




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](http://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/](http://www.healthcare.gov/sbc-glossary/) or call 1-800-310-2835 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$400 person / \$800 family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> is covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. <a href="#">Prescription drugs</a> : \$100 person / \$200 family	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$5,000 person / \$10,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Your <a href="#">cost-sharing</a> for benefits that are not <a href="#">Essential Health Benefits</a> under national health care reform, <a href="#">premiums</a> , health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://healthnewengland.org">healthnewengland.org</a> or call 1-800-310-2835 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply.	Not covered	<a href="#">Deductible</a> may apply to some office services.
	<a href="#">Specialist</a> visit	Tier 1: \$30 <a href="#">copay</a> /visit Tier 2: \$60 <a href="#">copay</a> /visit Chiropractor Services \$20/per visit <a href="#">Deductible</a> does not apply.	Not covered	See Chiropractic Rider for coverage details ( <i>children under age 13 require Prior Approval</i> ).
	<a href="#">Preventive care/screening/immunization</a>	No charge <a href="#">Deductible</a> does not apply.	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	Not covered	Must meet <a href="#">deductible</a> first. Imaging requires prior approval.
	Imaging (CT/PET scans, MRIs)	\$100 <a href="#">copay</a> (maximum 1 <a href="#">copay</a> per day)	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 <a href="#">prescription drug coverage</a> is available at <a href="https://info.caremark.com/oe/gic">https://info.caremark.com/oe/gic</a>	Tier 1 (Generic drugs)	\$10 retail <a href="#">copay</a> , \$25 mail order <a href="#">copay</a> /prescription.	Not covered	<a href="#">Prescription drug</a> coverage is administered by CVS Caremark. For additional information, visit <a href="http://www.expressscripts.com/gicrx">http://www.expressscripts.com/gicrx</a> or call Customer Service at <b>1-855-283-7679 (TTY 711)</b> Retail cost share is for up to a 30-day supply, mail order cost share is for up to a 90-day supply. Some drugs require prior authorization to be covered. Some drugs have quantity limitations. A 90-day supply of maintenance medications may be obtained at a CVS Pharmacy for the applicable mail-order <a href="#">copay</a> . If a drug has a generic equivalent, and
	Tier 2 (Brand/ <a href="#">Formulary</a> drugs)	\$30 retail <a href="#">copay</a> , \$75 mail order <a href="#">copay</a> /prescription.	Not covered	
	Tier 3 (Brand/Non- <a href="#">formulary</a> drugs)	\$65 retail <a href="#">copay</a> , \$165 mail order <a href="#">copay</a> /prescription.	Not covered	

What You Will Pay

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)	
				you buy the brand name (even if your physician indicates no substitutions), you will pay the generic-level <a href="#">copay</a> plus the cost difference between the generic and the brand name drug.
	<a href="#">Specialty drugs</a>	Limited to a 30-day supply with appropriate tier <a href="#">copay</a> (see above) when purchased at a designated specialty pharmacy.	Not covered	Must be obtained at a designated specialty pharmacy. Some drugs require prior authorization to be covered. Some drugs have a quantity limitation. Some specialty drugs may also be covered under your medical benefit.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$150 <a href="#">copay</a> /visit for freestanding ambulatory surgery center facility. \$250 <a href="#">copay</a> /visit for hospital outpatient facility.	Not covered	Maximum of four outpatient surgery <a href="#">copays</a> per policy year. Prior approval is required for some services. This <a href="#">copay</a> is based on the type of service. The \$150 ambulatory <a href="#">copay</a> applies to GI/Eye procedures. To find out if this <a href="#">copay</a> 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
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$100 <a href="#">copay</a> /visit	\$100 <a href="#">copay</a> /visit.	Must meet <a href="#">deductible</a> first. <a href="#">Copay</a> waived if admitted directly from the ER.
	<a href="#">Emergency medical transportation</a>	No charge	No charge	Must meet <a href="#">deductible</a> first. For ground ambulance services from <a href="#">out-of-plan providers</a> , 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.
	<a href="#">Urgent care</a>	\$20 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply.	Not covered	None

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 have a hospital stay	Facility fee (e.g., hospital room)	\$275 <a href="#">copay</a> /admission	Not covered	Must meet <a href="#">deductible</a> first. Maximum of one inpatient admission <a href="#">copay</a> per quarter. 100 days per calendar year limit for <a href="#">skilled nursing facility care</a> .
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply.	Not covered	Prior approval is required for some services.
	Inpatient services	No charge	Not covered	Must meet <a href="#">deductible</a> first. Some services may require prior approval.
If you are pregnant	Office visits	No charge <a href="#">Deductible</a> does not apply.	Not covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of service, <a href="#">deductible</a> and <a href="#">copays</a> may apply.
	Childbirth/delivery professional services	No charge <a href="#">Deductible</a> does not apply.	Not covered	None
	Childbirth/delivery facility services	\$275 <a href="#">copay</a> /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	<a href="#">Home health care</a>	No charge	Not covered	Prior approval is required.
	<a href="#">Rehabilitation services</a>	\$20 <a href="#">copay</a> /visit per treatment type <a href="#">Deductible</a> does not apply.	Not covered	Physical and occupational therapy; covered for 30 visits per acute episode, per Policy Year. The limit does not apply when services are provided to treat Autism Spectrum Disorder.
	<a href="#">Habilitation services</a>	\$20 <a href="#">copay</a> /visit per treatment type <a href="#">Deductible</a> does not apply.	Not covered	Early intervention services are covered for children from birth to age 3 with no member <a href="#">cost sharing</a> . Applied Behavioral Analysis (ABA) to treat autism spectrum disorders is covered with no member <a href="#">cost sharing</a> .
	<a href="#">Skilled nursing care</a>	No charge	Not covered	Skilled nursing services in the home. Prior

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)	
				approval is required.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	Not covered	Prior approval is required for some items.
	<a href="#">Hospice services</a>	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to one every 24 months. <a href="#">Deductible</a> does not apply.
	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Children's Dental Check-up</li> <li>Children's Glasses</li> <li>Cosmetic Surgery</li> </ul>	<ul style="list-style-type: none"> <li>Dental Care (Adult) (except for the limited services specified in your <a href="#">plan</a> materials)</li> <li>Long Term Care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Private Duty Nursing</li> <li>Routine Foot Care (Routine foot care is covered if you have diabetes)</li> <li>Weight Loss Programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Abortion</li> <li>Bariatric Surgery (requires prior approval)</li> <li>Chiropractic Care</li> </ul>	<ul style="list-style-type: none"> <li>Hearing Aids</li> <li>Infertility Treatment (requires prior approval)</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care (Adult)</li> </ul>

**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](http://www.dol.gov/ebsa/healthreform). 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](http://www.HealthCare.gov) or call 1-800-318-2596.

**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](http://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](http://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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$400
■ <a href="#">Specialist copay</a>	\$30
■ Hospital (facility) <a href="#">copay</a>	\$275
■ Laboratory <a href="#">copay</a>	\$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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<a href="#">Cost sharing</a>	
<a href="#">Deductibles</a>	\$400
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$700</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$400
■ <a href="#">Specialist copay</a>	\$30
■ Primary care visit <a href="#">copay</a>	\$20
■ Laboratory <a href="#">copay</a>	\$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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<a href="#">Cost sharing</a>	
<a href="#">Deductibles</a>	\$60
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$260</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$400
■ <a href="#">Specialist copay</a>	\$30
■ Hospital ER (facility) <a href="#">copay</a>	\$100
■ Ambulance services <a href="#">copay</a>	\$0

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<a href="#">Cost sharing</a>	
<a href="#">Deductibles</a>	\$400
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$620</b>

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 (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). 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 people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

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

Health New England provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, you may 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](mailto: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: 8/28/2024*

## 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。通訳をご利用になるには、(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 quý vị cần thông dịch viên xin gọi (800) 310-2835 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý 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

