

	<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/LGsampEoC. 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>
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Important Questions	Answers	Why This Matters
What is the overall deductible?	In-Network: \$2,500 member/ \$5,000 family Out-of-Network: \$5,000 member/ \$10,000 family Benefits are administered on a calendar year basis.	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: In-Network emergency medical transportation , 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 .	This plan covers some items and services even if you haven't yet met the deductible amount. But, a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services
What is the out-of-pocket limit for this plan?	In-Network: \$4,500 member/ \$9,000 family Out-of-Network: \$9,000 member / \$18,000 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 for 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 <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.harvardpilgrim.org/public/find-a-provider or call 1-888-333-4742 for a list of <u>network 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 <u>plan's 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	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>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.
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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 visit a health care <u>provider</u> 's office or clinic	Primary care visit to treat an injury or illness	Level 1: \$35 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	No <u>copay</u> for the first office visit/Member.
	<u>Specialist</u> visit	Level 1: \$35 <u>copay</u> /visit; <u>deductible</u> does not apply Level 2: \$50 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> / <u>immunization</u>	No charge; <u>deductible</u> does not apply	50% <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 <u>plan</u> will pay for.

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: 30% coinsurance Laboratory: 30% coinsurance	X-rays: 50% coinsurance Laboratory: 50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% 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/2026Select4T Please note: This prescription drug formulary is Pending Regulatory Approval	Generic drugs	30-Day Retail Tier 1: \$10 copay /prescription; deductible does not apply 90-Day Mail Tier 1: \$20 copay /prescription; deductible does not apply	30-Day Retail Tier 1: \$10 copay /prescription; deductible does not apply 90-Day Mail Tier 1: \$20 copay /prescription; deductible does not apply	Select formulary - covers a limited list; not all drugs are covered. You pay retail price for Out of Network pharmacy drugs and are reimbursed minus applicable cost sharing . Covered only outside of service area. Prescription drug Out-of-Pocket Maximum : \$1,000 member/ \$2,000 family
	Preferred brand drugs	30-Day Retail Tier 2: \$20 copay /prescription; deductible does not apply 90-Day Mail Tier 2: \$40 copay /prescription; deductible does not apply	30-Day Retail Tier 2: \$20 copay /prescription; deductible does not apply 90-Day Mail Tier 2: \$40 copay /prescription; deductible does not apply	
	Non-preferred brand drugs	30-Day Retail Tier 3: \$30 copay /prescription; deductible does not apply 90-Day Mail Tier 3: \$60 copay /prescription; deductible does not apply	30-Day Retail Tier 3: \$30 copay /prescription; deductible does not apply 90-Day Mail Tier 3: \$60 copay /prescription; deductible does not apply	

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)	
	<u>Specialty drugs</u>	30-Day Retail Tier 3: \$30 <u>copay</u> /prescription; <u>deductible</u> does not apply 90-Day Mail Tier 3: \$60 <u>copay</u> /prescription; <u>deductible</u> does not apply 30-Day Retail Tier 4: \$50 <u>copay</u> /prescription; <u>deductible</u> does not apply 90-Day Mail Tier 4: \$100 <u>copay</u> /prescription; <u>deductible</u> does not apply	30-Day Retail Tier 3: \$30 <u>copay</u> /prescription; <u>deductible</u> does not apply 90-Day Mail Tier 3: \$60 <u>copay</u> /prescription; <u>deductible</u> does not apply 30-Day Retail Tier 4: \$50 <u>copay</u> /prescription; <u>deductible</u> does not apply 90-Day Mail Tier 4: \$100 <u>copay</u> /prescription; <u>deductible</u> does not apply	Some drugs must be obtained through a Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Out-of-Network <u>preauthorization</u> required. \$500 penalty if not obtained.
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	30% <u>coinsurance</u>		None
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u> ; <u>deductible</u> does not apply		None
	<u>Urgent care</u>	Urgent care center: \$50 <u>copay</u> /visit; <u>deductible</u> does not apply	Urgent care center: 50% <u>coinsurance</u>	<u>Cost sharing</u> may vary based on location.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Out-of-Network <u>preauthorization</u> required. \$500 penalty if not obtained.
	Physician/surgeon fee	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	No <u>copay</u> for the first mental health/substance abuse visit/Member.
	Inpatient services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	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 are pregnant	Office visits	\$35 copay /visit; deductible does not apply	50% coinsurance	Cost sharing does not apply for preventive services (such as routine prenatal visits).
	Childbirth/delivery professional services	No charge; deductible does not apply	50% coinsurance	
	Childbirth/delivery facility services	No charge; deductible does not apply	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	None
	Rehabilitation services	Physical Therapy: \$35 copay /visit; deductible does not apply	Physical Therapy: 50% coinsurance	Occupational, physical & speech therapy – 60 combined visits /calendar year Out-of-Network preauthorization required. \$500 penalty if not obtained.
	Habilitation services	Occupational Therapy: \$35 copay /visit; deductible does not apply Speech Therapy: \$35 copay /visit; deductible does not apply	Occupational Therapy: 50% coinsurance Speech Therapy: 50% coinsurance	
	Skilled nursing care	30% coinsurance	50% coinsurance	
	Durable medical equipment	30% coinsurance	50% coinsurance	
	Hospice services	30% coinsurance	50% coinsurance	For inpatient see “If you have a hospital stay”
	Children’s eye exam	\$35 copay /visit; deductible does not apply	50% coinsurance	1 exam/calendar year
If your child needs dental or eye care	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.)

• Children's glasses	• Dental Care (Adult)	• Routine foot care (except for diabetes or systemic circulatory diseases)
• Cosmetic Surgery	• Long-Term Care	• Services that are not Medically Necessary
	• Non-emergency care when traveling outside the U.S.	• Weight Loss Programs
	• Private-duty nursing	

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/calendar year	• Chiropractic Care - 40 visits/calendar year	• Infertility Treatment
• Bariatric surgery	• Hearing Aids - \$3,000/aid every 36 months, for each impaired ear	• Routine eye care (Adult) – 1 exam/calendar 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 Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Centers for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.ccio.cms.gov, or for more information on your rights to continue coverage, you can contact the Member Service number listed on your ID card or call 1-888-333-4742. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](http://HealthInsuranceMarketplace.gov). For more information about the [Marketplace](http://Marketplace.gov), 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 on how 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, Inc.
1 Wellness Way
Canton, MA 02021-1166
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

Consumer for Affordable Health Care
12 Church Street, PO Box 2409
Augusta, Maine 04338-2490
1-800-965-7476
www.mainecahc.org
consumerhealth@mainecahc.org

Maine Bureau of Insurance
34 State House
Station Augusta, ME 04333
1-207-624-8475
1-800-300-5000

Does this plan 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](#).

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

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 section.](#)

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	\$2,500
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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 \$12,700

In this example, Peg would pay:

Cost Sharing
Deductibles \$1,300
Copayments \$0
Coinsurance \$0

What isn't covered

Limits or exclusions \$0

The total Peg would pay is \$1,300

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

■ The plan's overall deductible	\$2,500
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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 \$5,600

In this example, Joe would pay:

Cost Sharing
Deductibles \$100
Copayments \$300
Coinsurance \$0

What isn't covered

Limits or exclusions \$0

The total Joe would pay is \$400

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

■ The plan's overall deductible	\$2,500
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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 \$2,800

In this example, Mia would pay:

Cost Sharing
Deductibles \$900
Copayments \$200
Coinsurance \$300

What isn't covered

Limits or exclusions \$0

The total Mia would pay is \$1,400

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 (телефон: 711).

(Arabic)

اتباع: إذا كنت تتكلم اللغة العربية ، خدمات المساعدة اللغوية متوفرة لك مجاناً. اتصل على 1 888-333-4742 (TTY: 711)

ខ្មែរ (Cambodian) សូមចូលចិត្តលើខ្លួន: បើអ្នកនឹងបាយភាសាខ្មែរ; ឱ្យខ្លួនសេវាកម្មបញ្ជីប្រចាំថ្ងៃ ចូលរួមការអ្នកបាយភាសាខ្មែរ។ ចូលទូរសព្ទ 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).

 Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of New England and HPHC Insurance Company. (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 સહય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 1-888-333-4742 (TTY: 711)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາວົາ ວາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາວົາ, ໂດຍບໍ່ເສັງຄ່າ, ເມັນມີຜ້ອມໃຫ້ທ່ານ. ໂທ 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).



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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 (including pregnancy, sexual orientation, and gender identity). HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

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 (including pregnancy, sexual orientation, and gender identity), you can file a grievance with: Civil Rights Compliance Officer, 1 Wellness Way, Canton, MA 02021-1166, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@point32health.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>.



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