Harvard Pilgrim Health Care of New England

**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services
**NH Local Choice HMO Silver 2500**

**Coverage Period: 01/01/2025 — 12/31/2025**
**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=PD0000201724**. 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: $2,500 member / $5,000 family<br>Tier 2: $7,000 member / $14,000 family<br>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 **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, 2, and 3 **prescription drugs**, and the following Tier 1 **Provider** services: **provider** office visits, **Rehabilitation services**, and **Habilitation services** 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**.<br>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?** | $9,100 member / $18,200 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://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) | |
| | | 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 | Level 1: $40 copay/ visit; deductible does not apply | 40% coinsurance | Not covered | None |
| | Specialist visit | Level 1: $40 copay/ visit; deductible does not apply<br>Level 2: $80 copay/ visit; deductible does not apply | 40% coinsurance | Not covered | None |
| | Preventive care/ screening/ | No charge; deductible does not apply | | Not covered | Prescribed FDA approved contraceptives are not subject to cost-shares. |

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|---|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | | Non-Participating Provider (You will pay the most) | |
| | | Tier 1 Provider | Tier 2 Provider | | |
| | immunization | | | | 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) | X-rays: 20% **coinsurance**<br>Laboratory: 20% **coinsurance** | X-rays: 40% **coinsurance**<br>Laboratory: 40% **coinsurance** | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | 20% **coinsurance** | 40% **coinsurance** | Not covered | None |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at **www.harvardpilgrim.org/2025CoreNH5T**. | Generic drugs | 30-Day Retail Tier 1: $10 **copay**/ prescription; **deductible** does not apply<br>90-Day Mail Tier 1: $20 **copay**/ prescription; **deductible** does not apply<br>30-Day Retail Tier 2: $35 **copay**/ prescription; **deductible** does not apply<br>90-Day Mail Tier 2: $70 **copay**/ prescription; **deductible** does not apply | | Not covered | Core NH formulary - covers a limited list; not all drugs are covered<br>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: $100 **copay**/ prescription; **deductible** does not apply<br>90-Day Mail Tier 3: $200 **copay**/ prescription; **deductible** does not apply | | Not covered | |
| | Non-preferred brand drugs | 30-Day Retail Tier 4: 30% **coinsurance**<br>90-Day Mail Tier 4: 30% **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 | | |
| | Specialty drugs | 30-Day Retail Tier 4: 30% coinsurance<br>90-Day Mail Tier 4: 30% coinsurance<br>30-Day Retail Tier 5: 40% coinsurance<br>90-Day Mail Tier 5: 40% coinsurance | | Not covered | Some drugs must be obtained through a Specialty Pharmacy. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | Not covered | None |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | Not covered | |
| **If you need immediate medical attention** | Emergency room care | Medical Emergency Services: $500 copay/ visit<br>Services that do not meet the definition of Medical Emergency: 50% coinsurance | | | None |
| | Emergency Medical Transportation | 20% coinsurance | | | None |
| | Urgent Care | Urgent care center: $50 copay/ visit; deductible does not apply | | Urgent care center: Not covered | Non-participating providers 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) | 20% coinsurance | 40% coinsurance | Not covered | None |
| | Physician/surgeon fee | 20% coinsurance | 40% coinsurance | Not covered | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $40 copay/ visit; deductible does not apply | | Not covered | None |
| | Inpatient services | 20% coinsurance | | Not covered | |

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| | | 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 | $40 copay/ visit; deductible does not apply | 40% coinsurance | Not covered | Cost sharing does not apply for preventive services (such as routine prenatal visits). |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | Not covered | |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | Not covered | None |
| | Rehabilitation services<br>Habilitation services | Physical Therapy: $60 copay/ visit; deductible does not apply<br>Occupational Therapy: $60 copay/ visit; deductible does not apply<br>Speech Therapy: $60 copay/ visit; deductible does not apply | Physical Therapy: 40% coinsurance<br>Occupational Therapy: 40% coinsurance<br>Speech Therapy: 40% coinsurance | Not covered | Physical, Occupational & Speech Therapy - 60 combined visits/ calendar year |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | Not covered | - 100 days/ calendar year |
| | Durable medical equipment | 20% coinsurance | | Not covered | None |
| | Hospice services | 20% coinsurance | 40% 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 | $40 copay/ visit; deductible does not apply | 40% 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 | 50% Coinsurance; deductible does not apply | | | - 1 exam/ 6 months up to end of month child turns 19 |

## 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)
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- Long-Term Care
- 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 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 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/insurance**
consumerservices@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 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**.

**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) | |
|---|---|
| ■ The plan's overall deductible | $2,500 |
| ■ Specialist copayment | $80 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |
| **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 | $2,500 |
| Copayments | $60 |
| Coinsurance | $2,000 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$4,560** |

| Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition) | |
|---|---|
| ■ The plan's overall deductible | $2,500 |
| ■ Specialist copayment | $80 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |
| **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 | $100 |
| Copayments | $1,800 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,900** |

| Mia's Simple Fracture (in-network emergency room visit and follow up care) | |
|---|---|
| ■ The plan's overall deductible | $2,500 |
| ■ Specialist copayment | $80 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |
| **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 | $2,200 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,600** |

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 1-877-907-4742 (TTY: 711).

**Português (Portuguese)** ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-877-907-4742 (TTY: 711).

**Kreyòl Ayisyen (French Creole)** ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 1-877-907-4742 (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 1-877-907-4742（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 1-877-907-4742 (TTY: 711).

**Русский (Russian)** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-907-4742 (телетайп: 711).

**العربية (Arabic)**

**إنتباه:** إذا أنت تتكلم اللغة **العربية**، خدمات المساعدة اللغوية متوفرة لك مجانا. **إتصل على 1 877-907-4742** (TTY: 711)

**ខ្មែរ (Cambodian)** ប្រសិនជាអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-877-907-4742 (TTY: 711)។

**Français (French)** ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-907-4742 (ATS: 711).

**Italiano (Italian)** ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-907-4742 (TTY: 711).

**한국어 (Korean)** '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-907-4742 (TTY: 711) 번으로 전화해 주십시오.

**Ελληνικά (Greek)** ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-877-907-4742 (TTY: 711).

**Polski (Polish)** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-907-4742 (TTY: 711).

**हिंदी (Hindi)** ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्तमें उपलब्ध है. जानकारी के लिये फोन करे. 1-877-907-4742 (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. 1-877-907-4742 (TTY: 711)

**ພາສາລາວ (Lao)** ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-877-907-4742 (TTY: 711).

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-877-907-4742 (TTY: 711).

## 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.