ConnectiCare

Small Group Market
Choice Mass POS Copay $40
Point-Of-Service 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 $0 per family	$2,500 per member $7,500 per family
Separate Prescription Drug Deductible	None	None
Out-of-Pocket Maximum Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services	$7,900 per member $15,800 per family	$10,000 per member $30,000 per family
Benefits	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Provider Office Visits		
Adult/Pediatric Preventive Visits	No charge	20% coinsurance after plan deductible
Primary Care Provider Office/ Telemedicine Visits includes services for illness, injury, follow-up care and consultations	$40 copayment/visit	20% coinsurance after plan deductible
Telemedicine Services services rendered by a Teladoc® provider	No charge	20% coinsurance after plan deductible
Specialist Office/Telemedicine Visits	$60 copayment/visit	20% coinsurance after plan deductible
Mental Health and Substance Abuse Office Visits	$40 copayment/visit	20% coinsurance after plan deductible
Outpatient Diagnostic Services		
Advanced Radiology CT/PET Scan, MRI	$200 copayment/visit	20% coinsurance after plan deductible
Laboratory Services	$25 copayment/visit	20% coinsurance after plan deductible

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Non-Advanced Radiology X-ray, Diagnostic	$60 copayment/visit	20% coinsurance after plan deductible
Prescription Drugs – Retail Pharmacy (cost share based on 30 day supply per prescription)		
Preferred Generic Tier 1	$30 copayment/prescription	$30 copayment/prescription
Non-preferred Generic Tier 2	50% coinsurance up to a maximum of $300 per prescription	50% coinsurance up to a maximum of $300 per prescription
Preferred Brand Tier 3	$60 copayment/prescription	$60 copayment/prescription
Non-Preferred Brand Tier 4	50% coinsurance up to a maximum of $300 per prescription	50% coinsurance up to a maximum of $300 per prescription
Specialty Drugs – (cost share up to 30 day supply per prescription - These drugs generally require pre-authorization and may require special handling)		
Preferred Specialty Tier 5	50% coinsurance up to a maximum of $350 per prescription (specialty retail only)	Not covered
Non-Preferred Specialty 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 Tier 1	$60 copayment/prescription	Not covered
Non-preferred Generic Tier 2	50% coinsurance up to a maximum of $600 per prescription	Not covered
Preferred Brand Tier 3	$120 copayment/prescription	Not covered
Non-Preferred Brand 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	20% coinsurance after plan deductible

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Physical and Occupational Therapy up to 60 visits per calendar year (includes services combined for physical and occupational therapy) Speech and hearing therapy, prescribed by applicable law, apply to, but are not limited by the visit maximum	$50 copayment/visit	20% coinsurance after plan deductible
Other Services		
Chiropractic Services up to 20 visits per year	$50 copayment/visit	20% coinsurance after plan deductible
Diabetic Equipment and Supplies	20% coinsurance	20% coinsurance after plan deductible
Durable Medical Equipment (DME)	20% coinsurance	20% coinsurance after plan deductible
Home Health Care Services	No charge	20% coinsurance deductible does not apply
Outpatient Services in a hospital or ambulatory facility	$250 copayment/visit at an Ambulatory Surgical Facility $500 copayment/visit at an Outpatient Hospital Facility	20% coinsurance after plan deductible
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	20% coinsurance after plan deductible
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	50% coinsurance after plan deductible
Basic Services	50% coinsurance	50% coinsurance after plan deductible

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Major Services	50% coinsurance	50% coinsurance after plan deductible
Orthodontia Services medically necessary only	50% coinsurance	50% coinsurance after plan deductible
Pediatric Vision Care (for children under age 20)		
Prescription Eye Glasses one pair of frames and lenses or contact lens per calendar year	Lenses: $50 Collection frames: $50 Non-collection frames: $50 up to the collection frame allowance; any amount over is payable by the member minus a 20% discount	20% coinsurance after plan deductible
Routine Eye Exam by a Specialist up to one visit per year	$50 copayment/visit	20% coinsurance after plan deductible
Additional Covered Services		
Adult Routine Eye Exam by a Specialist - over age 20 up to one visit per year	$50 copayment/visit	20% coinsurance after plan deductible
Allergy Injections up to 20 visits per year	See primary care or specialist services	20% coinsurance after plan deductible
Allergy Testing up to one visit per year	See primary care or specialist services	20% coinsurance after plan deductible
Artificial Limbs includes associated supplies and equipment	20% coinsurance	20% coinsurance after plan deductible
Inpatient Physician Services	No charge	20% coinsurance after plan deductible
Outpatient mental health, alcohol and substance abuse treatment intensive outpatient treatment and partial hospitalization	$100 copayment/visit	20% coinsurance after plan deductible
Retail Clinic	$40 copayment/visit	20% coinsurance after plan deductible

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.
- To learn more about your **Teladoc®** benefits contact **Teladoc®** at teladoc.com/connecticare or call 1-800-835-2362 (TTY: 711).
- 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, 2022, 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, 2022. 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.