



	<p style="text-align: center;">□ □ □ □</p> <p>For more information about your coverage, or to get a copy of the complete terms of coverage, <a href="#">_____</a>. For general definitions of common terms, such as <a href="#">_____</a>, <a href="#">_____</a>, <a href="#">_____</a>, <a href="#">_____</a>, <a href="#">_____</a>, or other <a href="#">_____</a> terms, see the Glossary. You can view the Glossary at <a href="#">_____</a> or call <a href="#">_____</a> to request a copy.</p>
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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 <a href="#">_____</a> covers
_____	Yes: <a href="#">_____</a> , <a href="#">_____</a> , <a href="#">_____</a> , prescription drugs, outpatient mental health services, <a href="#">_____</a> , <a href="#">_____</a> office visits, <a href="#">_____</a> , <a href="#">_____</a> , routine eye exams, are covered before you meet your <a href="#">_____</a> .	This <a href="#">_____</a> covers some items and services even if you haven't yet met the <a href="#">_____</a> amount. But, a <a href="#">_____</a> or <a href="#">_____</a> may apply. For example, this <a href="#">_____</a> covers certain <a href="#">_____</a> without <a href="#">_____</a> and before you meet your <a href="#">_____</a> . See a list of covered <a href="#">_____</a> at <a href="#">_____</a>
_____	No.	You don't have to meet <a href="#">_____</a> for specific services
_____	\$2,500 member / \$5,000 family	The <a href="#">_____</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">_____</a> , they have to meet their own <a href="#">_____</a> until the overall family <a href="#">_____</a> 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 available at	Generic drugs is	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
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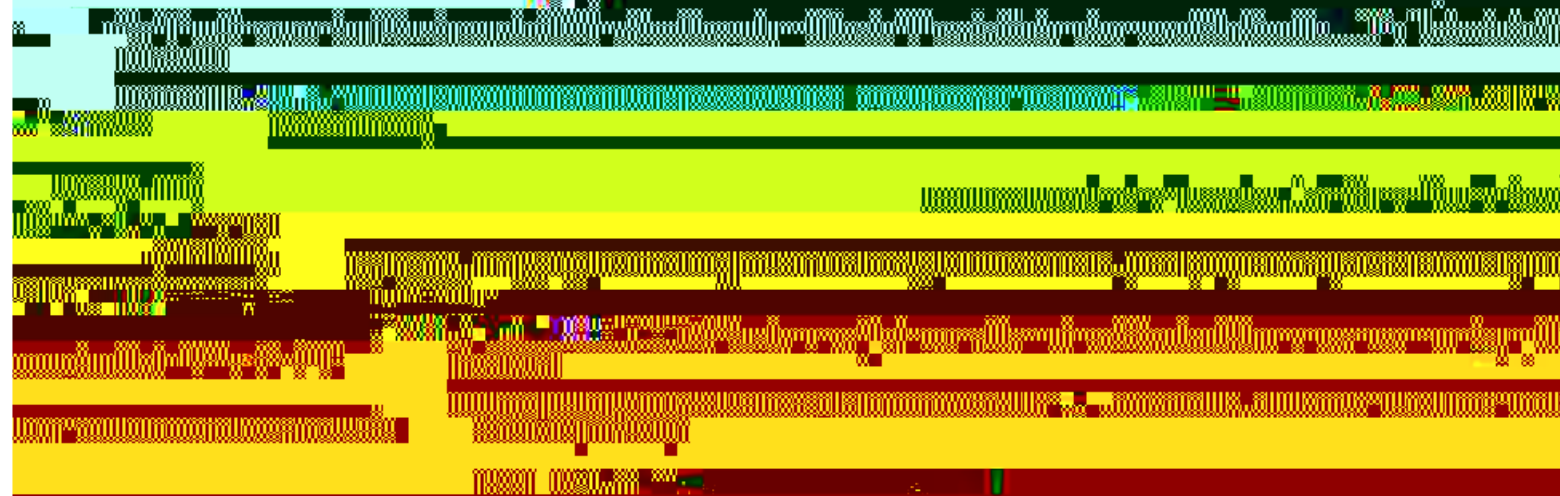
## Language Assistance Services

**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, serviços de assistência lingüística, de forma gratuita, estão a sua disposição. Ligue para 1-888-333-4742 (TTY: 711).

**Kreyòl Ayisyen (French Creole)** ATANSYON: Si ou pale Kreyòl Ayisyen, sèvis asistans langyèk, de fòm gratis, estàn a ou dispozisyon. Llamè pou 1-888-333-4742 (TTY: 711).

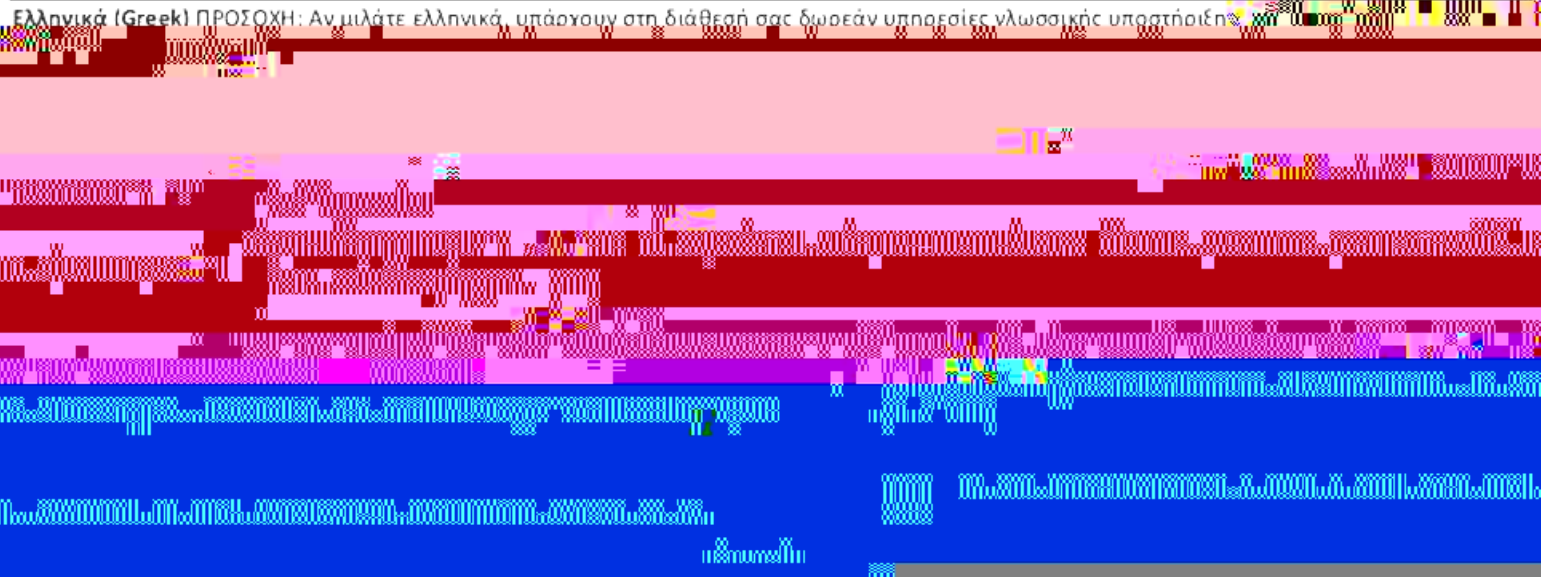
**繁體中文 (Traditional Chinese)**





**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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