Harvard Pilgrim Health Care of New England

New Hampshire

The Harvard Pilgrim HMO

Coverage Period: 01/01/2016 — 12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or **plan** document at **www.harvardpilgrim.org** or by calling **1-888-333-4742**.

Important Questions	Answers	Why this matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your costs for services this **plan** covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this **plan** covers.
Is there an out–of–pocket limit on my expenses?	Yes. $6,000 per member per calendar year/ $12,000 per family per calendar year	The **out-of-pocket** limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you **plan** for health care expenses.
What is not included in the out–of–pocket limit?	Please see your Schedule of Benefits for out-of-pocket maximum exclusions for your plan.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the **plan** will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see **www.harvardpilgrim.org** or call **1-888-333-4742**.	If you use an in-**network** doctor or other health care **provider**, this **plan** will pay some or all of the costs of covered services. Be aware, your in-**network** doctor or hospital may use an out-of-**network provider** for some services. **Plans** use the term in-**network**, preferred, or participating for **providers** in their **network**. See the chart starting on page 2 for how this **plan** pays different kinds of **providers**.
Do I 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 the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this **plan** doesn't cover are listed on page 6 . See your policy or **plan** document for additional information about **excluded services**.

Questions: Call 1-888-333-4742 or visit us at **www.harvardpilgrim.org**. If you are not clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at **www.harvardpilgrim.org/fhcr** or call **1-888-333-4742** to request a copy.

- Co-payments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Co-insurance is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the **plan**'s **allowed amount** for an overnight hospital stay is $1,000, your co-insurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the **plan** pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This **plan** may encourage you to use participating **providers** by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Participating Provider	Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 Copayment per visit	Not covered	None
	Specialist visit	$15 Copayment per visit	Not covered	None
	Other practitioner office visit	$15 Copayment per visit	Not covered	Cost sharing may vary for certain practitioners.
	Preventive care/screening/immunization	No charge	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.harvardpilgrim.org/2016Premium3T** .	Most generic drugs	**30-Day Supply Retail Pharmacy Tier 1:** No charge **90-Day Supply Retail Pharmacy Tier 1:** No charge **90-Day Supply Mail Order Pharmacy Tier 1:** No charge		None
	Preferred brand drugs	**30-Day Supply Retail Pharmacy Tier 2:** $25 Copayment **90-Day Supply Retail Pharmacy Tier 2:** $75 Copayment **90-Day Supply Mail Order Pharmacy Tier 2:** $25 Copayment		Some generic drugs are in this tier.
	Non-preferred brand drugs	**30-Day Supply Retail Pharmacy Tier 3:** $40 Copayment **90-Day Supply Retail Pharmacy Tier 3:** $120 Copayment **90-Day Supply Mail Order Pharmacy Tier 3:** $40 Copayment		Same as above.
	Specialty drugs	All drugs are covered in Retail Pharmacy and Mail Order Pharmacy Tiers 1 — 3		Must be obtained through a Specialty Pharmacy.

Common Medical Event	Services You May Need	Participating Provider	Non-Participating Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency Room Services	$50 Copayment per visit This Copayment is waived if admitted to the hospital directly from the emergency room.	Same As Participating **Provider**	None
	Emergency Medical Transportation	No charge	Same As Participating **Provider**	None
	Urgent Care	**Convenience care clinic** $15 Copayment per visit **Urgent care clinic** $15 Copayment per visit **Hospital Urgent Care Clinic:** $25 Copayment per visit	**Convenience care clinic** Not Covered **Urgent care clinic** Not Covered **Urgent care hospital facility** Same As Participating **Provider**	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	None
	Physician/surgeon fee	No charge	Not covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**Group Therapy:** $10 Copayment per visit **Individual Therapy:** $15 Copayment per visit	Not covered	None
	Mental/Behavioral health inpatient services	No charge	Not covered	None
	Substance use disorder outpatient services	**Group Therapy:** $10 Copayment per visit **Individual Therapy:** $15 Copayment per visit	Not covered	None
	Substance use disorder inpatient services	No charge	Not covered	None

Common Medical Event	Services You May Need	Participating Provider	Non-Participating Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	No charge	Not covered	None
If you need help recovering or have other special health needs	**Home health care**	No charge	Not covered	None
	Rehabilitation services (Inpatient)	No charge	Not covered	– Limited to 60 days per calendar year
	Habilitation services (Outpatient)	$15 Copayment per visit	Not covered	– Physical Therapy – limited to 40 visits per calendar year – Occupational Therapy – limited to 40 visits per calendar year – Speech Therapy – limited to 40 visits per calendar year Physical, Occupational, and Speech therapies visit limits are combined per calendar year
	Skilled nursing care	No charge	Not covered	– Limited to 100 days per calendar year
	Durable medical equipment	20% Coinsurance	Not covered	None
	Hospice services	No charge	Not covered	If inpatient services are required, please see "If you have a hospital stay".
If your child needs dental or eye care	Eye exam	$15 Copayment per visit	Not covered	– Limited to 1 exam per calendar year You may have other coverage under a Vision Rider.
	Glasses	Not covered	Not covered	You may have other coverage under a Vision Rider.
	Dental check-up	No charge	Not covered	– Limited to 2 exams per calendar year

Common Medical Event	Services You May Need	Participating Provider	Non-Participating Provider	Limitations & Exceptions
	– Up to the age of 13			You may have other coverage under a Dental Rider.

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 • Bariatric Surgery • Chiropractic Care • Hearing Aids • Infertility Treatments • Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the **plan**, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the **plan**. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the **plan** at **1–800–333–4742**. You may also contact your state insurance department, 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**

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your **plan**, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can 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 Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

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.

About these Coverage Examples:

These examples show how this **plan** might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different **plans**.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this **plan**. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays: $7,390**
- **Patient pays: $150**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$150
Total	**$150**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays: $3,730**
- **Patient pays: $1,670**

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Co-pays	$1,590
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,670**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health **plan**.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any **member** covered under this **plan**.
- **Out-of-pocket** expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health **plan** allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other **plans**, you'll find the same Coverage Examples. When you compare **plans**, check the "Patient Pays" box in each example. The smaller that number, the more coverage the **plan** provides.

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in **out-of-pocket** costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay **out-of-pocket** expenses.