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

NH Local Choice HMO Bronze

Coverage Period: 01/01/2026 — 12/31/2026

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/public/eoc?pdid=PD0000200063**. 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?	**Medical & Prescription Drug Deductible: Tier 1:** $7,200 member / $14,400 family **Tier 2:** $8,700 member / $17,400 family Benefits are administered on a calendar 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. Preventive care, **Tiers 1 and 2** prescription drugs, and any combination of first **3** Primary Care provider office visits per member, and any combination of first **3** mental/behavioral health and substance use outpatient services per member 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?	$8,700 member / $17,400 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, 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 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
		Participating Provider (You will pay the least)		Non-Participating Provider (You will pay the most)	
		Tier 1 Provider	Tier 2 Provider		
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**Visits 1-3: Level 1:** $40 copay/ visit; deductible does not apply **Visits 4+:** 50% coinsurance	0% coinsurance	Not covered	First 3 Primary Care office visits apply copay
	Specialist visit	**Visits 1-3: Level 1:** $40 copay/ visit; deductible does not apply **Visits 4+:** 50% coinsurance	0% coinsurance	Not covered	
	Preventive care/ screening/ immunization	No charge; deductible does not apply Prescribed FDA approved contraceptives are not subject to cost-shares.		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
		Participating Provider (You will pay the least)		Non-Participating Provider (You will pay the most)	
		Tier 1 Provider	Tier 2 Provider		
If you have a test	Diagnostic test (x-ray, blood work)	**X-rays:** 50% coinsurance **Laboratory:** 50% coinsurance	**X-rays:** 0% coinsurance **Laboratory:** 0% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	50% coinsurance	0% coinsurance	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at **www.harvardpilgrim.org/2023CoreNH5T**.	Generic drugs	**30-Day Retail Tier 1:** $10 copay/ prescription; deductible does not apply **90-Day Mail Tier 1:** $20 copay/ prescription; deductible does not apply **30-Day Retail Tier 2:** $35 copay/ prescription; deductible does not apply **90-Day Mail Tier 2:** $70 copay/ prescription; deductible does not apply			Core NH formulary - covers a limited list; not all drugs are covered
	Preferred brand drugs	**30-Day Retail Tier 3:** 35% coinsurance **90-Day Mail Tier 3:** 35% coinsurance			Some generic drugs are in this tier
	Non-preferred brand drugs	**30-Day Retail Tier 4:** 40% coinsurance **90-Day Mail Tier 4:** 40% coinsurance			Same as above
	Specialty drugs	**30-Day Retail Tier 4:** 40% coinsurance **90-Day Mail Tier 4:** 40% coinsurance **30-Day Retail Tier 5:** 40% coinsurance **90-Day Mail Tier 5:** 40% coinsurance			Some drugs must be obtained through a Specialty Pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	0% coinsurance	Not covered	None
	Physician/surgeon fees	50% coinsurance	0% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)		Non-Participating Provider (You will pay the most)	
		Tier 1 Provider	Tier 2 Provider		
If you need immediate medical attention	Emergency room care	**Medical Emergency Services:** 50% coinsurance **Services that do not meet the definition of Medical Emergency:** 50% coinsurance			None
	Emergency Medical Transportation	50% coinsurance			None
	Urgent Care	**Convenience care clinic:** 50% coinsurance **Urgent care center:** 50% coinsurance **Hospital urgent care center:** 50% coinsurance	**Convenience care clinic:** 50% coinsurance **Urgent care center:** 50% coinsurance **Hospital urgent care center:** 0% coinsurance	**Convenience care clinic:** Not covered **Urgent care center:** Not covered **Hospital urgent care center:** Same As Participating Provider	Non-participating providers are only covered outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance	0% coinsurance	Not covered	None
	Physician/surgeon fee	50% coinsurance	0% coinsurance	Not covered	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	**Visits 1-3:** No charge; deductible does not apply **Visits 4+:** 50% coinsurance		Not covered	No charge for first 3 mental health/substance abuse visits
	Inpatient services	50% coinsurance		Not covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)		Non-Participating Provider (You will pay the most)	
		Tier 1 Provider	Tier 2 Provider		
If you are pregnant	Office visits	**Visits 1-3:** $40 copay/ visit; deductible does not apply **Visits 4+:** 50% coinsurance	0% coinsurance	Not covered	Cost sharing does not apply for preventive services. First 3 Primary Care office visits apply copay
	Childbirth/delivery professional services	50% coinsurance	0% coinsurance	Not covered	
	Childbirth/delivery facility services	50% coinsurance	0% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	50% coinsurance	0% coinsurance	Not covered	None
	Rehabilitation services	**Physical Therapy:** 50% coinsurance **Occupational Therapy:** 50% coinsurance **Speech Therapy:** 50% coinsurance	**Physical Therapy:** 0% coinsurance **Occupational Therapy:** 0% coinsurance **Speech Therapy:** 0% coinsurance	Not covered	Physical, Occupational & Speech Therapy - 60 combined visits/ calendar year
	Habilitation services				
	Skilled nursing care	50% coinsurance	0% coinsurance	Not covered	- 100 days/ calendar year
	Durable medical equipment	50% coinsurance		Not covered	None
	Hospice services	50% coinsurance	0% coinsurance	Not covered	For inpatient see "If you have a hospital stay"

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)		Non-Participating Provider (You will pay the most)	
		Tier 1 Provider	Tier 2 Provider		
If your child needs dental or eye care	Children's eye exam	50% coinsurance	0% coinsurance	Not covered	- 1 exam/ calendar year
	Children's glasses	Reimbursed first $100, 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.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Infertility Treatment
- 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 (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.)

- Acupuncture
- Bariatric surgery
- Chiropractic Care
- Hearing Aids - 1 hearing aid/ impaired ear
- Routine eye care (Adult) - 1 exam every 2 calendar years

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 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 of New England, Inc.
1 Wellness Way
Canton, MA 02021-1166
Telephone: 1-888-333-4742
Fax: 1-617-509-3085

New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301
1-800-852-3416
www.nh.gov/
insuranceconsumerservices@ins.nh.gov

State of New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301
1-603-271-2261

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**	$7,200
■ **Specialist *coinsurance***	50%
■ **Hospital (facility) *coinsurance***	50%
■ **Other *coinsurance***	50%

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	$7,200
Copayments	$40
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$8,700**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ **The plan's overall deductible**	$7,200
■ **Specialist *coinsurance***	50%
■ **Hospital (facility) *coinsurance***	50%
■ **Other *coinsurance***	50%

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	$1,900
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,600**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ **The plan's overall deductible**	$7,200
■ **Specialist *coinsurance***	50%
■ **Hospital (facility) *coinsurance***	50%
■ **Other *coinsurance***	50%

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	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,810**

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

Harvard Pilgrim Health Care

a Point32Health company

Language Assistance Services

Arabic (العربية) انتباه: إذا كنت تتحدث لغة أخرى غير الإنجليزية، فإن خدمات المساعدة اللغوية متاحة لك مجانًا. يرجىالاتصال بالرقم الموجود على بطاقة هوية العضو الخاصة بك.

French (Français) ATTENTION : Si vous parlez une langue autre que l'anglais, des services d'assistance linguistique gratuits sont à votre disposition. Veuillez appeler le numéro indiqué sur votre carte d'adhérent.

Greek (Ελληνικά) ΠΡΟΣΟΧΗ: Εάν μιλάτε κάποια άλλη γλώσσα πέρα από τα αγγλικά, γλωσσικές υπηρεσίες χωρίς χρέωση είναι στη διάθεσή σας. Καλέστε τον αριθμό στην κάρτα μέλους σας.

Gujarati (ગુજરાતી) ધ્યાન આપો: જો તમે અંગ્રેજી સિવાય બીજી ભાષા બોલો છો, તો ભાષા હિાય વિાઓ, તમારા માટે મફત ઉપલબ્ધ છે. કૃપા કરીને તમારા ભ્યિ આઈડી કાડડ પરના નંબર પર કૉલ કરો.

Haitian Creole (Kreyòl Ayisyen) ATANSYON: Si w pale yon lang ki pa Anglè, gen sèvis èd pou lang ki disponib gratis pou ou. Tanpri rele nimewo ki sou kat ID manm ou a.

Hindi (हिंदी) ध्यान दें: अगर आप अंग्रेजी के अलावा कोई दूसरी भाषा बोलते हैं, तो भाषा सहायता सेवाएं आपके ललए ननःशुल्क उपलब्ध हैं। कृ पया अपने सदस्य आईडी काडड पर ददए गए नंबर पर कॉल करें।

Italian (Italiano) ATTENZIONE: se parli una lingua diversa dall'inglese, sono disponibili gratuitamente servizi di assistenza linguistica. Chiama il numero indicato sulla tua tessera membro identificativa.

Khmer (ភាសាខ្មែរ) ប្រសិនបរអ្នក កនិយាយភាសាបសងេបប៉ុពីភាសាអង់បលេ ស បសវាកម្មជំនួ យភាសា ដលែឥតលិតថ្លេ លឺអាចរកបានសម្រាប់អ្នក ក។ សូ មទូរស័ព្ទ បលខទូរស័ព្ទ ID កាតសមាជិករបស់អ្នក ក។

Korean (한국어) 알림: 영어 이외의 언어를 사용하신다면 언어 지원 서비스를 무료로 제공해 드립니다. 가입자 ID 카드에 명시된 번호로 전화하시기 바랍니다.

Lao (ພາສາລາວ) ກະລຸນາ ຮັບຊາບ: ຖ້າ ທ່ານເວົ້າພາສາອື່ນທີ່ບໍ່ແ ມ່ນພາສາ ອັງກິດ, ທ່ານສາມາດໃຊ້ບໍລິການນັດານພາສາໄ ດ້ ໂດຍບໍ່ເສຍ ຄ່າ. ກະລຸນາໂທຫາເບີທີ່ຢູ່ໃນ ບັດປະຈຳ ຕົວສະມາຊິກຂອງ ທ່ານ.

Polish (polski) UWAGA: Jeśli posługujesz się językiem innym niż angielski, możesz bezpłatnie korzystać z usług pomocy językowej. Zadzwoń pod numer podany na Twojej karcie członkowskiej.

Portuguese (Português) ATENÇÃO: caso fale outro idioma que não o inglês, são-lhe disponibilizados gratuitamente serviços de assistência linguística. Ligue para o número no seu cartão de identificação de membro.

Russian (Русский) ВНИМАНИЕ! Если вы не говорите на английском языке, то можете бесплатно воспользоваться услугами языковой поддержки. Позвоните по номеру, указанному на вашей идентификационной карте участника.

Spanish (Español) ATENCIÓN: Si usted habla un idioma que no sea inglés, están disponibles para usted, sin costo, servicios de asistencia en otros idiomas. Llame al número que figura en su tarjeta de identificación de miembro.

Traditional Chinese (繁體中文) 注意事項：如果您講非英語的其他語言，我們可以為您提供免費的語言協助服務。請撥打您會員 ID 卡上的電話號碼。

Vietnamese (Tiếng Việt) LƯU Ý: Nếu quý vị nói ngôn ngữ khác không phải tiếng Anh, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Vui lòng gọi đến số điện thoại trên thẻ ID hội viên của quý vị.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Please call the number on your member ID card.

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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 (see below for contact information).

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:

Point32Health Civil Rights Legal Coordinator
1 Wellness Way
Canton, MA 02021-1166

866-750-2074, TTY service: 711
Fax: 617-668-2754
Email: **OCRCoordinator@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 (TDD)

Complaint forms are available at **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.

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