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?	In-Network: $250 member/ $500 family Out-of-Network: $1,500 member/ $3,000 family Benefits are administered on a calendar year basis.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, they have to meet their own individual deductible until the overall family deductible amount has been met.
Are there services covered before you meet your deductible?	Yes: Prescription drugs, emergency room care, emergency medical transportation, In-Network preventive care, provider office visits, durable medical equipment, Rehabilitation services and Habilitation services, 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: $3,000 member/ $6,000 family Out-of-Network: $4,500 member/ $9,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits 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://hphc.providerlookuponlinesearch.com/gateway?plan_ids=%5B%22A0020124%22%5D** 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 permission from this plan.

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 (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	$30 copay/ visit; deductible does not apply	30% coinsurance	None
	Specialist visit	$30 copay/ visit; deductible does not apply	30% coinsurance	None
	Preventive care/ screening/ immunization	No charge; deductible does not apply	30% 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: No charge; deductible does not apply Laboratory: No charge; deductible does not apply	X-rays: 30% coinsurance Laboratory: 30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	5% 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	$10 copay/ up to 30 day supply; deductible does not apply $20 copay/ 31-90 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).
	Preferred brand drugs	$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 $50 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	
	Non-preferred brand drugs	$45 copay/ up to 30 day supply; deductible does not apply	$45 copay/ up to 30 day supply; deductible does not apply	**IMPORTANT:** GLP-1 weight-loss drugs are covered with a 50%

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)	
		$90 copay/ 31-60 day supply; deductible does not apply $135 copay/ 61- 90 day supply; deductible does not apply $90 copay/ mail order (up to 90 day supply); deductible does not apply	Mail order - NA	coinsurance; does not apply to the deductible. Separate out-of-pocket limit of $2,000 per member. Up to a 30-day supply at a participating pharmacy.
	Specialty drugs	Copays stated above based on drug type	Not covered	Up to 30-day supply at Maxor Specialty Pharmacy. List of specialty medications at **www.maxor.com[maxorplus]**.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% coinsurance	30% coinsurance	None
	Physician/surgeon fees	5% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	$150 copay/ visit; deductible does not apply		None
	Emergency medical transportation	No charge; deductible does not apply		None
	Urgent care	Urgent care center: $30 copay/ visit; deductible does not apply	Urgent care center: 30% coinsurance	Cost sharing may vary based on location.
If you have a hospital stay	Facility fee (e.g., hospital room)	5% coinsurance	30% coinsurance	None
	Physician/surgeon fee	5% coinsurance	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/ visit; deductible does not apply	30% coinsurance	None
	Inpatient services	5% coinsurance	30% 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 are pregnant	Office visits	$30 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	5% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	5% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge; deductible does not apply	30% coinsurance	None
	Rehabilitation services Habilitation services	Physical Therapy: $10 copay/ visit; deductible does not apply Occupational Therapy: $10 copay/ visit; deductible does not apply Speech Therapy: $10 copay/ visit; deductible does not apply	Physical Therapy: 30% coinsurance Occupational Therapy: 30% coinsurance Speech Therapy: 30% coinsurance	Occupational Therapy - 60 visits/ calendar year Physical Therapy - 60 visits/ calendar year
	Skilled nursing care	5% 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	$30 copay/ visit; deductible does not apply	30% coinsurance	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.)		
• Acupuncture	• Long-Term Care	• Routine foot care (except for diabetes or systemic circulatory diseases)
• Children's glasses	• Private-duty nursing	• Services that are not Medically Necessary
• Cosmetic Surgery		• Weight Loss Programs
• Dental Care (Adult)		

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.)		
• Bariatric surgery	• Hearing Aids - $2,000/aid every 36 months, for each impaired ear up to age 22	• Non-emergency care when traveling outside the U.S.
• Chiropractic Care - 20 visits/calendar year	• Infertility Treatment	• 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: the Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**, or the Department of Health and Human Services, Centers for Consumer Information and Insurance Oversight, at **1-877-267-2323 x61565** or **www.cciio.cms.gov**, or for more information on your rights to continue coverage, you can contact the Member Service number listed on your ID card or call **1-888-333-4742**. 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.
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

Does this plan 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**.

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**.

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)	
■ The plan's overall deductible	$250
■ Specialist copayment	$30
■ Hospital (facility) coinsurance	5%
■ Other coinsurance	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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$750**

Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
■ The plan's overall deductible	$250
■ Specialist copayment	$30
■ Hospital (facility) coinsurance	5%
■ Other coinsurance	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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$300**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	$250
■ Specialist copayment	$30
■ Hospital (facility) coinsurance	5%
■ Other coinsurance	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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$300
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$570**

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 quí vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quí 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 اَللُّغة **اَلعربية** ، خَدَمات اَلمُساعَدة اَللُّغوية مُتَوفرة لك مَجانا. ً **إتصل على 1 888-333-4742**

(TTY: 711)

ខ្មែរ (Cambodian) ប្រសុំជូនដំណឹង៖ 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).

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 ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 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).

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

(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 (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.

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