Harvard Pilgrim Health Care

Massachusetts

Harvard Pilgrim Health Care, Inc.
The Harvard Pilgrim Best Buy Tiered Copayment ChoiceNet℠ HMO

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

Coverage Period: 7/1/2013 — 6/30/2014

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

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.dol.gov/ebsa/healthreform** or by calling **1-888-333–4742**.

Important Questions	Answers	Why this matters:
What is the overall deductible?	**Tier 1 Providers:** $250 per Member per Plan Year / $750 per Family per Plan Year **Tier 2 Providers:** $250 per Member per Plan Year / $750 per Family per Plan Year **Tier 3 Providers:** $250 per Member per Plan Year / $750 per Family per Plan Year The deductible applies to benefits specifically cited in the chart starting on Page 3 . For other benefits see your Plan document.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**. Primary Care Physicians, Specialists, Hospitals that are preferred providers are placed in one of "three" tiers. Members' cost sharing depends on the providers they use. Tier 1 providers are the lowest cost. Tier 3 providers are the highest cost.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this **plan** covers.
Is there an out–of–pocket limit on my expenses?	Yes. $2,000 per member per Plan Year / $4,000 per family per Plan Year	The **out-of-pocket limit** 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.
What is not included in the out-of-pocket limit?	Durable Medical Equipment, Prosthetic Devices, and Outpatient Prescription Drugs may not be included.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 3 describes specific coverage limits, such as limits on the number of office visits.

Questions: Call 1-888-333-4742 or visit us at **www.harvardpilgrim.org**. If you are not clear about any of the bolded 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.

Important Questions	Answers	Why this matters:
Does this plan use a network of providers?	Yes. For a list of participating **providers**, see **www.harvardpilgrim.org** or call **1-888-333-4742**.	If you use an in-network doctor or other health care **provider**, 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 **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.
Do I 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 the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7 . See your policy or plan document for additional information about **excluded services**.

- Co-payments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Co-insurance 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 co-insurance 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 participating providers by charging you lower deductibles, co-payments and co-insurance amounts.

Common MEDICAL Event	Services You May Need	Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Tier 1 Primary Care Copayment: $20 per visit Tier 2 Primary Care Copayment: $20 per visit Tier 3 Primary Care Copayment: $20 per visit	Your member cost sharing will depend upon the types of services provided and the tier placement of the provider.
	Specialist visit	Tier 1 Specialty and Hospital Based Care Copayment: $25 per visit Tier 2 Specialty and Hospital Based Care Copayment: $35 per visit Tier 3 Specialty and Hospital Based Care Copayment: $45 per visit	Your member cost sharing will depend upon the types of services provided and the tier placement of the provider.
	Other practitioner office visit	Tier 1 Primary Care Copayment: $20 per visit	– Chiropractic Care is limited. Cost sharing may vary for certain practitioners.
	Preventive care/ screening / immunization	No charge	None
If you have a test	Diagnostic test (x-ray, blood work)	**Non-Hospital Based Facility:** Tier 1 Deductible, then no charge **Physician and Hospital Based Facility:** Tier 1 Deductible, then no charge Tier 2 Deductible, then no charge Tier 3 Deductible, then no charge	None
	Imaging (CT/PET scans, MRIs)	**Non-Hospital Based Facility:** Tier 1 Deductible, then $100 Copayment per procedure **Physician and Hospital Based Facility:** Tier 1 Deductible, then $100 Copayment per procedure	

Common MEDICAL Event	Services You May Need	Participating Provider	Limitations & Exceptions
		Tier 2 Deductible, then $100 Copayment per procedure Tier 3 Deductible, then $100 Copayment per procedure	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.harvardpilgrim.org**.	Most generic drugs	**Retail Pharmacy Tier 1:** $10 Copayment	– Retail Pharmacy – limited to 30 day supply per refill – Mail Order Pharmacy – limited to 90 day supply per refill
	Preferred brand drugs	**Retail Pharmacy Tier 2:** $25 Copayment	Same as above.
	Non-preferred brand drugs	**Retail Pharmacy Tier 3:** $50 Copayment	Some generic drugs are in this tier. Same as above.
	Specialty drugs	All drugs are covered in Retail Pharmacy and Mail Order Pharmacy Tiers 1 — 3	Must be obtained through a Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Tier 1 Deductible, then $150 Copayment per visit Tier 2 Deductible, then $150 Copayment per visit Tier 3 Deductible, then $150 Copayment per visit	None
	Physician/surgeon fees	Tier 1 Deductible, then no charge Tier 2 Deductible, then no charge Tier 3 Deductible, then no charge	None
If you need immediate medical attention	Emergency Room Services	Tier 1 Deductible, then $100 Copayment per visit Cost sharing applies to all providers.	This Copayment is waived if admitted to the hospital directly from the emergency room.
	Emergency Medical Transportation	Tier 1 Deductible, then no charge Cost sharing applies to all providers.	None
	Urgent Care	See "Primary Care Visit to treat an Injury or Illness" or "Specialist Visit" listed on Page 3 .	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Tier 1 Deductible, then $300 Copayment per admission Tier 2 Deductible, then $300 Copayment per admission Tier 3 Deductible, then $700 Copayment per admission	None
	Physician / surgeon fee	Tier 1 Deductible, then no charge Tier 2 Deductible, then no charge Tier 3 Deductible, then no charge	None

Common MEDICAL Event	Services You May Need	Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	**Group Therapy:** $10 Copayment per visit **Individual Therapy:** $20 Tier 1 Primary Care Copayment per visit	None
	Mental / Behavioral health inpatient services	Tier 1 Deductible, then $200 Copayment per admission	None
	Substance use disorder outpatient services	**Group Therapy:** $10 Copayment per visit **Individual Therapy:** $20 Tier 1 Primary Care Copayment per visit	None
	Substance use disorder inpatient services	Tier 1 Deductible, then $200 Copayment per admission	None
If you are pregnant	Prenatal and postnatal care	No charge	None
	Delivery and all inpatient services	Tier 1 Deductible, then $300 Copayment per admission Tier 2 Deductible, then $300 Copayment per admission Tier 3 Deductible, then $700 Copayment per admission	None
If you need help recovering or have other special health needs	Home health care	Tier 1 Deductible, then no charge	None
	Rehabilitation services (Inpatient)	Tier 1 Deductible, then no charge	None
	Habilitation services (Outpatient)	Tier 1 Primary Care Copayment: $20 per visit	– Physical Therapy – limited to 30 visits per Plan Year – Occupational Therapy – limited to 30 visits per Plan Year
	Skilled nursing care	Tier 1 Deductible, then 20% Coinsurance	– Limited to 100 days per Plan Year
	Durable medical equipment	Tier 1 Deductible, then no charge	None
	Hospice service	Tier 1 Deductible, then no charge	If inpatient services are required, please see "If you have a hospital stay".

Common MEDICAL Event	Services You May Need	Participating Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No charge	– Limited to 1 exams per 2 Plan Years You may have other coverage under a Vision Rider.
	Glasses	Not covered	You may have other coverage under a Vision Rider.
	Dental check-up – Up to the age of 13	Tier 1 Primary Care Copayment: $20 per visit	– Limited to 2 exams per Plan Year You may have other coverage under a Dental Rider.

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.)
• Acupuncture • Hearing Aids • 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 • 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.)
• Bariatric Surgery • Chiropractic Care • Infertility Treatments • Routine eye care (Adult)

Your Rights to Continue Coverage:

** Individual health insurance sample-

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at **1–800–333–4742**. You may also contact your state insurance department at: .

OR

** Group health coverage sample-

If you lose coverage under the **plan**, then, depending upon 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 **1–800–333–4742**. 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**, or the U.S. Department of Health and Human Services at **1-877-267-2323 x61565** or **www.cciio.cms.gov**.

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 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

Health Care for All
30 Winter Street, Suite 1004
Boston, MA 02108
1-800-272-4232
http://www.hcfama.org/helpline

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 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**.

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.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays: $6,820**
- **Patient pays: $720**

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	$250
Co-pays	$320
Co-insurance	$0
Limits or exclusions	$150
Total	**$720**

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

- **Amount owed to providers: $5,400**
- **Plan pays: $3,540**
- **Patient pays: $1,860**

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	$140
Co-pays	$1,640
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,860**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.