New Hampshire
MyDoc HMO Silver Care (HSA)

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* 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. This is a Health Savings Account (HSA) compatible plan. The plan will begin to pay benefits once any individual or combinations of individuals has met the family deductible.	Combined Medical and Prescription Drugs $3,000 per individual $6,000 per family
***Calendar Year Benefits**	
Coinsurance applies to most but not all benefits.	10%
Maximum Out-of-Pocket* 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. This is a Health Savings Account compatible plan. For family policies, no one family Member is responsible for more than $6,850** of the family Out-of-Pocket Maximum. The plan will begin to pay benefits for an individual family member once his/her individual out-of-pocket expenses reach $6,850**, or once the combined out-of-pocket expenses of all family members reaches the Family Out-of-Pocket Maximum amount.	Combined Medical and Prescription Drugs: $4,750 per individual $9,500 per family

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

If you have further questions, please call the Minuteman Member Services Line at 1-855-644-1776, Monday – Friday, 8 a.m. to 5 p.m. or visit www.minutemanhealth.org

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Benefit	Deductible Applies	Copay or Coinsurance
Prescription Drugs 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	Yes	0% Coinsurance after you have met the deductible
Tier 2 Brand Name (Preferred)	Yes	0% Coinsurance after you have met the deductible
Tier 3 Brand Name (Non-Preferred)	Yes	40% Coinsurance after you have met the deductible
Tier 4 Specialty Drugs	Yes	50% Coinsurance after you have met the deductible
Tier 5 Affordable Care Act (ACA) Preventive Drugs	No	$0
Mail Service Pharmacy (90-day supply)		
Tier 1 Generics	Yes	0% Coinsurance after you have met the deductible
Tier 2 Brand Name (Preferred)	Yes	0% Coinsurance after you have met the deductible
Tier 3 Brand Name (Non-Preferred)	Yes	40% Coinsurance after you have met the deductible
Tier 4 Specialty Drugs	Yes	50% Coinsurance after you have met the deductible
Tier 5 Affordable Care Act (ACA) Preventive Drugs	No	$0
Preventive Care		
Adult Routine Exams	No	$0
Preventive Screenings (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 (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

[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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Benefit	Deductible Applies	Copay or Coinsurance
Routine Mammograms (limited to one per Calendar Year)	No	$0
Screening Colonoscopy or Sigmoidoscopy (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)	Yes	10% Coinsurance after you have met the deductible
Specialist Office Visit	Yes	10% Coinsurance after you have met the deductible
Allergy Injections	Yes	10% Coinsurance after you have met the deductible
Allergy Testing	Yes	10% Coinsurance after you have met the deductible
Cardiac Rehabilitation		
• Office Visit	Yes	10% Coinsurance after you have met the deductible
• Hospital Outpatient or Other Approved Facility	Yes	10% Coinsurance after you have met the deductible
Chemotherapy/Radiation Therapy/Infusion Therapy	Yes	10% Coinsurance after you have met the deductible
Chiropractic Services (limited to 12 visits per Calendar Year)	Yes	10% Coinsurance after you have met the deductible
Mental Health and Substance Abuse Disorder Office Visit	Yes	10% Coinsurance after you have met the deductible
Nutritional Counseling (limited to 4 visits per Calendar Year)	Yes	10% Coinsurance after you have met the deductible
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	Yes	10% Coinsurance after you have met the deductible
• Hospital Outpatient or Other Approved Facility	Yes	10% Coinsurance after you have met the deductible

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Benefit	Deductible Applies	Copay or Coinsurance
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	Yes	10% Coinsurance after you have met the deductible
• Hospital Outpatient or Other Approved Facility	Yes	10% Coinsurance after you have met the deductible
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	10% Coinsurance after you have met the deductible
• Physician/Surgeon Fees for services rendered in Hospital, Ambulatory Surgical Center or other approved facility	Yes	10% Coinsurance after you have met the deductible
• Services rendered in Specialist Office	Yes	10% Coinsurance after you have met the deductible
Second Opinions	Yes	10% Coinsurance after you have met the deductible
Emergency Care		
Ambulance and Transportation Services # (Non-emergency transportation requires Prior Authorization.)	Yes	10% Coinsurance after you have met the deductible
Emergency Room Care (copay waived if admitted)	Yes	10% Coinsurance after you have met the deductible
Urgent Care Center or Facilities		
• Freestanding or Retail Walk-In Clinic (not hospital owned)	Yes	10% Coinsurance after you have met the deductible
• Hospital-based Urgent Care Center or Facility	Yes	10% Coinsurance 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)	Yes	10% Coinsurance after you have met the deductible
Lab Services	Yes	10% Coinsurance after you have met the deductible
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

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Radiological Services – Ultrasound, X-rays, Non-Routine Mammograms	Yes	10% Coinsurance after you have met the deductible
Sleep Study (maximum of two per Calendar Year)	Yes	10% Coinsurance after you have met the deductible; for home sleep study 0% Coinsurance after you have met the deductible
Inpatient Care		
Facility Fees for Acute Hospital Care#	Yes	10% Coinsurance after you have met the deductible
Facility Fees for Acute Inpatient Rehabilitation # (limited to up to 60 days per Calendar Year)	Yes	10% Coinsurance after you have met the deductible
Facility Fees for Bariatric Surgery#	Yes	10% Coinsurance after you have met the deductible
Facility Fees for Human Organ Transplants and Bone Marrow Transplants#	Yes	10% Coinsurance after you have met the deductible
Facility Fees for Reconstruction Surgery as a result of Mastectomy	Yes	10% Coinsurance after you have met the deductible
Facility Fees for Inpatient Mental Health and Substance Abuse Disorder Services	Yes	10% Coinsurance after you have met the deductible
Facility Fees for Skilled Nursing Facility# (limited to 100 days per Calendar Year)	Yes	10% Coinsurance after you have met the deductible
Physician/Surgeon Fees for Inpatient Services	Yes	10% Coinsurance 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)#	Yes	10% Coinsurance after you have met the deductible
• Prescription drugs	Yes	Cost sharing varies by Tier
• Services provided by licensed psychiatrist, advanced practice registered nurse, psychologist, clinical social worker	Yes	10% Coinsurance after you have met the deductible
• Services provided by licensed speech therapists, occupational therapists, physical therapists#	Yes	10% Coinsurance after you have met the deductible

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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	
Surgical Treatment of Non-Dental Conditions# (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	10% Coinsurance after you have met the deductible
Diabetic Treatment, Services & Supplies		
• Outpatient Services		
○ Specialist Office Visit	Yes	10% Coinsurance after you have met the deductible
• Lab Services	Yes	10% Coinsurance after you have met the deductible
• Durable Medical Equipment# (some DME requires Prior Authorization)	Yes	20% Coinsurance after you have met the deductible
• Prescription Drugs	Yes	Cost sharing varies by Tier
• Group Diabetic Education Services	Yes	10% Coinsurance after you have met the deductible
Durable Medical Equipment, Prosthetic Equipment & Medical/Surgical Supplies		
Durable Medical Equipment# (some items require Prior Authorization)	Yes	20% Coinsurance after you have met the deductible
Hearing Aids (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. (one wig per Calendar Year)	Yes	20% Coinsurance after you have met the deductible
Early Intervention Services# (covered for children from birth to 36 months of age)		
• Services provided by licensed speech therapists, occupational therapists, physical therapists#	Yes	10% Coinsurance after you have met the deductible
• Services provided by licensed clinical social workers	Yes	10% Coinsurance after you have met the deductible

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Family Planning Services		
Office Visit (Deductible may apply to some office services)	Yes	10% Coinsurance after you have met the deductible
Preventive Contraceptive Services	No	$0
Other Services#		
Home Health Care Services#	Yes	10% Coinsurance after you have met the deductible
Hospice Services#	Yes	10% Coinsurance after you have met the deductible
Infusion Therapy#	Yes	10% Coinsurance after you have met the deductible
Kidney Dialysis	Yes	10% Coinsurance after you have met the deductible
Nutritional Support including non-prescription enteral formulas#	Yes	10% Coinsurance after you have met the deductible
Maternity Care		
Delivery/Hospital Care for Mother and Child (For continued coverage, child must be enrolled within 31 days of date of birth)	Yes	10% Coinsurance after you have met the deductible
Non-routine Prenatal and Postpartum Care	Yes	10% Coinsurance after you have met the deductible
Pediatric Vision Services for members under age 19		
Routine Eye Exam (one per Calendar Year)	No	$0
Collection Lenses (once per Calendar Year; available only if the contact lens benefit is not used)	Yes	10% Coinsurance after you have met the deductible
Collection Frames (once per Calendar Year)	Yes	10% Coinsurance after you have met the deductible
Contact Lenses (once per Calendar Year; available only if the eyeglass lens benefit is not used)	Yes	10% Coinsurance after you have met the deductible

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