SUMMARY OF BENEFITS

BLUE CHOICE® PLAN 2 $250 DEDUCTIBLE

HUGHP NON-UNION POS

Harvard University Group Health Plan administered in part by Blue Cross Blue Shield of Massachusetts

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YOUR CARE

This is a summary of your benefits administered by Blue Cross Blue Shield of Massachusetts in partnership with Harvard University Group Health Plan (HUGHP). If you have questions, visit **hughp.harvard.edu** or contact HUGHP Member Services at **1-617-495-2008**.

Your Primary Care Provider (PCP)

When you join this plan, you must choose a primary care provider (PCP) for you and each covered member of your family from the HUGHP network of participating providers. If you need help finding a PCP, visit **hughp.harvard.edu** or call Member Services. Once you have chosen a PCP for yourself and any dependents on your plan, call Member Services to let them know your selection(s). Taking this step is essential to ensure claims payment.

Your HUGHP PCP is the first person you should call when you need medical care. The doctor will evaluate your condition and decide the most appropriate course of treatment. If you need to see a specialist, your PCP will make sure that any necessary referrals are in place. Your physician may also work with Blue Cross Blue Shield regarding the Utilization Review Requirements, which are Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. Information regarding Utilization Review is detailed in your Blue Cross Blue Shield of Massachusetts benefit description.

If you are scheduled to see a specialist and are uncertain if a referral is in place, be sure to call your PCP's office to confirm. When specialty care is coordinated by your PCP, your out-of-pocket expenses will be lower.

Your Deductible

Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for certain benefits under this plan. The plan year begins on January 1 and ends on December 31 of each year. Your deductibles are **$250** per member (or **$750** per family) for PCP/Plan-Approved services and **$750** per member (or **$2,500** per family) for Self-Referred services.

When You Choose to Receive Care on Your Own (Self-Referred)

Your health plan also allows you to seek most medically necessary care without a referral from your PCP. If you arrange care on your own or choose to see a licensed health care provider who is not part of the HUGHP network, you will have additional out-of-pocket expenses. If you require hospitalization, you, or someone on your behalf, must call HUGHP Member Services before you're admitted (or within 48 hours of an emergency or maternity admission) to ensure maximum benefits.

For most self-referred services, after meeting your plan-year deductible, you pay a coinsurance of the remaining covered charges. See the chart for your cost share. When services are rendered by a provider that has a payment agreement with Blue Cross Blue Shield of Massachusetts or with a local Blue Cross and/or Blue Shield plan, these providers usually accept the total charge allowed as full payment for covered services. 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). See your benefit description (and riders, if any) for information about the allowed charge and how your deductible and coinsurance are calculated.

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 coinsurance for covered services. Your out-of-pocket maximums are **$1,500** per member (or **$4,500** per family) for PCP/Plan-Approved services and **$2,500** per member (or **$7,500** per family) for Self-Referred services.

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 emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay. See the chart for your cost share.

Telehealth Services

Telehealth services are covered when the same in-person service would be covered by the health plan and the use of telehealth is appropriate. Your health care provider will work with you to determine if a telehealth visit is medically appropriate for your health care needs or if an in-person visit is required. For a list of telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.org**, consult Find a Doctor, or call the Member Service number on your ID card.

Service Area

The plan's service area includes all cities and towns in the Commonwealth of Massachusetts.

When Outside the Service Area

If you're traveling outside the plan's service area and you need urgent or emergency care, you should go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. To receive the highest level of benefits, any additional follow-up care must be arranged by your PCP.

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.

Domestic Partner Coverage

Domestic partner coverage may be available for eligible dependents. Contact your plan sponsor for more information.

HUGHP provides health care services through its network of participating adult primary care physicians. The network includes the group practices based at Harvard University Health Services (HUHS), Harvard Vanguard Medical Associates (HVMA), Dedham Medical Associates, Granite Medical Group, and PMG Physician Associates. Each of these multi-specialty group practices offers a wide range of primary and specialty medical services.

New for 2023: The pediatric primary care network includes Atrius Health, Mount Auburn Pediatrics, and all other Blue Cross Blue Shield HMO Blue pediatricians and family medicine practitioners in Massachusetts for dependent children up to age 26.

Covered Services	Your Cost For PCP/Plan-Approved Benefits	Your Cost For Self-Referred Benefits
Preventive Care		
Well-child care exams	Nothing, no deductible	30% coinsurance after deductible*
Routine adult physical exams, including related tests	Nothing, no deductible	30% coinsurance after deductible*
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible	30% coinsurance after deductible*
Routine hearing exams, including routine tests	Nothing, no deductible	30% coinsurance after deductible*
Hearing aids	Nothing, no deductible	30% coinsurance after deductible*
Routine vision exams (one per calendar year)	Nothing, no deductible	30% coinsurance after deductible*
Family planning services—office visits	Nothing, no deductible	30% coinsurance after deductible*
Outpatient Care		
Emergency room visits	$100 per visit, no deductible (waived if admitted or for observation stay)	$100 per visit, no deductible (waived if admitted or for observation stay)
Office or health center visits (medical or specialty)	$30 per visit, no deductible	30% coinsurance after deductible*
Mental health or substance use treatment	$30 per visit, no deductible	20% coinsurance, no deductible*
Outpatient telehealth services • With a covered medical or specialty provider • With a covered provider for mental health services • With the PCP/Plan-Approved designated telehealth vendor	 $30 per visit, no deductible $15 per visit, no deductible $15 per visit, no deductible	 Same as in-person visit 20% coinsurance, no deductible* Not applicable
Chiropractors' office visits (up to 18 visits per calendar year)	$30 per visit, no deductible	30% coinsurance after deductible*
Acupuncture visits (up to 20 visits per calendar year)	$30 per visit, no deductible	$30 per visit, no deductible*
Short-term rehabilitation therapy—physical and occupational (up to 100 visits per calendar year**)	$30 per visit, no deductible	30% coinsurance after deductible*
Speech, hearing, and language disorder treatment—speech therapy	$30 per visit, no deductible	30% coinsurance after deductible*
Diagnostic X-rays and lab tests	Nothing, no deductible	30% coinsurance after deductible*
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	10% coinsurance after deductible	30% coinsurance after deductible*
Home health care and hospice services	10% coinsurance after deductible	30% coinsurance after deductible*
Oxygen and equipment for its administration	Nothing, no deductible	30% coinsurance after deductible*
Durable medical equipment—such as wheelchairs, crutches, hospital beds	10% coinsurance after deductible***	30% coinsurance after deductible*
Prosthetic devices	10% coinsurance after deductible	30% coinsurance after deductible*
Surgery and related anesthesia • Office or health center services • Ambulatory surgical facility, hospital outpatient department, or surgical day care unit	 $30 per visit†, no deductible 10% coinsurance after deductible	 30% coinsurance after deductible* 30% coinsurance after deductible*
Inpatient Care (including maternity care)		
General or chronic disease hospital care (as many days as medically necessary)	10% coinsurance after deductible	30% coinsurance after deductible*
Mental hospital or substance use facility care (as many days as medically necessary)	10% coinsurance after deductible	30% coinsurance after deductible*
Rehabilitation hospital care (up to 60 days per calendar year)	10% coinsurance after deductible	30% coinsurance after deductible*
Skilled nursing facility care (up to 100 days per calendar year)	10% coinsurance after deductible	30% coinsurance after deductible*

* In addition to your deductible and coinsurance, you may be responsible for any balance of charges above the allowed charge.

** 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.

*** Cost share waived for one breast pump per birth, including supplies.

† 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.

Get the Most from Your Plan: Visit hughp.harvard.edu or call HUGHP Member Services at 1-617-495-2008 to learn about discounts, savings, resources, and special programs available to you, like those listed below.

Wellness Participation Program Fitness Reimbursement: a program that rewards participation in qualified fitness programs or equipment (See your benefit description for details.)	$150 per calendar year per policy
Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program (See your benefit description for details.)	$150 per calendar year per policy

24/7 Nurse Line: Speak to a registered nurse, day or night, to get immediate guidance and advice. Call 1-888-247-BLUE (2583). No additional charge.

QUESTIONS?

For questions about your plan, call 1-617-495-2008, or visit us online at bluecrossma.com/hughp.

Limitations and Exclusions. These pages summarize the benefits of your HUGHP/Blue Choice Plan 2 health care plan. Your Blue Cross Blue Shield of Massachusetts benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the Blue Cross and Blue Shield of Massachusetts benefit description and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; dental care; prescription drugs for use outside of the hospital; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders. **Note:** Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.

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MASSACHUSETTS

NONDISCRIMINATION NOTICE

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. It does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS PROVIDES:

- Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print or other formats).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call Member Service at the number on your ID card.

If you believe that Blue Cross Blue Shield of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with the Civil Rights Coordinator by mail at Civil Rights Coordinator, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126; phone at **1-800-472-2689 (TTY: 711)**; fax at **1-617-246-3616**; or email at **civilrightscoordinator@bcbsma.com**.

If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, online at **ocrportal.hhs.gov**; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, DC 20201; by phone at **1-800-368-1019** or **1-800-537-7697 (TDD)**.

Complaint forms are available at **hhs.gov**.

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MASSACHUSETTS

PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES

Spanish/Español: 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**).

Portuguese/Português: 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**).

Chinese/简体中文: 注意：如果您讲中文，我们可向您免费提供语言协助服务。请拨打您 ID 卡上的号码联系会员服务部（TTY 号码：**711**）。

Haitian Creole/Kreyòl Ayisyen: ATANSYON: Si ou pale kreyòl ayisyen, sèvis asistans nan lang disponib pou ou gratis. Rele nimewo Sèvis Manm nan ki sou kat Idantitifkasyon w lan (Sèvis pou Malantandan TTY: **711**).

Vietnamese/Tiếng Việt: LƯU Ý: Nếu quý vị nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cung cấp cho quý vị miễn phí. Gọi cho Dịch vụ Hội viên theo số trên thẻ ID của quý vị (TTY: **711**).

Russian/Русский: ВНИМАНИЕ: если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Позвоните в отдел обслуживания клиентов по номеру, указанному в Вашей идентификационной карте (телетайп: **711**).

Arabic/ةيبر:

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هُويتك (جهاز الهاتف النصي للصم والبكم "TTY": **711**).

Mon-Khmer, Cambodian/ខ្មែរ: ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខនៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (TTY: **711**)។

French/Français: ATTENTION : si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le Service adhérents au numéro indiqué sur votre carte d'assuré (TTY : **711**).

Italian/Italiano: ATTENZIONE: se parlate italiano, sono disponibili per voi servizi gratuiti di assistenza linguistica. Chiamate il Servizio per i membri al numero riportato sulla vostra scheda identificativa (TTY: **711**).

Korean/한국어: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드에 있는 전화번호(TTY: **711**)를 사용하여 회원 서비스에 전화하십시오.

Greek/Ελληνικά: ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε την Υπηρεσία Εξυπηρέτησης Μελών στον αριθμό της κάρτας μέλους σας (ID Card) (TTY: **711**).

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Polish/Polski: UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej. Należy zadzwonić do Działu obsługi ubezpieczonych pod numer podany na identyfikatorze (TTY: **711**).

Hindi/हिंदी: ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए नि:शुल्क उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वाई.: **711**).

Gujarati/ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમને ભાષાકીય સહાયતા સેવાઓ વિના મૂલ્યે ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર આપેલા નંબર પર Member Service ને કૉલ કરો (TTY: **711**).

Tagalog/Tagalog: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tawagan ang Mga Serbisyo sa Miyembro sa numerong nasa iyong ID Card (TTY: **711**).

Japanese/日本語: お知らせ：日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。IDカードに記載の電話番号を使用してメンバーサービスまでお電話ください（TTY: **711**）。

German/Deutsch: ACHTUNG: Wenn Sie Deutsche sprechen, steht Ihnen kostenlos fremdsprachliche Unterstützung zur Verfügung. Rufen Sie den Mitgliederdienst unter der Nummer auf Ihrer ID-Karte an (TTY: **711**).

Persian/پارسیان:

توج: اگر زبان شما فارسی است، خدمات کمک زبانی ب صورت رایگان در اختیار شما قرار می گیرد. با شمار تلفن مندرج بر روی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: **711**).

Lao/ພາສາລາວ: ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: **711**).

Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'déé' nóomba biká'ígíiji̜' béésh bee hodíílnih (TTY: **711**).

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