Harvard Pilgrim Health Care

Massachusetts

The Harvard Pilgrim Core Coverage 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=213,9144048=portal=PORTAL** or by calling **1-888-333-4742**.

Important Questions	Answers	Why this matters:
What is the overall deductible?	$3,000 per member / $6,000 per family per Plan Year The **deductible** applies to benefits cited in the chart starting on Page 2 .	You must pay all the costs up to the **deductible** amount before this **plan** begins to pay for covered services you use. Check your policy or **plan** document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this **plan** covers.
Is there an out–of–pocket limit on my expenses?	Yes. $5,250 per / $10,500 per family per Plan Year	The **out-of-pocket** 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 **plan** for health care expenses.
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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the **plan** will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.harvardpilgrim.org** or call **1-888-333-4742**.	If you use an in-**network** doctor or other health care **provider**, this **plan** will pay some or all of the costs of covered services. Be aware, your in-**network** doctor or hospital may use an out-of-**network provider** for some services. **Plans** use the term in-**network**, preferred, or participating for **providers** in their **network**. See the chart starting on page 2 for how this **plan** pays different kinds of **providers**.
Do I 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 the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this **plan** doesn't cover are listed on page 6 . See your policy or **plan** document for additional information about **excluded services**.

- Co-payments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Co-insurance is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the **plan**'s **allowed amount** 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.
- The amount the **plan** pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This **plan** may encourage you to use participating **providers** by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Participating Provider	Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 Copay/ visit Deductible, then 10% Coinsurance	Not Covered	First 3 office visits/ Member (6/ family) apply Copay.
	Specialist visit	$35 Copay/ visit Deductible, then 10% Coinsurance	Not Covered	Same as above.
	Other practitioner office visit	$35 Copay/ visit Deductible, then 10% Coinsurance	Not Covered	Same as above.
	Preventive care/screening/immunization	No charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then 10% Coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Deductible, then 10% Coinsurance	Not Covered	None

Common Medical Event	Services You May Need	Participating Provider	Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.harvardpilgrim.org/ 2017Value5T**.	Most generic drugs	**30-Day Retail Pharmacy Tier 1:** $5 Copay **90-Day Mail Order Pharmacy Tier 1:** $12.50 Copay **30-Day Retail Pharmacy Tier 2:** $25 Copay **90-Day Mail Order Pharmacy Tier 2:** $62.50 Copay		Value formulary - covers a limited list of drugs.
	Preferred brand drugs	**30-Day Retail Pharmacy Tier 3:** $80 Copay **90-Day Mail Order Pharmacy Tier 3:** $200 Copay		Some generic drugs are in this tier.
	Non-preferred brand drugs	**30-Day Retail Pharmacy Tier 4:** $110 Copay **90-Day Mail Order Pharmacy Tier 4:** $330 Copay		Same as above.
	Specialty drugs	**30-Day Retail Pharmacy Tier 4:** $110 Copay **90-Day Mail Order Pharmacy Tier 4:** $330 Copay **30-Day Retail Pharmacy Tier 5:** 20% Coinsurance up to $500/ prescription **90-Day Mail Order Pharmacy Tier 5:** 20% Coinsurance up to $1,500/ prescription		Some drugs must be obtained through a Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then 10% Coinsurance	Not Covered	None
	Physician/surgeon fees	Deductible, then 10% Coinsurance	Not Covered	None
If you need immediate medical attention	Emergency Room Services	$250 Copay/ visit	Same As Participating **Provider**	None
	Emergency Medical Transportation	Deductible, then 10% Coinsurance	Same As Participating **Provider**	None
	Urgent Care	**Convenience care clinic:** $35 Copay/ visit Deductible, then 10% Coinsurance **Urgent care clinic (including hospital urgent care clinic):** $35 Copay/ visit Deductible, then 10% Coinsurance	Not covered	First 3 office visits/ Member (6/ family) apply Copay.

Common Medical Event	Services You May Need	Participating Provider	Non-Participating Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 10% Coinsurance	Not Covered	None
	Physician/surgeon fee	Deductible, then 10% Coinsurance	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**Group Therapy:** No charge Deductible, then 10% Coinsurance **Individual Therapy:** No charge Deductible, then 10% Coinsurance	Not Covered	No charge for first 3 mental health/substance abuse visits/ Member (6/ family).
	Mental/Behavioral health inpatient services	Deductible, then 10% Coinsurance	Not Covered	None
	Substance use disorder outpatient services	**Group Therapy:** No charge Deductible, then 10% Coinsurance **Individual Therapy:** No charge Deductible, then 10% Coinsurance	Not Covered	No charge for first 3 mental health/substance abuse visits/ Member (6/ family).
	Substance use disorder inpatient services	Deductible, then 10% Coinsurance	Not Covered	None
If you are pregnant	Prenatal and postnatal care	No charge	Not Covered	None
	Delivery and all inpatient services	Deductible, then 10% Coinsurance	Not Covered	None

Common Medical Event	Services You May Need	Participating Provider	Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	**Home health care**	Deductible, then 10% Coinsurance	Not Covered	None
	Rehabilitation services (Inpatient)	Deductible, then 10% Coinsurance	Not Covered	– 60 days per Plan Year
	Habilitation services (Outpatient)	$35 Copay/ visit Deductible, then 10% Coinsurance	Not Covered	First 3 office visits/ Member (6/ family) apply Copay. Physical & Occupational Therapy – 60 combined visits per Plan Year
	Skilled nursing care	Deductible, then 10% Coinsurance	Not Covered	– Limited to 100 days per Plan Year
	Durable medical equipment	Deductible, then 20% Coinsurance	Not Covered	– 1 synthetic monofilament wig per Plan Year
	Hospice services	Deductible, then 10% Coinsurance	Not Covered	For inpatient services, see "If you have a hospital stay".
If your child needs dental or eye care	Eye exam	$35 Copay/ visit Deductible, then 10% Coinsurance	Not Covered	First 3 office visits/ Member (6/ family) apply Copay. – 1 exam per Plan Year
	Glasses	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	– Limited to 2 exam per 12 months You have other coverage under a Dental Rider.

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	• 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

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.)		
• Abortion • Acupuncture	• Bariatric Surgery • Chiropractic Care • Hearing Aids	• Infertility Treatment • Routine eye care (Adult) • Weight Loss Programs

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**, or the U.S. Department of Health and Human Services at **1-877-267-2323 x61565** or **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

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: $4,250**
- **Patient pays: $3,290**

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
Total	**$7,540**

Patient pays:

Deductibles	$3,000
Co-pays	$10
Co-insurance	$130
Limits or exclusions	$150
Total	**$3,290**

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

- **Amount owed to providers: $5,400**
- **Plan pays: $2,870**
- **Patient pays: $2,530**

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
Total	**$5,400**

Patient pays:

Deductibles	$900
Co-pays	$1,550
Co-insurance	$0
Limits or exclusions	$80
Total	**$2,530**

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?

✗ **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?

✗ **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.

Harvard Pilgrim Health Care

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 ألُلغةِ **ألعربية** ، خَدَمات ألمُساعَدة ألُلغوية مُتَوفرة لك مَجانا. ً **إتصل على 1 888-333-4742**

(TTY: 711)

ខ្មែរ (Cambodian) ប្រសុំជូនដំណឹង៖ 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).

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. ໂທຣ 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).

(Continued)

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. 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.