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, https://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 1-888-333-4742 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,500** individual/ **$3,000** family for	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network preventive and prenatal care.	This plan covers some items and services even if you haven't yet met your 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://healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$3,000** individual / **$6,000** family for in-network/PCP approved; **$6,000** individual/ **$12,000** family out-of-network/self-referred.	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalty fees, 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.harvardpilgrim.org or call 1-888-333-4742 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 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	15% coinsurance	35% coinsurance	None
	Specialist visit	15% coinsurance	35% coinsurance	None
	Preventive care/screening/ immunization	No charge	35% 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.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	35% coinsurance	None
	Imaging (CT/PET scans, MRIs)	15% coinsurance	35% coinsurance	Prior approval may be required for certain services. If prior approval is not received for out-of-network providers, you are responsible for the first $500 of the eligible expense which will not count toward the Deductible or Out-of-Pocket limit.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	15% coinsurance, then $7/prescription retail & $14/prescription mail-order	Must submit receipt to be reimbursed allowed cost minus applicable out-of-network coinsurance and/or copayment.	Covers up to a 30-day supply purchased at retail. Covers up to 90-day supply purchased by mail order from Express Scripts.
	Preferred brand drugs	15% coinsurance, then $20/prescription retail & $50/prescription mail-order		
	Non-preferred brand drugs	15% coinsurance then, $45/prescription retail & $110/prescription mail-order		
	Specialty drugs	15% coinsurance, then Copayments vary based on tier of prescription. Visit www.express-scripts.com for details.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	35% coinsurance	Prior approval may be required for certain services. If prior approval is not received 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)	
	Physician/surgeon fees	15% coinsurance	35% coinsurance	out-of-network providers, you are responsible for the first $500 of the eligible expense which will not count toward the Deductible or Out-of-Pocket limit.
If you need immediate medical attention	Emergency room care	15% coinsurance	35% coinsurance	None
	Emergency medical transportation	15% coinsurance	35% coinsurance	None
	Urgent care	15% coinsurance	35% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	35% coinsurance	Prior approval may be required for certain services. If prior approval is not received for out-of-network providers, you are responsible for the first $500 of the eligible expense which will not count toward the Deductible or Out-of-Pocket limit.
	Physician/surgeon fees	15% coinsurance	35% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance	35% coinsurance	None
	Inpatient services	15% coinsurance	35% coinsurance	Prior approval may be required for certain services. If prior approval is not received for out-of-network providers, you are responsible for the first $500 of the eligible expense which will not count toward the Deductible or Out-of-Pocket limit.
If you are pregnant	Office visits	15% coinsurance	35% coinsurance	None
	Childbirth/delivery professional services	15% coinsurance	35% coinsurance	None
	Childbirth/delivery facility services	15% coinsurance	35% coinsurance	None
If you need help recovering or have other special health	Home health care	15% coinsurance	35% coinsurance	Prior approval required for in-network and out-of-network providers. If prior approval is not received for out-of-network providers, you are

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)	
needs				responsible for the first $500 of the eligible expense which will not count toward the Deductible or Out-of-Pocket limit.
	Rehabilitation services	15% coinsurance	35% coinsurance	Prior approval required for in-network and out-of-network providers. If prior approval is not received for out-of-network providers, you are responsible for the first $500 of the eligible expense which will not count toward the Deductible or Out-of-Pocket limit. Limited to 60 days per plan year, inpatient; and up to 100 days per plan year combined outpatient physical and occupational therapy.
	Habilitation services			
	Skilled nursing care	15% coinsurance	35% coinsurance	Prior approval required for in-network and out-of-network providers. If prior approval is not received for out-of-network providers, you are responsible for the first $500 of the eligible expense which will not count toward the Deductible or Out-of-Pocket limit. Limited to 100 days per plan year.
	Durable medical equipment	15% coinsurance	35% coinsurance	None
	Hospice services	15% coinsurance	35% coinsurance	For inpatient services, see "If you have a hospital stay.
If your child needs dental or eye care	Children's eye exam	No charge	35% coinsurance	Limited to one routine eye exam per plan year. You may have other coverage under a vision plan.
	Children's glasses	Not covered	Not covered	You may have coverage under a vision plan.
	Children's dental check-up	Not covered	Not covered	You may have coverage under a dental plan.

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.)

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (limited to 20 visits per plan year) • Bariatric surgery • Chiropractic care (limited to 18 visits per plan year)	• Hearing aids • Infertility treatment • Non-emergency care when travelling outside the US	• Routine eye care (limited to one exam per plan year) • Routine foot care (limited to patients with diabetes)

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272). For more information on your rights to continue coverage, contact the plan at 1-888-333-4742. 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 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 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 plan meet the Minimum Value Standards? **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:
Spanish (Español): Para obtener asistencia en Español, llame al 888-333-4742.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-333-4742.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 888-333-4742.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 888-333-4742

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	$1,500
Specialist *coinsurance*	15%
Hospital (facility) *coinsurance*	15%
Other *coinsurance*	15%

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	**$12,730**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist *coinsurance*	15%
Hospital (facility) *coinsurance*	15%
Other *coinsurance*	15%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$480
Coinsurance	$440
What isn't covered	
Limits or exclusions	$50
The total Joe would pay is	**$2,470**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist *coinsurance*	15%
Hospital (facility) *coinsurance*	15%
Other *coinsurance*	15%

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	**$1,920**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$290
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,790**

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