SUMMARY OF BENEFITS

HMO Blue New England
$1,000 Deductible
Plan-Year Deductible: $1,000/$2,000

Hampshire College

Download the MyBlue Member App—Get instant and secure access to your personal health care information any time you need it. A simple tap connects you to your claims history, your ID card, financial accounts, even your doctor. Download the app from the App Store® or Google Play™.

This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.
Your Care

Your Primary Care Provider (PCP)
When you enroll in this health plan, you must choose a primary care provider. Be sure to choose a PCP who can accept you and your family members and who participates in the network of providers in New England. For children, you may choose a participating network pediatrician as the PCP.

For a list of participating PCPs or OB/GYN physicians, 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.

If you have trouble choosing a doctor, Member Service can help. They can give you the doctor's gender, the medical school she or he attended, and whether there are languages other than English spoken in the office.

Referrals
Your PCP is the first person you call when you need routine or sick care. If your PCP decides that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist, who is likely affiliated with your PCP's hospital or medical group.

You will not need prior authorization or referral to see a HMO Blue New England network provider who specializes in OB/GYN services. Your providers may also work with Blue Cross Blue Shield of Massachusetts regarding referrals and Utilization Review Requirements, including Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. For detailed information about Utilization Review, see your subscriber certificate.

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 of Massachusetts. Your deductible for medical benefits is $1,000 per member (or $2,000 per family). Your deductible for prescription drug benefits is $250 per member (or $500 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 (including prescription drug copayments), and coinsurance for covered services. Your out-of-pocket maximum is $2,000 per member (or $4,000 per family).

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
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 bluecrossma.com; consult the Provider Directory; or call the Member Service number on your ID card.

Service Area

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 subscriber certificate 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 subscriber certificate (and riders, if any) for exact coverage details.
### Your Medical Benefits

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Your Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
</tr>
<tr>
<td>Well-child care visits</td>
<td>Nothing, no deductible</td>
</tr>
<tr>
<td>Routine adult physical exams, including related tests</td>
<td>Nothing, no deductible</td>
</tr>
<tr>
<td>Routine GYN exams, including related lab tests (one per calendar year)</td>
<td>Nothing, no deductible</td>
</tr>
<tr>
<td>Routine hearing exams, including routine tests</td>
<td>Nothing, no deductible</td>
</tr>
<tr>
<td>Hearing aids (up to $2,000 per ear every 36 months for a member age 21 or younger)</td>
<td>All charges beyond the maximum, no deductible</td>
</tr>
<tr>
<td>Routine vision exams (one every 24 months)</td>
<td>Nothing, no deductible</td>
</tr>
<tr>
<td>Family planning services–office visits</td>
<td>Nothing, no deductible</td>
</tr>
<tr>
<td><strong>Outpatient Care</strong></td>
<td></td>
</tr>
<tr>
<td>Emergency room visits</td>
<td>$200 per visit, no deductible (waived if admitted or for observation stay)</td>
</tr>
<tr>
<td>Office or health center visits, when performed by:</td>
<td></td>
</tr>
<tr>
<td>• Your PCP, OB/GYN physician, nurse practitioner, nurse midwife, physician assistant, or limited services clinic</td>
<td>$25 per visit, no deductible</td>
</tr>
<tr>
<td>• Other covered providers</td>
<td>$35 per visit, no deductible</td>
</tr>
<tr>
<td>Chiropractors’ office visits</td>
<td>$35 per visit, no deductible</td>
</tr>
<tr>
<td>Mental health or substance abuse treatment</td>
<td>$25 per visit, no deductible</td>
</tr>
<tr>
<td>Short-term rehabilitation therapy–physical and occupational (up to 60 visits per calendar year*)</td>
<td>$35 per visit after deductible</td>
</tr>
<tr>
<td>Speech, hearing, and language disorder treatment–speech therapy</td>
<td>$35 per visit after deductible</td>
</tr>
<tr>
<td>Diagnostic X-rays and lab tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests</td>
<td>Nothing after deductible</td>
</tr>
<tr>
<td>Home health care and hospice services</td>
<td>Nothing, no deductible</td>
</tr>
<tr>
<td>Oxygen and equipment for its administration</td>
<td>Nothing after deductible</td>
</tr>
<tr>
<td>Durable medical equipment–such as wheelchairs, crutches, hospital beds</td>
<td>20% coinsurance after deductible**</td>
</tr>
<tr>
<td>Prosthetic devices</td>
<td>20% coinsurance after deductible**</td>
</tr>
<tr>
<td>Surgery and related anesthesia in an office or health center, when performed by:</td>
<td>$25 per visit***, no deductible</td>
</tr>
<tr>
<td>• Your PCP, OB/GYN physician, nurse practitioner, nurse midwife, or physician assistant</td>
<td>$35 per visit***, no deductible</td>
</tr>
<tr>
<td>• Other covered providers</td>
<td></td>
</tr>
<tr>
<td>Surgery in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit</td>
<td>Nothing after deductible</td>
</tr>
<tr>
<td><strong>Inpatient Care (including maternity care)</strong></td>
<td></td>
</tr>
<tr>
<td>General or chronic disease hospital care (as many days as medically necessary)</td>
<td>Nothing after deductible†</td>
</tr>
<tr>
<td>Mental hospital or substance abuse facility care (as many days as medically necessary)</td>
<td>Nothing, no deductible</td>
</tr>
<tr>
<td>Rehabilitation hospital care (up to 60 days per calendar year)</td>
<td>Nothing after deductible</td>
</tr>
<tr>
<td>Skilled nursing facility care (up to 100 days per calendar year)</td>
<td>Nothing after deductible</td>
</tr>
</tbody>
</table>

* 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.
*** 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.
† Deductible waived for mental health admissions.
Prescription Drug Benefits*  
At designated retail pharmacies  
(up to a 30-day formulary supply for each prescription or refill)  
$10 after deductible for Tier 1  
$35 after deductible for Tier 2  
$60 after deductible for Tier 3  

Through the designated mail service pharmacy  
(up to a 90-day formulary supply for each prescription or refill)  
$20 after deductible for Tier 1***  
$70 after deductible for Tier 2  
$120 after deductible for Tier 3  

* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred drugs.  
** Cost share may be waived for certain covered drugs and supplies.  
*** Certain generic medications are available through the mail service pharmacy at $9, no deductible. For more information, go to bluecrossma.com/mail-service-pharmacy.

Get the Most from Your Plan  
Visit us at bluecrossma.com or call 1-800-358-2227 to learn about discounts, savings, resources, and special programs available to you, like those listed below.

**Fitness Reimbursement: a benefit that rewards participation in qualified fitness programs**  
This fitness benefit applies for fees paid to: a health club with cardiovascular and strength-training equipment; or a fitness studio offering instructor-led group classes for certain cardiovascular and strength-training programs.  
(See your subscriber certificate for details.)  
Reimbursement for up to 3 consecutive months membership fees of one membership or, alternatively up to 10 fitness classes, per individual or family per calendar year

**Weight Loss Reimbursement: a benefit that rewards participation in a qualified weight loss program**  
This weight loss program benefit applies for fees paid to: hospital-based or non-hospital-based weight loss programs that focus on eating and physical activity habits and behavioral/lifestyle counseling with certified health professionals.  
(See your subscriber certificate for details.)  
Reimbursement for up to 3 months participation fees, per individual or family per calendar year

**24/7 Nurse Care Line—A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583)**  
No additional charge

Questions?  
For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-358-2227, or visit us online at bluecrossma.com. Interested in receiving information from us via e-mail? Go to bluecrossma.com/email to sign up.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your subscriber certificate and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the subscriber certificate and riders will govern. Some of the services not covered are: 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 subscriber certificate and riders.
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: وجوب أن يكون هذا اللغة العربية، تتوفر خدمات المساعدة اللغوية مجانًا بالنسبة للك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هويتك (جهاز الهاتف TTY: 711).

Mon-Khmer, Cambodian:// ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរបាន ឱ្យ យើងយើងនឹងផ្តល់មូលដ្ឋាននៃអស្ចារ្យមួយ ដូចជាអំពីការបង្កើតបណ្តាញខ្មែរមួយ ដូចជាអ្នកគិតថ្លៃគឺអាចរកបានសបរាជ។ 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).


Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association
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 निःशुल्क उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वाइ.: 711).

Gujarati/ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમારી ભાષા સહાયતા સેવાઓ ની મૂળમાં ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર આપેલ નંબર પર મેમબર સેવા ને કૉલ 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ト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）。


Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOIĞÍ: Diné k’ehjí yánílf’i’go saad bee yát’i’ éí t’aájíįk’e bee niká’a’doowolgo éí ná’ahoot’i’. Díí bee ani'tahígi nínaaltsoos bine’deé’ nóomba biká’iigu’ii’ béésh bee hodíilnih (TTY: 711).