Harvard Pilgrim Health Care

Harvard Pilgrim Health Care
1600 Crown Colony Drive
Quincy, MA 02169
www.harvardpilgrim.org

Mrs. Heike Westphal
80 BROAD ST APT 601
BOSTON, MA 02110

Quote Number: 00021629
Quote Date: January 10, 2018

Dear Mrs. Heike Westphal,

Thank you for your interest in Harvard Pilgrim. We are pleased to provide you a quote for health insurance coverage effective February 1, 2018. This quote is based on the information outlined below, which was provided by you when you submitted your request.

You'll also want to review the helpful plan documents and important information about the special programs and additional savings for Harvard Pilgrim members that were sent with this quote. If you have any questions about the coverage, you can reach us online or by phone, using the contact information provided within the quote below.

Covered Person	Date of Birth	Tobacco Usage	Zip Code
Self	December 27,1970	N/A	02110
Dependent 1	March 07,2010	N/A	02110

The following premiums are based on the list of covered individuals and their particulars provided. The premium will be adjusted if any of these parameters are altered.

Product Name	Network	Metal Tier	Monthly Premium
Best Buy HMO 1000 - Flex	HPHC Full Network - HMO - FLEX	Gold	$1,040.19

Please visit www.harvardpilgrim.org or call (800)208-1221 and we will be happy to answer any additional questions about the coverage and complete your application. The following page(s) provide a comparison of the product(s) quoted.

Product Compare

Category	Best Buy HMO 1000 - Flex
Premium	$1,040.19
Network	HPHC Full Network - HMO - FLEX
Metal Tier	Gold
Deductible	
In-Network Medical Deductible	T1: Indv: $1,000 / Family: $1000 per person | $2500 per family / T2: Indv: Not Applicable / Family: per person not applicable | per family not applicable
In-Network Pharmacy Deductible	T1: Indv: $0 / Family: $0 per person | $0 per family / T2: Indv: Not Applicable / Family: per person not applicable | per family not applicable
Combined Med and Pharmacy Deductible	T1: N/A / T2: N/A
Out-of-Network Deductible	N/A
Combined Out-of-Network Deductible	N/A
Office Visit	
Primary Care office visit	T1: $25.00 Copay / T2: N/A
Specialty office visit	T1: $40.00 Copay / T2: N/A
Prenatal and Postnatal care	T1: No Charge / T2: No Charge
Preventive care/screen/Immune	T1: No Charge / T2: No Charge

Urgent/ Emergency Services

Urgent care-freestanding clinic	T1: $40.00 Copay / T2: N/A
Emergency Room	T1: $300.00 Copay / T2: N/A

Out of Pocket Maximum

In-Network Medical OOPM	T1: N/A / T2: N/A
In-Network Pharmacy OOPM	T1: N/A / T2: N/A
Combined Med and Pharmacy OOPM	T1: Indv: $5,750 / Family: $5750 per person | $11500 per family / T2: Indv: Not Applicable / Family: per person not applicable | per family not applicable
Out-of-Network OOPM	N/A
Combined Out-of-Network OOPM	N/A

Pharmacy

Prescription Drugs	$5/$30/$60/$90/20% (T5 $250/script max)

Inpatient Service

Hospitalization	T1: $200.00 Copay per Stay after deductible / T2: N/A

Outpatient Services

Outpatient Surgery	T1: $50.00 Copay / T2: $200.00 Copay after deductible

Lab and Radiology

Outpatient Lab	T1: No Charge / T2: $40.00 Copay after deductible
Outpatient X-ray	T1: $40.00 Copay after deductible / T2: N/A

High End Radiology	T1: $200.00 Copay after deductible / T2: N/A

Vision

Routine Eye Exam (Adult)	T1: $25.00 Copay / T2: N/A
Routine Eye Exam for Children	T1: $25.00 Copay / T2: N/A

Other Services

Chiropractic Care	T1: $40.00 Copay / T2: N/A
Acupuncture	T1: $40.00 Copay / T2: N/A
Fitness Reimbursement	Available
Pediatric Dental	Covered

Product SOB

SOB	Get SOB for Best Buy HMO 1000 - Flex