New Hampshire
MyDoc POS Silver Value 5000
w/Child Dental
Small Group

Effective Date 1/1/2016

Summary of Benefits Chart

Your Minuteman Health POS 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. If you fail to obtain Prior Authorization you may have a Reduction of Benefit up to the amount indicated below. (For example, Acute Hospital Care below)

	In-Plan Preferred	In-Plan Non-Preferred	Out of 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.	Combined Medical ,Dental and Prescription Drugs $5,000 per individual $10,000 per family		Not Covered
No one Member is responsible for more than the individual deductible. All members accumulate to the family deductible.			Not Covered
***Policy Year Benefits**			
Coinsurance applies to most but not all benefits.	0%	20%	Not Applicable
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. No one Member is responsible for more than the Individual Maximum Out-of-Pocket. All Members accumulate to the family Maximum Out-of-Pocket.	Combined Medical, Dental and Prescription Drugs $6,450 per individual $12,900 per family		Not Covered
Reduction of Benefit Applies to certain services if Prior Authorization is required but not obtained.	Not Applicable	Services that require an Inpatient admission: $750 Services that do not require an Inpatient admission: 50% of the cost of the services or $750, whichever is less	Not Applicable

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Benefit	Preferred In-Plan Providers		Non-Preferred In-Plan Providers	
	Deductible Applies	Copay or Coinsurance	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	No	$20 Copay		
Tier 2 Brand Name (Preferred)	No	$40 Copay		
Tier 3 Brand Name (Non-Preferred)	Yes	40% Coinsurance after you have met the Prescription Drug deductible		
Tier 4 Specialty Drugs	Yes	50% Coinsurance after you have met the Prescription Drug deductible		
Tier 5 Affordable Care Act (ACA) Preventive Drugs	No	$0		
Mail Service Pharmacy (90-day supply)				
Tier 1 Generics	No	$40 Copay		
Tier 2 Brand Name (Preferred)	No	$80 Copay		
Tier 3 Brand Name (Non-Preferred)	Yes	40% Coinsurance after you have met the Prescription Drug deductible		
Tier 4 Specialty Drugs	Yes	50% Coinsurance after you have met the Prescription Drug deductible		
Tier 5 Affordable Care Act (ACA) Preventive Drugs	No	$0		
Preventive Care				
Adult Routine Exams	No	$0	No	$0
Preventive Screenings (listed under "Outpatient Preventive Care" in the Covered Benefits Section of the Policy)	No	$0	No	$0
Routine Child and Adult Immunizations	No	$0	No	$0
Routine Eye Exams for Adults (limited to one per Calendar Year)	No	$0	No	$0
Routine Pediatric Vision Services for Children under age 19 described later in the chart	No	$0	No	$0
Routine Prenatal and Postpartum Care	No	$0	No	$0
Routine Mammograms (limited to one per Calendar Year)	No	$0	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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	Deductible Applies	Copay or Coinsurance	Deductible Applies	Copay or Coinsurance
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	No	$0
Well Child Care	No	$0	No	$0
Women's Preventive Services including one routine gynecological exam per Calendar Year	No	$0	No	$0
Outpatient Care				
Primary Care Office Visit (Non-Routine)	No	$25 Copay	Yes	20% Coinsurance after you have met the deductible
Specialist Office Visit	No	$50 Copay	Yes	20% Coinsurance after you have met the deductible
Allergy Injections	No	$50 Copay	Yes	20% Coinsurance after you have met the deductible
Allergy Testing	No	$50 Copay	Yes	20% Coinsurance after you have met the deductible
Cardiac Rehabilitation				
• Office Visit	No	$25 Copay	Yes	20% Coinsurance after you have met the deductible
• Hospital Outpatient or Other Approved Facility	No	$50 Copay	Yes	20% Coinsurance after you have met the deductible
Chemotherapy and Radiation Therapy	Yes	0% Coinsurance after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Chiropractic Services (limited to 12 visits per Calendar Year)	No	$25 Copay	Yes	20% Coinsurance after you have met the deductible
Mental Health and Substance Abuse Disorder Office Visit	No	$25 Copay	Yes	20% Coinsurance after you have met the deductible
Nutritional Counseling (limited to 4 visits per Calendar Year)	No	$25 Copay	Yes	20% Coinsurance after you have met the deductible

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	Deductible Applies	**Copay or Coinsurance**	**Deductible Applies**	**Copay or Coinsurance**
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	$25 Copay	Yes	20% Coinsurance after you have met the deductible
• Hospital Outpatient or Other Approved Facility	No	$50 Copay	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)				
• Office Visit	No	$25 Copay	Yes	20% Coinsurance after you have met the deductible
• Hospital Outpatient or Other Approved Facility	No	$50 Copay	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)				
• Facility Fees from Hospital, Ambulatory Surgical Center or other approved facility	Yes	$0 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible and a Reduction of Benefit if Prior Auth is required and not obtained
• Physician/Surgeon Fees for services rendered in Hospital, Ambulatory Surgical Center or other approved facility	Yes	$0 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
• Services rendered in Specialist Office	No	$50 Copay	Yes	20% Coinsurance after you have met the deductible
Second Opinions	No	$50 Copay	Yes	20% Coinsurance after you have met the deductible
Emergency Care				
Ambulance and Transportation Services # (Non-emergency transportation requires Prior Authorization.)	Yes	$250 Copay after you have met the deductible	Yes	$250 Copay after you have met the deductible
Emergency Room Care (copay waived if admitted)	Yes	$150 Copay after you have met the deductible	Yes	$150 Copay after you have met the deductible
Urgent Care Center or Facilities				
• Freestanding or Retail Walk-In Clinic (not hospital-owned)	No	$25 Copay	Yes	$25 Copay after you have met the deductible

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	Deductible Applies	**Copay or Coinsurance**	**Deductible Applies**	**Copay or Coinsurance**
• Hospital-based Urgent Care Center or Facility	Yes	$50 Copay after you have met the deductible	Yes	$50 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)	Yes	$250 Copay after you have met the deductible. Prior Authorization is required.	Yes	20% Coinsurance after you have met the deductible. Prior Authorization is required.
Lab Services				
• Select Labs	No	$0 Copay	n/a	n/a
• Non-Select Labs	Yes	$75 Copay after you have met the deductible	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	Yes	Cost sharing varies by location of service
Radiological Services – Ultrasound, X-rays, Non-Routine Mammograms	Yes	$100 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Sleep Study (maximum of two per Calendar Year)	Yes	$250 Copay after you have met the deductible. One Copay per year; for home sleep study $0 Copay after you have met the deductible	Yes	$250 Copay plus 20% Coinsurance, after you have met the deductible. One Copay per year; for home sleep study $20% Coinsurance after you have met the deductible
Inpatient Care				
Facility Fees for Acute Hospital Care#	Yes	$250 Copay after you have met the deductible	Yes	$250 Copay plus 20% Coinsurance after you have met the deductible and $750 Reduction of Benefit if Prior Auth is required and not obtained

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Facility Fees for Acute Inpatient Rehabilitation # (limited to up to 60 days per Calendar Year)	Yes	$250 Copay after you have met the deductible	Yes	$250 Copay plus 20% Coinsurance after you have met the deductible and $750 Reduction of Benefit if Prior Auth is required and not obtained
Facility Fees for Bariatric Surgery#	Yes	$250 Copay after you have met the deductible	Yes	$250 Copay plus 20% Coinsurance after you have met the deductible and $750 Reduction of Benefit if Prior Auth is required and not obtained
Facility Fees for Human Organ Transplants and Bone Marrow Transplants#	Yes	$250 Copay after you have met the deductible	Yes	$250 Copay plus 20% Coinsurance after you have met the deductible and $750 Reduction of Benefit if Prior Auth is required and not obtained
Facility Fees for Reconstruction Surgery as a result of Mastectomy	Yes	$250 Copay after you have met the deductible	Yes	$250 Copay plus 20% Coinsurance after you have met the deductible and $750 Reduction of Benefit if Prior Auth is required and not obtained
Facility Fees for Inpatient Mental Health and Substance Abuse Disorder Services	Yes	$250 Copay after you have met the deductible	Yes	$250 Copay plus 20% Coinsurance after you have met the deductible and $750 Reduction of Benefit if Prior Auth is required and not obtained
Facility Fees for Skilled Nursing Facility# (limited to 100 days per Calendar Year)	Yes	$250 Copay after you have met the deductible	Yes	$250 Copay plus 20% Coinsurance after you have met the deductible and $750 Reduction of Benefit if Prior Auth is required and not obtained
Physician/Surgeon Fees for Inpatient Services	Yes	$0 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible

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	Deductible Applies	**Copay or Coinsurance**	**Deductible Applies**	**Copay or Coinsurance**
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	$25 Copay	Yes	20% Coinsurance after you have met the deductible and a Reduction of Benefit if Prior Auth is required and not obtained
• Prescription drugs	See Prescription Drug benefit	Cost sharing varies by Tier		
• Services provided by licensed psychiatrist, advanced practice registered nurse, psychologist, clinical social worker	No	$25 Copay	Yes	20% Coinsurance after you have met the deductible
• Services provided by licensed speech therapists, occupational therapists, physical therapists (not subject to visit limits)	No	$25 Copay	Yes	20% Coinsurance after you have met the deductible
Dental Services				
Pediatric Dental Services for Members under age 19 described later in the chart				
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	$150 Copay after you have met the deductible	Yes	$150 Copay after you have met the deductible
Diabetic Treatment, Services & Supplies				
• Outpatient Services				
○ Specialist Office Visit	No	$50 Copay	Yes	20% Coinsurance after you have met the deductible
• Lab Services	See Lab Services benefit	See Lab Services benefit	Yes	See Lab Services Benefit
• Durable Medical Equipment# (some DME requires Prior Authorization)	Yes	20% Coinsurance after you have met the deductible	Yes	40% Coinsurance after you have met the deductible
• Prescription Drugs	See Prescription Drug benefit	Cost sharing varies by Tier		
• Group Diabetic Education Services	No	$25 Copay	Yes	20% Coinsurance after you have met the deductible

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	Deductible Applies	**Copay or Coinsurance**	**Deductible Applies**	**Copay or Coinsurance**
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	Yes	40% Coinsurance after you have met the deductible and a Reduction of Benefit if Prior Auth is required and not obtained
Hearing Aids (one hearing aid per hearing impaired ear as needed)	Yes	20% Coinsurance after you have met the deductible	Yes	40% Coinsurance after you have met the deductible and a Reduction of Benefit if Prior Auth is required and not obtained
Prosthetic Limbs	Yes	20% Coinsurance after you have met the deductible	Yes	40% Coinsurance after you have met the deductible. Prior Authorization is required.
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	Yes	40% 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	No	$25 Copay	Yes	20% Coinsurance after you have met the deductible
• Services provided by licensed clinical social workers	No	$25 Copay	Yes	20% Coinsurance after you have met the deductible
Family Planning Services				
Office Visit (Deductible may apply to some office services)	No	$50 Copay	Yes	20% Coinsurance after you have met the deductible
Preventive Contraceptive Services	No	$0	No	$0
Other Services#				
Home Health Care Services#	Yes	0% Coinsurance after you have met the deductible	Yes	20% Coinsurance after you have met the deductible and a Reduction of Benefit if Prior Auth is required and not obtained

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	Deductible Applies	**Copay or Coinsurance**	**Deductible Applies**	**Copay or Coinsurance**
Hospice Services#	Yes	0% Coinsurance after you have met the deductible	Yes	20% Coinsurance after you have met the deductible and a Reduction of Benefit if Prior Auth is required and not obtained
Infusion Therapy#	Yes	0% Coinsurance after you have met the deductible	Yes	20% Coinsurance after you have met the deductible and a Reduction of Benefit if Prior Auth is required and not obtained
Kidney Dialysis	Yes	0% Coinsurance after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Nutritional Support including non-prescription enteral formulas#	Yes	0% Coinsurance after you have met the deductible	Yes	20% 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	$250 Copay after you have met the deductible	Yes	$250 Copay plus 20% Coinsurance after you have met the deductible
Non-routine Prenatal and Postpartum Care	No	$50 Copay	Yes	20% Coinsurance after you have met the deductible
Pediatric Vision Services for members under age 19				
Routine Eye Exam (one per Calendar Year)	No	$0	No	$0
Collection Lenses (once per Calendar Year; available only if the contact lens benefit is not used)	No	$0	Yes	20% Coinsurance after you have met the deductible
Collection Frames (once per Calendar Year)	No	$0	Yes	20% Coinsurance after you have met the deductible
Contact Lenses (once per Calendar Year; available only if the eyeglass lens benefit is not used)	No	$0	Yes	20% Coinsurance after you have met the deductible
Pediatric Dental Services for members under age 19				
Diagnostic & Preventive Services				
Topical fluoride treatment, once every 6 months (Deductible and Coinsurance does not apply for Children up to age 5)	Yes	50% Coinsurance after you have met the deductible		
Periodic oral exams, 2 per year	Yes	50% Coinsurance after you have met the deductible		
Routine cleanings, once every 6 months	Yes	50% Coinsurance after you have met the deductible		

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	Deductible Applies	Copay or Coinsurance	Deductible Applies	Copay or Coinsurance
Bitewing x-rays, 1 set every 6 months	Yes	50% Coinsurance after you have met the deductible		
Panoramic x-rays, 1 image every 60 months	Yes	50% Coinsurance after you have met the deductible		
Minor Restorative Services				
Fillings	Yes	50% Coinsurance after you have met the deductible		
Pre-fabricated stainless steel crowns, under age 15, 1 per tooth every 60 months	Yes	50% Coinsurance after you have met the deductible		
Pre-fabricated porcelain crowns, primary, 1 per tooth every 60 months	Yes	50% Coinsurance after you have met the deductible		
Simple tooth extractions	Yes	50% Coinsurance after you have met the deductible		
Incisions and drainage of abscess	Yes	50% Coinsurance after you have met the deductible		
Tissue conditioning	Yes	50% Coinsurance after you have met the deductible		
Repair of crowns	Yes	50% Coinsurance after you have met the deductible		
Palliative treatment of dental pain	Yes	50% Coinsurance after you have met the deductible		
Adjustment of dentures	Yes	50% Coinsurance after you have met the deductible		
Complex Restorative Services				
Crowns, 1 per tooth every 60 months	Yes	50% Coinsurance after you have met the deductible		
Root canals	Yes	50% Coinsurance after you have met the deductible		
Periodontic services, limits vary	Yes	50% Coinsurance after you have met the deductible		
Endodontic services, limits vary	Yes	50% Coinsurance after you have met the deductible		
Onlay, metallic, 1 every 60 months	Yes	50% Coinsurance after you have met the deductible		
Inlay, metallic, 1 every 60 months	Yes	50% Coinsurance after you have met the deductible		
Dentures, 1 every 50 months	Yes	50% Coinsurance after you have met the deductible		
Implants, 1 every 60 months	Yes	50% Coinsurance after you have met the deductible		
Orthodontic Services *All Orthodontic Treatment Requires Preauthorization*				
Only medically necessary orthodontic treatment is covered	Yes	50% Coinsurance after you have met the deductible		

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