

**New Hampshire
MyDoc HMO Silver HSA 2050
w/Child Dental
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>This is a Health Savings Account compatible plan. The plan will begin to pay benefits once any individual or a combination of individuals has met the family deductible.</p>	<p>Combined Medical, Dental and Prescription Drugs</p> <p>\$2,050 per individual</p> <p>\$4,100 per family</p>
<p>*Policy Year Benefits</p>	
<p>Coinsurance applies to most but not all benefits.</p>	<p>10%</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>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.</p>	<p>Combined Medical, Dental and Prescription Drugs:</p> <p>\$6,000 per individual</p> <p>\$12,000 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	Yes	20% Coinsurance after you have met the deductible
Tier 2 Brand Name (Preferred)	Yes	30% 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
<i>Mail Service Pharmacy (90-day supply)</i>		
Tier 1 Generics	Yes	20% Coinsurance after you have met the deductible
Tier 2 Brand Name (Preferred)	Yes	30% 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
<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

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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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		
<ul style="list-style-type: none"> • Office Visit 	Yes	10% Coinsurance after you have met the deductible
<ul style="list-style-type: none"> • Hospital outpatient or other approved facility 	Yes	10% Coinsurance after you have met the deductible
Chemotherapy and Radiation 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)		
<ul style="list-style-type: none"> • Office Visit 	Yes	10% Coinsurance after you have met the deductible

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Benefit	Deductible Applies	Copay or Coinsurance
<ul style="list-style-type: none"> Hospital outpatient or other approved facility 	Yes	10% 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 	Yes	10% Coinsurance after you have met the deductible
<ul style="list-style-type: none"> 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)		
<ul style="list-style-type: none"> Facility Fees from Hospital, Ambulatory Surgical Center or other approved facility 	Yes	10% Coinsurance after you have met the deductible
<ul style="list-style-type: none"> Physician/Surgeon Fees for services rendered in Hospital, Ambulatory Surgical Center or other approved facility 	Yes	10% Coinsurance after you have met the deductible
<ul style="list-style-type: none"> 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
<i>Emergency & Urgent Care</i>		
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		
<ul style="list-style-type: none"> Freestanding or Retail Walk-In Clinic (not hospital-owned) 	Yes	10% Coinsurance after you have met the deductible
<ul style="list-style-type: none"> Hospital-based Urgent Care Center or Facility 	Yes	10% 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	10% Coinsurance after you have met the deductible
Lab Services	Yes	10% Coinsurance after you have met the deductible

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Benefit	Deductible Applies	Copay or Coinsurance
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	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
<i>Inpatient Care</i>		
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
<i>Autism Spectrum Disorder #</i>		
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

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<ul style="list-style-type: none"> Services provided by licensed speech therapists, occupational therapists, physical therapists (not subject to visit limits) 	Yes	10% Coinsurance after you have met the deductible
<i>Dental Services</i>		
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	10% Coinsurance after you have met the deductible
<i>Diabetic Treatment, Services & Supplies</i>		
<ul style="list-style-type: none"> Outpatient Services <ul style="list-style-type: none"> Specialist Office Visit 	Yes	10% Coinsurance after you have met the deductible
<ul style="list-style-type: none"> Lab Services 	Yes	10% Coinsurance after you have met the deductible
<ul style="list-style-type: none"> Durable Medical Equipment# (some DME requires Prior Authorization) 	Yes	20% Coinsurance after you have met the deductible
<ul style="list-style-type: none"> Prescription Drugs 	Yes	Cost sharing varies by Tier
<ul style="list-style-type: none"> Group Diabetic Education Services 	Yes	10% Coinsurance after you have met the deductible
<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)		
<ul style="list-style-type: none"> Services provided by licensed speech therapists, occupational therapists, physical therapists 	Yes	10% Coinsurance after you have met the deductible
<ul style="list-style-type: none"> Services provided by licensed clinical social workers 	Yes	10% Coinsurance after you have met the deductible

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<i>Family Planning Services</i>		
Office Visit (Deductible may apply to some office services)	Yes	10% Coinsurance after you have met the deductible
Preventive Contraceptive Services	No	\$0
<i>Other Services#</i>		
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
<i>Nutritional Support</i> including non-prescription enteral formulas#	Yes	10% 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	10% Coinsurance after you have met the deductible
Non-routine Prenatal and Postpartum Care	Yes	10% 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)	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
<i>Pediatric Dental Services for members under age 19</i>		
Diagnostic & Preventive Services		
<ul style="list-style-type: none"> • Topical fluoride treatment, once every 6 months (Deductible and Coinsurance does not apply for Children up to age 5) 	Yes	50% after you have met the deductible
<ul style="list-style-type: none"> • Periodic oral exams, 2 per year 	Yes	50% after you have met the deductible
<ul style="list-style-type: none"> • Routine cleanings, once every 6 months 	Yes	50% after you have met the deductible

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

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