



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 ?	Individual coverage: \$3,000 individual. Family coverage: \$3,000 individual / \$6,000 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. <u>Preventive care services</u> are covered before you meet your <u>deductible</u> .	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 ?	In-plan: \$6,000 individual / \$12,000 family. Out-of-plan: \$7,500 individual / \$15,000 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 <u>cost-sharing</u> for benefits that are not <u>Essential Health Benefits</u> under national health care reform, <u>premiums</u> , 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 <u>provider's office or clinic</u>	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit	20% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$35 <u>copay</u> /visit \$20 <u>copay</u> /visit for chiropractor. \$20 <u>copay</u> /visit for acupuncture.	20% <u>coinsurance</u> For chiropractor: \$20 <u>copay</u> /visit, then 20% <u>coinsurance</u>	Chiropractic care limited to 12 visits per calendar year. Acupuncture limited to 12 visits per calendar year.
	<u>Preventive care/screening/immunization</u>	No charge <u>Deductible</u> does not apply.	20% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Radiology: 10% <u>coinsurance</u> Lab: 10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Includes CT Scans, PET Scans, MRIs, MRAs and Nuclear Cardiac Imaging. Prior approval is required. Prior approval is required for services from in-plan PHCS <u>providers</u> and out-of-plan <u>providers</u> . Without prior approval, services will not be covered.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <u>www.hnedirect.com/FormularyLookup/Default.aspx</u>	Tier 1 (Generic drugs)	\$20 retail <u>copay</u> , \$40 mail order <u>copay</u> /prescription.	\$20 retail <u>copay</u> , then 20% <u>coinsurance</u> /prescription	Covers up to a 30-day supply (retail); up to a 90-day supply (mail order). Mail order from out-of-plan <u>providers</u> is not covered. Mail order is not available for specialty drugs. Prior approval is required for some <u>prescription drugs</u> . Without prior approval, a drug may not be covered.
	Tier 2 (Brand/Formulary drugs)	\$50 retail <u>copay</u> , \$100 mail order <u>copay</u> /prescription.	\$50 retail <u>copay</u> , then 20% <u>coinsurance</u> /prescription	
	Tier 3 (Brand/Non-formulary drugs)	\$100 retail <u>copay</u> , \$300 mail order <u>copay</u> /prescription.	\$100 retail <u>copay</u> , then 20% <u>coinsurance</u> /prescription	
	Tier 4 (Specialty/Formulary)	\$150 retail <u>copay</u>	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)	
	drugs)	/prescription.		
	Tier 5 (Specialty/Non-Formulary drugs)	\$250 retail <u>copay</u> /prescription.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Prior approval is required for some services. For in-plan PHCS <u>providers</u> and out-of-plan <u>providers</u> , without prior approval, benefit could be reduced by \$1,000.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> /visit	\$100 <u>copay</u> /visit	None
	<u>Emergency medical transportation</u>	\$100 <u>copay</u> per member per day	\$100 <u>copay</u> per member per day	For ground ambulance services from out-of-plan <u>providers</u> , 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.
	<u>Urgent care</u>	\$35 <u>copay</u> /visit	20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	60 days per calendar year limit for inpatient <u>rehabilitation</u> . 100 days per calendar year limit for <u>skilled nursing facility care</u> . Prior approval is required for non-emergency admissions to in-plan PHCS facilities and out-of-plan facilities. Without prior approval, benefit could be reduced by \$1,000.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> /visit	20% <u>coinsurance</u>	Prior approval is required for some services.
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Prior approval is required for non-emergency admissions to in-plan PHCS facilities and out-of-plan facilities. Without prior approval, benefit could be reduced by \$1,000.
If you are pregnant	Office visits	No charge	20% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive</u>

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)	
		<u>Deductible</u> does not apply.		<u>services</u> . Depending on the type of service, deductible and <u>copays</u> may apply.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Coverage for child is limited to routine newborn nursery charges. For continued coverage, child must be enrolled within 30 days of date of birth. Prior approval is required. For in-plan PHCS <u>providers</u> and out-of-plan <u>providers</u> , if you don't get prior approval, benefit could be reduced by \$1,000.
If you need help recovering or have other special health needs	Home health care	No charge	20% <u>coinsurance</u>	Prior approval is required. For in-plan PHCS <u>providers</u> and out-of-plan <u>providers</u> , without prior approval, benefit could be reduced by \$1,000.
	Rehabilitation services	\$35 <u>copay</u> /visit per treatment type	20% <u>coinsurance</u>	Limited to 60 visits per calendar year for physical or occupational therapy. Prior approval is required for speech therapy after the initial evaluation. For in-plan PHCS <u>providers</u> and out-of-plan <u>providers</u> , without prior approval, benefit could be reduced by \$1,000.
	Habilitation services	\$35 <u>copay</u> /visit per treatment type	20% <u>coinsurance</u>	Early intervention services are covered for children from birth to age 3. Applied Behavioral Analysis (ABA) to treat autism spectrum disorders is covered. Prior approval is required for ABA services from in-plan PHCS <u>providers</u> and out-of-plan <u>providers</u> . Without prior approval, services will not be covered. Copays do not apply to in-plan early intervention and ABA services.
	Skilled nursing care	No charge	20% <u>coinsurance</u>	Skilled nursing services in the home. Prior approval is required. For in-plan PHCS <u>providers</u> and out-of-plan <u>providers</u> , if you

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)	
				don't get prior approval, benefit could be reduced by \$1,000.
	Durable medical equipment	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Prior approval is required. For in-plan PHCS <u>providers</u> and out-of-plan <u>providers</u> , if you don't get prior approval, benefit could be reduced by \$1,000.
	Hospice services	No charge	20% <u>coinsurance</u>	Prior approval is required. For in-plan PHCS <u>providers</u> and out-of-plan <u>providers</u> , if you don't get prior approval, benefit could be reduced by \$1,000.
If your child needs dental or eye care	Children's eye exam	No charge for routine exams. <u>Deductible</u> does not apply.	20% <u>coinsurance</u>	Routine exams limited to one per calendar 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	\$3,000
■ Specialist copay	\$35
■ Hospital (facility) coinsurance	10%
■ Laboratory coinsurance	10%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$3,000
Copayments	\$30
Coinsurance	\$900
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$3,930

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$3,000
■ Specialist copay	\$35
■ Primary care visit copay	\$25
■ Laboratory coinsurance	10%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$2,200
Copayments	\$300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$2,500

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$3,000
■ Specialist copay	\$35
■ Hospital ER (facility) copay	\$100
■ 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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

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.

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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)

Lao	ທ່ານມີສິດທິ 'ຈະໄດ້' ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທິດປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ, ໂທຟຣີ ຫາຫາຍເລກໂທລະສັບສາລະສະມາຊິກທິດໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ, ກົດເລກ 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).