Choice plans

Plan name	2023 Calendar Year	2023 Calendar Year	2023 Contract Year	2023 Contract Year	2023 Contract Year
	Choice Mass HMO Copay $30	**Choice Mass POS Copay $30**	**Choice Mass HMO Copay $2,000/$4,000**	**Choice Mass HMO Copay $2,500/$5,000**	**Choice Mass POS Copay $3,000/$6,000**
NETWORK ACCESS	**Hampden, Hampshire, Berkshire, and Franklin Counties in MA, all of CT, parts of RI, and NY through EmblemHealth Prime Network**		**Hampden, Hampshire, Berkshire, and Franklin Counties in MA, all of CT, parts of RI, and NY through EmblemHealth Prime Network**		
PLAN/MEDICAL DEDUCTIBLE					
Deductible (individual/family)	$0	$0	$2,000 per member $4,000 per family	$2,500 per member $5,000 per family	$3,000 per member $6,000 per family
Maximum out-of-pocket limit (individual/family)	$8,500 per member $17,000 per family	$8,500 per member $17,000 per family	$7,000 per member $14,000 per family	$8,000 per member $16,000 per family	$8,500 per member $17,000 per family
IN-NETWORK MEDICAL BENEFITS					
Preventive care/screenings/immunizations	No charge	No charge	No charge	No charge	No charge
Primary care services	$30 copayment/visit	$30 copayment/visit	$30 copayment/visit; deductible does not apply	$30 copayment/visit after plan deductible	$35 copayment/visit; deductible does not apply
Telemedicine visits through Teladoc®[1]	**Primary Care, Mental Health, and General Medical Services:** No charge **Dermatologist:** $60 copayment/visit	**Primary Care, Mental Health, and General Medical Services:** No charge **Dermatologist:** $60 copayment/visit	**Primary Care, Mental Health, and General Medical Services:** No charge **Dermatologist:** $50 copayment/visit; deductible does not apply	**Primary Care, Mental Health, and General Medical Services:** No charge **Dermatologist:** $60 copayment/visit after plan deductible	**Primary Care, Mental Health, and General Medical Services:** No charge **Dermatologist:** $65 copayment/visit; deductible does not apply
Specialist services	$60 copayment/visit	$60 copayment/visit	$50 copayment/visit; deductible does not apply	$60 copayment/visit after plan deductible	$65 copayment/visit; deductible does not apply
Mental health and substance abuse office visits	$30 copayment/visit	$30 copayment/visit	$30 copayment/visit; deductible does not apply	$30 copayment/visit after plan deductible	$35 copayment/visit; deductible does not apply
Vision	$50 copayment/visit	$50 copayment/visit	$50 copayment/visit; deductible does not apply	$50 copayment/visit; deductible does not apply	$25 copayment/visit; deductible does not apply
Walk-in/urgent care center	$100 copayment/visit	$100 copayment/visit	$100 copayment/visit; deductible does not apply	$100 copayment/visit after plan deductible	$150 copayment/visit; deductible does not apply
Worldwide emergency coverage[2]	$400 copayment/visit	$400 copayment/visit	$400 copayment/visit after plan deductible	$400 copayment/visit after plan deductible	$500 copayment/visit after plan deductible
Hospital – inpatient treatment	$500 copayment/day up to $1,000 per admission	$500 copayment/day up to $1,000 per admission	$500 copayment per admission after plan deductible	$500 copayment/day up to $1,000 per admission after plan deductible	$500 copayment/day up to $1,000 per admission after plan deductible
Hospital – outpatient treatment	$500 copayment/visit	$500 copayment/visit	$500 copayment/visit after plan deductible	$500 copayment/visit after plan deductible	$500 copayment/visit after plan deductible
Outpatient surgery in freestanding locations	$250 copayment/visit	$250 copayment/visit	$500 copayment/visit after plan deductible	$500 copayment/visit after plan deductible	$500 copayment/visit after plan deductible
Lab services	$15 copayment/visit	$15 copayment/visit	$10 copayment/visit; deductible does not apply	$10 copayment/visit after plan deductible	$25 copayment/visit after plan deductible
X-rays	$60 copayment/visit	$60 copayment/visit	$50 copayment/visit; deductible does not apply	$50 copayment/visit after plan deductible	$65 copayment/visit after plan deductible
Advanced imaging (CT scans & MRI)	$200 copayment/visit	$200 copayment/visit	$200 copayment/visit after plan deductible	$200 copayment/visit after plan deductible	$300 copayment/visit after plan deductible
OUT-OF-NETWORK MEDICAL BENEFITS					
Deductible (individual/family)	Not covered	$2,500 per member $7,500 per family	Not covered	Not covered	$6,000 per member $12,000 per family
Coinsurance	Not covered	20% coinsurance after plan deductible	Not covered	Not covered	30% coinsurance after plan deductible
Maximum out-of-pocket limit (individual/family)	Not covered	$10,000 per member $30,000 per family	Not covered	Not covered	$9,000 per member $18,000 per family
PRESCRIPTION DRUG BENEFIT					
Prescription drug deductible (individual/family)	None	None	None	None	None
Tier 1 – Preferred generic drugs	$30 copayment/prescription	$30 copayment/prescription	$30 copayment/prescription; deductible does not apply	$30 copayment/prescription; deductible does not apply	$40 copayment/prescription; deductible does not apply
Tier 2 – Non-preferred generic drugs	50% coinsurance up to a maximum of $300 per prescription	50% coinsurance up to a maximum of $300 per prescription	50% coinsurance up to a maximum of $300 per prescription; deductible does not apply	50% coinsurance up to a maximum of $300 per prescription; deductible does not apply	50% coinsurance up to a maximum of $300 per prescription; deductible does not apply
Tier 3 – Preferred brand drugs	$60 copayment/prescription	$60 copayment/prescription	$60 copayment/prescription; deductible does not apply	$60 copayment/prescription; deductible does not apply	$80 copayment/prescription; deductible does not apply
Tier 4 – Non-preferred brand drugs	50% coinsurance up to a maximum of $300 per prescription	50% coinsurance up to a maximum of $300 per prescription	50% coinsurance up to a maximum of $300 per prescription; deductible does not apply	50% coinsurance up to a maximum of $300 per prescription; deductible does not apply	50% coinsurance up to a maximum of $300 per prescription; deductible does not apply
Tier 5 – Preferred specialty drugs	50% coinsurance up to a maximum of $350 per prescription (specialty retail only)	50% coinsurance up to a maximum of $350 per prescription (specialty retail only)	50% coinsurance up to a maximum of $500 per prescription; deductible does not apply (specialty retail only)	50% coinsurance up to a maximum of $350 per prescription; deductible does not apply (specialty retail only)	50% coinsurance up to a maximum of $250 per prescription; deductible does not apply (specialty retail only)
Tier 6 – Non-preferred specialty drugs	50% coinsurance up to a maximum of $750 per prescription (specialty retail only)	50% coinsurance up to a maximum of $750 per prescription (specialty retail only)	50% coinsurance up to a maximum of $750 per prescription; deductible does not apply (specialty retail only)	50% coinsurance up to a maximum of $750 per prescription; deductible does not apply (specialty retail only)	50% coinsurance up to a maximum of $750 per prescription; deductible does not apply (specialty retail only)

[1]Telemedicine is not appropriate for all covered services, and restrictions apply. Primary care — members must be 18 or older.
[2]Subject to limitations.

ConnectiCare

Choice plans

Plan name	2023 Contract Year Choice Mass POS HSA Copay $2,500/$5,000	2023 Contract Year Choice Mass POS HSA Copay $4,500/$9,000
NETWORK ACCESS	**Hampden, Hampshire, Berkshire, and Franklin Counties in MA, all of CT, parts of RI, and NY through EmblemHealth Prime Network**	
PLAN/MEDICAL DEDUCTIBLE		
Deductible (individual/family)	$2,500 per member $5,000 per family	$4,500 per member $9,000 per family
Maximum out-of-pocket limit (individual/family)	$7,050 per member $14,100 per family	$6,400 per member $12,800 per family
IN-NETWORK MEDICAL BENEFITS		
Preventive care/screenings/immunizations	No charge	No charge
Primary care services	$30 copayment/visit after plan deductible	$35 copayment/visit after plan deductible
Telemedicine visits through Teladoc[1]	**Primary Care, Mental Health, and General Medical Services:** 0% coinsurance after plan deductible **Dermatologist:** $50 copayment/visit after plan deductible	**Primary Care, Mental Health, and General Medical Services:** 0% coinsurance after plan deductible **Dermatologist:** $60 copayment/visit after plan deductible
Specialist services	$50 copayment/visit after plan deductible	$60 copayment/visit after plan deductible
Mental health and substance abuse office visits	$30 copayment/visit after plan deductible	$35 copayment/visit after plan deductible
Vision	$25 copayment/visit; deductible does not apply	$25 copayment/visit; deductible does not apply
Walk-in/urgent care center	$100 copayment/visit after plan deductible	$100 copayment/visit after plan deductible
Worldwide emergency coverage[2]	$300 copayment/visit after plan deductible	$300 copayment/visit after plan deductible
Hospital – inpatient treatment	$250 copayment/day up to $1,000 per admission after plan deductible	$250 copayment/day up to $500 per admission after plan deductible
Hospital – outpatient treatment	$250 copayment/visit after plan deductible	$250 copayment/visit after plan deductible
Outpatient surgery in freestanding locations	$250 copayment/visit after plan deductible	$250 copayment/visit after plan deductible
Lab services	$25 copayment/visit after plan deductible	$25 copayment/visit after plan deductible
X-rays	$50 copayment/visit after plan deductible	$60 copayment/visit after plan deductible
Advanced imaging (CT scans & MRI)	$250 copayment/visit after plan deductible	$200 copayment/visit after plan deductible
OUT-OF-NETWORK MEDICAL BENEFITS		
Deductible (individual/family)	$6,000 per member $12,000 per family	$7,000 per member $14,000 per family
Coinsurance	30% coinsurance after plan deductible	30% coinsurance after plan deductible
Maximum out-of-pocket limit (individual/family)	$9,000 per member $18,000 per family	$10,000 per member $20,000 per family
PRESCRIPTION DRUG BENEFIT		
Prescription drug deductible (individual/family)	Included in plan deductible	Included in plan deductible
Tier 1 – Preferred generic drugs	$40 copayment/prescription after plan deductible	$40 copayment/prescription after plan deductible
Tier 2 – Non-preferred generic drugs	50% coinsurance up to a maximum of $300 per prescription after plan deductible	50% coinsurance up to a maximum of $300 per prescription after plan deductible
Tier 3 – Preferred brand drugs	$60 copayment/prescription after plan deductible	$60 copayment/prescription after plan deductible
Tier 4 – Non-preferred brand drugs	50% coinsurance up to a maximum of $300 per prescription after plan deductible	50% coinsurance up to a maximum of $300 per prescription after plan deductible
Tier 5 – Preferred specialty drugs	50% coinsurance up to a maximum of $250 per prescription after plan deductible (specialty retail only)	50% coinsurance up to a maximum of $250 per prescription after plan deductible (specialty retail only)
Tier 6 – Non-preferred specialty drugs	50% coinsurance up to a maximum of $750 per prescription after plan deductible (specialty retail only)	50% coinsurance up to a maximum of $750 per prescription after plan deductible (specialty retail only)

[1]Telemedicine is not appropriate for all covered services, and restrictions apply. Primary care — members must be 18 or older.
[2]Subject to limitations.