<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0</td>
<td>See the chart starting on page 2 for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet <strong>deductibles</strong> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes. $2,000 individual / $6,000 family for medical; $4,600 individual / $7,200 for prescriptions</td>
<td>The <strong>out-of-pocket limit</strong> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums and health care this plan does not cover</td>
<td>Even though you pay these expenses, they don’t count toward the <strong>out-of-pocket limit</strong>.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for <strong>specific</strong> covered services, such as office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. See <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a> or call 1-888-333-4742 for a list of network providers.</td>
<td>If you use an in-network doctor or other health care <strong>provider</strong>, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <strong>provider</strong> for some services. Plans use the term in-network, <strong>preferred</strong>, or participating for <strong>providers</strong> in their <strong>network</strong>. See the chart starting on page 2 for how this plan pays different kinds of <strong>providers</strong>.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>Yes, written consent is required but some restrictions apply.</td>
<td>This plan will pay some or all of the costs to see a <strong>specialist</strong> for covered services but only if you have the plan’s permission before you see the <strong>specialist</strong>.</td>
</tr>
<tr>
<td>Are there services this plan doesn’t cover?</td>
<td>Yes.</td>
<td>Some of the services this plan doesn’t cover are listed on page 4. See your policy or plan document for additional information about <strong>excluded services</strong>.</td>
</tr>
</tbody>
</table>

**Questions:** Call 1-888-333-4742 or visit us at [www.harvardpilgrim.org](http://www.harvardpilgrim.org).
If you aren’t clear about any of the underlined terms used in this form, 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. **SBC #16 HPHC HMO (HUCTW & ATC Unions)**
Harvard University Medical Plan:
Harvard Pilgrim Health Care (HPHC) HMO

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2017-12/31/2017

Coverage for: Individual and Family | Plan Type: HMO

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven’t met your deductible.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- **This plan may encourage you to use network providers** by charging you lower deductibles, copayments and coinsurance amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$20 copayment/visit</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$20 copayment/visit</td>
<td>Primary Care Physician (PCP) referral is required for most specialty care.</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$20 copayment/ chiropractic care and acupuncture</td>
<td>Chiropractic Limited to 18 visits per plan year; acupuncture limited to 20 visits per plan year</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>none</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$50 copayment</td>
<td>Prior approval required.</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$7 copayment/ prescription(retail); $14 copayment/prescription (mail-order)</td>
<td>Covers up to a 30-day supply purchased at retail. Covers up to a 90-day supply purchased by mail order from Catamaran.</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.catamaranrx.com">www.catamaranrx.com</a></td>
<td>Preferred brand drugs</td>
<td>$20 copayment/ prescription(retail); $50 copayment/prescription (mail-order)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$45 copayment/ prescription(retail); $110 copayment/prescription (mail-order)</td>
<td></td>
</tr>
</tbody>
</table>

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## Common Medical Event

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<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
</table>

### Specialty drugs
- Visit [www.catamaranrx.com](http://www.catamaranrx.com) for specialty drug copayments and restrictions/exclusions.

### If you have outpatient surgery
- Facility fee (e.g., ambulatory surgery center): $100 copayment
- Physician/surgeon fees: $100 copayment

### If you need immediate medical attention
- Emergency room services: $100 copayment/visit
- Emergency medical transportation: No charge
- Urgent care: $20 copayment/visit

### If you have a hospital stay
- Facility fee (e.g., hospital room): $100 copayment
- Physician/surgeon fee: $100 copayment

### If you have mental health, behavioral health, or substance abuse needs
- Mental/Behavioral health outpatient services: $20 copayment/visit
- Mental/Behavioral health inpatient services: $100 copayment
- Substance use disorder outpatient services: $20 copayment/visit
- Substance use disorder inpatient services: $100 copayment

### If you are pregnant
- Prenatal and postnatal care: No charge
- Delivery and all inpatient services: $100 copayment

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# Harvard University Medical Plan:
Harvard Pilgrim Health Care (HPHC) HMO

**Coverage Period:** 01/01/2017-12/31/2017

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs  
**Coverage for:** Individual and Family  
**Plan Type:** HMO

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<th>Your Cost If You Use an In-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>No charge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$20 copayment/visit</td>
<td>Limited to 60 days per plan year.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$20 copayment/visit</td>
<td>Limited to 60 visits per plan year.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>Limited to 100 days per plan year.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>Coverage for wigs limited to $350 per plan year. Coverage for hearing aids is limited to members age 19 or younger.</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>No charge</td>
<td>For inpatient services, see “If you have a hospital stay”.</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td>Eye exam</td>
<td>No charge</td>
<td>Limited to 1 exam per plan year. You may have other coverage under a vision plan.</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not covered</td>
<td>You may have other coverage under a vision plan.</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>$20 copayment/visit</td>
<td>Coverage is available for children up to age 13, limited to 2 exams per plan year. You may have other coverage under a dental plan.</td>
</tr>
</tbody>
</table>

## Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Does NOT Cover</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cosmetic surgery</td>
<td>Long-term care</td>
</tr>
<tr>
<td>Dental care (Adult)</td>
<td>Non-emergency care when travelling outside the U.S.</td>
</tr>
<tr>
<td></td>
<td>Private-duty nursing</td>
</tr>
<tr>
<td></td>
<td>Weight loss programs</td>
</tr>
</tbody>
</table>
**Harvard University Medical Plan:**
**Harvard Pilgrim Health Care (HPHC) HMO**

**Coverage Period:** 01/01/2017-12/31/2017

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs  
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**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 limited to 20 visits per plan year
- Bariatric surgery
- Chiropractic care limited to 18 visits per plan year
- Hearing aids for members age 19 or younger
- Infertility treatment
- Routine eye care
- Routine foot care limited to members with diabetes

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**Your Rights to Continue Coverage:**
If you lose coverage under the plan, then, depending on the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium,** which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-333-4742. You may also contact your state insurance department, 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).

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**Your Grievance and Appeals Rights:**
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance.** For questions about your rights, this notice, or assistance, you can contact: HPHC Member Services at 1-888-333-4742. You may also contact the U.S. Department of Labor’s Employee Benefits Security Administration at 1-866-444-3272 or visit their website at [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. Contact Heath Care for All at 1-617-350-7279. For TTY, call 1-617-350-0974.

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**Does this Coverage Provide Minimum Essential Coverage?**
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy **does provide minimum essential coverage.**

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**Does this Coverage Meet the Minimum Value Standard?**
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage **does meet the minimum value standard for the benefits it provides.**

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**Language Access Services:**
Spanish (Español): Para obtener asistencia en Español, llame al 1-888-333-4742.

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Harvard University Medical Plan: Harvard Pilgrim Health Care (HPHC) HMO
Coverage Examples

Coverage Period: 01/01/2017-12/31/2017
Coverage for: Individual and Family | Plan Type: HMO

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

<table>
<thead>
<tr>
<th>Having a baby (normal delivery)</th>
<th>Managing type 2 diabetes (routine maintenance of a well-controlled condition)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount owed to providers:</strong> $7,540</td>
<td><strong>Amount owed to providers:</strong> $5,400</td>
</tr>
<tr>
<td><strong>Plan pays:</strong> $7,360</td>
<td><strong>Plan pays:</strong> $4,900</td>
</tr>
<tr>
<td><strong>Patient pays:</strong> $180</td>
<td><strong>Patient pays:</strong> $500</td>
</tr>
</tbody>
</table>

**Sample care costs:**
- Hospital charges (mother) $2,700
- Routine obstetric care $2,100
- Hospital charges (baby) $900
- Anesthesia $900
- Laboratory tests $500
- Prescriptions $200
- Radiology $200
- Vaccines, other preventive $40

**Total** $7,540

**Patient pays:**
- Deductibles $0
- Copays $30
- Coinsurance $0
- Limits or exclusions $150

**Total** $180

**Sample care costs:**
- Prescriptions $2,900
- Medical Equipment and Supplies $1,300
- Office Visits and Procedures $700
- Education $300
- Laboratory tests $100
- Vaccines, other preventive $100

**Total** $5,400

**Patient pays:**
- Deductibles $0
- Copays $420
- Coinsurance $0
- Limits or exclusions $80

**Total** $500

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don’t include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

### Does the Coverage Example predict my own care needs?

**✘ No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

**✘ No.** Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

**✔ Yes.** When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

**✔ Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you’ll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.