MyDoc PPO Select Silver HSA 2000

Effective Date 1/1/2016

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. This is a Health Savings Account (HSA) compatible plan. For family policies the plan will begin to pay benefits once any individual or combination of individuals has met the family deductible.	Combined Medical and Prescription Drugs $2,000** per individual $4,000** per family	Medical Only $4,000 per individual $8,000 per family
***May be based on a Calendar Year or Policy Year Basis**		
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. This is a Health Savings Account compatible plan. For family policies, no one family Member is responsible for more than $6,850** of the family Out-of-Pocket Maximum for In-Plan Providers and $11,850** for Out-of-Plan Providers.	Combined Medical and Prescription Drugs $5,500 per individual $11,000 per family	Medical Only $10,500 per individual $21,000 per family
Reduction of Benefit Applies to certain services if Prior Authorization is required but not obtained.	Not Applicable	$750

**Amount to increase annually as allowed by federal and/or state law or regulation.

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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	$20 Copay after you have met the deductible	Not Covered	
Tier 2 Brand Name (Preferred)	Yes	50% Coinsurance after you have met the deductible	Not Covered	
Tier 3 Brand Name (Non-Preferred)	Yes	50% Coinsurance after you have met the deductible	Not Covered	
Mail Service Pharmacy (up to 90-day supply)				
Tier 1 Generics	Yes	$40 Copay after you have met the deductible	Not Covered	
Tier 2 Brand Name (Preferred)	Yes	50% Coinsurance after you have met the deductible	Not Covered	
Tier 3 Brand Name (Non-Preferred)	Yes	50% Coinsurance after you have met the deductible	Not Covered	
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.		Not Covered	
Preventive Care				
Adult Routine Exams	No	$0	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	Yes	20% Coinsurance after you have met the deductible
Routine Child and Adult Immunizations	No	$0	Yes	20% Coinsurance after you have met the deductible
Routine Eye Exams for Adults (limited to one per Calendar Year)	No	$0	Yes	20% Coinsurance after you have met the deductible
Routine Eye Exams for Children (Limited to one per Calendar Year)	No	$0	Yes	20% Coinsurance after you have met the deductible
Routine Prenatal and Postpartum Care	No	$0	Yes	20% Coinsurance after you have met the deductible
Routine Mammograms (limited to one per Calendar Year)	No	$0	Yes	20% Coinsurance after you have met the deductible

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	Deductible Applies	Copay or Coinsurance	Deductible Applies	Copay or Coinsurance
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	Yes	20% Coinsurance after you have met the deductible
Well Child Care	No	$0	Yes	20% Coinsurance after you have met the deductible
Women's Preventive Services including one routine gynecological exam per Calendar Year	No	$0	Yes	20% Coinsurance after you have met the deductible
Outpatient Care				
Primary Care Office Visit (Non-Routine)	Yes	$30 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Specialist Office Visit	Yes	$45 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	$45 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Cardiac Rehabilitation	Yes	$45 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 (limited to 12 visits per Calendar Year)	Yes	$45 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)	Yes	$0 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Hearing Tests	Yes	$45 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Mental Health and Substance Abuse Disorder Office Visit	Yes	$30 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Nutritional Counseling	Yes	$30 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	$45 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	$45 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	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
• Physician/Surgeon Fees for services rendered in Hospital, Ambulatory Surgical Center or other approved facility	Yes	20% Coinsurance after you have met the deductible	Yes	40% Coinsurance after you have met the deductible
• Services rendered in Specialist Office	Yes	$45 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	$45 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	20% Coinsurance after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Emergency Room Care (copay waived if admitted)	Yes	20% Coinsurance after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Urgent Care Center or Facilities	Yes	$30 Copay after you have met the deductible	Yes	$30 Copay 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	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.
Lab Services	Yes	20% Coinsurance after you have met the deductible	Yes	40% 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)	See Outpatient Surgical Services and Procedures	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% Coinsurance after you have met the deductible	Yes	40% Coinsurance after you have met the deductible
Sleep Study (maximum of two per Calendar Year)				
• Approved Facility	Yes	20% Coinsurance after you have met the deductible	Yes	40% 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	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
Facility Fees for Acute Inpatient Rehabilitation # (limited to up to 60 days per Calendar Year)	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
Facility Fees for Bariatric Surgery#	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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Benefit	In-Plan Providers		Out-of-Plan Providers	
	Deductible Applies	**Copay or Coinsurance**	**Deductible Applies**	**Copay or Coinsurance**
Facility Fees for Human Organ Transplants and Bone Marrow Transplants#	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
Facility Fees for Inpatient Mental Health and Substance Abuse Disorder Services#	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
Facility Fees for Skilled Nursing Facility# (limited to 100 days per Calendar Year)	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
Physician/Surgeon Fees for Inpatient services	Yes	20% Coinsurance after you have met the deductible	Yes	40% 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	$30 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
• Neuropsychological evaluations#	Yes	$45 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
• 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.)	Yes	20% Coinsurance after you have met the deductible
• Prescription drugs	See Prescription Drug Benefit	Cost sharing varies by Tier	Not Covered	
• Psychiatric Care	Yes	$45 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
• Psychological Care	Yes	$45 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:				
○ Services provided by licensed or certified speech therapists, occupational therapists, physical therapists	Yes	$45 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
○ Services provided by licensed or certified social worker	Yes	$30 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	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
• Specialist visit (including oral and plastic surgeons, orthodontists, dentist and audiologists)	Yes	$45 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
• Speech therapy	Yes	$45 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
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	Yes	20% Coinsurance after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Diabetic Treatment, Services & Supplies				
• Outpatient Services	Yes	$45 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
• Lab Services	Yes	20% Coinsurance after you have met the deductible	Yes	40% 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 & $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 & $750 Reduction of Benefit if

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	Deductible Applies	**Copay or Coinsurance**	**Deductible Applies**	**Copay or Coinsurance**
				Prior Auth is required and not obtained.
• Prescription Drugs	See Prescription Drug Benefit	Cost sharing varies by Tier	Not Covered	
• Group Diabetic Education Services	Yes	$30 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
• Individual Diabetic Education	Yes	$45 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 & $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 Authorization member pays 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	$45 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Other Services#				
Home Health Care Services#	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
Hospice Services#	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
Infusion Therapy#	Yes	20% Coinsurance after you have met the deductible	Yes	40% Coinsurance after you have met the deductible and $750

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	Deductible Applies	Copay or Coinsurance	Deductible Applies	Copay or Coinsurance
				Reduction of Benefit if Prior Auth is required and not obtained
Kidney Dialysis	Yes	20% Coinsurance after you have met the deductible	Yes	40% Coinsurance after you have met the deductible
Nutritional Support including non-prescription enteral formulas#	Yes	20% Coinsurance after you have met the deductible	Yes	40% 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	20% Coinsurance after you have met the deductible	Yes	40% Coinsurance after you have me the deductible
Non-routine Prenatal and Postpartum Care	Yes	$45 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible
Infertility Services#				
• Facility Fees for Inpatient Care#	Yes	20% Coinsurance after you have met the deductible	Yes	40% Coinsurance after you have met the deductible. Without Prior Auth member pays all costs.
• Physician/Surgeon Fees for Inpatient Care	Yes	20% Coinsurance after you have met the deductible	Yes	40% Coinsurance after you have met the deductible. Without Prior Auth member pays all costs.
• Lab Test#	Yes	20% Coinsurance after you have met the deductible	Yes	40% Coinsurance after you have met the deductible. Without Prior Auth member pays all costs.
• Office Visit (Deductible may apply to some office services)	Yes	$45 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible. Without Prior Auth member pays 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	20% Coinsurance after you have met the deductible	Yes	40% Coinsurance after you have met the deductible. Without Prior Auth member pays all costs.
○ Physician/Surgeon Fees for services rendered in Hospital, Ambulatory Surgical Center or other approved facility	Yes	20% Coinsurance after you have met the deductible	Yes	40% Coinsurance after you have met the deductible. Without Prior Auth member pays all costs.

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	Deductible Applies	**Copay or Coinsurance**	**Deductible Applies**	**Copay or Coinsurance**
○ Services rendered in PCP Office including OB/GYN, Nurse Practitioner	Yes	$30 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible. Without Prior Auth member pays all costs.
○ Services rendered in Specialist Office	Yes	$45 Copay after you have met the deductible	Yes	20% Coinsurance after you have met the deductible. Without Prior Auth member pays all costs.
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	$45 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	$45 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

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 <u>one</u> 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