




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?	In-Plan: \$2,000 individual / \$4,000 family Out-of-Plan: \$4,000 individual / \$8,000 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. In-Plan: 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?	In-plan: \$6,000 individual / \$12,000 family. Out-of-plan: \$12,000 individual / \$24,000 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	\$25 copay /visit Deductible does not apply.	20% coinsurance	Deductible may apply to some in-plan office services.
	Specialist visit	\$40 copay /visit \$20 copay /visit for chiropractor. \$20 copay /visit for acupuncture. Deductible does not apply.	20% coinsurance For chiropractor: \$20 copay /visit, then 20% coinsurance	Deductible may apply to some in-plan office services. Acupuncture limited to 12 visits per calendar year.
	Preventive care/screening/immunization	No charge Deductible does not apply.	20% coinsurance	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	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	\$100 copay	20% coinsurance	Includes CT Scans, PET Scans, MRIs, MRAs and Nuclear Cardiac Imaging. Prior approval is required. Prior approval is required for services from extended network providers and out-of-plan providers . Without prior approval, services will not be covered.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.hnedirect.com/Form	Tier 1 (Generic drugs)	\$30 retail copay , \$60 mail order copay /prescription. Deductible does not apply.	\$30 retail copay , then 20% coinsurance /prescription	Covers up to a 30-day supply (retail); up to a 90-day supply (mail order). Mail order from out-of-plan providers is not covered. 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)	\$80 retail copay , \$160 mail order copay /prescription.	\$80 retail copay , then 20% coinsurance /prescription	

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)	
ularyLookup/Default.aspx		<u>Deductible</u> does not apply.		
	Tier 3 (Brand/Non-formulary drugs)	\$125 retail <u>copay</u> , \$375 mail order <u>copay</u> /prescription. <u>Deductible</u> does not apply.	\$125 retail <u>copay</u> , then 20% <u>coinsurance</u> /prescription	
	Tier 4 (Specialty/Formulary drugs)	\$150 retail <u>copay</u> /prescription. <u>Deductible</u> does not apply.	Not covered	
	Tier 5 (Specialty/Non-Formulary drugs)	\$200 retail <u>copay</u> /prescription. <u>Deductible</u> does not apply.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$50 <u>copay</u>	20% <u>coinsurance</u>	Prior approval is required for some services. For extended network <u>providers</u> and out-of-plan <u>providers</u> , without prior approval, benefit could be reduced by \$500. This <u>copay</u> is based on the type of service. To find out if this <u>copay</u> applies to a specific procedure, please contact Health New England Member Services at 1-800-310-2835.
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	None
If you need immediate medical attention	Emergency room care	\$500 <u>copay</u> /visit	\$500 <u>copay</u> /visit	None
	Emergency medical transportation	\$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.

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)	
	Urgent care	\$40 <u>copay</u> /visit <u>Deductible</u> does not apply.	20% <u>coinsurance</u>	<u>Deductible</u> may apply to some In-Plan office services.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 <u>copay</u> /admission	20% <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 extended network facilities and out-of-plan facilities. Without prior approval, benefit could be reduced by \$500.
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> /visit <u>Deductible</u> does not apply.	20% <u>coinsurance</u>	Prior approval is required for some services.
	Inpatient services	\$100 <u>copay</u> /admission	20% <u>coinsurance</u>	Prior approval is required for non-emergency admissions to extended network facilities and out-of-plan facilities. Without prior approval, benefit could be reduced by \$500.
If you are pregnant	Office visits	No charge <u>Deductible</u> does not apply.	20% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service, deductible and <u>copays</u> may apply.
	Childbirth/delivery professional services	No charge <u>Deductible</u> does not apply.	20% <u>coinsurance</u>	None
	Childbirth/delivery facility services	\$100 <u>copay</u> /admission	20% <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 extended network <u>providers</u> and out-of-plan <u>providers</u> , if you don't get prior approval, benefit could be reduced by \$500.

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 need help recovering or have other special health needs	Home health care	No charge	20% <u>coinsurance</u>	Prior approval is required. For extended network <u>providers</u> and out-of-plan <u>providers</u> , without prior approval, benefit could be reduced by \$500.
	Rehabilitation services	\$40 <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 extended network <u>providers</u> and out-of-plan <u>providers</u> , without prior approval, benefit could be reduced by \$500.
	Habilitation services	\$40 <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 extended network <u>providers</u> and out-of-plan <u>providers</u> . Without prior approval, services will not be covered. Early intervention and ABA services from in-plan providers are covered with no member <u>cost sharing</u> .
	Skilled nursing care	No charge	20% <u>coinsurance</u>	Skilled nursing services in the home. Prior approval is required. For extended network <u>providers</u> and out-of-plan <u>providers</u> , if you don't get prior approval, benefit could be reduced by \$500.
	Durable medical equipment	20% <u>coinsurance</u> <u>Deductible</u> does not apply.	20% <u>coinsurance</u>	Prior approval is required. For extended network <u>providers</u> and out-of-plan <u>providers</u> , if you don't get prior approval, benefit could be reduced by \$500.
	Hospice services	No charge <u>Deductible</u> does not apply.	20% <u>coinsurance</u>	Prior approval is required. For extended network <u>providers</u> and out-of-plan <u>providers</u> , if you don't get prior approval, benefit could be reduced by \$500.
	Children's eye exam	No charge for routine	Not covered except	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)	
If your child needs dental or eye care		exams. <u>Deductible</u> does not apply.	for children under age 19. For children under age 19 you will pay charges in excess of a \$28 reimbursement.	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% <u>coinsurance</u>	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 <u>allowed amount</u> .

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.)

<ul style="list-style-type: none"> • Cosmetic Surgery • Dental Care (Adult) (except for the limited services specified in your plan materials) 	<ul style="list-style-type: none"> • Long Term Care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private Duty Nursing • Routine Foot Care (Routine foot care is covered if you have diabetes)
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

<ul style="list-style-type: none"> • Abortion • Acupuncture • Bariatric Surgery (requires prior approval) • Chiropractic Care 	<ul style="list-style-type: none"> • 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) 	<ul style="list-style-type: none"> • Routine eye care (Adult) • Weight Loss Programs (reimbursement per calendar year :\$300 per individual up to \$600 per family)
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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	\$40
■ Hospital (facility) copay	\$100
■ 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$2,200

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	\$40
■ Primary care visit copay	\$25
■ 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,600
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,600

Mia's Simple Fracture

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

■ The plan's overall deductible	\$2,000
■ Specialist copay	\$40
■ 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$200
Coinsurance	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,260

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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