

MyDoc PPO National Gold 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
<p>Deductible per Year</p> <p>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.</p> <p>No one Member is responsible for more than the individual deductible. All members accumulate to the family deductible.</p>	<p>Combined Medical and Dental</p> <p>\$1,000 per individual</p> <p>\$2,000 per family</p>	<p>Combined Medical and Dental</p> <p>\$3,000 per individual</p> <p>\$6,000 per family</p>
<p>Based on a Policy Year Benefit</p>		
<p>Maximum Out-of-Pocket</p> <p>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.</p> <p>No one Member is responsible for more than the Individual Maximum Out-of-Pocket. All Members accumulate to the family Maximum Out-of-Pocket.</p>	<p>Combined Medical, Dental and Prescription Drugs</p> <p>\$5,000 per individual</p> <p>\$10,000 per family</p>	<p>Combined Medical and Dental</p> <p>\$6,000 per individual</p> <p>\$12,000 per family</p>
<p>Reduction of Benefit</p> <p>Applies to certain services if Prior Authorization is required but not obtained.</p>	<p>Not Applicable</p>	<p>\$750</p>

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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	
<i>In-Plan Pharmacy (up to 30-day supply)</i>				
Tier 1 Generics	No	\$20 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		
<i>Mail Service Pharmacy (up to 90-day supply)</i>				
Tier 1 Generics	No	\$40 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# 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	
<i>Preventive Care</i>				
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
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	\$30 Copay	Yes	20% Coinsurance after you have met the deductible
Specialist Office Visit	No	\$45 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	\$45 Copay	Yes	20% Coinsurance after you have met the deductible
Cardiac Rehabilitation	No	\$45 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	\$45 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	\$45 Copay	Yes	20% Coinsurance after you have met the deductible
Nutritional Counseling	No	\$30 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	\$45 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	\$45 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# (some services require Prior Authorization; cost sharing varies by location of service)				
<ul style="list-style-type: none"> Facility Fees from services rendered in Hospital, Ambulatory Surgical Center or other approved facility 	Yes	\$250 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
<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	Yes	20% Coinsurance after you have met the deductible
<ul style="list-style-type: none"> Services rendered in Specialist office 	No	\$45 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	\$45 Copay	Yes	20% Coinsurance after you have met the deductible
Third Opinions	No	\$45 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	\$100 Copay after you have met the deductible	Yes	\$100 Copay after you have met the deductible
Emergency Room Care (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	\$30 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	\$200 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	\$20 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	\$20 Copay after you have met the deductible	Yes	20% Coinsurance 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	Yes	20% Coinsurance after you have met the deductible
<ul style="list-style-type: none"> • 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	\$500 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# (limited to up to 60 days per Calendar Year)	Yes	\$500 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	\$500 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	\$500 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# (limited to 100 days per Calendar Year)	Yes	\$500 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
<i>Mental Health and Substance Abuse Services</i>				
Facility Fees for Mental Health and Substance Abuse Disorder Services	Yes	\$500 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: <ul style="list-style-type: none"> • Intensive Outpatient Programs • Partial Hospitalization 	Yes	\$0 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Neuropsychological Evaluations#	No	\$30 Copay	Yes	20% Coinsurance after you have met the deductible
Office Visits	No	\$30 Copay	Yes	20% Coinsurance after you have met the deductible
<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	\$30 Copay	Yes	20% Coinsurance after you have met the deductible
<ul style="list-style-type: none"> • 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
<ul style="list-style-type: none"> • Prescription drugs 	No	Cost sharing varies by Tier	Not Covered	
<ul style="list-style-type: none"> • Psychiatric Care 	No	\$30 Copay	Yes	20% Coinsurance after you have met the deductible
<ul style="list-style-type: none"> • Psychological Care 	No	\$30 Copay	Yes	20% Coinsurance after you have met the deductible
<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 ○ Services provided by licensed or certified social worker 	No	\$45 Copay	Yes	20% Coinsurance after you have met the deductible
	No	\$30 Copay	Yes	20% Coinsurance after you have met the deductible
<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	\$500 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
<ul style="list-style-type: none"> Specialist visit (including oral and plastic surgeons, orthodontists, dentist and audiologists) 	No	\$45 Copay	Yes	20% Coinsurance after you have met the deductible
<ul style="list-style-type: none"> Speech therapy 	No	\$45 Copay	Yes	20% Coinsurance after you have met the deductible
<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	Yes	\$150 Copay after you have met the deductible
<i>Diabetic Treatment, Services & Supplies</i>				
<ul style="list-style-type: none"> Outpatient Services 	No	\$45 Copay	Yes	20% Coinsurance after you have met the deductible
<ul style="list-style-type: none"> Lab Services 	Yes	\$20 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> Prescription Drugs 	No	Cost sharing varies by Tier	Not Covered	
<ul style="list-style-type: none"> Group Diabetic Education Services 	No	\$30 Copay	Yes	20% Coinsurance after you have met the deductible
<ul style="list-style-type: none"> Individual Diabetic Education 	No	\$45 Copay	Yes	20% Coinsurance after you have met the deductible
<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	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 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. (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	\$45 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	\$500 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Non-routine Prenatal and Postpartum Care	No	\$45 Copay	Yes	20% Coinsurance after you have met the deductible
Infertility Services#				
<ul style="list-style-type: none"> • Facility Fees for Inpatient Care# 	Yes	\$500 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
<ul style="list-style-type: none"> • 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
<ul style="list-style-type: none"> • Lab Test# 	Yes	\$20 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
<ul style="list-style-type: none"> • Office Visit (Deductible may apply to some office services) 	No	\$45 Copay	Yes	20% Coinsurance after you have met the deductible. Without Prior Auth, member is responsible for all costs
<ul style="list-style-type: none"> • Outpatient Surgery & Procedures# (cost sharing varies by location of service) <ul style="list-style-type: none"> ○ Facility Fees from services rendered in Hospital, Ambulatory Surgical Center or other approved facility 				
<ul style="list-style-type: none"> ○ Facility Fees from services rendered in Hospital, Ambulatory Surgical Center or other approved facility 	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

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	Deductible Applies	Copay or Coinsurance	Deductible Applies	Copay or Coinsurance
<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	Yes	20% Coinsurance after you have met the deductible. Without Prior Auth, member is responsible for all costs
<ul style="list-style-type: none"> ○ Services rendered in PCP Office including OB/GYN, Nurse Practitioner 	No	\$30 Copay	Yes	20% Coinsurance after you have met the deductible. Without Prior Auth, member is responsible for all costs
<ul style="list-style-type: none"> ○ Services rendered in Specialist Office 	No	\$45 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:				
<ul style="list-style-type: none"> • Speech Therapy# 	No	\$45 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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<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	Yes	20% Coinsurance after you have met the deductible and \$750 Reduction of Benefit if Prior Auth is required and not obtained
<ul style="list-style-type: none"> Licensed audiologist or hearing instrument specialist visits 	No	\$45 Copay	Yes	20% Coinsurance after you have met the deductible
<ul style="list-style-type: none"> 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
<i>Pediatric Vision Services for members under age 19</i>				
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)				
<ul style="list-style-type: none"> Contact lens evaluation/fitting 	No	\$0 Copay	Yes	20% Coinsurance after you have met the deductible
<ul style="list-style-type: none"> Contact lenses 	Yes	50% Coinsurance after you have met the deductible	Yes	70% Coinsurance after you have met the deductible
<i>Pediatric Dental Services for members under age 19</i>				
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 <ul style="list-style-type: none"> • 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

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

MyDoc PPO National Gold Plus

Effective 1/1/2017

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 <i>All Orthodontic Treatment Requires Preauthorization</i>				
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

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

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