Harvard Pilgrim Health Care

Choice Plus Copay Harvard Pilgrim

EXPRESS SCRIPTS®

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, visit https://www.myuhc.com or call 1-844-298-8929. 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 https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-844-298-8929 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network*: $750.00 Individual / $1,500.00 Family. Non-Network*: $3,000.00 Individual / $6,000.00 Family per calendar year, *Deductibles cross-apply.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Care and primary care services with copay 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, there are no other deductibles.	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.
What is the out-of-pocket limit for this plan?	For network provider*: $6,000.00 Individual / $12,000.00 Family. For out-of-network providers*: $12,000.00 Individual / $24,000.00 Family per calendar year *Out-of-pockets cross-apply.	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 limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain pre-notification for services.	Even though you pay these expenses, they don't count toward the out-of-pocket.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 1-844-298-8929 for a list of network providers. See https://www.Express-Scripts.com/BrownBrownInc for a list of network pharmacy 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 a referral.

All **coinsurance** costs shown in this chart are after your **deductible** has been met.

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.	$25.00 copay/visit. (Mental/Behavioral Health and Substance Abuse – please see below).	40% coinsurance	Copays apply for provider's telemedicine or virtual visits except, $0 copay by a Designated Virtual Network Provider. No Designated Virtual Provider visit coverage for out of network. If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply.
	Specialist visit	$50.00 copay/visit	40% coinsurance	None
	Preventive care/screening/ immunization	No charge, deductible does not apply.	40% 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. $750.00 paid maximum out of network per calendar year. No maximum in network.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Prior Authorization required non-network for Sleep Studies.

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)	
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at** www.Express-Scripts.com/BrownBrownInc	Generic Drugs (Tier 1)	Retail: $15 copay Mail Order: $45 copay	Retail: Not covered	Covers up to a 30-day retail supply; up to 90-day home delivery. Mandatory generic: You are responsible for the Tier 3 copay plus cost difference between the generic and brand medication when generic equivalent is available but not filled. Step therapy program applies.
	Preferred brand drugs (Tier 2)	Retail: $50 copay Mail Order: $150 copay	Retail: Not covered	
	Non-preferred brand drugs (Tier 3)	Retail: $90 copay Mail Order: $270 copay	Retail: Not covered	
	Specialty drugs (Tier 4)	Retail: $200 copay Mail Order: $600 copay	Retail: Not covered Mail Order: N/A	Specialty drugs filled by Accredo.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Mandatory Second Opinion is required for certain surgeries or $750 copay and applicable coinsurance and deductible applies.
If you need immediate medical attention	Emergency room care	$400.00 copay/visit	$400.00 copay/visit	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None.
	Urgent care	$40.00 copay/visit	40% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Out-of-network: $250 copay applies in addition to calendar year deductible and applicable coinsurance. Prior Authorization required out-of-network or $1,000.00 penalty applies.
	Physician/surgeon fees	20% coinsurance	40% 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 need mental health, behavioral health, or substance abuse services	Outpatient services	No charge /Office Visit All other services: 20% coinsurance.	40% coinsurance	Cognitive Behavioral Therapy provided by AbleTo is covered at 100% no cost share for the initial consultation and ongoing therapeutic treatments. AbleTo is a contracted provider for Optum Behavioral services specifically for Cognitive Behavioral Therapy. Prior Authorization for certain outpatient services - required non-network. Prior Authorization is also required for Benefits provided for Applied Behavioral Analysis (ABA).
	Inpatient services	Platinum Preferred Network Substance Abuse Provider: deductible and coinsurance waived Other In-Network Provider: 20% coinsurance	40% coinsurance	Prior Authorization required non-network or $1,000.00 penalty.
If you are pregnant	Office visits	$25.00 copay/initial visit only.	40% coinsurance	Prior Authorization required non-network Inpatient stays that exceed normal 48 hours for vaginal delivery or 96 hours for cesarean or $1,000.00 penalty. Routine pre-natal care is covered at no charge.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Prior Authorization required non-network for Home Health Care and Private Duty Nursing. 60 visits per calendar year.
	Rehabilitation services	20% coinsurance	40% 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)	
	Habilitation services	20% coinsurance	40% coinsurance	None
	Skilled nursing care	20% coinsurance	40% coinsurance	Prior Authorization required non-network for Skilled Nursing or Private Duty Nursing. 60 days per calendar year in network and out of network combined.
	Durable medical equipment	20% coinsurance	40% coinsurance	Prior Authorization required non-network for DME devices.
	Hospice services	20% coinsurance	40% coinsurance	Prior Authorization required non-network for Hospice In-patient Only or $1,000.00 penalty.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	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 Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Adult routine vision exam (i.e. refraction)
- Cosmetic Surgery
- Dental Care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic care
- Hearing aids
- Fertility treatment
- Private-duty nursing
- Routine foot care

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/healthreform. 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: 1-844-298-8929 or visit https://www.myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

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 plan meet the Minimum Value Standards? 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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-844-298-8929.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-298-8929.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-844-298-8929.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-298-8929.

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 (deductibles, copayments 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)

■ **The plan's overall deductible**	**$750.00**
■ **Specialist copayment**	**$50.00**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750.00
Copayments	$50.00
Coinsurance	$2,380.00
What isn't covered	
Limits or exclusions	$0.00
The total Peg would pay is	**$3,180.00**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ **The plan's overall deductible**	**$750.00**
■ **Specialist copayment**	**$50.00**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750.00
Copayments	$200.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Joe would pay is	**$950.00**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ **The plan's overall deductible**	**$750.00**
■ **Specialist copayment**	**$50.00**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750.00
Copayments	$400.00
Coinsurance	$330.00
What isn't covered	
Limits or exclusions	$10.00
The total Mia would pay is	**$1,490.00**

We do not treat members differently because of sex, age, race, color, disability, or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability, or national origin, you can send a complaint to the Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.