



	<p>_____</p> <p>_____ of the complete terms of coverage, _____</p> <p>_____, _____, _____, _____, _____, _____, or other _____ terms, see the Glossary. You can view the Glossary at _____ or call _____ 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 _____ 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 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
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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) 注意：如果您會說繁體中文，免費的語言協助服務是為您準備的。請撥打 1-888-333-4742 (TTY: 711)。

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