SUMMARY OF BENEFITS

HUGHP 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

Faculty and Nonunion Staff

This health plan, on its own, does not meet Minimum Creditable Coverage Standards for Massachusetts residents that went into effect as of January 1, 2014, as part of the Massachusetts Health Care Reform Law. If this is a group health plan offered to you through your place of employment, contact your employer or plan sponsor to determine if it offers other health plan options that meet Minimum Creditable Coverage standards. Your employer or other plan sponsor may also offer supplemental plans you can add to this insured health plan in order to meet Minimum Creditable Coverage.
Your Choice

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. 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.

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 Blue Cross Blue Shield. 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.

After your plan-year deductible has been met, you pay 15 percent coinsurance for most in-network covered services. For outpatient preventive health services, you pay nothing for each covered visit. The plan-year deductible does not apply to these services.

Please 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 several 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 our Physician Selection Service at 1-800-821-1388

When You Choose Non-Preferred Providers.

After your plan-year deductible has been met, you pay 35 percent coinsurance for most out-of-network covered services. Payments for out-of-network benefits are based on the Blue Cross Blue Shield of Massachusetts allowed charge as defined in your subscriber certificate. 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 medical and prescription drug 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 in-network deductible, you pay a 15 percent coinsurance for in-network or out-of-network emergency room services.

Utilization Review Requirements.

You must follow the requirements of Utilization Review, which are Pre-Admission Review, Pre-Service Approval for certain outpatient services, Concurrent Review and Discharge Planning, and Individual Case Management. If you need non-emergency or non-maternity hospitalization, you or someone on your behalf must call the number on your ID card for pre-approval. Information concerning Utilization Review is detailed in your subscriber certificate and riders. If you do not notify Blue Cross Blue Shield and receive pre-approval, your benefits may be reduced or denied.

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 subscriber certificate (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

HUGHP provides health care services through its network of participating providers. The network includes the group practices based at Harvard University Health Services (HUHS), Harvard Vanguard Medical Associates (HVMA), Dedham Medical Associates, Granite Medical Group, Southboro Medical Group, South Shore Medical Center, and Reliant Medical Group (formerly Fallon Clinic). Each of these multi-specialty group practices offers a wide range of primary and specialty medical services to adults and children. When you receive services from or authorized in advance by HUGHP network providers, you and any covered family members enjoy generous benefits. If you choose to seek care on your own, your out-of-pocket expenses will be higher.

<table>
<thead>
<tr>
<th>Plan Specifics</th>
<th>Your Cost In-Network</th>
<th>Your Cost Out-of-Network</th>
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<tbody>
<tr>
<td><strong>Plan-year deductible</strong>&lt;br&gt;The entire family deductible must be satisfied before benefits are provided for any one member enrolled under a family membership.</td>
<td>$1,500 per individual membership/$3,000 per family membership for in-network and out-of-network services combined.</td>
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<tr>
<td><strong>Plan-year out-of-pocket maximum</strong>&lt;br&gt;The entire family out-of-pocket maximum must be satisfied before any one member enrolled under a family membership receives full benefits.</td>
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### Covered Services

#### Preventive Care

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 from age 3 through age 18

- Routine adult physical exams, including related tests, for members age 19 or older (one per calendar year)<br>Nothing, no deductible 35% coinsurance after deductible
- Routine GYN exams, including related lab tests (one per calendar year)<br>Nothing, no deductible 35% coinsurance after deductible
- Routine hearing exams, including routine tests<br>Nothing, no deductible 35% coinsurance after deductible
- Routine vision exams (one per calendar year)<br>Nothing, no deductible 35% coinsurance after deductible
- Family planning services–office visits<br>Nothing, no deductible 35% coinsurance after deductible

#### Other Outpatient Care

- Emergency room visits<br>15% coinsurance after deductible 15% coinsurance after deductible
- Clinic visits; physicians’, and podiatrists’ office visits<br>15% coinsurance after deductible 35% coinsurance after deductible
- Mental health or substance treatment<br>15% coinsurance after deductible 35% coinsurance after deductible
- Chiropractors’ office visits (up to 18 visits per calendar year)<br>15% coinsurance after deductible 35% coinsurance after deductible
- Short-term rehabilitation therapy–physical and occupational (up to 100 visits per calendar year*)<br>15% coinsurance after deductible 35% coinsurance after deductible
- Speech, hearing, and language disorder treatment–speech therapy<br>15% coinsurance after deductible 35% coinsurance after deductible
- Diagnostic X-rays, lab tests, and other tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests (excluding routine tests)<br>15% coinsurance after deductible 35% coinsurance after deductible
- Oxygen and equipment for its administration<br>15% coinsurance after deductible 35% coinsurance after deductible
- Home health care and hospice services<br>15% coinsurance after deductible 35% coinsurance after deductible
- Prosthetic devices<br>15% coinsurance after deductible 35% coinsurance after deductible
- Durable medical equipment–such as wheelchairs, crutches, hospital beds<br>15% coinsurance after deductible 35% coinsurance after deductible

#### Hearing Benefits

- Routine hearing exams<br>Nothing, no deductible 35% coinsurance after deductible
- Hearing aids – one hearing aid per ear for members up to age 19 or younger<br>Nothing, no deductible 35% coinsurance after deductible
- Surgery and related anesthesia<br>15% coinsurance after deductible 35% coinsurance after deductible

#### Inpatient Care (including maternity care)

- General or chronic disease hospital care (as many days as medically necessary)<br>15% coinsurance after deductible 35% coinsurance after deductible
- Mental hospital or substance abuse facility care (as many days as medically necessary)<br>15% coinsurance after deductible 35% coinsurance after deductible
- Rehabilitation hospital care (up to 60 days per calendar year)<br>15% coinsurance after deductible 35% coinsurance after deductible
- Skilled nursing facility care (up to 100 days per calendar year)<br>15% coinsurance after deductible 35% coinsurance after deductible

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care.
** In-network cost share waived for one breast pump per birth.
Get the Most from Your Plan.

Visit us at www.bluecrossma.com/membercentral 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>
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<tbody>
<tr>
<td>Reimbursement for a membership at a health club or for fitness classes</td>
<td>$150 per calendar year per policy</td>
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<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>
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<tr>
<td>Reimbursement for participation in a qualified weight loss program</td>
<td>$150 per calendar year per policy</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>
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<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>
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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. The benefits described are covered when arranged by your HUGUP primary care physician. 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 the hospital; cosmetic surgery; custodial care; hearing aids for members over age 19; 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.

Please Note: Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.