


## The Harvard Pilgrim Best Buy HMO


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

**Coverage Period:** 01/01/2021 — 12/31/2021  
**Coverage for:** Individual + Family | **Plan Type:** HMO

	<p>The Summary of Benefits and Coverage (SBC) document will help you choose a health <a href="#">plan</a>. The SBC shows you how you and the <a href="#">plan</a> would share the cost for covered health care services. <b>NOTE: Information about the cost of this <a href="#">plan</a> (called the premium) will be provided separately. This is only a summary.</b> For more information about your coverage, or to get a copy of the complete terms of coverage, <a href="http://www.harvardpilgrim.org/LGsampleEOC">www.harvardpilgrim.org/LGsampleEOC</a>. For general definitions of common terms, such as <a href="#">allowed amount</a>, <a href="#">balance billing</a>, <a href="#">coinsurance</a>, <a href="#">copayment</a>, <a href="#">deductible</a>, <a href="#">provider</a>, or other <b>underlined</b> terms see the Glossary. You can view the Glossary at <a href="http://www.healthcare.gov/sbc-glossary">www.healthcare.gov/sbc-glossary</a> or call 1-888-333-4742 to request a copy.</p>	
Important Questions	Answers	Why this matters
<p>What is the overall <a href="#">deductible</a>?</p>	<p>\$1,000 member/ \$2,000 family Benefits are administered on a calendar year basis.</p>	<p>Generally you must pay all the costs up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the policy, they have to meet their own individual <a href="#">deductible</a> until the overall family <a href="#">deductible</a> amount has been met.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes: <a href="#">durable medical equipment</a>, <a href="#">emergency room care</a>, prescription drugs, outpatient mental health services, <a href="#">preventive care</a>, <a href="#">provider</a> office visits, routine eye exams, are covered before you meet your <a href="#">deductibles</a>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But, a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p>\$5,000 member/ \$10,000 family</p>	<p>The <a href="#">out-of-pocket limit</a> 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 <a href="#">out-of-pocket limit</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>

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

Important Questions	Answers	Why this matters
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="https://www.harvardpilgrim.org/public/find-a-provider">https://www.harvardpilgrim.org/public/find-a-provider</a> or call 1-888-333-4742 for a list of <u>preferred providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays ( <u>balance-billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes, some exceptions apply.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	None
	<u>Specialist</u> visit	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	None
	<u>Preventive care</u> / <u>screening</u> / <u>immunization</u>	No charge; <u>deductible</u> 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	<u>Diagnostic test</u> (x-ray, blood work)	<b>X-rays:</b> No charge <b>Laboratory:</b> No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$75 <u>copay</u> /procedure up to \$150/calendar year; <u>deductible</u> does not apply	Not covered	Cost sharing may vary for certain imaging services.

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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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="http://www.harvardpilgrim.org/2021Premium3T">prescription drug coverage</a> is available at <a href="http://www.harvardpilgrim.org/2021Premium3T">www.harvardpilgrim.org/2021Premium3T</a> .	Low Cost Generic drugs	*30 Day- Supply Retail Pharmacy Tier 1: \$5 copay; *90 Day Supply Retail Pharmacy Tier 1: \$15 copay; *90 Day Supply Mail Order Pharmacy Tier 1: \$10 copay		*Deductible does not apply
	High Cost Generic drugs	*30 Day- Supply Retail Pharmacy Tier 2: \$20 copay; *90 Day Supply Retail Pharmacy Tier 2: \$60 copay; *90 Day Supply Mail Order Pharmacy Tier 2: \$40 copay		Your plan covers a limited list of drugs. Not all drugs are covered
	Preferred brand drugs	*30 Day- Supply Retail Pharmacy Tier 3: \$30 copay; *90 Day Supply Retail Pharmacy Tier 3: \$90 copay; *90 Day Supply Mail Order Pharmacy Tier 3: \$60 copay		
	Non-preferred brand drugs	*30 Day- Supply Retail Pharmacy Tier 4: \$50 copay; *90 Day Supply Retail Pharmacy Tier 4: \$150 copay; *90 Day Supply Mail Order Pharmacy Tier 4: \$150 copay;		
	<a href="#">Specialty drugs</a>	*30 Day- Supply Retail Pharmacy Tier 5: \$100 copay; *90 Day Supply Retail Pharmacy Tier 5: \$300 copay;		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None
	Physician/surgeon fees	No charge	Not covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$100 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply		None
	<a href="#">Emergency medical transportation</a>	No charge		None
	<a href="#">Urgent care</a>	<b>Convenience care clinic:</b> \$25 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply <b>Urgent care center:</b> \$25 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply <b>Hospital urgent care center:</b> \$25 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	<b>Convenience care clinic:</b> Not Covered <b>Urgent care center</b> Not Covered <b>Hospital urgent care center</b> Same As Participating <a href="#">Provider</a>	Services with non-participating providers are only covered outside of the service area.

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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 have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	None
	Physician/surgeon fee	No charge	Not covered	
If you have a hospital stay If you have mental health, behavioral health, or	Outpatient services	\$25 <u>copay</u> /visit; <u>deductible</u>	Not covered	None
	Inpatient services	No charge	Not covered	
If you have mental health, behavioral health, or substance abuse needs	Office visits	\$25 <u>copay</u> /visit; <u>deductible</u>	Not covered	None <u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	No charge	Not covered	
If you are pregnant If you need help recovering or have other special health needs	Childbirth/delivery facility services	No charge	Not covered	None <u>Cost sharing</u> does not apply for <u>preventive services</u> .
	<u>Home health care</u>	No charge	Not covered	
If you need help recovering or have other special health needs	<u>Rehabilitation services</u>	No charge	Not covered	Occupational therapy – 30 visits /calendar year Physical therapy – 30 visits /calendar year
	<u>Habilitation services</u>	No charge	Not covered	
	<u>Skilled nursing care</u>	No charge	Not covered	
	<u>Durable medical</u>	20% <u>coinsurance</u> ;	Not covered	Wigs – \$350/calendar year
	<u>Hospice services</u>	No charge	Not covered	For inpatient see “If you have a hospital stay”.

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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 your child needs dental or eye care	Children’s eye exam	\$25 <b>copay</b> /visit; <b>deductible</b> 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; <b>deductible</b> does not apply	Not covered	2 exams/calendar year
<b>Excluded Services &amp; Other Covered Services:</b>				
<b>Services Your <u>Plan</u> Does NOT Cover (This isn’t a complete list. Check your policy or <u>plan</u> document for other <u>excluded services</u>.)</b>				
	<ul style="list-style-type: none"> <li>• Long-Term (Custodial) Care</li> <li>• Most Cosmetic Surgery</li> <li>• Most Dental Care (Adult)</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine foot care</li> <li>• Services that are not Medically Necessary</li> <li>• Weight Loss Programs</li> </ul>		
<b>Other Covered Services (This isn’t a complete list. Check your policy or <u>plan</u> document for other covered services and your costs for these services.)</b>				
<ul style="list-style-type: none"> <li>• Acupuncture - 20 visits/calendar year</li> <li>• Bariatric surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic Care - 20 visits/calendar year</li> <li>• Hearing Aids - \$2,000/aid every 36 months, for each impaired ear</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility Treatment</li> <li>• Routine eye care (Adult) – 1 exam/calendar year</li> </ul>		

**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 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:

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

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**

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

**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 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:**

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.*

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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 <a href="#">plan's overall deductible</a>	\$1,000	■ The <a href="#">plan's overall deductible</a>	\$1,000	■ The <a href="#">plan's overall deductible</a>	\$1,000
■ <a href="#">Specialist copayment</a>	\$25	■ <a href="#">Specialist copayment</a>	\$25	■ <a href="#">Specialist copayment</a>	\$25
■ <a href="#">Hospital (facility) copayment</a>	\$0	■ <a href="#">Hospital (facility) copayment</a>	\$0	■ <a href="#">Hospital (facility) copayment</a>	\$0
■ <a href="#">Other copayment</a>	\$0	■ <a href="#">Other copayment</a>	\$0	■ <a href="#">Other copayment</a>	\$0
This EXAMPLE event includes services like: <a href="#">Specialist</a> office visits ( <i>prenatal care</i> ) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <a href="#">Diagnostic tests</a> ( <i>ultrasounds and blood work</i> ) <a href="#">Specialist visit</a> ( <i>anesthesia</i> )		This EXAMPLE event includes services like: <a href="#">Primary care physician</a> office visits ( <i>including disease education</i> ) <a href="#">Diagnostic tests</a> ( <i>blood work</i> ) <a href="#">Prescription drugs</a> <a href="#">Durable medical equipment</a> ( <i>glucose meter</i> )		This EXAMPLE event includes services like: <a href="#">Emergency room care</a> ( <i>including medical supplies</i> ) <a href="#">Diagnostic test</a> ( <i>x-ray</i> ) <a href="#">Durable medical equipment</a> ( <i>crutches</i> ) <a href="#">Rehabilitation services</a> ( <i>physical therapy</i> )	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,000	<a href="#">Deductibles</a>	\$100	<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$0	<a href="#">Copayments</a>	\$300	<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0	<a href="#">Coinsurance</a>	\$0	<a href="#">Coinsurance</a>	\$50
<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
<b>The total Peg would pay is</b>	<b>\$1,000</b>	<b>The total Joe would pay is</b>	<b>\$400</b>	<b>The total Mia would pay is</b>	<b>\$1,250</b>

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 1-888-333-4742 (TTY: 711).

Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-888-333-4742 (TTY: 711).

Kreyòl Ayisyen (French Creole) ATANSYON: Si nou parle Kreyòl Ayisyen, yo ka asistans pou sèvis ki disponib an lang nou pou gratis. Rele 1-888-333-4742 (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 1-888-333-4742 (TTY: 711)。

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói tiếng Việt, dịch vụ hỗ trợ dịch của chúng tôi sẵn sàng phục vụ bạn miễn phí. Gọi số 1-888-333-4742 (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Позвоните 1-888-333-4742 (телефон: 711).

العربية | Arabic

بمجرد إتاحة الخدمات في اللغة العربية، اتصلت للمساعدة لأكثر من مرة. لك نحن نقدم لكم، اتصل على 1-888-333-4742

(TTY: 711)

ខ្មែរ (Cambodian) ប្រសិនបើ អ្នកនិយាយភាសាខ្មែរ មានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទ 1-888-333-4742 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique que vous devez proposer gratuitement. Appelez le 1-888-333-4742 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili i servizi di assistenza linguistica gratuiti. Chiamate il numero 1-888-333-4742 (TTY: 711).





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**한국어 (Korean):** 알림: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-333-4742 (TTY: 711) 번으로 전화해 주십시오.

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**Ελληνικά (Greek):** ΠΡΟΣΧΕΤΗ: Ενημερώστε ελλήνων ασθενείς σχετικά με τη δωρεάν υπηρεσία υποστήριξης γλώσσας που είναι διαθέσιμη. Κλήτε στο 1-888-333-4742 (TTY: 711).

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**Polski (Polish):** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać bezpłatnie z pomocy językowej. Zadzwoń do numer 1-888-333-4742 (TTY: 711).

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**हिंदी (Hindi):** ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये शपथकी सहायता मुफ्त में उपलब्ध है. जानकारी के लिये फोन करें: 1-888-333-4742 (TTY: 711)

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**ગુજરાતી (Gujarati):** ધ્યાન આપો : જો તમે ગુજરાતી બોલતા હો તો આપને માટે ભાષાસેવા સહાયતા મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો: 1-888-333-4742 (TTY: 711)


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**ආසානො (Sinhala):** විදහනය: ඉන්දියා භාෂා භාවිතා කිරීමේදී, සහාය සේවාවක් නොමිලේ ලබාගත හැක. විදහාදීම සඳහා, සහාය සේවාවට කථනා කරන්න. විදහා 1-888-333-4742 (TTY: 711).

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**ATTENTION:** If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-333-4742 (TTY: 711).

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

(Continued)

## 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. HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

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, you can file a grievance with: Civil Rights Compliance Officer, 93 Worcester St, Wellesley, MA 02481, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: [civil\\_rights@harvardpilgrim.org](mailto:civil_rights@harvardpilgrim.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.

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