

MyDoc HMO Gold 1500 Plus

Effective Date 1/1/2017

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
Policy Year Benefits	
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: \$3,000 per individual \$6,000 per family

If you have further questions, please call the Minuteman Member Services Line at 1-855-MHI-1776, Monday – Friday, 8 a.m. to 6 p.m. or visit www.minutemanhealth.org

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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 (up to 30-day supply)</i>		
Tier 1 Generics	No	\$15 Copay
Tier 2 Brand Name (Preferred)	No	\$30 Copay
Tier 3 Brand Name (Non-Preferred)	No	\$50 Copay
Affordable Care Act (ACA) Preventive Drugs	No	\$0 Copay
<i>Mail Service Pharmacy (up to 90-day supply)</i>		
Tier 1 Generics	No	\$30 Copay
Tier 2 Brand Name (Preferred)	No	\$60 Copay
Tier 3 Brand Name (Non-Preferred)	No	\$150 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.	
<i>Preventive Care</i>		
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
<i>Outpatient Care</i>		
Primary Care Office Visit (Non-Routine)	No	\$20 Copay
Specialist Office Visit	No	\$40 Copay
Allergy Injections	Yes	\$0 Copay after you have met the deductible
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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Hearing Tests	No	\$40 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	\$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)		
<ul style="list-style-type: none"> Facility Fees from Hospital, Ambulatory Surgical Center or other approved facility 	Yes	\$0 Copay 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	\$0 Copay after you have met the deductible
<ul style="list-style-type: none"> Services rendered in Specialist Office 	No	\$40 Copay
Second Opinions	No	\$40 Copay
Third Opinions	No	\$40 Copay
<i>Emergency & Urgent Care</i>		
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 (copay waived if admitted)	Yes	\$150 Copay after you have met the deductible
Urgent Care Center or Facilities	No	\$20 Copay
<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	\$150 Copay after you have met the deductible.
Lab Services	Yes	\$50 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 benefit	Cost sharing varies by location of service
Radiological Services – Ultrasound, X-rays, Non-Routine Mammograms	Yes	\$100 Copay after you have met the deductible
Sleep Study (maximum of two per Calendar Year)		
<ul style="list-style-type: none"> Approved Facility 	Yes	\$250 Copay, after you have met the deductible. One Copay per year
<ul style="list-style-type: none"> Home sleep study 	Yes	\$0 Copay after you have met the deductible

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<i>Inpatient Care</i>		
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 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
<i>Mental Health and Substance Abuse Services</i>		
Facility Fees for Mental Health and Substance Abuse Disorder Services	Yes	\$0 Copay after you have met the deductible
Intermediate services including but not limited to: <ul style="list-style-type: none"> • Intensive Outpatient Programs • Partial Hospitalization 	Yes	\$0 Copay after you have met the deductible
Neuropsychological Evaluations#	No	\$20 Copay
Office Visits	No	\$20 Copay
<i>Autism Spectrum Disorder #</i>		
Services to diagnose and treat Autism Spectrum Disorder include:		
<ul style="list-style-type: none"> • Habilitative or Rehabilitative care Includes applied behavioral analysis (ABA)# 	No	\$20 Copay
<ul style="list-style-type: none"> • Other test to diagnose ASD# (some tests may require Prior Approval) 	Yes	Copay amount depends on type of test as listed elsewhere in this chart (Lab Services, Diagnostic Imaging, Diagnostic Testing, etc.)
<ul style="list-style-type: none"> • Prescription drugs 	No	Cost sharing varies by Tier
<ul style="list-style-type: none"> • Psychiatric care 	No	\$20 Copay
<ul style="list-style-type: none"> • Psychological care 	No	\$20 Copay
<ul style="list-style-type: none"> • Therapeutic care: <ul style="list-style-type: none"> ○ Services provided by licensed or certified speech therapists, occupational therapists, physical therapists 	No	\$40 Copay
<ul style="list-style-type: none"> ○ Services provided by licensed or certified social worker 	No	\$20 Copay
<i>Cleft Palate and Cleft Lip for Children#</i>		
Services to cover the treatment of cleft lip and cleft palate includes:		
<ul style="list-style-type: none"> • Medical, dental, oral and facial surgery 	Yes	\$0 Copay after you have met the deductible
<ul style="list-style-type: none"> • Specialist visit (including oral and plastic surgeons, orthodontists, dentist and audiologists) 	No	\$40 Copay
<ul style="list-style-type: none"> • Speech therapy 	No	\$40 Copay

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<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 in an Emergency Room	Yes	\$150 Copay after you have met the deductible
<i>Diabetic Treatment, Services & Supplies</i>		
• Outpatient Services	No	\$40 Copay
• Lab Services	Yes	\$50 Copay after you have met the deductible
• Durable Medical Equipment#	Yes	20% Coinsurance after you have met the deductible
• Insulin Pumps & 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	\$20 Copay
• Individual Diabetic Education	No	\$40 Copay
<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
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
<i>Family Planning Services</i>		
Office Visit (Deductible may apply to some office services)	No	\$40 Copay
<i>Maternity Care</i>		
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	\$0 Copay after you have met the deductible
Non-routine Prenatal and Postpartum Care	No	\$40 Copay
<i>Infertility Services#</i>		
• Facility Fees for Inpatient Care#	Yes	\$0 Copay after you have met the deductible
• Physician/Surgeon Fees for Inpatient Care	Yes	\$0 Copay after you have met the deductible
• Lab Test#	Yes	\$50 Copay after you have met the deductible
• 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	\$0 Copay after you have met the deductible

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<ul style="list-style-type: none"> ○ Physician/Surgeon Fees for services rendered in Hospital, Ambulatory Surgical Center or other approved facility 	Yes	\$0 Copay after you have met the deductible
<ul style="list-style-type: none"> ○ Services rendered in PCP Office including OB/GYN, Nurse Practitioner 	No	\$20 Copay
<ul style="list-style-type: none"> ○ Services rendered in Specialist Office 	No	\$40 Copay
<i>Other Services#</i>		
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
<i>Nutritional Support</i> including non-prescription enteral formulas#	Yes	\$0 Copay after you have met the deductible
<i>Speech, Hearing, and Language Disorders#</i> (Prior Approval is required for speech therapy services after the initial evaluation). This includes coverage for hearing aids for Members age 21 or younger as follows:		
<ul style="list-style-type: none"> • Speech Therapy# 	No	\$40 Copay
<ul style="list-style-type: none"> • 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
<ul style="list-style-type: none"> • Licensed audiologist or hearing instrument specialist visits 	No	\$40 Copay
<ul style="list-style-type: none"> • Supplies, including ear molds 	Yes	20% Coinsurance after you have met the deductible
<i>Pediatric Vision Services for members under age 19</i>		
Routine Eye Exam (limited to one per Calendar Year)	No	\$0 Copay
Collection Lenses & Lens Treatments (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)		
<ul style="list-style-type: none"> • Contact lens evaluation/fitting 	No	\$0 Copay
<ul style="list-style-type: none"> • Contact lenses 	Yes	50% 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 	Yes	50% after you have met the deductible

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(Deductible and Coinsurance does not apply for Children up to age 5)		
• 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
• 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 <ul style="list-style-type: none"> ○ 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
• 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

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<ul style="list-style-type: none"> • Implants, 1 every 60 months 	Yes	50% after you have met the deductible
Orthodontic Services <i>All Orthodontic Treatment Requires Preauthorization</i>		
<ul style="list-style-type: none"> • Only medically necessary orthodontic treatment is covered 	Yes	50% after you have met the deductible

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® On-Line

Minuteman Health will reimburse membership fee only at one 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