Minuteman Health

MyDoc PPO Select Silver 1750 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

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?	**$1,750** for individual policy/**$3,500** for family policy in-network. Does not apply to in-network preventive care, primary care visits, or prescription drugs. **$4,750** for individual policy/**$9,500** for family policy for out-of-network medical services.	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?	Yes **$250** for individual/**$500** for family for prescription drug coverage. Does not apply to generic drugs. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$6,600** for individual policy/**$13,200** for family policy for in-network. **$10,250** for individual policy/**$16,500** for family policy for out-of-network medical expenses.	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 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

Questions: Call 1-855-MHI-1776 or visit us at www.minutemanhealth.org.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-855-MHI-1776 to request a copy.

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 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.

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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay per visit	$30 copay after deductible per visit	————————none————————
	Specialist visit	$50 copay after deductible per visit	$50 copay after deductible per visit	————————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
	Other practitioner office visit	Chiropractor $50 copay after deductible per visit Acupuncturist Not Covered	Chiropractor $50 copay after deductible per visit Acupuncturist 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)	Lab $50 copay after deductible X-Ray $150 copay after deductible	Lab $50 copay after deductible X-Ray $150 copay after deductible	——————none——————
	Imaging (CT/PET scans, MRIs)	$400 copay after deductible per test	$400 copay after deductible per test	Prior approval required. If Prior approval is not obtained, benefits may be reduced.

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
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.minutemanhealth.org	Generic drugs	$20 copay retail/$40 copay mail order per prescription	Not Covered	Covered drugs are listed on Minuteman Health's formulary and must be obtained from in-network pharmacies.
	Preferred brand drugs	$40 copay retail/$80 copay mail order after prescription deductible per prescription	Not Covered	Covered drugs are listed on Minuteman Health's formulary and must be obtained from in-network pharmacies.
	Non-preferred brand drugs	$70 copay retail/$210 copay mail order after prescription deductible per prescription	Not Covered	Covered drugs are listed on Minuteman Health's formulary and must be obtained from in-network pharmacies.
	Specialty drugs	$70 copay retail/$210 copay mail order after prescription deductible per prescription	Not Covered	Covered drugs are listed on Minuteman Health's formulary and must be obtained from in-network pharmacies.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay after deductible per visit	$250 copay after deductible per visit	Benefits may be reduced if prior approval is required and not obtained for out-of-network services.
	Physician/surgeon fees	No charge after deductible	No charge after deductible	Some services require prior approval.
If you need immediate medical	Emergency room services	$350 copay after deductible per visit	$350 copay after deductible per visit	Copay waived if admitted

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
attention	Emergency medical transportation	$250 copay after deductible per trip	$250 copay after deductible per trip	——————none——————
	Urgent care	$30 copay per visit	$30 copay after deductible per visit	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,000 copay after deductible per stay	$1,000 copay after deductible per stay	Benefits may be reduced if prior approval is required and not obtained for out-of-network services.
	Physician/surgeon fee	No charge after deductible	No charge after deductible	Some services require prior approval
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay per visit	$30 copay after deductible per visit	——————none——————
	Mental/Behavioral health inpatient services	$1,000 copay after deductible per stay	$1,000 copay 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	$30 copay per visit	$30 copay after deductible per visit	——————none——————
	Substance use disorder inpatient services	$1,000 copay after deductible per stay	$1,000 copay 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	$1,000 copay after deductible per stay	$1,000 copay after deductible per stay	——————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
If you need help recovering or have other special health needs	Home health care	No charge after deductible	20% coinsurance after deductible per visit	Benefits may be reduced if prior approval is required and not obtained for out-of-network services.
	Rehabilitation services	$50 copay after deductible per visit	$50 copay after deductible per visit	Limited to 60 visits per member per calendar year
	Habilitation services	$50 copay after deductible per visit	$50 copay after deductible per visit	
	Skilled nursing care	$1,000 copay after deductible per stay	$1,000 copay 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	20% coinsurance after deductible per item	40% coinsurance after deductible per item	Benefits may be reduced if prior approval is required and not obtained for out-of-network services.
	Hospice service	No charge after deductible	20% 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	50% coinsurance after deductible per visit	70% coinsurance after deductible per visit	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** $4,610
- **Patient pays** $2,930

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	$1,750
Co-pays	$1,030
Co-insurance	$0
Limits or exclusions	$150
Total	**$2,930**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,890
- **Patient pays** $2,510

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	$1,400
Co-pays	$780
Co-insurance	$250
Limits or exclusions	$80
Total	**$2,510**

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.