HPHC Insurance Company

New Hampshire

The HPHC Insurance Company Best Buy Tiered Copayment PPO — LP — Silver

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

Coverage Period: 12/01/2016 — 11/30/2017

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

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 **https://www.harvardpilgrim.org/portal/page?_pageid=213,7864030=portal=PORTAL** or by calling **1-888-333-4742**.

Important Questions	Answers	Why this matters:
What is the overall deductible?	**In-Network:** $5,000 per member per calendar year/ $10,000 per family per calendar year **Out-of-Network:** $6,000 per member per calendar year/ $12,000 per family per calendar year The **deductible** applies to benefits cited in the chart starting on Page 3 , for other benefits see your Plan document.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
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 3 for other costs for services this **plan** covers.
Is there an out–of–pocket limit on my expenses?	Yes. **In and Out-of-Network Combined:** $6,250 per member per calendar year/ $12,500 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?	Premiums, balance-billed 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the **plan** will pay for *specific* covered services, such as office visits.

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.

MD0000003746, RX0000001253
DN0000000139, VS0000000050
FORM NO. 2073_PD0000004701

Important Questions	Answers	Why this matters:
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 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this **plan**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8 . See your policy or plan document for additional information about **excluded services**.

- 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	**Copayment Level 1:** $40 Copayment per visit	Deductible, then 20% Coinsurance	None
	Specialist visit	**Copayment Level 1:** $40 Copayment per visit **Copayment Level 2:** $80 Copayment per visit	Deductible, then 20% Coinsurance	**Copayment** Level 1 services are generally services of primary care **providers**. **Copayment** Level 2 services are generally **specialists**.
	Other practitioner office visit	**Copayment Level 1:** $40 Copayment per visit	Deductible, then 20% Coinsurance	Cost sharing may vary for certain practitioners.
	Preventive care/ screening/ immunization	No charge	20% Coinsurance	None
If you have a test	Diagnostic test (x-ray, blood work)	**Select LP Providers** No charge **Other Plan Providers** Deductible, then no charge	Deductible, then 20% Coinsurance	In some plans, the Deductible applies to x-rays.
	Imaging (CT/PET scans, MRIs)	Deductible, then no charge	Deductible, then 20% Coinsurance	None

Common Medical Event	Services You May Need	Participating Provider	Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.harvardpilgrim.org/2016Value5T** .	Most generic drugs	**30-Day Supply Retail Pharmacy Tier 1:** $5 Copayment **90-Day Supply Retail Pharmacy Tier 1:** $15 Copayment **90-Day Supply Mail Order Pharmacy Tier 1:** $10 Copayment **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:** $50 Copayment		Value formulary - Your plan covers a limited list of drugs. Not all drugs are covered.
	Preferred brand drugs	**30-Day Supply Retail Pharmacy Tier 3:** 30% Coinsurance subject to a maximum of $550 per prescription or prescription refill **90-Day Supply Retail Pharmacy Tier 3:** 30% Coinsurance subject to a maximum of $1,650 per prescription or prescription refill **90-Day Supply Mail Order Pharmacy Tier 3:** 30% Coinsurance subject to a maximum of $1,100 per prescription or prescription refill		Same as above.
	Non-preferred brand drugs	**30-Day Supply Retail Pharmacy Tier 4:** 35% Coinsurance subject to a maximum of $550 per prescription or prescription refill **90-Day Supply Retail Pharmacy Tier 4:** 35% Coinsurance subject to a maximum of $1,650 per prescription or prescription refill **90-Day Supply Mail Order Pharmacy Tier 4:** 35% Coinsurance subject to a maximum of $1,100 per prescription or prescription refill		Some generic drugs are in this tier. Same as above.
	Specialty drugs	**30-Day Supply Retail Pharmacy Tier 4:** 35% Coinsurance subject to a maximum of $550 per prescription or prescription refill **90-Day Supply Retail Pharmacy Tier 4:** 35% Coinsurance subject to a maximum of $1,650 per prescription or prescription refill **90-Day Supply Mail Order Pharmacy Tier 4:** 35% Coinsurance subject to a maximum of $1,100 per prescription or prescription refill		Must be obtained through a Specialty Pharmacy.

Common Medical Event	Services You May Need	Participating Provider	Non-Participating Provider	Limitations & Exceptions
		30-Day Supply Retail Pharmacy Tier 5: 40% Coinsurance subject to a maximum of $550 per prescription or prescription refill **90-Day Supply Retail Pharmacy Tier 5:** 40% Coinsurance subject to a maximum of $1,650 per prescription or prescription refill **90-Day Supply Mail Order Pharmacy Tier 5:** 40% Coinsurance subject to a maximum of $1,100 per prescription or prescription refill		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**Select LP Providers** $150 Copayment per visit **Other Plan Providers** Deductible, then no charge	Deductible, then 20% Coinsurance	None
	Physician/surgeon fees	**Select LP Providers** No charge **Other Plan Providers** Deductible, then no charge	Deductible, then 20% Coinsurance	None
If you need immediate medical attention	Emergency Room Services	Deductible, then $250 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	Deductible, then no charge	Same As Participating **Provider**	None
	Urgent Care	**Convenience care clinic:** $40 Copayment per visit **Urgent care clinic:** $80 Copayment per visit **Hospital urgent care clinic:** Deductible, then $125 Copayment per visit	**Convenience care clinic:** Deductible, then 20% Coinsurance **Urgent care clinic:** Deductible, then 20% Coinsurance **Hospital urgent care clinic:** Same As Participating **Provider**	None

Common Medical Event	Services You May Need	Participating Provider	Non-Participating Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then no charge	Deductible, then 20% Coinsurance	None
	Physician/surgeon fee	Deductible, then no charge	Deductible, then 20% Coinsurance	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:** $40 Copayment per visit	20% Coinsurance	None
	Mental/Behavioral health inpatient services	No charge	Deductible, then 20% Coinsurance	None
	Substance use disorder outpatient services	**Group Therapy:** $10 Copayment per visit **Individual Therapy:** $40 Copayment per visit	20% Coinsurance	None
	Substance use disorder inpatient services	No charge	Deductible, then 20% Coinsurance	None
If you are pregnant	Prenatal and postnatal care	No charge	20% Coinsurance	None
	Delivery and all inpatient services	Deductible, then no charge	Deductible, then 20% Coinsurance	None
If you need help recovering or have other special health needs	Home health care	No charge	Deductible, then 20% Coinsurance	None
	Rehabilitation services (Inpatient)	Deductible, then no charge	Deductible, then 20% Coinsurance	– Limited to 100 days per calendar year
	Habilitation services (Outpatient)	**Copayment Level 1:** $40 Copayment per visit	Deductible, then 20% Coinsurance	– Physical Therapy – limited to 20 visits per calendar year – Occupational Therapy – limited to 20 visits per calendar year – Speech Therapy – limited to 20 visits per calendar year
	Skilled nursing care	Deductible, then no charge	Deductible, then 20% Coinsurance	– Limited to 100 days per calendar year

Common Medical Event	Services You May Need	Participating Provider	Non-Participating Provider	Limitations & Exceptions
	Durable medical equipment	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance	None
	Hospice service	No charge	Deductible, then 20% Coinsurance	If inpatient services are required, please see "If you have a hospital stay".
If your child needs dental or eye care	Eye exam	**Copayment Level 1:** $40 Copayment per visit	Deductible, then 20% Coinsurance	– Limited to 1 exam per calendar year You may have other coverage under a Vision Rider.
	Glasses – Up to the age of 19	The Plan will reimburse you for the first $100, then 50% of your remaining covered charges	The Plan will reimburse you for the first $100, then 50% of your remaining covered charges	Each Dependent under the age of 19 is eligible for coverage every 12 months for either (A) prescription eyeglass frames and lenses or (B) prescription contact lenses. Reimbursement for disposable contact lenses is limited to a 6 month supply.
	Dental check-up – Up to the age of 19	50% Coinsurance	50% Coinsurance	– Limited to 1 exam per 6 months You 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.)
• Infertility Treatment • Long-Term (Custodial) Care • Most Cosmetic Surgery • Most Dental Care (Adult) • 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.)
• Abortion • Acupuncture • Bariatric Surgery • Chiropractic Care • Hearing Aids • Non-emergency care when traveling outside the U.S. • 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
HPHC Insurance Company, 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

State of New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301
1-603-271-2261

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: $3,760**
- **Patient pays: $3,780**

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**

Note: These examples assume that the member 1) has Individual coverage and 2) receives services at a Select Hospital. Cost sharing for Family coverage will differ.

Patient pays:

Deductibles	$3,620
Co-pays	$10
Co-insurance	$0
Limits or exclusions	$150
Total	**$3,780**

Note: These examples assume that the member 1) has Individual coverage and 2) receives services at a Select Hospital. Cost sharing for Family coverage will differ.

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

- **Amount owed to providers: $5,400**
- **Plan pays: $3,480**
- **Patient pays: $1,920**

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	$1,840
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,920**

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.