HPHC Insurance Company

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Harvard Pilgrim Access America

Coverage Period: 07/01/2024 — 06/30/2025
Coverage for: Individual + Family | Plan Type: PPO

⚠	**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.healthcare.gov/sbc-glossary** or call **1-844-442-7324** 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 of the costs from **providers** 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. The following In-Network services: **preventive care**, **provider** office visits, 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. 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?	Yes. Prescription Drug **Deductible**: $100 member / $200 family 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?	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 for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** 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?	Premiums, balance-billing 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. This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See **https://www.harvardpilgrim.org/public/find-a-provider** or call **1-844-442-7324** for a list of network 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?	No.	You can see the specialist you choose without a referral.

	All copayment and coinsurance costs shown in this chart are both before 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	$20 copay/ visit; deductible does not apply	20% coinsurance	None
	Specialist visit	$45 copay/ visit; deductible does not apply	20% coinsurance	None
	Preventive care/ screening/ immunization	No charge; deductible does not apply	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan 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: No charge Laboratory: No charge	X-rays: 20% coinsurance Laboratory: 20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$100 copay/ scan	20% coinsurance	Participating Providers limited to a maximum of 1 copay/ Member/ day. 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 **https://info.caremark.com/oe/gic**.	Generic drugs	Retail: $10 copay after deductible Maintenance 90/Mail Order: $25 copay after deductible	Not covered	Prescription drug coverage is administered by NEWPBM. For additional information, visit **https://info.caremark.com/oe/gic** or call Customer Service at **1-877-876-7214 (TTY 711)**. Retail cost share is up to a 30-day supply; mail order cost share is up to a 90-day supply. Some drugs require prior authorization. Some drugs are subject to quantity limitations. A 90-day supply of maintenance medications may be obtained at a CVS Pharmacy for the applicable mail order copay. If a drug has a generic equivalent, and you buy the brand name (even if your physician indicates no substitutions), you will pay the generic-level copay plus the cost difference between the generic and the brand name drug.
	Preferred brand drugs	Retail: $30 copay after deductible Maintenance 90/Mail Order: $75 copay after deductible	Not covered	You pay retail price for Out of Network pharmacy drugs and are reimbursed minus applicable cost sharing. Covered only outside of service area.
	Non-preferred brand drugs	Retail: $65 copay after deductible Maintenance 90/Mail Order: $165 copay after deductible	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)	
	Specialty drugs	Limited to a 30-day supply with appropriate tier copay (see above) when purchased at a designated specialty pharmacy	Not covered	Must be obtained at a designated specialty pharmacy. Some drugs require prior authorization. Some drugs are subject to quantity limitations. Some specialty drugs may also be covered under your medical benefit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay/ visit	20% coinsurance	4 Surgical Day Care Copays/ member/ year. Out-of-Network preauthorization required. $500 penalty if not obtained
	Physician/surgeon fees	No charge	20% coinsurance	
If you need immediate medical attention	Emergency room care	$100 copay/ visit		Copay waived if admitted
	Emergency medical transportation	No charge		None
	Urgent care	Urgent care center: $20 copay/ visit; deductible does not apply	Urgent care center: 20% coinsurance	Cost sharing may vary based on Urgent Care location.
If you have a hospital stay	Facility fee (e.g., hospital room)	$275 copay/ admit	20% coinsurance	1 Medical or Mental Health/Substance Abuse Hospital Inpatient Copay/ Member each Quarter. Out-of-Network preauthorization required. $500 penalty if not obtained
	Physician/surgeon fee	No charge	20% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/ visit; deductible does not apply	20% coinsurance	$0 copay for first three Mental Health, Behavioral Health/Substance Abuse telehealth visits. Out-of-Network preauthorization required. $200 penalty if not obtained
	Inpatient services	$275 copay/ admit; deductible does not apply	20% coinsurance	1 Medical or Mental Health/Substance Abuse Hospital Inpatient Copay/ Member each Quarter. Out-of-Network preauthorization required. $200 penalty if not obtained

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	$20 copay/ visit; deductible does not apply	20% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No charge	20% coinsurance	None
	Childbirth/delivery facility services	$275 copay/ admit	20% coinsurance	**1** Medical or Mental Health/Substance Abuse Hospital Inpatient Copay/ Member each Quarter.
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	None
	Rehabilitation services Habilitation services	Physical Therapy: $20 copay/ visit; deductible does not apply Occupational Therapy: $20 copay/ visit; deductible does not apply Speech Therapy: $20 copay/ visit; deductible does not apply	Physical Therapy: 20% coinsurance Occupational Therapy: 20% coinsurance Speech Therapy: 20% coinsurance	Physical Therapy - 30 visits/ Plan Year Occupational Therapy - 30 visits/ Plan Year Out-of-Network preauthorization required. $500 penalty if not obtained
	Skilled nursing care	20% coinsurance	20% coinsurance	- 100 days/ Plan Year
	Durable medical equipment	20% coinsurance	20% coinsurance	Out-of-Network preauthorization required. $500 penalty if not obtained
	Hospice services	No charge	20% coinsurance	For inpatient see "If you have a hospital stay"
If your child needs dental or eye care	Children's eye exam	Optometrist: $20 copay/ visit; deductible does not apply Ophthalmologists: $45 copay/ visit; deductible does not apply	Optometrist: 20% coinsurance Ophthalmologists: 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 Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Cosmetic Surgery • Dental Care (Adult)	• Long-Term Care • Private-duty nursing	• Routine foot care (except for diabetes or systemic circulatory diseases) • Services that are not Medically Necessary

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 - only for detoxification for Substance Use Disorder • Bariatric surgery • Chiropractic Care - 20 visits/ year	• Hearing Aids - $2,000/ hearing aid every 24 months/ impaired ear up to age 22 • Hearing Aids - up to $1,700 every 24 months/ impaired ear 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 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, Center for Consumer Information and Insurance Oversight, at **1-877-267-2323 x61565** or **www.cciio.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 **1-844-442-7324**. 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 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
HPHC Insurance Company, 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

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

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**.

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**.

Language Access Services:

Para obtener asistencia en Español, llame al **1-844-442-7324**.

如果需要中文的帮助, 请拨打这个号码 **1-844-442-7324**.

De assistência em Português, por favor ligue **1-844-442-7324**.

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 (deductibles, copayments 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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$600
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$900**

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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,500**

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$300
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$850**

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 quí vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quí 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 (телетайп: 711).

العربية (Arabic)

إنتباه: إذا أنت تتكلم اَللُّغة **اَلعربية** ، خَدَمات اَلمُساعَدة اَللُّغوية مُتَوفرة لك مَجانا. ً **إتصل على 1 888-333-4742**

(TTY: 711)

ខ្មែរ (Cambodian) ប្រសុំជូនដំណឹង៖ បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 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).

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 સહાય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 1-888-333-4742 (TTY: 711)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 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).

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, 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 (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.

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