**Important Questions** | **Answers** | **Why this matters**
--- | --- | ---
What is the overall **deductible**? | $400 member / $800 family | 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 **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.

Are there services covered before you meet your **deductible**? | Yes. **Preventive care**, **provider** office visits, mental health, **rehabilitation services**, and **habilitation services** are covered before you meet your **deductible**. | This **plan** covers some items and services even if you haven’t yet met the **deductible** amount. But, a **copayment** or **coinsurance** may apply.

Are there other **deductibles** for specific services? | Yes. **Prescription Drug Deductible**: $100 member / $200 family. There are no other specific **deductibles**. | You must pay all of the costs for these services up to the specific **deductible** amount before this **plan** begins to pay for these services.

What is the **out-of-pocket limit** for this **plan**? | $5,000 member / $10,000 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 family **out-of-pocket limit** has been met.
### Important Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Why this matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is not included in the <strong>out-of-pocket limit</strong>?</td>
<td>Premiums, balance-billed charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the <strong>out-of-pocket limit</strong>.</td>
</tr>
<tr>
<td>Will you pay less if you use a <strong>network provider</strong>?</td>
<td>Yes. See <a href="http://www.providerlookuponline.com/harvardpilgrim/po7/Search.aspx">www.providerlookuponline.com/harvardpilgrim/po7/Search.aspx</a> or call 1-888-333-4742 for a list of <strong>preferred providers</strong>.</td>
<td>This plan uses a <strong>provider network</strong>. You will pay less if you use a <strong>provider</strong> in the plan's <strong>network</strong>. You will pay the most if you use an <strong>out-of-network provider</strong>, and you might receive a bill from a <strong>provider</strong> for the difference between the provider's charge and what your plan pays (balance-billing). Be aware, your <strong>network provider</strong> might use an <strong>out-of-network provider</strong> for some services (such as lab work). Check with your <strong>provider</strong> before you get services.</td>
</tr>
<tr>
<td>Do you need a <strong>referral</strong> to see a <strong>specialist</strong>?</td>
<td>Yes, some exceptions apply.</td>
<td>This plan will pay some or all of the costs to see a <strong>specialist</strong> for covered services but only if you have a <strong>referral</strong> before you see the <strong>specialist</strong>.</td>
</tr>
</tbody>
</table>

**Copayments** and **coinsurance** cost shown in this chart are both before and after your **deductible** has been met, if a **deductible** applies.

### Common Medical Event

<table>
<thead>
<tr>
<th>Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care <strong>provider</strong>'s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td><strong>Network Provider</strong> (You will pay the least): $20 <strong>copay</strong>/ visit; <strong>deductible</strong> does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Specialist</strong> visit</td>
<td><strong>Out-of-Network Provider</strong> (You will pay the most): <strong>Level 1</strong>: $30 <strong>copay</strong>/ visit; <strong>deductible</strong> does not apply</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td><strong>Preventive care/screening/immunization</strong></td>
<td><strong>Level 2</strong>: $60 <strong>copay</strong>/ visit; <strong>deductible</strong> does not apply</td>
<td>None</td>
</tr>
<tr>
<td>If you have a test</td>
<td><strong>Diagnostic test</strong> (x-ray, blood work)</td>
<td>No charge</td>
<td><strong>Not covered</strong></td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td><strong>copay</strong>/ scan</td>
<td>Participating Providers limited to a maximum of one *<em>copay</em>/ Member/ day.</td>
</tr>
</tbody>
</table>

---

**Note:**
- **copay**
- **deductible**
- **Level 1**
- **Level 2**

### Event Details

- **Out-of-pocket limit**
- **Network provider**
- **Preferred provider**
- **Out-of-network provider**
- **Provider network**
- **Deductible**
<table>
<thead>
<tr>
<th>Common Medical Event</th>
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</tr>
</thead>
</table>
| If you need drugs to treat your illness or condition | Generic drugs | Retail: $10 copay after deductible  
Maintenance 90/Mail Order: $25 copay after deductible | Prescription drug coverage is administered by Express Scripts. For additional information, visit [www.express-scripts.com/gicrx](http://www.express-scripts.com/gicrx) or call Customer Service at 1-855-283-7679 (TTY 711). Retail cost share is for up to a 30-day supply; mail order cost share is for up to a 90-day supply. Some drugs require prior authorization to be covered. Some drugs have quantity limitations. A 90-day supply of maintenance medications may be obtained at a CVS Pharmacy for the applicable mail order copay. If a drug has a generic equivalent, and you buy the brand name (even if your physician indicates no substitutions), you will pay the generic-level copay plus the cost difference between the generic and the brand name drug. |
| | Preferred brand drugs | Retail: $30 copay after deductible  
Maintenance 90/Mail Order: $75 copay after deductible |  |
| | Non-preferred brand drugs | Retail: $65 copay after deductible  
Maintenance 90/Mail Order: $165 copay after deductible |  |
<p>| Specialty drugs | Limited to a 30-day supply with appropriate tier copay (see above) when purchased at a designated specialty pharmacy | Must be obtained at a designated specialty pharmacy. Some drugs require prior authorization to be covered. Some drugs have quantity limitations. Some specialty drugs may also be covered under your medical benefit. |  |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$250 <a href="#">copay</a>/ visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td><a href="#">Emergency room care</a></td>
<td>$100 <a href="#">copay</a>/ visit</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td><a href="#">Emergency medical transportation</a></td>
<td>No charge</td>
<td>None</td>
</tr>
<tr>
<td><strong>Urgent care</strong></td>
<td>Convenience care clinic: $10 <a href="#">copay</a>/ visit; <a href="#">deductible</a> does not apply Urgent care clinic (including hospital urgent care clinic): $20 <a href="#">copay</a>/ visit; <a href="#">deductible</a> does not apply</td>
<td>Convenience care clinic: $10 <a href="#">copay</a>/ visit; <a href="#">deductible</a> does not apply Urgent care clinic (including hospital urgent care clinic): $20 <a href="#">copay</a>/ visit; <a href="#">deductible</a> does not apply</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>Tier 1: $275 <a href="#">copay</a>/ admit Tier 2: $500 <a href="#">copay</a>/ admit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you have mental health, behavioral health, or substance abuse needs</strong></td>
<td>Outpatient services</td>
<td>$20 <a href="#">copay</a>/ visit; <a href="#">deductible</a> does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$275 <a href="#">copay</a>/ admit; <a href="#">deductible</a> does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$20 copay/visit; deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
|                      | Childbirth/delivery facility services | Tier 1: $275 copay/ admit  
Tier 2: $500 copay/ admit | Not covered | Up to one Medical or Mental Health & Substance Abuse Hospital Inpatient Copay/ Member each Quarter. |
| If you need help recovering or have other special health needs | **Home health care** | No charge | Not covered | None |
|                      | **Rehabilitation services** | Physical & Occupational Therapy: $20 copay/ visit; deductible does not apply  
Speech Therapy: No charge; deductible does not apply | Not covered | Physical & Occupational Therapy – 90 consecutive days/ illness or injury |
|                      |                      | 20% coinsurance | Not covered | – 45 days/ year |
|                      | **Habilitation services** | Physical & Occupational Therapy: $20 copay/ visit; deductible does not apply  
Speech Therapy: No charge; deductible does not apply | Not covered | |
|                      | **Skilled nursing care** | 20% coinsurance | Not covered | |

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
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<table>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>Hospice services</td>
<td>No charge</td>
<td>Not covered</td>
<td>For inpatient services, see “If you have a hospital stay”</td>
</tr>
</tbody>
</table>

### If your child needs dental or eye care

- **Children’s eye exam**
  - Optometrist: $20 *copay*/ visit; *deductible* does not apply
  - Ophthalmologists:
    - **Level 1**: $30 *copay*/ visit; *deductible* does not apply
    - **Level 2**: $60 *copay*/ visit; *deductible* does not apply
  - Not covered
  - – 1 exam every 24 months

- **Children’s glasses**
  - Not covered
  - None

- **Children’s dental check-up**
  - Not covered
  - None

### Excluded Services & Other Covered Services:

#### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- 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 (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic Care - 20 visits/ year
- Hearing Aids - $2,000/ hearing aid every 24 months/ impaired ear up to age 22
- Hearing Aids - up to $1,700 every 2 years for age 22 or older
- Infertility Treatment - 5 cycles advanced reproductive technology/ lifetime
- Routine eye care (Adult) - 1 exam every 24 months
Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

**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 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:

<table>
<thead>
<tr>
<th>Agency</th>
<th>Address</th>
<th>Phone Number</th>
<th>Web Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPHC Member Appeals-Member Services Department</td>
<td>1600 Crown Colony Drive, Quincy, MA 02169</td>
<td>1-888-333-4742</td>
<td><a href="http://www.hcfama.org/helpline">http://www.hcfama.org/helpline</a></td>
</tr>
<tr>
<td>Department of Labor’s Employee Benefits Security Administration</td>
<td>1-866-444-3272</td>
<td><a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a></td>
<td>1-800-272-4232</td>
</tr>
<tr>
<td>Health Care for All</td>
<td>30 Winter Street, Suite 1004</td>
<td>Boston, MA 02108</td>
<td></td>
</tr>
</tbody>
</table>

**Does this plan provide Minimum Essential Coverage?** Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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 page.
### Summary of Benefits and Coverage:

**What this Plan Covers & What You Pay For Covered Services**

**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)

- **The plan’s overall deductible** $500
- **Specialist copayment** $30
- **Hospital (facility) copayment** $275
- **Other copayment** $0

This EXAMPLE event includes services like:

- Specialist office visits *(prenatal care)*
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests *(ultrasounds and blood work)*
- Specialist visit *(anesthesia)*

**Total Example Cost** $12,731

In this example, Peg would pay:

- **Deductibles** $500
- **Copayments** $280
- **Coinsurance** $0
- **What isn’t covered** $0

**The total Peg would pay is** $780

#### Managing Joe’s type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan’s overall deductible** $500
- **Specialist copayment** $30
- **Hospital (facility) copayment** $275
- **Other copayment** $0

This EXAMPLE event includes services like:

- Primary care physician office visits *(including disease education)*
- Diagnostic tests *(blood work)*
- Prescription drugs
- Durable medical equipment *(glucose meter)*

**Total Example Cost** $7,389

In this example, Joe would pay:

- **Deductibles** $320
- **Copayments** $1,620
- **Coinsurance** $0
- **What isn’t covered** $0

**The total Joe would pay is** $1,970

#### Mia’s Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan’s overall deductible** $500
- **Specialist copayment** $30
- **Hospital (facility) copayment** $275
- **Other copayment** $0

This EXAMPLE event includes services like:

- Emergency room care *(including medical supplies)*
- Diagnostic test *(x-ray)*
- Durable medical equipment *(crutches)*
- Rehabilitation services *(physical therapy)*

**Total Example Cost** $1,925

In this example, Mia would pay:

- **Deductibles** $400
- **Copayments** $120
- **Coinsurance** $0
- **What isn’t covered** $0

**The total Mia would pay is** $520

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

Español (Spanish) ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-888-333-4742 (TTY: 711).


Kreyòl Ayisyen (French Creole) ATANSYON: Si nou pale Kreyòl Ayisyen, gen asistans pou sévis ki disponib nan lang nou pou gratis. Rele 1-888-333-4742 (TTY: 711).

简体中文 (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）。


Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-333-4742 (телетайп: 711).

العربية (Arabic) إنذار: إذا انت تتكلم اللغة العربية، خدمات المساعدة اللغوية متوفرة لك مجاناً. اتصل على 1-888-333-4742 (TTY: 711)

ភាសាខ្មែរ (Cambodian) ប្រការជាតិអំពីការជួយការចេញ្កាយជាអំពីភាសាខ្មែរគ្រប់គ្រងជាមួយដោយសមាតភាសាខ្មែរ 1-888-333-4742 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 1-888-333-4742 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l’italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-333-4742 (TTY: 711).

(Continued)

(Continued)
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 our 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: Civil Rights Compliance Officer, 93 Worcester St, 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, HHIB Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7997 (TTY)