

The Harvard Pilgrim HMO

Coverage Period: 01/01/2017 — 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs


Coverage for: Individual + Family | Plan Type: HMO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or [plan](#) document at [https://www.harvardpilgrim.org/portal/page?\\_pageid=213,9144133=portal=PORTAL](https://www.harvardpilgrim.org/portal/page?_pageid=213,9144133=portal=PORTAL) or by calling 1-888-333-4742.

Important Questions	Answers	Why this matters:
What is the overall deductible?	\$0	See the chart starting on page 2 for your costs for services this <a href="#">plan</a> covers.
Are there other deductibles for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services, but see the chart starting on page 2 for other costs for services this <a href="#">plan</a> covers.
Is there an out-of-pocket limit on my expenses?	Yes. \$3,000 per member / \$6,000 per family per Plan Year	The <a href="#">out-of-pocket</a> limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you <a href="#">plan</a> for health care expenses.
What is not included in the out-of-pocket limit?	Prescription Drugs, premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Is there an overall annual limit on what the <a href="#">plan</a> pays?	No.	The chart starting on page 2 describes any limits on what the <a href="#">plan</a> will pay for <i>specific</i> covered services, such as office visits.
Does this <a href="#">plan</a> use a <a href="#">network</a> of <a href="#">providers</a> ?	Yes. For a list of <a href="#">preferred providers</a> , see <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a> or call 1-888-333-4742.	If you use an in- <a href="#">network</a> doctor or other health care <a href="#">provider</a> , this <a href="#">plan</a> will pay some or all of the costs of covered services. Be aware, your in- <a href="#">network</a> doctor or hospital may use an out-of- <a href="#">network provider</a> for some services. <a href="#">Plans</a> use the term in- <a href="#">network</a> , preferred, or participating for <a href="#">providers</a> in their <a href="#">network</a> . See the chart starting on page 2 for how this <a href="#">plan</a> pays different kinds of <a href="#">providers</a> .
Do I need a referral to see a <a href="#">specialist</a> ?	Yes, some exceptions apply.	This plan will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have the plan's permission before you see the <a href="#">specialist</a> .
Are there services this <a href="#">plan</a> doesn't cover?	Yes.	Some of the services this <a href="#">plan</a> doesn't cover are listed on page 5. See your policy or <a href="#">plan</a> document for additional information about <a href="#">excluded services</a> .

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	<ul style="list-style-type: none"> <li>• Co-payments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.</li> <li>• Co-insurance is your share of the costs of a covered service, calculated as a percent of the <b>allowed amount</b> for the service. For example, if the <b>plan's allowed amount</b> for an overnight hospital stay is \$1,000, your co-insurance payment of 20% would be \$200. This may change if you haven't met your deductible.</li> <li>• The amount the <b>plan</b> pays for covered services is based on the <b>allowed amount</b>. If an out-of-network <b>provider</b> charges more than the <b>allowed amount</b>, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the <b>allowed amount</b> is \$1,000, you may have to pay the \$500 difference. (This is called balance billing.)</li> <li>• This <b>plan</b> may encourage you to use participating <b>providers</b> by charging you lower deductibles, co-payments and co-insurance amounts.</li> </ul>
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Common Medical Event	Services You May Need	Participating Provider	Non-Participating Provider	Limitations & Exceptions
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	<b>Level 1:</b> \$40 Copay/ visit	Not covered	None
	<b>Specialist</b> visit	<b>Level 1:</b> \$40 Copay/ visit <b>Level 2:</b> \$60 Copay/ visit	Not covered	None
	Other practitioner office visit	<b>Level 1:</b> \$40 Copay/ visit	Not covered	Cost sharing may vary for certain practitioners.
	Preventive care/screening/immunization	No charge	Not covered	None
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	\$40 Copay	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$300 Copay/ procedure	Not covered	None
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.harvardpilgrim.org/2017Value5T">www.harvardpilgrim.org/2017Value5T</a> .	Most generic drugs	<b>30-Day Retail Pharmacy Tier 1:</b> \$5 Copay <b>90-Day Mail Order Pharmacy Tier 1:</b> \$12.50 Copay <b>30-Day Retail Pharmacy Tier 2:</b> \$25 Copay <b>90-Day Mail Order Pharmacy Tier 2:</b> \$62.50 Copay		Value formulary - covers a limited list of drugs. <b>Pharmacy Out-of-pocket limit:</b> \$2,000 per member / \$4,000 per family per Plan Year
	Preferred brand drugs	<b>30-Day Retail Pharmacy Tier 3:</b> \$75 Copay <b>90-Day Mail Order Pharmacy Tier 3:</b> \$187.50 Copay		Some generic drugs are in this tier.
	Non-preferred brand drugs	<b>30-Day Retail Pharmacy Tier 4:</b> \$100 Copayment <b>90-Day Mail Order Pharmacy Tier 4:</b> \$300 Copayment		Same as above.

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

<b>Common Medical Event</b>	<b>Services You May Need</b>	<b>Participating Provider</b>	<b>Non-Participating Provider</b>	<b>Limitations &amp; Exceptions</b>
	Specialty drugs	<b>30-Day Retail Pharmacy Tier 4:</b> \$100 Copay <b>90-Day Mail Order Pharmacy Tier 4:</b> \$300 Copay <b>30-Day Retail Pharmacy Tier 5:</b> 20% Coinsurance up to \$250/ prescription <b>90-Day Mail Order Pharmacy Tier 5:</b> 20% Coinsurance up to \$750/ prescription		Some drugs must be obtained through a Specialty Pharmacy.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$750 Copay/ visit	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
<b>If you need immediate medical attention</b>	Emergency Room Services	\$300 Copay/ visit	Same As Participating <b>Provider</b>	None
	<b>Emergency Medical Transportation</b>	No charge	Same As Participating <b>Provider</b>	None
	<b>Urgent Care</b>	<b>Convenience care clinic:</b> \$40 Copay/ visit <b>Urgent care clinic (including hospital urgent care clinic):</b> \$60 Copay/ visit	Not covered	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$1,000 Copay/ admission	Not covered	None
	Physician/surgeon fee	No charge	Not covered	None
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	<b>Group Therapy:</b> \$10 Copay/ visit <b>Individual Therapy: Level 1:</b> \$40 Copay/ visit	Not covered	None
	Mental/Behavioral health inpatient services	\$1,000 Copay/ admission	Not covered	None
	Substance use disorder outpatient services	<b>Group Therapy:</b> \$10 Copay/ visit <b>Individual Therapy: Level 1:</b> \$40 Copay/ visit	Not covered	None

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<b>Common Medical Event</b>	<b>Services You May Need</b>	<b>Participating Provider</b>	<b>Non-Participating Provider</b>	<b>Limitations &amp; Exceptions</b>
	Substance use disorder inpatient services	\$1,000 Copay/ admission	Not covered	None
<b>If you are pregnant</b>	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	\$1,000 Copay/ admission	Not covered	None
<b>If you need help recovering or have other special health needs</b>	<b>Home health care</b>	No charge	Not covered	None
	<b>Rehabilitation services</b> (Inpatient)	\$1,000 Copay/ admission	Not covered	– 60 days per Plan Year
	<b>Habilitation services</b> (Outpatient)	<b>Level 1:</b> \$40 Copay/ visit	Not covered	Physical & Occupational Therapy – 60 combined visits per Plan Year
	<b>Skilled nursing care</b>	\$1,000 Copay/ admission	Not covered	– 100 days per Plan Year
	<b>Durable medical equipment</b>	20% Coinsurance	Not covered	– 1 synthetic monofilament wig per Plan Year
	<b>Hospice services</b>	No charge	Not covered	For inpatient services, see “If you have a hospital stay”.
<b>If your child needs dental or eye care</b>	Eye exam	<b>Level 1:</b> \$40 Copay/ visit	Not covered	– 1 exam per Plan Year
	Glasses – Up to the age of 19	Reimbursed first \$50, then 50% of covered charges	Reimbursed first \$50, then 50% of covered charges	Frames & lenses OR contacts every 12 months
	Dental check-up – Up to the age of 19	50% Coinsurance	50% Coinsurance	– 2 exam per 12 months

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**EXCLUDED SERVICES & OTHER COVERED SERVICES:**

Services Your <b>Plan</b> Does NOT Cover (This isn't a complete list. Check your policy or <b>plan</b> document for other <b>excluded services</b> .)		
<ul style="list-style-type: none"> <li>• Long-Term (Custodial) Care</li> <li>• Most Cosmetic Surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Most Dental Care (Adult)</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Services that are not Medically Necessary</li> </ul>
Other Covered Services (This isn't a complete list. Check your policy or <b>plan</b> document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> <li>• Abortion</li> <li>• Acupuncture</li> </ul>	<ul style="list-style-type: none"> <li>• Bariatric Surgery</li> <li>• Chiropractic Care</li> <li>• Hearing Aids</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility Treatment</li> <li>• Routine eye care (Adult)</li> <li>• Weight Loss Programs</li> </ul>

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### Your Rights to Continue Coverage:

If you lose coverage under the **plan**, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the **plan**. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the **plan** at **1-800-333-4742**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://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](http://www.cciio.cms.gov)

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your **plan**, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can 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](http://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 Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

### 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.

## About these Coverage Examples:

These examples show how this **plan** might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different **plans**.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this **plan**. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: **\$7,540**
- Plan pays: **\$5,930**
- Patient pays: **\$1,610**

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

<b>Deductibles</b>	\$0
Co-pays	\$1,460
Co-insurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$1,610</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: **\$5,400**
- Plan pays: **\$3,360**
- Patient pays: **\$2,040**

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$0
Co-pays	\$1,960
Co-insurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$2,040</b>



## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health **plan**.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any **member** covered under this **plan**.
- **Out-of-pocket** expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

**X No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

**X No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health **plan** allows.

### Can I use Coverage Examples to compare plans?

**✓ Yes.** When you look at the Summary of Benefits and Coverage for other **plans**, you'll find the same Coverage Examples. When you compare **plans**, check the "Patient Pays" box in each example. The smaller that number, the more coverage the **plan** provides.

### Are there other costs I should consider when comparing plans?

**✓ Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in **out-of-pocket** costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay **out-of-pocket** expenses.





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)**

انتباه: إذا أنت تتكلم اللغة العربية ، خدمات المساعدة اللغوية متوفرة لك مجاناً. إتصل على 1 888-333-4742 (TTY: 711 )

**ខ្មែរ (Cambodian)** ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ, 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).

**한국어 (Korean)** '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-333-4742 (TTY: 711) 번으로 전화해 주십시오.

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**ελληνικά (Greek)** ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-888-333-4742 (TTY: 711).

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**Polski (Polish)** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-333-4742 (TTY: 711).

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**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)

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**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)

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**ພາສາລາວ (Lao)** ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ຈະມີພ້ອມໃຫ້ທ່ານ. ໂທສ 1-888-333-4742 (TTY: 711).

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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).

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### **General Notice About Nondiscrimination and Accessibility Requirements**

Harvard Pilgrim Health Care complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Harvard Pilgrim Health Care does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Harvard Pilgrim Health Care:

- 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 Harvard Pilgrim Health Care 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](mailto: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>.