Harvard Pilgrim Health Care

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
The Harvard Pilgrim Maine's Choice Plus HMO

Coverage Period: 07/01/2024 — 06/30/2025
Coverage for: Individual + Family | Plan Type: HMO

	**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?	Preferred **Deductible**: $4,000 member/$8,000 family Standard **Deductible**: $6,000 member/$12,000 family 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: **Preventive care**, prescription drugs, Preferred Network **provider** office visits, **emergency room care**, outpatient mental health services, **Rehabilitation services**, **Habilitation services**, routine eye exams, 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?	Preferred Network: $6,000 member/$12,000 family Standard Network: $7,350 member/$14,700 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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations & Exceptions
		Participating Provider		Non-Participating Provider	
		Preferred Network	Standard Network		
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Level 1: $35 **copay**/visit; **deductible** does not apply	Level 1: $50 **copay**/visit; **deductible** does not apply	Not covered	No **copay** for the first office visit/Member.
	Specialist visit	Level 1: $35 **copay**/visit; **deductible** does not apply Level 2: $50 **copay**/visit; **deductible** does not apply	Level 1: $50 **copay**/visit; **deductible** does not apply Level 2: 40% **coinsurance**	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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations & Exceptions
		Participating Provider		Non-Participating Provider	
		Preferred Network	Standard Network		
					Then check what your **plan** will pay for.
If you have a test	**Diagnostic test** (x-ray, blood work)	X-rays: 20% **coinsurance** Laboratory: 20% **coinsurance**	X-rays: 40% **coinsurance** Laboratory: 40% **coinsurance**	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% **coinsurance**	40% **coinsurance**	Not covered	**Cost sharing** may vary for certain imaging services
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: $5 **copay**/prescription; **deductible** does not apply 90-Day Mail Tier 1: $10 **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 $250; **deductible** does not apply 90-Day Mail Tier 4: 30% **coinsurance** up to $500; **deductible** does not apply		Not covered	
	Specialty drugs	30-Day Retail Tier 4: 30% **coinsurance** up to $250; **deductible** does not apply 90-Day Mail Tier 4: 30% **coinsurance** up to $500; **deductible** does not apply 30-Day Retail Tier 5: 30% **coinsurance** up to $250; **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
		Participating Provider		Non-Participating Provider	
		Preferred Network	Standard Network		
		90-Day Mail Tier 5: 30% coinsurance up to $500; deductible does not apply			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Not covered	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	$300 copay/visit; deductible does not apply			None
	Emergency Medical Transportation	20% coinsurance; deductible does not apply			None
	Urgent Care	Urgent care center: $35 copay/visit; deductible does not apply	Urgent care center: $50 copay/visit; deductible does not apply	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)	20% coinsurance	40% coinsurance	Not covered	None
	Physician/surgeon fee	20% coinsurance	40% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay/visit; deductible does not apply		Not covered	No copay for the first mental health/substance abuse visit/Member.
	Inpatient services	20% coinsurance		Not covered	None
If you are pregnant	Office visits	$35 copay/visit; deductible does not apply	$50 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	20% coinsurance	40% coinsurance	Not covered	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations & Exceptions
		Participating Provider		Non-Participating Provider	
		Preferred Network	Standard Network		
If you need help recovering or have other special health needs	Home health care	20% coinsurance		Not covered	None
	Rehabilitation services Habilitation services	Physical Therapy: $50 copay/visit; deductible does not apply Occupational Therapy: $50 copay/visit; deductible does not apply Speech Therapy: $50 copay/visit; deductible does not apply	Physical Therapy: 40% coinsurance Occupational Therapy: 40% coinsurance Speech Therapy: 40% coinsurance	Not covered	Occupational, physical & speech therapy – 60 combined visits /calendar year
	Skilled nursing care	20% coinsurance	40% coinsurance	Not covered	100 days/calendar year combined with Inpatient Rehabilitation services.
	Durable medical equipment	20% coinsurance		Not covered	Wigs – $350/calendar year
	Hospice services	20% coinsurance		Not covered	For inpatient see "If you have a hospital stay"
If your child needs dental or eye care	Children's eye exam	$35 copay/visit; deductible does not apply	$50 copay/visit; deductible does not apply	Not covered	1 exam/calendar year
	Children's glasses	Not covered			None
	Children's dental check-up	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 • 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/calendar year • Bariatric surgery	• Chiropractic Care - 40 visits/calendar year • Hearing Aids - $3,000/aid every 36 months, for each impaired ear	• Infertility Treatment • 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
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 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**	$4,000	■ **The plan's overall deductible**	$4,000	■ **The plan's overall deductible**	$4,000
■ **Specialist copayment**	$50	■ **Specialist copayment**	$50	■ **Specialist copayment**	$50
■ **Hospital (facility) coinsurance**	20%	■ **Hospital (facility) coinsurance**	20%	■ **Hospital (facility) coinsurance**	20%
■ **Other coinsurance**	20%	■ **Other coinsurance**	20%	■ **Other coinsurance**	20%
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	$4,000	Deductibles	$100	Deductibles	$400
Copayments	$50	Copayments	$1,500	Copayments	$600
Coinsurance	$1,700	Coinsurance	$0	Coinsurance	$200
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	**$5,750**	**The total Joe would pay is**	**$1,600**	**The total Mia would pay is**	**$1,200**

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