

New Hampshire
MyDoc HMO Gold Basic 1000
Small Group
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 |
|--|---|
| <p>Deductible per Year*</p> <p>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.</p> <p>No one Member is responsible for more than the individual deductible. All members accumulate to the family deductible.</p> | <p>Combined Medical and Prescription Drugs</p> <p>\$1,000 per individual</p> <p>\$2,000 per family</p> |
| <p>*Calendar Year Benefits</p> | |
| <p>Coinsurance applies to most but not all benefits.</p> | <p>20%</p> |
| <p>Maximum Out-of-Pocket*</p> <p>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.</p> <p>No one Member is responsible for more than the Individual Maximum Out-of-Pocket. All Members accumulate to the family Maximum Out-of-Pocket.</p> | <p>Combined Medical and Prescription Drugs:</p> <p>\$3,500 per individual</p> <p>\$7,000 per family</p> |

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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 | |
| <i>In-Plan Pharmacy (30-day supply)¹</i> | | |
| Tier 1 Generics | No | \$10 Copay |
| Tier 2 Brand Name (Preferred) | No | 30% Coinsurance |
| 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 |
| <i>Mail Service Pharmacy (90-day supply)</i> | | |
| Tier 1 Generics | No | \$20 Copay |
| Tier 2 Brand Name (Preferred) | No | 30% Coinsurance |
| 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 |
| <i>Preventive Care</i> | | |
| 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 |
| 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 |

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.

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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|---|---------------------------|---|
| 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 | \$30 Copay |
| Specialist Office Visit | Yes | 20% Coinsurance after you have met the deductible |
| Allergy Injections | Yes | 20% Coinsurance after you have met the deductible |
| Allergy Testing | Yes | 20% Coinsurance after you have met the deductible |
| Cardiac Rehabilitation | | |
| <ul style="list-style-type: none"> • Office Visit | No | \$30 Copay |
| <ul style="list-style-type: none"> • Hospital Outpatient or Other Approved Facility | Yes | 20% Coinsurance after you have met the deductible |
| Chemotherapy/Radiation Therapy/Infusion Therapy | Yes | 20% Coinsurance after you have met the deductible |
| Chiropractic Services (limited to 12 visits per Calendar Year) | No | \$30 Copay |
| Mental Health and Substance Abuse Disorder Office Visit | No | \$30 Copay |
| Nutritional Counseling (limited to 4 visits per Calendar Year) | No | \$30 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) | | |
| <ul style="list-style-type: none"> • Office Visit | No | \$30 Copay |
| <ul style="list-style-type: none"> • Hospital Outpatient or Other Approved Facility | Yes | 20% Coinsurance after you have met the deductible |
| 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) | | |
| <ul style="list-style-type: none"> • Office Visit | No | \$30 Copay |
| <ul style="list-style-type: none"> • Hospital Outpatient or Other Approved Facility | Yes | 20% Coinsurance after you have met the deductible |
| Outpatient Surgical Services and Procedures # (some services require Prior Authorization; cost sharing varies by location of service) | | |
| <ul style="list-style-type: none"> • Facility Fees from Hospital, Ambulatory Surgical Center or other approved facility | Yes | 20% Coinsurance after you have met the deductible |

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|---|---|--|
| <ul style="list-style-type: none"> Physician/Surgeon Fees for services rendered in Hospital, Ambulatory Surgical Center or other approved facility | Yes | 20% Coinsurance after you have met the deductible |
| <ul style="list-style-type: none"> Services rendered in Specialist Office | Yes | 20% Coinsurance after you have met the deductible |
| Second Opinions | Yes | 20% Coinsurance after you have met the deductible |
| <i>Emergency Care</i> | | |
| Ambulance and Transportation Services # (non-emergency transportation requires Prior Authorization.) | Yes | 20% Coinsurance after you have met the deductible |
| Emergency Room Care (copay waived if admitted) | Yes | 20% Coinsurance after you have met the deductible |
| Urgent Care Center or Facilities | | |
| <ul style="list-style-type: none"> Freestanding or Retail Walk-In Clinic (not hospital owned) | No | \$30 Copay |
| <ul style="list-style-type: none"> Hospital-based Urgent Care Center or Facility | Yes | 20% Coinsurance after you have met the deductible |
| <i>Labs, Tests and Imaging</i> | | |
| 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 | 20% Coinsurance after you have met the deductible |
| Lab Services | Yes | 20% 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 |
| Radiological Services – Ultrasound, X-rays, Non-Routine Mammograms | Yes | 20% Coinsurance after you have met the deductible |
| Sleep Study (maximum of two per Calendar Year) | Yes | 20% Coinsurance after you have met the deductible; for home sleep study 0% Coinsurance after you have met the deductible |
| <i>Inpatient Care</i> | | |
| Facility Fees for Acute Hospital Care# | Yes | 20% Coinsurance after you have met the deductible |

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|--|---|---|
| Facility Fees for Acute Inpatient Rehabilitation # (limited to up to 60 days per Calendar Year) | Yes | 20% Coinsurance after you have met the deductible |
| Facility Fees for Bariatric Surgery# | Yes | 20% Coinsurance after you have met the deductible |
| Facility Fees for Human Organ Transplants and Bone Marrow Transplants# | Yes | 20% Coinsurance after you have met the deductible |
| Facility Fees for Reconstruction Surgery as a result of Mastectomy | Yes | 20% Coinsurance after you have met the deductible |
| Facility Fees for Inpatient Mental Health and Substance Abuse Disorder Services# | Yes | 20% Coinsurance after you have met the deductible |
| Facility Fees for Skilled Nursing Facility# (limited to 100 days per Calendar Year) | Yes | 20% Coinsurance after you have met the deductible |
| Physician/Surgeon Fees for Inpatient Services | Yes | 20% Coinsurance after you have met the deductible |
| <i>Autism Spectrum Disorder</i> | | |
| Services to diagnose and treat Autism Spectrum Disorder in accordance with New Hampshire law. Treatment plan required. | | |
| <ul style="list-style-type: none"> • Applied behavioral analysis (ABA)# | No | \$30 Copay |
| <ul style="list-style-type: none"> • Prescription drugs | See Prescription Drug benefit | Cost sharing varies by Tier |
| <ul style="list-style-type: none"> • Services provided by licensed psychiatrist, advanced practice registered nurse, psychologist, clinical social worker | No | \$30 Copay |
| <ul style="list-style-type: none"> • Services provided by licensed speech therapists, occupational therapists, physical therapists# | No | \$30 Copay |
| <i>Dental Services</i> | | |
| 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 | 20% Coinsurance after you have met the deductible |
| <i>Diabetic Treatment, Services & Supplies</i> | | |
| <ul style="list-style-type: none"> • Outpatient Services | | |

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| ○ Specialist Office Visit | Yes | 20% Coinsurance after you have met the deductible |
| • Lab Services | Yes | 20% 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 | See Prescription Drug benefit | Cost sharing varies by Tier |
| • Group Diabetic Education Services | No | \$30 Copay |
| <i>Durable Medical Equipment, Prosthetic Equipment & Medical/Surgical Supplies</i> | | |
| 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 |
| <i>Early Intervention Services#</i> (covered for children from birth to 36 months of age) | | |
| • Services provided by licensed speech therapists, occupational therapists, physical therapists# | No | \$30 Copay |
| • Services provided by licensed clinical social workers | No | \$30 Copay |
| <i>Family Planning Services</i> | | |
| Office Visit (Deductible may apply to some office services) | Yes | 20% Coinsurance after you have met the deductible |
| Preventive Contraceptive Services | No | \$0 |
| <i>Other Services#</i> | | |
| Home Health Care Services# | Yes | 20% Coinsurance after you have met the deductible |
| Hospice Services# | Yes | 20% Coinsurance after you have met the deductible |
| Infusion Therapy# | Yes | 20% Coinsurance after you have met the deductible |

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| Kidney Dialysis | Yes | 20% Coinsurance after you have met the deductible |
| <i>Nutritional Support</i> including non-prescription enteral formulas# | Yes | 20% Coinsurance after you have met the deductible |
| <i>Maternity Care</i> | | |
| Delivery/Hospital Care for Mother and Child (For continued coverage, child must be enrolled within 31 days of date of birth) | Yes | 20% Coinsurance after you have met the deductible |
| Non-routine Prenatal and Postpartum Care | Yes | 20% Coinsurance after you have met the deductible |
| <i>Pediatric Vision Services for members under age 19</i> | | |
| 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) | No | \$0 |
| Collection Frames (once per Calendar Year) | No | \$0 |
| Contact Lenses (once per Calendar Year; available only if the eyeglass lens benefit is not used) | No | \$0 |

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