

The Harvard Pilgrim Best Buy HMO

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

Coverage Period: 07/01/2017 — 06/30/2018


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/LGsampleEOC or by calling 1-888-333-4742. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary at www.healthcare.gov/sbc-glossary to request a copy.

Important Questions	Answers	Why this matters
What is the overall <u>deductible</u> ?	\$1,000 member/ \$2,000 family	Generally you must pay all the costs up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, they have to meet their own individual <u>deductible</u> until the overall family <u>deductible</u> amount has been met.
Are there services covered before you meet your <u>deductible</u> ?	Yes: <u>durable medical equipment</u> , <u>emergency room care</u> , outpatient mental health services, <u>preventive care</u> , <u>provider</u> office visits, <u>rehabilitation services</u> , <u>habilitation services</u> , routine eye exams, are covered before you meet your <u>deductibles</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But, a <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$2,000 member/ \$4,000 family Separate <u>out-of-pocket limit</u> applies to Pharmacy, see "If you need drugs to treat your illness or condition".	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> until the overall family <u>out-of-pocket limit</u> has been met.

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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, 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> ?		Yes, some exceptions apply.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .	
		All <u>copayments</u> and <u>coinsurance</u> cost shown in this chart after your <u>deductible</u> has been met, if a <u>deductible</u> 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	\$10 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	None
	<u>Specialist</u> visit	\$10 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	None
	<u>Preventive care</u> / <u>screening</u> / <u>immunization</u>	No charge; <u>deductible</u> does not apply	Not covered	None
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge; <u>deductible</u> does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge; <u>deductible</u> does not apply	Not covered	Cost sharing may vary for certain imaging services.

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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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.harvardpilgrim.org/2017Premium3T .	Generic drugs	30-Day Retail Tier 1: \$10 <u>copay</u> /prescription; <u>deductible</u> does not apply 90-Day Mail Tier 1: \$10 <u>copay</u> /prescription; <u>deductible</u> does not apply		Prescription drug Out-of-Pocket Maximum: \$4,000 member/ \$8,000 family
	Preferred brand drugs	30-Day Retail Tier 2: \$30 <u>copay</u> /prescription; <u>deductible</u> does not apply 90-Day Mail Tier 2: \$30 <u>copay</u> /prescription; <u>deductible</u> does not apply		Some generic drugs are in this tier.
	Non-preferred brand drugs	30-Day Retail Tier 3: \$50 <u>copay</u> /prescription; <u>deductible</u> does not apply 90-Day Mail Tier 3: \$50 <u>copay</u> /prescription; <u>deductible</u> does not apply		Same as above.
	<u>Specialty drugs</u>	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)	No charge	Not covered	None
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	<u>Emergency room care</u>	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	Same As Participating <u>Provider</u>	None
	<u>Emergency medical transportation</u>	No charge	Same As Participating <u>Provider</u>	None
	<u>Urgent care</u>	Convenience care clinic: \$10 <u>copay</u> /visit; <u>deductible</u> does not apply Urgent care clinic: \$10 <u>copay</u> /visit; <u>deductible</u> does not apply Hospital Urgent Care Clinic: \$25 <u>copay</u> /visit; <u>deductible</u> does not apply	Convenience care clinic: Not covered Urgent care clinic: Not covered Urgent care hospital facility: Same As Participating <u>Provider</u>	Services with non-participating providers are only covered outside of the service area.

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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 hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	None
	Physician/surgeon fee	No charge	Not covered	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	\$10 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	None
	Inpatient services	No charge; <u>deductible</u> does not apply	Not covered	
If you are pregnant	Office visits	\$10 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge; <u>deductible</u> does not apply	Not covered	None
	<u>Rehabilitation services</u>	\$10 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	Occupational, physical & speech therapy – 40 combined visits /year
	<u>Habilitation services</u>	\$10 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	
	<u>Skilled nursing care</u>	No charge	Not covered	100 days/year
	<u>Durable medical equipment</u>	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	Not covered	None
	<u>Hospice services</u>	No charge; <u>deductible</u> does not apply	Not covered	For inpatient services, see “If you have a hospital stay”.

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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 your child needs dental or eye care	Children's eye exam	\$10 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	1 exam/year
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up – Up to age of 13	No charge; <u>deductible</u> does not apply	No charge; <u>deductible</u> does not apply	2 exams/year
Excluded Services & Other Covered Services:				
Services Your <u>Plan</u> Does NOT Cover (This isn't a complete list. Check your policy or <u>plan</u> document for other <u>excluded services</u>.)				
<ul style="list-style-type: none"> • Infertility Treatment • Long-Term (Custodial) Care 		<ul style="list-style-type: none"> • Most Cosmetic Surgery • Most Dental Care (Adult) • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • 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 <u>plan</u> document for other covered services and your costs for these services.)				
<ul style="list-style-type: none"> • Acupuncture - 20 visits/year • Bariatric surgery 		<ul style="list-style-type: none"> • Chiropractic Care - 12 visits/year • Hearing Aids - to \$1,500 / aid every 60 months, for each impaired ear 	<ul style="list-style-type: none"> • Routine eye care (Adult) – 1 exam/year 	

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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
Harvard Pilgrim Health Care of
New England, 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

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

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. —————

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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	\$1,000	■ The plan's overall deductible	\$1,000	■ The plan's overall deductible	\$1,000
■ Specialist copayment	\$10	■ Specialist copayment	\$10	■ Specialist copayment	\$10
■ Hospital (facility)	\$0	■ Hospital (facility)	\$0	■ Hospital (facility)	\$0
■ Other	\$0	■ Other	\$0	■ Other	\$0
This EXAMPLE event includes services like:		This EXAMPLE event includes services like:		This EXAMPLE event includes services like:	
Specialist office visits (<i>prenatal care</i>)		Primary care physician office visits (<i>including disease education</i>)		Emergency room care (<i>including medical supplies</i>)	
Childbirth/Delivery Professional Services		Diagnostic tests (<i>blood work</i>)		Diagnostic test (<i>x-ray</i>)	
Childbirth/Delivery Facility Services		Prescription drugs		Durable medical equipment (<i>crutches</i>)	
Diagnostic tests (<i>ultrasounds and blood work</i>)		Durable medical equipment (<i>glucose meter</i>)		Rehabilitation services (<i>physical therapy</i>)	
Specialist visit (<i>anesthesia</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>	
<u>Deductibles</u>	\$1,000	<u>Deductibles</u>	\$0	<u>Deductibles</u>	\$590
<u>Copayments</u>	\$80	<u>Copayments</u>	\$1,540	<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$0	<u>Coinsurance</u>	\$0	<u>Coinsurance</u>	\$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	\$1,080	The total Joe would pay is	\$1,570	The total Mia would pay is	\$680

The **plan** would be responsible for the other costs of these EXAMPLE covered services.