BLUE CHOICE® PLAN 2

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

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:

- COVERAGE AND BENEFITS
- CLAIMS AND BALANCES
- DIGITAL ID CARD

Sign in

Download the app, or create an account at bluecrossma.com/hughp.
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. He or she 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 concerning 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 concerning 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.

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. When you seek care on your own without a referral from your HUGHP PCP, 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, you must meet a plan-year deductible before benefits are provided. If you are not sure when your plan year begins, contact Member Services. Your deductible for care you seek on your own is $750 per member (or $2,500 per family).

After meeting your plan-year deductible, you pay a coinsurance for 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. 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 $2,000 per member (or $6,000 per family) for PCP/Plan-Approved services and $2,500 per member (or $7,500 per family) for Self-Referred services.

Urgent Care
If you need care right away, always call your PCP first. Your PCP’s office will determine if you need to be seen, will schedule an appointment if necessary, and tell you where to go to seek treatment. Depending on the urgency of your condition, you will be seen in a medical office or instructed to go to the nearest emergency room. The copayment you are charged will depend on where you are seen.

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
You are covered for certain medical and mental health services for conditions that can be treated through video visits from an approved telehealth provider. Most telehealth services are available by using the Well Connection website at wellconnection.com on your computer, or the Well Connection app on your mobile device, when you prefer not to make an in-person visit for any reason to a doctor or therapist. Some providers offer telehealth services through their own video platforms. For a list of telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at bluecrossma.com, consult the Provider Directory, 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. The service area is the geographic area in which you will receive all of your health care services and supplies.

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.
### Covered Services

<table>
<thead>
<tr>
<th>Preventive Care</th>
<th>Your Cost For PCP/Plan-Approved Benefits</th>
<th>Your Cost For Self-Referred Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-child care visits</td>
<td>Nothing</td>
<td>30% coinsurance after deductible*</td>
</tr>
<tr>
<td>Routine adult physical exams, including related tests</td>
<td>Nothing</td>
<td>30% coinsurance after deductible*</td>
</tr>
<tr>
<td>Routine GYN exams, including related lab tests (one per calendar year)</td>
<td>Nothing</td>
<td>30% coinsurance after deductible*</td>
</tr>
<tr>
<td>Routine hearing exams, including routine tests</td>
<td>Nothing</td>
<td>30% coinsurance after deductible*</td>
</tr>
<tr>
<td>Hearing aids</td>
<td>Nothing</td>
<td>30% coinsurance after deductible*</td>
</tr>
<tr>
<td>Routine vision exams (one per calendar year)</td>
<td>Nothing</td>
<td>30% coinsurance after deductible*</td>
</tr>
<tr>
<td>Family planning services–office visits</td>
<td>Nothing</td>
<td>30% coinsurance after deductible*</td>
</tr>
</tbody>
</table>

### Outpatient Care

| Emergency room visits                  | $100 per visit (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                                           | 30% coinsurance after deductible* |
| Mental health or substance use treatment | $30 per visit                                           | 20% coinsurance, no deductible*   |
| Telehealth services for simple medical conditions or mental health | $30 per visit                                           | Not covered                      |
| Chiropractors’ office visits (up to 18 visits per calendar year) | $30 per visit                                           | 30% coinsurance after deductible* |
| Acupuncture visits (up to 20 visits per calendar year) | $30 per visit                                           | $30 per visit, no deductible*    |
| Short-term rehabilitation therapy–physical and occupational (up to 100 visits per calendar year**) | $30 per visit                                           | 30% coinsurance after deductible* |
| Speech, hearing, and language disorder treatment–speech therapy | $30 per visit                                           | 30% coinsurance after deductible* |
| Diagnostic X-rays and lab tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests | Nothing                                  | 30% coinsurance after deductible* |
| Home health care and hospice services   | Nothing                                  | 30% coinsurance after deductible* |
| Oxygen and equipment for its administration | Nothing                                  | 30% coinsurance after deductible* |
| Durable medical equipment–such as wheelchairs, crutches, hospital beds | Nothing                                  | 30% coinsurance after deductible* |
| Prosthetic devices                     | Nothing                                  | 30% coinsurance after deductible* |
| Surgery and related anesthesia         | $30 per visit***                             | 30% coinsurance after deductible* |
| • Office or health center services     | Nothing                                  | 30% coinsurance after deductible* |
| • Ambulatory surgical facility, hospital outpatient department, or surgical day care unit | Nothing                                  | 30% coinsurance after deductible* |

### Inpatient Care (including maternity care)

| General or chronic disease hospital care (as many days as medically necessary) | Nothing                                  | 30% coinsurance after deductible* |
| Mental hospital or substance use facility care (as many days as medically necessary) | Nothing                                  | 30% coinsurance after deductible* |
| Rehabilitation hospital care (up to 60 days per calendar year) | Nothing                                  | 30% coinsurance after deductible* |
| Skilled nursing facility care (up to 100 days per calendar year) | Nothing                                  | 30% coinsurance after deductible* |

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* 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.

*** 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.
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.

QUESTIONS?

For questions about your plan, call 1-617-495-2008, or visit us online at bluecrossma.com/hughp.
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.
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 Idantitifikasyon w lan (Sèvis pou Malantandan TTY: 711).


Arabic/عربية: انبه: إذا كنت تتحدث اللغة العربية، فتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هويتك (جهاز الهاتف المعصم: 711).

Mon-Khmer, Cambodian/ខ្មែរ: ការជូនដំណឹង៖ ប្រសិនប្រើអ្នកនិយាយភាសា ខ្មែរ បសវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចរកបានសបរាយានអ្នក។ សូមទូរស័ព្ទបៅខ្្នកបសវាសរាជិកតាមបេ្បៅបេើ្រ័ណ្ណ សរាគា េ្លៃួនរ្រស់អ្នក (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/Ληληνικά: 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).

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association