Harvard Pilgrim Health Care of New England

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

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=PD0000100588**. 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:** $6,500 member / $13,000 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 **4** **provider** office visits per member (up to **8** per family), and any combination of first **4** mental/behavioral health and substance use outpatient services per member (up to **8** per family) 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
		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	**Visits 1-4: Level 1:** $40 **copay**/ visit; **deductible** does not apply **Visits 5+:** 20% **coinsurance**	Not covered	First 4 office visits/ Member (8/ family) apply **copay**
	Specialist visit	**Visits 1-4: Level 1:** $40 **copay**/ visit; **deductible** does not apply **Level 2:** $80 **copay**/ visit; **deductible** does not apply **Visits 5+:** 20% **coinsurance**	Not covered	None
	Preventive care/ **screening**/**immunization**	No charge; **deductible** does not apply	Not covered	Prescribed FDA approved contraceptives are not subject to cost-shares. You may have to pay for services that aren't preventive. Ask your provider

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 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 **Laboratory:** 20% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% 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/2022CoreNH5T**.	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:** 30% coinsurance **90-Day Mail Tier 3:** 30% coinsurance		Some generic drugs are in this tier
	Non-preferred brand drugs	**30-Day Retail Tier 4:** 35% coinsurance **90-Day Mail Tier 4:** 35% coinsurance		Same as above
	Specialty drugs	**30-Day Retail Tier 4:** 35% coinsurance **90-Day Mail Tier 4:** 35% 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)	20% coinsurance	Not covered	None
	Physician/surgeon fees	20% coinsurance	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 need immediate medical attention	Emergency room care	**Medical Emergency Services:** $500 copay/ visit **Services that do not meet the definition of Medical Emergency:** 50% coinsurance		None
	Emergency medical transportation	20% coinsurance		None
	Urgent care	**Convenience care clinic:** **Visits 1-4:** $40 copay/ visit; deductible does not apply **Visits 5+:** 20% coinsurance **Urgent care center:** **Visits 1-4:** $50 copay/ visit; deductible does not apply **Visits 5+:** 20% coinsurance **Hospital urgent care center:** $250 copay/ visit	**Convenience care clinic:** Not covered **Urgent care center:** Not covered **Hospital urgent care center:** Same As Participating Provider	First 4 office visits/ Member (8/ family) apply copay
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/ admit, then 20% coinsurance	Not covered	None
	Physician/surgeon fee	20% coinsurance	Not covered	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	**Visits 1-4:** No charge; deductible does not apply **Visits 5+:** 20% coinsurance	Not covered	No charge for first 4 mental health/substance abuse visits/ Member (8/ family)
	Inpatient services	$500 copay/ admit, then 20% coinsurance	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)	
If you are pregnant	Office visits	**Visits 1-4:** $40 copay/ visit; deductible does not apply **Visits 5+:** 20% coinsurance	Not covered	Cost sharing does not apply for preventive services. First 4 office visits/ Member (8/ family) apply copay
	Childbirth/delivery professional services	20% coinsurance	Not covered	Cost sharing does not apply for preventive services.
	Childbirth/delivery facility services	$500 copay/ admit, then 20% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	None
	Rehabilitation services Habilitation services	**Physical Therapy:** 20% coinsurance **Occupational Therapy:** 20% coinsurance **Speech Therapy:** 20% coinsurance	Not covered	Physical, Occupational & Speech Therapy - 60 combined visits/ calendar year
	Skilled nursing care	$500 copay/ admit, then 20% coinsurance	Not covered	- 100 days/ calendar year
	Durable medical equipment	20% coinsurance	Not covered	None
	Hospice services	20% coinsurance	Not covered	For inpatient see "If you have a hospital stay"
If your child needs dental or eye care	Children's eye exam	$40 copay/ visit; deductible does not apply	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

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)	
	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.)				
• 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 • 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**	$6,500
■ **Specialist *coinsurance***	20%
■ **Hospital (facility) *copayment***	$500
■ **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	$6,500
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$7,100**

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
■ **The plan's overall deductible**	$6,500
■ **Specialist *coinsurance***	20%
■ **Hospital (facility) *copayment***	$500
■ **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	$1,800
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,500**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ **The plan's overall deductible**	$6,500
■ **Specialist *coinsurance***	20%
■ **Hospital (facility) *copayment***	$500
■ **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	$2,800
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.

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

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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.