ConnectiCare

Small Group Market
Choice Mass HMO Copay $2500/$5000 ded.
Open Access Contract Year deductible 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	$2,500 per member $5,000 per family	N/A per member N/A per family
Separate Prescription Drug Deductible	None	N/A per member N/A per family
Out-of-Pocket Maximum (Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services)	$8,000 per member $16,000 per family	N/A per member 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/ Telemedicine Visits (includes services for illness, injury, follow-up care and consultations)	$30 copayment/visit after plan deductible	Not covered
Telemedicine Services (services rendered by a Teladoc® provider) Primary Care – members must be 18 or older	**Primary Care, Mental Health and General Medical Services:** No charge **Dermatologist:** $60 copayment/visit after plan deductible	Not covered
Specialist Office/Telemedicine Visits	$60 copayment/visit after plan deductible	Not covered
Mental Health and Substance Abuse Office Visits	$30 copayment/visit after plan deductible	Not covered
Outpatient Diagnostic Services		

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Advanced Radiology (CT/PET Scan, MRI)	$200 copayment/visit after plan deductible	Not covered
Laboratory Services	$10 copayment/visit after plan deductible	Not covered
Non-Advanced Radiology (X-ray, Diagnostic)	$50 copayment/visit after plan deductible	Not covered
Prescription Drugs – Retail Pharmacy (cost share based on 30 day supply per prescription)		
Preferred Generic Tier 1	$30 copayment/prescription; deductible does not apply	Not covered
Non-preferred Generic Tier 2	50% coinsurance up to a maximum of $300 per prescription; deductible does not apply	Not covered
Preferred Brand Tier 3	$60 copayment/prescription; deductible does not apply	Not covered
Non-Preferred Brand Tier 4	50% coinsurance up to a maximum of $300 per prescription; deductible does not apply	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 Tier 5	50% coinsurance up to a maximum of $350 per prescription; deductible does not apply (specialty retail only)	Not covered
Non-Preferred Specialty Tier 6	50% coinsurance up to a maximum of $750 per prescription; deductible does not apply (specialty retail only)	Not covered
Prescription – Mail Order Pharmacy (up to a 90 day supply per prescription)		
Preferred Generic Tier 1	$60 copayment/prescription; deductible does not apply	Not covered
Non-preferred Generic Tier 2	50% coinsurance up to a maximum of $600 per prescription; deductible does not apply	Not covered
Preferred Brand Tier 3	$120 copayment/prescription; deductible does not apply	Not covered
Non-Preferred Brand Tier 4	50% coinsurance up to a maximum of $750 per prescription; deductible does not apply	Not covered

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Outpatient Rehabilitative and Habilitative Services (60 visits per contract year limit combined for physical and occupational therapies. Separate 60 visits per contract year limit combined for Habilitative physical and occupational therapies.)		
Speech Therapy	$50 copayment/visit after plan deductible	Not covered
Physical and Occupational Therapy (up to 60 visits per 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 after plan deductible	Not covered
Other Services		
Chiropractic Services (up to 20 visits per year)	$50 copayment/visit after plan deductible	Not covered
Diabetic Equipment and Supplies	20% coinsurance after plan deductible	Not covered
Durable Medical Equipment (DME)	20% coinsurance after plan deductible	Not covered
Home Health Care Services	No charge	Not covered
Outpatient Services (in a hospital or ambulatory facility)	$500 copayment/visit after plan deductible	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 contract year)	$500 copayment/day up to $1,000 per admission after plan deductible	Not covered
Emergency and Urgent Care		
Ambulance Services	0% coinsurance after plan deductible	Same as In-network benefit
Emergency Room (copayment waived if admitted)	$400 copayment/visit after plan deductible	Same as In-network benefit
Urgent Care Centers	$100 copayment/visit after plan deductible	Same as In-network benefit
Pediatric Dental Care (for children under age 20)		
Diagnostic & Preventive	No charge	Not covered

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Basic Services	50% coinsurance after plan deductible	Not covered
Major Services	50% coinsurance after plan deductible	Not covered
Orthodontia Services (medically necessary only)	50% coinsurance after plan deductible	Not covered
Pediatric Vision Care (for children under age 20)		
Prescription Eye Glasses (one pair of frames and lenses per 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	Not covered
Routine Eye Exam by a Specialist (up to one visit per year)	$50 copayment/visit; deductible does not apply	Not covered
Additional Covered Services		
Adult Routine Eye Exam by a Specialist (over age 20 - up to one visit per year)	$50 copayment/visit; deductible does not apply	Not covered
Allergy Injections (Unlimited)	See primary care or specialist services	Not covered
Allergy Testing (up to one visit per year)	See primary care or specialist services	Not covered
Artificial Limbs (includes associated supplies and equipment)	20% coinsurance after plan deductible	Not covered
Inpatient Physician Services	0% coinsurance after plan deductible	Not covered
Outpatient mental health, alcohol and substance abuse treatment (intensive outpatient treatment and partial hospitalization)	$100 copayment/visit after plan deductible	Not covered
Retail Clinic	$30 copayment/visit after plan deductible	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 Contract year.
- Certain services require prior authorization, please refer to your Membership Agreement for a detailed list of services or call member service at 1-800-251-7722.
- 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, 2023, 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, 2023. 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.