# MyDoc PPO National Gold 1500 Plus

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**<br>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.<br>No one Member is responsible for more than the individual deductible. All members accumulate to the family deductible. | Combined Medical and Dental<br>$1,500 per individual<br>$3,000 per family | Combined Medical and Dental<br>$3,000 per individual<br>$6,000 per family |
| **Based on a Policy Year Benefit** | | |
| **Maximum Out-of-Pocket**<br>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.<br>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<br>$3,000 per individual<br>$6,000 per family | Combined Medical and Dental<br>$6,000 per individual<br>$12,000 per family |
| **Reduction of Benefit**<br>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<br>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 | No | $15 Copay | Not Covered | |
| Tier 2 Brand Name (Preferred) | No | $30 Copay | | |
| Tier 3 Brand Name (Non-Preferred) | No | $50 Copay | | |
| Affordable Care Act (ACA) Preventative Drugs | No | $0 Copay | | |
| ***Mail Service Pharmacy (up to 90-day supply)*** | | | | |
| Tier 1 Generics | No | $30 Copay | Not Covered | |
| Tier 2 Brand Name (Preferred) | No | $60 Copay | | |
| Tier 3 Brand Name (Non-Preferred) | No | $150 Copay | | |
| Affordable Care Act (ACA) Preventative Drugs | No | $0 Copay | | |
| Oral Oncology Drugs#<br>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<br>(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 |
| 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 |

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|---|---|---|---|---|
| | Deductible Applies | Copay or Coinsurance | Deductible Applies | Copay or Coinsurance |
| 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) | No | $20 Copay | Yes | 20% Coinsurance after you have met the deductible |
| Specialist Office Visit | No | $40 Copay | 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 | No | $40 Copay | Yes | 20% Coinsurance after you have met the deductible |
| Cardiac Rehabilitation | No | $40 Copay | 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 | No | $40 Copay | 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 | No | $40 Copay | Yes | 20% Coinsurance after you have met the deductible |
| Nutritional Counseling | No | $20 Copay | Yes | 20% Coinsurance after you have met the deductible |
| 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) | No | $40 Copay | 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 | No | $40 Copay | Yes | 20% Coinsurance after you have met the deductible |

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|---|---|---|---|---|
| | Deductible Applies | Copay or Coinsurance | Deductible Applies | Copay or Coinsurance |
| Outpatient Surgical Services and Procedures#<br>(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 | $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 |
| • Physician/Surgeon Fees for services rendered in Hospital, Ambulatory Surgical Center or other approved facility | Yes | $0 Copay after you have met the deductible | Yes | 20% Coinsurance after you have met the deductible |
| • Services rendered in Specialist office | No | $40 Copay | Yes | 20% Coinsurance after you have met the deductible and $750 Reduction of Benefit if Prior Auth is required and not obtained |
| Second Opinions | No | $40 Copay | Yes | 20% Coinsurance after you have met the deductible |
| Third Opinions | No | $40 Copay | 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 | $150 Copay after you have met the deductible | Yes | $150 Copay after you have met the deductible |
| Emergency Room Care<br>(copay waived if admitted) | Yes | $150 Copay after you have met the deductible | Yes | $150 Copay after you have met the deductible |
| Urgent Care Center or Facilities | No | $20 Copay | Yes | 20% Coinsurance 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 | $150 Copay after you have met the deductible | Yes | 20% Coinsurance after you have met the deductible<br>Without Prior Auth, member is responsible for all costs |
| Lab Services | 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 |
| 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 | $100 Copay after you have met the deductible | Yes | 20% Coinsurance after you have met the deductible |
| Sleep Study<br>(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 | $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 |
| Facility Fees for Acute Inpatient Rehabilitation#<br>(limited to up to 60 days per Calendar Year) | 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 |
| Facility Fees for Bariatric Surgery# | 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 |
| Facility Fees for Human Organ Transplants and Bone Marrow Transplants# | 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 |
| Facility Fees for Skilled Nursing Facility#<br>(limited to 100 days per Calendar Year) | 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 |
| Physician/Surgeon Fees for Inpatient services | Yes | $0 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 |
| ***Mental Health and Substance Abuse Services*** | | | | |
| Facility Fees for Mental Health and Substance Abuse Disorder 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 |
| Intermediate services including but not limited to:<br>• Intensive Outpatient Programs<br>• Partial Hospitalization | Yes | $0 Copay after you have met the deductible | Yes | 20% Coinsurance after you have met the deductible |
| Neuropsychological Evaluations# | No | $20 Copay | Yes | 20% Coinsurance after you have met the deductible |
| Office Visits | No | $20 Copay | 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)# | No | $20 Copay | 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 | No | Cost sharing varies by Tier | Not Covered | |
| • Psychiatric Care | No | $20 Copay | Yes | 20% Coinsurance after you have met the deductible |
| • Psychological Care | No | $20 Copay | Yes | 20% Coinsurance after you have met the deductible |
| • Therapeutic Care: | | | | |
| ○ Services provided by licensed or certified speech therapists, occupational therapists, physical therapists | No | $40 Copay | Yes | 20% Coinsurance after you have met the deductible |
| ○ Services provided by licensed or certified social worker | No | $20 Copay | 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 | $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 |
| • Specialist visit (including oral and plastic surgeons, orthodontists, dentist and audiologists) | No | $40 Copay | Yes | 20% Coinsurance after you have met the deductible |
| • Speech therapy | No | $40 Copay | 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#<br>(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 | Yes | $150 Copay after you have met the deductible |
| ***Diabetic Treatment, Services & Supplies*** | | | | |
| • Outpatient Services | No | $40Copay | Yes | 20% Coinsurance after you have met the deductible |
| • Lab Services | Yes | $50 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 |
| ○ 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 |
| • Prescription Drugs | No | Cost sharing varies by Tier | Not Covered | |
| • Group Diabetic Education Services | No | $20 Copay | Yes | 20% Coinsurance after you have met the deductible |
| • Individual Diabetic Education | No | $40 Copay | 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 |

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|---|---|---|---|---|
| | Deductible Applies | Copay or Coinsurance | Deductible Applies | Copay or Coinsurance |
| Prosthetic Limbs | Yes | 20% Coinsurance after you have met the deductible | Yes | 40% Coinsurance after you have met the deductible<br>Without Prior Auth, member is responsible for all costs |
| Wigs (Scalp Hair Prosthesis) for hair loss due to treatment of any form of cancer or leukemia.<br>(one wig per Calendar Year) | 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) | No | $40 Copay | 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 | $0 Copay after you have met the deductible | Yes | 20% Coinsurance after you have met the deductible |
| Non-routine Prenatal and Postpartum Care | No | $40 Copay | Yes | 20% Coinsurance after you have met the deductible |
| ***Infertility Services#*** | | | | |
| • Facility Fees for Inpatient Care# | Yes | $0 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 |
| • Physician/Surgeon Fees for Inpatient Care | Yes | $0 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 Test# | 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 |
| • Office Visit (Deductible may apply to some office services) | No | $40 Copay | 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) | | | | |
| ○ Facility Fees from services rendered in Hospital, Ambulatory Surgical Center or other approved facility | Yes | $0 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 |

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|---|---|---|---|---|
| | **Deductible Applies** | **Copay or Coinsurance** | **Deductible Applies** | **Copay or Coinsurance** |
| ○ Physician/Surgeon Fees for services rendered in Hospital, Ambulatory Surgical Center or other approved facility | Yes | $0 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 |
| ○ Services rendered in PCP Office including OB/GYN, Nurse Practitioner | No | $20 Copay | Yes | 20% Coinsurance after you have met the deductible. Without Prior Auth, member is responsible for all costs |
| ○ Services rendered in Specialist Office | No | $40 Copay | 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 |
| 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# | No | $40 Copay | 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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| • 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 | No | $40 Copay | 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 |
| • 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 | 50% Coinsurance after you have met the deductible | Yes | 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 |

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| 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<br>• 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 |
| 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 |

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| Benefit | In-Plan Providers | | Out-of-Plan Providers | |
|---|---|---|---|---|
| | Deductible Applies | Copay or Coinsurance | Deductible Applies | Copay or Coinsurance |
| 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<br>*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 |

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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.** |
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| ***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:<br>• Weight Watchers® Traditional meetings<br>• Weight Watchers® at Work meetings<br>• Weight Watchers® On-Line |
| Minuteman Health will reimburse membership fee only at one of the fitness facilities listed below per family per Calendar Year:<br>• 6 months of membership at Planet Fitness, W-Fitness or Work out World OR<br>• 3 months of membership at YMCA or Gold's Gym OR<br>• 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