Harvard Pilgrim Health Care

a Point32Health company

2025 SBSB Small Group Plan Offerings

For employers with 1 to 9 eligible employees

2025 SBSB Small Group Plans — Effective January 1, 2025, through December 31, 2025.

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)	Co-insurance	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 MD0000201427 RX0000201233 DN0000201175	$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)
														Rx Out-of-Pocket Maximum: $750/$1,500	
HMO 500 - Flex Metal level - Gold MD0000201446 RX0000201234 DN0000201176	$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 MD0000201458 RX0000201234 DN0000201176	$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 MD0000201431 RX0000201234 DN0000201176	$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 MD0000201433 RX0000201234 DN0000201176	$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 Value - Flex Metal level - Silver MD0000201436 RX0000201236 DN0000201177	$55 copay/$75 copay	$2,000/$4,000 Embedded	$9,200/$18,400 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)	$10/$60/Deductible then $160/Deductible then $360/Deductible then 20% (T5: $1,500 coinsurance max)
														Rx Deductible[3]: $250/$500	
HMO 2500 - Flex Metal level - Gold MD0000201434 RX0000201234 DN0000201176	$25 copay/$50 copay Copay waived for first non-routine PCP visit	$2,500/$5,000 Embedded	$7,000/$14,000 Embedded	None	$500 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 3000 - Flex Metal level - Silver MD0000201437 RX0000201237 DN0000201177	$50 copay/$75 copay Copay waived for first non-routine PCP visit	$3,000/$6,000 Embedded	$9,200/$18,400 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 MD0000201414 RX0000201239 DN0000201178	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 MD0000201428 RX0000201241 DN0000201178	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 MD0000201429 RX0000201242 DN0000201178	Deductible then $35 copay/Deductible then $55 copay	$3,400/$6,800 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)

[1] An explanation of embedded vs. non-embedded can be found in our key insurance terms to know.

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														Retail	Mail
Open Plans															
Focus HMO															
Focus HMO 1000 Metal level - Gold MD0000201448 RX0000201234 DN0000201176	$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 MD0000201450 RX0000201234 DN0000201176	$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 MD0000201451 RX0000201237 DN0000201177	$50 copay/$75 copay Copay waived for first non-routine PCP visit	$3,000/$6,000 Embedded	$9,200/$18,400 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)
PPO Access HSA															
PPO Access HSA 3400 - Flex Metal level - Silver MD0000201460 RX0000201242 DN0000201181	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: None OON: 20%	IN: Deductible then $400 copay OON: Same as IN	IN: Deductible then $55 copay OON: Deductible then 20%	IN: Deductible then $400 copay 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 Access HSA 5000 - Flex Metal level - Bronze MD0000201457 RX0000201245 DN0000201187	IN: Deductible then $75 copay/Deductible then $150 copay OON: Deductible then 20%	IN: $5,000/$10,000 OON: $10,000/$20,000 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 45%/Deductible then 45%/Deductible then 50% (T3: $125/coinsurance max T4: $250 coinsurance max T5: $500 coinsurance max)	Deductible then $10/Deductible then $60/Deductible then 45%/Deductible then 45%/Deductible then 50% (T3: $250 coinsurance max T4: $750 coinsurance max T5: $1,500 coinsurance max)
Connector Plans															
Standard Platinum - Flex MD0000201392 RX0000201220 DN0000201163	$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 MD0000201393 RX0000201222 DN0000201165	$20 copay/$40 copay	$1,000/$2,000 Embedded	$6,000/$12,000 Embedded	None	$250 copay	$40 copay	Deductible then $200 copay	Deductible then $100 copay	Deductible then $25 copay	Deductible then $35 copay	Deductible then $150 copay	$40 copay	$50 copay	$25/$45/Deductible then $75	$50/$90/Deductible then $225
Standard Silver MD0000201394 RX0000201223 DN0000201166	$25 copay/$60 copay	$2,000/$4,000 Embedded	$9,200/$18,400 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 MD0000201404 RX0000201227 DN0000201170	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 MD0000201398 RX0000201228 DN0000201171	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 2000 Value II - Flex Metal level - Gold MD0000201399 RX0000201229 DN0000201172	$25 copay/$50 copay	$2,000/$4,000 Embedded	$5,650/$11,300 Embedded	None	Deductible then $350 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: $200 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	$60/Deductible then $120/Deductible then $375
														Rx Deductible[3]: $250/$500	
HMO 3500 - Flex Metal level - Bronze MD0000201401 RX0000201231 DN0000201174	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 copay Others: Deductible then $75 copay	Deductible then $75 copay	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 $65 copay	Deductible then $50 copay	$5/$30/Deductible then 45%/Deductible then 45%/Deductible then 50% (T3: $125/coinsurance max T4: $250 coinsurance max T5: $500 coinsurance max)	$10/$60/Deductible then 45%/Deductible then 45%/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 2024 Plan Versions															
HMO 1500 Value - Flex Metal level - Gold MD0000201432 RX0000201235 DN0000201185	$40 copay/$75 copay	$1,500/$3,000 Embedded	$8,700/$17,400 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 MD0000201445 RX0000201237 DN0000201177	$50 copay/$75 copay Copay waived for first non-routine PCP visit	$4,000/$8,000 Embedded	$9,200/$18,400 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 2500 - Flex Metal level - Silver MD0000201447 RX0000201240 DN0000201178	Deductible then $35 copay/Deductible then $55 copay	$2,500/$5,000 Non-embedded	$8,050/$16,100 Embedded	None	Deductible then $500 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 MD0000201430 RX0000201243 DN0000201178	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	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 45%/Deductible then 45%/Deductible then 50% (T3: $125/coinsurance max T4: $250 coinsurance max T5: $500 coinsurance max)	Deductible then $10/Deductible then $60/Deductible then 45%/Deductible then 45%/Deductible then 50% (T3: $250 coinsurance max T4: $750 coinsurance max 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

What's not covered on our MA Small Group plans.

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 as provided by health benefits
- 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
- 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 small group plans

- Physical therapy and occupational therapy — combined 60 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

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:

Civil Rights Compliance Officer
1 Wellness Way
Canton, MA 02021-1166

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/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

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

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 સહાય સેવાઓ, તમારા માટે મફત ઉપલબ્ધ છે. કૃપા કરીને તમારા સભ્ય આઈડી કાર્ડ પરના નંબર પર કૉલ 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। कृपया अपने सदस्य आईडी कार्ड पर दिए 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) ប្រសិនបើអ្នកនិយាយភាសាផ្សេងក្រៅពីភាសាអង់គ្លេស សេវាកម្មជំនួយភាសា ដែលឥតគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមហៅទៅកាន់លេខនៅលើ ID កាតសមាជិករបស់អ្នក។

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

Lao (ພາສາລາວ) ກະລຸນາຮັບຊາບ: ຖ້າທ່ານເວົ້າພາສາອື່ນທີ່ບໍ່ແມ່ນພາສາອັງກິດ, ທ່ານສາມາດໃຊ້ບໍລິການດ້ານພາສາໄດ້ ໂດຍບໍ່ເສຍຄ່າ. ກະລຸນາໂທຫາເບີທີ່ຢູ່ໃນບັດປະຈຳຕົວສະມາຊິກຂອງທ່ານ.

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.

Contact us

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

Harvard Pilgrim Health Care

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