This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.harvardpilgrim.org or by calling 1-888-333-4742.

<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>$250 individual/$500 family for out-of-network care. Does not apply to mental/behavioral health/substance about outpatient services and emergency room and transport.</td>
<td>You must pay all the costs up to the <strong>deductible</strong> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <strong>deductible</strong> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <strong>deductible</strong>.</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 in-network medical; $1,000 individual/$2,000 family for out-of-network medical; $4,600 individual/ $7,200 family for prescription.</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, balance-billed charges and health care this plan doesn’t 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 specific 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>No.</td>
<td>You can see the <strong>specialist</strong> you choose without permission from the plan.</td>
</tr>
</tbody>
</table>

Questions: Call 1-888-333-4742 or visit us at 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 or call 1-888-333-4742 to request a copy. SBC #22 HPCH PPO (Local 26 Union)
Harvard University Medical Plan: Harvard Pilgrim Health Care (HPHC) PPO

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: PPO

| Are there services this plan doesn’t cover? | Yes. | Some of the services this plan doesn’t cover are listed on page 5. See your policy or plan document for additional information about excluded services. |

- **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.

### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-network Provider</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>$15 copayment/visit</td>
<td>Deductible, then 20% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$15 copayment/visit</td>
<td>Deductible, then 20% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td>Other practitioner office visit</td>
<td>$15 copayment/chiropractic care and acupuncture</td>
<td>Deductible, then 20% coinsurance</td>
<td>Chiropractic Limited to 18 visits per plan year; acupuncture limited to 20 visits per plan year</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Deductible, then 20% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>Deductible, then 20% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
<td>Deductible, then 20% coinsurance</td>
<td>Prior approval required.</td>
</tr>
</tbody>
</table>

Questions: Call 1-888-333-4742 or visit us at 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 or call 1-888-333-4742 to request a copy. SBC #22 HPCH PPO (Local 26 Union)
# Harvard University Medical Plan:
## Harvard Pilgrim Health Care (HPHC) PPO

**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:** PPO

<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>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
</table>
| If you need drugs to treat your illness or condition | Generic drugs | $5 copayment/prescription (retail)  
$10 copayment/ prescription (mail order) | | Covers up to a 30-day supply purchased at retail. Covers up to a 90-day supply purchased by mail order from Catamaran). |
| More information about prescription drug coverage is available at [www.catamaranrx.com]({#}) | Preferred brand drugs | $15 copayment/prescription (retail)  
$35 copayment/ prescription (mail order) | | |
| | Non-preferred brand drugs | $40 copayment/prescription (retail)  
$100 copayment/ prescription (mail order) | | |
| | Specialty drugs | | Information about the cost of specialty drugs is available at [www.catamaranrx.com]({#}) | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | Deductible, then 20% coinsurance | Prior approval required for out-of-network providers. If prior approval is not received, you are responsible for the first $500 of the eligible expense which will not count toward the Deductible or Out-of-Pocket maximum. |
| | Physician/surgeon fees | No charge | Deductible, then 20% coinsurance | |
| If you need immediate medical attention | Emergency room services | $40 copayment/visit | | Waived if admitted to the hospital directly from the emergency room. |
| | Emergency medical transportation | No charge | |  
| | Urgent care | $15 copayment/visit | Deductible, then 20% coinsurance |  
| | | | |  
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | Deductible, then 20% coinsurance | Prior approval required. If prior approval is not received, you are responsible for the first $500 of the eligible expense which will not count toward the Deductible or Out-of-Pocket maximum. |
| | Physician/surgeon fee | No charge | Deductible, then 20% coinsurance | |

---

**Questions:** Call 1-888-333-4742 or visit us at [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 #22 HPCH PPO (Local 26 Union)**
### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-network Provider</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental/Behavioral health outpatient services</td>
<td>$15 copayment/visit</td>
<td>20% coinsurance</td>
<td>Prior approval required for certain services. If prior approval is not received, you are responsible for the first $500 of the eligible expense which will not count toward the Deductible or Out-of-Pocket maximum.</td>
</tr>
<tr>
<td>Mental/Behavioral health inpatient services</td>
<td>No charge</td>
<td>Deductible, then 20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Substance use disorder outpatient services</td>
<td>$15 copayment/visit</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Substance use disorder inpatient services</td>
<td>No charge</td>
<td>Deductible, then 20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prenatal and postnatal care</td>
<td>No charge</td>
<td>Deductible, then 20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Delivery and all inpatient services</td>
<td>No charge</td>
<td>Deductible, then 20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>No charge</td>
<td>Deductible, then 20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>No charge</td>
<td>Deductible, then 20% coinsurance</td>
<td>Limited to 60 days per plan year.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>$15 copayment/visit</td>
<td>Deductible, then 20% coinsurance</td>
<td>Limited to 60 days per plan year.</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>Deductible, then 20% coinsurance</td>
<td>Limited to 100 days per plan year.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>Deductible, then 20% coinsurance</td>
<td>Coverage for wigs limited to $350 per plan year. Blood glucose monitors are not subject to cost sharing out-of-network. Coverage for hearing aids is limited to members age 19 or younger.</td>
</tr>
<tr>
<td>Hospice service</td>
<td>No charge</td>
<td>Deductible, then 20% coinsurance</td>
<td>For inpatient services, see “If you have a hospital stay.”</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td></td>
<td></td>
<td>Limited to one routine exam per plan year. You may have other coverage under a vision plan.</td>
</tr>
<tr>
<td>Eye exam</td>
<td>$15 copayment/visit</td>
<td>Deductible, then 20% coinsurance</td>
<td></td>
</tr>
</tbody>
</table>
# Summary of Benefits and Coverage

## What this Plan Covers & What it Costs

**Coverage for:** Individual and Family  
**Plan Type:** PPO  
**Coverage Period:** 01/01/2017-12/31/2017

<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>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glasses</td>
<td></td>
<td>Not covered</td>
<td>Deductible, then 20% coinsurance</td>
<td>You may have other coverage under a vision plan.</td>
</tr>
<tr>
<td>Dental check-up</td>
<td></td>
<td>$20 copayment/visit</td>
<td></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:

#### Services Your Plan Does NOT Cover

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Private-duty nursing
- Weight loss programs

#### Other Covered Services

- Acupuncture limited to 20 visits per plan year
- Bariatric surgery
- Chiropractic care up to 18 visits per plan year
- Hearing aids for members age 19 or younger
- Infertility treatment
- Non-emergency care when travelling outside the U.S.
- Routine eye care limited to one exam per plan year
- Routine foot care limited to members with diabetes

### 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).

**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 #22 HPCH PPO (Local 26 Union)**
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. 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.

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.

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.

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


Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-333-4742.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne’ 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:

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.

---

**Having a baby**
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $7,360
- **Patient pays:** $180

**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

**Managing type 2 diabetes**
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,970
- **Patient pays:** $430

**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: $350
- Coinsurance: $0
- Limits or exclusions: $80
- **Total:** $430

---

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.

---

**Questions:** Call 1-888-333-4742 or visit us at 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 or call 1-888-333-4742 to request a copy. **SBC #22 HPCH PPO (Local 26 Union)**
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.