2022 PLAN COMPARISON AND RATES

Northeastern University
Human Resources

MEDICAL

	High Deductible PPO With HSA		Core PPO		Enhanced PPO	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network
HSA University Funding	$500 Individual / $1,000 Family		N/A		N/A	
Annual Deductible	$1,500 Individual $3,000 Family	$2,500 Individual $5,000 Family	$250 Individual $500 Family	$500 Individual $1,000 Family	None	$500 Individual $1,000 Family
Out-of-Pocket Maximum	$2,500 Individual $5,000 Family	$4,000 Individual $8,000 Family	$2,500 Individual $5,000 Family	$4,000 Individual $8,000 Family	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family
Hospital Inpatient	90% after deductible	70% after deductible	90% after deductible	70% after deductible	Covered in full	80% after deductible
Outpatient Day Surgery	90% after deductible	70% after deductible	90% after deductible	70% after deductible	Covered in full	80% after deductible
High-Tech Imaging	90% after deductible	70% after deductible	90% after deductible	70% after deductible	Freestanding: covered in full / Hospital: $100 copay	80% after deductible
Emergency Room	90% after deductible		$100 copay		$100 copay	
Office Visits						
Preventive Care	Covered in full	80% after deductible	Covered in full	70% after deductible	Covered in full	80% after deductible
PCP Visit (non-preventive)	90% after deductible	70% after deductible	$25 copay	70% after deductible	$20 copay	80% after deductible
Specialist	90% after deductible	70% after deductible	$35 copay	70% after deductible	$30 copay	80% after deductible
Prescription drugs						
Retail (up to 30-day supply)	$5 / $30 / $50 after deductible	Not covered	$5 / $30 / $50	Not covered	$5 / $30 / $50	Not covered
Mail (up to 90-day supply)	$10 / $60 / $100 after deductible	Not covered	$10 / $60 / $100	Not covered	$10 / $60 / $100	Not covered

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DENTAL

	Value*	Value Plus
Annual Deductible	$50 Individual / $100 Family	$50 Individual / $100 Family
Coinsurance for Type I Services: Preventive and diagnostic services	100% – no deductible	100% – no deductible
Coinsurance for Type II Services: Basic restorative services (e.g. fillings)	50% after deductible	80% after deductible
Coinsurance for Type III Services: Major restorative services (e.g. crowns and bridges)	Not covered	50% after deductible
Annual Plan Maximum	$750 per person	$2,000 per person
Orthodontia Coinsurance/Copay	N/A	50%
Orthodontia Lifetime Maximum (Adult and Child)	N/A	$1,500 per person

VISION

	Cost	Frequency
Exam	$0 copay	Once every 12 months
Single Vision, Bifocal, and Trifocal Lenses	$20 copay	Once every 12 months
Frames	$0 copay, $130 allowance; 80% of charge over $130	Once every 24 months
Contact Lenses	$0 copay, $150 allowance	Once every 12 months

LIFE INSURANCE

	Basic	Supplemental
Coverage	2x annual base salary, up to $500,000, at no cost to you (age-reduction schedule applies at age 65 and 70). Please verify that your beneficiary information is entered and correct.	You can purchase 1x, 2x, 3x or 4x base salary to a maximum of $500,000 (age-reduction schedule applies at age 65 and 70). A Statement of Health may be required.

LEGAL PLAN

Monthly Premiums	$9/paycheck for individual and family.
Coverage	The MetLaw Legal plan provides fully covered services for many personal legal matters including real estate, estate planning, civil lawsuits, elder-care issues and more.

* The Value plan does not allow for a rollover of the unused portion of the annual maximum benefit.

2022 PLAN COMPARISON AND RATES

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PER PAYCHECK CONTRIBUTIONS

MEDICAL

	High Deductible PPO w/HSA	Core PPO	Enhanced PPO
Employee	$82.69	$116.13	$137.89
Employee + Spouse/Domestic Partner*	$206.72	$290.31	$344.73
Employee + Child(ren)	$198.45	$278.70	$330.94
Family (Employee, Spouse/Domestic Partner* + Child[ren])	$223.26	$313.54	$372.31

Please note: If you are paid on a bi-weekly basis, flat-rate deductions (such as medical, dental, and vision premiums) and reimbursement account contributions will be split evenly between your two paychecks each month. In months with a third pay date, your third paycheck will have no corresponding deductions.

DENTAL

	Value	Value Plus
Employee	$4.64	$6.72
Employee + Spouse/Domestic Partner*	$11.60	$16.80
Employee + Child(ren)	$12.07	$17.47
Family (Employee, Spouse/Domestic Partner* + Child[ren])	$14.85	$21.50

VISION

	Vision
Employee	$3.21
Employee + Spouse/Domestic Partner*	$7.70
Employee + Child(ren)	$7.38
Family (Employee, Spouse/Domestic Partner* + Child[ren])	$8.98

Please note: If you are paid on a bi-weekly basis, flat-rate deductions (such as medical, dental, and vision premiums) and reimbursement account contributions will be split evenly between your two paychecks each month. In months with a third pay date, your third paycheck will have no corresponding deductions.

* A domestic partner is not recognized by the federal government as a qualified dependent. You may provide medical, dental, and vision coverage for domestic partners; however, under federal tax law, the portion of your premiums that is attributable to your domestic partner is not exempt from Social Security, Medicare, and FUTA taxes, or federal income tax. This means that if you cover a domestic partner, the following tax rules apply:

- You will incur state and federal taxes on the portion of the medical, dental, and vision premiums that is paid by Northeastern for your domestic partner's insurance. The value of these premiums is called imputed income.
- The portion of the premium paid by you for your domestic partner's coverage will be deducted from your salary as a post-tax benefit.
- Please contact HR-Benefits@northeastern.edu for more information.