MyDoc HMO Silver Plus

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*	Combined Medical and Prescription Drugs
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.	$2,000 per individual $4,000 per family
No one Member is responsible for more than the individual deductible. All members accumulate to the family deductible	
***Calendar Year Benefits**	
Maximum Out-of-Pocket*	Combined Medical and Prescription Drugs:
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.	$6,850 per individual** $13,700 per family**
No one Member is responsible for more than the Individual Maximum Out-of-Pocket. All Members accumulate to the family Maximum Out-of-Pocket.	

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

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 Silver Plus

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	$13 Copay
Tier 2 Brand Name (Preferred)	Yes	$30 Copay after you have met the deductible
Tier 3 Brand Name (Non-Preferred)	Yes	$50 Copay after you have met the deductible
Mail Service Pharmacy (up to 90-day supply)		
Tier 1 Generics	No	$26 Copay
Tier 2 Brand Name (Preferred)	Yes	$60 Copay after you have met the deductible
Tier 3 Brand Name (Non-Preferred)	Yes	$150 Copay after you have met the deductible
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)	Yes	$15 Copay after you have met the deductible
Specialist Office Visit	Yes	$45 Copay after you have met the deductible
Allergy Injections	Yes	$0 Copay after you have met the deductible
Allergy Testing	Yes	$45 Copay 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 5 p.m. or visit www.minutemanhealth.org

Benefit	Deductible Applies	Copay or Coinsurance
Cardiac Rehabilitation	Yes	$45 Copay after you have met the deductible
Chemotherapy and Radiation Therapy	Yes	$0 after you have met the deductible
Chiropractic Services (limited to 12 visits per Calendar Year)	Yes	$45 Copay after you have met the deductible
Early Intervention Services (Covered for children from birth to age 3)	No	$0 Copay
Hearing Tests	Yes	$45 Copay after you have met the deductible
Mental Health and Substance Abuse Disorder Office Visit	Yes	$15 Copay after you have met the deductible
Nutritional Counseling	Yes	$15 Copay after you have met the deductible
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.	Yes	$45 Copay 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
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	$750 Copay after you have met the deductible
• Physician/Surgeon Fees for services rendered in Hospital, Ambulatory Surgical Center or other approved facility	Yes	$0 Copay after you have met the deductible
• Services rendered in Specialist Office	Yes	$45 Copay after you have met the deductible
Second Opinions	Yes	$45 Copay after you have met the deductible
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)	Yes	$250 Copay after you have met the deductible
Emergency Room Care (copay waived if admitted)	Yes	$350 Copay after you have met the deductible
Urgent Care Center or Facilities	Yes	$15 Copay 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	$400 Copay 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 5 p.m. or visit www.minutemanhealth.org

Benefit	Deductible Applies	Copay or Coinsurance
Lab Services	Yes	$50 Copay 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 benefit	Cost sharing varies by location of service
Radiological Services – Ultrasound, X-rays, Non-Routing Mammograms	Yes	$150 Copay after you have met the deductible
Sleep Study (maximum of two per Calendar Year)		
• Approved Facility	Yes	$250 after you have met the deductible. One Copay per year
• Home sleep study	Yes	$0 copay after you have met the deductible
Inpatient Care		
Facility Fees for Acute Hospital Care#	Yes	$1,000 Copay after you have met the deductible
Facility Fees for Acute Inpatient Rehabilitation # (limited to up to 60 days per Calendar Year)	Yes	$1,000 Copay after you have met the deductible
Facility Fees for Bariatric Surgery#	Yes	$1,000 Copay after you have met the deductible
Facility Fees for Human Organ Transplants and Bone Marrow Transplants#	Yes	$1,000 Copay after you have met the deductible
Facility Fees for Inpatient Mental Health and Substance Abuse Disorder Services#	Yes	$1,000 Copay after you have met the deductible
Facility Fees for Skilled Nursing Facility# (limited to 100 days per Calendar Year)	Yes	$1,000 Copay after you have met the deductible
Physician/Surgeon Fees for Inpatient Services	Yes	$0 Copay 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	$15 Copay after you have met the deductible
• Neuropsychological evaluations#	Yes	$45 Copay 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.)
• Prescription drugs	See Prescription Drug benefit	Cost sharing varies by Tier
• Psychiatric care	Yes	$15 Copay after you have met the deductible
• Psychological care	Yes	$15 Copay 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 5 p.m. or visit www.minutemanhealth.org

Benefit	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
○ Services provided by licensed or certified social worker	Yes	$15 Copay 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	$1,000 Copay after you have met the deductible
• Specialist visit (including oral and plastic surgeons, orthodontists, dentist and audiologists)	Yes	$45 Copay after you have met the deductible
• Speech therapy	Yes	$45 Copay 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	$350 Copay after you have met the deductible
Diabetic Treatment, Services & Supplies		
• Outpatient Services	Yes	$45 Copay after you have met the deductible
• Lab Services	Yes	$50 Copay after you have met the deductible
• Durable Medical Equipment#	Yes	20% Coinsurance after you have met the deductible
• Insulin Pumps & Insulin Pump Supplies#	Yes	$0 Copay after you have met the deductible
• Prescription Drugs	See Prescription Drug benefit	Cost sharing varies by Tier
• Group Diabetic Education Services	Yes	$15 Copay after you have met the deductible
• Individual Diabetic Education	Yes	$45 Copay 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
Prosthetic Limbs#	Yes	20% Coinsurance after you have met the deductible
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
Family Planning Services		
Office Visit (Deductible may apply to some office services)	Yes	$45 Copay 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 5 p.m. or visit www.minutemanhealth.org

Benefit	Deductible Applies	Copay or Coinsurance
Other Services		
Home Health Care Services#	Yes	$0 Copay after you have met the deductible
Hospice Services#	Yes	$0 Copay after you have met the deductible
Infusion Therapy#	Yes	$0 Copay after you have met the deductible
Kidney Dialysis	Yes	$0 Copay after you have met the deductible
Nutritional Support including non-prescription enteral formulas#	Yes	$0 Copay 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	$1,000 Copay after you have met the deductible
Non-routine Prenatal and Postpartum Care	Yes	$45 Copay after you have met the deductible
Infertility Services#		
• Facility Fees for Inpatient Care#	Yes	$1,000 Copay after you have met the deductible
• Physician/Surgeon Fees for Inpatient Care	Yes	$0 Copay after you have met the deductible
• Lab Test#	Yes	$50 Copay after you have met the deductible
• Office Visit# (Deductible may apply to some office services)	Yes	$45 Copay after you have met the deductible
• 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	$750 Copay after you have met the deductible
○ Physician/Surgeon Fees for services rendered in Hospital, Ambulatory Surgical Center or other approved facility	Yes	$0 Copay after you have met the deductible
○ Services rendered in PCP Office including OB/GYN, Nurse Practitioner	Yes	$15 Copay after you have met the deductible
○ Services rendered in Specialist Office	Yes	$45 Copay after you have met the deductible
Speech, Hearing, and Language Disorders# (Prior Approval is required for speech therapy services after the initial evaluation). This includes coverage for hearing aids for Members age 21 or younger as follows:		
• Speech Therapy#	Yes	$45 Copay after you have met the deductible
• 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
• Licensed audiologist or hearing instrument specialist visits	Yes	$45 Copay after you have met the deductible
• Supplies, including ear molds	Yes	20% 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 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 <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

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