Clarification on SBC format

As of April 1, 2017 the federal government has issued a new format for the Summary of Benefits and Coverage (SBC) document. One of the most significant changes to the format is the way deductibles are referenced in the cost-sharing chart. The cost-sharing chart shows copayments and coinsurance after the deductible has been met.

- A statement appears at the top of the chart noting that all copayments and coinsurance are after the deductible has been met, if a deductible applies (see example below). Please note that this wording appears only at the top of the chart.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
</tbody>
</table>
| If you have a test   | Diagnostic test (x-ray, blood work) | X-rays: No charge  
Laboratory: Select Providers: No charge; deductible does not apply.  
Other Plan Providers: No charge | Not covered | None |
|                      | Imaging (CT/PET scans, MRIs)   | No charge | Not covered | Cost sharing may vary for certain imaging services. |

We encourage readers to reference Schedule of Benefits documents for cost-sharing details. The Schedule of Benefits is the contract between a member and Harvard Pilgrim Health Care and is the more complete document.

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/LGsampleEOC](http://www.harvardpilgrim.org/LGsampleEOC). 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](http://www.healthcare.gov/sbc-glossary) or call 1-888-333-4742 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this matters</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>Out-of-Network: $500 member/ $1,000 family&lt;br&gt;Benefits are administered on a calendar year basis.</td>
<td>Generally you must pay all the costs up to the <strong>deductible</strong> amount before this <strong>plan</strong> begins to pay. If you have other family members on the policy, they have to meet their own individual <strong>deductible</strong> until the overall family <strong>deductible</strong> amount has been met.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes: <strong>In-Network</strong> durable medical equipment, emergency room care, emergency medical transportation, outpatient mental health services, preventive care, provider office visits, rehabilitation services, habilitation services, routine eye exams, are covered before you meet your <strong>deductibles</strong>.</td>
<td>This <strong>plan</strong> covers some items and services even if you haven't yet met the <strong>deductible</strong> amount. But, a <strong>copayment</strong> or <strong>coinsurance</strong> may apply.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>Yes. <strong>Prescription Drug Deductible</strong>: $100 member/$200 family&lt;br&gt;There are no other specific <strong>deductibles</strong>.</td>
<td>You must pay all of the costs for these services up to the specific <strong>deductible</strong> amount before this <strong>plan</strong> begins to pay for these services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>In-Network: $2,500 member/ $5,000 family&lt;br&gt;Out-of-Network: $2,000 member / $4,000 family</td>
<td>The <strong>out-of-pocket limit</strong> is the most you could pay in a year of covered services. If you have other family members in this plan, they have to meet their own <strong>out-of-pocket limit</strong> until the overall family <strong>out-of-pocket limit</strong> has been met.</td>
</tr>
</tbody>
</table>
### Important Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answers</th>
<th>Why this matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td><strong>Premiums, balance-billing</strong> charges, penalties for failure to obtain preauthorization for services and health care this plan doesn't cover</td>
<td>Even though you pay these expenses, they don't count toward the <strong>out-of-pocket limit</strong>.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="https://www.providerlookuponline.com/harvardpilgrim/po7/Search.aspx">https://www.providerlookuponline.com/harvardpilgrim/po7/Search.aspx</a> or call 1-888-333-4742 for a list of preferred providers.</td>
<td>This plan uses a <strong>provider network</strong>. 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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without permission from this plan.</td>
</tr>
</tbody>
</table>

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td><strong>$25 copay</strong>/visit; deductible does not apply</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Specialist visit</td>
<td><strong>$25 copay</strong>/visit; deductible does not apply</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No charge; deductible does not apply</td>
<td>20% coinsurance</td>
</tr>
</tbody>
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<tbody>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge; <strong>deductible</strong> does not apply</td>
<td>20% <strong>coinsurance</strong></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge; <strong>deductible</strong> does not apply</td>
<td>20% <strong>coinsurance</strong></td>
<td>Cost sharing may vary for certain imaging services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Out-of-Network Preauthorization</strong> required. Penalty $500 if approval not received before services obtained.</td>
</tr>
<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>30-Day Retail Tier 1: $10 <strong>copay</strong>/prescription</td>
<td>30-Day Mail Tier 1: $20 <strong>copay</strong>/prescription</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>30-Day Retail Tier 2: $25 <strong>copay</strong>/prescription</td>
<td>30-Day Mail Tier 2: $50 <strong>copay</strong>/prescription</td>
<td>Some generic drugs are in this tier.</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>30-Day Retail Tier 3: $45 <strong>copay</strong>/prescription</td>
<td>30-Day Mail Tier 3: $90 <strong>copay</strong>/prescription</td>
<td>Same as above.</td>
</tr>
<tr>
<td></td>
<td><strong>Specialty drugs</strong></td>
<td>All drugs are covered in Retail Pharmacy and Mail Order Pharmacy Tiers 1 — 3</td>
<td></td>
<td>Some drugs must be obtained through a Specialty Pharmacy.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$500 <strong>copay</strong>/visit; <strong>deductible</strong> does not apply</td>
<td>$500 <strong>copay</strong>/visit then 20% <strong>coinsurance</strong></td>
<td><strong>Out-of-Network Preauthorization</strong> required. Penalty $500 if approval not received before services obtained.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge; <strong>deductible</strong> does not apply</td>
<td>20% <strong>coinsurance</strong></td>
<td></td>
</tr>
</tbody>
</table>
### Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

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<td></td>
<td><strong>Network Provider</strong>&lt;br&gt;(You will pay the least)</td>
<td><strong>Out-of-Network Provider</strong>&lt;br&gt;(You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>What You Will Pay</strong></td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$200 <strong>copay</strong>/visit; <strong>deductible</strong> does not apply</td>
<td>Same As Participating Provider</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Emergency medical transportation</td>
<td>No charge; <strong>deductible</strong> does not apply</td>
<td>Same As Participating Provider</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Urgent care</td>
<td>Convenience care clinic:&lt;br&gt;$25 <strong>copay</strong>/visit;&lt;br&gt;<strong>deductible</strong> does not apply</td>
<td>Convenience care clinic:&lt;br&gt;Urgent care clinic (including hospital urgent care clinic):&lt;br&gt;$25 <strong>copay</strong>/visit;&lt;br&gt;<strong>deductible</strong> does not apply</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$500 <strong>copay</strong>/admit; <strong>deductible</strong> does not apply</td>
<td>$500 <strong>copay</strong>/admit then 20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Physician/surgeon fee</td>
<td>No charge; <strong>deductible</strong> does not apply</td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Outpatient services</td>
<td>$25 <strong>copay</strong>/visit; <strong>deductible</strong> does not apply</td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Inpatient services</td>
<td>$500 <strong>copay</strong>/admit; <strong>deductible</strong> does not apply</td>
<td>$500 <strong>copay</strong>/admit then 20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$25 <strong>copay</strong>/visit; <strong>deductible</strong> does not apply</td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Childbirth/delivery professional services</td>
<td>No charge; <strong>deductible</strong> does not apply</td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Childbirth/delivery facility services</td>
<td>$500 <strong>copay</strong>/admit; <strong>deductible</strong> does not apply</td>
<td>$500 <strong>copay</strong>/admit then 20% <strong>coinsurance</strong></td>
</tr>
</tbody>
</table>
## Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

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<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td><strong>Home health care</strong></td>
<td>No charge; <strong>deductible</strong> does not apply</td>
<td>20% <strong>coinsurance</strong></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td><strong>Rehabilitation services</strong></td>
<td>$25 <strong>copay</strong>/visit; <strong>deductible</strong> does not apply</td>
<td>20% <strong>coinsurance</strong></td>
<td>Occupational therapy – 60 consecutive days/condition Physical therapy – 60 consecutive days/condition <strong>Out-of-Network Preauthorization</strong> required. Penalty $500 if approval not received before services obtained.</td>
</tr>
<tr>
<td></td>
<td><strong>Habilitation services</strong></td>
<td>$25 <strong>copay</strong>/visit; <strong>deductible</strong> does not apply</td>
<td>20% <strong>coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Skilled nursing care</strong></td>
<td>$500 <strong>copay</strong>/admit; <strong>deductible</strong> does not apply</td>
<td>$500 <strong>copay</strong>/admit then 20% <strong>coinsurance</strong></td>
<td>100 days/calendar year</td>
</tr>
<tr>
<td></td>
<td><strong>Durable medical equipment</strong></td>
<td>20% <strong>coinsurance</strong>; <strong>deductible</strong> does not apply</td>
<td>20% <strong>coinsurance</strong></td>
<td>Wigs – $350/calendar year <strong>Out-of-Network Preauthorization</strong> required. Penalty $500 if approval not received before services obtained.</td>
</tr>
<tr>
<td></td>
<td><strong>Hospice services</strong></td>
<td>No charge; <strong>deductible</strong> does not apply</td>
<td>20% <strong>coinsurance</strong></td>
<td>For inpatient services, see “If you have a hospital stay”.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>$25 <strong>copay</strong>/visit; <strong>deductible</strong> does not apply</td>
<td>20% <strong>coinsurance</strong></td>
<td>1 exam/calendar year</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up – Up to age of 13</td>
<td>No charge; <strong>deductible</strong> does not apply</td>
<td>20% <strong>coinsurance</strong></td>
<td>2 exams/calendar year</td>
</tr>
</tbody>
</table>

### 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.)

- Long-Term (Custodial) Care
- Most Cosmetic Surgery
- Private-duty nursing
- Routine foot care
- Services that are not Medically Necessary
<table>
<thead>
<tr>
<th></th>
<th>Most Dental Care (Adult)</th>
<th>Weight Loss Programs</th>
</tr>
</thead>
</table>

**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.)*

- Acupuncture - 20 visits/calendar year
- Bariatric surgery
- Chiropractic Care - $500/calendar year
- Hearing Aids
- Infertility Treatment
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) – 1 exam/calendar year
Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

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 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. 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 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:

<table>
<thead>
<tr>
<th>HPHC Member Appeals-Member Services Department</th>
<th>Department of Labor’s Employee Benefits Security Administration</th>
<th>Health Care for All</th>
<th>Massachusetts Division of Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harvard Pilgrim Health Care, Inc.</td>
<td>1-866-444-3272</td>
<td>30 Winter Street, Suite 1004</td>
<td>1000 Washington Street, Suite 810</td>
</tr>
<tr>
<td>1600 Crown Colony Drive</td>
<td><a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a></td>
<td>Boston, MA 02108</td>
<td>Boston, MA 02118–6200</td>
</tr>
<tr>
<td>Quincy, MA 02169</td>
<td></td>
<td>1-800-272-4232</td>
<td>1-617-521-7794</td>
</tr>
<tr>
<td>Fax: 1-617-509-3085</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Does this plan provide Minimum Essential Coverage? Yes

If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Coverage 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.

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.
**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services

### 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 (deductible, copayment 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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan’s overall deductible</strong></td>
<td><strong>The plan’s overall deductible</strong></td>
<td><strong>The plan’s overall deductible</strong></td>
</tr>
<tr>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Specialist copayment</strong></td>
<td><strong>Specialist copayment</strong></td>
<td><strong>Specialist copayment</strong></td>
</tr>
<tr>
<td>$25</td>
<td>$25</td>
<td>$25</td>
</tr>
<tr>
<td><strong>Hospital (facility) copayment</strong></td>
<td><strong>Hospital (facility) copayment</strong></td>
<td><strong>Hospital (facility) copayment</strong></td>
</tr>
<tr>
<td>$500</td>
<td>$500</td>
<td>$500</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td><strong>Other</strong></td>
<td><strong>Other</strong></td>
</tr>
<tr>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>This EXAMPLE event includes services like:</strong></td>
<td><strong>This EXAMPLE event includes services like:</strong></td>
<td><strong>This EXAMPLE event includes services like:</strong></td>
</tr>
<tr>
<td>Specialist office visits (prenatal care)</td>
<td>Primary care physician office visits (including disease education)</td>
<td>Emergency room care (including medical supplies)</td>
</tr>
<tr>
<td>Childbirth/Delivery Professional Services</td>
<td>Diagnostic tests (blood work)</td>
<td>Diagnostic test (x-ray)</td>
</tr>
<tr>
<td>Childbirth/Delivery Facility Services</td>
<td>Prescription drugs</td>
<td>Durable medical equipment (crutches)</td>
</tr>
<tr>
<td>Diagnostic tests (ultrasounds and blood work)</td>
<td>Durable medical equipment (glucose meter)</td>
<td>Rehabilitation services (physical therapy)</td>
</tr>
<tr>
<td>Specialist visit (anesthesia)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Example Cost</strong></td>
<td><strong>Total Example Cost</strong></td>
<td><strong>Total Example Cost</strong></td>
</tr>
<tr>
<td>$12,731</td>
<td>$7,389</td>
<td>$1,925</td>
</tr>
</tbody>
</table>

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td><strong>Copayments</strong></td>
<td><strong>Coinsurance</strong></td>
</tr>
<tr>
<td>$100</td>
<td>$500</td>
<td>$0</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td><strong>What isn’t covered</strong></td>
<td><strong>What isn’t covered</strong></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
<td>Limits or exclusions</td>
</tr>
<tr>
<td><strong>The total Peg would pay is</strong></td>
<td><strong>The total Joe would pay is</strong></td>
<td><strong>The total Mia would pay is</strong></td>
</tr>
<tr>
<td>$600</td>
<td><strong>$1,610</strong></td>
<td><strong>$170</strong></td>
</tr>
</tbody>
</table>

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

Espanol (Spanish) ATENCION: Si usted habla espanol, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-888-333-4742 (TTY: 711).


Kreyòl Ayisyen (French Creole) ATANSYON: Si nou pale 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 YÊU: Nếu quý vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quý 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) إناث: إذا أنت تتكلم اللغة العربية، خدمات المساعدة اللغوية متوفرة لك مجانا. إنصل على 1-888-333-4742 (TTY: 711)

ភាសាខ្មែរ (Cambodian) បើអ្នកនិយាយភាសាខ្មែរ យើងមានអត្ថប្រយោជន៍ដែលអាចបង្កើតស៊ីមស៊ីមប្រយោជន៍របស់អ្នកមាននៅទីនេះ 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).

(Continued)
한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-333-4742 (TTY: 711) 번으로 전화해 주십시오.
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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.

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, you can file a grievance with: Civil Rights Compliance Officer, 93 Worcester St, Wellesley, MA 02481, (617) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@harvardpilgrim.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 505F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7597 (TTY)