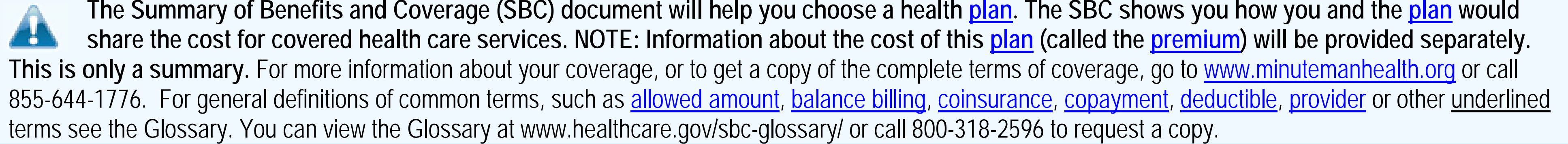
# MyDoc HMO 1500

Coverage Period: Beginning on or after 10/01/2017
**Coverage for:** Individual/Family | **Plan Type:** HMO



**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, go to www.minutemanhealth.org or call 855-644-1776. 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 800-318-2596 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | $1,500/Individual or $3,000/family | If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| Are there services covered before you meet your deductible? | Yes, Primary Care Visits, Specialist Visits, Lab Tests, some prescription drugs, x-rays and Preventive Care are covered before you meet your 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. |
| 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? | $4,000/Individual or $8,000/family | The out-of-pocket limit is the most you could pay in a year for covered services. |
| What is not included in the out-of-pocket limit? | Copayments for certain services, premiums and 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. See www.minutemanhealth.org/members/Doctor-Pharmacy-Search or call 855-644-1776 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. |

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| 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 | $25 copay per visit. Deductible does not apply. | Not Covered | None |
| | Specialist visit | $40 copay per visit. Deductible does not apply. | Not Covered | None |
| | Preventive care/screening/ immunization | No Charge | Not Covered | Contraceptive methods approved by FDA and prescribed for a woman by her health care provider, subject to reasonable medical management, will be covered without cost sharing requirements |
| If you have a test | Diagnostic test (x-ray, blood work) | Lab:<br>No Charge<br>X-Ray:<br>No Charge | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | $150 copay after Deductible | Not Covered | Prior authorization required |
| If you need drugs to treat your illness or condition<br>More information about prescription drug coverage is available at https://www.minutemanhealthdirect.org/formulary_search/ | Generic drugs (Tier 1) | $15 copay retail; $30 copay mail order per prescription. Deductible does not apply. | Not Covered | Cost-sharing covers up to 30-day supply at retail pharmacy; up to 90-day supply at mail order pharmacy (maintenance drugs only); 90-day supply of maintenance drugs also available at retail pharmacy (3 retail cost-sharing amounts apply) |
| | Preferred brand drugs (Tier 2) | $35 copay retail; $70 copay mail order per prescription. Deductible does not apply. | Not Covered | |
| | Non-preferred brand drugs (Tier 3) | $70 copay retail; $210 copay mail order per prescription. Deductible does not apply. | Not Covered | |

| 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) | |
| | Specialty drugs (Tier 4) | $70 copay retail;$210 copay mail order per prescription. Deductible does not apply. | Not Covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | $250 copay after deductible per visit | Not Covered | Some services require prior authorization; cost sharing varies by location of services. |
| | Physician/surgeon fees | No Charge after deductible | Not Covered | Some services require prior authorization. |
| If you need immediate medical attention | Emergency room care | $150 copay after deductible per visit | | Copay waived if admitted |
| | Emergency medical transportation | $150 copay after deductible | | None |
| | Urgent care | $40 copay per visit. Deductible does not apply. | | No coverage for urgent care received from non-participating providers located inside the Minuteman service area. Cost-sharing varies by location of service. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | $250 copay after deductible per stay | Not Covered | Some services require prior authorization |
| | Physician/surgeon fees | No Charge after deductible | Not Covered | Some services require prior authorization |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | $25 copay per visit. Deductible does not apply. | Not Covered | None |
| | Inpatient services | $250 copay after deductible per stay | Not Covered | Some services require prior authorization |
| If you are pregnant | Office visits | $25 copay per visit. Deductible does not apply. | Not Covered | Cost-sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., an ultrasound). |
| | Childbirth/delivery professional services | No Charge after deductible | Not Covered | |
| | Childbirth/delivery facility services | $250 copay after deductible per stay | Not Covered | |

| 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 after Deductible | Not Covered | Some services require prior authorization |
| | Rehabilitation services | $40 copay per visit. Deductible does not apply. | Not Covered | Limited to 60 visits per member per calendar year for a combination of physical and occupational therapies. |
| | Habilitation services | $40 copay per visit. Deductible does not apply. | Not Covered | |
| | Skilled nursing care | $250 copay after Deductible per stay | Not Covered | Limited to 100 days per calendar year |
| | Durable medical equipment | 20% coinsurance after Deductible per item | Not Covered | Some services require prior authorization |
| | Hospice services | No Charge after deductible | Not Covered | Some services require prior authorization |
| If your child needs dental or eye care | Children's eye exam | No Charge | Not covered | Limited to one exam per calendar year |
| | Children's glasses | No Charge | Not covered | Coverage limited to one pair of collection glasses per calendar year |
| | Children's dental check-up | 50% coinsurance after Deductible | Not covered | Dental check-ups are limited to two per 12-month period |

## 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.)**

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

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Abortion services (including elective abortions)
- Bariatric surgery
- Chiropractic care
- Coverage outside the United States, see www.minutemanhealth.org
- Hearing aids
- Infertility treatment
- Routine eye care (adult)
- Weight loss programs

**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 855-644-1776. 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 Minuteman at 855-644-1776 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, 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 plan provide Minimum Essential Coverage?** Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet 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.

**Language Access Services:**
Spanish (Español): Para obtener asistencia en Español, llame al 855-644-1776.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855-644-1776.
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 855-644-1776.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 855-644-1776.

*——————————————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 prenatal care and a hospital delivery)

- The plan's overall deductible $1,500
- Specialist copayment $40
- Hospital (facility) coinsurance N/A
- Other coinsurance 20%

**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 | $12,800 |
|---|---|

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

| *Cost-Sharing* | |
|---|---|
| Deductibles | $1,500 |
| Copayments | $600 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$2,100** |

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

- The plan's overall deductible $1,500
- Specialist copayment $40
- Hospital (facility) coinsurance N/A
- Other coinsurance 20%

**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 | $7,400 |
|---|---|

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

| *Cost-Sharing* | |
|---|---|
| Deductibles* | $80 |
| Copayments | $1,710 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,790** |

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

- The plan's overall deductible $1,500
- Specialist copayment $40
- Hospital (facility) coinsurance N/A
- Other coinsurance 20%

**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 | $1,900 |
|---|---|

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

| *Cost-Sharing* | |
|---|---|
| Deductibles* | $1,310 |
| Copayments | $260 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,570** |

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact Minuteman at 855-644-1776 or go to www.minutemanhealth.org.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

Minuteman Health

**Translation Information**

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| **English** | If you, or someone you are helping, have questions about Minuteman, you have the right to get help and information in your language at no cost. To speak with an interpreter, call (855) 644-1776. |
| **Arabic** | إذا كان لديك أنت، أو شخص ما تقدم له المساعدة، أية أسئلة حول Minuteman، يحق لك الحصول على المساعدة والمعلومات بلغتك دون اية تكلفة. للتحدث إلى مترجم فوري، اتصل على الرقم 1776-644 (855). |
| **Brazilian Portuguese** | Se você ou alguém que você esteja ajudando tem dúvidas sobre a Minuteman, você tem o direito de obter ajuda e informações no seu idioma sem nenhum custo. Para falar com um intérprete, ligue para (855) 644-1776. |
| **Canadian French** | Si vous, ou quelqu'un que vous aidez, avez des questions sur Minuteman, vous avez le droit d'obtenir de l'aide et une information dans votre langue et ce, gratuitement. Pour parler avec un interprète, appelez le (855) 644-1776. |
| **Greek** | Εάν εσείς ή κάποιος τον οποίο βοηθάτε έχει ερωτήσεις για την Minuteman, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς κόστος. Για να μιλήσετε με έναν διερμηνέα, καλέστε το (855) 644-1776. |
| **Gujarati** | જો તમે અથવા તમે જેને મદદ કરી રહ્યા હો તેવી વ્યક્તિને મિનટમેન હેલ્થ (Minuteman) વિશે પ્રશ્નો હોય તો તમારી પાસે વિના મૂલ્યે તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે (855) 644-1776 પર કૉલ કરો. |
| **Haitian Creole** | Si ou menm, oswa yon moun ou ap ede, gen kesyon konsènan Minuteman, ou gen dwa pou jwenn èd ak enfòmasyon nan lang pa ou gratis. Pou pale ak yon entèprèt, rele (855) 644-1776. |
| **Hindi** | अगर आपको या ऐसे किसी व्यक्ति को, जिसकी आप मदद कर रहे हैं, मिनटमैन हेल्थ (Minuteman) को लेकर कुछ पूछना है तो आपको अपनी भाषा में मुफ्त सहायता और जानकारी प्राप्त करने का अधिकार है। दुभाषिये के साथ बात करने के लिए (855) 644-1776 पर फोन करें। |
| **Indonesian** | Apabila Anda, atau orang yang sedang Anda bantu, memiliki pertanyaan tentang Minuteman, Anda berhak untuk mendapat bantuan dan informasi dalam bahasa Anda secara gratis. Untuk berbicara dengan salah seorang penerjemah lisan, hubungi (855) 644-1776. |
| **Italian** | In caso di domande da parte vostra, o da parte di persone da voi assistite, in merito a Minuteman, avete il diritto di ricevere assistenza e informazioni nella vostra lingua senza alcun costo. Per parlare con un interprete, chiamare il numero (855) 644-1776. |

Minuteman Health

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|---|---|
| **Khmer (Cambodian)** | ប្រសិនបើលោកអ្នកឬអ្នកណាម្នាក់ ដែលលោកអ្នកកំពុងតែជួយ ហើយមានសំណួរអំពី កម្មវិធីម៉ីនុតមេន ហ៊ុល Minuteman នោះ លោកអ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែភាសា សូមហៅទូរស័ព្ទលេខ (855) 644-1776 ។ |
| **Kirundi** | Nimba wowe, canke undimuntu ufasha, mufite ikibazo cerekanye Minuteman, mufise uburenganzira bwo kuronka ubufasha na amakuru mururimi rwanyu kubuntu. Kuvugana na umusemuzi, hamagara (855) 644-1776. |
| **Korean** | 귀하 또는 귀하를 돕고 있는 사람이 Minuteman(미니트맨 의료보험)에 대해 질문이 있으면, 귀하께서는 귀하의 언어로 도움과 정보를 무료로 받을 권리가 있습니다. 통역과 말씀하려면, (855) 644-1776으로 전화하십시오. |
| **Laotian** | ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກໍາລັງໃຫ້ການຊ່ວຍເຫຼືອຢູ່ມີຄໍາຖາມກ່ຽວກັບ Minuteman, ທ່ານມີສິດຂໍຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານບໍ່ເສຍຄ່າໄດ້. ເພື່ອລົມກັບຜູ້ແປພາສາ, ໃຫ້ໂທຫາເບີ (855) 644-1776. |
| **Mexican Spanish** | Si usted, o alguien a quien está ayudando, tiene preguntas sobre Minuteman, tiene derecho a obtener ayuda e información en su idioma sin ningún costo. Para hablar con un intérprete, llame al (855) 644-1776. |
| **Nepali** | यदि तपाईं, वा तपाईंले मद्दत गर्ने कसैको, मिनिटम्यान हेल्थ (Minuteman) बारे प्रश्नहरू भए, तपाईंले कुनै खर्च बेगर आफ्नो भाषामा सहयोग र जानकारी पाउने अधिकार हुन्छ। कुनै दोभाषेसँग कुरा गर्न,<br>( 1776-644 (855मा कल गर्नुहोस्। |
| **Polish** | Jeśli Ty, lub osoba której oferujesz pomoc, posiada pytania na temat programu Minuteman, przysługuje Ci prawo do pomocy oraz informacji w języku ojczystym bez poniesionych kosztów. Tłumacz jest dostępny pod numerem<br>(855) 644-1776. |
| **Russian** | Если у вас или у лица, которому вы помогаете, есть вопросы о плане Minuteman, вы имеете право бесплатно получить помощь и информацию на вашем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону (855) 644-1776. |
| **Serbo-Croatian** | Ako vi ili neko kome pomažete, imate pitanja o Minuteman zdravstvenom planu, imate pravo da dobijete pomoć i informacije na svom jeziku bez ikakvih dodatnih troškova. Da biste razgovarali sa prevodiocem, nazovite (855) 644-1776. |

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| **Somali** | Haddii adiga, ama qof aad caawinaysid, qabo su'aalo ku saabsan Minuteman, waxa aad xaq u leedahay inaad heshid caawimaad iyo macluumaad lagugu siiyo luqaddaada kharash la'aan. Si aad ula hadashid turjubaan, wac (855) 644-1776. |
| **Traditional Chinese** | 如果您或您正在幫助之人士對Minuteman存疑，您有權免費獲得母語援助和母語資訊。請致電(855) 644-1776聯絡口譯員。 |
| **Vietnamese** | Nếu quý vị, hoặc người nào đó mà quý vị đang giúp đỡ, có các thắc mắc về Minuteman, thì quý vị có quyền nhận sự giúp đỡ và các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, hãy gọi (855) 644-1776. |

**Non-Discrimination Information**

Minuteman Health, Inc. (MHI) complies with all applicable state and Federal civil rights laws and does not discriminate, exclude or treat individuals differently on the basis of race, color, national origin, age, disability or sex.

MHI provides the following free language services to people whose primary language is not English: (1) qualified interpreters available by phone; (2) plan information available in other languages. If you need these services, contact the Member Services Team at 855-644-1776 Monday through Friday from 8am until 6pm.

If you believe that Minuteman 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 in person or by mail, fax or email. If you need help filing a grievance, Minuteman's Complaints and Appeals Manager is available to help you.

To file by mail, fax or email, contact: Complaints and Appeals Manager; P.O. Box 120025; Boston, MA 02111; 855-644-1776; MA TTY Number: 800-439-2370; NH TTY Number: 800-735-2964; Fax: 888-225-8716; appealscomplaints@minutemanhealth.org.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by mail or phone at: U.S. Department of Health and Human Services; 200 Independence Avenue SW, Room 509F; HHH Building; Washington, DC 20201; Phone: 800–368–1019, 800–537–7697 (TTY).

You can also submit a complaint electronically through the Office for Civil Rights Complaint Portal. Forms are available at http://www.hhs.gov/ocr/office/file/index.html.