
	<p>The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> 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.</p>
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Important Questions	Answers	Why This Matters
What is the overall <u>deductible</u>?	In-Network: Tier 1: \$0 Tier 2: \$1,000 member/ \$2,500 family Out-of-Network: \$1,000 member/ \$2,500 family Benefits are administered on a calendar year basis.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the policy, they have to meet their own individual <u>deductible</u> until the overall family <u>deductible</u> amount has been met.
Are there services covered before you meet your <u>deductible</u>?	Yes: <u>Prescription drugs</u> , <u>emergency room care</u> , <u>emergency medical transportation</u> , routine eye exams, In-Network <u>preventive care</u> , <u>provider</u> office visits, <u>durable medical equipment</u> , <u>Rehabilitation services</u> , <u>Habilitation services</u> , and Tier 1 <u>diagnostic tests</u> and imaging are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	In and Out-of-Network Combined: \$2,000 member / \$3,500 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.

Important Questions	Answers	Why This Matters
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See https://hphc.providerlookuponlinesearch.com/gateway?plan_ids=%5B%22A0980125%22%5D or call 1-888-333-4742 for a list of <u>preferred providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance-billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

	All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.
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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider		Out-of-Network Provider (You will pay the most)	
		CCHC Provider (You will pay the least)	HPHC Provider		
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$10 <u>copay</u> / visit; <u>deductible</u> does not apply	\$50 <u>copay</u> / visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$10 <u>copay</u> / visit; <u>deductible</u> does not apply	\$50 <u>copay</u> / visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> / immunization	No charge; <u>deductible</u> does not apply		30% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your <u>plan</u> will pay for.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider		Out-of-Network Provider (You will pay the most)	
		CCHC Provider (You will pay the least)	HPHC Provider		
If you have a test	Diagnostic test (x-ray, blood work)	X-rays: No charge; deductible does not apply Laboratory: No charge; deductible does not apply	X-rays: 30% coinsurance Laboratory: 30% coinsurance	X-rays: 30% coinsurance Laboratory: 30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge; deductible does not apply	30% coinsurance	30% coinsurance	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.maxor.com[maxorplus] .	Generic drugs	(CCHC Pharmacy) \$5 copay / up to 90 day supply; deductible does not apply	(Network Pharmacy) \$10 copay / up to 30 day supply; deductible does not apply, \$20 copay / 31-60 day supply; deductible does not apply, \$30 copay / 61- 90 day supply; deductible does not apply \$20 copay / mail order (up to 90 day supply); deductible does not apply	\$10 copay / up to 30 day supply; deductible does not apply Mail order - NA	Up to a 90-day supply (retail pharmacy at 1 copay per 30 day supply); 90-day supply (mail order prescription); up to 90-day supply at CCHC pharmacy.
	Preferred brand drugs	(CCHC Pharmacy) \$10 copay / mail order (up to 90 day supply); deductible does not apply	(Network Pharmacy) \$25 copay / up to 30 day supply; deductible does not apply, \$50 copay / 31-60 day supply; deductible does not apply, \$75 copay / 61- 90 day supply; deductible does not apply \$35 copay / mail order (up to 90 day supply); deductible does not apply	\$25 copay / up to 30 day supply; deductible does not apply Mail order - NA	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider		Out-of-Network Provider (You will pay the most)	
		CCHC Provider (You will pay the least)	HPHC Provider		
	Non-preferred brand drugs	(CCHC Pharmacy) \$20 copay / mail order (up to 90 day supply); deductible does not apply	(Network Pharmacy) \$45 copay / up to 30 day supply; deductible does not apply, \$90 copay / 31-60 day supply; deductible does not apply, \$135 copay / 61- 90 day supply; deductible does not apply \$55 copay / mail order (up to 90 day supply); deductible does not apply	\$45 copay / up to 30 day supply; deductible does not apply Mail order - NA	IMPORTANT: GLP-1 weight-loss drugs are covered up to a 30-day supply at CCHC pharmacy or through a participating pharmacy if not available.
	Specialty drugs	Copays stated above based on drug type		Not covered	Up to 30-day supply at CCHC or Maxor Specialty Pharmacy if not available at CCHC pharmacy. List of specialty medications at www.maxor.com[maxorplus] .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge; deductible does not apply	30% coinsurance	30% coinsurance	None
	Physician/surgeon fees	No charge; deductible does not apply	30% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	\$100 copay / visit; deductible does not apply			None
	Emergency Medical Transportation	No charge; deductible does not apply			None
	Urgent Care	Urgent care center: \$10 copay / visit; deductible does not apply	Urgent care center: \$50 copay / visit; deductible does not apply	Urgent care center: 30% coinsurance	Cost sharing may vary based on Urgent Care location.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider		Out-of-Network Provider (You will pay the most)	
		CCHC Provider (You will pay the least)	HPHC Provider		
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge; deductible does not apply	30% coinsurance	30% coinsurance	None
	Physician/surgeon fee	No charge; deductible does not apply	30% coinsurance	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 copay / visit; deductible does not apply		30% coinsurance	None
	Inpatient services	No charge; deductible does not apply		30% coinsurance	
If you are pregnant	Office visits	\$10 copay / visit; deductible does not apply	\$50 copay / visit; deductible does not apply	30% coinsurance	Cost sharing does not apply for preventive services (such as routine prenatal visits).
	Childbirth/delivery professional services	No charge; deductible does not apply	30% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	No charge; deductible does not apply	30% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge; deductible does not apply	\$25 copay / visit; deductible does not apply	30% coinsurance	None
	Rehabilitation services	Physical Therapy: No charge; deductible does not apply	Physical Therapy: \$35 copay / visit; deductible does not apply	Physical Therapy: 30% coinsurance	Occupational Therapy - 60 visits/ calendar year Physical Therapy - 60 visits/ calendar year
	Habilitation services	Occupational Therapy: No charge; deductible does not apply Speech Therapy: No charge; deductible does not apply	Occupational Therapy: \$35 copay / visit; deductible does not apply Speech Therapy: \$35 copay / visit; deductible does not apply	Occupational Therapy: 30% coinsurance Speech Therapy: 30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider		Out-of-Network Provider (You will pay the most)	
		CCHC Provider (You will pay the least)	HPHC Provider		
	Skilled nursing care	No charge; deductible does not apply	10% coinsurance	30% coinsurance	- 100 days/ calendar year combined with Inpatient Rehabilitation services
	Durable medical equipment	30% coinsurance ; deductible does not apply		30% coinsurance	None
	Hospice services	No charge; deductible does not apply		30% coinsurance	For inpatient see “If you have a hospital stay”
If your child needs dental or eye care	Children’s eye exam	\$25 copay / visit; deductible does not apply			- 1 exam/ calendar year
	Children’s glasses	Not covered			None
	Children’s dental check-up	Not covered			None

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"> • Acupuncture • Children’s glasses • Cosmetic Surgery • Dental Care (Adult) 	<ul style="list-style-type: none"> • Long-Term Care • Private-duty nursing 	<ul style="list-style-type: none"> • Routine foot care (except for diabetes or systemic circulatory diseases) • 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"> • Bariatric surgery • Chiropractic Care - 20 visits/calendar year 	<ul style="list-style-type: none"> • Hearing Aids - \$2,000/aid every 36 months, for each impaired ear up to age 22 • Infertility Treatment 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Routine eye care (Adult) – 1 exam/calendar 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: Maine Bureau of Insurance, Department of Professional and Financial Regulation, 34 State House Station, Augusta, ME 04333-0334, **(800) 300-5000**, or contact Harvard Pilgrim at the number on the back of your ID card. Other coverage options may be available to you too, including buying individual insurance coverage through the **CoverME.gov**. For more information, about the **CoverME.gov**, visit **www.CoverME.gov** or call **1-866-636-0355**.

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. 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
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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 plan 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 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 ([deductibles](#), [copayments](#) 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	\$10	■ Specialist copayment	\$10	■ Specialist copayment	\$10
■ Hospital (facility) coinsurance	0%	■ Hospital (facility) coinsurance	0%	■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%	■ Other coinsurance	0%	■ Other coinsurance	0%
This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)		This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</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	\$0	Deductibles	\$0	Deductibles	\$0
Copayments	\$0	Copayments	\$100	Copayments	\$100
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	\$0	The total Joe would pay is	\$100	The total Mia would pay is	\$170

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).

Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-888-333-4742 (TTY: 711).

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

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu quý vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quý vị miễn phí. Gọi số 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)

إنتباه: إذا أنت تتكلم اللغة العربية، خدمات المساعدة اللغوية متوفرة لك مجاناً. إتصل على 1 888-333-4742

(TTY: 711)

ខ្មែរ (Cambodian) ព្រះសុខសង្ឃ: បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 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).



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한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-333-4742 (TTY: 711) 번으로 전화해 주십시오.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-888-333-4742 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-333-4742 (TTY: 711).

हिंदी (Hindi) ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्तमें उपलब्ध है. जानकारी के लिये फोन करे. 1-888-333-4742 (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. 1-888-333-4742 (TTY: 711)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-333-4742 (TTY: 711).

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

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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 (including pregnancy, sexual orientation, and gender identity). HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

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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