Harvard Pilgrim Health Care of New England

New Hampshire

The Harvard Pilgrim ElevateHealth℠ Options HMO

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

Coverage Period: 07/01/2022 — 06/30/2023
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?	**Tier 1 Deductible:** $2,000 member /$4,000 family **Tier 2 Deductible:** $4,000 member /$8,000 family Benefits are administered on a Plan 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, and the following **ElevateHealth Options** Network services: **provider** office visits, x-rays, laboratory, **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?	$6,000 member/$12,000 family	The **out-of-pocket limit** 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 **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 preferred 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, 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 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	
		ElevateHealth Options Network	Other HPHC Network		
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**Level 1:** $25 copay/visit; deductible does not apply	20% coinsurance	Not covered	No copay for the first 2 office visits/Member.
	Specialist visit	**Level 1:** $25 copay/visit; deductible does not apply **Level 2:** $50 copay/visit; deductible does not apply	20% 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	
		ElevateHealth Options Network	Other HPHC Network		
					Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	**X-rays:** No charge; deductible does not apply **Laboratory:** No charge; deductible does not apply	**X-rays:** 20% coinsurance **Laboratory:** 20% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	20% 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/2022Premium4T**.	Generic drugs	**30-Day Retail Tier 1:** $5 copay/prescription; deductible does not apply **90-Day Mail Tier 1:** $5 copay/prescription; deductible does not apply **30-Day Retail Tier 2:** $15 copay/prescription; deductible does not apply **90-Day Mail Tier 2:** $15 copay/prescription; deductible does not apply			None
	Preferred brand drugs	**30-Day Retail Tier 3:** $30 copay/prescription; deductible does not apply **90-Day Mail Tier 3:** $30 copay/prescription; deductible does not apply			Some generic drugs are in this tier.
	Non-preferred brand drugs	**30-Day Retail Tier 4:** $50 copay/prescription; deductible does not apply **90-Day Mail Tier 4:** $50 copay/prescription; deductible does not apply			Same as above.
	Specialty drugs	All drugs are covered in Retail Pharmacy and Mail Order Pharmacy Tiers 1 — 4			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	
		ElevateHealth Options Network	Other HPHC Network		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**Non-hospital affiliated:** $150 copay/visit; deductible does not apply **Hospital affiliated:** $150 copay/visit	**Non-hospital affiliated:** 20% coinsurance **Hospital affiliated:** 20% coinsurance	Not covered	None
	Physician/surgeon fees	**Non-hospital affiliated:** No charge; deductible does not apply **Hospital affiliated:** No charge	**Non-hospital affiliated:** 20% coinsurance **Hospital affiliated:** 20% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	$250 copay/visit			None
	Emergency Medical Transportation	No charge			None
	Urgent Care	**Convenience care clinic:** $25 copay/visit; deductible does not apply **Urgent care center:** $35 copay/visit; deductible does not apply **Hospital urgent care center:** $150 copay/visit	**Convenience care clinic:** $25 copay/visit; deductible does not apply **Urgent care center:** $35 copay/visit; deductible does not apply **Hospital urgent care center:** 20% coinsurance	Not covered	Services with non-participating providers are only covered outside of the service area
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Not covered	None
	Physician/surgeon fee	No charge	20% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations & Exceptions
		Participating Provider		Non-Participating Provider	
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If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$25 copay/visit; deductible does not apply		Not covered	No copay for the first 2 mental health/substance abuse visits/Member.
	Inpatient services	No charge; deductible does not apply		Not covered	None
If you are pregnant	Office visits	$25 copay/visit; deductible does not apply	20% coinsurance	Not covered	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No charge	20% coinsurance	Not covered	
	Childbirth/delivery facility services	No charge	20% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge; deductible does not apply	No charge; deductible does not apply	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:** 20% coinsurance **Occupational Therapy:** 20% coinsurance **Speech Therapy:** 20% coinsurance	Not covered	Occupational, physical & speech therapy – 60 combined visits /Plan Year
	Skilled nursing care	No charge	20% coinsurance	Not covered	100 days/Plan Year combined with Inpatient Rehabilitation services.
	Durable medical equipment	20% coinsurance		Not covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations & Exceptions
		Participating Provider		Non-Participating Provider	
		ElevateHealth Options Network	Other HPHC Network		
	Hospice services	No charge	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	$25 copay/visit; deductible does not apply	20% coinsurance	Not covered	1 exam/Plan Year
	Children's glasses	Not covered			None
	Children's dental check-up	Not covered	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.)

- 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
- 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/Plan Year
- Bariatric surgery
- Chiropractic Care - 20 visits/Plan Year
- Hearing Aids - $1,500/aid every 60 months, for each impaired ear
- Infertility Treatment
- Routine eye care (Adult) – 1 exam/Plan 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 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**. 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 of New England, 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

New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301
1-800-852-3416
www.nh.gov/insurance
consumerservices@ins.nh.gov

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 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**	$2,000	■ **The plan's overall deductible**	$2,000	■ **The plan's overall deductible**	$2,000
■ **Specialist *copayment***	$50	■ **Specialist *copayment***	$50	■ **Specialist *copayment***	$50
■ **Hospital (facility) *coinsurance***	0%	■ **Hospital (facility) *coinsurance***	0%	■ **Hospital (facility) *coinsurance***	0%
■ **Other *coinsurance***	0%	■ **Other *coinsurance***	0%	■ **Other *coinsurance***	0%
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	$2,000	Deductibles	$0	Deductibles	$2,000
Copayments	$50	Copayments	$1,200	Copayments	$300
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	**$2,050**	**The total Joe would pay is**	**$1,200**	**The total Mia would pay is**	**$2,300**

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 palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan 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 quí vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quí vị 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. Звоните 1-888-333-4742 (телетайп: 711).

العربية (Arabic)

إنتباه: إذا أنت تتكلم اَللُّغة **اَلعربية** ، خَدَمات اَلمُساعَدة اَللُّغوية مُتَوفرة لك مَجانا. ً **إتصل على 1 888-333-4742**

(TTY: 711)

ខ្មែរ (Cambodian) ប្រសុំជូនដំណឹង៖ បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-888-333-4742 (TTY: 711)។

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

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

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

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-888-333-4742 (TTY: 711).

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

हिंदी (Hindi) ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्तमें उपलब्ध है. जानकारी के लिये फोन करे. 1-888-333-4742 (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. 1-888-333-4742 (TTY: 711)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-333-4742 (TTY: 711).

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).

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

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General Notice About Nondiscrimination and Accessibility Requirements

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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, sex, sexual orientation, or 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.