# New Hampshire
# MyDoc HMO Silver Assistance A

Effective Date 1/1/2016

**Summary of Benefits Chart**

**Your Minuteman Health HMO Plan**
This chart provides a summary of key services offered by your plan. Your Policy has a full description of your plan's benefits and provisions.

**Note about Prior Authorization:**
Some services require Prior Authorization. These services are marked with "#" in the chart.

| | **In-Plan** |
|---|---|
| **Deductible per Year***<br>You must pay this amount for Covered Services before MHI will begin to pay benefits. As indicated in the chart below, some services are not subject to the deductible. | Medical Only<br>$1,200 per individual<br>$2,400 per family |
| No one Member is responsible for more than the individual deductible. All members accumulate to the family deductible. | |
| ***Calendar Year Benefits** | |
| **Coinsurance applies to some services** | |
| **Maximum Out-of-Pocket***<br>You are protected by an Out-of-Pocket Maximum each year. Once you reach this amount you will not have to pay Copays, Coinsurance, Deductibles for the remainder of the year. Included in your Out-of-Pocket Maximum are your Deductible, Copays and Coinsurance. | Combined Medical and Prescription Drugs:<br>$2,250** per individual<br>$4,500** per family |
| No one Member is responsible for more than the Individual Maximum Out-of-Pocket. All Members accumulate to the family Maximum Out-of-Pocket. | |

**Maximum amount to increase annually as allowed by federal and/or state law or regulation.



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| Benefit | Deductible Applies | Copay or Coinsurance |
|---|---|---|
| Prescription Drugs<br>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. | Please see the Prescription Drug section in your Policy for details about your prescription drug coverage | |
| ***In-Plan Pharmacy (30-day supply)[1]*** | | |
| Tier 1 Generics | No | $10 Copay |
| Tier 2 Brand Name (Preferred) | No | $25 Copay |
| Tier 3 Brand Name (Non-Preferred) | No | $50 Copay |
| Tier 4 Specialty Drugs | No | $50 Copay |
| Tier 5 Affordable Care Act (ACA) Preventive Drugs | No | $0 |
| ***Mail Service Pharmacy (90-day supply)*** | | |
| Tier 1 Generics | No | $30 Copay |
| Tier 2 Brand Name (Preferred) | No | $60 Copay |
| Tier 3 Brand Name (Non-Preferred) | No | $150 Copay |
| Tier 4 Specialty Drugs | No | $150 Copay |
| Tier 5 Affordable Care Act (ACA) Preventive Drugs | No | $0 |
| ***Preventive Care*** | | |
| Adult Routine Exams | No | $0 |
| Preventive Screenings<br>(listed under "Outpatient Preventive Care" in the Covered Benefits Section of the Policy) | No | $0 |
| Routine Child and Adult Immunizations | No | $0 |
| Routine Eye Exams for Adults<br>(limited to one per Calendar Year) | No | $0 |
| Routine Pediatric Vision Services for Children under age 19 described later in the chart | No | $0 |
| Routine Prenatal and Postpartum Care | No | $0 |
| Routine Mammograms<br>(limited to one per Calendar Year) | No | $0 |
| Screening Colonoscopy or Sigmoidoscopy<br>(limited to annual high-sensitivity fecal occult blood testing, sigmoidoscopy every 5 years combined with high-sensitivity fecal occult blood testing every 3 years, and screening colonoscopy at intervals of 10 years.) | No | $0 |
| Well Child Care | No | $0 |
| Women's Preventive Services including one routine gynecological exam per Calendar Year | No | $0 |
| ***Outpatient Care*** | | |
| Primary Care Office Visit (Non-Routine) | No | $10 Copay |
| Specialist Office Visit | No | $20 Copay |
| Allergy Injections | No | $20 Copay |
| Allergy Testing | No | $20 Copay |

[1] This program allows you to receive up to a 90-day supply of maintenance medications at participating retail pharmacies. A Copay will apply to each 30-day supply. To find out more about the 90-day retail program, you can call Member Services or visit the Pharmacy section at www.minutemanhealth.org.

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|---|---|---|
| Cardiac Rehabilitation | | |
| • Office Visit | No | $10 Copay |
| • Hospital Outpatient or Other Approved Facility | No | $20 Copay |
| Chemotherapy/Radiation Therapy/Infusion Therapy | Yes | $0 Copay after you have met the deductible |
| Chiropractic Services (limited to 12 visits per Calendar Year) | No | $10 Copay |
| Mental Health and Substance Abuse Disorder Office Visit | No | $10 Copay |
| Nutritional Counseling (limited to 4 visits per Calendar Year) | No | $10 Copay |
| Outpatient Habilitation Services# (limited to 20 visits per member per Calendar Year for physical therapy, 20 visits per member per Calendar Year for occupational therapy, 20 visits per member per Calendar Year for speech therapy) | | |
| • Office Visit | No | $10 Copay |
| • Hospital Outpatient or Other Approved Facility | No | $20 Copay |
| Outpatient Rehabilitation Services# (includes respiratory therapy, limited to 20 visits per member per Calendar Year for physical therapy, 20 visits per member per Calendar Year for occupational therapy, 20 visits per member per Calendar Year for speech therapy) | | |
| • Office Visit | No | $10 Copay |
| • Hospital Outpatient or Other Approved Facility | No | $20 Copay |
| Outpatient Surgical Services and Procedures # (some services require Prior Authorization; cost sharing varies by location of service) | | |
| • Facility Fees from Hospital, Ambulatory Surgical Center or other approved facility | Yes | $0 Copay after you have met the deductible |
| • Physician/Surgeon Fees for services rendered in Hospital, Ambulatory Surgical Center or other approved facility | Yes | $0 Copay after you have met the deductible |
| • Services rendered in Specialist Office | No | $20 Copay |
| Second Opinions | No | $20 Copay |
| ***Emergency Care*** | | |
| Ambulance and Transportation Services # (non-emergency transportation requires Prior Authorization.) | Yes | $50 Copay after you have met the deductible |
| Emergency Room Care (copay waived if admitted) | Yes | $50 Copay after you have met the deductible |
| Urgent Care Center or Facilities | | |
| • Freestanding or Retail Walk-In Clinic (not hospital-owned) | Yes | $10 Copay after you have met the deductible |
| • Hospital-based Urgent Care Center or Facility | Yes | $20 Copay after you have met the deductible |
| ***Labs, Tests and Imaging*** | | |
| Diagnostic Imaging# - CT Scans, MRIs, MRAs, PET Scans, Nuclear Cardiac Imaging (Prior Authorization Required. Nuclear Cardiac Imaging requires Prior Authorization only when done in doctor's office) | No | $150 Copay |



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|---|---|---|
| Lab Services | No | $0 Copay |
| Other Diagnostic Testing (some services such as sigmoidoscopies, endoscopies, colonoscopies, arthroscopies, needle aspirations, and biopsies are covered under the Outpatient Surgical Services and Procedures Copay/Coinsurance benefit) | See Outpatient Surgical Services and Procedures | Cost sharing varies by location of service |
| Radiological Services – Ultrasound, X-rays, Non-Routine Mammograms | No | $0 Copay |
| Sleep Study (maximum of two per Calendar Year) | Yes | $250 Copay after you have met the deductible; (One Copay per year; $0 Copay after you have met the deductible for home sleep study) |
| ***Inpatient Care*** | | |
| Facility Fees for Acute Hospital Care# | Yes | $250 Copay after you have met the deductible |
| Facility Fees for Acute Inpatient Rehabilitation # (limited to up to 60 days per Calendar Year) | Yes | $250 Copay after you have met the deductible |
| Facility Fees for Bariatric Surgery# | Yes | $250 Copay after you have met the deductible |
| Facility Fees for Human Organ Transplants and Bone Marrow Transplants# | Yes | $250 Copay after you have met the deductible |
| Facility Fees for Reconstruction Surgery as a result of Mastectomy | Yes | $250 Copay after you have met the deductible |
| Facility Fees for Inpatient Mental Health and Substance Abuse Disorder Services | Yes | $250 Copay after you have met the deductible |
| Facility Fees for Skilled Nursing Facility# (limited to 100 days per Calendar Year) | Yes | $250 Copay after you have met the deductible |
| Physician/Surgeon Fees for Inpatient Services | Yes | $0 Copay after you have met the deductible |
| ***Autism Spectrum Disorder*** | | |
| Services to diagnose and treat Autism Spectrum Disorder in accordance with New Hampshire law. Treatment plan required. | | |
| • Applied behavioral analysis (ABA)# | No | $10 Copay |
| • Prescription drugs | No | Cost sharing varies by Tier |
| • Services provided by licensed psychiatrist, advanced practice registered nurse, psychologist, clinical social worker | No | $10 Copay |
| • Services provided by licensed speech therapists, occupational therapists, physical therapists# | No | $10 Copay |
| ***Dental Services*** | | |
| Dental Services for Children under age 19 | This policy does not include pediatric dental services. Pediatric dental coverage can be purchased as a standalone product. Please contact your insurance carrier or producer, or seek assistance through Healthcare.gov if you wish to purchase pediatric dental coverage or stand-alone dental services product | |



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| Surgical Treatment of Non-Dental Conditions#<br>(some services are subject to the Outpatient Surgical Services and Procedures Copay/Coinsurance. Deductible may apply to some office services) | | |
| Emergency Dental Care (Accidental injury) in an Emergency Room | Yes | $50 Copay after you have met the deductible |
| ***Diabetic Treatment, Services & Supplies*** | | |
| • Outpatient Services | | |
| ○ Specialist Office Visit | No | $20 Copay |
| • Lab Services | No | $0 Copay |
| • Durable Medical Equipment#<br>(some DME requires Prior Authorization) | Yes | 20% Coinsurance after you have met the deductible |
| • Prescription Drugs | No | Cost sharing varies by Tier |
| • Group Diabetic Education Services | No | $10 Copay |
| ***Durable Medical Equipment, Prosthetic Equipment & Medical/Surgical Supplies*** | | |
| Durable Medical Equipment#<br>(some items require Prior Authorization) | Yes | 20% Coinsurance after you have met the deductible |
| Hearing Aids<br>(one hearing aid per hearing impaired ear as needed) | Yes | 20% Coinsurance after you have met the deductible |
| Prosthetic Limbs | Yes | 20% Coinsurance after you have met the deductible |
| Wigs (Scalp Hair Prosthesis) for hair loss due to treatment of any form of cancer, leukemia or permanent hair loss due to injury.<br>(one wig per Calendar Year) | Yes | 20% Coinsurance after you have met the deductible |
| ***Early Intervention Services#***<br>(covered for children from birth to 36 months of age) | | |
| • Services provided by licensed speech therapists, occupational therapists, physical therapists# | No | $10 Copay |
| • Services provided by licensed clinical social workers | No | $10 Copay |
| ***Family Planning Services*** | | |
| Office Visit (Deductible may apply to some office services) | No | $20 Copay |
| Preventive Contraceptive Services | No | $0 |
| ***Other Services#*** | | |
| Home Health Care Services# | Yes | $0 Copay after you have met the deductible |
| Hospice Services# | Yes | $0 Copay after you have met the deductible |
| Infusion Therapy# | Yes | $0 Copay after you have met the deductible |
| Kidney Dialysis | Yes | $0 Copay after you have met the deductible |
| ***Nutritional Support*** including non-prescription enteral formulas# | Yes | $0 Copay after you have met the deductible |



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| ***Maternity Care*** | | |
| Delivery/Hospital Care for Mother and Child<br>(For continued coverage, child must be enrolled within 31 days of date of birth) | Yes | $250 Copay after you have met the deductible |
| Non-routine Prenatal and Postpartum Care | No | $20 Copay |
| ***Pediatric Vision Services for members under age 19*** | | |
| Routine Eye Exam<br>(one per Calendar Year) | No | $0 |
| Lenses<br>(once per Calendar Year; available only if the contact lens benefit is not used) | No | $0 |
| Frames<br>(once per Calendar Year) | No | $0 |
| Contact Lenses<br>(once per Calendar Year; available only if the eyeglass lens benefit is not used) | No | $0 |



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