



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?	<p>\$3,350 for individual policy/ \$6,700 for family policy for in-network services. Does not apply to in-network preventive care.</p> <p>\$6,300 for individual policy/ \$13,000 for family policy for out-of-network services.</p>	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 1 st). See the chart starting on page 3 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 3 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	<p>Yes. \$6,550 for individual policy/\$13,100 for family policy for in-network services.</p> <p>\$11,000 for individual policy/ \$23,000 for family policy for out-of-network services.</p>	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, 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 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a	Yes, Minuteman Health	If you use an in-network doctor or other health care provider , this plan will pay some or all

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Important Questions	Answers	Why this Matters:
network of providers?	Network-MA. See www.minutemanhealth.org or call 1-855-MHI-1776 for a list of participating providers.	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 3 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	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 7. 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.

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MyDoc PPO National Bronze HSA 3350 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: PPO

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	\$50 copay after deductible per visit	20% coinsurance after deductible per visit	_____none_____
	Specialist visit	\$80 copay after deductible per visit	20% coinsurance after deductible per visit	_____none_____
	Other practitioner office visit	<u>Chiropractor</u> \$80 copay after deductible per visit <u>Acupuncturist</u> Not Covered	<u>Chiropractor</u> 20% coinsurance after deductible per visit <u>Acupuncturist</u> Not Covered	_____none_____
	Preventive care/screening/immunization	No Charge	20% Coinsurance after deductible per visit	_____none_____
If you have a test	Diagnostic test (x-ray, blood work)	<u>Lab</u> \$100 copay after deductible <u>X-Ray</u> \$150 copay after deductible	<u>Lab</u> 20% coinsurance after deductible <u>X-Ray</u> 20% coinsurance after deductible	_____none_____
	Imaging (CT/PET scans, MRIs)	35% coinsurance after deductible per test	55% coinsurance after deductible per test	Prior approval required. If Prior approval is not obtained, benefits may be reduced.

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		In-network Provider	Out-of-network Provider	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.minutemanhealth.org	Generic drugs	\$30 copay retail/\$60 copay mail order after deductible per prescription	Not Covered	Covered drugs are listed on Minuteman Health's formulary and must be obtained from in-network providers.
	Preferred brand drugs	50% coinsurance after deductible per prescription	Not Covered	Covered drugs are listed on Minuteman Health's formulary and must be obtained from in-network providers.
	Non-preferred brand drugs	50% coinsurance after deductible per prescription	Not Covered	Covered drugs are listed on Minuteman Health's formulary and must be obtained from in-network providers.
	Specialty drugs	50% coinsurance after deductible per prescription	Not Covered	Covered drugs are listed on Minuteman Health's formulary and must be obtained from in-network providers.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	35% coinsurance after deductible per visit	55% coinsurance after deductible per visit	Benefits may be reduced if prior approval is required and not obtained for out-of-network services.
	Physician/surgeon fees	35% coinsurance after deductible	55% coinsurance after deductible	Some services require prior approval.
If you need immediate medical attention	Emergency room services	35% coinsurance after deductible per visit	35% coinsurance after deductible per visit	_____none_____
	Emergency medical transportation	35% coinsurance after deductible per trip	55% coinsurance after deductible per trip	_____none_____

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		In-network Provider	Out-of-network Provider	
	Urgent care	\$50 copay after deductible per visit	20% coinsurance after deductible per visit	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	35% coinsurance after deductible per stay	55% coinsurance after deductible per stay	Benefits may be reduced if prior approval is required and not obtained for out-of-network services.
	Physician/surgeon fee	35% coinsurance after deductible	55% coinsurance after deductible	Some services require prior approval
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$50 copay after deductible per visit	20% coinsurance after deductible per visit	_____none_____
	Mental/Behavioral health inpatient services	35% coinsurance after deductible per stay	55% coinsurance after deductible per stay	Some benefits may be reduced if prior approval is required and not obtained for out-of-network services.
	Substance use disorder outpatient services	\$50 copay after deductible per visit	20% coinsurance after deductible per visit	_____none_____
	Substance use disorder inpatient services	35% coinsurance after deductible per stay	55% coinsurance after deductible per stay	Some benefits may be reduced if prior approval is required and not obtained for out-of-network services.
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance after deductible per visit	_____none_____
	Delivery and all inpatient services	35% coinsurance after deductible per stay	55% coinsurance after deductible per stay	_____none_____

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		In-network Provider	Out-of-network Provider	
If you need help recovering or have other special health needs	Home health care	35% coinsurance after deductible	55% coinsurance after deductible per visit	Benefits may be reduced if prior approval is required and not obtained for out-of-network services.
	Rehabilitation services	\$80 copay after deductible per visit	20% coinsurance after deductible per visit	Limited to 60 visits per member per calendar year
	Habilitation services	\$80 copay after deductible per visit	20% coinsurance after deductible per visit	
	Skilled nursing care	35% coinsurance after deductible per stay	55% coinsurance after deductible per stay	Benefits may be reduced if prior approval is required and not obtained for out-of-network services. Limited to 100 days per year.
	Durable medical equipment	35% coinsurance after deductible per item	55% coinsurance after deductible per item	Benefits may be reduced if prior approval is required and not obtained for out-of-network services.
	Hospice service	35% coinsurance after deductible	55% coinsurance after deductible per visit	Benefits may be reduced if prior approval is required and not obtained for out-of-network services.
If your child needs dental or eye care	Eye exam	No charge	20% coinsurance after deductible per visit	Limited to one per calendar year
	Glasses	Not Covered	Not Covered	—————none—————
	Dental check-up	\$15 copay + 50% coinsurance after deductible per visit	\$15 copay + 70% coinsurance after deductible per visit	Dental check-ups are limited to two per 12 month period

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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 your 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.

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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.**

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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, kwijjigo holne' 1-877-644-1776.

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

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Coverage Examples

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 \$2,450**
- **Patient pays \$5,090**

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	\$3,350
Co-pays	\$20
Co-insurance	\$1,570
Limits or exclusions	\$150
Total	\$5,090

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

- **Amount owed to providers: \$5,400**
- **Plan pays \$1,820**
- **Patient pays \$3,580**

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	\$3,350
Co-pays	\$1,200
Co-insurance	\$250
Limits or exclusions	\$80
Total	\$3,580

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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.

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