Harvard Pilgrim Health Care

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Clear Choice POS Silver 3000

Coverage Period: 01/01/2024 — 12/31/2024
Coverage for: Individual + Family | Plan Type: POS

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/public/eoc?pdid=PD0000201396**. 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?	Medical & **Prescription Drug Deductible**: In-Network: $3,000 member / $6,000 family Out-of-Network: $6,000 member / $12,000 family Benefits are administered on a calendar year basis.	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 **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your deductible?	Yes. Tiers 1, 2, and 3 **prescription drugs**, and the following In-Network services: **preventive care**, **provider** office visits, **Rehabilitation services** and **Habilitation services**, Non-hospital affiliated facility day surgery, Non-hospital based laboratory and imaging are covered before you meet your **deductible**.	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?	In-Network: $9,100 member / $18,200 family Out-of-Network: $18,200 member / $36,400 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 limits** 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, penalties for failure to obtain preauthorization for services, 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.

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: $40 copay/ visit; deductible does not apply	50% coinsurance	$0 copay for first visit
	Specialist visit	Level 1: $40 copay/ visit; deductible does not apply Level 2: $80 copay/ visit; deductible does not apply	50% coinsurance	None
	Preventive care/ screening/ immunization	No charge; deductible does not apply	50% 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.

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 a test	Diagnostic test (x-ray, blood work)	X-rays: 40% coinsurance Laboratory: Non-Hospital Based: $15 copay/ visit; deductible does not apply Hospital Based: 40% coinsurance	X-rays: 50% coinsurance Laboratory: 50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	Non-Hospital Based: $250 copay/ visit; deductible does not apply Hospital Based: 40% coinsurance	50% coinsurance	Out-of-Network preauthorization required. $500 penalty if not obtained
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at **www.harvardpilgrim.org/ 2024Value5T**.	Generic drugs	30-Day Retail Tier 1: $15 copay/ prescription; deductible does not apply 90-Day Mail Tier 1: $30 copay/ prescription; deductible does not apply 30-Day Retail Tier 2: $25 copay/ prescription; deductible does not apply 90-Day Mail Tier 2: $50 copay/ prescription; deductible does not apply	Not covered	Value 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: $50 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: 30% coinsurance up to $300 90-Day Mail Tier 4: 30% coinsurance up to $600	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)	
	Specialty drugs	30-Day Retail Tier 4: 30% coinsurance up to $300 90-Day Mail Tier 4: 30% coinsurance up to $600 30-Day Retail Tier 5: 50% coinsurance up to $600 90-Day Mail Tier 5: 50% coinsurance up to $1,200	Not covered	Some drugs must be obtained through a Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Non-hospital affiliated facility: $300 copay/ visit; deductible does not apply Hospital affiliated facility: 40% coinsurance	50% coinsurance	Out-of-Network preauthorization required. $500 penalty if not obtained
	Physician/surgeon fees	Non-hospital affiliated facility: No charge; deductible does not apply Hospital affiliated facility: 40% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	40% coinsurance		None
	Emergency medical transportation	40% coinsurance		None
	Urgent care	Urgent care center: $40 copay/ visit; deductible does not apply	Urgent care center: 50% coinsurance	Cost sharing may vary based on Urgent Care location.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	50% coinsurance	Out-of-Network preauthorization required. $500 penalty if not obtained
	Physician/surgeon fee	40% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay/ visit; deductible does not apply	50% coinsurance	$0 copay for first mental health/substance abuse visit
	Inpatient services	40% coinsurance	50% coinsurance	Out-of-Network preauthorization required. $500 penalty if not obtained

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 are pregnant	Office visits	$40 copay/ visit; deductible does not apply	50% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	40% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	40% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	40% coinsurance	50% coinsurance	Out-of-Network preauthorization required. $500 penalty if not obtained
	Rehabilitation services Habilitation services	Physical Therapy: $40 copay/ visit; deductible does not apply Occupational Therapy: $40 copay/ visit; deductible does not apply Speech Therapy: $40 copay/ visit; deductible does not apply	Physical Therapy: 50% coinsurance Occupational Therapy: 50% coinsurance Speech Therapy: 50% coinsurance	Physical, Occupational & Speech Therapy - 60 combined visits/ calendar year Out-of-Network preauthorization required. $500 penalty if not obtained
	Skilled nursing care	40% coinsurance	50% coinsurance	- 150 days/ calendar year combined with Inpatient Rehabilitation services
	Durable medical equipment	40% coinsurance	50% coinsurance	Out-of-Network preauthorization required. $500 penalty if not obtained
	Hospice services	40% coinsurance	50% coinsurance	For inpatient see "If you have a hospital stay"
If your child needs dental or eye care	Children's eye exam	$40 copay/ visit; deductible does not apply	50% coinsurance	1 exam/calendar year
	Children's glasses	Reimbursed first $50, then 50% of covered charges; deductible does not apply		Frames & lenses OR contacts every 24 months up to end of month child turns 19
	Children's dental check-up	No charge; deductible does not apply	20% coinsurance; deductible does not apply	- 1 exam/ 6 months up to end of month child turns 19

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.)		
• Cosmetic Surgery • Dental Care (Adult)	• Long-Term Care • 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.)		
• Abortion • Acupuncture • Bariatric surgery • Chiropractic Care	• Hearing Aids - 1 hearing aid/ impaired ear every 36 months up to age 19 • Hearing Aids - $3,000/ impaired ear every 36 months for all other members • Infertility Treatment	• Non-emergency care when traveling outside the U.S. • 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: Maine Bureau of Insurance, Department of Professional and Financial Regulation, 34 State House Station, Augusta, ME 04333-0334, **(800) 300-5000**, or contact Harvard Pilgrim at the number on the back of your ID card. Other coverage options may be available to you too, including buying individual insurance coverage through the **CoverME.gov**. For more information, about the **CoverME.gov**, visit **www.CoverME.gov** or call **1-866-636-0355**.

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

Consumer for Affordable Health Care
12 Church Street, PO Box 2409
Augusta, Maine 04338-2490
1-800-965-7476
www.mainecahc.org
consumerhealth@mainecahc.org

Maine Bureau of Insurance
34 State House
Station Augusta, ME 04333
1-207-624-8475
1-800-300-5000

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**.

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**.

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 (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)		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**	$3,000	■ **The plan's overall deductible**	$3,000	■ **The plan's overall deductible**	$3,000
■ **Specialist copayment**	$80	■ **Specialist copayment**	$80	■ **Specialist copayment**	$80
■ **Hospital (facility) coinsurance**	40%	■ **Hospital (facility) coinsurance**	40%	■ **Hospital (facility) coinsurance**	40%
■ **Other copayment**	$15	■ **Other copayment**	$15	■ **Other coinsurance**	40%
This EXAMPLE event includes services like:		**This EXAMPLE event includes services like:**		**This EXAMPLE event includes services like:**	
Specialist office visits (*prenatal care*)		Primary care physician office visits (*including disease education*)		Emergency room care (*including medical supplies*)	
Childbirth/Delivery Professional Services		Diagnostic tests (*blood work*)		Diagnostic test (*x-ray*)	
Childbirth/Delivery Facility Services		Prescription drugs		Durable medical equipment (*crutches*)	
Diagnostic tests (*ultrasounds and blood work*)		Durable medical equipment (*glucose meter*)		Rehabilitation services (*physical therapy*)	
Specialist visit (*anesthesia*)					
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:**	
Cost Sharing		*Cost Sharing*		*Cost Sharing*	
Deductibles	$3,000	Deductibles	$0	Deductibles	$2,200
Copayments	$300	Copayments	$1,700	Copayments	$300
Coinsurance	$3,400	Coinsurance	$0	Coinsurance	$0
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$0	Limits or exclusions	$0	Limits or exclusions	$0
The total Peg would pay is	**$6,700**	**The total Joe would pay is**	**$1,700**	**The total Mia would pay is**	**$2,500**

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

Language Assistance Services

Español (Spanish) ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-877-907-4742 (TTY: 711).

Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-877-907-4742 (TTY: 711).

Kreyòl Ayisyen (French Creole) ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 1-877-907-4742 (TTY: 711).

繁體中文 (Traditional Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-907-4742（TTY：711）。

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu quí vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quí vị miễn phí. Gọi số 1-877-907-4742 (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-907-4742 (телетайп: 711).

العربية (Arabic)

إنتباه: إذا أنت تتكلم اللغة **العربية**، خدمات المساعدة اللغوية متوفرة لك مجانا. **إتصل على 1 877-907-4742** (TTY: 711)

ខ្មែរ (Cambodian) ប្រសិនជាអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-877-907-4742 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-907-4742 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-907-4742 (TTY: 711).

한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-907-4742 (TTY: 711) 번으로 전화해 주십시오.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-877-907-4742 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-907-4742 (TTY: 711).

हिंदी (Hindi) ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्तमें उपलब्ध है. जानकारी के लिये फोन करे. 1-877-907-4742 (TTY: 711)

ગુજરાતી (Gujarati) ધ્યાન આપો : જો તમે ગુજરાતી બોલતા હો તો આપને માટે ભાષાકીય સહાય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 1-877-907-4742 (TTY: 711)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-877-907-4742 (TTY: 711).

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-877-907-4742 (TTY: 711).

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.

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: Civil Rights Compliance Officer, 1 Wellness Way, Canton, MA 02021-1166, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@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 (TTY)

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

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.