


Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2022 — 12/31/2022


Coverage for: Individual + Family | Plan Type: HMO


 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, www.harvardpilgrim.org/LGsampleEOC. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other **underlined** terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-888-333-4742 to request a copy.

Important Questions	Answers	Why this matters
What is the overall deductible ?	Medical & Prescription Drug Deductible: \$1,500 member/ \$3,000 family Benefits are administered on a Plan Year basis.	Generally you must pay all the costs up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible ?	Yes: preventive care , routine eye exams, are covered before you meet your deductibles .	This plan covers some items and services even if you haven't yet met the deductible amount. But, a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services
What is the out-of-pocket limit for this plan ?	\$4,000 member/ \$8,000 family	The out-of-pocket limit is the most you could pay in a year of covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met.

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What is not included in the out-of-pocket limit ?	Premiums , balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See https://www.harvardpilgrim.org/public/find-a-provider or call 1-888-333-4742 for a list of preferred providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance-billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	Yes, some exceptions apply.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .

 Deductible will apply to all services in this chart unless otherwise noted. All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Out-of-Network Provider	
If you visit a health care provider 's office or clinic	Primary care visit to treat an injury or illness	Level 1: \$25 copay /visit	Not covered	None
	Specialist visit	Level 1: \$25 copay /visit	Not covered	None
	Preventive care / screening / immunization	No charge; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will)	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	X-rays: No charge Laboratory: No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Cost sharing may vary for certain imaging services.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at - www.optumrx.com or call 1 855-546-3439. This plan follows the OptumRx Premium Formulary.	Generic drugs	Retail: \$15 Mail Order: \$30	Not Covered	30-day supply - retail / 90-day supply - mail order. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by OptumRx. Some prescriptions require prior authorization. Certain preventive medications (including certain contraceptives) are covered at no charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered.
	Preferred brand drugs	Retail: \$40 Mail Order: \$80	Not Covered	
	Non-preferred brand drugs	Retail: \$60 Mail Order: \$120	Not Covered	
	Specialty drugs	Generic: \$15 Preferred brand: \$40 Non-preferred: \$60	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None
	Physician/surgeon fees	No charge	Not covered	

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	\$100 copay /visit		None
	Emergency medical transportation	No charge		None
	Urgent care	Convenience care clinic: \$25 copay /visit Urgent care center: \$25 copay /visit Hospital urgent care center: \$25 copay /visit	Convenience care clinic: Not Covered Urgent care center Not Covered Hospital urgent care center Same As Participating Provider	Services with non-participating providers are only covered outside of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	None
	Physician/surgeon fee	No charge	Not covered	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	\$25 copay /visit	Not covered	None
	Inpatient services	No charge	Not covered	
If you are pregnant	Office visits	\$25 copay /visit	Not covered	Cost sharing does not apply for preventive services .
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	None
	Rehabilitation services	Physical Therapy: \$25 copay /visit Occupational Therapy: \$25 copay /visit Speech Therapy: \$25 copay /visit	Not covered	Occupational & physical therapy – 60 combined visits /Plan Year
	Habilitation services			
	Skilled nursing care	No charge	Not covered	100 days/Plan Year
	Durable medical equipment	30% coinsurance	Not covered	Wigs – \$350/Plan Year
	Hospice services	No charge	Not covered	For inpatient see “If you have a hospital stay”.
If your child needs dental or eye care	Children’s eye exam	No charge; deductible does not apply	Not covered	1 exam/Plan Year
	Children’s glasses	Not covered	Not covered	None
	Children’s dental check-up – Up to age of 13	\$25 copay /visit	Not covered	2 exams/Plan Year
Excluded Services & Other Covered Services:				
Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services .)				
	<ul style="list-style-type: none"> • Long-Term (Custodial) Care • Most Cosmetic Surgery • Most Dental Care (Adult) • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private-duty nursing • Routine foot care • Services that are not Medically Necessary • Weight Loss Programs 		
Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)				
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery 	<ul style="list-style-type: none"> • Chiropractic Care • Hearing Aids - \$2,000/aid every 36 months, for each impaired ear up to age 22 	<ul style="list-style-type: none"> • Infertility Treatment • Routine eye care (Adult) – 1 exam/Plan Year 		

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

HPHC Member Appeals-Member
Services Department
Harvard Pilgrim Health Care, Inc.
1600 Crown Colony Drive
Quincy, MA 02169
Telephone: 1-888-333-4742
Fax: 1-617-509-3085

Department of Labor's Employee
Benefits Security Administration
1-866-444-3272
www.dol.gov/ebsa/healthreform

Health Care for All
30 Winter Street, Suite 1004
Boston, MA 02108
1-800-272-4232
<http://www.hcfama.org/helpline>

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this Coverage Meet the Minimum Value Standard? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium](#) tax credit to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Para obtener asistencia en Español, llame al 1-888-333-4742.

如果需要中文的帮助, 请拨打这个号码 1-888-333-4742.

De assistência em Português, por favor ligue 1-888-333-4742.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductible](#), [copayment](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$1,500	■ The plan's overall deductible	\$1,500	■ The plan's overall deductible	\$1,500
■ Specialist copayment	\$40	■ Specialist copayment	\$40	■ Specialist copayment	\$40
■ Hospital (facility)	\$0	■ Hospital (facility)	\$0	■ Hospital (facility)	\$0
■ Other	\$0	■ Other	\$0	■ Other	\$0
This EXAMPLE event includes services like:		This EXAMPLE event includes services like:		This EXAMPLE event includes services like:	
Specialist office visits (<i>prenatal care</i>)		Primary care physician office visits (<i>including disease education</i>)		Emergency room care (<i>including medical supplies</i>)	
Childbirth/Delivery Professional Services		Diagnostic tests (<i>blood work</i>)		Diagnostic test (<i>x-ray</i>)	
Childbirth/Delivery Facility Services		Prescription drugs		Durable medical equipment (<i>crutches</i>)	
Diagnostic tests (<i>ultrasounds and blood work</i>)		Durable medical equipment (<i>glucose meter</i>)		Rehabilitation services (<i>physical therapy</i>)	
Specialist visit (<i>anesthesia</i>)					
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$1,500	Deductibles	\$1,500	Deductibles	\$1,500
Copayments	\$0	Copayments	\$100	Copayments	\$200
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$70
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$0	Limits or exclusions	\$0	Limits or exclusions	\$0
The total Peg would pay is	\$1,500	The total Joe would pay is	\$1,600	The total Mia would pay is	\$1,770

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-333-4742
(ITY: 711).

 Harvard Pilgrim Health Care includes Harvard Pilgrim Health care, Harvard Pilgrim Health Care of New England and HPH Insurance Company.

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General Notice About Nondiscrimination and Accessibility Requirements

Harvard Pilgrim Health Care and its affiliates, as noted below ("HPHC") comply with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

HPHC:

- 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, audio, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters.

If you need these services, contact the Civil Rights Compliance Officer.

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with the Civil Rights Compliance Officer, 93 Worcester Street, Wellesley, MA 02481, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085. Email: civil_rights@harvardpilgrim.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer 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, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019, (800) 537-7697 (TTY)

Complaint forms are available at <http://www.hhs.gov/oeo/ofic/file/index.html>.

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

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