-network)	
Women's Health			
Birth Control Devices	Not available	Covered in full	30% co-insurance
Gynecology	Not covered Available at HUHS	Covered in full	30% co-insurance
Infertility Services–Outpatient Medical Care	Limited services available	$35 copayment	30% co-insurance
		May be subject to clinic's and physicians' office visit limit	
Maternity Care Office Visits	Not covered Available at HUHS	Covered in full	30% co-insurance
Voluntary Termination of Pregnancy	$350 benefit (paid to facility with HUHS referral)	See Surgery (Outpatient) benefit	See Surgery (Outpatient) benefit
Urgent/Emergency Care			
Ambulance Services	Not available	Covered in full	Covered in full
Hospital Emergency Room	Not available	$100 copayment (waived if admitted)	$100 copayment (waived if admitted)
Urgent Care	Covered in full	$35 copayment	30% co-insurance
		Subject to clinic's and physicians' office visit limit	
Traveling Out of the Country	Only Student Health Insurance Plan benefits are available; all covered services are considered out-of-network, excluding emergency room visits.		

* Hospital Choice Cost Sharing will group Massachusetts acute care hospitals into two categories for inpatient admissions, outpatient day surgery, and outpatient diagnostic high-tech radiology testing. Members can control their out-of-pocket costs based on the hospital they choose for care.

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)****	$17 for Tier 1 $40 for Tier 2 $55 for Tier 3	Not covered
Through the designated mail order pharmacy **(up to a 90-day*** formulary supply for each prescription or refill)****	$51 for Tier 1 $120 for Tier 2 $165 for Tier 3	Not covered

* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred brand-name drugs.
** Cost share may be waived for certain covered drugs and supplies.
*** Certain medications limited to 30-day supply.

Pediatric Essential Dental Benefits*	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% co-insurance after deductible
Group 3 – Major Restorative Services: tooth replacement, resin crowns, and occlusal guards	50% co-insurance after deductible
Orthodontic Services: medically necessary orthodontic care pre-authorized for a qualified member	50% co-insurance, no deductible

* All covered services are limited to members until the end of the month they turn age 19, and may be subject 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.

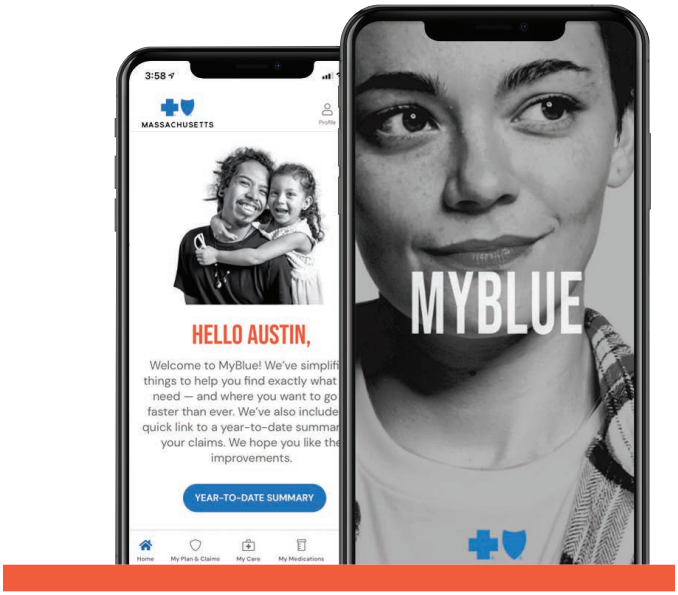
Disclaimer: All benefits are subject to medical necessity criteria. The benefit description defines the terms and conditions of your coverage, and will govern if questions arise. HUHS services are limited in scope and subject to change.

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 PLAN IN YOUR HAND

Staying on top of your coverage has never been easier, faster, or more convenient. Once you sign in or create a MyBlue app account, you can see all of your benefits, all in one place.

- **Track claims and benefits**
- **Your medications at a glance**
- **Find a Doctor**
- **Download your digital ID card**
- **Check deductible balances**



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MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Blue Cross Member Service at the number on your Blue Cross ID card (TTY: **711**).
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).
ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

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