ConnectiCare

# Small Group Market
# Choice Mass HMO Copay $40
# HMO Open Access Calendar Year Plan
# Benefit Summary
# Non-Tiered Network Plan

✔ This health plan meets Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance. Please refer to the "Important Information" section of this Benefit Summary for additional information.

| **Deductible and Out-of-Pocket Maximum** | **In-Network (INET) Member Pays** | **Out-of-Network (OON) Member Pays** |
|---|---|---|
| **Plan deductible** | $0 per member<br>$0 per family | N/A per member<br>N/A per family |
| **Separate Prescription Drug Deductible** | None | N/A per member<br>N/A per family |
| **Out-of-Pocket Maximum**<br>Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services | $7,900 per member<br>$15,800 per family | N/A per member<br>N/A per family |
| **Benefits** | **In-Network (INET) Member Pays** | **Out-of-Network (OON) Member Pays** |
| **Provider Office Visits** | | |
| **Adult/Pediatric Preventive Visits** | No charge | Not covered |
| **Primary Care Provider Office Visits**<br>(includes services for illness, injury, follow-up care and consultations) | $40 copayment/visit | Not covered |
| **Specialist Office Visits** | $60 copayment/visit | Not covered |
| **Mental Health and Substance Abuse Office Visits** | $40 copayment/visit | Not covered |
| **Outpatient Diagnostic Services** | | |
| **Advanced Radiology**<br>(CT/PET Scan, MRI) | $200 copayment/visit | Not covered |
| **Laboratory Services** | $25 copayment/visit | Not covered |
| **Non-Advanced Radiology**<br>(X-ray, Diagnostic) | $60 copayment/visit | Not covered |
| **Prescription Drugs – Retail Pharmacy (cost share based on 30 day supply per prescription)** | | |

| Benefits | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|---|---|---|
| **Preferred Generic**<br>Tier 1 | $30 copayment/prescription | Not covered |
| **Non-preferred Generic**<br>Tier 2 | 50% coinsurance up to a maximum of $300 per prescription | Not covered |
| **Preferred Brand**<br>Tier 3 | $60 copayment/prescription | Not covered |
| **Non-Preferred Brand**<br>Tier 4 | 50% coinsurance up to a maximum of $300 per prescription | Not covered |
| **Specialty Drugs – (cost share up to 30 day supply per prescription - These drugs generally require pre-authorization and may require special handling)** | | |
| **Preferred Specialty**<br>Tier 5 | 50% coinsurance up to a maximum of $350 per prescription (specialty retail only) | Not covered |
| **Non-Preferred Specialty**<br>Tier 6 | 50% coinsurance up to a maximum of $750 per prescription (specialty retail only) | Not covered |
| **Prescription – Mail Order Pharmacy (up to a 90 day supply per prescription)** | | |
| **Preferred Generic**<br>Tier 1 | $60 copayment/prescription | Not covered |
| **Non-preferred Generic**<br>Tier 2 | 50% coinsurance up to a maximum of $600 per prescription | Not covered |
| **Preferred Brand**<br>Tier 3 | $120 copayment/prescription | Not covered |
| **Non-Preferred Brand**<br>Tier 4 | 50% coinsurance up to a maximum of $600 per prescription | Not covered |
| **Outpatient Rehabilitative and Habilitative Services 60 visits per calendar year limit combined for physical and occupational therapies. Separate 60 visits per calendar year limit combined for Habilitative physical and occupational therapies.** | | |
| **Speech Therapy** | $50 copayment/visit | Not covered |
| **Physical and Occupational Therapy**<br>up to 60 visits per calendar year (includes services combined for physical and occupational therapy)<br>Speech and hearing therapy, prescribed by applicable law, apply to, but are not limited by the visit maximum | $50 copayment/visit | Not covered |

| Benefits | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|---|---|---|
| **Other Services** | | |
| **Chiropractic Services** up to 20 visits per year | $50 copayment/visit | Not covered |
| **Diabetic Equipment and Supplies** | 20% coinsurance | Not covered |
| **Durable Medical Equipment** (DME) | 20% coinsurance | Not covered |
| **Home Health Care Services** | No charge | Not covered |
| **Outpatient Services** (in a hospital or ambulatory facility) | $250 copayment/visit at an Ambulatory Facility<br><br>$500 copayment/visit at an Outpatient Hospital Facility | Not covered |
| **Inpatient Services** | | |
| **Inpatient hospital services include mental health, substance abuse, maternity, hospice, skilled nursing facility* and all IP settings.** (*skilled nursing facility stay is limited to 100 days per Calendar year) | $500 copayment/day up to $1,000 per admission | Not covered |
| **Emergency and Urgent Care** | | |
| **Ambulance Services** | No charge | Same as In-network benefit |
| **Emergency Room** copayment waived if admitted | $400 copayment/visit | Same as In-network benefit |
| **Urgent Care Centers** | $100 copayment/visit | Same as In-network benefit |
| **Pediatric Dental Care (for children under age 20)** | | |
| **Diagnostic & Preventive** | No charge | Not covered |
| **Basic Services** | 50% coinsurance | Not covered |
| **Major Services** | 50% coinsurance | Not covered |
| **Orthodontia Services** (medically necessary only) | 50% coinsurance | Not covered |
| **Pediatric Vision Care (for children under age 20)** | | |
| **Prescription Eye Glasses** one pair of frames and lenses per year | Lenses: $50<br>Collection frames: $50<br>Non-collection frames: $50 up to the collection frame allowance; any amount over is payable by the member minus a 20% discount | Not covered |

| Benefits | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|---|---|---|
| **Routine Eye Exam by a Specialist**<br>up to one visit per year | $50 copayment/visit | Not covered |
| **Additional Covered Services** | | |
| **Adult Routine Eye Exam by a Specialist - over age 20**<br>up to one visit per year | $50 copayment/visit | Not covered |
| **Allergy Injections**<br>up to 20 visits per year | See primary care or specialist office visits | Not covered |
| **Allergy Testing**<br>up to one visit per year | See primary care or specialist office visits | Not covered |
| **Artificial Limbs**<br>(includes associated supplies and equipment) | 20% coinsurance | Not covered |
| **Inpatient Physician Services** | No charge | Not covered |
| **Outpatient mental health, alcohol and substance abuse treatment**<br>intensive outpatient treatment and partial hospitalization | $100 copayment/visit | Not covered |
| **Retail Clinic** | $40 copayment/visit | Not covered |
| **Telemedicine** | See primary care or specialist office visits | Not covered |

**Important information**

- This is a brief summary of benefits. Refer to your Membership Agreement for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager. All benefits described are per member per calendar year.
- If you have questions regarding your plan, visit our website at www.connecticare.com or call us at (860) 674-5757 or 1-800-251-7722.
- Under this program covered prescription drugs and supplies are put into categories (i.e., tiers) to designate how they are to be covered and the member's cost-share. The placement of a drug or supply into one of the tiers is determined by the ConnectiCare Pharmacy Services Department and approved by the ConnectiCare Pharmacy & Therapeutics Committee based on the drug's or supply's clinical effectiveness and cost, not on whether it is a generic drug or supply or brand name drug or supply.
- Most Specialty drugs are dispensed through Specialty Pharmacies by mail, up to a 30-day supply. Specialty Pharmacies have the same Member Cost Share as all other participating pharmacies and are not part of ConnectiCare's Voluntary Mail Order program. The Member Cost Share for Specialty Pharmacy is different from the Cost Share for ConnectiCare's Mail Order program.

## Massachusetts Requirement to Purchase Health Insurance

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents 18 years of age and older, must have health insurance coverage that meets the Minimum Creditable Coverage standards set forth by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability of individual hardship. For more information call Connector at 1-877-MA-ENROLL or visit the Connector website www.mahealthconnector.org.

This health plan **meets Minimum Creditable Coverage standards** that are effective January 1, 2021, as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you **will satisfy** the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2021. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

**If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.**