**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 1-800-791-7944 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 1-800-791-7944 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $0 | See the Common Medical Events chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | Yes. All covered services are covered without a deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | **Medical:** $2,000 individual / $4,000 family. **Pharmacy:** $3,000 individual / $6,000 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. Visit healthnewengland.org or call 1-800-791-7944 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. |

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022) (HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

| 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 | $20 copay/visit | Not covered | None |
| | Specialist visit | $35 copay/visit<br>$20 copay/visit for chiropractor.<br>$20 copay/visit for acupuncture | Not covered | Chiropractic limited to 12 visits per calendar year (children under age 13 require Prior Approval). Acupuncture limited to 12 visits per calendar year. |
| | Preventive care/screening/ immunization | No charge | 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) | No charge | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | $100 copay | Not covered | Includes CT Scans, PET Scans, MRIs, MRAs and Nuclear Cardiac Imaging. Prior approval is required. |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at http://www.hnedirect.com/FormularyLookup/Default.aspx | Tier 1 (Generic drugs) | $10 retail copay,<br>$20 mail order copay /prescription | Not covered | Covers up to a 30-day supply (retail); up to a 90-day supply (mail order). Prior approval is required for some prescription drugs. Without prior approval, a drug may not be covered. |
| | Tier 2 (Brand/Formulary drugs) | $25 retail copay,<br>$50 mail order copay /prescription | Not covered | |
| | Tier 3 (Brand/Non-formulary drugs) | $50 retail copay,<br>$110 mail order copay /prescription | Not covered | |
| | Specialty drugs | Copay depends on drug tier. | Not covered | Prior approval is required for some prescription drugs. Without prior approval, a drug may not be covered. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $150 copay/day | Not covered | Prior approval is required for some services. This copay is based on the type of service, not where it is performed. To find out if this copay applies to a specific procedure, please contact Health New England Member Services at 1-800-791-7944. |
| | Physician/surgeon fees | No charge | 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 need immediate medical attention** | Emergency room care | $100 copay/visit | $100 copay/visit | None |
| | Emergency medical transportation | $25 copay/member/day | $25 copay/member/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 | $35 copay/visit | Not covered | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $500 copay/admission | Not covered | 100 days per calendar year limit for skilled nursing facility care and Inpatient Rehabilitation. Prior Approval Required. |
| | Physician/surgeon fees | No charge | Not covered | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $20 copay/visit | Not covered | Prior approval is required. |
| | Inpatient services | $500 copay/admission | Not covered | Prior approval is required. |
| **If you are pregnant** | Office visits | No charge | Not covered | Cost sharing does not apply for preventive services. Depending on the type of service, copays may apply. |
| | Childbirth/delivery professional services | No charge | Not covered | None |
| | Childbirth/delivery facility services | $500 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. |

| 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 | Not covered | Prior approval is required. |
| | Rehabilitation services | $20 copay/visit per treatment type | Not covered | Limited to 60 visits per Calendar Year for physical or occupational therapy. The Calendar year limit does not apply to services that are part of a home health plan. The limit also does not apply when services are provided to treat autism spectrum disorder.) Services that are part of a home health plan and services provided to treat autism spectrum disorder require Prior Approval.) |
| | Habilitation services | $35 copay/visit per treatment type | Not covered | Early intervention services covered for children from birth to age 3 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 | Not covered | Prior approval is required for some items. |
| | Hospice services | No charge | Not covered | Prior approval is required. |
| **If your child needs dental or eye care** | Children's eye exam | No charge | Not covered | 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.)**

- Bariatric Surgery (requires prior approval)
- 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.)**

- Acupuncture
- Chiropractic Care
- Hearing Aids (limited to members age 21 and under, $2,000 per hearing aid per ear each 36 months)
- Infertility Treatment (some services require Prior Approval)
- Routine eye care (Adult)
- Weight Loss Programs ($400 payment for a family can be split among family members of the plan. The maximum for each member on the plan is $200.)

**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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 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: Health New England Member Services at (800)791-7944 or visit healthnewengland.org.

**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 | $0 |
| Specialist copay | $35 |
| Hospital (facility) copay | $500 |
| Laboratory copay | $0 |

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

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

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$500** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copay | $35 |
| Primary care visit copay | $20 |
| Laboratory copay | $0 |

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

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

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $900 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$900** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copay | $35 |
| Hospital ER (facility) copay | $100 |
| Ambulance services copay | $25 |

**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 | $0 |
| Copayments | $200 |
| Coinsurance | $20 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$220** |

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

## Notice Informing Individuals of Nondiscrimination and Accessibility

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: 12/13/2022*

## 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.

➲

BeHealthy Partnership members, this information is about your BeHealthy Partnership benefits. If you have questions, need this document translated, need someone to read this or other printed information to you, or want to learn more about any of our benefits or services, 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. For questions about your Behavioral Health, call MBHP at: (800) 495-0086 (TTY: (617) 790-4130) 24 hours a day, 7 days a week, or visit www.masspartnership.com.

Medicare Advantage members, Health New England Medicare Advantage is an HMO, HMO-POS, and PPO Plan with a Medicare contract. Enrollment in Health New England Medicare Advantage depends on contract renewal. If you have any questions regarding this document, please contact the toll-free member phone number listed on your health plan ID card, (TTY: 711).

| | |
|---|---|
| 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) |
| German | Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Mitgliedsnummer an, die auf Ihrem Krankenversicherungsausweis aufgeführt ist, und drücken Sie die 0. (TTY: 711) |
| Japanese | あなたには、無料であなたの言語でヘルプと情報を得る権利があります。通訳を依頼するには、健康保険証に記載されているフリーダイヤルの会員番号に電話し、0 を押してください。(TTY: 711) |
| Chinese | 您有權免費以您使用的語言獲得幫助和訊息。如需口譯員，請撥打您的保健計劃 ID 卡上列出的免費會員電話號碼，按 0。(TTY: 711) |
| French Creole | Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. (TTY: 711) |
| Vietnamese | Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. (TTY: 711). |
| Russian | Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия (телетайп: 711) |
| Arabic | يحق لك الحصول على المساعدة والمعلومات بلغتك مجانًا. لطلب مترجم، اتصل برقم هاتف العضو المجاني على بطاقة تعريف خطتك الصحية، ثم اضغط على 0. (TTY:711) |

| | |
|---|---|
| Mon-Khmer, Cambodian | អ្នកមានសិទ្ធិទ្ួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអ្ស់ថ្លៃ។ ដ ើមបីដសនើស ំអ្នកបកប្រប សូមទ្ូរស័ពទដៅដលខឥតដេញថ្លៃសំរាប់សមាជិក ឬ លមានកត់ដៅកនុងប័ណ្ណ ID គំដរាងស ខភាពរបស់អ្នក រួេដ ើយ េ 0។ (TTY: 711) |
| French | Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d’affilié du régime de soins de santé et appuyez sur la touche 0. (ATS: 711). |
| Italian | Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti (TTY: 711). |
| Korean | 귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711 |
| Greek | Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. (TTY: 711). |
| Polish | Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. (TTY: 711). |
| Hindi | आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711 |
| Gujarati | તમારી ભાષામાં વિના મૂલ્યે મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયાની વિનંતી કરવા માટે તમારા હેલ્થ પ્લાન ID કાર્ડ પર જણાવેલા ટોલ-ફ્રી નંબર પર કૉલ કરો અને 0 દબાવો. (TTY: 711). |
| Lao | ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫ ຼືອແລະຂ ໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບ ໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂ ຮ້ອງນາຍພາສາ,ໂທຜ ຣິຫາຫມາຍເລກໂທລະສັບສ າລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,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). |