**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-310-2835 or visit healthnewengland.org and sign into the Member Portal. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-310-2835 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $2,000 individual / $4,000 family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care, office visits, chiropractic care & prescription drugs are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | $6,500 individual / $13,000 family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Your cost-sharing for benefits that are not Essential Health Benefits under national health care reform, premiums, 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 healthnewengland.org or call 1-800-310-2835 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's 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 a referral. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Plan Provider (You will pay the least) | Out-of-Plan Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $50 copay/visit<br>Deductible does not apply. | Not covered | Deductible may apply to some office services. |
| | Specialist visit | $20 copay/visit<br>$25 copay/visit for chiropractor.<br>$20 copay/visit for acupuncture.<br>Deductible does not apply. | Not covered | Deductible may apply to some office services.<br>Chiropractic care limited to 12 visits per calendar year.<br>Acupuncture limited to 12 visits per calendar year. |
| | Preventive care/screening/ immunization | No charge<br>Deductible does not apply. | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Radiology: No charge<br>Lab: No charge | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | $250 copay (maximum 3 copays per year) | Not covered | Includes CT Scans, PET Scans, MRIs, MRAs and Nuclear Cardiac Imaging. Prior approval is required. |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at www.hnedirect.com/FormularyLookup/Default.aspx | Tier 1 (Generic drugs) | $25 retail copay, $50 mail order copay /prescription.<br>Deductible does not apply. | Not covered | Covers up to a 30-day supply (retail); up to a 90 day supply (mail order). Prior approval is required for some prescription drugs. Without prior approval, a drug may not be covered. |
| | Tier 2 (Brand/Formulary drugs) | $50 retail copay, $100 mail order copay /prescription.<br>Deductible does not apply. | Not covered | |
| | Tier 3 (Brand/Non-formulary drugs) | $150 retail copay, $450 mail order copay | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Plan Provider (You will pay the least) | Out-of-Plan Provider (You will pay the most) | |
| | | /prescription. Deductible does not apply. | | |
| | Specialty drugs | Copay depends on drug tier. Deductible does not apply. | Not covered | Prior approval is required for some prescription drugs. Without prior approval, a drug may not be covered. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $350 copay | Not covered | Prior approval is required for some services. This copay is based on the type of service. To find out if this copay applies to a specific procedure, please contact Health New England Member Services at 1-800-310-2835. |
| | Physician/surgeon fees | No charge | Not covered | None |
| **If you need immediate medical attention** | Emergency room care | $300 copay/visit Deductible does not apply. | $300 copay/visit Deductible does not apply. | None |
| | Emergency medical transportation | $100 copay per member per day | $100 copay per member per day | For ground ambulance services from out-of-plan providers, only ambulance transport and mileage are covered. Ancillary supplies or services (such as ECG tracing, drugs, intubation and measuring of oxygen in the blood) will not be covered if billed as separate line items. |
| | Urgent care | $50 copay/visit Deductible does not apply. | Not covered | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $600 copay/admission | Not covered | 60 days per calendar year limit for inpatient rehabilitation. 100 days per calendar year limit for skilled nursing facility care. |
| | Physician/surgeon fees | No charge | Not covered | None |
| **If you need mental health, behavioral** | Outpatient services | $50 copay/visit Deductible does not | Not covered | Prior approval is required for some services. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Plan Provider (You will pay the least) | Out-of-Plan Provider (You will pay the most) | |
| **health, or substance abuse services** | | apply. | | |
| | Inpatient services | $600 copay/admission | Not covered | Prior approval is required. |
| **If you are pregnant** | Office visits | No charge Deductible does not apply. | Not covered | Cost sharing does not apply for preventive services. Depending on the type of service, deductible and copays may apply. |
| | Childbirth/delivery professional services | No charge Deductible does not apply | Not covered | None |
| | Childbirth/delivery facility services | $600 copay/admission | Not covered | Coverage for child is limited to routine newborn nursery charges. For continued coverage, child must be enrolled within 30 days of date of birth. |
| **If you need help recovering or have other special health needs** | Home health care | No charge | Not covered | Prior approval is required. |
| | Rehabilitation services | $50 copay/visit per treatment type | Not covered | Limited to 60 visits per calendar year for physical or occupational therapy. Prior approval is required for speech therapy after the initial evaluation. |
| | Habilitation services | $50 copay/visit per treatment type | Not covered | Early intervention services are covered for children from birth to age 3 with no member cost sharing. Applied Behavioral Analysis (ABA) to treat autism spectrum disorders is covered with no member cost sharing. |
| | Skilled nursing care | No charge | Not covered | Skilled nursing services in the home. Prior approval is required. |
| | Durable medical equipment | 20% coinsurance Deductible does not apply. | Not covered | Prior approval is required. |
| | Hospice services | No charge Deductible does not apply. | Not covered | Prior approval is required. |
| **If your child needs** | Children's eye exam | No charge for routine | Not covered | Routine exams limited to one per calendar |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Plan Provider (You will pay the least) | Out-of-Plan Provider (You will pay the most) | |
| **dental or eye care** | | exams. Deductible does not apply. | | year. |
| | Children's glasses | Not covered | Not covered | None |
| | Children's dental check-up | Not covered | Not covered | None |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Children's Dental Check-up
- Children's Glasses
- Cosmetic Surgery
- Dental Care (Adult) (except for the limited services specified in your plan materials)
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine Foot Care (Routine foot care is covered if you have diabetes)

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Abortion
- Acupuncture
- Bariatric Surgery (requires prior approval)
- Chiropractic Care
- Hearing Aids (limited to members age 21 and under, $2,000 per hearing aid per ear each 36 months, requires prior approval)
- Infertility Treatment (requires prior approval)
- Routine eye care (Adult)
- Weight Loss Programs (reimbursement per calendar year :$200 per individual up to $400 per family)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. You can also contact your state insurance department. Massachusetts resident can contact The Massachusetts Division of Insurance at 877-563-4467, or doicss.mailbox@state.ma.us, or https://www.mass.gov/health-care. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. You may be able to buy individual coverage through your state's marketplace, if applicable. If you are a resident of Massachusetts, contact the Massachusetts Health Connector at www.mahealthconnector.org.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Member Services at the number on your plan ID Card or your plan sponsor (usually the employer or organization that provides your health insurance). Or you can contact the Office of Patient Protection at 1-800-436-7757 or www.mass.gov/hpc/opp. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

**Does this plan provide Minimum Essential Coverage?** **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards?** **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

***To see examples of how this plan might cover costs for a sample medical situation, see the next section.***

## About these Coverage Examples:

**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 (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $2,000 |
| Specialist copay | $50 |
| Hospital (facility) copay | $600 |
| Laboratory copay | $0 |

**This EXAMPLE event includes services like:**
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,000 |
| Copayments | $600 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$2,600** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $2,000 |
| Specialist copay | $50 |
| Primary care visit copay | $50 |
| Laboratory copay | $0 |

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $60 |
| Copayments | $1,400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,460** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $2,000 |
| Specialist copay | $50 |
| Hospital ER (facility) copay | $300 |
| Ambulance services copay | $100 |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,700 |
| Copayments | $400 |
| Coinsurance | $20 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,120** |

The plan would be responsible for the other costs of these EXAMPLE covered services.

## Notice Informing Individuals of Nondiscrimination and Accessibility

Health New England complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health New England does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health New England:

- **Provides free aids and services to people with disabilities to communicate effectively with us, such as:**
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- **Provides free language services to people whose primary language is not English, such as:**
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Susan O'Connor, Vice President and General Counsel.

If you believe that Health New England has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Susan O'Connor, Vice President and General Counsel, One Monarch Place, Suite 1500, Springfield, MA 01104-1500, Phone: (888) 270-0189, TTY: 711, Fax: (413) 233-2685 or ComplaintsAppeals@hne.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Susan O'Connor, Vice President and General Counsel is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, (800) 368-1019, (800) 537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

**Multi-Language Services**

We're here to help you. We can give you information in other formats and different languages. All translation services are free to members. If you have questions regarding this document please call the toll-free member phone number listed on your health plan ID card, (TTY:711), Monday through Friday, 8:00 a.m.-6:00 p.m.

Last reviewed: 7/31/2019

| | |
|---|---|
| English | You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. (TTY: 711) |
| Spanish | Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. (TTY: 711) |
| Portuguese | Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. (TTY: 711) |

| | |
|---|---|
| Chinese | 您有權免費以您使用的語言獲得幫助和訊息。如需口譯員，請撥打您的保健計劃 ID 卡上列出的免費會員電話號碼，按 0。(TTY: 711) |
| French Creole | Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. (TTY: 711) |
| Vietnamese | Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. (TTY: 711). |
| Russian | Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия (телетайп: 711) |
| Arabic | يحق لك الحصول على المساعدة والمعلومات بلغتك مجانًا. لطلب مترجم، اتصل برقم هاتف العضو المجاني على بطاقة تعريف خطتك الصحية، ثم اضغط على 0. (TTY:711) |
| Mon-Khmer, Cambodian | អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដ ើមបីដសនើស ំអ្នកបកប្រប សូមទ្ូរស័ពទដៅដលខឥតដេញថ្លៃសំរាប់សមាជិក ឬ លមានកត់ដៅកនុងប័ណ្ណ ID គំដរាងស ខភាពរបស់អ្នក រួេដ ើយ េ 0។ (TTY: 711) |
| French | Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. (ATS: 711). |
| Italian | Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti (TTY: 711). |
| Korean | 귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711 |
| Greek | Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. (TTY: 711). |
| Polish | Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. (TTY: 711). |
| Hindi | आप के पास अपनी भाषा में सहायता एवं जानकारी निःशुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711 |
| Gujarati | તમારી·ભાષામાં·વિના·મૂલ્યે·મદદ·અને·માહિતી·મેળવવાનો·તમને·અધિકાર·છે.·દુભાષિયાની·વિનંતી·કરવા·માટે·તમારા·હેલ્થ·પ્લાન·ID·કાર્ડ·પર·જણાવેલા·ટોલ-ફ્રી·નંબર·પર·કૉલ·કરો·અને·0·દબાવો.·(TTY:·711).¤ |

| | |
|---|---|
| Lao | ທ ່ ານມ ີ ສ ິ ດທ ີ ່ ຈະໄດ ້ ຮ ັ ບການຊ ່ ວຍເຫ ຼ ືອແລະຂ ້ ມ ູ ນຂ ່ າວສານທ ີ ່ ເປ ັ ນພາສາຂອງທ ່ ານບ ່ ມ ີ ຄ ່ າໃຊ ້ ຈ ່ າຍ. ເພ ື ່ ອຂ ຮ ້ ອງນາຍພາສາ,ໂທຟຣ ີ ຫາທມາຍເລກໂທລະສ ັ ບສ ານ ັ ບສະມາຊ ິ ກທ ີ ່ ໄດ ້ ລະບ ຸ ໄວ ້ ໃນບ ັ ດສະມາຊ ິ ກຂອງທ ່ ານ,ກ ົ ດເລກ 0. (TTY: 711). |
| Albanian | Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. (TTY: 711). |
| Tagalog | May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. (TTY: 711). |