

Important Questions	Answers	Why This Matters
What is the overall deductible ?	Out-of-Network: \$250 member/ \$500 family 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:	

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What is not included in the out of pocket 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 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 d'Uboig 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 .

/ent	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 Laboratory: No charge; deductible does not apply	X-rays: 20% coinsurance Laboratory: 20% coinsurance	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 need immediate medical attention	Emergency room care 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	

(See the [plan](#) document for other covered services and your costs for these services.)



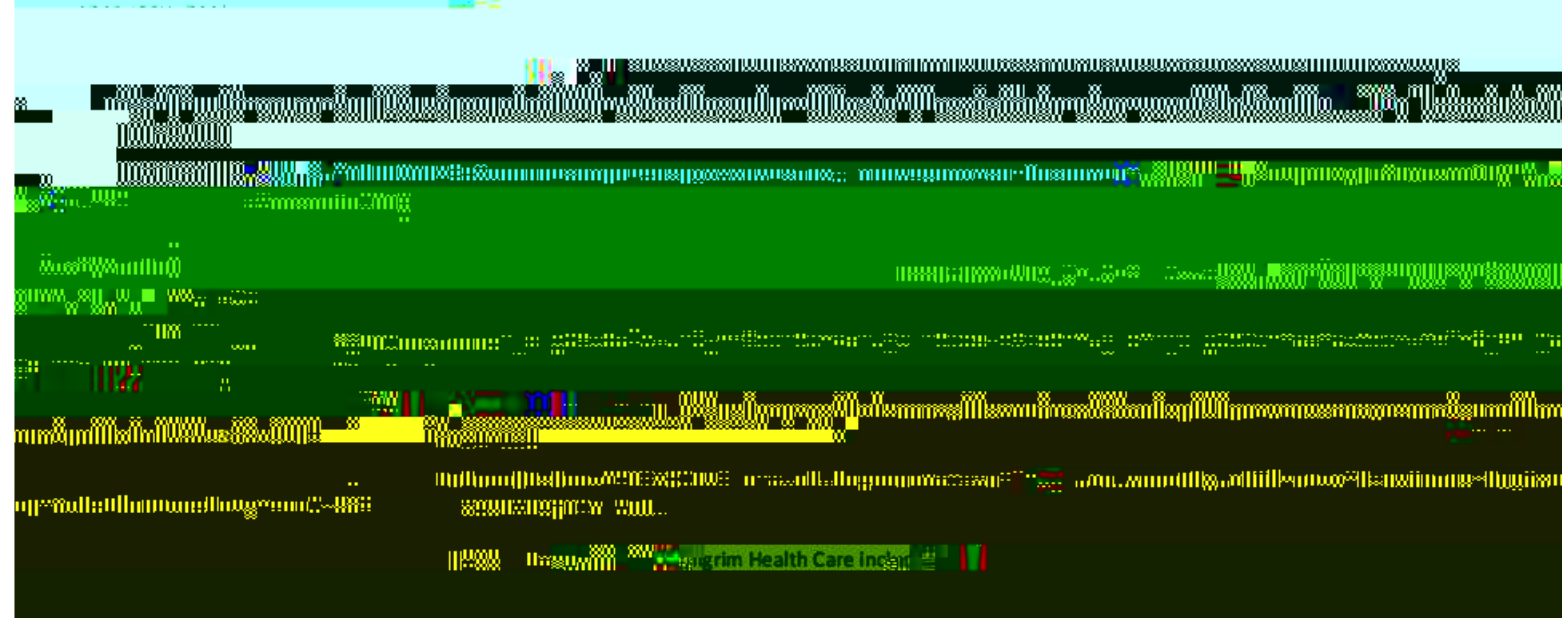
This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the [cost-sharing](#) amounts (

Language Assistance Services

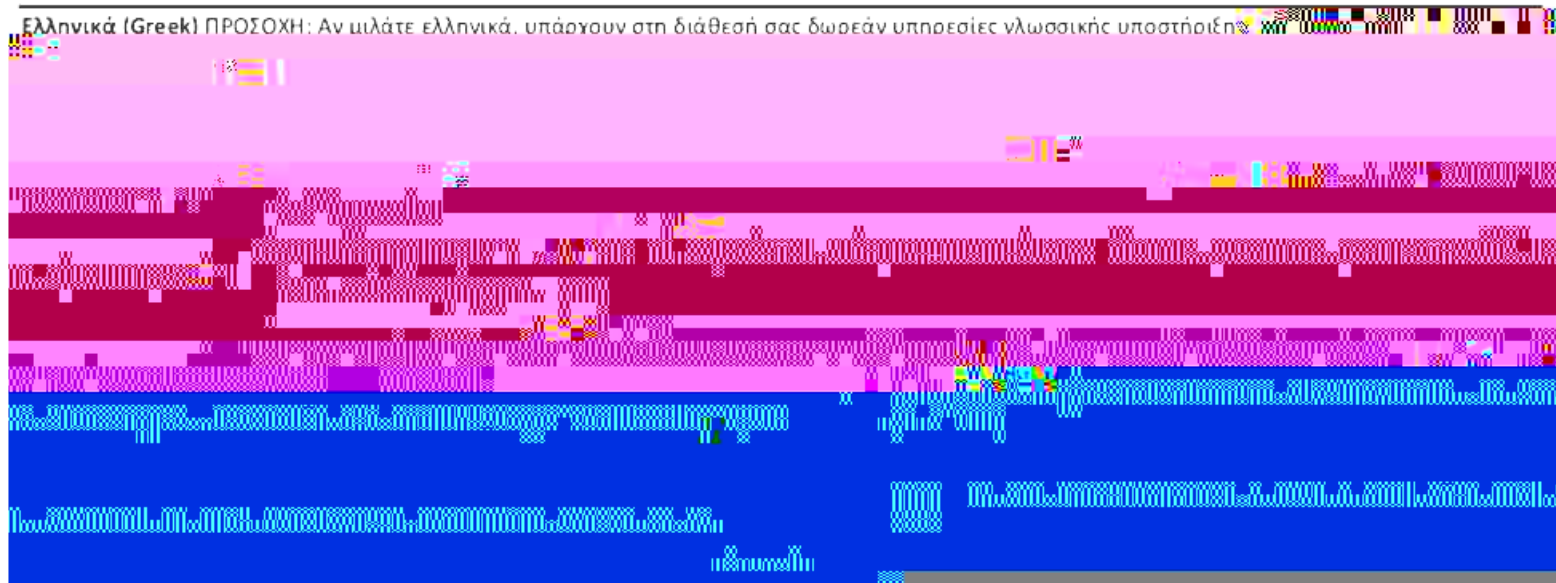
Español (Spanish) ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-888-333-4742 (TTY: 711).

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 pral fwe Kreyòl Ayisyen, sèvis asistans lingwistik, de fòm gratis, estàn a ou disponib. Apele 1-888-333-4742 (TTY: 711).



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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