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 http://Ambetter.NHhealthyfamilies.com or by calling 1-844-265-1278, TTY/TDD 1-855-742-0123.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0;** the deductible will be paid by the Premium Assistance Program.	See the chart starting on page 2 for your costs for services this plan covers.
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 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes, for network providers **$600** individual. No, for non-network providers.	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 and non-network services this plan doesn't 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.
Does this plan use a network of providers?	Yes. See **http://Ambetter.NHhealthyfamilies.com/findadoc** or call **1-844-865-1278** 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 network specialist.	You can see the **specialist** you choose without a referral; however, prior authorization is required 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 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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 in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** 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	$3 Copay/visit	Not covered	-----None-----
	Specialist visit	$8 Copay/visit	Not covered	Prior approval required.
	Other practitioner office visit	$3 Copay/visit	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)	No charge	Not covered	Prior approval required.
	Imaging (CT/PET scans, MRIs)	$35 Copay	Not covered	Prior approval required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://Ambetter.NHhealthyfamilies.com/formulary/.	Generic drugs	$4 Copay	Not covered	-----None-----
	Preferred brand drugs	$8 Copay	Not covered	Prior approval required.
	Non-preferred brand drugs	$8 Copay	Not covered	Prior approval required
	Specialty drugs	$8 Copay	Not covered	Prior approval required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not covered	Prior approval required.
	Physician/surgeon fees	No Charge	Not covered	Prior approval required.

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	No Charge	No Charge	-----None-----
	Emergency medical transportation	No Charge	No Charge	-----None-----
	Urgent care	No Charge	Not covered	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	$125 Copay	Not covered	Prior approval required.
	Physician/surgeon fee	No Charge	Not covered	Prior approval required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$3 Copay	Not covered	Prior approval required.
	Mental/Behavioral health inpatient services	$125 Copay	Not covered	Prior approval required.
	Substance use disorder outpatient services	$3 Copay	Not covered	Prior approval required.
	Substance use disorder inpatient services	$125 Copay	Not covered	Prior approval required.
If you are pregnant	Prenatal and postnatal care	No Charge	Not covered	Prior approval required. Prenatal care is not subject to cost-sharing and is covered as Preventive Care.
	Delivery and all inpatient services	No Charge	Not covered	Prior approval required.

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	Not covered	Prior approval required.
	Rehabilitation services	$3 Copay for OT and PT ; $8 Copay for ST	Not covered	Prior approval required after limits have been met. 20 Visit(s) per year per therapy (OT, ST and PT)
	Habilitation services	$8 Copay	Not covered	Prior authorization required after limits have been met. Shared with outpatient rehabilitation limits.
	Skilled nursing care	No Charge	Not covered	Prior approval required. 100 Days per Year in a facility
	Durable medical equipment	No Charge	Not covered	Prior approval required.
	Hospice service	No Charge	Not covered	Prior approval required.
If your child needs dental or eye care	Eye exam	$0 Copay	Not covered	1 Visit(s) per Year.
	Glasses	$0 Copay	Not covered	1 Item(s) per Year.
	Dental check-up	Not covered	Not covered	-----None-----

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
- Infertility treatment
- Private-duty nursing
- Weight loss programs
- Cosmetic surgery
- Long-term care
- Routine eye care (Adult)
- Dental care
- Non-emergency care when traveling outside the U.S.
- Routine foot care (Not related to diabetes treatment)

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.)**

- Abortion services (Limited to services for which federal funding is allowed)
- Hearing aids
- Bariatric surgery
- Chiropractic care (Limited to 12 specialist visits per year)

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-844-265-1278**,** TTY/TDD 1-855-742-0123. You may also contact your state insurance department at: New Hampshire Insurance Department, 21 South Fruit Street, Suite 14, Concord, NH 03301, Phone No. 800-852-3416.

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: New Hampshire Insurance Department, 21 South Fruit Street, Suite 14, Concord, NH 03301, Phone No. 800-852-3416.

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 1-844-265-1278**,** TTY/TDD 1-855-742-0123.

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** $7,190
- **Patient pays** $0

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:

PAP enrollees are eligible for exemption from cost-sharing while pregnant and for 60 days following pregnancy. You must notify the NH Department of Health and Human Services of your pregnancy to have cost-sharing suspended.	
Total	**$0**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $5,160
- **Patient pays** $240

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$240
Coinsurance	$0
Limits or exclusions	$0
Total	**$240**

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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.