MyDoc HMO 1500

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 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 $1,500 per individual $3,000 per family
Based on a Policy Year Benefit	
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 or 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: $4,000 per individual $8,000 per family

If you have further questions, please call the Minuteman Member Services Team at 855-644-1776 (Monday through Friday from 8am to 6pm) or visit www.minutemanhealth.org.

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 (up to 30-day supply)		
Tier 1 Generics	No	$15 Copay
Tier 2 Brand Name (Preferred)	No	$35 Copay
Tier 3 Brand Name (Non-Preferred)	No	$70 Copay
Affordable Care Act (ACA) Preventive Drugs	No	$0 Copay
Mail Service Pharmacy (up to 90-day supply)		
Tier 1 Generics	No	$30 Copay
Tier 2 Brand Name (Preferred)	No	$70 Copay
Tier 3 Brand Name (Non-Preferred)	No	$210 Copay
Affordable Care Act (ACA) Preventive Drugs	No	$0 Copay
Oral Oncology Drugs# Please see the Prescription Drug Rider to your EOC for details about your coverage.	Your payment responsibilities for prescribed oral oncology medications will be covered at the same level as intravenously administered or injected cancer medications that are covered as medical benefits.	
Preventive Care		
Adult Routine Exams (limited to one per Calendar Year)	No	$0
Preventive Screenings (listed under "Outpatient Preventive Care" in the Covered Benefits Section of the EOC)	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		
Routine Prenatal and Postpartum Care	No	$0
Routine Mammograms (limited to one per Calendar Year)	No	$0
Screening Colonoscopy or Sigmoidoscopy (limited to one every five Calendar Years, office visits prior to the procedure are subject to applicable Deductible and Copays/Coinsurance)	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)	No	$25 Copay
Specialist Office Visit	No	$40 Copay
Allergy Injections	No	$25 Copay
Allergy Testing	No	$40 Copay
Cardiac Rehabilitation	No	$40 Copay
Chemotherapy and Radiation Therapy	Yes	$0 Copay after you have met the Deductible
Chiropractic Services	No	$40 Copay
Early Intervention Services (Covered for children from birth to age 3)	No	$0 Copay

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Benefit	Deductible Applies	Copay or Coinsurance
Hearing Tests	No	$40 Copay
Nutritional Counseling	No	$25 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	$40 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	$40 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	$250 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	$40 Copay
Second Opinions	No	$40 Copay
Third Opinions	No	$40 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	$150 Copay after you have met the Deductible
Emergency Room Care	Yes	$150 Copay after you have met the Deductible
Urgent Care Center or Facilities	No	$40 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	$150 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

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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	$250 Copay after you have met the Deductible
Facility Fees for Acute Inpatient Rehabilitation# (limited to up to 60 days per Calendar Year)	Yes	$250 Copay after you have met the Deductible
Facility Fees for Bariatric Surgery#	Yes	$250 Copay after you have met the Deductible
Facility Fees for Human Organ Transplants and Bone Marrow Transplants#	Yes	$250 Copay after you have met the Deductible
Facility Fees for Skilled Nursing Facility# (limited to 100 days per Calendar Year)	Yes	$250 Copay after you have 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 Disorder Services	Yes	$250 Copay after you have met the Deductible
Intermediate services including, but not limited to: • Intensive Outpatient Programs • Partial Hospitalization	Yes	$0 Copay after you have met the Deductible
Neuropsychological Evaluations#	No	$25 Copay
Office Visits	No	$25 Copay
Autism Spectrum Disorder#		
Services to diagnose and treat Autism Spectrum Disorder include:		
• Habilitative or Rehabilitative care Includes applied behavioral analysis (ABA)#	No	$25 Copay
• Other test to diagnose ASD# (some tests may require Prior Authorization)	Depends on type of test as listed elsewhere in this chart (Lab Services, Diagnostic Imaging, Diagnostic Testing, etc.)	Copay amount depends on type of test as listed elsewhere in this chart (Lab Services, Diagnostic Imaging, Diagnostic Testing, etc.)
• Prescription drugs	No	Cost-sharing varies by Tier
• Psychiatric care	No	$25 Copay
• Psychological care	No	$25 Copay
• Therapeutic care:		
o Services provided by licensed or certified speech therapists, occupational therapists, physical therapists	No	$40 Copay
o Services provided by licensed or certified social worker	No	$25 Copay
Cleft Palate and Cleft Lip for Children#		
Services to cover the treatment of cleft lip and cleft palate includes:		
• Medical, dental, oral and facial surgery	Yes	$0 Copay after you have met the Deductible
• Specialist visit (including oral and plastic surgeons, orthodontists, dentists and audiologists)	No	$40 Copay
• Speech therapy	No	$40 Copay

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Benefit	Deductible Applies	Copay or Coinsurance
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 in an Emergency Room	Yes	$150 Copay after you have met the Deductible
Diabetic Treatment, Services & Supplies		
Outpatient Services	No	$40 Copay
Lab Services	No	$0
Durable Medical Equipment#	Yes	20% Coinsurance after 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 Tier
Group Diabetic Education Services	No	$25 Copay
Individual Diabetic Education	No	$40 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
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 or leukemia (one wig per Calendar Year)	Yes	20% Coinsurance after you have met the Deductible
Family Planning Services		
Office Visit (Deductible may apply to some office services)	No	$40 Copay
Maternity Care		
Delivery/Hospital Care for Mother and Child (coverage for child limited to routine newborn nursery charges. For continued coverage, child must be enrolled within 31 days of date of birth)	Yes	$250 Copay after you have met the Deductible
Non-routine Prenatal and Postpartum Care	No	$40 Copay
Infertility Services#		
Facility Fees for Inpatient Care#	Yes	$250 Copay after you have met the Deductible
Physician/Surgeon Fees for Inpatient Care	Yes	$0 Copay after you have met the Deductible
Lab Test#	No	$0
Office Visit# (Deductible may apply to some office services)	No	$40 Copay
Outpatient Surgery & Procedures# (cost-sharing varies by location of service)		
• Facility Fees from Hospital, Ambulatory Surgical Center or other approved facility	Yes	$250 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 PCP Office including OB/GYN, Nurse Practitioner	No	$25 Copay

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Benefit	Deductible Applies	Copay or Coinsurance
• Services rendered in Specialist Office	No	$40 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 formulas#	Yes	$0 Copay after you have met the Deductible
Speech, Hearing and Language Disorders# Prior Authorization is required for speech therapy services after the initial evaluation. This includes coverage for hearing aids for Members age 21 or younger as follows:		
Speech Therapy#	No	$40 Copay
One hearing aid per hearing impaired ear every 36 months, up to $2,000 for each hearing aid	Yes	$0 Copay after you have met the Deductible
Licensed audiologist or hearing instrument specialist visits	No	$40 Copay
Supplies, including ear molds	Yes	20% Coinsurance after you have met the Deductible
Pediatric Vision Services for Members under age 19		
Routine Eye Exam (limited to one per Calendar Year)	No	$0 Copay
Collection Lenses & Lens Treatment (once per Calendar Year; available only if the contact lens benefit is Not used)	No	$0 Copay
Non-Collection Lenses & Lens Treatments (once per Calendar Year; available only if the contact lens benefit is not used)	Yes	50% Coinsurance after you have met the Deductible
Collection Frames (once per Calendar Year, available only if the contact lens benefit is not used)	No	$0 Copay
Non-Collection Frames (once per Calendar Year, available only if the contact lens benefit is not used)	Yes	50% Coinsurance after you have met the Deductible
Contact Lenses (once per Calendar Year; available only if the eyeglass lens benefit is not used)		
• Contact lens evaluation/fitting	No	$0 Copay
• Contact lenses	Yes	50% 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% 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

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Benefit	Deductible Applies	Copay or Coinsurance
• 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
• Sealants	Yes	50% after you have met the Deductible
• Space maintainers	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
• Surgical extractions	Yes	50% after you have met the Deductible
• Incisions and drainage of abscess	Yes	50% after you have met the Deductible
• General Anesthesia o Minor treatment for pain relief	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
• Periodontics 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 Prior Authorization*		
• Only medically necessary orthodontic treatment is covered	Yes	50% after you have met the Deductible

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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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