Harvard Pilgrim Health Care

**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services
HMO 6000 Value - Flex

Coverage Period: 11/20/2025 — 11/19/2026
**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/public/eoc?pdid=PD0000201954**. 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?** | Medical & **Prescription Drug Deductible**: $6,000 member / $12,000 family<br>Benefits are administered on a Plan Year basis. | 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**, **provider** office visits, Tiers 1 and 2 **prescription drugs**, services from Flex **Providers**, and Non-hospital based imaging, **Rehabilitation services** and **Habilitation services** 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?** | $9,200 member / $18,400 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 limits** 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?** | Pediatric Dental Care, 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, & 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 | $55 copay/ visit; deductible does not apply | Not covered | None |
| | Specialist visit | $55 copay/ visit; deductible does not apply | 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. Then check what your plan will pay for. |

| 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 test** | Diagnostic test (x-ray, blood work) | X-rays: $350 copay/ visit; deductible does not apply<br>Laboratory: Flex Providers: $55 copay/ visit; deductible does not apply<br>Other Plan Providers: $100 copay/ visit | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | Non-Hospital Based: $1,000 copay/ procedure<br>Hospital Based: $1,500 copay/ procedure | Not covered | None |
| **If you need drugs to treat your illness or condition**<br>More information about prescription drug coverage is available at **www.harvardpilgrim.org/ 2025CoreMA5T**. | Generic drugs | 30-Day Retail Tier 1: No charge; deductible does not apply<br>90-Day Mail Tier 1: No charge; deductible does not apply<br>30-Day Retail Tier 2: $50 copay/ prescription; deductible does not apply<br>90-Day Mail Tier 2: $100 copay/ prescription; deductible does not apply | Not covered | Core MA formulary - covers a limited list; not all drugs are covered<br>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: $80 copay/ prescription<br>90-Day Mail Tier 3: $160 copay/ prescription | Not covered | |
| | Non-preferred brand drugs | 30-Day Retail Tier 4: $120 copay/ prescription<br>90-Day Mail Tier 4: $360 copay/ prescription | Not covered | |
| | Specialty drugs | 30-Day Retail Tier 4: $120 copay/ prescription<br>90-Day Mail Tier 4: $360 copay/ prescription | Not covered | Some drugs must be obtained through a Specialty Pharmacy. |

| 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) | |
| | | 30-Day Retail Tier 5: 50% coinsurance up to $500<br>90-Day Mail Tier 5: 50% coinsurance up to $1,500 | | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Flex Providers: No charge<br>Other Plan Providers: $1,500 copay/ visit | Not covered | None |
| | Physician/surgeon fees | Flex Providers: No charge; deductible does not apply<br>Other Plan Providers: No charge; deductible does not apply | Not covered | |
| **If you need immediate medical attention** | Emergency room care | $1,500 copay/ visit | | None |
| | Emergency medical transportation | No charge | | None |
| | Urgent care | Urgent care center: $70 copay/ visit; deductible does not apply | Urgent care center: Not covered | Non-participating providers only covered outside the service area. Cost sharing may vary based on Urgent Care location. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $1,500 copay/ admit | Not covered | None |
| | Physician/surgeon fee | No charge | Not covered | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $55 copay/ visit; deductible does not apply | Not covered | None |
| | Inpatient services | $1,500 copay/ admit | Not covered | None |
| **If you are pregnant** | Office visits | $55 copay/ visit; deductible does not apply | Not covered | Cost sharing does not apply for preventive services. |
| | Childbirth/delivery professional services | No charge | Not covered | |
| | Childbirth/delivery facility services | $1,500 copay/ admit | Not covered | |

| 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 help recovering or have other special health needs** | Home health care | No charge | Not covered | None |
| | Rehabilitation services<br>Habilitation services | Physical Therapy: Non-hospital based: $55 copay/ visit; deductible does not apply Hospital based: $150 copay/ visit<br>Occupational Therapy: Non-hospital based: $55 copay/ visit; deductible does not apply Hospital based: $150 copay/ visit<br>Speech Therapy: Non-hospital based: $55 copay/ visit; deductible does not apply Hospital based: $150 copay/ visit | Not covered | Physical & Occupational Therapy - 60 combined visits/ Plan Year |
| | Skilled nursing care | $1,500 copay/ admit | Not covered | - 100 days/ Plan Year |
| | Durable medical equipment | 35% coinsurance | Not covered | - 1 synthetic monofilament wig/ Plan Year |
| | Hospice services | No charge | Not covered | For inpatient see “If you have a hospital stay” |
| **If your child needs dental or eye care** | Children’s eye exam | $55 copay/ visit; deductible does not apply | Not covered | 1 exam/Plan Year |
| | Children’s glasses | Reimbursed first $50, then 50% of covered charges; deductible does not apply | | Frames & lenses OR contacts every 12 months up to end of month child turns 19 |
| | Children’s dental check-up | Not covered | | Off exchange plans **must** have separate coverage |

## 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.) | | |
|---|---|---|
| • Cosmetic Surgery | • Non-emergency care when traveling outside the U.S. | • Routine foot care (except for diabetes or systemic circulatory diseases) |
| • Dental Care (Adult) | • Private-duty nursing | • Services that are not Medically Necessary |
| • Long-Term Care | | |

| 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.) | | |
|---|---|---|
| • Abortion | • Chiropractic Care | • Routine eye care (Adult) - 1 exam/ Plan Year |
| • Acupuncture | • Hearing Aids - $2,000/ hearing aid every 36 months/ impaired ear up to age 22 | • Weight Loss Programs - 3 months of Weight Watchers traditional OR at Work/ Plan Year |
| • Bariatric surgery | • Infertility Treatment | |

**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, Center 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**

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 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**.

**Language Access Services:**

Para obtener asistencia en Español, llame al **1–888–333–4742**.

SMSMSMSMSMSMSMSM, SMSMSMSMSMSMSM **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 (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** | $6,000 |
| ■ **Specialist copayment** | $55 |
| ■ **Hospital (facility) copayment** | $1,500 |
| ■ **Other copayment** | $55 |
| **This EXAMPLE event includes services like:** | |
| Specialist office visits (*prenatal 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 | $6,000 |
| Copayments | $2,400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$8,400** |

| Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition) | |
|---|---|
| ■ **The plan's overall deductible** | $6,000 |
| ■ **Specialist copayment** | $55 |
| ■ **Hospital (facility) copayment** | $1,500 |
| ■ **Other copayment** | $55 |
| **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 | $4,100 |
| Copayments | $600 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$4,700** |

| Mia's Simple Fracture (in-network emergency room visit and follow up care) | |
|---|---|
| ■ **The plan's overall deductible** | $6,000 |
| ■ **Specialist copayment** | $55 |
| ■ **Hospital (facility) copayment** | $1,500 |
| ■ **Other copayment** | $350 |
| **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 | $2,100 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,500** |

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

Harvard Pilgrim Health Care

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# Language Assistance Services

**Arabic (العربية)** انتباه: إذا كنت تتحدث لغة أخرى غير الإنجليزية، فإن خدمات المساعدة اللغوية متاحة لك مجانًا. يرجى الاتصال بالرقم الموجود على بطاقة هوية العضو الخاصة بك.

**French (Français)** ATTENTION : Si vous parlez une langue autre que l'anglais, des services d'assistance linguistique gratuits sont à votre disposition. Veuillez appeler le numéro indiqué sur votre carte d'adhérent.

**Greek (Ελληνικά)** ΠΡΟΣΟΧΗ: Εάν μιλάτε κάποια άλλη γλώσσα πέρα από τα αγγλικά, γλωσσικές υπηρεσίες χωρίς χρέωση είναι στη διάθεσή σας. Καλέστε τον αριθμό στην κάρτα μέλους σας.

**Gujarati (ગુજરાતી)** ધ્યાન આપો: જો તમે અંગ્રેજી સિવાય બીજી ભાષા બોલો છો, તો ભાષા હિાય વિાઓ, તમારા માટે મફત ઉપલબ્ધ છે. કૃપા કરીને તમારા ભિ્ય આઈડી કાડ પરના નંબર પર કોલ કરો.

**Haitian Creole (Kreyòl Ayisyen)** ATANSYON: Si w pale yon lang ki pa Anglè, gen sèvis èd pou lang ki disponib gratis pou ou. Tanpri rele nimewo ki sou kat ID manm ou a.

**Hindi (हिंदी)** ध्यान दें: अगर आप अंग्रेजी के अलावा कोई दूसरी भाषा बोलते हैं, तो भाषा सहायता सेवाएं आपके लिए निःशुल्क उपलब्ध हैं। कृ पया अपने सदस्य आईडी काडड पर ददए गए नंबर पर कॉल करें।

**Italian (Italiano)** ATTENZIONE: se parli una lingua diversa dall'inglese, sono disponibili gratuitamente servizi di assistenza linguistica. Chiama il numero indicato sulla tua tessera membro identificativa.

**Khmer (ភាសាខ្មែរ)** ប្រសិនបរអ្ន កនិយាយភាសាបសងេបហ្ាពីភាសាអ្ងំបលរ េស បសវាកម្មជំនួ យភាសា ដលែឥតលិតថ្ល រ លីអាចរកហានសហ្រអ្ន ក។ សូ ម្ហ្ាហ្ាកាន់ បលខហ្ាបលី ID កាតសាធិករស់អ្ន ក។

**Korean (한국어)** 알림: 영어 이외의 언어를 사용하신다면 언어 지원 서비스를 무료로 제공해 드립니다. 가입자 ID 카드에 명시된 번호로 전화하시기 바랍니다.

**Lao (ພາສາລາວ)** ກະລຸນາ ຮັບຊາບ: ຖ້າ ທ່ານເວົ້າພາສາອື່ນ ທີ່ບ ແ ມ່ນພາສາ ອັງກດ, ທ່ານສາມາດໃຊ້ບໍລການ ຊ່ວຍເຫ ືອດ້ານພາສາ ໄ ດ ໂດຍ ບ່ເສຍ ຄ່າ. ກະລຸນາໂທຫາເບ ີ່ ທ ູ່ ຢ ູ່ ໃນ ບັດປະຈ ຳ ຕ ົ ວສະມາຊ ິ ກຂອງ ທ ່ ານ.

**Polish (polski)** UWAGA: Jeśli posługujesz się językiem innym niż angielski, możesz bezpłatnie korzystać z usług pomocy językowej. Zadzwoń pod numer podany na Twojej karcie członkowskiej.

**Portuguese (Português)** ATENÇÃO: caso fale outro idioma que não o inglês, são-lhe disponibilizados gratuitamente serviços de assistência linguística. Ligue para o número no seu cartão de identificação de membro.

**Russian (Русский)** ВНИМАНИЕ! Если вы не говорите на английском языке, то можете бесплатно воспользоваться услугами языковой поддержки. Позвоните по номеру, указанному на вашей идентификационной карте участника.

**Spanish (Español)** ATENCIÓN: Si usted habla un idioma que no sea inglés, están disponibles para usted, sin costo, servicios de asistencia en otros idiomas. Llame al número que figura en su tarjeta de identificación de miembro.

**Traditional Chinese (繁體中文)** 注意事項：如果您講非英語的其他語言，我們可以為您提供免費的語言協助服務。請撥打您會員 ID 卡上的電話號碼。

**Vietnamese (Tiếng Việt)** LƯU Ý: Nếu quý vị nói ngôn ngữ khác không phải tiếng Anh, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Vui lòng gọi đến số điện thoại trên thẻ ID hội viên của quý vị.

**ATTENTION:** If you speak a language other than English, language assistance services, free of charge, are available to you. Please call the number on your member ID card.

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# 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 (including pregnancy, sexual orientation and gender identity). HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity).**

## 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 (see below for contact information).

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 (including pregnancy, sexual orientation and gender identity) you can file a grievance with:

**Point32Health Civil Rights Legal Coordinator**
1 Wellness Way
Canton, MA 02021-1166

866-750-2074, TTY service: 711
Fax: 617-668-2754
Email: **OCRCoordinator@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 (TDD)

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**