

## The Harvard Pilgrim Primary Choice 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](http://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](http://www.harvardpilgrim.org/fhcr) or call 1-888-333-4742 to request a copy.

Important Questions	Answers	Why this matters
What is the overall <a href="#">deductible</a> ?	\$500 member / \$1,000 family	Generally you must pay all the costs up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> , <a href="#">provider</a> office visits, prescription drugs, imaging, outpatient surgery, <a href="#">emergency room care</a> , <a href="#">emergency medical transportation</a> , inpatient hospital stays, mental health, <a href="#">rehabilitation services</a> , and <a href="#">habilitation services</a> are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But, a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.
Are there other <a href="#">deductibles</a> for specific services?	Yes. <b>Prescription Drug Deductible:</b> \$100 member / \$200 family There are no other specific <a href="#">deductibles</a> .	You don't have to meet <a href="#">deductibles</a> for specific services
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$5,000 member / \$10,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year of covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limit</a> until family <a href="#">out-of-pocket limit</a> 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> ?	Premiums, balance-billed charges, and health care this plan 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 <a href="http://www.providerlookuponline.com/harvardpilgrim/po7/Search.aspx">www.providerlookuponline.com/harvardpilgrim/po7/Search.aspx</a> 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> .



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 <u>provider</u> 's office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> / visit; <u>deductible</u> does not apply.	Not covered	None
	<u>Specialist</u> visit	Level 1: \$30 <u>copay</u> / visit Level 2: \$60 <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

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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)	
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$100 <a href="#">copay</a> / scan	Not covered	Participating Providers limited to a maximum of one <a href="#">copay</a> / Member/ day.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.harvardpilgrim.org/2017Value3T">www.harvardpilgrim.org/2017Value3T</a> .	Generic drugs	<b>30-Day Retail Tier 1:</b> \$10 <a href="#">copay</a> / prescription <b>90-Day Mail Tier 1:</b> \$25 <a href="#">copay</a> / prescription		Value formulary - covers a limited list; not all drugs are covered.
	Preferred brand drugs	<b>30-Day Retail Tier 2:</b> \$30 <a href="#">copay</a> / prescription <b>90-Day Mail Tier 2:</b> \$75 <a href="#">copay</a> / prescription		Some generic drugs are in this tier.
	Non-preferred brand drugs	<b>30-Day Retail Tier 3:</b> \$65 <a href="#">copay</a> / prescription <b>90-Day Mail Tier 3:</b> \$165 <a href="#">copay</a> / prescription		Same as above.
	<a href="#">Specialty drugs</a>	All drugs are covered in Retail Pharmacy and Mail Order Pharmacy Tiers 1 - 3		Must be obtained through a Specialty Pharmacy.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$250 <a href="#">copay</a> / visit	Not covered	Up to four Surgical Day Care <a href="#">Copays</a> / member/ year.
	Physician/surgeon fees	No charge	Not covered	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$100 <a href="#">copay</a> / visit	Same As Participating <a href="#">Provider</a>	None
	<a href="#">Emergency medical transportation</a>	No charge	Same As Participating <a href="#">Provider</a>	None
	<a href="#">Urgent care</a>	<b>Convenience care clinic:</b> \$10 <a href="#">copay</a> / visit <b>Urgent care clinic (including hospital urgent care clinic):</b> \$20 <a href="#">copay</a> / visit <a href="#">Deductible</a> does not apply.	<b>Convenience care clinic:</b> \$10 <a href="#">copay</a> / visit <b>Urgent care clinic (including hospital urgent care clinic):</b> \$20 <a href="#">copay</a> / visit <a href="#">Deductible</a> does not apply.	None

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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)	<b>Tier 1:</b> \$275 <a href="#">copay</a> /admit <b>Tier 2:</b> \$500 <a href="#">copay</a> /admit	Not covered	Up to one Medical or Mental Health & Substance Abuse Hospital Inpatient <a href="#">Copay</a> /Member each Quarter.
	Physician/surgeon fee	No charge	Not covered	None
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	\$20 <a href="#">copay</a> / visit; <a href="#">deductible</a> does not apply.	Not covered	None
	Inpatient services	\$275 <a href="#">copay</a> / admit; <a href="#">deductible</a> does not apply.	Not covered	Up to one Medical or Mental Health & Substance Abuse Hospital Inpatient <a href="#">Copay</a> /Member each Quarter.
If you are pregnant	Office visits	\$20 <a href="#">copay</a> / visit; <a href="#">deductible</a> does not apply	Not covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	No charge	Not covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . 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 <a href="#">Copay</a> /Member each Quarter.
	Childbirth/delivery facility services	<b>Tier 1:</b> \$275 <a href="#">copay</a> /admit <b>Tier 2:</b> \$500 <a href="#">copay</a> /admit	Not covered	

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	Not covered	None
	<a href="#">Rehabilitation services</a>	Physical & Occupational Therapy: \$20 <a href="#">copay</a> /visit Speech Therapy: No charge <a href="#">Deductible</a> does not apply.	Not covered	Physical & Occupational Therapy – 90 consecutive days/ illness or injury
	<a href="#">Habilitation services</a>	Physical & Occupational Therapy: \$20 <a href="#">copay</a> /visit Speech Therapy: No charge <a href="#">Deductible</a> does not apply.	Not covered	
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	Not covered	– 45 days/ year
	<a href="#">Durable medical equipment</a>	No charge	Not covered	None
	<a href="#">Hospice services</a>	No charge	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	<b>Optometrist:</b> \$20 <a href="#">copay</a> / visit <b>Ophthalmologists:</b> <b>Level 1:</b> \$30 <a href="#">copay</a> / visit <b>Level 2:</b> \$60 <a href="#">copay</a> / visit <a href="#">Deductible</a> does not apply.	Not covered	– 1 exam every 24 months
	Children’s glasses	Not covered		None
	Children’s dental check-up	Not covered		None
<b>Excluded Services &amp; Other Covered Services:</b>				
<b>Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a>.)</b>				
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Long-Term (Custodial) Care</li><li>• Most Cosmetic Surgery</li></ul>	<ul style="list-style-type: none"><li>• Most Dental Care (Adult)</li><li>• Non-emergency care when traveling outside the U.S.</li><li>• Private-duty nursing</li></ul>	<ul style="list-style-type: none"><li>• Routine foot care</li><li>• Services that are not Medically Necessary</li><li>• Weight Loss Programs</li></ul>		
<b>Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your <a href="#">plan</a> document.)</b>				
<ul style="list-style-type: none"><li>• Bariatric surgery</li><li>• Chiropractic Care - 20 visits/ year</li></ul>	<ul style="list-style-type: none"><li>• Hearing Aids - \$2,000/ hearing aid every 36 months/ impaired ear up to age 22</li><li>• Hearing Aids - up to \$1,700 every 2 years for age 22 or older</li></ul>	<ul style="list-style-type: none"><li>• Infertility Treatment - 5 cycles advanced reproductive technology/ lifetime</li><li>• Routine eye care (Adult) - 1 exam every 24 months</li></ul>		

## 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](http://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](http://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](http://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](http://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. —————

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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	\$600	■ The plan's overall deductible	\$600	■ The plan's overall deductible	\$600
■ Specialist <a href="#">copayment</a>	\$30	■ Specialist <a href="#">copayment</a>	\$30	■ Specialist <a href="#">copayment</a>	\$30
■ Hospital (facility) <a href="#">copayment</a>	\$275	■ Hospital (facility) <a href="#">copayment</a>	\$275	■ Hospital (facility) <a href="#">copayment</a>	\$275
■ Other <a href="#">copayment</a>	\$0	■ Other <a href="#">copayment</a>	\$0	■ Other <a href="#">copayment</a>	\$0
<b>This EXAMPLE event includes services like:</b>		<b>This EXAMPLE event includes services like:</b>		<b>This EXAMPLE event includes services like:</b>	
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> )					
<b>Total Example Cost</b>	<b>\$12,731</b>	<b>Total Example Cost</b>	<b>\$7,389</b>	<b>Total Example Cost</b>	<b>\$1,925</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$600	<a href="#">Deductibles</a>	\$320	<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$280	<a href="#">Copayments</a>	\$1,620	<a href="#">Copayments</a>	\$120
<a href="#">Coinsurance</a>	\$0	<a href="#">Coinsurance</a>	\$0	<a href="#">Coinsurance</a>	\$0
<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
<b>The total Peg would pay is</b>	<b>\$880</b>	<b>The total Joe would pay is</b>	<b>\$1,970</b>	<b>The total Mia would pay is</b>	<b>\$620</b>

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 (TIY: 711).

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**Portugues (Portuguese)** ATENÇÃO: Se você fala português, encontramos-se disponíveis serviços linguísticos gratuitos. Ligue para 1-888-333-4742 (TIY: 711).

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**Kreyol Ayisyen (French Creole)** ATANSYON: Sinou pale Kreyol Ayisyen, gen asistans pou sevis ki disponib nan lang nou pou gratis. Rele 1-888-333-4742 (TIY: 711).

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**•BEPX (Traditional Chinese)** 請打 1-888-333-4742 (TIY: 711)。

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**Tiếng Việt (Vietnamese)** CHÚ Ý: Nếu bạn nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ miễn phí. Gọi 1-888-333-4742 (TIY: 711).

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**Русский (Russian)** Внимание: Если вы говорите по-русски, мы предоставляем бесплатные услуги по переводу. Позвоните по номеру 1-888-333-4742 (TIY: 711).

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(TIY: 711)

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**ខ្មែរ (Cambodian)** សូម ទាក់ទង 1-888-333-4742 (TIY: 711)។

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**Français (French)** ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-333-4742 (ATS: 711).

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**Italiano (Italian)** ATENZIONE: In caso la lingua parlata sia 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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AITENrION: If you speak a language other than English, language assistance services, free of charge, are  
available to you. Call 1-888-333-4742 (TY: 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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## 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. HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

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](mailto: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/portals/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>.

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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