



**The Harvard Pilgrim HMO**

**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered

Services

**Massachusetts**

**Coverage Period:** 01/01/2020 **—** 12/31/2020

**Coverage for:** Individual + Family | **Plan Type:** HMO

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|  | **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/LGsampleEOC**](http://www.harvardpilgrim.org/LGsampleEOC). 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**](http://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?** | $250 member/ $500 familyBenefits are administered on a calendar year basis. | Generally you must pay all the costs up to the  **deductible** amount before this  **plan** begins to pay. If you have other family members on the policy, they have to meet their own individual  **deductible** until the overall family  **deductible** amount has been met. |
| **Are there services covered before you meet your deductible?** | Yes:  **emergency room care**, prescription drugs, outpatient mental health services,  **preventive care**,  **provider** office visits, routine eye exams, are covered before you meet your **deductibles**. | This  **plan** covers some items and services even if you haven’t yet met the  **deductible** amount. But, a  **copayment** or  **coinsurance** may apply. |
| **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?** | $2,000 member/ $4,000 family | The **out-of-pocket limit** is the most you could pay in a year of covered services. If you have other family members in this plan, they have to meet their own  **out-of-pocket limit** until the overall family **out-of-pocket limit** has been met. |

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| **Important Questions** | **Answers** | **Why this matters** |
| **What is not included in the out–of–pocket limit?** | **Premiums**,  **balance-billing** charges, 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 [**https://www.providerlookuponline.com/ harvardpilgrim/po7/Search.aspx**](https://www.providerlookuponline.com/harvardpilgrim/po7/Search.aspx) or call **1-888-333-4742** for a list of  **preferred 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?** | Yes, some exceptions apply. | This **plan** will pay some or all of the costs to see a **specialist** for covered services but only if you have a  **referral** before you see the  **specialist**. |
|  | All  **copayment** and  **coinsurance** costs shown in this chart are after your  **deductible** has been met, if a  **deductible** applies. |
|  |  | **What You Will Pay** | **Limitations, Exceptions,** |
| **Common Medical Event** | **Services You May Need** | **Network Provider****(You will pay the least)** | **Out-of-Network Provider****(You will pay the most)** | **& Other Important****Information** |
| **If you visit a health care provider’s office or clinic** | Primary care visit to treat an injury or illness | $25 **copay**/visit;  **deductible**does not apply | Not covered | None |
| **Specialist** visit | $25 **copay**/visit;  **deductible**does not apply | Not covered | None |
| **Preventive care**/ **screening**/ **immunization** | No charge;  **deductible** does not apply | Not covered | 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. |

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| **If you have a test** | **Diagnostic test** (x-ray, blood work) | **X-rays:** No charge**Laboratory:** No charge | Not covered | None |
| Imaging (CT/PET scans, MRIs) | No charge | Not covered | Cost sharing may vary for certain imaging services. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug****coverage** is available at[www.optumrx.com](http://www.optumrx.com). | Generic drugs | 30-Day Supply Retail Pharmacy Tier 1: $15 Copayment 90-Day Supply Mail Order Pharmacy Tier 1: $30 Copayment  | None |
| Preferred brand drugs | 30-Day Supply Retail Pharmacy Tier 2: $30 Copayment 90-Day Supply Mail Order Pharmacy Tier 2: $60 Copayment  | None |
| Non-preferred brand drugs | 30-Day Supply Retail Pharmacy Tier 3: $50 Copayment 90-Day Supply Mail Order Pharmacy Tier 3: $150 Copayment  | None |
| **Specialty drugs** | All drugs are covered in Retail Pharmacy and Mail Order Pharmacy Tiers 1 – 3  | None |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $150  **copay**/visit | Not covered | None |
| Physician/surgeon fees | No charge | Not covered |

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| **If you need immediate medical attention** | **Emergency room care** | $100  **copay**/visit;  **deductible** does not apply | None |
| **Emergency medical transportation** | No charge | None |
| **Urgent care** | **Convenience care clinic:**$25 **copay**/visit;  **deductible**does not apply**Urgent care center:**$25 **copay**/visit;  **deductible**does not apply**Hospital urgent care center:**$25 **copay**/visit;  **deductible**does not apply | **Convenience care clinic:**Not Covered**Urgent care center**Not Covered**Hospital urgent care****center**Same As Participating**Provider** | Services withnon-participating providersare only covered outside ofthe service area. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $250  **copay**/admit | Not covered | None |
| Physician/surgeon fee | No charge | Not covered |
| **If you have mental health, behavioral health, or substance abuse needs** | Outpatient services | $25 **copay**/visit;  **deductible**does not apply | Not covered | None |
| Inpatient services | $250  **copay**/admit | Not covered |
| **If you are pregnant** | Office visits | $25 **copay**/visit;  **deductible**does not apply | Not covered | **Cost sharing** does not apply for  **preventive services**. |
| Childbirth/delivery professional services | No charge | Not covered |
| Childbirth/delivery facility services | $250  **copay**/admit | Not covered |

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| **If you need help recovering or have other special health needs** | **Home health care** | No charge | Not covered | None |
| **Rehabilitation services** | No charge | Not covered | Occupational therapy – 30 visits /calendar year Physical therapy – 30 visits/calendar year |
| **Habilitation services** |
| **Skilled nursing care** | $250  **copay**/admit | Not covered | None |
| **Durable medical equipment** | No charge | Not covered | Wigs – $350/calendar year |
| **Hospice services** | No charge | Not covered | For inpatient see “If you have a hospital stay”. |
| **If your child needs dental or eye care** | Children’s eye exam | $25 **copay**/visit;  **deductible**does not apply | Not covered | 1 exam/calendar year |
| Children’s glasses | Not covered | Not covered | None |
| Children’s dental check-up– Up to age of 13 | No charge;  **deductible** does not apply | Not covered | 2 exams/calendar year |
| **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.)** |
|  | • Long-Term (Custodial) Care• Most Cosmetic Surgery• Most Dental Care (Adult)• Non-emergency care when traveling outside the U.S. | • Private-duty nursing• Routine foot care• Services that are not Medically Necessary• Weight Loss Programs |
| **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 - 20 visits/calendar year• Bariatric surgery | • Chiropractic Care - 20 visits/calendar year• Hearing Aids - $2,000/aid every 36 months, for each impaired ear | • Infertility Treatment• Routine eye care (Adult) – 1 exam/calendar year |

**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**](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:**



*————— To see examples of how this plan might cover costs for a sample medical situation, see the next page. —————*

**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**](https://www.healthcare.gov/sbc-glossary/#provider) 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)**

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **■ The plan’s overall deductible** | $250 |  | **■ The plan’s overall deductible** | $250 |  | **■ The plan’s overall deductible** | $250 |
| **■ Specialist  *copayment*** | $25 |  | **■ Specialist  *copayment*** | $25 |  | **■ Specialist  *copayment*** | $25 |
| **■ Hospital (facility)*****copayment*** | $250 |  | **■ Hospital (facility)*****copayment*** | $250 |  | **■ Hospital (facility)*****copayment*** | $250 |
| **■ Other** | $0 |  | **■ Other** | $0 |  | **■ Other** | $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*)

**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*)

**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 $12,731 Total Example Cost $7,389 Total Example Cost $1,925**

**In this example, Peg would pay: In this example, Joe would pay: In this example, Mia would pay:**

*Cost Sharing Cost Sharing Cost Sharing*

**Deductibles** $250 **Deductibles** $220 **Deductibles** $250

**Copayments** $250 **Copayments** $250 **Copayments** $80

**Coinsurance** $0 **Coinsurance** $0 **Coinsurance** $0

*What isn’t covered What isn’t covered What isn’t covered*

Limits or exclusions $0 Limits or exclusions $30 Limits or exclusions $0

**The total Peg would pay is**

**$500 The total Joe would pay is $500 The total Mia would pay is $330**

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





