HPHC Insurance Company

**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services
**The HPHC Insurance Company Best Buy HSA PPO**

**Coverage Period: 01/01/2027 — 12/31/2027**
**Coverage for: Individual + Family | Plan Type: PPO**

| | |
|---|---|
|  | **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 **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:<br>In and Out-of-Network Combined: $3,500 member/$7,000 family<br>Benefits 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: **In-Network** **preventive care**, 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?** | In and Out-of-Network Combined:<br>In-Network: $3,500 member/ $7,000 family<br>Out-of-Network: $7,000 member / $14,000 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, 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?** | No. | You can see the specialist you choose without permission from this plan. |



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 | 10% coinsurance | 30% coinsurance | None |
| | Specialist visit | 10% coinsurance | 30% coinsurance | None |
| | Preventive care/ screening/ immunization | No charge; deductible does not apply | 30% 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) | X-rays: 10% coinsurance<br>Laboratory: 10% coinsurance | X-rays: 30% coinsurance<br>Laboratory: 30% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 30% coinsurance | Cost sharing may vary for certain imaging services.<br>Out-of-Network preauthorization required.<br>$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 need drugs to treat your illness or condition** More information about prescription drug coverage is available at **www.harvardpilgrim.org/ 2027Select3T** | Generic drugs | Retail-30-day supply: You pay **10% Coinsurance** Retail & Home Delivery- 90-day: You pay **10% Coinsurance** | No Coverage | |
| | Preferred brand drugs | Retail-30-day supply: You pay **10% Coinsurance** Retail & Home Delivery- 90-day: You pay **10% Coinsurance** | No Coverage | |
| | Non-preferred brand drugs | Retail-30-day supply: You pay **10% Coinsurance** Retail & Home Delivery- 90-day: You pay **10% Coinsurance** | No Coverage | |
| | Specialty drugs | Generic: You pay 10% Coinsurance Preferred:You pay 10% Coinsurance Non-Preferred: You pay 10% Coins | No Coverage | Up to a 30-day supply (retail & Home), with certain limitations, including Prior Authorization, Step Therapy, Quantity Limits |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 30% coinsurance | Out-of-Network preauthorization required. $500 penalty if not obtained. |
| | Physician/surgeon fees | 10% coinsurance | 30% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | 10% coinsurance | | None |
| | Emergency medical transportation | 10% coinsurance | | None |
| | Urgent care | Urgent care center: 10% coinsurance | Urgent care center: 30% coinsurance | Cost sharing may vary based on location. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 30% coinsurance | Out-of-Network preauthorization required. $500 penalty if not obtained. |
| | Physician/surgeon fee | 10% coinsurance | 30% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 10% coinsurance | 30% coinsurance | None |
| | Inpatient services | 10% coinsurance | 30% coinsurance | None |

| 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 | 10% coinsurance | 30% coinsurance | Cost sharing does not apply for preventive services (such as routine prenatal visits). |
| | Childbirth/delivery professional services | 10% coinsurance | 30% coinsurance | |
| | Childbirth/delivery facility services | 10% coinsurance | 30% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance | 30% coinsurance | None |
| | Rehabilitation services<br>Habilitation services | Physical Therapy:<br>10% coinsurance<br>Occupational Therapy:<br>10% coinsurance<br>Speech Therapy:<br>10% coinsurance | Physical Therapy:<br>30% coinsurance<br>Occupational Therapy:<br>30% coinsurance<br>Speech Therapy:<br>30% coinsurance | Out-of-Network preauthorization required. $500 penalty if not obtained. |
| | Skilled nursing care | 10% coinsurance | 30% coinsurance | 150 days/calendar year combined with Inpatient Rehabilitation services. |
| | Durable medical equipment | 10% coinsurance | 30% coinsurance | Out-of-Network preauthorization required. $500 penalty if not obtained. |
| | Hospice services | 10% coinsurance | 30% coinsurance | For inpatient see "If you have a hospital stay" |
| **If your child needs dental or eye care** | Children's eye exam | No charge; deductible does not apply | 30% coinsurance | 1 exam/calendar year |
| | Children's glasses | Not covered | Not covered | None |
| | Children's dental check-up | Not covered | Not covered | None |

## 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 | • Dental Care (Adult) | • Routine foot care (except for diabetes or systemic circulatory diseases) |
| • Cosmetic Surgery | • Long-Term Care | • Services that are not Medically Necessary |
| | • Private-duty nursing | • 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 | • Chiropractic Care | • Infertility Treatment |
| • Bariatric surgery | • Hearing Aids - $3,000/aid every 36 months, for each impaired ear | • 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: 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
HPHC Insurance Company, 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

**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** | $3,500 | ■ **The plan's overall deductible** | $3,500 | ■ **The plan's overall deductible** | $3,500 |
| ■ **Specialist coinsurance** | 10% | ■ **Specialist coinsurance** | 10% | ■ **Specialist coinsurance** | 10% |
| ■ **Hospital (facility) coinsurance** | 10% | ■ **Hospital (facility) coinsurance** | 10% | ■ **Hospital (facility) coinsurance** | 10% |
| ■ **Other coinsurance** | 10% | ■ **Other coinsurance** | 10% | ■ **Other coinsurance** | 10% |
| **This EXAMPLE event includes services like:**<br>Specialist office visits (*prenatal care*)<br>Childbirth/Delivery Professional Services<br>Childbirth/Delivery Facility Services<br>Diagnostic tests (*ultrasounds and blood work*)<br>Specialist visit (*anesthesia*) | | **This EXAMPLE event includes services like:**<br>Primary care physician office visits (*including disease education*)<br>Diagnostic tests (*blood work*)<br>Prescription drugs<br>Durable medical equipment (*glucose meter*) | | **This EXAMPLE event includes services like:**<br>Emergency room care (*including medical supplies*)<br>Diagnostic test (*x-ray*)<br>Durable medical equipment (*crutches*)<br>Rehabilitation services (*physical therapy*) | |
| **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 | $3,500 | Deductibles | $3,500 | Deductibles | $2,800 |
| Copayments | $0 | Copayments | $0 | Copayments | $0 |
| 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 | $0 | Limits or exclusions | $0 |
| **The total Peg would pay is** | **$3,500** | **The total Joe would pay is** | **$3,500** | **The total Mia would pay is** | **$2,800** |

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

Harvard Pilgrim Health Care

a Point32Health company

# Language Assistance Services

**Arabic (العربية)** انتباه: إذا كنت تتحدث لغة أخرى غير الإنجليزية، فإن خدمات المساعدة اللغوية متاحة لك مجانًا. يرجىالاتصال 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 હિાય વિાઓ, તમારા માટે મફત ઉપલબ્ધ છે. કૃપા કરીને તમારા ભિ્ય આઈડી કાડ્ડ 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 ननःशिुल्क 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)** បុរសិនបរអុន កនិយាយភាសាបសងេបហ្គាំពីភាសាអុង់បលេ សបសវាកមុមជំនួ យភាសា ដលែឥតលិតថ្លៃ លីអាចរកហានសហ្គារអុន ក។ សូ មុហ្គាំហ្គាត់ កន់ បលខហ្គាំបលី ID កាតសាធិករស់អុន ក។

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

**Lao (ພາສາລາວ)** ກະລຸນາ ຮັບຊາບ: ຖ້າ ທ່ານເວົ້າພາສາອື່ນ ທີ່ບໍ່ແ ມ່ນພາສາ ອັງກດ, ທ່ານສາມາດໃຊ້ບໍລການ ຊ່ວຍເຫ ລືອດ ້ານ ພາສາໄ ດ ້ ໂດຍ ບ່ເສຍ ຄ່າ. ກະລຸນາໂທຫາເບ ີ ໍ ໍ ໍ

# 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**

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

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