MyDoc HMO 1000

Effective Date 10/1/2017

Summary of Benefits Chart

Your Minuteman Health HMO Plan

This chart provides a summary of key services offered by your plan. Your Policy/Member Agreement 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 some cases, if you do not obtain Prior Authorization, benefits may be denied and you may be responsible for all costs.

	In-Plan
Deductible per Year	Combined Medical and Dental
You must pay this amount for Covered Services before	\$1,000 per individual
MHI will begin to pay benefits. As indicated in the chart below, some services are not subject to the Deductible.	\$2,000 per family
No one Member is responsible for more than the individual Deductible. All Members accumulate to the family Deductible.	
Based on a Policy Year Benefit	
Maximum Out-of-Pocket	Combined Medical, Dental and Prescription Drugs:
You are protected by an Out-of-Pocket Maximum each	\$3,500 per individual
year. Once you reach this amount you will not have to pay Copays, Coinsurance or Deductibles for the remainder of the year. Included in your Out-of-Pocket Maximum are your Deductible, Copays and Coinsurance.	\$7,000 per family
No one Member is responsible for more than the Individual Maximum Out-of-Pocket. All Members accumulate to the family Maximum Out-of-Pocket.	

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Benefit	Deductible Applies	Copay or Coinsurance
Prescription Drugs		otion Drug section in your
Contraceptive methods approved by FDA and prescribed for	Policy for details about your prescription drug	
a woman by her health care provider, subject to reasonable	coverage.	
medical management, will be covered without cost-sharing		
requirements.		
In-Plan Pharmacy (up to 30-day supply)		
Tier 1 Generics	No	\$10 Copay
Tier 2 Brand Name (Preferred)	No	\$30 Copay
Tier 3 Brand Name (Non-Preferred)	No	\$60 Copay
Affordable Care Act (ACA) Preventive Drugs	No	\$0 Copay
Mail Service Pharmacy (up to 90-day supply)	1 - 10	1 + 0 - 0 - 0 - 0 - 0 - 0 - 0 - 0 - 0 - 0
Tier 1 Generics	No	\$20 Copay
Tier 2 Brand Name (Preferred)	No	\$60 Copay
Tier 3 Brand Name (Non-Preferred)	No	\$180 Copay
Affordable Care Act (ACA) Preventive Drugs	No	\$0 Copay
Oral Oncology Drugs#		sibilities for prescribed ora
Please see the Prescription Drug Rider to your EOC for		will be covered at the
details about your coverage.	same level as intraven	
details about your coverage.		ations that are covered as
	medical benefits.	ations that are covered as
Preventive Care	medicai benefits.	
Adult Routine Exams (limited to one per Calendar Year)	No	\$0
Preventive Screenings	No	\$0
(listed under "Outpatient Preventive Care" in the Covered	110	30
Benefits Section of the EOC)		
Routine Child and Adult Immunizations	No	\$0
Routine Eye Exams for Adults	No	\$0
(limited to one per Calendar Year)	110	30
Routine Pediatric Vision Services for Children under age 19		
described later in the chart		
Routine Prenatal and Postpartum Care	No	\$0
Routine Mammograms	No	\$0
(limited to one per Calendar Year)	110	40
Screening Colonoscopy or Sigmoidoscopy	No	\$0
(limited to one every five Calendar Years, office visits prior	110	\$0
to the procedure are subject to applicable Deductible and		
Copays/Coinsurance)		
Well Child Care	No	\$0
Women's Preventive Services including one routine	No	\$0
gynecological exam per Calendar Year	110	\$0
Outpatient Care		
Primary Care Office Visit (Non-Routine)	No	\$20 Copay
Specialist Office Visit	No	\$35 Copay
Allergy Injections	No	\$20 Copay
Allergy Testing	No	\$35 Copay
Cardiac Rehabilitation	No	\$20 Copay
		\$0 Copay after you have
	Voc	
Chemotherapy and Radiation Therapy	Yes	met the Deductible
	Yes	

Benefit	Deductible Applies	Copay or Coinsurance
Hearing Tests	No	\$35 Copay
Nutritional Counseling	No	\$20 Copay
Short-Term Rehabilitation Services# (limited to 60 visits per Member per Calendar Year for a combination of physical and occupational therapies). Benefit limit does not apply for covered services to treat autism spectrum disorders.	No	\$35 Copay
Outpatient Habilitation Services# (limited to 60 visits per Member per Calendar Year for a combination of physical and occupational therapies). Benefit limit does not apply for covered services to treat Early Intervention.	No	\$35 Copay
Outpatient Surgical Services and Procedures#		
(some services require Prior Authorization; cost-sharing varies		
 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	\$35 Copay
Second Opinions	No	\$35 Copay
Third Opinions	No	\$35 Copay
Emergency & Urgent Care		
Ambulance and Transportation Services# (non-emergency transportation requires Prior Authorization. If Prior Authorization is not obtained for non-emergency transportation, Member pays all costs)	Yes	\$100 Copay after you have met the Deductible
Emergency Room Care	Yes	\$100 Copay after you have met the Deductible
Urgent Care Center or Facilities	No	\$35 Copay
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	No	\$0
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 benefit	Cost-sharing varies by location of service
Radiological Services – Ultrasound, X-rays, Non-Routine Mammograms	No	\$0
Sleep Study (maximum of two per Calendar Year)	•	
Approved Facility	Yes	\$250 Copay, after you have met the Deductible. One Copay per year

Benefit	Deductible Applies	Copay or Coinsurance
Home sleep study	Yes	\$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#	Yes	\$0 Copay after you have
(limited to up to 60 days per Calendar Year)		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	Yes	\$0 Copay after you have
Marrow Transplants#		met the Deductible
Facility Fees for Skilled Nursing Facility#	Yes	\$0 Copay after you have
(limited to 100 days per Calendar Year)		met the Deductible
Physician/Surgeon Fees for Inpatient Services	Yes	\$0 Copay after you have
		met the Deductible
Mental Health and Substance Abuse Services		
Facility Fees for Mental Health and Substance Abuse	Yes	\$0 Copay after you have
Disorder Services		met the Deductible
Intermediate services including, but not limited to:	Yes	\$0 Copay after you have
 Intensive Outpatient Programs 		met the Deductible
Partial Hospitalization		
Neuropsychological Evaluations#	No	\$20 Copay
Office Visits	No	\$20 Copay
Autism Spectrum Disorder#		
Services to diagnose and treat Autism Spectrum Disorder inclu	ıde:	
Habilitative or Rehabilitative care	No	\$20 Copay
Includes applied behavioral analysis (ABA)#		
Other test to diagnose ASD#	Depends on type of	Copay amount depends
(some tests may require Prior Authorization)	test as listed	on type of test as listed
	elsewhere in this	elsewhere in this chart
	chart (Lab Services,	(Lab Services,
	Diagnostic Imaging,	Diagnostic Imaging,
	Diagnostic Testing,	Diagnostic Testing, etc.)
	etc.)	
 Prescription drugs 	No	Cost-sharing varies by
		Tier
Psychiatric care	No	\$20 Copay
 Psychological care 	No	\$20 Copay
Therapeutic care:		
 Services provided by licensed or certified 	No	\$35 Copay
speech therapists, occupational therapists,		
physical therapists		
 Services provided by licensed or certified 	No	\$20 Copay
social worker		
Cleft Palate and Cleft Lip for Children#		
Services to cover the treatment of cleft lip and cleft palate incl	udes:	
Medical, dental, oral and facial surgery	Yes	\$0 Copay after you have
		met the Deductible
Specialist visit (including oral and plastic surgeons,	No	\$35 Copay
orthodontists, dentists and audiologists)		
Speech therapy	No	\$35 Copay
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Benefit	Deductible Applies	Copay or Coinsurance
Dental Services		
Pediatric Dental Services for Members under age 19 described	d later in the chart	
Surgical Treatment of Non-Dental Conditions#		
(some services are subject to the Outpatient Surgical Services	and Procedures Copay/C	oinsurance. Deductible
may apply to some office services)	1 7	
Emergency Dental Care in an Emergency Room	Yes	\$100 Copay after you
		have met the Deductible
Diabetic Treatment, Services & Supplies		
Outpatient Services	No	\$35 Copay
Lab Services	No	\$0
Durable Medical Equipment#	Yes	20% Coinsurance after
1 1		you have met the
		Deductible
Insulin Pumps and Insulin Pump Supplies#	Yes	\$0 Copay after you have
		met the Deductible
Prescription Drugs	No	Cost-sharing varies by
1		Tier
Group Diabetic Education Services	No	\$20 Copay
Individual Diabetic Education	No	\$35 Copay
Durable Medical Equipment, Prosthetic Equipment & Medic	al/Surgical Supplies	1 3
Durable Medical Equipment#	Yes	20% Coinsurance after
(some items require Prior Authorization)		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	Yes	20% Coinsurance after
any form of cancer or leukemia		you have met the
(one wig per Calendar Year)		Deductible
Family Planning Services		
Office Visit (Deductible may apply to some office services)	No	\$35 Copay
Maternity Care		1 7
Delivery/Hospital Care for Mother and Child	Yes	\$0 Copay after you have
(coverage for child limited to routine newborn nursery		met the Deductible
charges. For continued coverage, child must be enrolled		
within 31 days of date of birth)		
Non-routine Prenatal and Postpartum Care	No	\$35 Copay
Infertility Services#		
Facility Fees for Inpatient Care#	Yes	\$0 Copay after you have
, 1		met the Deductible
Physician/Surgeon Fees for Inpatient Care	Yes	\$0 Copay after you have
, and a great and a property of the control of the		met the Deductible
Lab Test#	No	\$0
Office Visit# (Deductible may apply to some office services)	No	\$35 Copay
Outpatient Surgery & Procedures# (cost-sharing varies by loca		1 4
Facility Fees from Hospital, Ambulatory Surgical	Yes	\$0 Copay after you have
Center or other approved facility		met the Deductible
Physician/Surgeon Fees for services rendered in	Yes	\$0 Copay after you have
Hospital, Ambulatory Surgical Center or other		met the Deductible
approved facility		
Services rendered in PCP Office including	No	\$20 Copay
OB/GYN, Nurse Practitioner		copu,
OD/O 114, Marse I factitioner	L	<u> </u>

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Benefit	Deductible Applies	Copay or Coinsurance
Services rendered in Specialist Office	No	\$35 Copay
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	Yes	\$0 Copay after you have
formulas#		met the Deductible
Speech, Hearing and Language Disorders#		
Prior Authorization is required for speech therapy services aft	er the initial evaluation.	This includes coverage for
hearing aids for Members age 21 or younger as follows:	T	1 ***
Speech Therapy#	No	\$35 Copay
One hearing aid per hearing-impaired ear every 36 months,	Yes	\$0 Copay after you have
up to \$2,000 for each hearing aid		met the Deductible
Licensed audiologist or hearing instrument specialist visits	No	\$35 Copay
Supplies, including ear molds	Yes	20% Coinsurance after
		you have met the
		Deductible
Pediatric Vision Services for Members under age 19	T	1
Routine Eye Exam (limited to one per Calendar Year)	No	\$0 Copay
Collection Lenses & Lens Treatment	No	\$0 Copay
(once per Calendar Year; available only if the contact lens		
benefit is not used)	**	700 4 7 .
Non-Collection Lenses & Lens Treatments	Yes	50% Coinsurance after
(once per Calendar Year; available only if the contact lens		you have met the
benefit is not used)) Y	Deductible
Collection Frames	No	\$0 Copay
(once per Calendar Year, available only if the contact lens		
benefit is not used)	N/	500/ G :
Non-Collection Frames	Yes	50% Coinsurance after
(once per Calendar Year, available only if the contact lens		you have met the Deductible
benefit is not used)		Deductible
Contact Lenses (once per Calendar Year; available only if the eyeglass lens be	anofit is not used)	
	No	\$0 Copay
Contact lens evaluation/fitting	Yes	50% Coinsurance after
 Contact lenses 	ies	you have met the
		Deductible
Pediatric Dental Services for Members under age 19		Deductible
Diagnostic & Prevent	iva Sarvicas	
	Yes	50% after you have met
represent measures determined, enter exert a menung	1 55	the Deductible
(Deductible and Coinsurance does not apply for		the Deductible
Children up to age 5)	Yes	50% ofter you have met
• Periodic oral exams, 2 per year	1 68	50% after you have met the Deductible
Posting cleanings on (Yes	50% after you have met
• Routine cleanings, once every 6 months	1 55	the Deductible
		the Deductible

Bitewing x-rays, 1 set every 6 months Panoramic x-rays, 1 image every 60 months Scalants Panoramic x-rays, 1 image every 60 months Scalants Yes So% after you have met the Deductible Scalants Yes So% after you have met the Deductible Space maintainers Yes So% after you have met the Deductible Fillings Yes So% after you have met the Deductible Minor Restorative Services Fillings Yes So% after you have met the Deductible Pre-fabricated stainless steel crowns, under age 15, 1 Yes So% after you have met the Deductible Pre-fabricated porcelain crowns, primary, 1 per tooth every 60 months Pre-fabricated porcelain crowns, primary, 1 per tooth every 60 months Simple tooth extractions Yes So% after you have met the Deductible Surgical extractions Yes So% after you have met the Deductible Incisions and drainage of abscess Yes So% after you have met the Deductible Incisions and drainage of abscess Yes So% after you have met the Deductible General Anesthesia Ominor treatment for pain relief Tissue conditioning Yes So% after you have met the Deductible Palliative treatment of dental pain Yes So% after you have met the Deductible Adjustment of dentares Complex Restorative Services Complex Restorative Services Complex Restorative Services Complex Restorative Services Periodontics services, limits vary Yes So% after you have met the Deductible De	Benefit		Deductible Applies	Copay or Coinsurance	
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Fillings Fillings Fillings Fre-fabricated stainless steel crowns, under age 15, 1 per tooth every 60 months Fre-fabricated porcelain crowns, primary, 1 per tooth every 60 months Fre-fabricated porcelain crowns, primary, 1 per tooth every 60 months Fre-fabricated porcelain crowns, primary, 1 per tooth every 60 months Simple tooth extractions Simple tooth extractions Fre-fabricated porcelain crowns, primary, 1 per tooth every 60 months Simple tooth extractions Fre-fabricated porcelain crowns, primary, 1 per tooth every 60 months Fre-fabricated porcelain crowns, primary, 1 per tooth every 60 months Fre-fabricated porcelain crowns, primary, 1 per tooth every 60 months Fre-fabricated porcelain crowns, under age 15, 1 per 50% after you have met the Deductible Fre-fabricated porcelain crowns Fre-fabricated porcelain crowns, under age 15, 1 per 50% after you have met the Deductible Fre-fabricated porcelain crowns primary, 1 per 50% after you have met the Deductible Fre-fabricated porcelain crowns primary, 1 per 50% after you have met the Deductible Fre-fabricated porcelain crowns primary, 1 per 50% after you have met the Deductible Fre-fabricated porcelain crowns primary, 1 per 50% after you have met the Deductible Fre-fabricated porcelain crowns primary, 1 per 50% after you have met the Deductible Fre-fabricated porcelain crowns primary, 1 per 50% after you have met the Deductible Fre-fabricated porcelain crowns, primary, 1 per 50% after you have met the Deductible Fre-fabricated porcelain crowns, primary, 1 per 50% after you have met the Deductible Fre-fabricated porcelain crowns, primary, 1 per 50% after you have met the Deductible Fre-fabricated porcelain crowns, primary, 1 per 50% after you have met the Deductible Fre-fabricated porcelain crowns, primary, 1 per 50% after you have met the Deductible Fre-fabricated porcelain crowns, primary, 1 per 50% after you have met the Deductible Fre-fabricated porcelain crowns, primary, 1 per 50% after you have met the Deductible Fre-fabricated po					
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Effective Date 10/1/2017

Minuteman Health has a 24-Hour Nurse Line. An experienced nurse will listen to your concerns and help you choose the care that's right for you.

Fitness & Weight Loss Benefit

Minuteman Health will reimburse 5 months membership fee only in Weight Watchers® per family per Calendar Year. Qualifying Weight Watchers® services are:

- Weight Watchers® Traditional meetings
- Weight Watchers® at Work meetings
- Weight Watchers® Online

Minuteman Health will reimburse membership fee only at <u>one</u> of the fitness facilities listed below Per family per Calendar year:

- 6 months of membership at Planet Fitness, W-Fitness or Work Out World OR
- 3 months of membership at YMCA or Gold's Gym *OR*
- 2 months of membership at Boston Sports Club, FitCorp or LA Fitness

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