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New Hampshire

The Harvard Pilgrim Best Buy HMO — LP

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 deductible?	$1,000 member/ $3,000 family	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.
Are there services covered before you meet your deductible?	Yes: **preventive care**, **provider** office visits, services from Select LP Providers, **emergency room care**, outpatient mental health services, **habilitation services**, **rehabilitation services**, routine eye exams, are covered before you meet your **deductible**.	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.
Are there other deductibles for specific services?	Yes. **Durable Medical Equipment Deductible:** $100 member There are no other specific **deductibles**	You must pay all of the costs for these services up to the specific **deductible** amount before this **plan** begins to pay for these services.
What is the out–of–pocket limit for this plan?	$2,500 member/ $5,000 family Separate **out-of-pocket limit** applies to Pharmacy, see "If you need drugs to treat your illness or condition".	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?	Prescription drugs, **premiums**, **balance-billing** 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.providerlookuponline.com/harvardpilgrim/po7/Search.aspx** 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 **copayments** and **coinsurance** cost shown in this chart after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 **copay**/visit; **deductible** does not apply	Not covered	None
	Specialist visit	$25 **copay**/visit; **deductible** does not apply	Not covered	None
	Preventive care/ **screening**/ **immunization**	No charge; **deductible** does not apply	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 have a test	**Diagnostic test** (x-ray, blood work)	**X-rays:** No charge **Laboratory: Select LP Providers:** No charge; **deductible** 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.
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 **copay**/prescription; **deductible** does not apply **90-Day Mail Tier 1:** $10 **copay**/prescription; **deductible** does not apply		Prescription drug **Out-of-Pocket Maximum**:. $4,000 member/ $8,000 family
	Preferred brand drugs	**30-Day Retail Tier 2:** $30 **copay**/prescription; **deductible** does not apply **90-Day Mail Tier 2:** $30 **copay**/prescription; **deductible** does not apply		Some generic drugs are in this tier.
	Non-preferred brand drugs	**30-Day Retail Tier 3:** $50 **copay**/prescription; **deductible** does not apply **90-Day Mail Tier 3:** $50 **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.

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**Select LP Providers:** No charge; **deductible** does not apply **Other Plan Providers:** No charge	Not covered	None
	Physician/surgeon fees	**Select LP Providers:** No charge; **deductible** does not apply **Other Plan Providers:** No charge	Not covered	
If you need immediate medical attention	**Emergency room care**	$150 **copay**/visit; **deductible** does not apply	Same As Participating **Provider**	None
	Emergency medical transportation	No charge	Same As Participating **Provider**	None
	Urgent care	**Convenience care clinic:** $25 **copay**/visit; **deductible** does not apply **Urgent care clinic:** $25 **copay**/visit; **deductible** does not apply **Hospital Urgent care clinic:** $75 **copay**/visit; **deductible** does not apply	**Convenience care clinic:** Not covered **Urgent care clinic:** Not covered **Urgent care hospital facility:** Same As Participating **Provider**	Services with non-participating providers are only covered outside of the service area.
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	$25 **copay**/visit; **deductible** does not apply	Not covered	None
	Inpatient services	No charge; **deductible** does not apply	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 are pregnant	Office visits	$25 **copay**/visit; **deductible** 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	**Home health care**	No charge; **deductible** does not apply	Not covered	None
	Rehabilitation services	$25 **copay**/visit; **deductible** does not apply	Not covered	Occupational, physical & speech therapy – 60 combined visits /year
	Habilitation services	$25 **copay**/visit; **deductible** does not apply	Not covered	
	Skilled nursing care	No charge	Not covered	100 days/year combined with Inpatient Rehabilitation services.
	Durable medical equipment	20% **coinsurance**	Not covered	None
	Hospice services	No charge; **deductible** does not apply	Not covered	For inpatient services, see "If you have a hospital stay".
If your child needs dental or eye care	Children's eye exam	$25 **copay**/visit; **deductible** does not apply	Not covered	1 exam/year
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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.)

• Infertility Treatment	• Most Cosmetic Surgery • Most Dental Care (Adult)	• Private-duty nursing • Routine foot care

• Long-Term (Custodial) Care	• Non-emergency care when traveling outside the U.S.	• 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 - 20 visits/year • Bariatric surgery	• Chiropractic Care - 12 visits/year • Hearing Aids - to $1,500 / aid every 60 months, for each impaired ear	• Routine eye care (Adult) – 1 exam/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
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.

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**	$1,000
■ **Specialist *copayment***	$25
■ **Hospital (facility)**	$0
■ **Other**	$0

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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$80
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,080**

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

■ **The plan's overall deductible**	$1,000
■ **Specialist *copayment***	$25
■ **Hospital (facility)**	$0
■ **Other**	$0

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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,690
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$1,720**

Mia's Simple Fracture (in-network emergency room visit and follow up care)

■ **The plan's overall deductible**	$1,000
■ **Specialist *copayment***	$25
■ **Hospital (facility)**	$0
■ **Other**	$0

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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,100
Copayments	$130
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,250**

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