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**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](http://www.minutemanhealth.org) or by calling 1-855-644-1776.

| Important Questions                                       | Answers  | Why this Matters:  |
|---|--|--|
| What is the overall <b>deductible</b> ?                   | <b>\$2,000</b> for individual policy/ <b>\$4,000</b> for family policy. Deductible does not apply to preventive care and some prescription drugs.  | You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1 <sup>st</sup> ). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .   |
| Are there other <b>deductibles</b> for specific services? | No.  | You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.   |
| Is there an <b>out-of-pocket limit</b> on my expenses?    | Yes. <b>\$6,000</b> for individual policy/ <b>\$12,000</b> for family policy   | The <b>out-of-pocket limit</b> 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 <b>out-of-pocket limit</b> ?  | 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 <b>out-of-pocket limit</b> .   |
| 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 <i>specific</i> covered services, such as office visits.   |
| Does this plan use a <b>network of providers</b> ?        | Yes, this plan uses Minuteman Health Network-NH IND See <a href="http://www.minutemanhealth.org">www.minutemanhealth.org</a> or call 1-855-644-1776 for a list of participating providers. | If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, preferred, or <b>participating</b> for <b>providers</b> in their network. See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> . |

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| Important Questions                               | Answers  | Why this Matters:   |
|---|--|---|
| Do I need a referral to see a <b>specialist</b> ? | No. You don't need a referral to see a specialist. | You can see the <b>specialist</b> 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 6. See your policy or plan document for additional information about <b>excluded services</b> . |



- **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-Plan Provider  | Out-of-Plan Provider |   |
| If you visit a health care <b>provider's office or clinic</b> | Primary care visit to treat an injury or illness | \$30 copay after deductible   | Not Covered          | _____none_____  |
|   | Specialist visit                                 | 30% coinsurance after deductible per visit  | Not Covered          | _____none_____  |
|   | Other practitioner office visit                  | <u>Chiropractor</u><br>\$30 copay after deductible per visit<br><u>Acupuncturist</u><br>Not Covered | Not Covered          | Chiropractic Services are limited to 12 visits per Calendar Year. |
|   | Preventive care/screening/immunization           | No Charge   | Not Covered          | _____none_____  |

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| Common Medical Event   | Services You May Need                          | Your cost if you use an  |  | Limitations & Exceptions   |
|--|--|--|--|--|
|  |  | In-Plan Provider   | Out-of-Plan Provider                       |  |
| <b>If you have a test</b>  | Diagnostic test (x-ray, blood work)            | <u>Lab</u><br>30% coinsurance after deductible<br><u>X-Ray</u><br>30% coinsurance after deductible | Not Covered                                | —————none—————   |
|  | Imaging (CT/PET scans, MRIs)                   | 30% coinsurance after deductible   | Not Covered                                | Prior approval required.   |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <b>prescription drug coverage</b> is available at <a href="http://www.minutemanhealth.org">www.minutemanhealth.org</a> | Generic drugs                                  | \$20 copay retail/\$40 copay mail order per prescription   | Not Covered                                | Covered drugs are listed on Minuteman Health’s formulary                           |
|  | Preferred brand drugs                          | 30% coinsurance per prescription   | Not Covered                                | Covered drugs are listed on Minuteman Health’s formulary                           |
|  | Non-preferred brand drugs                      | 40% coinsurance after deductible per prescription  | Not Covered                                | Covered drugs are listed on Minuteman Health’s formulary                           |
|  | Specialty drugs                                | 50% coinsurance after deductible per prescription  | Not Covered                                | Covered drugs are listed on Minuteman Health’s formulary                           |
| <b>If you have outpatient surgery</b>  | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance after deductible per visit   | Not Covered                                | Some services require prior approval; cost sharing varies by location of services. |
|  | Physician/surgeon fees                         | 30% coinsurance after deductible   | Not Covered                                | Some services require prior approval.  |
| <b>If you need immediate medical attention</b>   | Emergency room services                        | 30% coinsurance after deductible per visit   | 30% coinsurance after deductible per visit | —————none—————   |

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# MyDoc HMO Silver Basic Limited

Coverage Period: 01/01/2016 – 12/31/2016

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

Coverage for: Individual/Family | Plan Type: HMO

| Common Medical Event  | Services You May Need                        | Your cost if you use an   |   | Limitations & Exceptions   |
|---|--|---|---|--|
|   |  | In-Plan Provider  | Out-of-Plan Provider  |  |
|   | Emergency medical transportation             | 30% coinsurance after deductible per trip   | 30% coinsurance after deductible per trip   | —————none—————   |
|   | Urgent care                                  | \$30 copay after deductible per visit at freestanding or retail walk-in clinic (not hospital owned) | \$30 copay after deductible per visit at freestanding or retail walk-in clinic (not hospital owned) | No coverage for urgent care received from non-participating providers located inside the MHI service area. Cost sharing varies by location of service. |
| <b>If you have a hospital stay</b>  | Facility fee (e.g., hospital room)           | 30% coinsurance after deductible per stay   | Not Covered   | Some services require prior approval   |
|   | Physician/surgeon fee                        | 30% coinsurance after deductible  | Not Covered   | Some services require prior approval   |
| <b>If you have mental health, behavioral health, or substance abuse needs</b> | Mental/Behavioral health outpatient services | \$30 copay after deductible   | Not Covered   | —————none—————   |
|   | Mental/Behavioral health inpatient services  | 30% coinsurance after deductible per stay   | Not Covered   | Some services require prior approval   |
|   | Substance use disorder outpatient services   | \$30 copay after deductible   | Not Covered   | —————none—————   |
|   | Substance use disorder inpatient services    | 30% coinsurance after deductible per stay   | Not Covered   | Some services require prior approval   |
| <b>If you are pregnant</b>  | Prenatal and postnatal care                  | No charge   | Not Covered   | —————none—————   |
|   | Delivery and all inpatient services          | 30% coinsurance after deductible per stay   | Not Covered   | —————none—————   |

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| Common Medical Event  | Services You May Need                         | Your cost if you use an                   |                      | Limitations & Exceptions  |
|---|---|---|----------------------|---|
|   |   | In-Plan Provider                          | Out-of-Plan Provider |   |
| <b>If you need help recovering or have other special health needs</b> | Home health care                              | 30% coinsurance after deductible          | Not Covered          | Some services require prior approval  |
|   | Rehabilitation services                       | \$30 copay after deductible per visit     | Not Covered          | Limited to 20 visits per member per Calendar year for physical therapy, 20 visits per member per Calendar year for occupational therapy, and 20 visits per member per Calendar year for speech therapy. |
|   | Habilitation services                         | \$30 copay after deductible per visit     | Not Covered          | Limited to 20 visits per member per Calendar year for physical therapy, 20 visits per member per Calendar year for occupational therapy, and 20 visits per member per Calendar year for speech therapy. |
|   | Skilled nursing care                          | 30% coinsurance after deductible per stay | Not Covered          | Limited to 100 days per year  |
|   | Durable medical equipment                     | 30% coinsurance after deductible per item | Not Covered          | Some services require prior approval  |
|   | Hospice service                               | 30% coinsurance after deductible          | Not Covered          | Some services require prior approval  |
|   | <b>If your child needs dental or eye care</b> | Eye exam                                  | No charge            | Not Covered   |
| Glasses   |   | No charge                                 | Not Covered          | Limited to one pair of glasses or one set of contact lenses per calendar year   |
| Dental check-up   |   | Not Covered                               | Not Covered          | Pediatric dental is NOT covered under this plan   |

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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 (adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Dental care (pediatric)
- 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)
- Coverage outside the United States, see [www.minutemanhealth.org](http://www.minutemanhealth.org).
- Hearing Aids
- Abortion Services (including elective abortions)
- Contraceptive methods approved by FDA and prescribed for a woman by her healthcare provider, subject to reasonable medical management, will be covered without cost-sharing requirements

For more details on the coverage associated with this plan, please visit <http://minutemanhealth.org/members/plans-new/2016/ind/nh-plan> 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.

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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 1-855-644-1776 or [www.minutemanhealth.org](http://www.minutemanhealth.org). Or you may write to us at Minuteman Health, Inc., P.O. Box 120025, Boston, MA 02112-0025.

Other contact information: New Hampshire Insurance Department at [1-800-852-3416](tel:1-800-852-3416) or [603-271-2261](tel:603-271-2261) and ask to speak with a Consumer Services Officer. Or you may write at New Hampshire Insurance Department, 21 South Fruit Street, Suite 14, Concord, NH 03301

## 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, kwiiijigo 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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## 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 \$4,030**
- **Patient pays \$3,510**

#### 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           |
| <b>Total</b>               | <b>\$7,540</b> |

#### Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$2,000        |
| Co-pays              | \$140          |
| Co-insurance         | \$1,340        |
| Limits or exclusions | \$30           |
| <b>Total</b>         | <b>\$3,510</b> |

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

- **Amount owed to providers: \$5,400**
- **Plan pays \$2,140**
- **Patient pays \$3,260**

#### 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          |
| <b>Total</b>                   | <b>\$5,400</b> |

#### Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$2,000        |
| Co-pays              | \$880          |
| Co-insurance         | \$380          |
| Limits or exclusions | \$0            |
| <b>Total</b>         | <b>\$3,260</b> |

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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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