Blue Care Elect® Saver

Plan-Year Deductible: $1,500/$3,000

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

HUGHP (HDHP Plan) - Faculty and Nonunion Staff
This is a summary of your benefits administered by Blue Cross Blue Shield of Massachusetts, Inc. in partnership with Harvard University Group Health Plan (HUGHP). If you have questions, contact HUGHP Member Services at 1-617-495-2008.

Your Choice

Your Deductible
Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for most benefits under this plan. If you are not sure when your plan year begins, contact Member Services. Your deductible is $1,500 per individual membership (or $3,000 per family membership) for in-network and out-of-network services combined. The entire family deductible must be satisfied before benefits are provided for any one member enrolled under a family membership.

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. See the charts for your cost share.

Note: If a preferred provider refers you to another provider for covered services (such as a lab or specialist), make sure the provider is a preferred provider in order to receive benefits at the in-network level. If the provider you use 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.

How to Find a Preferred Provider
There are a few ways to find a preferred provider:

• Look up a provider in the Provider Directory. If you need a copy of your directory, call Member Service at the number on your ID card.
• Visit the Blue Cross Blue Shield of Massachusetts website at www.bluecrossma.com/findadoctor
• Call the Physician Selection Service at 1-800-821-1388

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. See the charts for your cost share.

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 coinsurance).

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 maximum is $3,000 per individual membership (or $6,000 per family membership) for in-network services and $6,000 per individual membership (or $12,000 per family membership) for out-of-network services. The entire family out-of-pocket maximum must be satisfied before any one member enrolled under a family membership receives full benefits.

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). After your deductible, you pay a coinsurance for in-network or out-of-network emergency room services. See the chart your cost share.

Telehealth Services
You are covered for certain medical and behavioral health services for conditions that can be treated through video visits from an approved Telehealth provider. These Telehealth services are available by using your computer or mobile device when you prefer not to make an in-person visit for any reason to a doctor or therapist. For a list of Telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at www.bluecrossma.com; consult the Provider Directory; or call the Physician Selection Service at 1-800-821-1388.

Utilization Review Requirements
Certain services require pre-approval 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 (such as MRIs and CT Scans). You should work with your provider to determine if pre-approval is required. If your provider, or you, do not get pre-approval when it is required, your benefits will be reduced or denied, and you may be fully responsible for payment to the service provider. Refer to your benefit description for requirements and the process you should follow for Utilization Review, including Pre-Admission Review, Pre-Service Approval (for certain outpatient services), 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. Please 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.
## Your Medical Benefits

### Covered Services

<table>
<thead>
<tr>
<th>Preventive Care</th>
<th>Your Cost In-Network</th>
<th>Your Cost Out-of-Network</th>
</tr>
</thead>
</table>
| Well-child care exams, including routine tests, according to age-based schedule as follows:  
• 10 visits during the first year of life  
• Three visits during the second year of life (age 1 to age 2)  
• Two visits for age 2  
• One visit per calendar year for ages 3 and older | Nothing, no deductible | 35% coinsurance after deductible |
| Preventive care visits (one per calendar year) | Nothing, no deductible | 35% coinsurance after deductible |
| Routine GYN exams, including related lab tests (one per calendar year) | Nothing, no deductible | 35% coinsurance after deductible |
| Routine adult physical exams, including related tests, for members age 19 or older (one per calendar year) | Nothing, no deductible | 35% coinsurance after deductible |
| Routine hearing exams | Nothing, no deductible | 35% coinsurance after deductible |
| Hearing aids (one hearing aid per ear for members age 19 or younger) | Nothing, no deductible | 35% coinsurance after deductible |
| Routine vision exams (one per calendar year) | Nothing, no deductible | 35% coinsurance after deductible |
| Family planning services—office visits | Nothing, no deductible | 35% coinsurance after deductible |
| **Outpatient Care** | | |
| Emergency room visits | 15% coinsurance after deductible | 15% coinsurance after deductible |
| Clinic visits; physicians', and podiatrists' office visits | 15% coinsurance after deductible | 35% coinsurance after deductible |
| Mental health or substance abuse treatment | 15% coinsurance after deductible | 35% coinsurance after deductible |
| Chiropractors' office visits (up to 18 visits per calendar year) | 15% coinsurance after deductible | 35% coinsurance after deductible |
| Acupuncture services (up to 20 visits per calendar year) | 15% coinsurance after deductible | 15% coinsurance after deductible |
| Short-term rehabilitation therapy—physical and occupational (up to 100 visits per calendar year*) | 15% coinsurance after deductible | 35% coinsurance after deductible |
| Speech, hearing, and language disorder treatment—speech therapy | 15% coinsurance after deductible | 35% coinsurance after deductible |
| Diagnostic X-rays and lab tests including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests (excluding routine tests) | 15% coinsurance after deductible | 35% coinsurance after deductible |
| Oxygen and equipment for its administration | 15% coinsurance after deductible | 35% coinsurance after deductible |
| Home health care and hospice services | 15% coinsurance after deductible | 35% coinsurance after deductible |
| Durable medical equipment—such as wheelchairs, crutches, hospital beds | 15% coinsurance after deductible | 35% coinsurance after deductible |
| Prosthetic devices | 15% coinsurance after deductible | 35% coinsurance after deductible |
| Surgery and related anesthesia | 15% coinsurance after deductible | 35% coinsurance after deductible |
Get the Most from Your Plan.

Visit us at www.bluecrossma.com or call HUGHP Member Services at 1-617-495-2008 to learn about discounts, savings, resources, and special programs like those listed below that are available to you.

<table>
<thead>
<tr>
<th>Wellness Participation Program</th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Reimbursement for a membership at a health club or for fitness classes</strong></td>
<td><strong>$150 per calendar year per policy</strong></td>
</tr>
<tr>
<td>This fitness program applies for fees paid to: privately-owned or privately-sponsored health clubs or fitness facilities, including individual health clubs and fitness centers; YMCAs; YWCAs; Jewish Community Centers; and municipal fitness centers. (See your benefit description for details)</td>
<td></td>
</tr>
<tr>
<td><strong>Reimbursement for participation in a qualified weight loss program</strong></td>
<td><strong>$150 per calendar year per policy</strong></td>
</tr>
<tr>
<td>This weight loss program applies for fees paid to: a qualified hospital-based weight loss program or a Blue Cross Blue Shield of Massachusetts designated weight loss program. (See your benefit description for details)</td>
<td></td>
</tr>
<tr>
<td>Blue Care Line®—A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583)</td>
<td>No additional charge</td>
</tr>
</tbody>
</table>


For questions about Blue Cross Blue Shield of Massachusetts, visit the website at www.bluecrossma.com.

Interested in receiving information from Blue Cross Blue Shield of Massachusetts via e-mail? Go to www.bluecrossma.com/email to sign up.

Limitations and Exclusions. These pages summarize the benefits of your HUGHP/Blue Care Elect Saver 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 the plan doesn’t cover are: prescription drugs for use outside of the hospital; cosmetic surgery; custodial care; most dental care; 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.
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.
Translation Resources
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 Idantifikasyon w lan (Sèvis pou Malantandan TTY: 711).


Arabic/العربية: اتهاء: إذا كنت تتحدث اللغة العربية، فتوفر خدمات اللغة مجانا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هويتك (جهاز الهاتف تيفي تي: 711).

Mon-Khmer, Cambodian/ខ្មែរ: ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សីហ្គ៍ ដឹងអំពីការជូនដំណឹងអ្នក ដើម្បីបង្កើតការឆ្លើយតបសឹង និងយកសំណប្ប័្សម្រាប់សិទ្ធិការប្រើប្រាស់សំណុំសម្រាប់ជូនដំណឹង៖ អំណាច រៀន (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).


Greek/αλληνικά: ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, δισταγόμενες για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε την Υπηρεσία Εξυπηρέτησης Μελών στον αριθμό της κάρτας μέλους σας (ID Card) (TTY: 711).
**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 हिंदी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए निषेधक 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 તમારી મદદ સહાયતા સેવાઓ બીના મૂક્યાં ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર આપણી નંબર પર મ્યેમ્બર સેવા ને કોલ કરો (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:** توجه: 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:** ຄີດໍາເຫຼົິ່ນໄດ້: ໃຈດັ່ງເຈົ້າເວົົ້າພາສາລາວໄດ້, ທີ່ມັກບັນທັນຄີຍເຊັ່ນເຊິ່ງການທ່ານໄດ້ຮັບການຊ່ວຍເຫຼືອໄດ້. ທ່ານກ່າວມັກບັນທັນທ່ານເສັ່ນທ່ານທີ່ຕັບວ່າທ່ານໄດ້ຮັບການຊ່ວຍເຫຼືອທິດປະຈຸບັນ (TTY: 711).

**Navajo/Diné Bizaad:** BAA AKOHWIINDZIN DOOÎGİ: Dinê k’ehjí yáníí’í’go saad bee yát’é’ éí t’a’ąįįį’ k’e bee níka’a’dooωolgo éí ná’ahoot’é’. Dií bee aníihiígíí ninaaltsoos bine’déé’ nóomba bik’a’įįįį’ béisíh bee hodíílnihí (TTY: 711).