HPHC Insurance Company

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

Coverage Period: 01/01/2025 — 12/31/2025
Coverage for: Individual + Family | Plan Type: PPO

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/public/eoc?pdid=PD0000101159**. For general definitions of common terms, such as **allowed amount**, **balance billing**, **coinsurance**, **copayment**, **deductible**, **provider**, or other **underlined** terms, see 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:** **In-Network:** $5,000 member / $10,000 family **Out-of-Network:** $8,000 member / $16,000 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 **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. Certain preventive drugs, and the following **In-Network** services: **preventive care** and routine eye exams 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. 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?	**In-Network:** $7,000 member / $14,000 family **Out-of-Network:** $14,000 member / $28,000 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?	Pediatric Dental Care, premiums, balance-billed charges, penalties for failure to obtain **preauthorization** for services 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?	No	You can see the **specialist** you choose without a **referral**.

All **copayment** and **coinsurance** cost 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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**Level 1:** $60 **copay**/ visit	20% **coinsurance**	None
	Specialist visit	**Level 1:** $60 **copay**/ visit **Level 2:** $150 **copay**/ visit	20% **coinsurance**	None
	Preventive care/**screening**/ **immunization**	No charge; **deductible** does not apply	20% **coinsurance**	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:** $150 copay/ visit **Laboratory: Flex Providers:** $25 copay/ visit **Other Plan Providers:** $75 copay/ visit	**X-rays:** 20% coinsurance **Laboratory:** 20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	**Non-Hospital Based:** $500 copay/ procedure **Hospital Based:** $1,000 copay/ procedure	20% coinsurance	**Out-of-Network** preauthorization required. $500 penalty if not obtained
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at **www.harvardpilgrim.org/2022Value5T**.	Generic drugs	**30-Day Retail Tier 1:** $5 copay/ prescription **90-Day Mail Tier 1:** $10 copay/ prescription **30-Day Retail Tier 2:** $30 copay/ prescription **90-Day Mail Tier 2:** $60 copay/ prescription		Value formulary - covers a limited list; not all drugs are covered
	Preferred brand drugs	**30-Day Retail Tier 3:** 50% coinsurance up to $125 **90-Day Mail Tier 3:** 50% coinsurance up to $250		Some generic drugs are in this tier
	Non-preferred brand drugs	**30-Day Retail Tier 4:** 50% coinsurance up to $250 **90-Day Mail Tier 4:** 50% coinsurance up to $750		Same as above
	Specialty drugs	**30-Day Retail Tier 4:** 50% coinsurance up to $250 **90-Day Mail Tier 4:** 50% coinsurance up to $750 **30-Day Retail Tier 5:** 50% coinsurance up to $500 **90-Day Mail Tier 5:** 50% coinsurance up to $1,500		Some drugs must be obtained through a Specialty Pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**Flex Providers:** $250 copay/ visit **Other Plan Providers:** $1,000 copay/ visit	20% coinsurance	**Out-of-Network** preauthorization required. $500 penalty if not obtained
	Physician/surgeon fees	**Flex Providers:** No charge **Other Plan Providers:** No charge	20% coinsurance	

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	$1,500 copay/ visit		None
	Emergency medical transportation	$250 copay/ transport		None
	Urgent care	**Convenience care clinic:** $60 copay/ visit **Urgent care center:** $150 copay/ visit **Hospital urgent care center:** $150 copay/ visit	**Convenience care clinic:** 20% coinsurance **Urgent care center:** 20% coinsurance **Hospital urgent care center:** 20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,500 copay/ admit	20% coinsurance	**Out-of-Network** preauthorization required. $500 penalty if not obtained
	Physician/surgeon fee	No charge	20% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$60 copay/ visit	20% coinsurance	**Out-of-Network** preauthorization required. $500 penalty if not obtained
	Inpatient services	$1,500 copay/ admit	20% coinsurance	
If you are pregnant	Office visits	$60 copay/ visit	20% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	$1,500 copay/ admit	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	None
	Rehabilitation services Habilitation services	**Physical Therapy:** **Non-hospital based:** $40 copay/ visit **Hospital based:** $65 copay/ visit **Occupational Therapy:** **Non-hospital based:** $40 copay/ visit	**Physical Therapy:** 20% coinsurance **Occupational Therapy:** 20% coinsurance **Speech Therapy:** 20% coinsurance	Physical & Occupational Therapy - 60 combined visits/ Plan Year **Out-of-Network** preauthorization required. $500 penalty if not obtained

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)	
		Hospital based: $65 copay/ visit **Speech Therapy: Non-hospital based:** $40 copay/ visit **Hospital based:** $65 copay/ visit		
	Skilled nursing care	$1,500 copay/ admit	20% coinsurance	- 100 days/ Plan Year
	Durable medical equipment	20% coinsurance	20% coinsurance	- 1 synthetic monofilament wig/ Plan Year **Out-of-Network** preauthorization required. $500 penalty if not obtained
	Hospice services	No charge	20% coinsurance	For inpatient see "If you have a hospital stay"
If your child needs dental or eye care	Children's eye exam	$60 copay/ visit; deductible does not apply	20% coinsurance	- 1 exam/ Plan Year
	Children's glasses	Reimbursed first $50, then 50% of covered charges; deductible does not apply		Frames & lenses OR contacts every 12 months up to end of month child turns 19
	Children's dental check-up	Not covered		Off exchange plans **must** have separate coverage

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) • Private-duty nursing	• Routine foot care • Services that are not Medically Necessary

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.)

• Abortion • Acupuncture	• Hearing Aids - $2,000/ hearing aid every 36 months/ impaired ear up to age 22	• Routine eye care (Adult) - 1 exam/ Plan Year

• Bariatric surgery • Chiropractic Care	• Infertility Treatment • Non-emergency care when traveling outside the U.S.	• Weight Loss Programs - 3 months of Weight Watchers traditional OR at Work/ 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
HPHC Insurance Company, Inc.
1 Wellness Way
Canton, MA 02021-1166
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

Massachusetts Division of Insurance
1000 Washington Street, Suite 810
Boston, MA 02118–6200
1-617-521-7794

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? Not Applicable

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.

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**	$5,000
■ **Specialist *copayment***	$150
■ **Hospital (facility) *copayment***	$1,500
■ **Other *copayment***	$25
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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$5,000
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$6,500**

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
■ **The plan's overall deductible**	$5,000
■ **Specialist *copayment***	$150
■ **Hospital (facility) *copayment***	$1,500
■ **Other *copayment***	$25
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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$5,000
Copayments	$20
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$5,220**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ **The plan's overall deductible**	$5,000
■ **Specialist *copayment***	$150
■ **Hospital (facility) *copayment***	$1,500
■ **Other *copayment***	$150
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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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 1-877-907-4742 (TTY: 711).

Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-877-907-4742 (TTY: 711).

Kreyòl Ayisyen (French Creole) ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 1-877-907-4742 (TTY: 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 1-877-907-4742（TTY：711）。

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu quí vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quí vị miễn phí. Gọi số 1-877-907-4742 (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-907-4742 (телетайп: 711).

العربية (Arabic)

إنتباه: إذا أنت تتكلم اللغة **العربية**، خدمات المساعدة اللغوية متوفرة لك مجانا. **إتصل على 1 877-907-4742** (TTY: 711)

ខ្មែរ (Cambodian) ប្រសិនជាអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-877-907-4742 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-907-4742 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-907-4742 (TTY: 711).

한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-907-4742 (TTY: 711) 번으로 전화해 주십시오.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-877-907-4742 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-907-4742 (TTY: 711).

हिंदी (Hindi) ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्तमें उपलब्ध है. जानकारी के लिये फोन करे. 1-877-907-4742 (TTY: 711)

ગુજરાતી (Gujarati) ધ્યાન આપો : જો તમે ગુજરાતી બોલતા હો તો આપને માટે ભાષાકીય સહાય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 1-877-907-4742 (TTY: 711)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-877-907-4742 (TTY: 711).

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-877-907-4742 (TTY: 711).

General Notice About Nondiscrimination and Accessibility Requirements

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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 (including pregnancy, sexual orientation, and gender identity), you can file a grievance with: Civil Rights Compliance Officer, 1 Wellness Way, Canton, MA 02021-1166, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@point32health.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, D.C. 20201
(800) 368-1019, (800) 537-7697 (TTY)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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