| Important Questions | Answers | Why This Matters |
|---|---|---|
| What is the overall deductible? | Out-of-Network: $250 member / $500 family<br>Benefits are administered on a calendar 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: | |

| Important Questions | Answers | Why This Matters |
|---|---|---|
| What is not included in the outðofðpocket limit? | Premiums, balance-billing charges, penalties for failure to obtain preauthorization for services and health care this plan doesn't cover | Even though you pay these expenses, they don't count toward the outðofðpocket 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 planðs 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? | No. | You can see the specialist you choose without permission from this plan. |

| [redacted]vent | 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) | X-rays: No charge; deductible does not apply<br>Laboratory: No charge; deductible does not apply | X-rays: 20% coinsurance<br>Laboratory: 20% coinsurance | None |



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| 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 need immediate medical attention | Emergency room care<br>Emergency medical | $150 copay/visit; deductible does not apply | | 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) | |
| | Skilled nursing care | No charge; deductible does not apply | 20% coinsurance | |

| 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.) |
|---|
| |

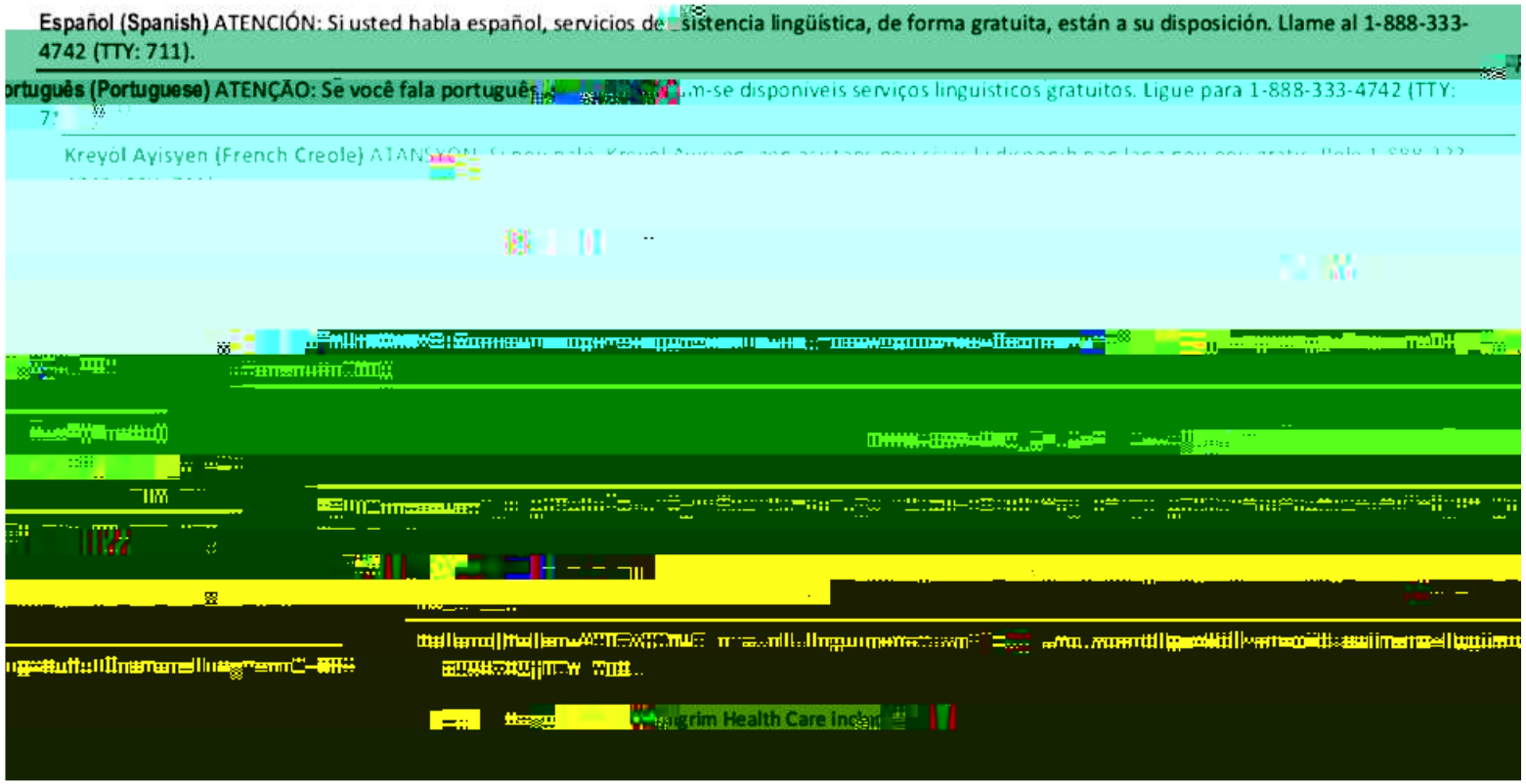
This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (

**Language Assistance Services**

**Español (Spanish)** ATENCIÓN: Si usted habla español, servicios de [illegible]sistencia lingüística, de forma gratuita, están a su disposición. Llame al **1-888-333-4742 (TTY: 711).**

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

Kreyòl Ayisyen (French Creole) ATANSYÒN: [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

## General Notice About Nondiscrimination and Accessibility Requirements