SUMMARY OF BENEFITS

Preferred Blue® PPO Saver

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

Hampshire College

MyBlue is a personalized way to access and manage your health plan. Get secure access to key plan information, claims history, and recent medications. Download or email a copy of your digital ID card. View your spending dashboard, important updates, alerts and notifications. Register or log in at bluecrossma.com/myblue or download the app on iTunes® 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 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 Blue Cross Blue Shield of Massachusetts. 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
To find a preferred provider:
- Look up a provider in the Provider Directory. If you need a copy of your directory or help choosing a provider, call the Member Service number on your ID card.
- Visit the Blue Cross Blue Shield of Massachusetts website at bluecrossma.com/findadoctor

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 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 (including prescription drug copayments), and coinsurance for covered services. Your out-of-pocket maximum is $4,500 per member (or $9,000 per family) for in-network and out-of-network services combined.

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 meeting your deductible, you pay nothing per visit for in-network or out-of-network emergency room services.

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.

Utilization Review Requirements
Certain services require pre-approval/prior authorization 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, and drugs. You should work with your health care provider to determine if pre-approval is required for any service your provider is suggesting. If your provider, or you, don’t get pre-approval when it’s required, your benefits will be denied, and you may be fully responsible for payment to the provider of the service. Refer to your subscriber certificate for requirements and the process you should follow for Utilization Review, including Pre-Admission Review, Pre-Service Approval, 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. 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.
<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Your Cost In-Network</th>
<th>Your Cost Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well-child care exams, including routine tests, according to age-based schedule</td>
<td>Nothing, no deductible</td>
<td>20% coinsurance, no deductible</td>
</tr>
<tr>
<td>as follows:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 10 visits during the first year of life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Three visits during the second year of life (age 1 to age 2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Two visits for age 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• One visit per calendar year for age 3 and older</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine adult physical exams, including related tests</td>
<td>Nothing, no deductible</td>
<td>20% coinsurance, no deductible</td>
</tr>
<tr>
<td>(one per calendar year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine GYN exams, including related lab tests (one per calendar year)</td>
<td>Nothing, no deductible</td>
<td>20% coinsurance, no deductible</td>
</tr>
<tr>
<td>Routine hearing exams, including related tests</td>
<td>Nothing, no deductible</td>
<td>20% coinsurance, 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 after deductible</td>
<td>20% coinsurance after deductible and all charges beyond the maximum</td>
</tr>
<tr>
<td>Routine vision exams (one every 24 months)</td>
<td>Nothing, no deductible</td>
<td>20% coinsurance, no deductible</td>
</tr>
<tr>
<td>Family planning services--office visits</td>
<td>Nothing, no deductible</td>
<td>20% coinsurance, no deductible</td>
</tr>
<tr>
<td><strong>Outpatient Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room visits</td>
<td>Nothing after deductible</td>
<td>Nothing after deductible</td>
</tr>
<tr>
<td>Office or health center visits</td>
<td>Nothing after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Mental health or substance use treatment</td>
<td>Nothing after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Telehealth services for simple medical conditions or mental health</td>
<td>Nothing after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Chiropractors’ office visits</td>
<td>Nothing after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Acupuncture visits (up to 12 visits per calendar year)</td>
<td>Nothing after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Short-term rehabilitation therapy--physical and occupational</td>
<td>Nothing after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>(up to 60 visits per calendar year*)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech, hearing, and language disorder treatment--speech therapy</td>
<td>Nothing after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Diagnostic X-rays and lab tests, including CT scans, MRIs,</td>
<td>Nothing after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>PET scans, and nuclear cardiac imaging tests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care and hospice services</td>
<td>Nothing after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Oxygen and equipment for its administration</td>
<td>Nothing after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Durable medical equipment--such as wheelchairs, crutches, hospital beds</td>
<td>20% coinsurance after deductible**</td>
<td>40% coinsurance after deductible**</td>
</tr>
<tr>
<td>Prosthetic devices</td>
<td>20% coinsurance after deductible</td>
<td>40% coinsurance after deductible</td>
</tr>
<tr>
<td>Surgery and related anesthesia</td>
<td>Nothing after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td><strong>Inpatient Care (including maternity care)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General or chronic disease hospital care</td>
<td>Nothing after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>(as many days as medically necessary)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental hospital or substance use facility care (as many days as medically</td>
<td>Nothing after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>necessary)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rehabilitation hospital care (up to 60 days per calendar year)</td>
<td>Nothing after deductible</td>
<td>20% coinsurance after deductible</td>
</tr>
<tr>
<td>Skilled nursing facility care (up to 100 days per calendar year)</td>
<td>Nothing after deductible</td>
<td>20% coinsurance 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.

** In-network cost share waived for one breast pump per birth (20% coinsurance after deductible out-of-network).
# Prescription Drug Benefits*

<table>
<thead>
<tr>
<th>At designated retail pharmacies</th>
<th>Your Cost In-Network**</th>
<th>Your Cost Out-of-Network**</th>
</tr>
</thead>
<tbody>
<tr>
<td>(up to a 30-day formulary supply for each prescription or refill)</td>
<td>$10 after deductible for Tier 1</td>
<td>$20 after deductible for Tier 1</td>
</tr>
<tr>
<td></td>
<td>$25 after deductible for Tier 2</td>
<td>$50 after deductible for Tier 2</td>
</tr>
<tr>
<td></td>
<td>$45 after deductible for Tier 3</td>
<td>$90 after deductible for Tier 3</td>
</tr>
</tbody>
</table>

| Through the designated mail order pharmacy | $20 after deductible for Tier 1*** | Not covered |
| (up to a 90-day formulary supply for each prescription or refill) | $50 after deductible for Tier 2 | |
|                                            | $135 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 brand-name drugs.

** Cost share may be waived for certain covered drugs and supplies.

*** Certain generic medications are available through the mail order pharmacy at $9, no deductible. For more information, go to bluecrossma.com/mail-order-pharmacy.

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## 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.

### Wellness Participation Program

<table>
<thead>
<tr>
<th>Wellness Participation Program</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fitness Reimbursement</strong>: a benefit that rewards participation in qualified fitness programs</td>
<td>$150 per calendar year per policy</td>
</tr>
<tr>
<td>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.)</td>
<td></td>
</tr>
</tbody>
</table>

| Weight Loss Reimbursement: a benefit that rewards participation in a qualified weight loss program | $150 per calendar year per policy |
| 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.) | |

| 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. Register for or log in to MyBlue, a personalized way to access your health care information, claims, and more, at bluecrossma.com/myblue.

### 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/قديم: 

Mon-Khmer, Cambodian/ខ្មែរ: សូមយើងដាក់គ្នាខាងក្នុងរកទុក្ខជាតិភាគរបស់អ្នក ដែលកំពុងតែងការបន្តិបត្រដ៏សិល្បៈ និងការផ្តល់ព័ត៌មានល្អបាន ដ៏សមារមានបន្តិចក្តីដ៏ម៉េរៈ ដែលអាចទទួលបានបានបាននៅក្នុងការបន្តិបត្រ (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/αληνικά: 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 हिंदी बोलते हैं, तो भाषा सहायता सेवाएं, आप के लिए निश्चित 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 બોલતો હો, તો તમાં ભાષા સહાય સેવાઓ દ્વારા મૂલ્યમોટ ઉપલબ્ધ છે. તમારી આઈડી કાર્ડ પર ભારતીય પ્રથમ નર્મા દ્વારા Member Service ના અંશ 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）。


Lao/ພາສາລາວ: ທໍາອາບເຫລືອກ: ຈາກເຈົ້າເວົ້າພາສາລາວ, ບັກການບັດເກຍການຄ້າຍເວົ້າເພື່ອເຮັດໃຫ້ການປະຕິບັດໂດຍປະເທດ. ທໍາອາບເຫລືອກການບັດເກຍການຄ້າຍເວົ້າເພື່ອເຮັດໃຫ້ການປະຕິບັດໂດຍປະເທດ (TTY: 711).