Harvard Pilgrim Health Care

Massachusetts

The Harvard Pilgrim Focus Network℠ HMO

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?	$0 Benefits are administered on a Plan Year basis.	See the Common Medical Events chart below for your costs for services this plan covers
Are there services covered before you meet your deductible?	Yes: **durable medical equipment**, **emergency room care**, **emergency medical transportation**, prescription drugs, outpatient mental health services, **preventive care**, **provider** office visits, **rehabilitation services**, **habilitation services**, 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?	$2,500 member/ $5,000 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.

Important Questions	Answers	Why this matters
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.

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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**Level 1:** $20 copay/visit	Not covered	No copay for the first 2 office visits/Member.
	Specialist visit	**Level 1:** $20 copay/visit **Level 2:** $35 copay/visit	Not covered	None
	Preventive care/ screening/ immunization	No charge	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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	**X-rays:** No charge **Laboratory:** No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	$100 copay/procedure	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)	$125 copay/visit	Not covered	None
	Physician/surgeon fees	No charge	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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:** $20 copay/visit **Urgent care center:** $20 copay/visit **Hospital urgent care center:** $20 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)	$250 copay/admit	Not covered	None
	Physician/surgeon fee	No charge	Not covered	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$20 copay/visit	Not covered	No copay for the first 2 mental health/substance abuse visits/Member.
	Inpatient services	No charge	Not covered	
If you are pregnant	Office visits	$20 copay/visit	Not covered	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$250 copay/admit	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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 Habilitation services	**Physical Therapy:** $20 copay/visit **Occupational Therapy:** $20 copay/visit **Speech Therapy:** $20 copay/visit	Not covered	Occupational & physical therapy – 60 combined visits /Plan Year
	Skilled nursing care	$250 copay/admit	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	Not covered	1 exam/Plan Year
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up – Up to age of 13	$20 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.)

	• Long-Term (Custodial) Care • Most Cosmetic Surgery • Most Dental Care (Adult) • Non-emergency care when traveling outside the U.S.	• 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.)

• Acupuncture • Bariatric surgery	• Chiropractic Care • Hearing Aids - $2,000/aid every 36 months, for each impaired ear up to age 22	• 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.

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**	$0	■ **The plan's overall deductible**	$0	■ **The plan's overall deductible**	$0
■ **Specialist *copayment***	$35	■ **Specialist *copayment***	$35	■ **Specialist *copayment***	$35
■ **Hospital (facility) *copayment***	$250	■ **Hospital (facility) *copayment***	$250	■ **Hospital (facility) *copayment***	$250
■ **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 (*prenatal care*)		Primary care physician office visits (*including disease education*)		Emergency room care (*including medical supplies*)	
Childbirth/Delivery Professional Services		Diagnostic tests (*blood work*)		Diagnostic test (*x-ray*)	
Childbirth/Delivery Facility Services		Prescription drugs		Durable medical equipment (*crutches*)	
Diagnostic tests (*ultrasounds and blood work*)		Durable medical equipment (*glucose meter*)		Rehabilitation services (*physical therapy*)	
Specialist visit (*anesthesia*)					
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:**	
Cost Sharing		*Cost Sharing*		*Cost Sharing*	
Deductibles	$0	Deductibles	$0	Deductibles	$0
Copayments	$300	Copayments	$200	Copayments	$300
Coinsurance	$0	Coinsurance	$0	Coinsurance	$70
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$0	Limits or exclusions	$0	Limits or exclusions	$0
The total Peg would pay is	**$300**	**The total Joe would pay is**	**$200**	**The total Mia would pay is**	**$370**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Language Assistance Services

Espanol(Spanish) ATENCI6N: Si usted habla espanol,servicios de asistencia lingiistica, de forma gratuita, estan a su disposici6n. Uame al 1-888-333-4742 (TIY: 711).

Portugues (Portuguese) ATEN<;AO: Se voce fala portugues,encontram-se disponiveis servios lngufsticos gratuitos. Ligue para 1-888-333-4742 (TIY: 711).

KreyolAyisyen (French Creole) ATANSYON: Si nou pale Kreyol Ayisyen,gen asistans pou sevis ki disponib nanlang nou pou gratis. Rele 1-888-333-4742 (TIY: 711).

繁體中文 (Traditional Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-333-4742（TTY：711）。

Tieng Viet (Vietnamese) CH UY: Neu quf vi n6i Tieng Viet,djch vu thong djch cua chUng toi n sang phuc VU qui Vi mi n phf. Goi so 1-888-333-4742 (TIY: 711).

PyccKHH (Russian) BHIIIMAHIIIE: ECJIH BbIroeopHTe HapyccKOM R3b1Ke, TO B3MAOCTYnHbI6ecn11aTHble yc11yr11 nepeBOAa. 3BOHHTe 1-888-333-4742 (re11era'1n: 711).

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Franais (French) ATTENTION: Si vous parlez fran ais,des services d'aide linguistique vous sent proposes gratuitement. Appelez le 1-888-333-4742 (ATS: 711).

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taliano {Italian) ATTENZIONE: In casela lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare i numero 1-888-333-4742 (TIY: 711).

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

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Polski IPolishl UWAGA: Jeieli m6wisz oo oolsku. moiesz skorzvstacz bezolatnei oomocv iezvkowei. Zadzwon ood numer 1-888-333-4742 CTIY: 7111.

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ATI.ENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-333-4742 (ITY: 71I).

\)J Harvard Pilgrim Health Care includes Harvard Pilgrim Health care, Harvard Pilgrim Health Care of New England and HPHCinsurance Company.

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GeneJalNotice About Nondiscrimination and Accessibility Requirements

Hervard IRgrim Heallh Care and Its affiliates as ncted below ("HPHC") comply v.ilh applicab e federaldvll rights laws and does not dlscrimlnate on the basis of race, cdor. national origin, age, dlsability, or sex. HPHC does not eio.:lude people er treat them differently becaure of ra::e, color, national origin, age, disabiity or rex.

HPHC:

- Provides free aids and services to people v.ilh dlsabilities to communicate effectively v.ith us, such as qualified sign la1"9uage interprelers and written infonration in otl"er fcrmats (large print, audio, otl"er fonnals)
- Provides free language seivices to people whose prlnary lang.Jage is not Ellgish. such as qualified interpreters.

If you need these services, conta ct olJ' CMI Rights Compliance Off1eer.

If you beleve that HPHC has failed to provide these serfls or dscrlminated in another way on the basis of race. oolcr, national crigin, age, dlsability or sex, you can file a grievance wlh: C•I Rights CQI11)1iance Officer, 93 Worcest EJ SI, Welles ey, MA 02481, (866) 750-2074, TIY service: 711, Fax: (617) 509-3085. Email: dvil_righls@harvar¢ilgim org. Yoo can file a gievance in person 01 by mail, fax or emai. If 1<>u need hep fing a grievance, the Civil Rights Compliaoce Cfficer is available to help you. Yoo can also e a civil righls complat w h the US. Department of Health and Human Services, Office for Civil RIgits, electronically lhrough the Office for Civil Rights Complaint Portal. ava latle al https Jocrportal hhs.gov ocr portal Aobb<js f, or by mail or phone at

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

Complaint fonns are available at http J/www.l'lhg ov foe<ofic&'file Index hln l.

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

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