Harvard Pilgrim Health Care

2024 SBSB Small Group Plan Offerings

For employers with 1 to 9 eligible employees

2024 SBSB Small Group Plans — Effective January 1, 2024, through December 31, 2024.
This is only a summary of plans. For more complete information, please refer to the Schedule of Benefits.

Plan Name	Office Visit (PCP/Specialist)	Deductible[1] (Individual/Family)	Out-of-Pocket Maximum[1] (Individual/Family)	Coinsurance	ER	Urgent Care	Inpatient	Day Surgery	Laboratory	X-Rays	Scans: CT, MRI, PET	PT/OT/ST	Acupuncture & Chiropractic	Rx Cost Sharing[2]	
														Retail	Mail
Open Plans															
HMO															
HMO 20 - Flex Metal level - Platinum MD0000201128 RX0000201077 DN0000201047	$20 copay/$40 copay Copay waived for first non-routine PCP visit	None	$2,500/$5,000 Embedded	None	$125 copay	$40 copay	$400 copay	Flex Provider: $150 copay Other: $500 copay	Flex Provider: Covered in full Other: $40 copay	$30 copay	Non-hospital based: $100 copay Hospital based: $200 copay	Non-hospital based: $20 copay, Hospital based: $40 copay	$40 copay	$5/$25/$40/$60/20% (T5: $250 coinsurance max)	$10/$50/$80/$180/20% (T5: $750 coinsurance max)
HMO 500 - Flex Metal level - Gold MD0000201129 RX0000201078 DN0000201048	$25 copay/$50 copay Copay waived for first non-routine PCP visit	$500/$1,000 Embedded	$7,000/$14,000 Embedded	None	$300 copay	$50 copay	Deductible then $250 copay	Flex Provider: $50 copay Other: Deductible then $300 copay	Flex Provider: Covered in full Other: Deductible then $45 copay	Deductible then $50 copay	Non-hospital based: $200 copay Hospital based: Deductible then $300 copay	Non-hospital based: $25 copay, Hospital based: Deductible then $50 copay	$50 copay	$5/$30/$60/$100/20% (T5: $250 coinsurance max)	$10/$60/$120/$300/20% (T5: $750 coinsurance max)
HMO 1000 - Flex Metal level - Gold MD0000201130 RX0000201078 DN0000201048	$25 copay/$50 copay Copay waived for first non-routine PCP visit	$1,000/$2,000 Embedded	$7,000/$14,000 Embedded	None	$300 copay	$50 copay	Deductible then $250 copay	Flex Provider: $50 copay Other: Deductible then $300 copay	Flex Provider: Covered in full Other: Deductible then $45 copay	Deductible then $50 copay	Non-hospital based: $200 copay Hospital based: Deductible then $300 copay	Non-hospital based: $25 copay, Hospital based: Deductible then $50 copay	$50 copay	$5/$30/$60/$100/20% (T5: $250 coinsurance max)	$10/$60/$120/$300/20% (T5: $750 coinsurance max)
HMO 1500 - Flex Metal level - Gold MD0000201131 RX0000201078 DN0000201048	$25 copay/$50 copay Copay waived for first non-routine PCP visit	$1,500/$3,000 Embedded	$7,000/$14,000 Embedded	None	$300 copay	$50 copay	Deductible then $250 copay	Flex Provider: $50 copay Other: Deductible then $300 copay	Flex Provider: Covered in full Other: Deductible then $45 copay	Deductible then $50 copay	Non-hospital based: $200 copay Hospital based: Deductible then $300 copay	Non-hospital based: $25 copay, Hospital based: Deductible then $50 copay	$50 copay	$5/$30/$60/$100/20% (T5: $250 coinsurance max)	$10/$60/$120/$300/20% (T5: $750 coinsurance max)
HMO 2000 - Flex Metal level - Gold MD0000201132 RX0000201078 DN0000201048	$25 copay/$50 copay Copay waived for first non-routine PCP visit	$2,000/$4,000 Embedded	$7,000/$14,000 Embedded	None	$300 copay	$50 copay	Deductible then $250 copay	Flex Provider: $50 copay Other: Deductible then $300 copay	Flex Provider: Covered in full Other: Deductible then $45 copay	Deductible then $50 copay	Non-hospital based: $200 copay Hospital based: Deductible then $300 copay	Non-hospital based: $25 copay, Hospital based: Deductible then $50 copay	$50 copay	$5/$30/$60/$100/20% (T5: $250 coinsurance max)	$10/$60/$120/$300/20% (T5: $750 coinsurance max)
HMO 2000 with Coinsurance - Flex Metal level - Gold MD0000201135 RX0000201090 DN0000201057	$40 copay/$75 copay	$2,000/$4,000 Embedded	$6,000/$12,000 Embedded	20%	Deductible then 20%	$75 copay	Deductible then 20%	Flex Provider: $200 copay Other: Deductible then 20%	Flex Provider: Covered in full Other: Deductible then 20%	Deductible then 20%	Non-hospital based: $250 copay Hospital based: Deductible then 20%	Non-hospital based: $35 copay Hospital based: Deductible then 20%	$50 copay	$5/$30/$60/$100/20% (T5: $250 coinsurance max)	$10/$60/$120/$300/20% (T5: $750 coinsurance max)
HMO 2000 Value - Flex Metal level - Silver MD0000201136 RX0000201079 DN0000201049	$55 copay/$75 copay	$2,000/$4,000 Embedded	$9,450/$18,900 Embedded	None	Deductible then $1,000 copay	$75 copay	Deductible then $1,000 copay	Flex Provider: $250 copay Other: Deductible then $1,000 copay	Flex Provider: $25 copay Other: Deductible then $75 copay	Deductible then $100 copay	Non-hospital based: $750 copay Hospital based: Deductible then $1,000 copay	Non-hospital based: $50 copay Hospital based: Deductible then $75 copay	$50 copay	$5/$30/Deductible then $80/Deductible then $120/Deductible then 20% (T5: $500 coinsurance max) Rx Deductible: $250/$500	$10/$60/Deductible then $160/Deductible then $360/Deductible then 20% (T5: $1,500 coinsurance max)
HMO 3000 - Flex Metal level - Silver MD0000201137 RX0000201080 DN0000201049	$50 copay/$75 copay Copay waived for first non-routine PCP visit	$3,000/$6,000 Embedded	$9,450/$18,900 Embedded	None	Deductible then $1,000 copay	$75 copay	Deductible then $1,000 copay	Flex Provider: $500 copay Other: Deductible then $1,000 copay	Flex Provider: Covered in full Other: Deductible then $100 copay	Deductible then $150 copay	Non-hospital based: $350 copay Hospital based: Deductible then $1,000 copay	Non-hospital based: $50 copay Hospital based: Deductible then $75 copay	$50 copay	$5/$30/$80/$120/20% (T5: $500 coinsurance max)	$10/$60/$160/$360/20% (T5: $1,500 coinsurance max)
HMO HSA															
HMO HSA 2000 - Flex Metal level - Silver MD0000201141 RX0000201082 DN0000201050	Deductible then $35 copay/Deductible then $55 copay	$2,000/$4,000 Non-embedded	$8,050/$16,100 Embedded	None	Deductible then $500 copay	Deductible then $55 copay	Deductible then $500 copay	Flex Provider: Deductible then $75 copay Other: Deductible then $300 copay	Flex Provider: Deductible then Covered in full Other: Deductible then $100 copay	Deductible then $55 copay	Non-hospital based: Deductible then $200 copay Hospital based: Deductible then $500 copay	Non-hospital based: Deductible then $35 copay Hospital based: Deductible then $55 copay	Deductible then $50 copay	Deductible then $5/Deductible then $30/Deductible then $80/Deductible then $120/Deductible then 20% (T5: $500 coinsurance max)	Deductible then $10/Deductible then $60/Deductible then $160/Deductible then $360/Deductible then 20% (T5: $1,500 coinsurance max)
HMO HSA 3000 - Flex Metal level - Silver MD0000201143 RX0000201084 DN0000201050	Deductible then $35 copay/Deductible then $55 copay	$3,000/$6,000 Non-embedded	$8,050/$16,100 Embedded	None	Deductible then $400 copay	Deductible then $55 copay	Deductible then $400 copay	Flex Provider: Deductible then Covered in full Other: Deductible then $250 copay	Flex Provider: Deductible then Covered in full Other: Deductible then $75 copay	Deductible then $55 copay	Non-hospital based: Deductible then $200 copay Hospital based: Deductible then $400 copay	Non-hospital based: Deductible then $35 copay Hospital based: Deductible then $55 copay	Deductible then $50 copay	Deductible then $5/Deductible then $30/Deductible then $80/Deductible then $120/Deductible then 20% (T5: $500 coinsurance max)	Deductible then $10/Deductible then $60/Deductible then $160/Deductible then $360/Deductible then 20% (T5: $1,500 coinsurance max)
HMO HSA 3400 - Flex Metal level - Silver MD0000201144 RX0000201085 DN0000201050	Deductible then $35 copay/Deductible then $55 copay	$3,400/$6,800 Non-embedded	$8,050/$16,100 Embedded	20%	Deductible then $400 copay	Deductible then $55 copay	Deductible then 20%	Flex Provider: Deductible then Covered in full Other: Deductible then $250 copay	Flex Provider: Deductible then Covered in full Other: Deductible then $75 copay	Deductible then $55 copay Per Visit	Non-hospital based: Deductible then $200 copay Hospital based: Deductible then $400 copay	Non-hospital based: Deductible then $35 copay Hospital based: Deductible then $55 copay	Deductible then $50 copay	Deductible then $5/Deductible then $30/Deductible then $80/Deductible then $120/Deductible then 20% (T5: $500 coinsurance max)	Deductible then $10/Deductible then $60/Deductible then $160/Deductible then $360/Deductible then 20% (T5: $1,500 coinsurance max)

[1] An explanation of embedded vs. non-embedded can be found in our key insurance terms to know.
[2] Preventive Rx applies for all HSA plans.

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														Retail	Mail
Open Plans															
PPO HSA															
PPO HSA 3400 - Flex Metal level - Silver MD0000201162 RX0000201085 DN0000201053	IN: Deductible then $35 copay/Deductible then $55 copay OON: Deductible then 20%	IN: $3,400/6,800 OON: $6,800/$13,600 Non-embedded	IN: $8,050/$16,100 OON: $16,100/$32,200 Embedded	IN: 20% OON: 20%	IN: Deductible then $400 copay OON: Same as IN	IN: Deductible then $55 copay OON: Deductible then 20%	IN: Deductible then 20% OON: Deductible then 20%	IN: Flex Provider: Deductible then Covered in full Other: Deductible then $250 copay OON: Deductible then 20%	IN: Flex Provider: Deductible then Covered in full Other: Deductible then $75 copay OON: Deductible then 20%	IN: Deductible then $55 copay OON: Deductible then 20%	IN: Non-hospital based: Deductible then $200 copay, Hospital based: Deductible then $400 copay OON: Deductible then 20%	IN: Non-hospital based: Deductible then $35 copay Hospital based: Deductible then $55 copay OON: Deductible then 20%	IN: Deductible then $50 copay OON: Deductible then 20%	Deductible then $5/Deductible then $30/Deductible then $80/Deductible then $120/Deductible then 20% (T5: $500 coinsurance max)	Deductible then $10/Deductible then $60/Deductible then $160/Deductible then $360/Deductible then 20% (T5: $1,500 coinsurance max)
PPO HSA 5000 - Flex Metal level - Bronze MD0000201163 RX0000201087 DN0000201054	IN: Deductible then $75 copay/Deductible then $150 copay OON: Deductible then 20%	IN: $5,000/$10,000 OON: $8,000/$16,000 Embedded	IN: $8,050/$16,100 OON: $16,100/$32,200 Embedded	IN: None OON: 20%	IN: Deductible then $1,500 copay OON: Same as IN	IN: Deductible then $150 copay OON: Deductible then 20%	IN: Deductible then $1,500 copay OON: Deductible then 20%	IN: Flex Provider: Deductible then $500 copay Other: Deductible then $1,000 copay OON: Deductible then 20%	IN: Flex Provider: Deductible then $25 copay Other: Deductible then $75 copay OON: Deductible then 20%	IN: Deductible then $150 copay OON: Deductible then 20%	IN: Non-hospital based: Deductible then $500 copay, Hospital based: Deductible then $1,000 copay OON: Deductible then 20%	IN: Non-hospital based: Deductible then $40 copay Hospital based: Deductible then $65 copay OON: Deductible then 20%	IN: Deductible then $50 copay OON: Deductible then 20%	Deductible then $5/Deductible then $30/Deductible then 50%/Deductible then 50%/Deductible then 50% (T3: $125/coinsurance max T4: $250 coinsurance max T5: $500 coinsurance max)	Deductible then $10/Deductible then $60/Deductible then 50%/Deductible then 50%/Deductible then 50% (T3: $250 coinsurance max T4: $750 coinsurance max T5: $1,500 coinsurance max)
Connector Plans															
Standard Platinum - Flex MD0000201122 RX0000201064 DN0000201034	$20 copay/$40 copay	None	$3,000/$6,000 Embedded	None	$150 copay	$40 copay	$500 copay	Flex Provider: $100 copay Other: $250 copay	Covered in full	Covered in full	Non-hospital based: $50 copay Hospital based: $150 copay	Non-hospital based: $20 copay Hospital based: $40 copay	$40 copay	$10/$25/$50	$20/$50/$150
Standard High Gold MD0000201116 RX0000201066 DN0000201036	$30 copay/$55 copay	None	$6,000/$12,000 Embedded	None	$350 copay	$55 copay	$750 copay	$500 copay	$25 copay	$75 copay	$250 copay	$55 copay	$50 copay	$30/$60/$90	$60/$120/$270
HMO 2000 Low - Flex Metal level - Gold MD0000201123 RX0000201070 DN0000201040	$25 copay/$50 copay	$2,000/$4,000 Embedded	$5,450/$10,900 Embedded	None	Deductible then $300 copay	$55 copay	Deductible then $750 copay	Flex Provider: $250 copay Other: Deductible then $500 copay	Flex Provider: $20 copay Other: Deductible then $50 copay	Deductible then $50 copay	Non-hospital based: $150 copay Hospital based: Deductible then $300 copay	Non-hospital based: $25 copay Hospital based: $50 copay	$50 copay	$30/Deductible then $60/Deductible then $125 Rx Deductible: $250/$500	$60/Deductible then $120/Deductible then $375
Standard Silver MD0000201117 RX0000201067 DN0000201037	$25 copay/$60 copay	$2,000/$4,000 Embedded	$9,450/$18,900 Embedded	None	Deductible then $350 copay	$60 copay	Deductible then $1,000 copay	Deductible then $500 copay	Deductible then $25 copay	Deductible then $50 copay	Deductible then $350 copay	$60 copay	$50 copay	$30/$55/Deductible then $75	$60/$110/Deductible then $225
Standard Low Silver HSA - Flex MD0000201125 RX0000201068 DN0000201038	Deductible then $30 copay/Deductible then $60 copay	$2,000/$4,000 Non-embedded	$7,050/$14,100 Embedded	None	Deductible then $300 copay	Deductible then $60 copay	Deductible then $750 copay	Flex Provider: Deductible then $250 copay Other: Deductible then $500 copay	Flex Provider: Deductible then $20 copay Other: Deductible then $60 copay	Deductible then $75 copay	Non-hospital based: Deductible then $200 copay Hospital based: Deductible then $500 copay	Non-hospital based: Deductible then $30 copay Hospital based: Deductible then $60 copay	Deductible then $50 copay	Deductible then $30/Deductible then $60/Deductible then $105	Deductible then $60/Deductible then $120/Deductible then $315
Standard High Bronze HSA - Flex MD0000201126 RX0000201069 DN0000201039	Deductible then $60 copay/Deductible then $90 copay	$3,600/$7,200 Embedded	$8,000/$16,000 Embedded	None	Deductible then $875 copay	Deductible then $90 copay	Deductible then $1,500 copay	Flex Provider: Deductible then $250 copay Other: Deductible then $500 copay	Flex Provider: Deductible then $25 copay Other: Deductible then $55 copay	Deductible then $135 copay	Non-hospital based: Deductible then $500 copay Hospital based: Deductible then $750 copay	Non-hospital based: Deductible then $60 copay Hospital based: Deductible then $90 copay	Deductible then $50 copay	Deductible then $30/Deductible then $120/Deductible then $200	Deductible then $60/Deductible then $240/Deductible then $600
HMO 3500 - Flex Metal level - Bronze MD0000201124 RX0000201072 DN0000201042	Deductible then $40 copay/Deductible then $65 copay	$3,500/$7,000 Embedded	$8,500/$17,000 Embedded	20%	Deductible then $1,500 copay	Deductible then $65 copay	Deductible then 20%	Flex Provider: Deductible then $250 copay Other: Deductible then $1,000 copay	Flex Provider: Ded then $25 Others: Deductible then $75	Deductible then $75 copay	Non-hospital based: Deductible then $500 Hospital-based: Deductible then $1,000	Non-hospital based: Deductible then $40 copay, Hospital based: Deductible then $65 copay	Deductible then $50 copay	$5/$30/Deductible then 50%/Deductible then 50%/Deductible then 50% (T3: $125/coinsurance max T4: $250 coinsurance max T5: $500 coinsurance max)	$10/$60/Deductible then 50%/Deductible then 50%/Deductible then 50% (T3: $250 coinsurance max T4: $750 coinsurance max T5: $1,500 coinsurance max)

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														Retail	Mail
Closed Plans - Only for Existing Groups on 2023 Plan Versions															
HMO															
HMO 1500 with Coinsurance - Flex Metal level - Gold MD0000201134 RX0000201078 DN0000201048	$40 copay/$75 copay	$1,500/$3,000 Embedded	$7,000/$14,000 Embedded	20%	Deductible then 20%	$75 copay	Deductible then 20%	Flex Provider: $200 copay Other: Deductible then 20%	Flex Provider: Covered in full Other: Deductible then 20%	Deductible then 20%	Non-hospital based: $250 copay Hospital based: Deductible then 20%	Non-hospital based: $35 copay Hospital based: Deductible then 20%	$50 copay	$5/$30/$60/$100/20% (T5: $250 coinsurance max)	$10/$60/$120/$300/20% (T5: $750 coinsurance max)
HMO 4000 - Flex Metal level - Silver MD0000201138 RX0000201080 DN0000201049	$50 copay/$75 copay Copay waived for first non-routine PCP visit	$4,000/$8,000 Embedded	$9,450/$18,900 Embedded	None	Deductible then $500 copay	$75 copay	Deductible then $750 copay	Flex Provider: $350 copay Other: Deductible then $750 copay	Flex Provider: Covered in full Other: Deductible then $75 copay	Deductible then $75 copay	Non-hospital based: $300 copay Hospital based: Deductible then $750 copay	Non-hospital based: $50 copay Hospital based: Deductible then $75 copay	$50 copay	$5/$30/$80/$120/20% (T5: $500 coinsurance max)	$10/$60/$160/$360/20% (T5: $1,500 coinsurance max)
HMO HSA															
HMO HSA 2500 - Flex Metal level - Silver MD0000201142 RX0000201083 DN0000201050	Deductible then $35 copay/Deductible then $55 copay	$2,500/$5,000 Non-embedded	$8,050/$16,100 Embedded	None	Deductible then $400 copay	Deductible then $55 copay	Deductible then $400 copay	Flex Provider: Deductible then Covered in full Other: Deductible then $250 copay	Flex Provider: Deductible then Covered in full Other: Deductible then $75 copay	Deductible then $55 copay	Non-hospital based: Deductible then $200 copay Hospital based: Deductible then $400 copay	Non-hospital based: Deductible then $35 copay Hospital based: Deductible then $55 copay	Deductible then $50 copay	Deductible then $5/Deductible then $30/Deductible then $80/Deductible then $120/Deductible then 20% (T5: $500 coinsurance max)	Deductible then $10/Deductible then $60/Deductible then $160/Deductible then $360/Deductible then 20% (T5: $1,500 coinsurance max)
HMO HSA 4000 - Flex Metal level - Bronze MD0000201145 RX0000201086 DN0000201050	Deductible then $75 copay/Deductible then $150 copay	$4,000/$8,000 Embedded	$8,050/$16,100 Embedded	None	Deductible then $1,500 copay	Deductible then $150 copay	Deductible then $1,500 copay	Flex Provider: Deductible then $750 copay Other: Deductible then $1,000 copay	Flex Provider: Deductible then $25 copay Other: Deductible then $75 copay	Deductible then $350 copay Per Visit	Non-hospital based: Deductible then $500 copay Hospital based: Deductible then $1,000 copay	Non-hospital based: Deductible then $40 copay Hospital based: Deductible then $150 copay	Deductible then $50 copay	Deductible then $5/Deductible then $30/Deductible then 50%/Deductible then 50%/Deductible then 50% (T3: $125/coinsurance max T4: $250 coinsurance max T5: $500 coinsurance max)	Deductible then $10/Deductible then $60/Deductible then 50%/Deductible then 50%/Deductible then 50% (T3: $250 coinsurance max T4: $750 coinsurance max T5: $1,500 coinsurance max)
Focus HMO															
Focus HMO 1000 Metal level - Gold MD0000201146 RX0000201078 DN0000201048	$25 copay/$50 copay Copay waived for first non-routine PCP visit	$1,000/$2,000 Embedded	$7,000/$14,000 Embedded	None	$300 copay	$50 copay	Deductible then $250 copay	Deductible then $300 copay	Deductible then $25 copay	Deductible then $50 copay	Deductible then $250 copay	$50 copay	$50 copay	$5/$30/$60/$100/20% (T5: $250 coinsurance max)	$10/$60/$120/$300/20% (T5: $750 coinsurance max)
Focus HMO 2000 Metal level - Gold MD0000201148 RX0000201078 DN0000201048	$25 copay/$50 copay Copay waived for first non-routine PCP visit	$2,000/$4,000 Embedded	$7,000/$14,000 Embedded	None	$300 copay	$50 copay	Deductible then $250 copay	Deductible then $300 copay	Deductible then $25 copay	Deductible then $50 copay	Deductible then $250 copay	$50 copay	$50 copay	$5/$30/$60/$100/20% (T5: $250 coinsurance max)	$10/$60/$120/$300/20% (T5: $750 coinsurance max)
Focus HMO 3000 Metal level - Silver MD0000201150 RX0000201080 DN0000201049	$50 copay/$75 copay Copay waived for first non-routine PCP visit	$3,000/$6,000 Embedded	$9,450/$18,900 Embedded	None	Deductible then $1,000 copay	$75 copay	Deductible then $1,000 copay	Deductible then $550 copay	Deductible then $75 copay	Deductible then $75 copay	Deductible then $450 copay	Deductible then $75 copay	$50 copay	$5/$30/$80/$120/20% (T5: $500 coinsurance max)	$10/$60/$160/$360/20% (T5: $1,500 coinsurance max)

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Key Insurance Terms

Premium
This is the monthly cost of your health insurance coverage and plan.

Cost sharing
Your out-of-pocket costs for services included within your health plan including copayments, deductibles, and coinsurance.

Copayments
A fixed dollar amount that you pay for certain covered benefits.

Deductible
The amount you owe or pay out-of-pocket during a coverage period (always one year) for certain covered benefits before your plan begins to pay.

Coinsurance
This is a fixed percentage of costs that you pay for covered services. For example, if you have a plan with coinsurance, you may have to pay 20% of a provider's bill for your care, while Harvard Pilgrim pays 80%. Coinsurance is usually something you pay after you have paid an annual deductible.

Out-of-pocket maximum
This is a limit on the total amount of cost sharing you have to pay annually for covered benefits. This includes copayments, coinsurance and deductibles. After you meet your out-of-pocket maximum, Harvard Pilgrim will pay all additional covered health care costs.

Embedded deductible/ out-of-pocket maximum
All non-HSA plans contain embedded deductibles and out-of-pocket maximums (OOPM). Embedded deductible refers to a family plan that has two components, an individual deductible and a family deductible. The maximum contribution by an individual toward the family deductible is limited to the individual deductible amount and allows for the individual to receive benefits before the family component is met. When any number of members collectively meet the family deductible, services for the entire family are covered for the remainder of the year.

Embedded OOPM (Out of Pocket Maximum) refers to a family plan that has two components, an individual OOPM and a family OOPM. The maximum contribution by an individual toward the family OOPM is limited to the individual OOPM and once met, the individual has no additional cost sharing for the remainder of the year. When any number of members collectively meet the family OOPM, then all members have no additional cost sharing for the remainder of the year.

In-network
Generally, this describes coverage for care that HMO, POS and PPO members receive from participating providers in the plan's network. In-network coverage typically costs less than out-of-network coverage. In most cases, if you have a POS plan, you need to have a referral from your primary care provider (PCP) to another participating provider in order for in-network cost sharing to apply.

Out-of-network
Out-of-network coverage applies to HMO, POS and PPO plans. Harvard Pilgrim will cover care that POS and PPO members receive from non-participating providers, but it usually costs more than in-network coverage. In addition, if you have a POS plan, you will — in most cases — have out-of-network coverage when you receive care for covered services from participating providers without your primary care provider's referral. HMO members cannot received care from out-of-network providers except in an emergency.

Tier
Medical plans often place providers and hospitals in different categories, or tiers, with different cost sharing amounts. Typically, you'll save money when you see Tier 1 providers.

HSA (health savings account)
This is a savings account that can help you pay for qualified health care expenses. You need to have a federally qualified high deductible health plan to be able to open an HSA. Check with your bank or financial advisor to see if they offer HSAs.

Important Legal Information

Excluded services from our plan

For a full list of services not covered, please refer to plan documents. Typically, exclusions include:

- Alternative services and treatments
- Dental care, except as described in the policy
- Any devices or special equipment needed for sports or occupational purposes
- Experimental, unproven, or investigational services or treatments
- Routine foot care, except for members diagnosed with diabetes or systemic circulatory disease
- Educational services or testing
- Cosmetic services or treatment
- Commercial diet plans and weight loss programs
- Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy
- Charges for services that were provided after the date on which membership ends
- Charges for any products or services related to non-covered benefits
- Wigs and scalp hair prostheses when hair loss is due to male pattern baldness, female pattern baldness, or natural or premature aging
- Services or supplies provided by (1) anyone related to a member by blood, marriage or adoption, or (2) anyone who ordinarily lives with the member
- Infertility treatment, except as described in the policy
- Costs for any services for which a member is entitled to treatment at government expense
- Costs for services for which payment is required to be made by a workers' compensation plan or an employer under state or federal law
- Private duty nursing
- Vision services, except as described in the policy
- Services that are not medically necessary
- Transportation, except as outlined in your Benefit Handbook
- HMO only: Delivery outside the service area after the 37th week of pregnancy, or after the member has been told that she is at risk for early delivery
- Over the counter hearing aids
- Any service, supply or medication when there is a less intensive Covered Benefit or more cost-effective alternative that can be safely and effectively provided
- Any service, supply or medication that is required by a third party that is not otherwise Medically Necessary (examples of a third party are an employer, an insurance company, a school or court)
- Services provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor

Limitations for Massachusetts individual plans

- Therapy services — Physical and occupational therapy — 60 combined visits per year
- Skilled nursing facility — 100 days per year
- Inpatient rehabilitation — 60 days per year
- Routine eye exam — 1 exam per year
- Wig — 1 synthetic monofilament wig per year

Broker compensation disclosure

Below are fees we pay to brokers and other entities to support enrollment for our plans:

Connector: Administrative fee: 2.5% of premium

eHealth: $15 Per Member Per Month (PMPM)

HSA (Non-Group): $39 Per Subscriber Per Month (PSPM)

SBSB (Non-Group): $38 Per Subscriber Per Month (PSPM)

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, sex, sexual orientation, or gender identity. Harvard Pilgrim Health Care does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Harvard Pilgrim Health Care:

- 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 Harvard Pilgrim Health Care 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

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/smartscreen/main.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
hhs.gov/ocr/office/file/index.html

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 ألُلْغةِ **ألعربية** ، خَدَمات ألمُساعَدة ألُلُغَوية 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 मुफ्त में 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).

Contact us

Already a member?
877-907-4742 (Current plan benefit questions)

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