Harvard Pilgrim Health Care

Massachusetts

The Harvard Pilgrim Independence℠ POS

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: POS

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**. 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.harvardpilgrim.org/fhcr** or call **1-888-333-4742** to request a copy.

Important Questions	Answers	Why this matters
What is the overall deductible?	**In-Network:** $500 member / $1,000 family **Out-of-Network:** $500 member / $1,000 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 **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your deductible?	Yes. **Emergency room care**, **emergency medical transportation**, prescription drugs, and the following In-Network services: **preventive care**, **provider** office visits, imaging, outpatient surgery, inpatient hospital stays, mental health, **rehabilitation services**, and **habilitation services** are covered before you meet your **deductible**.	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But, a **copayment** or **coinsurance** may apply.
Are there other deductibles for specific services?	Yes. **Prescription Drug Deductible:** $100 member / $200 family There are no other specific **deductibles**.	You don't have to meet **deductibles** for specific services
What is the out–of–pocket limit for this plan?	**In-Network:** $5,000 member / $10,000 family **Out-of-Network:** $5,000 member / $10,000 family	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 family **out-of-pocket limit** has been met.

Important Questions	Answers	Why this matters
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain preauthorization for services 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 **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.

Copayments and coinsurance cost shown in this chart are both before and after your deductible has been met, if a deductible 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 provider's office or clinic	Primary care visit to treat an injury or illness	**Level 1:** $10 copay/ visit **Level 2:** $20 copay/ visit **Level 3:** $40 copay/ visit Deductible does not apply.	20% coinsurance	None
	Specialist visit	**Level 1:** $30 copay/ visit **Level 2:** $60 copay/ visit **Level 3:** $90 copay/ visit Deductible does not apply.	20% coinsurance	None
	Preventive care/screening/ immunization	No charge; deductible does not apply.	20% coinsurance	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)	No charge	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$100 copay/ scan	20% coinsurance	Participating Providers limited to a maximum of one copay/ Member/ day. **Out-of-Network** preauthorization required. Penalty lesser of $500 if approval not received before services obtained.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at **www.harvardpilgrim.org/ 2017Value3T**.	Generic drugs	**30-Day Retail Tier 1:** $10 copay/ prescription **90-Day Mail Tier 1:** $25 copay/ prescription		Value formulary - covers a limited list; not all drugs are covered.
	Preferred brand drugs	**30-Day Retail Tier 2:** $30 copay/ prescription **90-Day Mail Tier 2:** $75 copay/ prescription		Some generic drugs are in this tier.
	Non-preferred brand drugs	**30-Day Retail Tier 3:** $65 copay/ prescription **90-Day Mail Tier 3:** $165 copay/ prescription		Same as above.
	Specialty drugs	All drugs are covered in Retail Pharmacy and Mail Order Pharmacy Tiers 1 - 3		Must be obtained through a Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay/ visit	20% coinsurance	Up to four Surgical Day Care Copays/ member/ year.
	Physician/surgeon fees	No charge	20% coinsurance	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 need immediate medical attention	Emergency room care	$100 copay/ visit	Same As Participating Provider	None
	Emergency medical transportation	No charge	Same As Participating Provider	None
	Urgent care	**Convenience care clinic:** $10 copay/ visit **Urgent care clinic (including hospital urgent care clinic):** $20 copay/ visit Deductible does not apply.	**Convenience care clinic:** 20% coinsurance **Urgent care clinic (including hospital urgent care clinic):** 20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	**Tier 1:** $275 copay/ admit **Tier 2:** $500 copay/ admit **Tier 3:** $1,500 copay/ admit	20% coinsurance	Up to one Medical or Mental Health & Substance Abuse Hospital Inpatient Copay/ Member each Quarter.
	Physician/surgeon fee	No charge	20% coinsurance	None
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$10 copay/ visit; deductible does not apply.	20% coinsurance	None
	Inpatient services	$275 copay/ admit; deductible does not apply.	20% coinsurance	Up to one Medical or Mental Health & Substance Abuse Hospital Inpatient Copay/ Member each Quarter.

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	**Level 1:** $10 copay/ visit **Level 2:** $20 copay/ visit **Level 3:** $40 copay/ visit Deductible does not apply.	20% coinsurance	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	20% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Up to one Medical or Mental Health & Substance Abuse Hospital Inpatient Copay/ Member each Quarter.
	Childbirth/delivery facility services	**Tier 1:** $275 copay/ admit **Tier 2:** $500 copay/ admit **Tier 3:** $1,500 copay/ admit	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	None
	Rehabilitation services	**Physical & Occupational Therapy:** $20 copay/ visit **Speech Therapy:** No charge Deductible does not apply.	20% coinsurance	Physical & Occupational Therapy – 90 consecutive days/ illness or injury
	Habilitation services	**Physical & Occupational Therapy:** $20 copay/ visit **Speech Therapy:** No charge Deductible does not apply.	20% coinsurance	

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)	
	Skilled nursing care	20% coinsurance	20% coinsurance	– 45 days/ year
	Durable medical equipment	No charge	20% coinsurance	None
	Hospice services	No charge	20% coinsurance	For inpatient services, see "If you have a hospital stay".
If your child needs dental or eye care	Children's eye exam	**Optometrist:** $20 copay/ visit **Ophthalmologists:** **Level 1:** $30 copay/ visit **Level 2:** $60 copay/ visit **Level 3:** $90 copay/ visit Deductible does not apply.	20% coinsurance	– 1 exam every 24 months
	Children's glasses	Not covered		None
	Children's dental check-up	Not covered		None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Long-Term (Custodial) Care
- Most Cosmetic Surgery
- Most Dental Care (Adult)
- Private-duty nursing
- Routine foot care
- Services that are not Medically Necessary
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic Care - 20 visits/ year
- Hearing Aids - $2,000/ hearing aid every 36 months/ impaired ear up to age 22
- Hearing Aids - up to $1,700 every 2 years for age 22 or older
- Infertility Treatment - 5 cycles advanced reproductive technology/ lifetime
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) - 1 exam every 24 months

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, 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

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**	$600
■ **Specialist *copayment***	$30
■ **Hospital (facility) *copayment***	$275
■ **Other *copayment***	$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	$600
Copayments	$280
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$880**

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
■ **The plan's overall deductible**	$600
■ **Specialist *copayment***	$30
■ **Hospital (facility) *copayment***	$275
■ **Other *copayment***	$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	$320
Copayments	$1,540
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$1,890**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ **The plan's overall deductible**	$600
■ **Specialist *copayment***	$30
■ **Hospital (facility) *copayment***	$275
■ **Other *copayment***	$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	$500
Copayments	$120
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$620**

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

Language Assistance Services

Espai'iol (Spanish) ATENCI6N: Si usted habla espanol, servicios de asistencia lingi.iistica,de forma gratuita, estan a su disposici6n. Llame al1-888-333-4742 (TIY: 711).

Portugues (Portuguese) ATEN<;AO:Se voce tala portugues,encontram-se disponiveis servi os linguisticos gratuitos. Ligue para 1-888-333-4742 (TIY: 711).

KreyolAyisyen (French Creole) ATANSYON: Si nou pale Kreyol Ayisyen,gen asistans pou sevis kidisponib nan lang nou pou gratis. Rele 1-888-333-4742 (TIY: 711).

•BEPX (TraditionalChinese) ī ī : ru1 1 f.fm ltlcp)t , 1_ fiiJJ;t ft gtillMii0 iU:U 1-888-333-4742 (nv : 111) 。

Tieng Vit (Vietnamese) CHU Y: Neu quivi n6i Tieng Vi t, dich vv thong dich cua chung toi sn sang phvc vv quivj mien phi. GQi so1-888-333-4742 (TIY: 711).

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Franis (French) ATIENTION: Si vous parlez fran ais,des services d'aide linguistique vous sont proposes gratuitement. Appelez le 1-888-333-4742 (ATS: 711).

Italiano (Italian) ATIENZIONE: In caso la lingua parlata si a l'italiano,sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-333-4742 (TIY: 711).

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Polski (Polish) UWAGA: Jezeli mowisz po polsku,mozesz skorzystac z bezptatnej pomocy j zykowej. Zadzwon pod numer 1-888-333-4742 (TTY: 711).

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AlTENrlON: If you speak a language other than English, language assistance services, free of charge, arc available to you. Call 1-888-333-4742 (lTY: 711).

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

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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, 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.

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