Harvard Pilgrim Health Care

Clarification on SBC format

As of April 1, 2017 the federal government has issued a new format for the *Summary of Benefits and Coverage* (SBC) document. One of the most significant changes to the format is the way deductibles are referenced in the cost-sharing chart. The cost-sharing chart shows copayments and coinsurance **after** the deductible has been met.

- A statement appears at the top of the chart noting that all copayments and coinsurance are **after the deductible has been met**, if a deductible applies (see example below). Please note that this wording appears only at the top of the chart.

⚠	**All copayments and coinsurance cost shown in this chart after your deductible has been met, if a deductible applies.**

- If the deductible does not apply to a benefit, the phrase "deductible does not apply" appears in the chart.
- If the "What You Will Pay" column, indicates "no charge," this means no charge **after** the deductible has been met.

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 Laboratory: Select Providers: No charge; deductible does not apply. Other Plan Providers: No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Cost sharing may vary for certain imaging services.

We encourage readers to reference *Schedule of Benefits* documents for cost-sharing details. The *Schedule of Benefits* is the contract between a member and Harvard Pilgrim Health Care and is the more complete document.

Harvard Pilgrim Health Care

Massachusetts

The Harvard Pilgrim Best Buy ChoiceNet℠ HMO

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

Coverage Period: 07/01/2018 — 06/30/2019

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, **http://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 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?	**Tier 1 Providers:** $400 member / $1,000 family **Tier 2 Providers:** $400 member / $1,000 family **Tier 3 Providers:** $400 member / $1,000 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. Preventive care, provider office visits, outpatient mental health services, Rehabilitation services, Habilitation services, emergency room 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.
Are there other deductibles for specific services?	Yes. **Prescription Drug Deductible:** $80 member/ $200 family	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out–of–pocket limit for this plan?	$4,000 member / $8,000 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 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-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.providerlookuponline.com/harvardpilgrim/po7/Search.aspx** 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
		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	**Tier 1 Primary Care:** $30 **copay**/ visit; **deductible** does not apply **Tier 2 Primary Care:** $30 **copay**/ visit; **deductible** does not apply **Tier 3 Primary Care:** $30 **copay**/ visit; **deductible** does not apply	Not covered	None
	Specialist visit	**Tier 1 Specialty & Hospital Based:** $45 **copay** / visit; **deductible** does not apply **Tier 2 Specialty & Hospital Based:** $45 **copay**/ visit; **deductible** does not apply **Tier 3 Specialty & Hospital Based:** $45 **copay**/ visit; **deductible** does not apply	Not covered	None

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)	
	Preventive care/ screening/ immunization	No charge; deductible does not apply	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.
If you have a test	Diagnostic test (x-ray, blood work)	**Non-Hospital Based:** No charge; deductible does not apply **Physician & Hospital Based: Tier 1 Providers:** No charge; deductible does not apply **Tier 2 Providers:** No charge; deductible does not apply **Tier 3 Providers:** No charge; deductible does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	**Non-Hospital Based:** $100 copay/ procedure **Physician & Hospital Based: Tier 1 Providers:** $100 copay/ procedure **Tier 2 Providers:** $100 copay/ procedure **Tier 3 Providers:** $100 copay/ procedure	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/ 2018Premium3T**.	Generic drugs	**30-Day Retail Tier 1:** $10 copay/ prescription **90-Day Mail Order Tier 1:** $20 copay/ prescription		None
	Preferred brand drugs	**30-Day Retail Tier 2:** $30 copay/ prescription **90-Day Mail Order Tier 2:** $60 copay/ prescription		Some generic drugs are in this tier.
	Non-preferred brand drugs	**30-Day Retail Tier 3:** $65 copay/ prescription **90-Day Mail Order Tier 3:** $130 copay/ prescription		Same as above.
	Specialty drugs	All drugs are covered in Retail Pharmacy and Mail Order Pharmacy Tiers 1 — 3		Some drugs must be obtained through a Specialty Pharmacy.

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**Tier 1 Providers:** $250 copay/ visit **Tier 2 Providers:** $250 copay/ visit **Tier 3 Providers:** $250 copay/ visit	Not covered	None
	Physician/surgeon fees	**Tier 1 Providers:** No charge **Tier 2 Providers:** No charge **Tier 3 Providers:** No charge	Not covered	
If you need immediate medical attention	Emergency room care	$100 copay/ visit; deductible does not apply		None
	Emergency medical transportation	No charge		None
	Urgent care	**Convenience care clinic: Tier 1:** $30 copay/ visit; deductible does not apply **Tier 2:** $30 copay/ visit; deductible does not apply **Tier 3:** $30 copay/ visit; deductible does not apply **Urgent care clinic (including hospital urgent care clinic): Tier 1:** $30 copay/ visit; deductible does not apply **Tier 2:** $30 copay/ visit; deductible does not apply **Tier 3:** $30 copay/ visit; deductible does not apply	Not covered	Services with non-participating providers are only covered outside of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	**Tier 1 Providers:** $500 copay/ admit **Tier 2 Providers:** $500 copay/ admit **Tier 3 Providers:** $1,000 copay/ admit	Not covered	None
	Physician/surgeon fee	**Tier 1 Providers:** No charge **Tier 2 Providers:** No charge **Tier 3 Providers:** No charge	Not covered	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	**Tier 1 Primary Care:** $30 copay/ visit; deductible does not apply	Not covered	None
	Inpatient services	$200 copay/ admit	Not covered	

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	**Tier 1 Primary Care:** $30 copay/ visit; deductible does not apply **Tier 2 Primary Care:** $30 copay/ visit; deductible does not apply **Tier 3 Primary Care:** $30 copay/ visit; deductible does not apply	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	**Tier 1 Providers:** No charge **Tier 2 Providers:** No charge **Tier 3 Providers:** No charge	Not covered	
	Childbirth/delivery facility services	**Tier 1 Providers:** $500 copay/ admit **Tier 2 Providers:** $500 copay/ admit **Tier 3 Providers:** $1,000 copay/ admit	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	None
	Rehabilitation services	$45 copay/ visit; deductible does not apply	Not covered	Occupational Therapy – 60 visits/ Plan Year Physical Therapy – 60 visits/ Plan Year
	Habilitation services	$45 copay/ visit; deductible does not apply	Not covered	
	Skilled nursing care	No charge	Not covered	– 100 days/ Plan Year
	Durable medical equipment	No charge	Not covered	None
	Hospice services	No charge	Not covered	For inpatient services, see "If you have a hospital stay".

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 your child needs dental or eye care	Children's eye exam	**Tier 1 Primary Care:** $30 copay/ visit; deductible does not apply **Tier 2 Primary Care:** $30 copay/ visit; deductible does not apply **Tier 3 Primary Care:** $30 copay/ visit; deductible does not apply	Not covered	– 1 exam/ Plan Year
	Children's glasses	Not covered		You may have other coverage under a Vision Rider.
	Children's dental check-up	No charge; deductible does not apply	Not covered	– 2 exams/ Plan Year up to age 13

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	• Non-emergency care when traveling outside the U.S. • Private-duty nursing • Most Dental Care (Adult)	• Routine foot care • 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 - 20 visits/ Plan Year • Bariatric surgery	• Chiropractic Care - 20 visits/ Plan Year • Hearing Aids - $2,000/ hearing aid every 36 months/ impaired ear	• Infertility Treatment • Routine eye care (Adult) - 1 exam/ 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 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.
1600 Crown Colony Drive
Quincy, MA 02169
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

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Coverage 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**.

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**	$400
■ **Specialist *copayment***	$45
■ **Hospital (facility) *copayment***	$500
■ **Other *copayment***	$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	**$12,731**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$80
Copayments	$520
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$600**

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
■ **The plan's overall deductible**	$400
■ **Specialist *copayment***	$45
■ **Hospital (facility) *copayment***	$500
■ **Other *copayment***	$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	**$7,389**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$80
Copayments	$1,730
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$1,840**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ **The plan's overall deductible**	$400
■ **Specialist *copayment***	$45
■ **Hospital (facility) *copayment***	$500
■ **Other *copayment***	$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	**$1,925**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$400
Copayments	$230
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$630**

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 اللُغة **العربية** ، خَدَمات اَلمُساعَدة اَللُغَوية مُتَوفرة لك مَجانا. **إتصل على 1 888-333-4742**
(TTY: 711)

ខ្មែរ (Cambodian) ប្រសូជូនដំណឹង៖ 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 मुफ्त में 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. 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).

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

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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. HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

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, you can file a grievance with: Civil Rights Compliance Officer, 93 Worcester St, Wellesley, MA 02481, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@harvardpilgrim.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.