Small Business Service Bureau, Inc.®

allways℠ HEALTH PARTNERS

SBSB Group Health Insurance Program for Sole-Proprietors and Small Employers in Massachusetts

Welcome! Enrollment in the health insurance plan of your choice is simple – ***only 3 easy steps***. Our Benefit Specialists are available to assist you and all information is confidential.

Step 1: **Obtain a premium quote** by contacting an SBSB Benefit Specialist at 1-800-472-7199, or by visiting us at www.SBSBHealth.com and click on Small Business Shopping for my Employees.

Step 2: **Apply for health insurance** by submitting the following to SBSB.

___ Completed Health Plan Group Census and Selection Form

___ Health Insurance Premium Quote

___ Have each employee participating in your group plan complete, sign, and date an Enrollment/Change Form. *(**Please note:** all dependent information including dates of birth must be accurate.)*

___ Waiver of Coverage Form for each employee opting out of your group insurance plan

___ Pediatric Dental Coverage Attestation Form (if applicable)

___ Include Proof of Business Documentation

- Tax Documentation: Schedule C, WR1 SE (or)
- Official third party payroll records

___ Complete the SBSB Membership Application

Step 3: **Submit** the first month premium and SBSB Annual Membership Dues ($85 for 1-4 employees; $125 for 5-9 employees) payable to SBSB.

Mail to: Small Business Service Bureau, Inc.
38 Austin Street
P.O. Box 15014
Worcester, MA 01615-0014

or FAX to:
1-508-792-3872

or scan and email to:
enroll@sbsb.com

All groups subject to health plan eligibility and underwriting requirements.
All enrollment documents, including the employee's enrollment form, must be completed, signed, dated, and submitted to the Small Business Service Bureau, Inc. prior to the desired effective date.

Join SBSB!
A Big PLUS for Small Business Success!

Member Information

Business Name _____

Name of Owner/Operator ☐ Mr. ☐ Mrs. ☐ Ms.

_____

FIRST NAME MIDDLE INITIAL LAST NAME

_____

TITLE DATE OF BIRTH

Business Address

_____

STREET (NO P.O. BOXES)

_____

CITY STATE ZIP

Mailing Address (if different from street address above)

_____

STREET / P.O. BOX

_____

CITY STATE ZIP

Is your business address the same as your home address?

☐ Yes ☐ No Do you: ☐ Rent ☐ Own ☐ Lease?

Business Telephone (_____) _____

Home Telephone (_____) _____

Fax No. (_____) _____

E-mail _____

Number of Full-Time Employees _____

Description of Business: _____

_____

EXAMPLES: ACCOUNTING, LAW, RETAIL CLOTHING SALES, COMPUTER CONSULTING, ETC.)

Business Structure (check one)

☐ Corporation ☐ Sole Proprietorship
☐ Partnership ☐ Subchapter S

Does your company have a probationary period for new employees? ☐ No ☐ Yes If yes, what is it? _____

_____

AUTHORIZED SIGNATURE **TITLE**

/ /

_____

PRINT NAME **DATE**

Please use the SBSB return-addressed envelope provided to submit your application(s).

☐ **Yes, I want to save money on group insurance and other benefits for my small business!**

Complete this section only if applying for health insurance through SBSB.

Health Insurance Effective Date Desired / /

If you are applying for health insurance, do not cancel any insurance until you are certain your new coverage is in effect.

I hereby certify and attest the information provided herein is true and complete to the best of my knowledge, and that I have the legal authority to execute this document on behalf of the company named herein. I certify that 100% of eligible people who are not covered by a spouse, parent or Medicare are enrolled in the SBSB Health Insurance Program. Furthermore, I certify that all current and future employees to be enrolled actively work full-time, as defined by state and federal laws, for financial compensation. I understand all health coverage becomes effective upon the approval of the provider or carrier. I further state I am aware the health provider retains the right to terminate coverage at any time if the statements made herein are not true and complete.

For information or assistance with this application, call an SBSB Membership Representative Toll Free at

1-800-472-7199.

Small Business Service Bureau, Inc.

A National Membership Organization for Small Business
38 Austin Street • P.O. Box 15014 • Worcester, MA 01615-0014

FOR SBSB USE ONLY

DATE _____ 090 _____ 260 _____ 400 _____

250 _____ 210 _____ 490 _____ 410 _____

240 _____ INITIAL BILL _____ EFF. DATE _____

REASON _____

Small Business Service Bureau, Inc.®

ALLWAYS HEALTH PARTNERS GROUP CENSUS AND PLAN SELECTION FORM

allways℠ HEALTH PARTNERS

Company Name: _____ Address: _____

EIN: _____ Company Email Address: _____

Tax ID: _____ SIC Code: _____

Total number of employees (ACA Definition)*:
Number of full-time and full-time equivalent employees (FTE's), including any part-time and seasonal employees who are employed at the time of the policy effective date working 30 or more hours per week. _____

Do you regularly employ at least one individual that is not an owner and/or spouse of an owner? ❑ Yes ❑ No

SBSB Credentialed Broker Name: _____

Broker Phone #: _____ BR#: _____
(if applicable)

Plan Selection: All members of a common employer group must participate in the same Benefit Plan Design.

Complete HMO Plans	
Complete HMO 25/40	❑
Complete HMO 500 25/45	❑
Complete HMO 1000 25/50	❑
Complete HMO 1500 25/50	❑
Complete HMO 2000 25/40/350	❑
Complete HMO 2000 25/45	❑
Complete HMO 2000 35%	❑
Complete HMO 2500 25/50	❑
Complete HMO 3000	❑
Complete HMO HSA 2500 30/45/250 Enchanced FlexRx	❑
Complete HMO HSA 3600 35/50 Enhanced FlexRx	❑

Choice Easy Tier HMO Plans	
Choice Easy Tier HMO 500	❑
Choice Easy Tier HMO 1000	❑
Choice Easy Tier HMO 1500	❑
Choice Easy Tier HMO 2000	❑
Choice Easy Tier HMO 1500 10%/30%	❑
Choice Easy Tier HMO 3000	❑
Choice Easy Tier HMO 2500 15%/35%	❑

Include all benefit eligible employees on payroll and any COBRA participants. Please attach additional listing if needed.

Employee Name	Waivers** (include reason)	Date of Birth	Date of Hire
1.			
2.			
3.			
4.			
5.			
6.			
7.			

* *To determine the FTE count we recommend using https://www.healthcare.gov/shop-calculators-fte/.*

** *If waiving right to group health care coverage at this time, please attach a completed waiver of coverage form.*

Employer Certification & Eligibility Guidelines

1. I hereby attest that this organization is an eligible regulated market small business as defined by Massachusetts state regulations. I verify that my organization is "a sole proprietorship, firm, corporation, partnership or association actively engaged in business who, on at least 50% of its working days during the preceding year, employed from among one to not more than 50 eligible employees, the majority of whom worked in Massachusetts." (211 CMR 66.04)
2. I confirm, for purposes of determining group size, that each of my firm's eligible employees "(a) works on a full-time basis with a normal work week of 30 or more hours, and includes an owner, a sole proprietor or a partner of a partnership; provided however, that such owner, sole proprietor, or partner is included as an employee under a health care plan of an eligible small business; and provided, however that "eligible employee" does not include an employee who works on a temporary or substitute basis; and (b) is hired to work for a period of not less than five months." (211 CMR 66.04)
3. I certify all current and future employees to be enrolled in the SBSB Group Health Program actively work for the company in the service area including eligible full-time and part-time employees (who will have met the probationary period as of the employer group's renewal rate effective date), as well as early retirees, but excluding COBRA participants and temporary employees. A full-time employee must work a normal work week of 30 hours or more and a part-time employee must work at least 20 hours per work week; both must be employed no less than 5 months a year.
4. I certify that my company contributes at least 50% towards the single premium rate and at least 33% of the premium rate for family coverage.
5. I further state that I am aware the health plan retains the right to terminate coverage retroactive to coverage effective date at any time if the statements made herein are not true and complete.
6. New Hires: a new employee must become effective on the first date of employment, or if there is a probationary period, on the first day following the completion of the probationary period; must be consistently applied for all new employees. Probationary periods must be 90 days or less. Part-time to full-time must become effective following the completion of the same probationary period as a new hire.

Please Note:

SBSB sponsored Health Plan requires 100% participation for groups of 1-5 lives and a minimum of 75% participation for group sizes 6-9.

Signed: _____ Date: _____

Authorized Company Representative

Name: _____

Please Print

All groups subject to health plan eligibility and underwriting requirements.
All enrollment documents, including the employee's application, must be completed, signed, dated, and submitted to SBSB five (5) business days prior to the desired effective date.

If you have any questions, please contact SBSB at 1-800-472-7199.

Mail to: Small Business Service Bureau, Inc.
38 Austin Street
P.O. Box 15014
Worcester, MA 01615-0014

or FAX to:
1-508-792-3872
or scan and email to:
enroll@sbsb.com

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Waiver/Verification of Alternative Coverage

Eligible Employees who refuse the SBSB Group Insurance Plan offered through their employer must verify they have alternative coverage.

I,_____ , certify that I am an employee of and that I am eligible for group health care coverage through_____ , my employer. I also certify that I am waiving my right to group health care coverage through my employer at this time because I have chosen health care coverage through ***(Check box that applies)***:

❑ COBRA ❑ Parent/Spouse ❑ Union ❑ Medicare ❑ Alternate group health program

Parent's / Spouse's Name: _____

Current Health Plan: _____

Health Plan Identification Number: _____

Group / Policy Number:_____

Notice of Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this health plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I understand that any person choosing to enroll later must meet the health plan's requirements for eligibility and for late enrollees.

Employee Name *(please print)*

Signature Date

I affirm that the assertions in this form are true and complete to the best of my knowledge, and I understand that the health plan has the right to terminate coverage, retroactive to the effective date of coverage, for any material misinformation (including omissions) contained in this form.

Signature of Authorized Company Representative Date

If you have any questions, please contact SBSB at 1-800-472-7199.

Return with the completed census and required documents to:
Small Business Service Bureau, Inc.
38 Austin Street • PO Box 15014 • Worcester, MA 01615-0014

Enrollment and Change Form

allways HEALTH PARTNERS

399 Revolution Drive, Suite 940, Somerville, MA 02145

Return to SBSB

Please use a ball point pen and press down firmly.

Application for Enrollment	**Change in Enrollment**	**Reason for Change in Enrollment**	
☐ New employee	☐ Add dependents	☐ Marriage	☐ Add disabled dependents
☐ Annual enrollment	☐ Remove dependents	☐ Birth of child	☐ Moved out of service area
☐ COBRA Continuation	☐ PCP/Site change	☐ Adoption of child*	☐ Voluntary
☐ Involuntary loss of prior group coverage*	☐ Termination	☐ Divorce	☐ Loss of dependent eligibility
☐ Other ____________	☐ Employee/dependent demographics	☐ Left employment	☐ Death, exact date ________
**Documentation required*	☐ Other ____________	☐ Reached age 65	

Group Information

AllWays Health Partners group number		Employer name		
Date of employment Month Day Year		Effective Date Month Day Year		Plan design

Intermediary
☐ Group
☐ Non-group

Employee Information

Last name		First name		M.I.
Date of birth (mm/dd/yy)	Social Security Number - -	Gender (m/f)	Home phone – *Include area code*	Email address
Street mailing address	Apt.	P.O. Box	City	State	Zip code

PCP and Site Information

For help finding a PCP in our network, please go to allwayshealthpartners.org and search our Find a Doctor tool.
You may change your PCP at any time.

Primary care site	
Your Primary Care Physician (Last name, First, M.I.)	Existing patient? ☐ Yes ☐ No

Language

What language do you speak most often? Please check (✓) the appropriate box. Knowing the main language spoken by you and your family members will help us to better serve your needs.

☐ English ☐ Spanish ☐ Cantonese ☐ Cape Verdean Creole ☐ French ☐ Haitian Creole ☐ Mandarin ☐ Portuguese ☐ Russian ☐ Vietnamese ☐ Other, please specify________________

Group Coverage

Type of AllWays Health Partners coverage (check only one)	In addition to AllWays Health Partners, my spouse or children are covered by a health plan offered by:			
☐ Self ☐ Individual & spouse ☐ Individual & child/children ☐ Family	Employer	Insurance co. name	Policy #	Effective date

Are you and/ or your spouse eligible for Medicare?	Self ☐ Yes ☐ No	If yes, are you enrolled in	☐ Medicare Part A ☐ Medicare Part B	Your Medicare policy number
	Spouse ☐ Yes ☐ No	If yes, is your spouse enrolled in	☐ Medicare Part A ☐ Medicare Part B	Your spouse's Medicare policy number

Please provide **ALL** information below for any eligible dependents you wish to enroll.

Spouse last name		First name	M.I.	Primary care site	Existing patient?
Date of birth	**Social Security Number** - -	Gender (m/f)	Other Insurance? ☐ Yes ☐ No	Primary care physician (last name, first name, M.I.)	☐ Yes ☐ No
Dependent last name		First name	M.I.	Primary care site	Existing patient?
Date of birth	**Social Security Number** - -	Gender (m/f)	Other Insurance? ☐ Yes ☐ No	Primary care physician (last name, first name, M.I.)	☐ Yes ☐ No
Dependent last name		First name	M.I.	Primary care site	Existing patient?
Date of birth	**Social Security Number** - -	Gender (m/f)	Other Insurance? ☐ Yes ☐ No	Primary care physician (last name, first name, M.I.)	☐ Yes ☐ No
Dependent last name		First name	M.I.	Primary care site	Existing patient?
Date of birth	**Social Security Number** - -	Gender (m/f)	Other Insurance? ☐ Yes ☐ No	Primary care physician (last name, first name, M.I.)	☐ Yes ☐ No
Dependent last name		First name	M.I.	Primary care site	Existing patient?
Date of birth	**Social Security Number** - -	Gender (m/f)	Other Insurance? ☐ Yes ☐ No	Primary care physician (last name, first name, M.I.)	☐ Yes ☐ No

Acknowledgement: The information supplied on this form is true and complete. I assign benefits to AllWays Health Partners for the cost of services when the liability for payment is the responsibility of another plan/HMO, worker's compensation plan or other coverage. I (we) agree that AllWays Health Partners and its affiliated health care providers may obtain or release my (our) medical information including medical records, medical coverage available or other medical data for the purposes of administering benefits, evaluating medical care provided, conducting quality assurance reviews and analysis, conducting medical research, and/or as required by law. I (we) understand that for AllWays Health Partners coverage to be in effect when medical care supplies are obtained, all care and supplies must be authorized and provided by participating care physicians (as listed above).

Acuerdo: La información proporcionada en esta forma es veraz y completa. Asigno (asignmos) beneficios a AllWays Health Partners por el costo de servicios cuando la responsabilidad del pago sea de otro plan de salud/HMO, plan de compensación para trabajadores o otro tipo de cobertura. Estoy (estamos) de acuerdo que AllWays Health Partners y sus Proveedores de Cuidado de Salud afiliados puenden obtener o divulger mi (nuestra) información médica, incluyendo registros medicos, cobertura médica disponible o otra información médica, con el própósito de administrar beneficios, evaluar la atención médica proporcionada, realizar revisiones y análisis de control de calidad, realizar investigaciones médica y/o cuando es requerida por la ley. Yo entiendo (entendemos) que para que la cobertura de AllWays Health Partners tenga vigencia para la obtención de suministros médicos, toda la atención y todos los sumistros deben ser autorizados y proporcionados por un medico de cuidado primario paricipante autorizado (segun se indica arriba).

All information must be completed and form signed before processing can begin

Employee's signature: ______________________________ Date: ____________

Employer contact

Return white original to AllWays Health Partners — Yellow copy to employer — Pink copy to employee

PRODUCT PORTFOLIO REFERENCE GRID

AllWays Health Partners Complete HMO Plans for Intermediary Small Group

Effective April 1, 2021

All plans meet Medicare Part D creditable coverage requirements.
All plans meet Minimum Creditable Coverage requirements.

				OUTPATIENT						INPATIENT		MENTAL HEALTH & SUBSTANCE USE (MH/SU)		PHARMACY
Complete HMO Plans	Metallic Tier	Deductible (D) Individual/ Family (embedded, unless otherwise noted)	Maximum Out-of-Pocket Individual/ Family (embedded)	Office Visit PCP/ Specialist	Emergency Room (Copayment waived if Admitted)	Diagnostic, Imaging & X-ray	Lab	High-tech Radiology	Outpatient Surgery	Inpatient Medical	SNF (100 days/ benefit period) and Rehab (60 days/ benefit period) per Admission	Outpatient MH/SU Visits including Rehab and Detox	Inpatient MH/SU per Admission	Pharmacy Cost-Sharing by Tiers for a 30-day supply 1/2/3/4/5/6
Complete HMO 25/40	Platinum	None	$3,000/$6,000	$25/$40	$150	$0	$0	$150	$250	$500	$500	$25	$500	$10/$25/$40/$80/$100/$250
Complete HMO 500 25/45	Gold	$500/$1,000	$7,900/$15,800	$25/$45	$250	$45	$45	$250	(D) $250	(D) $500	(D) $500	$25	(D) $500	$10/$30/$50/$100/$125/$250
Complete HMO 1000 25/50	Gold	$1,000/$2,000	$7,900/$15,800	$25/$50	$250	(D) $50	(D)	(D) $250	(D) $250	(D) $250	(D) $500	$25	(D) $500	$10/$30/$50/$100/$125/$250
Complete HMO 1500 25/50	Gold	$1,500/$3,000	$7,900/$15,800	$25/$50	$250	(D) $50	(D)	(D) $250	(D) $250	(D) $300	(D) $500	$25	(D) $500	$10/$30/$50/$100/$125/$250
Complete HMO 2000 25/40/350	Gold	$2,000/$4,000	$8,000/$16,000	$25/$40	$350	(D) $50	(D) $25	(D) $250	(D) $250	(D) $500	(D) $500	$25	(D) $500	$10/$30/$50/$100/$125/$250
Complete HMO 2000 25/45	Silver	$2,000/$4,000	$8,000/$16,000	$25/$45	(D) $750	(D) $125	(D) $45	(D) $350	(D) $250	(D) $500	(D) $500	$25	(D) $500	$10/$45/$175/$250/$175/$250
Complete HMO 2000 35%	Silver	$2,000/$4,000	$8,550/$17,100	$30/$50	(D) 35%	(D) $50	(D) $30	(D) 35%	(D) 35%	(D) 35%	(D) 35%	$30	(D) 35%	$10/$30/(D)35%/(D)35%/ (D)35%/(D)35%
Complete HMO 2500 25/50	Silver	$2,500/$5,000	$8,550/$17,100	$25/$50	(D) $300	(D) $60	(D) $25	(D) $250	(D) $250	(D) $500	(D) $500	$25	(D) $500	$10/$30/(D)$50/(D)$150/(D)$175/(D)$250
Complete HMO 3000	Silver	$3,000/$6,000	$8,550/$17,100	$40/$55	(D) $300	(D) $55	(D) $40	(D) $300	(D) $300	(D) $500	(D) $500	$40	(D) $500	$10/$30/$50/(D)$150/ $175/(D)$250
HSA Plans with Enhanced FlexRx (where certain preventive drugs bypass the plan's deductible)														
Complete HMO HSA 2500 30/45/250 Enhanced FlexRx	Silver	$2,500/$5,000 Aggregate	$7,000/$14,000	(D): $30/$45	(D) $250	(D) $45	(D) $45	(D) $150	(D) $250	(D) $500	(D) $500	(D) $30	(D) $500	(D) then: $10/$30/$60/$100/$125/$250
Complete HMO HSA 3600 35/50 Enhanced FlexRx	Silver	$3,600/$7,200	$7,000/$14,000	(D): $35/$50	(D) $750	(D) $50	(D) $50	(D) $500	(D) $1,000	(D) $1,000	(D) $1,000	(D) $35	(D) $1,000	(D) then: $10/$30/$60/$100/$125/$250

(D) = Deductible must be met first, then copayment or coinsurance may apply. Cost sharing for medical, behavioral health, pharmacy, and dental applies to the out-of-pocket maximum.
Note: Plans are ordered based on relativity to the first plan of each section.

allways℠ HEALTH PARTNERS

PRODUCT PORTFOLIO REFERENCE GRID

AllWays Health Partners HMO Plans for Intermediary Small Group

Effective April 1, 2021

Great Access and Value

- For members age 18 and younger: The first three PCP sick office visits and behavioral health office visits at no cost to members*
- An enhanced prescription drug benefit that includes a broad list of preventive medications covered before an HSA plan's deductible
- Our fitness reimbursement provides up to $150 for individual coverage or up to $300 for family coverage per calendar year.

*Does not apply to HSA plans

PRODUCT PORTFOLIO REFERENCE GRID

AllWays Health Partners Choice Easy Tier HMO Plans for Intermediary Small Group

Effective April 1, 2021

All plans meet Medicare Part D creditable coverage requirements.
All plans meet Minimum Creditable Coverage requirements.

				OUTPATIENT						INPATIENT		MENTAL HEALTH & SUBSTANCE USE (MH/SU)		PHARMACY
Choice Easy Tier HMO Plans	Metallic Tier	Deductible (D) Individual/ Family (embedded)	Out-of-Pocket Maximum Individual/ Family (embedded)	Office Visit PCP/ Specialist	Emergency Room (Copayment waived if Admitted)	Diagnostic, Imaging & X-ray	Lab	High-tech Radiology	Outpatient Surgery	Inpatient Medical	SNF (100 days/ benefit period) and Rehab (60 days/ benefit period) per Admission	Outpatient MH/SU Visits Including Rehab and Detox	Inpatient MH/SU per Admission	Pharmacy Cost-Sharing by Tiers for a 30-day supply 1/2/3/4/5/6
Choice Easy Tier HMO 500	Gold	$500/$1,000	$7,900/$15,800	$25/$40	$300	Tier 1: (D) $35 Tier 2: (D) $135	(D) $35	Tier 1: (D) Tier 2: (D) $450	Tier 1: (D) $250 Tier 2: (D) $1,500	Tier 1: (D) $500 Tier 2: (D) $2,000	(D) $500	$25	(D) $500	$10/$25/$50/ $100/$150/$250
Choice Easy Tier HMO 1000	Gold	$1,000/$2,000	$7,900/$15,800	$25/$40	$300	Tier 1: (D) $35 Tier 2: (D) $135	(D) $35	Tier 1: (D) $75 Tier 2: (D) $525	Tier 1: (D) $250 Tier 2: (D) $1,500	TTier 1: (D) $500 Tier 2: (D) $2,000	(D) $500	$25	(D) $500	$10/$25/$50/ $100/$150/$250
Choice Easy Tier HMO 1500	Gold	$1,500/$3,000	$7,900/$15,800	$25/$40	$300	Tier 1: (D) $35 Tier 2: (D) $135	(D) $35	Tier 1: (D) $75 Tier 2: (D) $525	Tier 1: (D) $250 Tier 2: (D) $1,500	Tier 1: (D) $500 Tier 2: (D) $2,000	(D) $500	$25	(D) $500	$10/$25/$50/ $100/$150/$250
Choice Easy Tier HMO 2000	Gold	$2,000/$4,000	$8,150/$16,300	$25/$40	$300	Tier 1: (D) Tier 2: (D) $100	(D)	Tier 1: (D) $75 Tier 2: (D) $525	Tier 1: (D) $250 Tier 2: (D) $1,500	Tier 1: (D) $500 Tier 2: (D) $2,000	(D) $500	$25	(D) $500	$10/$25/$50/ $100/$150/$250
Choice Easy Tier HMO 1500 10%/30%	Gold	$1,500/$3,000	$7,900/$15,800	$25/$40	(D) 10%	Tier 1: (D) $35 Tier 2: (D) $135	(D) $35	Tier 1: (D) 10% Tier 2: (D) 30%	Tier 1: (D) 10% Tier 2: (D) 30%	Tier 1: (D) 10% Tier 2: (D) 30%	(D) 10%	$25	(D) 10%	$10/$25/(D)30%/ (D)30%/(D)30%/(D)30%
Choice Easy Tier HMO 3000	Silver	$3,000/$6,000	$8,150/$16,300	$40/$50	(D) $500	Tier 1: (D) $125 Tier 2: (D) $225	(D) $75	Tier 1: (D) $500 Tier 2: (D) $1,500	Tier 1: (D) $250 Tier 2: (D) $1,500	Tier 1: (D) $500 Tier 2: (D) $2,000	(D) $500	$40	(D) $500	$10/$25/$50/ $100/$150/$250
Choice Easy Tier HMO 2500 15%/35%	Silver	$2,500/$5,000	$8,150/$16,300	$35/$50	(D) 15%	Tier 1: (D) $75 Tier 2: (D) $175	(D) $55	Tier 1: (D) 15% Tier 2: (D) 35%	Tier 1: (D) 15% Tier 2: (D) 35%	Tier 1: (D) 15% Tier 2: (D) 35%	(D) 15%	$35	(D) 15%	$10/$30/(D)35%/(D)35%/ (D)35%/(D)35%

(D) = Deductible must be met first, then copayment or coinsurance may apply. Cost sharing for medical, behavioral health, pharmacy, and dental applies to the out-of-pocket maximum.

Note: Plans are ordered based on relativity to the first plan on this grid.

IMPORTANT NOTICE: These plans include a Tiered Provider Network called Easy Tier Hospital Network. In these plans, members pay different levels of Copayments, Coinsurance, and/or Deductibles depending on the tier of the provider delivering a covered service or supply. These plans may make changes to a provider's benefit tier annually on January 1. Please consult the Easy Tier Hospital Network provider directory or visit **allwayshealthpartners.org** to determine the tier of providers in the Easy Tier Hospital Network.

Comprehensive benefits that are simple to understand and easy to use

About Easy Tier Hospital Network

Easy Tier plans are simple to understand and use. This plan divides the hospital network into higher and lower cost tiers: Tier 1 (lower cost) and Tier 2 (higher cost). In addition, the tiering is limited to these services: inpatient medical services, outpatient diagnostic imaging and X-ray (including ultrasound), outpatient high-tech radiology (CT Scans, MRIs, etc.), outpatient surgery, outpatient short-term rehabilitation (cardiac, physical, occupational, and speech therapy).

All hospitals in our Easy Tier Hospital Network plans must meet high-quality standards and are measured by a set of quality benchmarks from publicly available resources like Leapfrog and Hospital Compare. To determine a hospital's tier, we used statewide cost data from the Center for Health Information and Analysis, an agency of the Commonwealth of Massachusetts. Based on this data, we identified cost efficient hospitals by hospital type and placed these hospitals in Tier 1 (lower cost).

Tier 1, lower cost: Most hospitals and affiliated facilities fall into the lower-cost tier, including popular local hospitals like Newton-Wellesley Hospital, North Shore Medical Center, and South Shore Hospital.

Tier 2, higher cost: Higher cost sharing applies only to the following hospitals and some of their affiliated facilities: Beth Israel Deaconess Medical Center, Boston Children's Hospital, Boston Medical Center, Brigham and Women's Hospital, Dana Farber Cancer Institute, Massachusetts Eye and Ear Infirmary, Massachusetts General Hospital, New England Baptist Hospital, Tufts Medical Center, and UMASS Memorial Medical Center

To look up any network hospital's tier, visit **allwayshealthpartners.org**.

Embedded Deductible and/or Out-of-Pocket Maximum

All members are responsible for the individual deductible per benefit period. The family deductible can be satisfied by combining the deductibles paid by covered family members. With family coverage, the family out-of-pocket maximum is satisfied by combining the deductibles, coinsurance, and copayment amounts paid by covered family members. A covered family member will not exceed the individual out-of-pocket maximum amount.

Aggregate Deductible

With family coverage, the individual deductible amount does not apply. The entire family deductible amount must be met before benefits are payable for anyone in the family.

All Plans Include:

- Access to our strong and growing provider network that is on par with other insurers
- Exclusive access to On Demand℠ for convenient, high-quality virtual urgent care visits for minor illnesses or injuries right from a tablet, smart phone, or computer
- DoctorSmart℠ Rewards program gives members cash back when they select to have certain services with a high-value provider
- Fitness reimbursement: Up to $150 for individual coverage or $300 for family coverage per calendar year
- Weight loss benefit: Up to 6 months of membership at Weight Watchers or Jenny Craig*
- No limits for mental health/substance use outpatient office visits or inpatient admissions
- Childbirth education class reimbursement: $130 per pregnancy
- Pediatric vision benefits for members up to age 19 powered by EyeMed
- Pediatric Dental for members up to age 19 through Delta Dental

Medical Benefits (Outpatient, Inpatient, Other)

- No copayment, deductible or coinsurance applies to preventive services when through an in-network provider
- Routine eye exam at no cost sharing for members diagnosed with diabetes**
- Physical/occupational therapy: Coverage up to 60 combined visits for rehabilitation and habilitation each per benefit period
- For HMO plans, a referral is needed for any specialty care, with the following exceptions when provided by an AllWays Health Partners provider:
  - Gynecologist or Obstetrician for routine, preventive, or urgent care
  - Family planning services
  - Outpatient and diversionary behavioral health services
  - Emergency services provided by any provider
  - Routine eye exam
  - Physical, occupational, and speech therapy

Pharmacy Benefits

Our FlexRx℠ pharmacy solutions control pharmacy costs while offering money and time savings for members:

- 6-Tier coverage for a wide variety of medications, including a $10 low-cost tier**
- Coverage of 11 common prescriptions to treat chronic conditions, such as depression, diabetes, high cholesterol, and high blood pressure with $0 cost**
- An over-the-counter (OTC) drug benefit that covers many common OTC cough, cold, and allergy drugs and products with a prescription
- A 90-day supply of maintenance medications through mail order or retail pharmacies. Cost-sharing is 2x/2x/2x/3x of the 30-day supply, except on tiers with coinsurance.

*One per policy (either subscriber or dependent); weight loss membership benefit excludes food
**Deductible applies first for HSA plans, following IRS rules

Evidence of Coverage is comprised of the AllWays Health Partners Schedule of Benefits and Member Handbook.

Underwritten by AllWays Health Partners, Inc.

allwayshealthpartners.org

Member of Mass General Brigham

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