BlueCross® BlueShield®

HARVARD UNIVERSITY GROUP HEALTH PLAN

SUMMARY OF BENEFITS

NETWORK BLUE®
$250 DEDUCTIBLE

HUGHP NON-UNION HMO

Plan-Year Deductible: $250/$750

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.**

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 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. Your PCP 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 need to see a specialist, your PCP will make sure that any necessary referrals are in place. 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.

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. If you are not sure when your plan year begins, contact Member Services. Your deductible is **$250** per member (or **$750** per family).

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 **$1,500** per member (or **$4,500** per family).

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're 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 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. Any additional follow-up care must be arranged by your PCP. See your benefit description for more information.

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
Preventive Care	
Well-child care exams	**Nothing**, no deductible
Routine adult physical exams, including related tests	**Nothing**, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	**Nothing**, no deductible
Routine hearing exams, including routine tests	**Nothing**, no deductible
Hearing aids	**Nothing**, no deductible
Routine vision exams (one per calendar year)	**Nothing**, no deductible
Family planning services—office visits	**Nothing**, no deductible
Outpatient Care	
Emergency room visits	**$100** per visit, no deductible (waived if admitted or for observation stay)
Office or health center visits (medical and specialty)	**$30** per visit, no deductible
Mental health or substance use treatment	**$30** per visit, no deductible
Outpatient telehealth services • With a covered medical or specialty provider • With a covered provider for mental health services • With the designated telehealth vendor	 **$30** per visit, no deductible **$15** per visit, no deductible **$15** per visit, no deductible
Chiropractors' office visits (up to 18 visits per calendar year)	**$30** per visit, no deductible
Acupuncture visits (up to 20 visits per calendar year)	**$30** per visit, no deductible
Short-term rehabilitation therapy—physical and occupational (up to 100 visits per calendar year*)	**$30** per visit, no deductible
Speech, hearing, and language disorder treatment—speech therapy	**$30** per visit, no deductible
Diagnostic X-rays and lab tests	**Nothing**, no deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	**10% coinsurance** after deductible
Home health care and hospice services	**10% coinsurance** after deductible
Oxygen and equipment for its administration	**Nothing**, no deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	**10% coinsurance** after deductible**
Prosthetic devices	**10% 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
Inpatient Care (including maternity care)	
General or chronic disease hospital care (as many days as medically necessary)	**10% coinsurance** after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	**10% coinsurance** after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	**10% coinsurance** after deductible
Skilled nursing facility care (up to 100 days per calendar year)	**10% coinsurance** after deductible

* 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 highlight some of the benefits under your HUGHP/Network Blue plan. The benefits described are covered when arranged by your HUGHP primary care physician. Your Blue Cross Blue Shield of Massachusetts benefit description defines the terms and conditions of your coverage. Should any questions arise concerning benefits, the Blue Cross Blue Shield of Massachusetts benefit description will govern. Some of the services the plan doesn't cover are: custodial care; cosmetic surgery; 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, please refer to your benefit description. **Note:** Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.

001749635 (08/22) SH

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**.

001651238

55-1487 (6/22)

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**).

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, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍເສຍຄ່າ. 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'dééʼ nóomba biká'ígíiji̧' béésh bee hodíílnih (TTY: **711**).

001651831
55-1493 (6/22)