Harvard University Medical Plan:
Harvard University Group Health Plan (HUGHP) HMO

Coverage Period: 01/01/2017-12/31/2017
Coverage for: Individual and Family | Plan Type: HMO

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

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.hughp.harvard.edu or by calling 1-617-495-2008.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$250 person / $750 family. Does not apply to preventive and prenatal care, prescription drugs, some diagnostic testing, most office visits and emergency room and transportation.</td>
<td>You must pay all the costs up to the <strong>deductible</strong> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <strong>deductible</strong> 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 <strong>deductible</strong>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet <strong>deductibles</strong> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes. $1,500 person / $4,500 family.</td>
<td>The <strong>out-of-pocket limit</strong> 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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums and health care this plan doesn't cover.</td>
<td>Even though you pay these expenses, they don't count toward the <strong>out-of-pocket limit</strong>.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for <strong>specific covered services</strong>, such as office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. See <a href="http://www.hughp.harvard.edu">www.hughp.harvard.edu</a> or call 1-617-495-2008 for a list of network providers.</td>
<td>If you use an in-network doctor or other health care <strong>provider</strong>, 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 <strong>provider</strong> for some services. Plans use the term in-network, <strong>preferred</strong>, or participating for <strong>providers</strong> in their <strong>network</strong>. See the chart starting on page 2 for how this plan pays different kinds of <strong>providers</strong>.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>Yes, written consent is required but some restrictions apply.</td>
<td>This plan will pay some or all of the costs to see a <strong>specialist</strong> for covered services but only if you have the plan’s permission before you see the <strong>specialist</strong>.</td>
</tr>
<tr>
<td>Are there services this plan doesn’t cover?</td>
<td>Yes.</td>
<td>Some of the services this plan doesn’t cover are listed on page 4. See your policy or plan document for additional information about <strong>excluded services</strong>.</td>
</tr>
</tbody>
</table>

Questions: Call 1-617-495-2008 or visit us at www.hughp.harvard.edu.
If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at [bluecrossma/sbcglossary](http://bluecrossma/sbcglossary) or call 1-617-495-2008 to request a copy. SBC #1 HUGHP HMO (Nonunion)
Harvard University Medical Plan:
Harvard University Group Health Plan (HUGHP) HMO

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2017-12/31/2017

Coverage for: Individual and Family

Plan Type: HMO

- **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** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is $1,000, 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 **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$30 copayment/visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$30 copayment/visit</td>
<td>Primary Care Physician (PCP) referral is required for most specialty care.</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$30 copayment/chiropractic care and acupuncture</td>
<td>Chiropractic Limited to 18 visits per plan year; acupuncture limited to 20 visits per plan year.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Routine GYN exam limited to one exam per plan year.</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Deductible, then 10% coinsurance</td>
<td>Pre-authorization may be required for certain services.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Generic drugs</td>
<td>$7 copayment/ prescription(retail); $14 copayment/prescription (mail-order &amp; HUHS pharmacy)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$20 copayment/ prescription(retail); $50 copayment/prescription (mail-order &amp; HUHS pharmacy)</td>
<td>Covers up to a 30-day supply purchased at retail. Covers up to a 90-day supply purchased by mail order from Catamaran or HUHS Pharmacy (when prescribed by HUHS provider).</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$45 copayment/ prescription(retail); $110 copayment/prescription (mail-order &amp; HUHS pharmacy)</td>
<td></td>
</tr>
</tbody>
</table>

Questions: Call 1-617-495-2008 or visit us at www.hughp.harvard.edu.
If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at bluecrossma.com/sbcglossary or call 1-617-495-2008 to request a copy. **SBC #1 HUGHP HMO (Nonunion)**
# Harvard University Medical Plan:
Harvard University Group Health Plan (HUGHP) HMO

**Coverage Period:** 01/01/2017-12/31/2017

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage for:** Individual and Family  
**Plan Type:** HMO

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Deductible, then 10% coinsurance</td>
<td>Pre-authorization is required for certain services.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Deductible, then 10% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$100 copayment/visit</td>
<td>Waived if admitted directly from emergency room.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$30 copayment/visit</td>
<td>PCP referral is required for urgent care received both in and out of the service area.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>Deductible, then 10% coinsurance</td>
<td>Pre-authorization required.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>Deductible, then 10% coinsurance</td>
<td>Pre-authorization required.</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>$30 copayment/visit</td>
<td>Authorization is required for in-network outpatient visits over 12 per plan year.</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>Deductible, then 10% coinsurance</td>
<td>Pre-authorization is required.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$30 copayment/visit</td>
<td>Authorization is required for in-network outpatient visits over 12 per plan year.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>Deductible, then 10% coinsurance</td>
<td>Pre-authorization is required.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>No charge</td>
<td>Non-routine prenatal care must meet medical necessity guidelines.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>Deductible, then 10% coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

---

**Questions:** Call 1-617-495-2008 or visit us at [www.hughp.harvard.edu](http://www.hughp.harvard.edu).

If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at [bluecrossma/sbcglossary](http://bluecrossma/sbcglossary) or call 1-617-495-2008 to request a copy. **SBC #1 HUGHP HMO (Nonunion)**
### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage Period:** 01/01/2017-12/31/2017

**Coverage for:** Individual and Family  |  **Plan Type:** HMO

#### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>Deductible, then 10% coinsurance</td>
<td>Pre-authorization is required.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>Deductible, then 10% coinsurance</td>
<td>Pre-authorization is required. Limited to 60 days per plan year.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>$30 copayment/visit</td>
<td>PCP referral or authorization is required. Limited to 100 visits per plan year, combined physical and occupational therapy.</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>Deductible, then 10% coinsurance</td>
<td>Pre-authorization is required. Coverage is limited to 100 days per plan year.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>Deductible, then 10% coinsurance</td>
<td>Coverage for wigs is limited to one per plan year. Cost share waived for one breast pump per birth.</td>
</tr>
<tr>
<td>Hospice service</td>
<td>Deductible, then 10% coinsurance</td>
<td>Pre-authorization is required for certain services.</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye exam</td>
<td>No charge</td>
<td>Limited to one routine exam per plan year. You may have other coverage under a vision plan.</td>
</tr>
<tr>
<td>Glasses</td>
<td>Not covered</td>
<td>You may have other coverage under a vision plan.</td>
</tr>
<tr>
<td>Dental check-up</td>
<td>Not covered</td>
<td>You may have other coverage under a dental plan.</td>
</tr>
</tbody>
</table>

#### 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.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when travelling outside the U.S.
- Private-duty nursing

**Questions:** Call 1-617-495-2008 or visit us at www.hughp.harvard.edu.

If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at bluecrossma.com/sbcglossary or call 1-617-495-2008 to request a copy. SBC #1 HUGHP HMO (Nonunion)
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.)

- Acupuncture limited to 20 visits per plan year
- Bariatric surgery
- Chiropractic care limited to 18 visits per plan year
- Hearing aids limited to members age 19 or younger
- Infertility treatment
- Routine eye care limited to one exam per plan year
- Routine foot care limited to patients with systemic circulatory disease
- Weight loss programs limited to $150 per policy per plan year for qualified programs

Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending on 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 the plan at 1-617-495-2008. 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: HUGHP Member Services at 1-617-495-2008. You may also contact the U.S. Department of Labor’s Employee Benefits Security Administration at 1-866-444-3272 or visit their website at www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact Health Care for All at 1-617-350-7279. For TTY, call 1-617-350-0974.

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.
Harvard University Medical Plan:
Harvard University Group Health Plan (HUGHP) HMO

Coverage Period: 01/01/2017-12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual and Family | Plan Type: HMO

Language Access Services:


Portuguese (Português): De assistência em Português, por favor ligue 617-495-2008.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 617-495-2008.

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

Questions: Call 1-617-495-2008 or visit us at www.hughp.harvard.edu.
If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at bluecrossma.com/sbcglossary or call 1-617-495-2008 to request a copy. SBC #1 HUGHP HMO (Nonunion)
Harvard University Medical Plan:
Harvard University Group Health Program (HUGHP) HMO

Coverage Period: 01/01/2017-12/31/2017
Coverage for: Individual and Family | Plan Type: HMO

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.

Having a baby
(normal delivery)

- **Amount owed to providers**: $7,540
- **Plan pays**: $6,600
- **Patient pays**: $940

**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 $250
- Copays $40
- Coinsurance $500
- Limits or exclusions $150

**Total**: $940

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

- **Amount owed to providers**: $5,400
- **Plan pays**: $4,320
- **Patient pays**: $1,080

**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 $250
- Copays $670
- Coinsurance $80
- Limits or exclusions $80

**Total**: $1,080

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.

Questions: Call 1-617-495-2008 or visit us at www.hughp.harvard.edu.
If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at bluecrossma.com/sbcglossary or call 1-617-495-2008 to request a copy. SBC #1 HUGHP HMO (Nonunion)
Harvard University Medical Plan: Harvard University Group Health Program (HUGHP) HMO
Coverage Period: 01/01/2017-12/31/2017
Coverage for: Individual and Family | Plan Type: HMO

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 1-617-495-2008 or visit us at www.hughp.harvard.edu.
If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at bluecrossma.com/sbcglossary or call 1-617-495-2008 to request a copy. SBC #1 HUGHP HMO (Nonunion)