This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.healthnewengland.org or by calling 800.310.2835.

Important Questions	Answers	Why this Matters
What is the overall deductible?	$300 per member / $900 per family for the Policy Year. (doesn't apply to preventive care)	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket maximum on my expenses?	Yes. In-Network: $5,000 per individual / $10,000 per family	The out-of-pocket maximum is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket maximum?	Premiums and healthcare this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket maximum.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.healthnewengland.org or call 800.310.2835 for a list of participating **providers**.	If you use an in-plan doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-plan doctor or hospital may use an out-of-plan **provider** for some services. Plans use the term in-plan, in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copays** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-plan **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-plan hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-plan **providers** by charging you lower **deductibles**, **copays** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-plan Provider	Your cost if you use an Out-of-plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20/visit	Not covered	----------none----------
	Specialist visit	Tier 1: $30/visit, Tier 2: $60/visit, Tier 3: $90/visit	Not covered	----------none----------
	Other practitioner office visit	Not covered	Not covered	----------none----------
	Preventive care / screening / immunization	No charge	Not covered	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	Must meet deductible first. Imaging requires prior approval.
	Imaging (CT/PET scans, MRIs)	$100/visit, then deductible	Not covered	Requires prior approval. Maximum of one copay per day.
If you need drugs to treat your illness or condition. **More information about prescription drug coverage is available at healthnewengland.org.**	Generic drugs	$10 retail, $25 mail order / prescription	Not covered	Covers up to a 30-day retail supply or a 90-day mail order supply. Some drugs require prior approval.
	Formulary brand drugs	$30 retail, $75 mail order / prescription	Not covered	Covers up to a 30-day retail supply or a 90-day mail order supply. Some drugs require prior approval.
	Non-Formulary brand drugs	$65 retail, $165 mail order / prescription	Not covered	Covers up to a 30-day retail supply or a 90-day mail order supply. Some drugs require prior approval.
	Specialty drugs	Copay depends on drug category	Not covered	Some drugs require prior approval.

Common Medical Event	Services You May Need	Your cost if you use an In-plan Provider	Your cost if you use an Out-of-plan Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) and Physician/surgeon fees	$250/admission, then deductible	Not covered	Maximum of four outpatient surgery copays per Policy Year.
If you need immediate medical attention	Emergency room services	$100/visit	$100/visit	Must meet deductible first. Copay waived if admitted directly from ER.
	Emergency medical transportation	$25/member/day	$25/member/day	Must meet deductible first.
	Urgent care	$20/visit	Not covered	Members can also go to retail clinics such as MinuteClinics.
If you have a hospital stay	Facility fee (e.g., hospital room) and Physician/surgeon fees	$275/admission	Not covered	Must meet deductible first. Maximum of one inpatient admission copay per quarter.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20/visit	Not covered	Some services may require prior approval.
	Mental/Behavioral health inpatient services	No charge	Not covered	Must meet deductible first. Some services may require prior approval.
	Substance use disorder outpatient services	$20/visit	Not covered	Some services may require prior approval.
	Substance use disorder inpatient services	No charge	Not covered	Must meet deductible first. Some services may require prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	You may have copays for non-routine services.
	Delivery and all inpatient services	$275/admission	Not covered	Maximum of one inpatient admission copay per quarter. Must meet deductible first.

Common Medical Event	Services You May Need	Your cost if you use an In-plan Provider	Your cost if you use an Out-of-plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Must meet deductible first. Requires prior approval.
	Rehabilitation services	$25/visit/treatment type	Not covered	Limited to 90 consecutive days per condition per Policy Year for physical and occupational therapy. The limit does not apply when services are provided to treat autism spectrum disorder.
	Habilitation services	No charge	Not covered	Early intervention services covered for children from birth to age 3.
	Skilled nursing care	No charge	Not covered	Must meet deductible first. Limited to 100 days per Policy Year.
	Durable medical equipment	20% coinsurance	Not covered	Some items require prior approval. Oxygen related supplies not subject to coinsurance.
	Hospice service	No charge	Not covered	Must meet deductible first. Requires prior approval.
If your child needs dental or eye care	Eye exam	$20/visit	Not covered	Limited to one every 24 months.
	Glasses	Not covered	Not covered	----------none----------
	Dental check-up	Not covered	Not covered	----------none----------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Chiropractic Care
- Cosmetic Surgery
- Dental care (except for the limited services specified in your plan materials)
- Glasses
- 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)
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Bariatric surgery (requires prior approval)
- Hearing aids
- Infertility treatment (requires prior approval)
- Routine eye care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 800.310.2835. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 866.444.3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 877.267.2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

- Health New England Member Services at 800.310.2835.
- U.S. Department of Labor's Employee Benefits Security Administration at 866.444.EBSA (3472) or dol.gov/ebsa/healthreform.
- Office of Patient Protection at 800.436.7757.

Additionally, a consumer assistance program can help you file your **appeal**. Contact:

Health Care for All
30 Winter Street, Suite 1004
Boston, MA 02108
800.272.4232

or hcfama.org/helpline

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,940
- **Patient pays** $600

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$300
Copays	$300
Coinsurance	$0
Limits or exclusions	$0
Total	**$600**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,300
- **Patient pays** $1,100

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Copays	$1,000
Coinsurance	$0
Limits or exclusions	$0
Total	**$1,100**

NOTE: These numbers assume the patient has not met any part of his/her Policy Year deductible and is using in-network Tier 1 physicians and hospitals. If you go out of network, or see a Tier 2 or Tier 3 provider, your cost will be higher.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copays**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copays**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.