

	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. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other <u>underlined</u> 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.
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Important Questions	Answers	Why This Matters
What is the overall deductible ?	\$2,000 member/ \$4,000 family Benefits are administered on a Plan 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. 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?	No.	You don't have to meet deductibles for specific services
What is the out-of-pocket limit for this plan ?	\$6,600 member/ \$13,200 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 limit 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, 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.harvardpilgrim.org/public/find-a-provider 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 ?	Yes	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.
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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	Level 1: \$25 copay /visit; deductible does not apply	Not covered	None
	Specialist visit	Level 1: \$25 copay /visit; deductible does not apply Level 2: \$40 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.
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)	\$250 copay /procedure	Not covered	Cost sharing may vary for certain imaging services.

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 need drugs to treat your illness or condition More information about prescription drug coverage is available at www.harvardpilgrim.org/2026Select5T	Generic drugs	30-Day Retail Tier 1: \$5 copay /prescription; deductible does not apply 90-Day Mail Tier 1: \$12.50 copay /prescription; deductible does not apply 30-Day Retail Tier 2: \$25 copay /prescription; deductible does not apply 90-Day Mail Tier 2: \$62.50 copay /prescription; deductible does not apply	Not covered	Select formulary - covers a limited list; not all drugs are covered. You pay retail price for Out of Network pharmacy drugs and are reimbursed minus applicable cost sharing . Covered only outside of service area.
	Preferred brand drugs	30-Day Retail Tier 3: \$40 copay /prescription; deductible does not apply 90-Day Mail Tier 3: \$100 copay /prescription; deductible does not apply	Not covered	
	Non-preferred brand drugs	30-Day Retail Tier 4: \$60 copay /prescription; deductible does not apply 90-Day Mail Tier 4: \$180 copay /prescription; deductible does not apply	Not covered	
	Specialty drugs	30-Day Retail Tier 4: \$60 copay /prescription; deductible does not apply 90-Day Mail Tier 4: \$180 copay /prescription; deductible does not apply 30-Day Retail Tier 5: 20% coinsurance up to \$250; deductible does not apply 90-Day Mail Tier 5: 20% coinsurance up to \$750; deductible does not apply	Not covered	Some drugs must be obtained through a Specialty Pharmacy.

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 copay /visit	Not covered	None
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	Emergency room care	\$250 copay /visit; deductible does not apply		None
	Emergency medical transportation	No charge		None
	Urgent care	Urgent care center: \$40 copay /visit; deductible does not apply	Urgent care center: Not covered	Non-participating providers only covered outside the service area. Cost sharing may vary based on location.
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 need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 copay /visit; deductible does not apply	Not covered	None
	Inpatient services	\$250 copay /admit	Not covered	None
If you are pregnant	Office visits	\$25 copay /visit; deductible does not apply	Not covered	Cost sharing does not apply for preventive services (such as routine prenatal visits).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	\$250 copay /admit	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)	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	None
	Rehabilitation services	Physical Therapy: No charge	Not covered	Physical therapy – 20 visits /Plan Year Occupational therapy – 20 visits /Plan Year
	Habilitation services	Occupational Therapy: No charge Speech Therapy: No charge		
	Skilled nursing care	\$250 copay /admit	Not covered	100 days/Plan Year
	Durable medical equipment	20% coinsurance	Not covered	Wigs – \$350/Plan 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/Plan Year
	Children’s glasses	Not covered	Not covered	None
	Children’s dental check-up – Up to age of 13	\$25 copay /visit; deductible does not apply	Not covered	2 exams/Plan 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 .)		
• Children’s glasses • Cosmetic Surgery	• Dental Care (Adult) • Long-Term Care • Non-emergency care when traveling outside the U.S. • Private-duty nursing	• Routine foot care (except for diabetes or systemic circulatory diseases) • 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/Plan Year • Bariatric surgery	• Chiropractic Care - 12 visits/Plan Year • Hearing Aids - \$2,000/aid every 36 months, for each impaired ear up to age 22	• Infertility Treatment • Routine eye care (Adult) – 1 exam/Plan 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 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, Centers 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 1-888-333-4742. 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 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
Harvard Pilgrim Health Care, 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>

Massachusetts Division of Insurance
1000 Washington Street, Suite 810
Boston, MA 02118-6200
1-617-521-7794

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](#).

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](#).

Language Access Services:

Para obtener asistencia en Español, llame al 1-888-333-4742.

如果需要中文的帮助, 请拨打这个号码 1-888-333-4742.

De assistência em Português, por favor ligue 1-888-333-4742.

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 ([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)	
■ The plan's overall deductible	\$2,000	■ The plan's overall deductible	\$2,000	■ The plan's overall deductible	\$2,000
■ Specialist copayment	\$40	■ Specialist copayment	\$40	■ Specialist copayment	\$40
■ 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 (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)		This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$2,000	Deductibles	\$100	Deductibles	\$1,800
Copayments	\$300	Copayments	\$1,400	Copayments	\$300
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$0	Limits or exclusions	\$0	Limits or exclusions	\$0
The total Peg would pay is	\$2,300	The total Joe would pay is	\$1,500	The total Mia would pay is	\$2,100

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



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Language Assistance Services

Arabic (العربية) انتباه: إذا كنت تتحدث لغة أخرى غير الإنجليزية، فإن خدمات المساعدة اللغوية متاحة لك مجانًا. يرجى الاتصال بالرقم الموجود على بطاقة هوية العضو الخاصة بك.

French (Français) ATTENTION : Si vous parlez une langue autre que l'anglais, des services d'assistance linguistique gratuits sont à votre disposition. Veuillez appeler le numéro indiqué sur votre carte d'adhérent.

Greek (Ελληνικά) ΠΡΟΣΟΧΗ: Εάν μιλάτε κάποια άλλη γλώσσα πέρα από τα αγγλικά, γλωσσικές υπηρεσίες χωρίς χρέωση είναι στη διάθεσή σας. Καλέστε τον αριθμό στην κάρτα μέλους σας.

Gujarati (ગુજરાતી) ધ્યાન આપો: જો તમે અંગ્રેજી સિવાય બીજી ભાષા બોલો છો, તો ભાષા હિય વિચો, તમારા માટે મફત ઉપલબ્ધ છે. કૃપા કરીને તમારા ભિય આઈડી કાડ પરના નંબર પર કોલ કરો.

Haitian Creole (Kreyòl Ayisyen) ATANSYON: Si w pale yon lang ki pa Anglè, gen sèvis èd pou lang ki disponib gratis pou ou. Tanpri rele nimewo ki sou kat ID manm ou a.

Hindi (हिंदी) ध्यान दें: अगर आप अंग्रेजी के अलावा कोई दूसरी भाषा बोलते हैं, तो भाषा सहायता सेवाएं आपके ललए ननशुलूक उपलब्ध हैं। कृ पया अपने सदस्य आईडी काडड पर ददए गए नंबर पर कॉल करें।

Italian (Italiano) ATTENZIONE: se parli una lingua diversa dall'inglese, sono disponibili gratuitamente servizi di assistenza linguistica. Chiama il numero indicato sulla tua tessera membro identificativa.

Khmer (ភាសាខ្មែរ) ប្រសិនបើអ្នក កនិយាយភាសាបសដេបហ្វីភាសាអង់បលរ ស បសវកម្មម្តង យភាសា ដលៃឥតលិតថ្លៃ លីអាចរកបានសហ្វារអុន ក។ សូ មូហ្វហ្វីកាន់ បលខហ្វលី ID កាតសាជីកមស្តអុន ក។

Korean (한국어) 알람: 영어 이외의 언어를 사용하신다면 언어 지원 서비스를 무료로 제공해 드립니다. 가입자 ID 카드에 명시된 번호로 전화하시기 바랍니다.

Lao (ພາສາລາວ) ກະລຸນາ ຮັບຊາບ: ຖ້າ ທ່ານເວົ້າພາສາອື່ນທີ່ບໍ່ແມ່ນພາສາ ອັງກິດ, ທ່ານສາມາດໃຊ້ບໍລິການບໍ່ດານພາສາໄ ດ້ ໂດຍບໍ່ເສຍ ຄ່າ. ກະລຸນາໂທຫາເບີຜູ້ຍິນ ບັດປະຈຳ ຕົວສະມາຊິກຂອງ ທ່ານ.

Polish (polski) UWAGA: Jeśli posługujesz się językiem innym niż angielski, możesz bezpłatnie korzystać z usług pomocy językowej. Zadzwoń pod numer podany na Twojej karcie członkowskiej.

Portuguese (Português) ATENÇÃO: caso fale outro idioma que não o inglês, são-lhe disponibilizados gratuitamente serviços de assistência linguística. Ligue para o número no seu cartão de identificação de membro.

Russian (Русский) ВНИМАНИЕ! Если вы не говорите на английском языке, то можете бесплатно воспользоваться услугами языковой поддержки. Позвоните по номеру, указанному на вашей идентификационной карте участника.

Spanish (Español) ATENCIÓN: Si usted habla un idioma que no sea inglés, están disponibles para usted, sin costo, servicios de asistencia en otros idiomas. Llame al número que figura en su tarjeta de identificación de miembro.

Traditional Chinese (繁體中文) 注意事項: 如果您講非英語的其他語言, 我們可以為您提供免費的語言協助服務。請撥打您會員 ID 卡上的電話號碼。

Vietnamese (Tiếng Việt) LƯU Ý: Nếu quý vị nói ngôn ngữ khác không phải tiếng Anh, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Vui lòng gọi đến số điện thoại trên thẻ ID hội viên của quý vị.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Please call the number on your member ID card.

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 (see below for contact information).

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:

Point32Health Civil Rights Legal Coordinator

1 Wellness Way
Canton, MA 02021-1166

866-750-2074, TTY service: 711

Fax: 617-668-2754

Email: OCRCoordinator@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 (TDD)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html