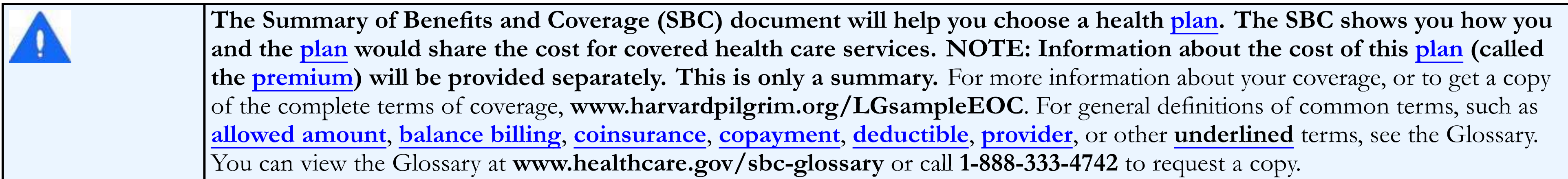
Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
MMHG Benchmark

Coverage Period: 07/01/2026 — 06/30/2027
Coverage for: Individual + Family | Plan Type: HMO



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**. 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** or call **1-888-333-4742** to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	Tier 1: $300 member/$900 familyTier 2: $300 member/$900 family Tier 3: $300 member/$900 family Benefits are administered on a Plan Year basis	Generally you must pay all the costs up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the policy, they have to meet their own individual **deductible** until the overall family **deductible** amount has been met.
Are there services covered before you meet your deductible?	Yes: **preventive care**, **provider** office visits, prescription drugs, outpatient mental health services, **rehabilitation services**, **habilitation services**, routine eye exams, are covered before you meet your **deductibles**.	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But, a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost-sharing** and before you meet your **deductible**. See a list of covered **preventive services** at **https://www.healthcare.gov/coverage/preventive-care-benefits/**
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services
What is the out–of–pocket limit for this plan?	$2,000 member/$4,000 family. Separate **out-of-pocket limit** applies to Pharmacy, see "If you need drugs to treat your illness or condition".	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limit** until the overall family **out-of-pocket limit** has been met.

Important Questions	Answers	Why This Matters
What is not included in the out–of–pocket limit?	Prescription drugs, **premiums**, **balance-billing** charges, and health care this **plan** doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Will you pay less if you use a network provider?	Yes. See **https://www.harvardpilgrim.org/public/find-a-provider** or call **1-888-333-4742** for a list of **network providers**.	This **plan** uses a **provider network**. 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.
Do you need a referral to see a specialist?	Yes	This **plan** will pay some or all of the costs to see a **specialist** for covered services but only if you have a **referral** before you see the **specialist**.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** 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)**	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Primary Care: Tier 1: $20 **copay**/visit; **deductible** does not apply. Tier 2: $20 **copay**/visit; **deductible** does not apply. Tier 3: $20 **copay**/visit; **deductible** does not apply.	Not covered	None
	Specialist visit	Specialty & Hospital Based: Tier 1: $60 **copay**/visit; **deductible** does not apply. Tier 2: $60 **copay**/visit; **deductible** does not apply. Tier 3: $60 **copay**/visit; **deductible** does not apply.	Not covered	None
	Preventive care/ screening/ immunization	No charge; **deductible** does not apply.	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 **plan** will pay for.

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)	
If you have a test	Diagnostic test (x-ray, blood work)	Non-Hospital Based: No charge Physician and Hospital Based: Tier 1: No charge Tier 2: No charge Tier 3: No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	Non-Hospital Based: No charge Physician and Hospital Based: Tier 1: $100 copay/procedure Tier 2: $100 copay/procedure Tier 3: $100 copay/procedure	Not covered	Cost sharing may vary for certain imaging services.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at **www.harvardpilgrim.org/2026Select3T**	Generic drugs	30-Day Retail Tier 1: $10 copay/prescription; deductible does not apply 90-Day Mail Tier 1: $25 copay/prescription; deductible does not apply	Not covered	Select formulary - covers a limited list; not all drugs are covered. You pay retail price for Out of Network pharmacy drugs and are reimbursed minus applicable cost sharing. Covered only outside of service area. Prescription drug Out-of-Pocket Maximum: $3,000 member/ $6,000 family
	Preferred brand drugs	30-Day Retail Tier 2: $30 copay/prescription; deductible does not apply 90-Day Mail Tier 2: $75 copay/prescription; deductible does not apply	Not covered	
	Non-preferred brand drugs	30-Day Retail Tier 3: $65 copay/prescription; deductible does not apply 90-Day Mail Tier 3: $165 copay/prescription; deductible does not apply	Not covered	

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)**	
	Specialty drugs	All drugs are covered in Retail Pharmacy and Mail Order Pharmacy Tiers 1 — 3	Not covered	Some drugs must be obtained through a Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Tier 1: $250 **copay**/visit Tier 2: $250 **copay**/visit Tier 3: $250 **copay**/visit	Not covered	None
	Physician/surgeon fees	Tier 1: No charge Tier 2: No charge Tier 3: No charge	Not covered	
If you need immediate medical attention	**Emergency room care**	$100 **copay**/visit		None
	Emergency medical transportation	No charge		None
	Urgent care	Urgent care center: Tier 1: $20 **copay**/visit; **deductible** does not apply Tier 2: $20 **copay**/visit; **deductible** does not apply Tier 3: $20 **copay**/visit; **deductible** does not apply	Urgent care center: Not covered	Non-participating providers only covered outside the service area. **Cost sharing** may vary based on location.
If you have a hospital stay	Facility fee (e.g., hospital room)	Tier 1: $500 **copay**/admit Tier 2: $500 **copay**/admit Tier 3: $1,500 **copay**/admit	Not covered	None
	Physician/surgeon fee	Tier 1: No charge Tier 2: No charge Tier 3: No charge	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 **copay**/visit; **deductible** does not apply	Not covered	None
	Inpatient services	$200 **copay**/admit	Not covered	None

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)	
If you are pregnant	Office visits	Tier 1 Primary Care: $20 **copay**/visit; **deductible** does not apply. Tier 2 Primary Care: $20 **copay**/visit; **deductible** does not apply. Tier 3 Primary Care: $20 **copay**/visit; **deductible** does not apply.	Not covered	**Cost sharing** does not apply for **preventive services** (such as routine prenatal visits).
	Childbirth/delivery professional services	Tier 1: No charge Tier 2: No charge Tier 3: No charge	Not covered	
	Childbirth/delivery facility services	Tier 1: $500 **copay**/admit Tier 2: $500 **copay** /admit Tier 3: $1,500 **copay**/admit	Not covered	
If you need help recovering or have other special health needs	**Home health care**	No charge	Not covered	None
	Rehabilitation services **Habilitation services**	Physical Therapy: $20 **copay**/visit; **deductible** does not apply. Occupational Therapy: $20 **copay**/visit; **deductible** does not apply. Speech Therapy: $20 **copay**/visit; **deductible** does not apply.	Not covered	Occupational & physical therapy – 60 combined visits /Plan Year
	Skilled nursing care	20% **coinsurance**	Not covered	– 100 days /Plan Year
	Durable medical equipment	No charge	Not covered	None
	Hospice services	No charge	Not covered	For inpatient see "If you have a hospital stay"
If your child needs dental or eye care	Children's eye exam	Tier 1: No charge; **deductible** does not apply. Tier 2: No charge; **deductible** does not apply. Tier 3: No charge; **deductible** does not apply.	Not covered	1 exam/2 years
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up – Up to age of 13	$20 **copay**/visit; **deductible** does not apply.	Not covered	2 exams/Plan Year

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.)		
• Children's glasses • Cosmetic Surgery	• Dental Care (Adult) • Long-Term Care • Non-emergency care when traveling outside the U.S. • Private-duty nursing	• Routine foot care (except for diabetes or systemic circulatory diseases) • Services that are not Medically Necessary • Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Acupuncture - 12 visits/Plan Year • Bariatric surgery	• Chiropractic Care - 20 visits/Plan Year • Hearing Aids - $1,500/impaired ear every 2 years	• Infertility Treatment • Routine eye care (Adult) – 1 exam/Plan Year

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 Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**, or the Department of Health and Human Services, Centers for Consumer Information and Insurance Oversight, at **1-877-267-2323 x61565** or **www.cciio.cms.gov**, or for more information on your rights to continue coverage, you can contact the Member Service number listed on your ID card or call **1-888-333-4742**. 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 on how 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:

HPHC Member Appeals-Member Services Department Harvard Pilgrim Health Care, Inc. 1 Wellness Way Canton, MA 02021-1166 **Telephone: 1-888-333-4742** **Fax: 1-617-509-3085**	Department of Labor's Employee Benefits Security Administration **1-866-444-3272** **www.dol.gov/ebsa/healthreform**	Health Care for All 30 Winter Street, Suite 1004 Boston, MA 02108 **1-800-272-4232** **http://www.hcfama.org/helpline**

Does this plan 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**.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes **plans**, **health insurance** available through the **Marketplace** or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of **Minimum Essential Coverage**, you may not be eligible for the **premium tax credit**.

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 section.