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, labs, 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?	Yes. $50 per child / $150 per family for non-preventive pediatric dental services.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$8,200 individual / $16,400 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	$10 copay/visit Deductible does not apply.	Not covered	Deductible may apply to some office services.
	Specialist visit	$30 copay/visit $20 copay/visit for chiropractor. $20 copay/visit for acupuncture. Deductible does not apply.	Not covered	Deductible may apply to some office services. Acupuncture limited to 12 visits per calendar year.
	Preventive care/screening/ immunization	No charge 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: $50 copay Lab: $25 copay Deductible does not apply to labs.	Not covered	None
	Imaging (CT/PET scans, MRIs)	$500 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 More information about **prescription drug coverage** is available at www.hnedirect.com/FormularyLookup/Default.aspx	Tier 1 (Generic drugs)	$10 retail copay, $20 mail order copay /prescription. Deductible does not apply.	Not covered	Covers up to a 30-day supply (retail); up to a 90 day supply (mail order). Mail order is not available for specialty drugs. 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. Deductible does not apply.	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)	
	Tier 3 (Brand/Non-formulary drugs)	$150 retail copay, $450 mail order copay /prescription. Deductible does not apply.	Not covered	
	Tier 4 (Specialty/Formulary drugs)	$200 retail copay /prescription. Deductible does not apply.	Not covered	
	Tier 5 (Specialty/Non-Formulary drugs)	$250 retail copay /prescription. Deductible does not apply.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$1,000 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	$500 copay/visit	$500 copay/visit	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	$30 copay/visit Deductible does not apply.	Not covered	Deductible may apply to some office services.
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,000 copay/admission	Not covered	60 days per calendar year limit for inpatient rehabilitation. 100 days per calendar year limit for skilled nursing facility care.

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)	
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/visit Deductible does not apply.	Not covered	Prior approval is required for some services.
	Inpatient services	$1,000 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	Not covered	None
	Childbirth/delivery facility services	$1,000 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	$30 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	$30 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.

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 your child needs dental or eye care	Children's eye exam	No charge for routine exams. Deductible does not apply.	Not covered except for children under age 19. For children under age 19 you will pay charges in excess of a $28 reimbursement.	Routine exams limited to one per calendar year. Routine exams for children under age 19 will be covered at no charge only if done by a provider participating with Health New England's children's vision care provider EyeMed.
	Children's glasses	No charge for 1 pair with a "Collection" frame; or $150 allowance + 20% off expense beyond allowance.	Not covered except for children under age 19. For children under age 19 you will pay expenses beyond allowed amounts. Allowed amounts depend on types of frames and lenses.	For children under age 19. Limited to one pair per calendar year. In-plan providers are providers participating with Health New England's children's vision care provider EyeMed.
	Children's dental check-up	No charge	20% coinsurance	For children under age 19. Out-of-plan dentists may also bill you for the difference between their charge and Health New England's contracted dental network's allowed amount.

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.)

- 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:

If you have Individual health insurance: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those

agencies is: 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. For information on buying individual coverage through the state marketplace, contact the Massachusetts Health Connector at www.mahealthconnector.org.

If you have Group health insurance 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. If you have group health insurance coverage 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? **Group plans: Yes** **Individual policies: Not Applicable**
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	**$30**
Hospital (facility) copay	**$1,000**
Laboratory copay	**$25**

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	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,100**

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	**$30**
Primary care visit copay	**$100**
Laboratory copay	**$25**

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	$0
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,000**

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

The plan's overall deductible	**$2,000**
Specialist copay	**$30**
Hospital ER (facility) copay	**$500**
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	$2,000
Copayments	$200
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,220**

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 aids and language services to people with disabilities and whose primary language is not English to communicate effectively with us. We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at (800) 310-2835 (TTY: 711). Someone who speaks your preferred language can help you.

This is a free service, which includes:

- **Qualified sign language interpreters**
- **Written information in other formats (large print, audio, accessible electronic formats, other formats)**
- **Qualified interpreters**
- **Information written in other languages**

If you need these services, you may also contact Susan O'Connor, Vice President and General Counsel, at One Monarch Place, Suite 1500, Springfield, MA 01104-1500, Phone: (888) 270-0189, TTY: 711, Fax: (413) 233-2685.

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 at the above address, phone or fax, or via email to 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**.

Reviewed: 9/5/2023

Multi-Language Interpreter 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.

English	We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at (800) 310-2835 (TTY: 711). Someone who speaks English can help you. This is a free service.
Spanish	Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al (800) 310-2835 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.
Portuguese	Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número (800) 310-2835 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.
German	Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter (800) 310-2835 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.
Japanese	当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、(800) 310-2835 (TTY: 711) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。
Chinese Mandarin	我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 (800) 310-2835 (TTY: 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。
Chinese Cantonese	您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 (800) 310-2835 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。
French Creole	Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan (800) 310-2835 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.
Vietnamese	Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi (800) 310-2835 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.
Russian	Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону (800) 310-2835 (телетайп: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic	إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (800) 310-2835 (TTY: 711). سيقوم شخص ما يتحدث
French	Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au (800) 310-2835 (ATS: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.
Italian	È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero (800) 310-2835 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.
Korean	당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 (800) 310-2835 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.
Polish	Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer (800) 310-2835 (TTY: 711). Ta usługa jest bezpłatna.
Hindi	हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें (800) 310-2835 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.
Tagalog	Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa (800) 310-2835 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.