Minuteman Health

MyDoc HMO Gold 2050 w/Child Dental

Coverage Period: 1/1/2016-12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | **Plan Type:** HMO

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.minutemanhealth.org or by calling 1-855-MHI-1776.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,050** for individual policy/**$4,100** for family policy. Does not apply to preventive care, primary care visits, specialist visits or prescription drugs.	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 limit on my expenses?	Yes. **$4,000** for individual policy/**$8,000** for family policy.	The **out-of-pocket limit** 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 limit?	Premiums, non-emergency out-of-network care, balance-billed charges, penalties for failing to obtain prior authorization and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
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, Minuteman Health Network-MA. See www.minutemanhealth.org or call 1-855-MHI-1776 for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term 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	No. You don't need a referral to	You can see the **specialist** you choose without permission from this plan.

see a specialist?	see a specialist.	
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**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network 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 **participating providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	Not Covered	——none——
	Specialist visit	$50 copay per visit	Not Covered	——none——
	Other practitioner office visit	Chiropractor $50 Copay per visit Acupuncturist 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)	Lab No charge after deductible X-Ray No charge after deductible	Not Covered	——none——

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	No charge after deductible	Not Covered	Prior approval required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.minutemanhealth.org	Generic drugs	$15 copay retail/$30 copay mail order per prescription	Not Covered	Covered drugs are listed on Minuteman Health's formulary
	Preferred brand drugs	$30 copay retail/$60 copay mail order per prescription	Not Covered	Covered drugs are listed on Minuteman Health's formulary
	Non-preferred brand drugs	$50 copay retail/$150 copay mail order per prescription	Not Covered	Covered drugs are listed on Minuteman Health's formulary
	Specialty drugs	$50 copay retail/$150 copay mail order per prescription	Not Covered	Covered drugs are listed on Minuteman Health's formulary
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible per visit	Not Covered	Some services require prior approval.
	Physician/surgeon fees	No charge after deductible	Not Covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	$150 copay after deductible per visit	$150 copay after deductible per visit	Copay waived if admitted
	Emergency medical transportation	$150 copay after deductible per trip	$150 copay after deductible per trip	——————none——————
	Urgent care	$25 copay per visit	$25 copay per visit	No coverage for urgent care received from non-participating providers located inside the MHI service area.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible per stay	Not Covered	Some services require prior approval
	Physician/surgeon fee	No charge after deductible	Not Covered	Some services require prior approval
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay per visit	Not Covered	——————none——————
	Mental/Behavioral health inpatient services	No charge after deductible per stay	Not Covered	Some services require prior approval
	Substance use disorder outpatient services	$25 copay per visit	Not Covered	——————none——————
	Substance use disorder inpatient services	No charge after deductible per stay	Not Covered	Some services require prior approval
If you are pregnant	Prenatal and postnatal care	No charge	Not Covered	——————none——————
	Delivery and all inpatient services	No charge after deductible per stay	Not Covered	——————none——————
If you need help recovering or have other special health needs	Home health care	No charge after deductible	Not Covered	Some services require prior approval
	Rehabilitation services	No charge after deductible per visit	Not Covered	Limited to 60 visits per member per calendar year
	Habilitation services	No charge after deductible per visit	Not Covered	
	Skilled nursing care	No charge after deductible per stay	Not Covered	Limited to 100 days per year
	Durable medical equipment	20% coinsurance after deductible per item	Not Covered	Some services require prior approval
	Hospice service	No charge after deductible	Not Covered	Some services require prior approval
If your child needs dental or eye care	Eye exam	No charge	Not Covered	Limited to one per calendar year
	Glasses	Not Covered	Not Covered	——————none——————

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
	Dental check-up	50% coinsurance after deductible per visit	Not Covered	Dental checkups are limited to two per 12 month period

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
- Cosmetic Surgery
- Dental care (adult)
- Glasses
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine foot care (for non-diabetics)

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
- Chiropractic Care (limited to 12 visits per calendar year)
- Abortion Services (including elective abortions)
- Coverage outside the United States, see www.minutemanhealth.org.
- Hearing Aids
- Infertility Treatment
- Routine eye care (adult)
- Weight loss programs

For more details on the coverage associated with this plan, please visit http://minutemanhealth.org/members/plans-new/pat-ma-plans-2016 to view the Explanation of Coverage (EOC).

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 you rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-MHI-1776. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 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 Minuteman Health at 1-855-MHI-1776 or www.minutemanhealth.org. Or you may write to us at Minuteman Health, Inc., P.O. Box 120025, Boston, MA 02112-0025.

Other contact information: Department of Labor's Employee Benefits Security Administrations, 1-866-444-3272 or www.dol.gov/ebsa/healthreform

Consumer Assistance Resource

If you need help, the consumer assistance program in Massachusetts can help you file your appeal.

Contact: Health Care for All
30 Winter Street, Suite 1004
Boston, MA 02108
(800) 272-4232
http://www.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.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-644-1776.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-644-1776.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-644-1776.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-644-1776.

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** $5,315
- **Patient pays** $2,225

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	$2,000
Co-pays	$25
Co-insurance	$0
Limits or exclusions	$150
Total	**$2,225**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,970
- **Patient pays** $2,430

Sample care costs:

Prescriptions	$2,100
Medical Equipment and Supplies	$1,700
Office Visits and Procedures	$730
Education	$390
Laboratory tests	$340
Vaccines, other preventive	$140
Total	**$5,400**

Patient pays:

Deductibles	$1,500
Co-pays	$600
Co-insurance	$250
Limits or exclusions	$80
Total	**$2,430**

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**, **co-payments**, and **co-insurance** 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 **co-payments**,

deductibles, and **co-insurance**. 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.