


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=PD0000201452. 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 <u>deductible</u> ?	Medical & <u>Prescription Drug Deductible</u> : Preferred <u>Deductible</u> : \$4,200 member /\$8,400 family Standard <u>Deductible</u> : \$7,500 member /\$15,000 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 <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> , Tiers 1, 2, and 3 <u>prescription drugs</u> , <u>provider</u> office visits, Non-hospital affiliated facility day surgery, Non-hospital based laboratory and imaging, and <u>Rehabilitation services</u> , and <u>Habilitation services</u> 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> ?	Preferred Network: \$9,100 member /\$18,200 family Standard Network: \$9,100 member /\$18,200 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 out-of-pocket limit ?	Pediatric Dental Care, 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://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	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](#) 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	
		Participating Provider (You will pay the least)			Non-Participating Provider (You will pay the most)
		Preferred Network	Standard Network		
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Level 1: \$35 copay / visit; deductible does not apply	Level 1: \$70 copay / visit; deductible does not apply	Not covered	\$0 copay for first visit
	Specialist visit	Level 1: \$35 copay / visit; deductible does not apply Level 2: \$80 copay / visit; deductible does not apply	Level 1: \$70 copay / visit; deductible does not apply Level 2: \$110 copay / visit; deductible does not apply	Not covered	None
	Preventive care/ screening /	No charge; deductible does not apply		Not covered	You may have to pay for services that aren't preventive. Ask your

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		Preferred Network	Standard Network		
	immunization			provider if the services needed are preventive. Then check what your plan will pay for.	
If you have a test	Diagnostic test (x-ray, blood work)	X-rays: 40% coinsurance Laboratory: Non-Hospital Based: \$15 copay / visit; deductible does not apply Hospital Based: 40% coinsurance	X-rays: 50% coinsurance Laboratory: 50% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	Non-Hospital Based: \$250 copay / visit; deductible does not apply Hospital Based: 40% coinsurance	50% 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/2024Value5T .	Generic drugs	30-Day Retail Tier 1: \$5 copay / prescription; deductible does not apply 90-Day Mail Tier 1: \$10 copay / prescription; deductible does not apply 30-Day Retail Tier 2: \$20 copay / prescription; deductible does not apply 90-Day Mail Tier 2: \$40 copay / prescription; deductible does not apply		Not covered	Value formulary - covers a limited list; not all drugs are covered. You pay retail price for Out of Network pharmacy drugs and are reimbursed minus applicable cost sharing . Covered only outside of service area.
	Preferred brand drugs	30-Day Retail Tier 3: \$50 copay / prescription; deductible does not apply 90-Day Mail Tier 3: \$100 copay / prescription; deductible does not apply		Not covered	
	Non-preferred brand drugs	30-Day Retail Tier 4: \$100 copay / prescription 90-Day Mail Tier 4: \$200 copay / prescription		Not covered	

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		Participating Provider (You will pay the least)			Non-Participating Provider (You will pay the most)
		Preferred Network	Standard Network		
	Specialty drugs	30-Day Retail Tier 4: \$100 copay / prescription 90-Day Mail Tier 4: \$200 copay / prescription 30-Day Retail Tier 5: \$250 copay / prescription 90-Day Mail Tier 5: \$500 copay / prescription		Not covered	Some drugs must be obtained through a Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Non-hospital affiliated facility: \$300 copay / visit; deductible does not apply Hospital affiliated facility: 40% coinsurance	50% coinsurance	Not covered	None
	Physician/surgeon fees	Non-hospital affiliated facility: No charge; deductible does not apply Hospital affiliated facility: 40% coinsurance	50% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	40% coinsurance			None
	Emergency Medical Transportation	40% coinsurance			None
	Urgent Care	Urgent care center: \$40 copay / visit; deductible does not apply	Urgent care center: 50% coinsurance	Urgent care center: Not covered	Non-participating providers are only covered outside the service area. Cost sharing may vary based on Urgent Care location.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	50% coinsurance	Not covered	None
	Physician/surgeon fee	40% coinsurance	50% coinsurance	Not covered	

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		Participating Provider (You will pay the least)			Non-Participating Provider (You will pay the most)
		Preferred Network	Standard Network		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 <u>copay</u> / visit; <u>deductible</u> does not apply		Not covered	\$0 <u>copay</u> for first mental health/substance abuse visit
	Inpatient services	40% <u>coinsurance</u>		Not covered	None
If you are pregnant	Office visits	\$35 <u>copay</u> / visit; <u>deductible</u> does not apply	\$70 <u>copay</u> / visit; <u>deductible</u> does not apply	Not covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	40% <u>coinsurance</u>		Not covered	None
	<u>Rehabilitation services</u>	Physical Therapy: \$40 <u>copay</u> / visit; <u>deductible</u> does not apply	Physical Therapy: \$60 <u>copay</u> / visit; <u>deductible</u> does not apply	Not covered	Physical, Occupational & Speech Therapy - 60 combined visits/ calendar year
	<u>Habilitation services</u>	Occupational Therapy: \$40 <u>copay</u> / visit; <u>deductible</u> does not apply	Occupational Therapy: \$60 <u>copay</u> / visit; <u>deductible</u> does not apply		
		Speech Therapy: \$40 <u>copay</u> / visit; <u>deductible</u> does not apply	Speech Therapy: \$60 <u>copay</u> / visit; <u>deductible</u> does not apply		
<u>Skilled nursing care</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Not covered	- 150 days/ calendar year combined with Inpatient <u>Rehabilitation services</u>	

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)
		Preferred Network	Standard Network		
	Durable medical equipment	40% coinsurance		Not covered	None
	Hospice services	40% coinsurance		Not covered	For inpatient see “If you have a hospital stay”
If your child needs dental or eye care	Children’s eye exam	\$35 copay / visit; deductible does not apply	\$110 copay / visit; deductible does not apply	Not covered	- 1 exam/ calendar year
	Children’s glasses	Reimbursed first \$50, then 50% of covered charges; deductible does not apply			Frames & lenses OR contacts every 24 months up to end of month child turns 19
	Children’s dental check-up	Not covered			Exchange plans may 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](#).)

- | | | |
|---|--|---|
| <ul style="list-style-type: none"> • Cosmetic Surgery • Dental Care (Adult) • Long-Term Care | <ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • 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"> • Abortion • Acupuncture • Bariatric surgery | <ul style="list-style-type: none"> • Chiropractic Care • Hearing Aids - 1 hearing aid/ impaired ear every 36 months up to age 19 • Hearing Aids - \$3,000/ impaired ear every 36 months for all other members | <ul style="list-style-type: none"> • Infertility Treatment • Routine eye care (Adult) - 1 exam/ calendar year |
|--|--|---|

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	\$4,200	■ The plan's overall deductible	\$4,200	■ The plan's overall deductible	\$4,200
■ Specialist copayment	\$70	■ Specialist copayment	\$70	■ Specialist copayment	\$70
■ Hospital (facility) coinsurance	40%	■ Hospital (facility) coinsurance	40%	■ Hospital (facility) coinsurance	40%
■ Other copayment	\$15	■ Other copayment	\$15	■ Other coinsurance	40%
This EXAMPLE event includes services like:		This EXAMPLE event includes services like:		This EXAMPLE event includes services like:	
Specialist office visits (<i>prenatal care</i>)		Primary care physician office visits (<i>including disease education</i>)		Emergency room care (<i>including medical supplies</i>)	
Childbirth/Delivery Professional Services		Diagnostic tests (<i>blood work</i>)		Diagnostic test (<i>x-ray</i>)	
Childbirth/Delivery Facility Services		Prescription drugs		Durable medical equipment (<i>crutches</i>)	
Diagnostic tests (<i>ultrasounds and blood work</i>)		Durable medical equipment (<i>glucose meter</i>)		Rehabilitation services (<i>physical therapy</i>)	
Specialist visit (<i>anesthesia</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	\$4,200	Deductibles	\$0	Deductibles	\$2,200
Copayments	\$300	Copayments	\$1,600	Copayments	\$300
Coinsurance	\$2,900	Coinsurance	\$0	Coinsurance	\$0
<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	\$7,400	The total Joe would pay is	\$1,600	The total Mia would pay is	\$2,500

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



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Language Assistance Services

Arabic (العربية) انتباه: إذا كنت تتحدث لغة أخرى غير الإنجليزية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً. يرجى الاتصال 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 સવાય બીજી ભાષા બોલો છો, તો ભાષા હિાય વિાઓ, તમારા માટે મફત ઉપલબ્ધ છે. કૃપા કરીને તમારા ભિ્ય આઈડી કાડ પરના નંબર પર કોલ 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। कृपया अपने सदस्य आईडी कार्ड 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) បុរសិនបអុន កនិយាយភាសាបសងេបប្រាំភាសាអង់បលស បសវាកមមជំនួ យភាសា ដលៃឥតលិតថុល លីអាចរកមានសហអុន ក។ សូ មុហៅកាន់ បលខហៅបល ID ភាគសាជីករសអុន 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 ທ່ານເວົ້າພາສາອື່ນໆ ບໍ່ແມ່ນພາສາ ອັງກິດ, ທ່ານສາມາດໃຊ້ບໍລິການນໍາທາງພາສາໄດ້ ໂດຍບໍ່ເສຍ ຄ່າ. ກະລຸນາໂທຫາເບີທ່ຽງໃນ 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.

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