



**Small Group Market**  
**Choice Mass POS Copay \$3000/\$6000**  
**Point-Of-Service Open Access Contract 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.

<b>Deductible and Out-of-Pocket Maximum</b>	<b>In-Network (INET) Member Pays</b>	<b>Out-of-network (OON) Member Pays</b>
<b>Plan deductible</b>	\$3,000 per member \$6,000 per family	\$6,000 per member \$12,000 per family
<b>Separate Prescription Drug Deductible</b>	None	None
<b>Out-of-Pocket Maximum</b> (Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services)	\$8,500 per member \$17,000 per family	\$9,000 per member \$18,000 per family
<b>Benefits</b>	<b>In-Network (INET) Member Pays</b>	<b>Out-of-network (OON) Member Pays</b>
<b>Provider Office Visits</b>		
<b>Adult/Pediatric Preventive Visits</b>	No charge	30% coinsurance after plan deductible
<b>Primary Care Provider Office/ Telemedicine Visits</b> (includes services for illness, injury, follow-up care and consultations)	\$35 copayment/visit; deductible does not apply	30% coinsurance after plan deductible
<b>Telemedicine Services</b> (services rendered by a Teladoc® provider)  Primary Care - members must be 18 or older	<b>Primary Care, Mental Health and General Medical Services:</b> No charge  <b>Dermatologist:</b> \$65 copayment/visit; deductible does not apply	30% coinsurance after plan deductible
<b>Specialist Office/Telemedicine Visits</b>	\$65 copayment/visit; deductible does not apply	30% coinsurance after plan deductible
<b>Mental Health and Substance Abuse Office Visits</b>	\$35 copayment/visit; deductible does not apply	30% coinsurance after plan deductible
<b>Outpatient Diagnostic Services</b>		

<b>Benefits</b>	<b>In-Network (INET) Member Pays</b>	<b>Out-of-network (OON) Member Pays</b>
<b>Advanced Radiology</b> (CT/PET Scan, MRI)	\$300 copayment/visit after plan deductible	30% coinsurance after plan deductible
<b>Laboratory Services</b>	\$25 copayment/visit after plan deductible	30% coinsurance after plan deductible
<b>Non-Advanced Radiology</b> (X-ray, Diagnostic)	\$65 copayment/visit after plan deductible	30% coinsurance after plan deductible
<b>Prescription Drugs - Retail Pharmacy (cost share based on 30 day supply per prescription)</b>		
<b>Preferred Generic</b> Tier 1	\$40 copayment/prescription; deductible does not apply	\$40 copayment/prescription; deductible does not apply
<b>Non-preferred Generic</b> Tier 2	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
<b>Preferred Brand</b> Tier 3	\$80 copayment/prescription; deductible does not apply	\$80 copayment/prescription; deductible does not apply
<b>Non-Preferred Brand</b> Tier 4	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
<b>Specialty Drugs - (cost share up to 30 day supply per prescription - These drugs generally require pre-authorization and may require special handling)</b>		
<b>Preferred Specialty</b> Tier 5	50% coinsurance up to a maximum of \$250 per prescription; deductible does not apply	Not covered
<b>Non-Preferred Specialty</b> Tier 6	50% coinsurance up to a maximum of \$750 per prescription; deductible does not apply	Not covered
<b>Prescription - Mail Order Pharmacy (up to a 90 day supply per prescription)</b>		
<b>Preferred Generic</b> Tier 1	\$80 copayment/prescription; deductible does not apply	Not covered
<b>Non-preferred Generic</b> Tier 2	50% coinsurance up to a maximum of \$600 per prescription; deductible does not apply	Not covered
<b>Preferred Brand</b> Tier 3	\$160 copayment/prescription; deductible does not apply	Not covered
<b>Non-Preferred Brand</b> Tier 4	50% coinsurance up to a maximum of \$600 per prescription; deductible does not apply	Not covered

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
<b>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.)</b>		
<b>Speech Therapy</b>	\$65 copayment/visit; deductible does not apply	30% coinsurance after plan deductible
<b>Physical and Occupational Therapy</b> (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)	\$65 copayment/visit; deductible does not apply	30% coinsurance after plan deductible
<b>Other Services</b>		
<b>Chiropractic Services</b> (up to 20 visits per year)	\$65 copayment/visit; deductible does not apply	30% coinsurance after plan deductible
<b>Diabetic Equipment and Supplies</b>	20% coinsurance; deductible does not apply	30% coinsurance after plan deductible
<b>Durable Medical Equipment (DME)</b>	20% coinsurance; deductible does not apply	30% coinsurance after plan deductible
<b>Home Health Care Services</b>	No charge	20% coinsurance; deductible does not apply
<b>Outpatient Services</b> (in a hospital or ambulatory facility)	\$500 copayment/visit after plan deductible	30% coinsurance after plan deductible
<b>Inpatient Services</b>		
<b>Inpatient hospital services include mental health, substance abuse, maternity, hospice, skilled nursing facility* and all IP settings.</b> (*skilled nursing facility stay is limited to 100 days per contract year)	\$500 copayment/day up to \$1,000 per admission after plan deductible	30% coinsurance after plan deductible
<b>Emergency and Urgent Care</b>		
<b>Ambulance Services</b>	\$500 copayment/service after plan deductible	Same as In-network benefit
<b>Emergency Room</b> (copayment waived if admitted)	\$500 copayment/visit after plan deductible	Same as In-network benefit
<b>Urgent Care Centers</b>	\$150 copayment/visit; deductible does not apply	Same as In-network benefit
<b>Pediatric Dental Care (for children under age 20)</b>		

<b>Benefits</b>	<b>In-Network (INET) Member Pays</b>	<b>Out-of-network (OON) Member Pays</b>
<b>Diagnostic &amp; Preventive</b>	No charge	50% coinsurance after plan deductible
<b>Basic Services</b>	50% coinsurance after plan deductible	50% coinsurance after plan deductible
<b>Major Services</b>	50% coinsurance after plan deductible	50% coinsurance after plan deductible
<b>Orthodontia Services</b> (medically necessary only)	50% coinsurance after plan deductible	50% coinsurance after plan deductible
<b>Pediatric Vision Care (for children under age 20)</b>		
<b>Prescription Eye Glasses</b> (one pair of frames and lenses or contact lens per contract 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	30% coinsurance after plan deductible
<b>Routine Eye Exam by a Specialist</b> (up to one visit per year)	\$25 copayment/visit; deductible does not apply	30% coinsurance after plan deductible
<b>Additional Covered Services</b>		
<b>Adult Routine Eye Exam by a Specialist</b> (over age 20 - up to one visit per year)	\$25 copayment/visit; deductible does not apply	30% coinsurance after plan deductible
<b>Allergy Injections</b> (Unlimited)	See primary care or specialist services	30% coinsurance after plan deductible
<b>Allergy Testing</b> (up to one visit per year)	See primary care or specialist services	30% coinsurance after plan deductible
<b>Artificial Limbs</b> (includes associated supplies and equipment)	20% coinsurance; deductible does not apply	30% coinsurance after plan deductible
<b>Inpatient Physician Services</b>	0% coinsurance after plan deductible	30% coinsurance after plan deductible
<b>Outpatient mental health, alcohol and substance abuse treatment</b> (intensive outpatient treatment and partial hospitalization)	\$100 copayment/visit after plan deductible	30% coinsurance after plan deductible
<b>Retail Clinic</b>	\$35 copayment/visit; deductible does not apply	30% 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 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](http://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](http://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](http://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](http://www.mass.gov/doi).**