



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; <u>deductible</u> 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.

The HPHC Insurance Company PPO

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

Coverage Period: 07/01/2020 — 06/30/2021

Coverage for: Individual + Family | **Plan Type:** PPO

|  | <p>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/LGsampleEOC. 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.</p> | |
|---|--|--|
| Important Questions | Answers | Why this matters |
| <p>What is the overall deductible?</p> | <p>In-Network: \$300 member/ \$900 family Out-of-Network: \$400 member/ \$800 family Benefits are administered on a Plan Year basis.</p> | <p>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 policy, they have to meet their own individual deductible until the overall family deductible amount has been met.</p> |
| <p>Are there services covered before you meet your deductible?</p> | <p>Yes: In-Network prescription drugs, outpatient mental health services, preventive care, provider office visits, rehabilitation services, habilitation services, routine eye exams, are covered before you meet your deductibles.</p> | <p>This plan covers some items and services even if you haven't yet met the deductible amount. But, a copayment or coinsurance may apply.</p> |
| <p>Are there other deductibles for specific services?</p> | <p>No.</p> | <p>You don't have to meet deductibles for specific services</p> |
| <p>What is the out-of-pocket limit for this plan?</p> | <p>In-Network: \$2,000 member/ \$4,000 family Out-of-Network: \$3,000 member Separate out-of-pocket limit applies to Pharmacy, see "If you need drugs to treat your illness or condition".</p> | <p>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.</p> |

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

| Important Questions | Answers | Why this matters |
|--|--|--|
| What is not included in the <u>out-of-pocket limit</u> ? | Prescription drugs, <u>premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain preauthorization for services and health care this <u>plan</u> doesn't cover | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Will you pay less if you use a <u>network provider</u> ? | Yes. See https://www.providerlookuponline.com/harvardpilgrim/po7/Search.aspx or call 1-888-333-4742 for a list of <u>preferred providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance-billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ? | No. | You can see the <u>specialist</u> you choose without permission from this <u>plan</u> . |



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 |
|---|---|--|--|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | Level 1: \$20 <u>copay</u> /visit; <u>deductible</u> does not apply | 20% <u>coinsurance</u> | None |
| | <u>Specialist</u> visit | Level 1: \$20 <u>copay</u> /visit; <u>deductible</u> does not apply Level 2: \$45 <u>copay</u> /visit; <u>deductible</u> does not apply | 20% <u>coinsurance</u> | None |
| | <u>Preventive care</u> / <u>screening</u> / <u>immunization</u> | No charge; <u>deductible</u> does not apply | 20% <u>coinsurance</u> | 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. |

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

| 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: No charge | X-rays: 20% coinsurance Laboratory: 20% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | \$100 copay /procedure | 20% coinsurance | Cost sharing may vary for certain imaging services. Out-of-Network preauthorization required. \$500 penalty if not obtained. |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.harvardpilgrim.org/2020Premium3T . | Generic drugs | 30-Day Retail Tier 1: \$10 copay /prescription; deductible does not apply 90-Day Mail Tier 1: \$25 copay /prescription; deductible does not apply | | Prescription drug Out-of-Pocket Maximum :. \$3,000 member/ \$6,000 family |
| | Preferred brand drugs | 30-Day Retail Tier 2: \$30 copay /prescription; deductible does not apply 90-Day Mail Tier 2: \$75 copay /prescription; deductible does not apply | | Some generic drugs are in this tier. |
| | Non-preferred brand drugs | 30-Day Retail Tier 3: \$65 copay /prescription; deductible does not apply 90-Day Mail Tier 3: \$165 copay /prescription; deductible does not apply | | 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. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$250 copay /visit | 20% coinsurance | Out-of-Network preauthorization required. \$500 penalty if not obtained. |
| | Physician/surgeon fees | No charge | 20% coinsurance | |

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

| 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 | \$100 copay /visit | | None |
| | Emergency medical transportation | No charge | | None |
| | Urgent care | Convenience care clinic: \$20 copay /visit; deductible does not apply Urgent care center: \$45 copay /visit; deductible does not apply Hospital urgent care center: \$45 copay /visit; deductible does not apply | Convenience care clinic: 20% coinsurance Urgent care center: 20% coinsurance Hospital urgent care center: 20% coinsurance | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$500 copay /admit | 20% coinsurance | Out-of-Network preauthorization required. \$500 penalty if not obtained. |
| | Physician/surgeon fee | No charge | 20% coinsurance | |
| If you have mental health, behavioral health, or substance abuse needs | Outpatient services | Level 1: \$20 copay /visit; deductible does not apply | 20% coinsurance | Out-of-Network preauthorization required. \$500 penalty if not obtained. |
| | Inpatient services | \$500 copay /admit | 20% coinsurance | |
| If you are pregnant | Office visits | Level 1: \$20 copay /visit; deductible does not apply | 20% coinsurance | Cost sharing does not apply for preventive services . |
| | Childbirth/delivery professional services | No charge | 20% coinsurance | |
| | Childbirth/delivery facility services | \$500 copay /admit | 20% coinsurance | |

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

| 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 help recovering or have other special health needs | Home health care | No charge | 20% coinsurance | None |
| | Rehabilitation services | Level 1: \$20 copay /visit; deductible does not apply | 20% coinsurance | Occupational therapy – 30 visits /Plan Year Physical therapy – 30 visits /Plan Year Out-of-Network preauthorization required. \$500 penalty if not obtained. |
| | Habilitation services | | | |
| | Skilled nursing care | \$500 copay /admit | 20% coinsurance | 100 days/Plan Year |
| | Durable medical equipment | 20% coinsurance of equipment cost to HPHC, not to exceed a Member's total expense of \$1,000/Plan Year | 20% coinsurance of equipment cost to HPHC, not to exceed a Member's total expense of \$1,000/Plan Year | Out-of-Network preauthorization required. \$500 penalty if not obtained. |
| | Hospice services | No charge | 20% coinsurance | For inpatient see "If you have a hospital stay". |
| If your child needs dental or eye care | Children's eye exam | No charge; deductible does not apply | 20% coinsurance | 1 exam/Plan Year |
| | Children's glasses | Not covered | Not covered | None |
| | Children's dental check-up – Up to age of 13 | No charge; deductible does not apply | 20% coinsurance | 2 exams/Plan Year |
| 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"> Acupuncture | | <ul style="list-style-type: none"> Long-Term (Custodial) Care Most Cosmetic Surgery | | <ul style="list-style-type: none"> Private-duty nursing Routine foot care Services that are not Medically Necessary |

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

| | | |
|---|--|--|
| <ul style="list-style-type: none"> • Chiropractic Care | <ul style="list-style-type: none"> • Most Dental Care (Adult) | <ul style="list-style-type: none"> • Weight Loss Programs |
| <p>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.)</p> | | |
| <ul style="list-style-type: none"> • Bariatric surgery | <ul style="list-style-type: none"> • Hearing Aids - \$2,000/aid every 36 months, for each impaired ear up to age 22 | <ul style="list-style-type: none"> • Infertility Treatment • Non-emergency care when traveling outside the U.S. • 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
HPHC Insurance Company, 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>

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.* —————

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

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) | | 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 | \$300 | ■ The plan's overall deductible | \$300 | ■ The plan's overall deductible | \$300 |
| ■ Specialist copayment | \$45 | ■ Specialist copayment | \$45 | ■ Specialist copayment | \$45 |
| ■ Hospital (facility) copayment | \$500 | ■ Hospital (facility) copayment | \$500 | ■ Hospital (facility) copayment | \$500 |
| ■ Other | \$0 | ■ Other | \$0 | ■ Other | \$0 |
| This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>) | | This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>) | | This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>) | |
| Total Example Cost | \$12,731 | Total Example Cost | \$7,389 | Total Example Cost | \$1,925 |
| 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 | \$300 | Deductibles | \$130 | Deductibles | \$300 |
| Copayments | \$580 | Copayments | \$1,690 | Copayments | \$150 |
| Coinsurance | \$0 | Coinsurance | \$0 | Coinsurance | \$40 |
| <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 | \$30 | Limits or exclusions | \$0 |
| The total Peg would pay is | \$880 | The total Joe would pay is | \$1,850 | The total Mia would pay is | \$490 |

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 quý vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quý 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 اللغة العربية، خدمات المساعدة اللغوية متوفرة لك مجاناً. إتصل على 1 888-333-4742

(TTY: 711)

ខ្មែរ (Cambodian) ប្រសិនបើ អ្នកនិយាយភាសាខ្មែរ, 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).

(Continued)

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 मुफ्तमें 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, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທສ 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.

(Continued)

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>.



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.

cc6589_memb_serv (11/9)