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?	**$3,000** for individual policy/ **$6,000** for family policy for in-network services. Does not apply to in-network preventive care or preventive drugs. **$5,000** for individual policy/ **$10,000** for family policy for out-of-network 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 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?	Yes. **$4,500** for individual policy/**$9,000** for family policy for in-network services. **$7,500** for individual policy/**$15,000** for family policy for out-of-network services.	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 *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.

Important Questions	Answers	Why this Matters:
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 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 8. 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	10% coinsurance after deductible per visit	30% coinsurance after deductible per visit	————————none————————
	Specialist visit	10% coinsurance after deductible per visit	30% coinsurance after deductible per visit	————————none————————
	Other practitioner office visit	Chiropractor 10% coinsurance after deductible per visit Acupuncturist Not Covered	Chiropractor 30% coinsurance 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 10% coinsurance after deductible X-Ray 10% coinsurance after deductible	Lab 30% coinsurance after deductible X-Ray 30% coinsurance after deductible	————————none————————
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible per test	30% coinsurance 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	$15 copay retail/$30 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 pharmacies.
	Preferred brand 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 pharmacies.
	Non-preferred brand drugs	$50 copay retail/$150 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 pharmacies.
	Specialty drugs	$50 copay retail/$150 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 pharmacies.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible per visit	30% 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	10% coinsurance after deductible	30% coinsurance after deductible	Some services require prior approval.

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 immediate medical attention	Emergency room services	10% coinsurance after deductible per visit	10% coinsurance after deductible per visit	——————none——————
	Emergency medical transportation	10% coinsurance after deductible per trip	10% coinsurance after deductible per trip	——————none——————
	Urgent care	10% coinsurance after deductible per visit	30% coinsurance after deductible per visit	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible per stay	30% 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	10% coinsurance after deductible	30% coinsurance after deductible	Some services require prior approval

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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance after deductible per visit	30% coinsurance after deductible per visit	————————none————————
	Mental/Behavioral health inpatient services	10% coinsurance after deductible per stay	30% 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	10% coinsurance after deductible per visit	30% coinsurance after deductible per visit	————————none————————
	Substance use disorder inpatient services	10% coinsurance after deductible per stay	30% 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	10% coinsurance after deductible per stay	30% coinsurance 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	10% coinsurance after deductible	30% coinsurance after deductible	Benefits may be reduced if prior approval is required and not obtained for out-of-network services.
	Rehabilitation services	10% coinsurance after deductible per visit	30% coinsurance after deductible per visit	Limited to 60 visits per member per calendar year
	Habilitation services	10% coinsurance after deductible per visit	30% coinsurance after deductible per visit	
	Skilled nursing care	10% coinsurance after deductible per stay	30% 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	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	10% coinsurance after deductible	30% coinsurance after deductible	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	10% coinsurance after deductible	30% coinsurance after deductible	Limited to one pair of glasses or one set of contact lenses per calendar year
	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 (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 (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
- 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/MinutemanHealth/media/2017%20EOCs/Massachusetts/Massachusetts%20PPO%20EOC.pdf 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.

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.

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 1-855-644-1776.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-644-1776.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-644-1776.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-644-1776.

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** $4,060
- **Patient pays** $3,480

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	$3,000
Co-pays	$40
Co-insurance	$440
Limits or exclusions	$0
Total	**$3,480**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $1,720
- **Patient pays** $3,680

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	$3,000
Co-pays	$640
Co-insurance	$40
Limits or exclusions	$0
Total	**$3,680**

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.

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.

Minuteman Health

Translation Information

English	If you, or someone you are helping, have questions about Minuteman Health, 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 Health، يحق لك الحصول على المساعدة والمعلومات بلغتك دون اية تكلفة. للتحدث إلى مترجم فوري، اتصل على الرقم (855) 644-1776.
Brazilian Portuguese	Se você ou alguém que você esteja ajudando tem dúvidas sobre a Minuteman Health, 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 Health, 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 Health, 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 Health) 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 Health, 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 Health) 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 Health, 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 Health, 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.
Khmer (Cambodian)	ប្រសិនបើលោកអ្នកឬអ្នកណាម្នាក់ ដែលលោកអ្នកកំពុងតែជួយ ហើយមានសំណួរអំពី កម្មវិធីមុីនុតមេន ហ៊ីល Minuteman Health នោះ លោកអ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មានជាភាសារបស់អ្នកដោយ ឥតគិតថ្លៃ។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែភាសា សូមហៅទូរស័ព្ទលេខ (855) 644-1776 ។
Kirundi	Nimba wowe, canke undimuntu ufasha, mufite ikibazo cerekanye Minuteman Health, 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 Health(미니트맨 의료보험)에 대해 질문이 있으면, 귀하께서는 귀하의 언어로 도움과 정보를 무료로 받을 권리가 있습니다. 통역과 말씀하려면, (855) 644-1776으로 전화하십시오.
Mexican Spanish	Si usted, o alguien a quien está ayudando, tiene preguntas sobre Minuteman Health, tiene derecho a obtener ayuda e información en su idioma sin ningún costo. Para hablar con un intérprete, llame al (855) 644-1776.

Translation Information

Nepali	यदि तपाईं, वा तपाईंले मद्दत गर्ने कसैको, मिनिटम्यान हेल्थ (Minuteman Health) बारे प्रश्नहरू भए, तपाईंले कुनै खर्च बेगर आफ्नो भाषामा सहयोग र जानकारी पाउने अधिकार हुन्छ। कुनै दोभाषेसँग कुरा गर्न, (855(644- 1776मा कल गर्नुहोस्।
Polish	Jeśli Ty, lub osoba której oferujesz pomoc, posiada pytania na temat programu Minuteman Health, przysługuje Ci prawo do pomocy oraz informacji w języku ojczystym bez poniesionych kosztów. Tłumacz jest dostępny pod numerem (855) 644-1776.
Russian	Если у вас или у лица, которому вы помогаете, есть вопросы о плане Minuteman Health, 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 netko kome pomažete, imate pitanja o Minuteman Health zdravstvenom planu, imate pravo da dobijete pomoć i informacije na svom jeziku bez ikakvih dodatnih troškova. Da biste razgovarali s prevoditeljem, nazovite (855) 644-1776.
Somali	Haddii adiga, ama qof aad caawinaysid, qabo su'aalo ku saabsan Minuteman Health, 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 Health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 Health, 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 (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 Health 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 Health'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.