**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 for x-ray and diagnostic imaging; $3 Copay for laboratory outpatient & professional services | Not covered | Prior approval required. |
| | Imaging (CT/PET scans, MRIs) | $35 Copay | 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 drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at http://ambetter.nhhealthyfamilies.com/2017formulary. | 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. |
| **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 after deductible | 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 after deductible | Not covered | Prior approval required. |
| | Substance use disorder outpatient services | $3 Copay | Not covered | Prior approval required. |
| | Substance use disorder inpatient services | $125 Copay after deductible | 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. 20 Visit(s) per year per therapy (OT, ST and PT) |
| | Habilitation services | $8 Copay | Not covered | Prior approval required. 20 Visit(s) per year per therapy (OT, ST and PT) |
| | 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.)**

- Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)
- Dental care
- Private-duty nursing
- Weight loss program
- Acupuncture
- Long-term care
- Routine eye care (Adult)
- Cosmetic surgery
- Non-emergency care when traveling outside the U.S.
- Routine foot care (Not related to diabetes treatment)s

**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
- Infertility treatment (See policy for coverage details)
- Chiropractic care (Limited to 12 specialists' visits per year)
- Hearing aids

## 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.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-265-1278**,** TTY/TDD 1-855-742-0123.

[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-844-265-1278**,** TTY/TDD 1-855-742-0123.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 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** $7,540
- **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** $5,120
- **Patient pays** $280

### 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 | $200 |
| Coinsurance | $0 |
| Limits or exclusions | $80 |
| **Total** | **$280** |

# 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.

| | |
|---|---|
| **Spanish:** | Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de NH Healthy Families, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-265-1278 (TTY/TDD 1-855-742-0123). |
| **French:** | Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from NH Healthy Families, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-844-265-1278 (TTY/TDD 1-855-742-0123). |
| **Chinese:** | 如果您，或是您正在協助的對象，有關於 Ambetter from NH Healthy Families 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-844-265-1278 (TTY/TDD 1-855-742-0123)。 |
| **Nepali:** | यदि तपाईं वा तपाईंले मद्दत गरिरहनुभएको कोही व्यक्तिसँग Ambetter from NH Healthy Families सम्बन्धी कुनै प्रश्नहरू भएको खण्डमा तपाईंहरूसँग आफ्नै भाषामा निःशुल्क मद्दत र जानकारी प्राप्त गर्ने अधिकार छ। दोभाषेसँग कुरा गर्नका लागि 1-844-265-1278 (TTY/TDD 1-855-742-0123) नम्बरमा कल गर्नुहोस्। |
| **Vietnamese:** | Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from NH Healthy Families, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-265-1278 (TTY/TDD 1-855-742-0123). |
| **Portuguese:** | Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Ambetter from NH Healthy Families, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-265-1278 (TTY/TDD 1-855-742-0123). |
| **Greek:** | Εάν εσείς ή κάποιος που βοηθάτε, έχετε ερωτήσεις σχετικά με την Ambetter from NH Healthy Families, έχετε το δικαίωμα να ζητήσετε βοήθεια και πληροφορίες στη γλώσσα σας, χωρίς χρέωση. Για να μιλήσετε με διερμηνέα, καλέστε το 1-844-265-1278 (TTY/TDD 1-855-742-0123). |
| **Arabic:** | إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from NH Healthy Families، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-844-265-1278 (TTY/TDD 1-855-742-0123). |
| **Serbo-Croatian:** | Ako Vi, ili neko kome pomažete, imate pitanja u vezi Ambetter from NH Healthy Families, imate pravo na besplatnu pomoć i informaciju na sopstvenom jeziku. Ukoliko želite da pričate sa prevodiocem, pozovite broj 1-844-265-1278 (TTY/TDD 1-855-742-0123). |
| **Indonesian:** | Jika Anda, atau orang yang Anda bantu, memiliki pertanyaan tentang Ambetter from NH Healthy Families, Anda berhak mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk berbicara dengan juru bicara, hubungi 1-844-265-1278 (TTY/TDD 1-855-742-0123). |
| **Korean:** | 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from NH Healthy Families 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-844-265-1278 (TTY/TDD 1-855-742-0123) 로 전화하십시오. |
| **Russian:** | В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from NH Healthy Families вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-844-265-1278 (TTY/TDD 1-855-742-0123). |
| **French Creole:** | Si oumenm, oubyen yon moun w ap ede, gen kesyon nou ta renmen poze sou Ambetter from NH Healthy Families, ou gen tout dwa pou w jwenn èd ak enfòmasyon nan lang manman w san sa pa koute w anyen. Pou w pale avèk yon entèprèt, sonnen nimewo 1-844-265-1278 (TTY/TDD 1-855-742-0123). |
| **Bantu:** | Niba wowe cyangwa undi muntu wese uri gufasha yaba afite ikibazo kijyanye na Ambetter from NH Healthy Families, ufite uburenganzira bwo guhabwa amakuru mu rurimi wunva utishyuye. Kugira ngo uvugane n'umusobanuzi, Hamagara 1-844-265-1278 (TTY/TDD 1-855-742-0123). |
| **Polish:** | Jeżeli ty lub osoba, której pomagasz, macie pytania na temat planów oferowanych za pośrednictwem Ambetter from NH Healthy Families, macie prawo poprosić o bezpłatną pomoc i informacje w języku ojczystym. Aby skorzystać z pomocy tłumacza, zadzwoń pod numer 1-844-265-1278 (TTY/TDD 1-855-742-0123). |



Ambetter from NH Healthy Families is underwritten by Celtic Insurance Company. © 2016 NH Healthy Families. All rights reserved.

## Statement of Non-Discrimination

Ambetter from NH Healthy Families complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Ambetter from NH Healthy Families does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from NH Healthy Families:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Ambetter from NH Healthy Families at 1-844-265-1278 (TTY/TDD 1-855-742-0123).

If you believe that Ambetter from NH Healthy Families 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 with: NH Healthy Families Appeal Department, 2 Executive Park Drive, Bedford, NH 03110, 1-844-265-1278 (TTY/TDD 1-855-742-0123), Fax 1-855-702-7343. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ambetter from NH Healthy Families is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.



Ambetter from NH Healthy Families is underwritten by Celtic Insurance Company. © 2016 NH Healthy Families. All rights reserved.