Summary of Benefits and Coverage:
The Harvard Pilgrim HMO

Coverage Period: 01/01/2024 — 12/31/2024
Coverage for: Individual + Family | Plan Type: HMO

of the complete terms of coverage, For more information about your coverage, or to get a copy . For general definitions of common terms, such as , , , , , , or other terms, see the Glossary. You can view the Glossary at or call to request a copy.

Important Questions	Answers	Why This Matters
	$0 Benefits are administered on a calendar year basis.	See the Common Medical Events chart below for your costs for services this covers
	Yes: , , prescription drugs, outpatient mental health services, , office visits, , , routine eye exams, are covered before you meet your .	This covers some items and services even if you haven't yet met the amount. But, a or may apply. For example, this covers certain without and before you meet your . See a list of covered at
	No.	You don't have to meet for specific services
	$2,500 member / $5,000 family	The is the most you could pay in a year for covered services. If you have other family members in this , they have to meet their own until the overall family has been met.

Important Questions	Answers	Why This Matters
	_____, _____ charges, and health care this ____ doesn't cover.	Even though you pay these expenses, they don't count toward the _____.
_____	Yes. See or call for a list of _____ _____.	This ____ uses a _____. You will pay less if you use a _____ in the _____ _____. You will pay the most if you use an _____, and you might receive a bill from a _____ for the difference between the provider's charge and what your ____ pays (_____). Be aware, your _____ might use an _____ for some services (such as lab work). Check with your _____ before you get services.
_____ _____	Yes	This ____ will pay some or all of the costs to see a _____ for covered services but only if you have a _____ before you see the _____.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
_____	Primary care visit to treat an injury or illness	$25 _____/visit	Not covered	None
	_____ visit	$25 _____/visit	Not covered	None
	_____/ _____/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your ____ will pay for.
	_____ (x-ray, blood work)	X-rays: No charge Laboratory: No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	$75 _____/procedure up to $150/calendar year	Not covered	_____ may vary for certain imaging services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
More information about is available at	Generic drugs	Harvard Pilgrim Health Care does NOT administer the Pharmacy benefit for Boston College. Please see separate OptumRx Summary of Benefits & Coverage for details.		Please see your employer group for information

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Outpatient services	$25 _____/visit	Not covered	None
	Inpatient services	No charge	Not covered	
	Office visits	$25 _____/visit	Not covered	_____ does not apply for _____.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	
	_____	No charge	Not covered	None

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).

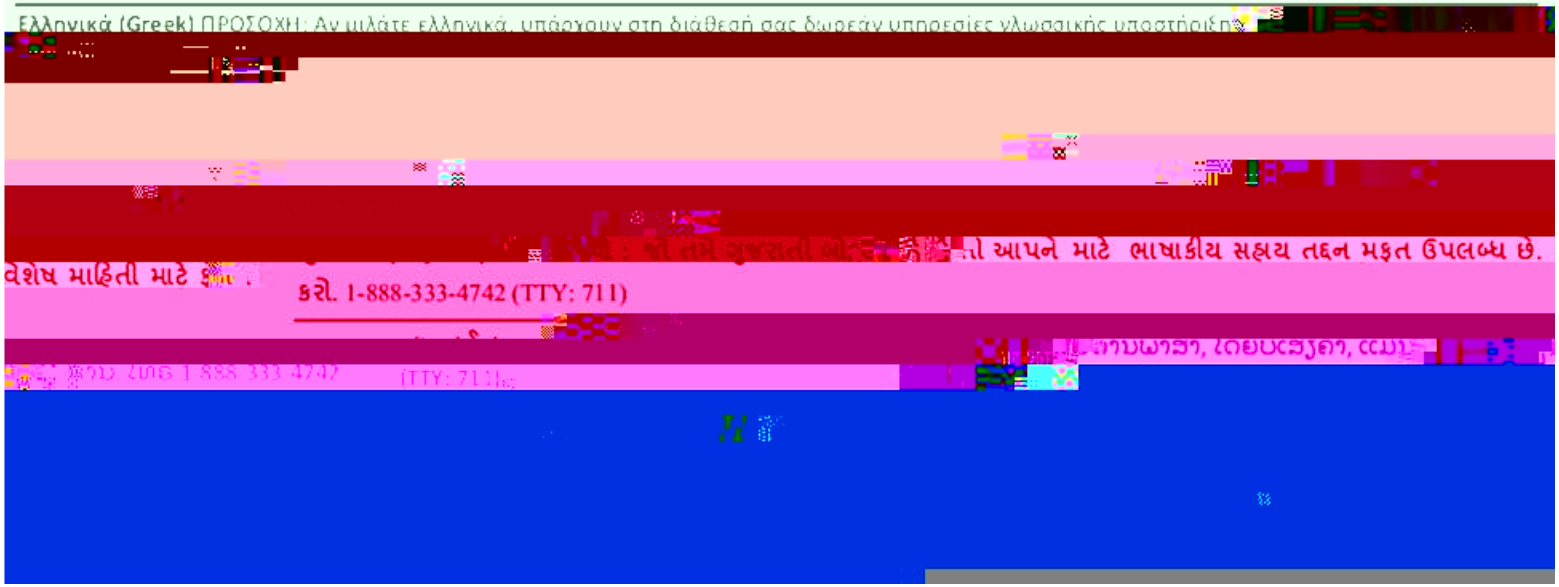
Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-888-333-4742 (TTY: 7[illegible]

Kreyòl Ayisyen (French Creole) ATANSYÒN: Si [illegible]

[illegible] (Traditional Chinese) [illegible]

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



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