New Hampshire
MyDoc HMO Silver Value 6000
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
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. No one Member is responsible for more than the individual deductible. All members accumulate to the family deductible.	Combined Medical and Dental $6,000 per individual $12,000 per family
***Policy Year Benefits**	
Coinsurance applies to some but not all services	
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 $6,850** per individual $13,700** per family

**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 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)	No	40% Coinsurance $500 per script maximum
Tier 4 Specialty Drugs	No	50% Coinsurance $500 per script maximum
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)	No	40% Coinsurance $1,500 per script maximum
Tier 4 Specialty Drugs	No	50% Coinsurance $1,500 per script maximum
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
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

[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
Outpatient Care		
Primary Care Office Visit (Non-Routine)	No	$15 Copay
Specialist Office Visit	No	$30 Copay
Allergy Injections	No	$30 Copay
Allergy Testing	No	$30 Copay
Cardiac Rehabilitation		
• Office Visit	No	$15 Copay
• Hospital Outpatient or Other Approved Facility	No	$30 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	$15 Copay
Mental Health and Substance Abuse Disorder Office Visit	No	$15 Copay
Nutritional Counseling (limited to 4 visits per Calendar Year)	No	$15 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	$15 Copay
• Hospital Outpatient or Other Approved Facility	No	$30 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	$15 Copay
• Hospital Outpatient or Other Approved Facility	No	$30 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	$30 Copay
Second Opinions	No	$30 Copay
Emergency Care		
Ambulance and Transportation Services # (Non-emergency transportation requires Prior Authorization.)	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
Urgent Care Center or Facilities		
• Freestanding or Retail Walk-In Clinic (not hospital owned)	No	$15 Copay

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• Hospital-based Urgent Care Center or Facility	Yes	$30 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	$0 Copay after you have met the deductible
Lab Services		
• Select Labs	No	$0 Copay
• Non-Select Labs	Yes	$75 Copay 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	$0 Copay 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
Inpatient Care		
Facility Fees for Acute Hospital Care#	Yes	$0 Copay after you have met the deductible
Facility Fees for Acute Inpatient Rehabilitation # (limited to up to 60 days per Calendar Year)	Yes	$0 Copay after you have met the deductible
Facility Fees for Bariatric Surgery#	Yes	$0 Copay after you have met the deductible
Facility Fees for Human Organ Transplants and Bone Marrow Transplants#	Yes	$0 Copay after you have met the deductible
Facility Fees for Reconstruction Surgery as a result of Mastectomy	Yes	$0 Copay after you have met the deductible
Facility Fees for Inpatient Mental Health and Substance Abuse Disorder Services	Yes	$0 Copay after you have met the deductible
Facility Fees for Skilled Nursing Facility# (limited to 100 days per Calendar Year)	Yes	$0 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	$15 Copay
• Prescription drugs	No	Cost sharing varies by Tier

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• Services provided by licensed psychiatrist, advanced practice registered nurse, psychologist, clinical social worker	No	$15 Copay
• Services provided by licensed speech therapists, occupational therapists, physical therapists	No	$15 Copay
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
Diabetic Treatment, Services & Supplies		
• Outpatient Services		
○ Specialist Office Visit	No	$50 Copay
• Lab Services	See Lab Services benefit	See Lab Services benefit
• Durable Medical Equipment# (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	$15 Copay
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	No	$15 Copay
• Services provided by licensed clinical social workers	No	$15 Copay
Family Planning Services		
Office Visit (Deductible may apply to some office services)	No	$30 Copay
Preventive Contraceptive Services	No	$0

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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
Maternity Care		
Delivery/Hospital Care for Mother and Child (For continued coverage, child must be enrolled within 31 days of date of birth)	Yes	$0 Copay after you have met the deductible
Non-routine Prenatal and Postpartum Care	No	$30 Copay
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)	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
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% after you have met the deductible
• Periodic oral exams, 2 per year	Yes	50% after you have met the deductible
• Routine cleanings, once every 6 months	Yes	50% after you have met the deductible
• 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

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• 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 *All Orthodontic Treatment Requires Preauthorization*		
• Only medically necessary orthodontic treatment is covered	Yes	50% after you have met the deductible

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