MyDoc PPO National Bronze 1750

Effective 1/1/2017

Summary of Benefits Chart

Your Minuteman Health PPO 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.

Please note: for Out-of-Plan services, you may be responsible for any Remaining Balances. A Remaining Balance is that portion of an Out-of-Plan Provider's charge that is above MHI's Maximum Allowable Fee.

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. (See, for example Diagnostic Imaging below) In other cases, if you fail to obtain Prior Authorization you may have a Reduction of Benefit up to the amount indicated below. (For example, Acute Hospital Care below). Remember that exclusions or limitations of this plan will still apply, even if you ask for Prior Authorization. For example, services that are not Medically Necessary are not covered, even if you ask for Prior Authorization.

	In-Plan Providers	Out-of-Plan Providers
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 $1,750 per individual $3,500 per family Prescription Drugs Only: $250 per individual $500 per family	Combined Medical and Dental $3,750 per individual $7,500 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, 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 $6,600 per individual $13,200 per family	Combined Medical and Dental $7,500 per individual $15,000 per family
Reduction of Benefit Applies to certain services if Prior Authorization is required but not obtained.	Not Applicable	$750

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Benefit	In-Plan Providers		Out-of-Plan Providers	
	Deductible Applies	**Copay or Coinsurance**	**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 Rider to your EOC for details about your prescription coverage		Not Covered	
In-Plan Pharmacy (up to 30-day supply)				
Tier 1 Generics	Yes	$30 Copay after you have met the prescription deductible	Not Covered	
Tier 2 Brand Name (Preferred)	Yes	50% Coinsurance after you have met the prescription deductible		
Tier 3 Brand Name (Non-Preferred)	Yes	50% Coinsurance after you have met the prescription deductible		
Affordable Care Act (ACA) Preventative Drugs	No	$0 Copay		
Mail Service Pharmacy (up to 90-day supply)				
Tier 1 Generics	Yes	$60 Copay after you have met the prescription deductible	Not Covered	
Tier 2 Brand Name (Preferred)	Yes	50% Coinsurance after you have met the prescription deductible		
Tier 3 Brand Name (Non-Preferred)	Yes	50% Coinsurance after you have met the prescription deductible		
Affordable Care Act (ACA) Preventative Drugs	No	$0 Copay		
Oral Oncology Drugs# Please see the Prescription Drug Rider to you 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.		Not Covered	
Preventive Care				
Adult Routine Exams (limited to one per Calendar Year)	No	$0 Copay	Yes	20% Coinsurance after you have met the deductible
Preventive Screenings (listed under “Outpatient Preventive Care” in the Covered Benefits Section of the Policy)	No	$0 Copay	Yes	20% Coinsurance after you have met the deductible
Routine Child and Adult Immunizations	No	$0 Copay	Yes	20% Coinsurance after you have met the deductible
Routine Eye Exams for Adults (limited to one per Calendar Year)	No	$0 Copay	Yes	20% Coinsurance after you have met the deductible

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	Deductible Applies	Copay or Coinsurance	Deductible Applies	Copay or Coinsurance
Routine Pediatric Vision Services for Children under age 19 described later in the chart				
Routine Prenatal and Postpartum Care	No	$0 Copay	Yes	20% Coinsurance after you have met the deductible
Routine Mammograms (limited to one per Calendar Year)	No	$0 Copay	Yes	20% Coinsurance after you have met the deductible
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 Copay	Yes	20% Coinsurance after you have met the deductible
Well Child Care	No	$0 Copay	Yes	20% Coinsurance after you have met the deductible
Women's Preventive Services including one routine gynecological exam per Calendar Year	No	$0 Copay	Yes	20% Coinsurance after you have met the deductible
Outpatient Care				
Primary Care Office Visit (Non-Routine)	Yes	$50 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Specialist Office Visit	Yes	$80 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Allergy Injections	Yes	$0 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Allergy Testing	Yes	$80 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Cardiac Rehabilitation	Yes	$80 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Chemotherapy and Radiation Therapy	Yes	$0 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Chiropractic Services	Yes	$80 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Early Intervention Services (Covered for children from birth to age three)	No	$0 Copay	Yes	20% Coinsurance after you have met the deductible
Hearing Tests	Yes	$80 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Nutritional Counseling	Yes	$50 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible

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	Deductible Applies	Copay or Coinsurance	Deductible Applies	Copay or Coinsurance
Short-Term Rehabilitation Services# (limited to 60 visits per member per Calendar Year for physical or occupational therapy or a combination of physical and occupational therapies)	Yes	$80 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
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	Yes	$80 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Outpatient Surgical Services and Procedures# (some services require Prior Authorization; cost sharing varies by location of service)				
• Facility Fees from services rendered in Hospital, Ambulatory Surgical Center or other approved facility	Yes	35% Coinsurance after you have met the deductible	Yes	55% Coinsurance after you have met the deductible and $750 Reduction of Benefit if Prior Auth is required and not obtained
• Physician/Surgeon Fees for services rendered in Hospital, Ambulatory Surgical Center or other approved facility	Yes	35% Coinsurance after you have met the deductible	Yes	55% Coinsurance after you have met the deductible
• Services rendered in Specialist office	Yes	$80 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible and $750 Reduction of Benefit if Prior Auth is required and not obtained
Second Opinions	Yes	$80 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Third Opinions	Yes	$80 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Emergency 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	$250 Copay after you have met the deductible	Yes	$250 Copay after you have met the deductible
Emergency Room Care (copay waived if admitted)	Yes	$750 Copay after you have met the deductible	Yes	$750 Copay after you have met the deductible
Urgent Care Center or Facilities	Yes	$50 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible

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	Deductible Applies	Copay or Coinsurance	Deductible Applies	Copay or Coinsurance
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	$1,000 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible Without Prior Auth, member is responsible for all costs
Lab Services	Yes	$250 Copay after you have met the deductible	Yes	20% Coinsurance 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)	Yes	Cost Sharing varies by location of service	Yes	Cost sharing varies by location of service
Radiological Services- Ultrasound, X-rays, Non-Routine Mammograms	Yes	$250 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Sleep Study (maximum of two per Calendar Year)				
• Approved Facility	Yes	$250 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
• Home sleep study	Yes	$0 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Inpatient Care				
Facility Fees for Acute Hospital Care#	Yes	35% Coinsurance after you have met the deductible	Yes	55% Coinsurance after you have met the deductible and $750 Reduction of Benefit if Prior Auth is required and not obtained
Facility Fees for Acute Inpatient Rehabilitation# (limited to up to 60 days per Calendar Year)	Yes	35% Coinsurance after you have met the deductible	Yes	55% Coinsurance after you have met the deductible and $750 Reduction of Benefit if Prior Auth is required and not obtained
Facility Fees for Bariatric Surgery#	Yes	35% Coinsurance after you have met the deductible	Yes	55% Coinsurance after you have met the deductible and $750 Reduction of Benefit if Prior Auth is required and not obtained

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	Deductible Applies	Copay or Coinsurance	Deductible Applies	Copay or Coinsurance
Facility Fees for Human Organ Transplants and Bone Marrow Transplants#	Yes	35% Coinsurance after you have met the deductible	Yes	55% Coinsurance after you have met the deductible and $750 Reduction of Benefit if Prior Auth is required and not obtained
Facility Fees for Skilled Nursing Facility# (limited to 100 days per Calendar Year)	Yes	$1,000 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible and $750 Reduction of Benefit if Prior Auth is required and not obtained
Physician/Surgeon Fees for Inpatient services	Yes	35% Coinsurance after you have met the deductible	Yes	55% Coinsurance after you have met the deductible
Mental Health and Substance Abuse Services				
Facility Fees for Mental Health and Substance Abuse Disorder Services	Yes	35% Coinsurance after you have met the deductible	Yes	55% Coinsurance after you have met the deductible and $750 Reduction of Benefit if Prior Auth is required and not obtained
Intermediate services including but not limited to: • Intensive Outpatient Programs • Partial Hospitalization	Yes	35% Coinsurance after you have met the deductible	Yes	55% Coinsurance after you have met the deductible
Neuropsychological Evaluations#	Yes	$50 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Office Visits	Yes	$50 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Autism Spectrum Disorder				
Services to diagnose and treat Autism Spectrum Disorder include:				
• Habilitative or Rehabilitative care includes applied behavioral analysis (ABA)#	Yes	$50 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
• Other test to diagnose ASD# (some test 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.)	Yes	20% Coinsurance after you have met the deductible
• Prescription drugs	Yes	Cost sharing varies by Tier	Not Covered	
• Psychiatric Care	Yes	$50 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
• Psychological Care	Yes	$50 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible

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	Deductible Applies	Copay or Coinsurance	Deductible Applies	Copay or Coinsurance
• Therapeutic Care:				
o Services provided by licensed or certified speech therapists, occupational therapists, physical therapists	Yes	$80 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
o Services provided by licensed or certified social worker	Yes	$50 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
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	35% Coinsurance after you have met the deductible	Yes	55% Coinsurance after you have met the deductible and $750 Reduction of Benefit if Prior Auth is required and not obtained
• Specialist visit (including oral and plastic surgeons, orthodontists, dentist and audiologists)	Yes	$80 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
• Speech therapy	Yes	$80 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
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	$750 Copay after you have met the deductible	Yes	$750 Copay after you have met the deductible
Diabetic Treatment, Services & Supplies				
• Outpatient Services	Yes	$80 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
• Lab Services	Yes	$250 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
• Durable Medical Equipment# (some DME requires Prior Authorization)	Yes	20% Coinsurance after you have met the deductible	Yes	40% Coinsurance after you have met the deductible and $750 Reduction of Benefit if Prior Auth is required and not obtained
o Insulin pumps & insulin pump supplies#	Yes	$0 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible and $750 Reduction of Benefit if Prior Auth is required and not obtained

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• Prescription Drugs	Yes	Cost sharing varies by Tier	Not Covered	
• Group Diabetic Education Services	Yes	$50 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
• Individual Diabetic Education	Yes	$80 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
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	Yes	40% Coinsurance after you have met the deductible and $750 Reduction of Benefit if Prior Auth is required and not obtained
Prosthetic Limbs	Yes	20% Coinsurance after you have met the deductible	Yes	40% Coinsurance after you have met the deductible Without Prior Auth, member is responsible for all costs
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; you are responsible for copay/coinsurance plus any additional cost over the Allowable Amount)	Yes	20% Coinsurance after you have met the deductible	Yes	40% Coinsurance after you have met the deductible
Family Planning Services				
Office Visit (Deductible may apply to some office services)	Yes	$80 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
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	35% Coinsurance after you have met the deductible	Yes	55% Coinsurance after you have met the deductible
Non-routine Prenatal and Postpartum Care	Yes	$80 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Infertility Services#				
• Facility Fees for Inpatient Care#	Yes	35% Coinsurance after you have met the deductible	Yes	55% Coinsurance after you have met the deductible. Without Prior Auth, member is responsible for all costs
• Physician/Surgeon Fees for Inpatient Care	Yes	35% Coinsurance after you have met the deductible	Yes	55% Coinsurance after you have met the deductible. Without Prior Auth, member is responsible for all costs

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	Deductible Applies	Copay or Coinsurance	Deductible Applies	Copay or Coinsurance
• Lab Test#	Yes	$250 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible. Without Prior Auth, member is responsible for all costs
• Office Visit (Deductible may apply to some office services)	Yes	$80 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible. Without Prior Auth, member is responsible for all costs
• Outpatient Surgery & Procedures# (cost sharing varies by location of service)				
o Facility Fees from services rendered in Hospital, Ambulatory Surgical Center or other approved facility	Yes	35% Coinsurance after you have met the deductible	Yes	55% Coinsurance after you have met the deductible. Without Prior Auth, member is responsible for all costs
o Physician/Surgeon Fees for services rendered in Hospital, Ambulatory Surgical Center or other approved facility	Yes	35% Coinsurance after you have met the deductible	Yes	55% Coinsurance after you have met the deductible. Without Prior Auth, member is responsible for all costs
o Services rendered in PCP Office including OB/GYN, Nurse Practitioner	Yes	$50 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible. Without Prior Auth, member is responsible for all costs
o Services rendered in Specialist Office	Yes	$80 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible. Without Prior Auth, member is responsible for all costs
Other Services#				
Home Health Care Services#	Yes	$0 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible and $750 Reduction of Benefit if Prior Auth is required and not obtained
Hospice Services#	Yes	$0 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible and $750 Reduction of Benefit if Prior Auth is required and not obtained
Infusion Therapy#	Yes	$0 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible and $750 Reduction of Benefit if Prior Auth is required and not obtained

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	Deductible Applies	**Copay or Coinsurance**	**Deductible Applies**	**Copay or Coinsurance**
Kidney Dialysis	Yes	$0 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Nutritional Support including non-prescription enteral formulas#	Yes	$0 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Speech, Hearing, and Language Disorders# (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:				
• Speech Therapy#	Yes	$80 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible and $750 Reduction of Benefit if Prior Auth is required and not obtained
• 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	Yes	20% Coinsurance after you have met the deductible and $750 Reduction of Benefit if Prior Auth is required and not obtained
• Licensed audiologist or hearing instrument specialist visits	Yes	$80 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
• Supplies, including ear molds#	Yes	20% Coinsurance after you have met the deductible	Yes	40% Coinsurance after you have met the deductible and $750 Reduction of Benefit if Prior Auth is required and not obtained
Pediatric Vision Services for members under age 19				
Routine Eye Exam (limited to one per Calendar Year)	No	$0 Copay	Yes	20% Coinsurance after you have met the deductible
Collection Lenses & Lens Treatments (once per Calendar Year; available only if the contact lens benefit is Not used)	No	$0 Copay	Yes	20% Coinsurance after you have met the deductible
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	Yes	70% 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	Yes	20% Coinsurance after you have met the deductible
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	Yes	70% 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	Yes	20% Coinsurance after you have met the deductible

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• Contact lenses	Yes	50% Coinsurance after you have met the deductible	Yes	70% 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% Coinsurance after you have met the deductible	Yes	70% Coinsurance after you have met the deductible
Periodic oral exams, 2 per year	Yes	$15 Copay + 50% Coinsurance after you have met the deductible	Yes	$15 Copay + 70% Coinsurance after you have met the deductible
Routine Cleanings, once every 6 months	Yes	50% Coinsurance after you have met the deductible	Yes	70% Coinsurance after you have met the deductible
Bitewing x-ray, 1 set every 6 months	Yes	50% Coinsurance after you have met the deductible	Yes	70% Coinsurance after you have met the deductible
Panoramic x-rays, 1 image every 60 months	Yes	50% Coinsurance after you have met the deductible	Yes	70% Coinsurance after you have met the deductible
Sealants	Yes	50% Coinsurance after you have met the deductible	Yes	70% Coinsurance after you have met the deductible
Space maintainers	Yes	50% Coinsurance after you have met the deductible	Yes	70% Coinsurance after you have met the deductible
Minor Restorative Services				
Fillings	Yes	50% Coinsurance after you have met the deductible	Yes	70% Coinsurance after you have met the deductible
Pre-fabricated stainless steel crowns, under age 15, 1 per tooth every 60 months	Yes	50% Coinsurance after you have met the deductible	Yes	70% Coinsurance after you have met the deductible
Pre-fabricated porcelain crowns, primary, 1 per tooth every 60 months	Yes	50% Coinsurance after you have met the deductible	Yes	70% Coinsurance after you have met the deductible
Simple tooth extractions	Yes	50% Coinsurance after you have met the deductible	Yes	70% Coinsurance after you have met the deductible
Surgical extractions	Yes	50% Coinsurance after you have met the deductible	Yes	70% Coinsurance after you have met the deductible
Incisions and drainage of abscess	Yes	50% Coinsurance after you have met the deductible	Yes	70% Coinsurance after you have met the deductible
General Anesthesia • Minor treatment for pain relief	Yes	50% Coinsurance after you have met the deductible	Yes	70% Coinsurance after you have met the deductible
Tissue conditioning	Yes	50% Coinsurance after you have met the deductible	Yes	70% Coinsurance after you have met the deductible

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	Deductible Applies	**Copay or Coinsurance**	**Deductible Applies**	**Copay or Coinsurance**
Repairs of crowns	Yes	50% Coinsurance after you have met the deductible	Yes	70% Coinsurance after you have met the deductible
Palliative treatment of dental pain	Yes	50% Coinsurance after you have met the deductible	Yes	70% Coinsurance after you have met the deductible
Adjustment of dentures	Yes	50% Coinsurance after you have met the deductible	Yes	70% Coinsurance after you have met the deductible
Complex Restorative Services				
Crowns, 1 per tooth every 60 months	Yes	50% Coinsurance after you have met the deductible	Yes	70% Coinsurance after you have met the deductible
Root canals	Yes	50% Coinsurance after you have met the deductible	Yes	70% Coinsurance after you have met the deductible
Periodontic services, limits vary	Yes	50% Coinsurance after you have met the deductible	Yes	70% Coinsurance after you have met the deductible
Endodontic services, limits vary	Yes	50% Coinsurance after you have met the deductible	Yes	70% Coinsurance after you have met the deductible
Onlay, metallic, 1 every 60 months	Yes	50% Coinsurance after you have met the deductible	Yes	70% Coinsurance after you have met the deductible
Inlay, metallic, 1 every 60 months	Yes	50% Coinsurance after you have met the deductible	Yes	70% Coinsurance after you have met the deductible
Dentures, 1 every 50 months	Yes	50% Coinsurance after you have met the deductible	Yes	70% Coinsurance after you have met the deductible
Implants, 1 every 60 months	Yes	50% Coinsurance after you have met the deductible	Yes	70% Coinsurance after you have met the deductible
Orthodontic Services *All Orthodontic Treatment Requires Preauthorization*				
Only medically necessary orthodontic treatment is covered	Yes	50% Coinsurance after you have met the deductible	Yes	70% Coinsurance after you have met the deductible

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

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

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

Minuteman Health

Translation Information

English	If you, or someone you are helping, have questions about Minuteman Health, you have the right to get help and information in your language at no cost. To speak with an interpreter, call (855) 644-1776.
Arabic	إذا كان لديك أنت، أو شخص ما تقدم له المساعدة، أية أسئلة حول Minuteman Health، يحق لك الحصول على المساعدة والمعلومات بلغتك دون اية تكلفة. للتحدث إلى مترجم فوري، اتصل على الرقم (855) 644-1776.
Brazilian Portuguese	Se você ou alguém que você esteja ajudando tem dúvidas sobre a Minuteman Health, você tem o direito de obter ajuda e informações no seu idioma sem nenhum custo. Para falar com um intérprete, ligue para (855) 644-1776.
Canadian French	Si vous, ou quelqu'un que vous aidez, avez des questions sur Minuteman Health, vous avez le droit d'obtenir de l'aide et une information dans votre langue et ce, gratuitement. Pour parler avec un interprète, appelez le (855) 644-1776.
Greek	Εάν εσείς ή κάποιος τον οποίο βοηθάτε έχει ερωτήσεις για την Minuteman Health, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς κόστος. Για να μιλήσετε με έναν διερμηνέα, καλέστε το (855) 644-1776.
Gujarati	જો તમે અથવા તમે જેને મદદ કરી રહ્યા હો તેવી વ્યક્તિને મિનટમેન હેલ્થ (Minuteman Health) વિશે પ્રશ્નો હોય તો તમારી પાસે વિના મૂલ્યે તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે (855) 644-1776 પર કૉલ કરો.
Haitian Creole	Si ou menm, oswa yon moun ou ap ede, gen kesyon konsènan Minuteman Health, ou gen dwa pou jwenn èd ak enfòmasyon nan lang pa ou gratis. Pou pale ak yon entèprèt, rele (855) 644-1776.
Hindi	अगर आपको या ऐसे किसी व्यक्ति को, जिसकी आप मदद कर रहे हैं, मिनटमैन हेल्थ (Minuteman Health) को लेकर कुछ पूछना है तो आपको अपनी भाषा में मुफ्त सहायता और जानकारी प्राप्त करने का अधिकार है। दुभाषिये के साथ बात करने के लिए (855) 644-1776 पर फोन करें।
Indonesian	Apabila Anda, atau orang yang sedang Anda bantu, memiliki pertanyaan tentang Minuteman Health, Anda berhak untuk mendapat bantuan dan informasi dalam bahasa Anda secara gratis. Untuk berbicara dengan salah seorang penerjemah lisan, hubungi (855) 644-1776.
Italian	In caso di domande da parte vostra, o da parte di persone da voi assistite, in merito a Minuteman Health, avete il diritto di ricevere assistenza e informazioni nella vostra lingua senza alcun costo. Per parlare con un interprete, chiamare il numero (855) 644-1776.
Khmer (Cambodian)	ប្រសិនបើលោកអ្នកឬអ្នកណាម្នាក់ ដែលលោកអ្នកកំពុងតែជួយ ហើយមានសំណួរអំពី កម្មវិធីមុីនុតមេន ហ៊ីល Minuteman Health នោះ លោកអ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មានជាភាសារបស់អ្នកដោយ ឥតគិតថ្លៃ។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែភាសា សូមហៅទូរស័ព្ទលេខ (855) 644-1776 ។
Kirundi	Nimba wowe, canke undimuntu ufasha, mufite ikibazo cerekanye Minuteman Health, mufise uburenganzira bwo kuronka ubufasha na amakuru mururimi rwanyu kubuntu. Kuvugana na umusemuzi, hamagara (855) 644-1776.
Korean	귀하 또는 귀하를 돕고 있는 사람이 Minuteman Health(미니트맨 의료보험)에 대해 질문이 있으면, 귀하께서는 귀하의 언어로 도움과 정보를 무료로 받을 권리가 있습니다. 통역과 말씀하려면, (855) 644-1776으로 전화하십시오.
Mexican Spanish	Si usted, o alguien a quien está ayudando, tiene preguntas sobre Minuteman Health, tiene derecho a obtener ayuda e información en su idioma sin ningún costo. Para hablar con un intérprete, llame al (855) 644-1776.

Translation Information

Nepali	यदि तपाईं, वा तपाईंले मद्दत गर्ने कसैको, मिनिटम्यान हेल्थ (Minuteman Health) बारे प्रश्नहरू भए, तपाईंले कुनै खर्च बेगर आफ्नो भाषामा सहयोग र जानकारी पाउने अधिकार हुन्छ। कुनै दोभाषेसँग कुरा गर्न, (855(644- 1776मा कल गर्नुहोस्।
Polish	Jeśli Ty, lub osoba której oferujesz pomoc, posiada pytania na temat programu Minuteman Health, przysługuje Ci prawo do pomocy oraz informacji w języku ojczystym bez poniesionych kosztów. Tłumacz jest dostępny pod numerem (855) 644-1776.
Russian	Если у вас или у лица, которому вы помогаете, есть вопросы о плане Minuteman Health, вы имеете право бесплатно получить помощь и информацию на вашем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону (855) 644-1776.
Serbo-Croatian	Ako vi ili netko kome pomažete, imate pitanja o Minuteman Health zdravstvenom planu, imate pravo da dobijete pomoć i informacije na svom jeziku bez ikakvih dodatnih troškova. Da biste razgovarali s prevoditeljem, nazovite (855) 644-1776.
Somali	Haddii adiga, ama qof aad caawinaysid, qabo su'aalo ku saabsan Minuteman Health, waxa aad xaq u leedahay inaad heshid caawimaad iyo macluumaad lagugu siiyo luqaddaada kharash la'aan. Si aad ula hadashid turjubaan, wac (855) 644-1776.
Traditional Chinese	如果您或您正在幫助之人士對Minuteman Health存疑，您有權免費獲得母語援助和母語資訊。請致電(855) 644-1776聯絡口譯員。
Vietnamese	Nếu quý vị, hoặc người nào đó mà quý vị đang giúp đỡ, có các thắc mắc về Minuteman Health, thì quý vị có quyền nhận sự giúp đỡ và các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, hãy gọi (855) 644-1776.

Non-Discrimination Information

Minuteman Health (MHI) complies with all applicable state and Federal civil rights laws and does not discriminate, exclude or treat individuals differently on the basis of race, color, national origin, age, disability or sex.

MHI provides the following free language services to people whose primary language is not English: (1) Qualified interpreters available by phone; (2) Plan information available in other languages. If you need these services, contact the Member Services Team at 855-644-1776 Monday through Friday from 8am until 6pm.

If you believe that Minuteman Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex you can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Minuteman Health's Complaints and Appeals Manager is available to help you.

To file by mail, fax, or email contact: Complaints and Appeals Manager; P.O. Box 120025; Boston, MA 02111; 855-644-1776; MA TTY Number: (800) 439-2370; NH TTY Number: (800) 735-2964; Fax: 888-225-8716; appealscomplaints@minutemanhealth.org

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by mail or phone at: U.S. Department of Health and Human Services; 200 Independence Avenue SW, Room 509F; HHH Building; Washington, DC 20201; Phone: 800–368–1019, 800–537–7697 (TTY).

You can also submit a complaint electronically through the Office for Civil Rights Complaint Portal. Forms are available at http:// www.hhs.gov/ocr/office/file/index.html.