MyDoc HMO Platinum Basic

Effective Date 1/1/2016

Summary of Benefits Chart

Your Minuteman Health HMO Plan
This chart provides a summary of key services offered by your plan. Your Policy/Member Agreement has a full description of your plan's benefits and provisions.

Note about Prior Authorization:
Some services require Prior Authorization. These services are marked with "#" in the chart. In some cases, if you do not obtain Prior Authorization, benefits may be denied and you may be responsible for all costs.

	In-Plan
Deductible per Year* You must pay this amount for Covered Services before MHI will begin to pay benefits. As indicated in the chart below, some services are not subject to the deductible. No one Member is responsible for more than the individual deductible. All members accumulate to the family deductible.	N/A
***Calendar Year Benefits**	
Maximum Out-of-Pocket* You are protected by an Out-of-Pocket Maximum each year. Once you reach this amount you will not have to pay Copays, Coinsurance, Deductibles for the remainder of the year. Included in your Out-of-Pocket Maximum are your Deductible, Copays and Coinsurance. No one Member is responsible for more than the Individual Maximum Out-of-Pocket. All Members accumulate to the family Maximum Out-of-Pocket.	Combined Medical and Prescription Drugs: $2,000 per individual $4,000 per family

If you have further questions, please call the Minuteman Member Services Line at 1-855-MHI-1776, Monday – Friday, 8 a.m. to 5 p.m. or visit www.minutemanhealth.org

MyDoc HMO Platinum Basic

Effective Date 1/1/2016

Benefit	Deductible Applies	Copay or Coinsurance
Prescription Drugs *Contraceptive methods approved by FDA and prescribed for a woman by her health care provider, subject to reasonable medical management, will be covered without cost sharing requirements.	Please see the Prescription Drug section in your Policy for details about your prescription drug coverage	
In-Plan Pharmacy (up to 30-day supply)		
Tier 1 Generics	No	$15 Copay
Tier 2 Brand Name (Preferred)	No	$30 Copay
Tier 3 Brand Name (Non-Preferred)	No	$50 Copay
Mail Service Pharmacy (up to 90-day supply)		
Tier 1 Generics	No	$30 Copay
Tier 2 Brand Name (Preferred)	No	$60 Copay
Tier 3 Brand Name (Non-Preferred)	No	$150 Copay
Oral Oncology Drugs# Please see the Prescription Drug Rider to your EOC for details about your coverage.	Your payment responsibilities for prescribed oral oncology medications will be covered at the same level as intravenously administered or injected cancer medications that are covered as medical benefits.	
Preventive Care		
Adult Routine Exams	No	$0
Preventive Screenings (listed under "Outpatient Preventive Care" in the Covered Benefits Section of the EOC)	No	$0
Routine Child and Adult Immunizations	No	$0
Routine Eye Exams for Adults (limited to one per Calendar Year)	No	$0
Routine Eye Exams for Children (limited to one per Calendar Year)	No	$0
Routine Prenatal and Postpartum Care	No	$0
Routine Mammograms (limited to one per Calendar Year)	No	$0
Screening Colonoscopy or Sigmoidoscopy (limited to one every five Calendar Years, office visits prior to the procedure are subject to applicable Deductible and Copays/Coinsurance)	No	$0
Well Child Care	No	$0
Women's Preventive Services including one routine gynecological exam per Calendar Year	No	$0
Outpatient Care		
Primary Care Office Visit (Non-Routine)	No	$25 Copay
Specialist Office Visit	No	$40 Copay
Allergy Injections	No	$0 Copay
Allergy Testing	No	$40 Copay
Cardiac Rehabilitation	No	$40 Copay
Chemotherapy and Radiation Therapy	No	$0 Copay
Chiropractic Services (limited to 12 visits per Calendar Year)	No	$40 Copay
Early Intervention Services (Covered for children from birth to age 3)	No	$0 Copay
Hearing Tests	No	$40 Copay
Mental Health and Substance Abuse Disorder Office Visit	No	$25 Copay
Nutritional Counseling	No	$25 Copay

If you have further questions, please call the Minuteman Member Services Line at 1-855-MHI-1776, Monday – Friday, 8 a.m. to 5 p.m. or visit www.minutemanhealth.org

MyDoc HMO Platinum Basic

Effective Date 1/1/2016

Benefit	Deductible Applies	Copay or Coinsurance
Short-Term Rehabilitation Services# (limited to 60 visits per member per Calendar Year for a combination of physical and occupational therapies). Benefit limit does not apply for covered services to treat Autism spectrum disorders.	No	$40 Copay
Outpatient Habilitation Services# (limited to 60 visits per member per Calendar Year for a combination of physical and occupational therapies). Benefit limit does not apply for covered services to treat Early Intervention.	No	$40 Copay
Outpatient Surgical Services and Procedures # (some services require Prior Authorization; cost sharing varies by location of service)		
• Facility Fees from Hospital, Ambulatory Surgical Center or other approved facility	No	$500 Copay
• Physician/Surgeon Fees for services rendered in Hospital, Ambulatory Surgical Center or other approved facility	No	$0 Copay
• Services rendered in Specialist Office	No	$40 Copay
Second Opinions	No	$40 Copay
Emergency & Urgent Care		
Ambulance and Transportation Services # (non-emergency transportation requires Prior Authorization. If Prior Authorization is not obtained for non-emergency transportation, member pays all costs)	No	$50 Copay
Emergency Room Care (copay waived if admitted)	No	$150 Copay
Urgent Care Center or Facilities	No	$25 Copay
Labs, Tests and Imaging		
Diagnostic Imaging# - CT Scans, MRIs, MRAs, PET Scans, Nuclear Cardiac Imaging (Prior Authorization Required. Nuclear Cardiac Imaging requires Prior Authorization only when done in doctor's office)	No	$150 Copay
Lab Services	No	$0 Copay
Other Diagnostic Testing (some services such as sigmoidoscopies, endoscopies, colonoscopies, arthroscopies, needle aspirations, and biopsies are covered under the Outpatient Surgical Services and Procedures Copay/Coinsurance benefit)	See Outpatient Surgical Services and Procedures benefit	Cost sharing varies by location of service
Radiological Services – Ultrasound, X-rays, Non-Routing Mammograms	No	$0 Copay
Sleep Study (maximum of two per Calendar Year)		
• Approved Facility	No	$250 Copay, One Copay per year
• Home sleep study	No	$0 Copay
Inpatient Care		
Facility Fees for Acute Hospital Care#	No	$500 Copay
Facility Fees for Acute Inpatient Rehabilitation # (limited to up to 60 days per Calendar Year)	No	$500 Copay

If you have further questions, please call the Minuteman Member Services Line at 1-855-MHI-1776, Monday – Friday, 8 a.m. to 5 p.m. or visit www.minutemanhealth.org

Benefit	Deductible Applies	Copay or Coinsurance
Facility Fees for Bariatric Surgery#	No	$500 Copay
Facility fees for Human Organ Transplants and Bone Marrow Transplants#	No	$500 Copay
Facility Fees for Inpatient Mental Health and Substance Abuse Disorder Services#	No	$500 Copay
Facility Fees for Skilled Nursing Facility# (limited to 100 days per Calendar Year)	No	$500 Copay
Physician/Surgeon Fees for Inpatient Services	No	$0 Copay
Autism Spectrum Disorder #		
Services to diagnose and treat Autism Spectrum Disorder include:		
• Habilitative or Rehabilitative care Includes applied behavioral analysis (ABA)#	No	$25 Copay
• Neuropsychological evaluations#	No	$40 Copay
• Other test to diagnose ASD# (some tests may require Prior Approval)	Depends on type of test as listed elsewhere in this chart (Lab Services, Diagnostic Imaging, Diagnostic Testing, etc.)	Copay amount depends on type of test as listed elsewhere in this chart (Lab Services, Diagnostic Imaging, Diagnostic Testing, etc.)
• Prescription drugs	No	Cost sharing varies by Tier
• Psychiatric care	No	$25 Copay
• Psychological care	No	$25 Copay
• Therapeutic care:		
○ Services provided by licensed or certified speech therapists, occupational therapists, physical therapists	No	$40 Copay
○ Services provided by licensed or certified social worker	No	$25 Copay
Cleft Palate and Cleft Lip for Children#		
Services to cover the treatment of cleft lip and cleft palate includes:		
• Medical, dental, oral and facial surgery	No	$500 Copay
• Specialist visit (including oral and plastic surgeons, orthodontists, dentist and audiologists)	No	$40 Copay
• Speech therapy	No	$40 Copay
Dental Services		
On Exchange Pediatric Dental Services for members under age 19	Please see the Explanation of Coverage for Your Health Connector-certified Dental Plan purchased separately.	
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	No	$150 Copay
Diabetic Treatment, Services & Supplies		
• Outpatient Services	No	$40 Copay
• Lab Services	No	$0 Copay
• Durable Medical Equipment#	No	20% Coinsurance
• Insulin Pumps & Insulin Pump Supplies#	No	$0 Copay
• Prescription Drugs	No	Cost sharing varies by Tier

MyDoc HMO Platinum Basic

Effective Date 1/1/2016

Benefit	Deductible Applies	Copay or Coinsurance
• Group Diabetic Education Services	No	$25 Copay
• Individual Diabetic Education	No	$40 Copay
Durable Medical Equipment, Prosthetic Equipment & Medical/Surgical Supplies		
Durable Medical Equipment# (some items require Prior Authorization)	No	20% Coinsurance
Prosthetic Limbs#	No	20% Coinsurance
Wigs (Scalp Hair Prosthesis) for hair loss due to treatment of any form of cancer or leukemia (one wig per Calendar Year)	No	20% Coinsurance
Family Planning Services		
Office Visit (Deductible may apply to some office services)	No	$40 Copay
Other Services		
Home Health Care Services#	No	$0 Copay
Hospice Services#	No	$0 Copay
Infusion Therapy#	No	$0 Copay
Kidney Dialysis	No	$0 Copay
Nutritional Support including non-prescription enteral formulas#	No	$0 Copay
Maternity Care		
Delivery/Hospital Care for Mother and Child (coverage for child limited to routine newborn nursery charges. For continued coverage, child must be enrolled within 31 days of date of birth)	No	$500 Copay
Non-routine Prenatal and Postpartum Care	No	$40 Copay
Infertility Services#		
• Facility Fees for Inpatient Care#	No	$500 Copay
• Physician/Surgeon Fees for Inpatient Care	No	$0 Copay
• Lab Test#	No	$0 Copay
• Office Visit# (Deductible may apply to some office services)	No	$40 Copay
• Outpatient Surgery & Procedures# (cost sharing varies by location of service)		
○ Facility Fees for Hospital, Ambulatory Surgical Center or other approved facility	No	$500 Copay
○ Physician/Surgeon Fees for services rendered in Hospital, Ambulatory Surgical Center or other approved facility	No	$0 Copay
○ Services rendered in PCP Office including OB/GYN, Nurse Practitioner	No	$25 Copay
○ Services rendered in Specialist Office	No	$40 Copay
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
• One hearing aid per hearing impaired ear every 36 months, up to $2,000 for each hearing aid	No	$0 Copay
• Licensed audiologist or hearing instrument specialist visits	No	$40 Copay
• Supplies, including ear molds	No	20% Coinsurance

If you have further questions, please call the Minuteman Member Services Line at 1-855-MHI-1776, Monday – Friday, 8 a.m. to 5 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. Call 866-389-7613
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 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