Small Business Service Bureau, Inc.®

Harvard Pilgrim Health Care

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 **(choose at least 1)**

- Tax Documentation: Schedule C, WR1 SE
- Business License or Permit for Commercial Operation
- Validation from MA Secretary of State's Office or applicable city/town clerk's office
- Copy of Business related Bank Statement
- Report from a business credit rating agency
- Declaration Statement of Worker's Compensation or Commercial Property/Casualty Insurance

___ 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.®

HARVARD PILGRIM HEALTH CARE GROUP CENSUS AND PLAN SELECTION FORM

Harvard Pilgrim Health Care

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 family member of an owner?
_____Yes _____No

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

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

a) Either includes ACA Required Pediatric Oral Health Services; or

b) Excludes this mandated benefit. If an employer group excludes Pediatric dental coverage, an Attestation Form must be submitted on behalf of all eligible employees and dependents.

HMO Plans	Pedi Dental	
	With	Without
HMO 25-Flex	❑	❑
HMO 500-Flex	❑	❑
HMO 1000-Flex	❑	❑
HMO 1500-Flex	❑	❑
HMO 2000-Flex	❑	❑
HMO 2000 with Coinsurance-Flex	❑	❑
HMO 2000-Value-Flex	❑	❑

HSA HMO Plans	Pedi Dental	
	With	Without
HSA HMO 2000-Flex	❑	❑
HSA HMO 3000-Flex	❑	❑
HSA HMO 3400-Flex	❑	❑

HMO Plans	Only offered with Pedi Dental
	With
HMO 2000 Low-Flex	❑
HMO 3000 Flex	❑
HMO 3500-Flex	❑

Core HMO Plans	Only offered with Pedi Dental
	With
HMO 1750 Core - Flex	❑
HMO 3500 Core - Flex	❑

Standard Connector	Only offered with Pedi Dental
	With
Standard Platinum-Flex	❑
Standard High Gold-Flex	❑
Standard Silver	❑
Standard Low Silver HSA-Flex	❑
Standard High Bronze	❑

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.			

*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

Small Business Service Bureau, Inc.®

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

The Harvard Pilgrim HMO Enrollment/Change Form

P.O. Box 9185 • Quincy, MA 02269
1-888-333-HPHC

Please return completed form to
Small Business Service Bureau, Inc.

REASON FOR SUBMISSION (Please check all that apply)

☐ **ENROLLMENT**
- ☐ NEW HIRE
- ☐ LOSS OF INSURANCE (ATTACH DOCUMENTS)
- ☐ ANNUAL OPEN ENROLLMENT
- ☐ COBRA
- ☐ TERMINATE DEPENDENT
- ☐ P/T TO F/T DATE _____
- ☐ OTHER _____

☐ **CHANGE**
- ☐ CHANGE COVERAGE TYPE
- ☐ ADD DEPENDENT LISTED BELOW (ATTACH DOCUMENTS)
- LISTED BELOW
- ☐ OTHER _____
- ☐ NAME/ADDRESS CHANGE
- ☐ LOSS OF INSURANCE
- ☐ MOVED FROM SERVICE AREA
- ☐ MARRIAGE DATE _____

☐ **TERMINATION**
- ☐ LEFT EMPLOYMENT
- ☐ NO LONGER ELIGIBLE
- ☐ VOLUNTARY CANCELLATION
- ☐ DECEASED DATE _____
- ☐ OTHER _____

CONTRACT / ID NUMBER	GROUP / COMPANY NAME	DATE OF HIRE	DIVISION	EFFECTIVE DATE
H P				

EMPLOYEE NAME

FIRST **MIDDLE** **LAST**

ADDRESS

APT. NO. STREET PO BOX

CITY STATE ZIP COUNTY

TELEPHONE (HOME) ( )

TELEPHONE (WORK) ( )

TYPE OF COVERAGE
☐ INDIVIDUAL ☐ 2-PERSON (Only where offered) MARITAL STATUS _____
☐ FAMILY ☐ OTHER _____

PLEASE USE THE CODES LISTED BELOW TO COMPLETE DEPENDENT RELATION BLOCK

02 SPOUSE 03 UNMARRIED CHILD UNDER 19 04 UNMARRIED STEPCHILD UNDER 19
05* UNMARRIED FULL-TIME STUDENT OVER AGE 19 06 HANDICAPPED (VERIFICATION REQUIRED) 07 EX-SPOUSE

IT IS VERY IMPORTANT THAT EACH MEMBER SELECT A PRIMARY CARE PHYSICIAN.
AS A PLAN MEMEBER YOU MUST CHOOSE A PRIMARY CARE PHYSICIAN (PCP). IF YOU DO NOT HAVE A PCP, NON-EMERGENCY AND MOST SPECIALITY CARE MAY NOT BE COVERED

FIRST MI LAST (IF NOT THE SAME AS EMPLOYEE)	LANGUAGE CODE	DATE OF BIRTH MO DAY YR	SEX	RELATION CODE	SOCIAL SECURITY NUMBER	SELECT A PRIMARY CARE PHYSICIAN AND TOWN FOR EACH MEMBER	ARE YOU A REGULAR PATIENT OF THIS DOCTOR?	DO NOT WRITE PCP#
EMPLOYEE		- -	M F	01	- -		Y N	
SPOUSE		- -	M F		- -		Y N	
DEPENDENT		- -	M F		- -		Y N	
DEPENDENT		- -	M F		- -		Y N	
DEPENDENT		- -	M F		- -		Y N	
DEPENDENT		- -	M F		- -		Y N	

LANGUAGE CODES (Optional)

WHAT LANGUAGE DO YOU SPEAK MOST OFTEN? PLEASE LIST THE APPROPRIATE CODE AFTER EACH MEMBER'S NAME. THIS INFORMATION WILL HELP US WORK TOWARD BEST MEETING YOUR NEEDS.

AS	CA	CV	EN	FR	HA	HM	IT	KH	LO	MN	PT	RU	SP	VI	OTHER ☐
American Sign Language	Cantonese	Cape Verdean	English	French	Hatian	Hmong	Italian	Khmer	Laotian	Mandarin	Portuguese	Russian	Spanish	Vietnamese	Specify

***IF YOU HAVE LISTED FULL-TIME STUDENT(S) OVER AGE 19 BUT UNDER THE MAXIMUM STUDENT AGE, SUPPLY THE FOLLOWING INFORMATION:**

STUDENT(S) NAME NAME OF SCHOOL(S)

THIS INFORMATION MAY BE USED TO VERIFY ELIGIBILITY

HAVE YOU EVER BEEN A MEMBER OF *Pilgrim Health Care*, Harvard Community Health Plan, HCHP OF NE, HPHC OR HPHC OF NE? ☐ YES ☐ NO

IF YOU WOULD LIKE TO RECEIVE A MENU OF ELECTRONIC WAYS TO INTERACT WITH US, LIST YOUR E-MAIL ADDRESS HERE.

EMAIL ADDRESS: _____ (OPTIONAL)

THE E-MAIL MENU YOU RECEIVE MAY INCLUDE CHOICES SUCH AS; SECURE E-MAIL WITH YOUR PHYSICIAN, REPLACEMENT OF HPHC MAILINGS WITH E-MAILS POINTING TO OUR WEB-SITES, HEALTH-RELATED UPDATES AND REMINDERS, AND OTHER POSSIBLE OPTIONS. CONFIDENTIAL E-MAIL WILL BE SENT THROUGH A SECURE WEB-SITE, AND YOU WILL RECEIVE NOTIFICATION THAT THERE IS A MESSAGE FOR YOU AT THE SITE. NON-CONFIDENTIAL UPDATES AND REMINDERS YOU ELECT TO RECEIVE WILL BE SENT DIRECTLY TO THE E-MAIL ADDRESS LISTED ABOVE.

YOUR E-MAIL ADDRESS WILL BE STORED IN A PROTECTED DATABASE AND WILL REMAIN CONFIDENTIAL.

I UNDERSTAND THAT MEMBERSHIP WILL BECOME EFFECTIVE UPON ACCEPTANCE BY THE PLAN AND THAT BENEFITS UNDER THE PLAN WILL BE EXPLAINED IN A SEPARATE DOCUMENT. I ALSO UNDERSTAND THAT THE SUBROGATION PROVISION APPLICABLE TO MAINE MEMBERS, OUTLINED IN A SEPARATE DOCUMENT, PERMITS SUBROGATION PAYMENTS ON A JUST AND EQUITABLE BASIS. DURING MY MEMBERSHIP, I AUTHORIZE ANY HEALTH CARE PROVIDER OR OTHER HEALTH PLAN TO PROVIDE MEDICAL INFORMATION AND RECORDS TO THE PLAN, THE PLAN ADMINISTRATOR, OR PLAN AFFILIATED HEALTH CARE PROVIDERS. I ALSO AUTHORIZE THE PLAN, THE PLAN ADMINISTRATOR, AND ANY PLAN HEALTH CARE PROVIDERS RENDERING SERVICES TO ME OR MY DEPENDENTS TO RECEIVE COPIES OF MY OR MY DEPENDENTS' MEDICAL RECORDS. I AUTHORIZE THE USE BY THE PLAN, AND ITS AGENTS, OF ANY INFORMATION OBTAINED HEREUNDER FOR THE DELIVERY OF HEALTH SERVICE, TO DETERMINE ELIGIBILITY AND ENTITLEMENT TO BENEFITS (INCLUDING REIMBURSEMENT BY THIRD PARTIES), FOR EDUCATION AND RESEARCH IN ACCORDANCE WITH GOVERNMENT REGULATIONS, AND FOR THE OTHER PLAN PROFESSIONAL ACTIVITIES SUCH AS UTILIZATION REVIEW, QUALITY ASSURANCE, CASE MANAGEMENT, REFERRAL AND AUTHORIZATION, DISEASE MANAGEMENT, FRAUD DETECTION AND CERTAIN OVERSIGHT ACTIVITIES, SUCH AS ACCREDITATION AND REGULATORY AUDITS. I UNDERSTAND THAT A COPY OF THIS FORM WILL BE GIVEN TO ME, OR TO MY AUTHORIZED REPRESENTATIVE, UPON REQUEST.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

THE EMPLOYEE, SPOUSE AND ALL DEPENDENTS AGED 18 YEARS AND OVER MUST SIGN THIS FORM FOR ENROLLMENT.

EMPLOYEE SIGNATURE DATE DEPENDENT SIGNATURE (age 18 years – over) DATE DEPENDENT SIGNATURE (age 18 years – over) DATE

SPOUSE SIGNATURE (if applicable) DATE DEPENDENT SIGNATURE (age 18 years – over) DATE EMPLOYER SIGNATURE DATE

PLEASE RETURN ONE COPY TO SMALL BUSINESS SERVICE BUREAU, INC. SUBSCRIBER PLEASE MAKE A COPY TO USE AS YOUR TEMPORARY HARVARD PILGRIM ID WHP458 11/03

Small Business Service Bureau, Inc.®

Harvard Pilgrim Health Care

Pediatric Dental Attestation Form

Your health plan coverage provided by Harvard Pilgrim or its affiliates (the "Health Plan") DOES NOT include coverage for pediatric dental services, as required by the Patient Protection and Affordable Care Act. By signing below, I am attesting that each person covered under the Health Plan, now or in the future, also has coverage under the separate employer group dental plan listed above (the "Dental Plan") for the term of the Health Plan. The Dental Plan is an appropriate Exchange-certified stand-alone dental plan. Upon request, I agree to provide Harvard Pilgrim with documentation necessary to verify that each person covered under the Health Plan is also covered by the Dental Plan. If I am not able to provide such documentation or if Harvard Pilgrim determines that any person covered under the Health Plan is not also covered by an appropriate Exchange-certified stand-alone dental plan, I agree that Harvard Pilgrim may, without further consent from the employer group, charge the employer group appropriate premium for coverage of pediatric dental services. In addition, Harvard Pilgrim may, at its discretion, charge appropriate premium for coverage of pediatric dental services retroactively for the period during which any person covered by the Health Plan was not also covered by an appropriate Exchange-certified stand-alone dental plan.

Plan Sponsor Attestation

The undersigned, as duly-authorized representative for_____ ("Plan Sponsor"), hereby attests to Harvard Pilgrim Health Care that each member covered under the Harvard Pilgrim Health Care plan has obtained separate pediatric dental coverage from an Exchange-Certified dental plan that covers the member for the dates for which the Harvard Pilgrim Health Care plan is effective.

Certified by:_____ Date:_____

Harvard Pilgrim Health Care

Massachusetts Small Group Intermediary Products Plan Year 2021

Guiding Massachusetts
to better health.

cc90598 10_20

2021 product enhancements and updates

HMO 3500 - Flex *NEW*

We've enhanced our HMO portfolio by adding a competitive, more affordable non-HSA option with a higher deductible.[1]

Unlimited acupuncture and chiropractic visits

Our plans currently include unlimited chiropractic visits, and members on our 2021 Massachusetts plans will have unlimited acupuncture visits as well. Cost sharing will apply according to the terms of the member's plan.

Over-the-counter prescriptions available

We are adding certain over-the-counter (OTC) drugs to all of our formularies, including OTC drugs in certain therapy classes. Therapy classes include cough, cold and allergy; dermatology; gastrointestinal; pain; and ophthalmic preparations. Members must get a prescription for the OTC drug from their provider and will pay Tier 1 Rx cost sharing.

Benefit changes for 2021[2]

- **HMO 3000 - Flex**
  Our current HMO 3500 Flex will have a lower deductible of $3,000.
- **HMO 2000 Value - Flex**
  Our current HMO 2500 - Flex will have a lower deductible of $2,000.
- **PPO HSA 5000 - Flex**
  Our current PPO HSA 4500 - Flex will have many benefit cost-sharing changes for 2021, including an increased deductible of $5,000.

IMPORTANT REMINDERS

No cost sharing for Doctor On Demand urgent care visits

Members enrolled in non-HSA plans are not required to pay cost sharing for urgent care virtual visits with Doctor On Demand providers. Members on HSA plans will be billed for these visits, which will apply toward the in-network deductible.

One free PCP/behavioral health visit

Members on most of our non-HSA plans will receive one non-routine PCP and behavioral health visit at no charge. This excludes Standard Connector and Core HMO plans.

Increased fitness reimbursement up to $300

Virtual fitness subscriptions and fitness trackers are also eligible for reimbursement in lieu of a gym membership fee, up to $150 each for two family members.[3]

Save money with mail-order Rx

Outside of Standard Connector plans, all plans feature cost-savings opportunities on mail-order pharmacy cost sharing for generic and brand name drugs (Tiers 1, 2 and 3).

Lower cost sharing from freestanding providers

Members will pay lower cost sharing for services when using providers not affiliated with or owned by hospitals on most plans. Freestanding providers include ambulatory surgical centers; labs; high-end radiology centers; and physical, occupational and speech therapists. Available in all plans except Core plans (Flex providers are included on Core plans), Focus plans and certain Standard Connector plans. See Schedule of Benefits for details.

Preventive Rx included on all HSA plans

Preventive Rx benefits are available on all HSA plans.

HMO out-of-area dependent coverage

As of January 1, 2019, Harvard Pilgrim covers only unforeseen emergency care and urgent care for HMO out-of-area dependent members. This coverage is consistent with all other HMO plans for members who are traveling outside their plan's enrollment area.

†The current HMO 3500 - Flex is now the HMO 3000 - Flex.

[2] Please refer to the product grid on pages 3-8 for additional benefit changes.

[3] Reimbursement is limited to two members on a family contract. Must be currently enrolled in Harvard Pilgrim at the time of reimbursement. Restrictions apply. Fitness reimbursement may be considered taxable income. For tax information, members should consult their tax advisor.

2021 Massachusetts plan offerings

Massachusetts Small Group Intermediary Plans - Effective January 1, 2021 through December 31, 2021.

This is only a summary of plans. For more complete information, please refer to the Schedule of Benefits.

HMO

Product Name	Office Visit	Deductible	Out-of-Pocket Max	Co-insurance	ER	Urgent Care	Inpatient	Day Surgery	Labs	X-rays	Scans: CT, MRI, PET	PT/OT/ST	Chiro & Acupuncture	Rx Cost Sharing	
														Retail	Mail
HMO 25 - Flex **Metal Tier: Platinum** MD0000100147 RX0000100086 DN0000100045	$25/$40 Copay waived for first non-routine PCP visit	None/ None	$3,000/ $6,000	None	$125	Urgent care: $40 Convenience care: $25	$750 per admit	Flex provider: $150 Other: $500	Flex provider: CIF Other: $40	$40	Non-hospital-based: $125 per procedure Hospital-based: $200 per procedure	Non-hospital-based: $25 Hospital-based: $40	$40	$5/$25/$40/$60/20% (T5 $250 script max)	$10/$50/$80/ $180/20% (T5 $750/script max)
HMO 500 - Flex **Metal Tier: Gold** MD0000100148 RX0000100085 DN0000100046	$25/$50 Copay waived for first non-routine PCP visit	$500/ $1,000 Embedded	$7,000/ $14,000	None	$300	Urgent care: $50 Convenience care: $25	Ded then $200 per admit	Flex provider: $50 Other: Ded then $300	Flex provider: CIF Other: Ded then $45	Ded then $45	Non-hospital-based: $200 per procedure Hospital-based: Ded then $300 per procedure	Non-hospital-based: $25 Hospital-based: Ded then $50	$50	$5/$30/$60/ $100/20% (T5 $250/script max)	$10/$60/$120/ $300/20% (T5 $750/script max)
HMO 1000 - Flex **Metal Tier: Gold** MD0000100149 RX0000100085 DN0000100046	$25/$50 Copay waived for first non-routine PCP visit	$1,000/ $2,000 Embedded	$7,000/ $14,000	None	$300	Urgent care: $50 Convenience care: $25	Ded then $200 per admit	Flex provider: $50 Other: Ded then $300	Flex provider: CIF Other: Ded then $45	Ded then $45	Non-hospital-based: $200 per procedure Hospital-based: Ded then $300 per procedure	Non-hospital-based: $25 Hospital-based: Ded then $50	$50	$5/$30/$60/ $100/20% (T5 $250/script max)	$10/$60/$120/ $300/20% (T5 $750/script max)
HMO 1500 - Flex **Metal Tier: Gold** MD0000100150 RX0000100085 DN0000100046	$25/$50 Copay waived for first non-routine PCP visit	$1,500/ $3,000 Embedded	$7,000/ $14,000	None	$300	Urgent care: $50 Convenience care: $25	Ded then $250 per admit	Flex provider: $75 Other: Ded then $300	Flex provider: CIF Other: Ded then $45	Ded then $45	Non-hospital-based: $200 per procedure Hospital-based: Ded then $300 per procedure	Non-hospital-based: $25 Hospital-based: Ded then $50	$50	$5/$30/$60/ $100/20% (T5 $250/script max)	$10/$60/$120/ $300/20% (T5 $750/script max)
HMO 2000 - Flex **Metal Tier: Gold** MD0000100151 RX0000100085 DN0000100046	$25/$50 Copay waived for first non-routine PCP visit	$2,000/ $4,000 Embedded	$7,000/ $14,000	None	$300	Urgent care: $50 Convenience care: $25	Ded then $250 per admit	Flex provider: $75 Other: Ded then $300	Flex provider: CIF Other: Ded then $45	Ded then $45	Non-hospital-based: $200 per procedure Hospital-based: Ded then $300 per procedure	Non-hospital-based: $25 Hospital-based: Ded then $50	$50	$5/$30/$60/ $100/20% (T5 $250/script max)	$10/$60/$120/ $300/20% (T5 $750/script max)

HMO

Massachusetts Small Group Intermediary Plans - Effective January 1, 2021 through December 31, 2021.

This is only a summary of plans. For more complete information, please refer to the Schedule of Benefits.

Product Name	Office Visit	Deductible	Out-of-Pocket Max	Co-insurance	ER	Urgent Care	Inpatient	Day Surgery	Labs	X-rays	Scans: CT, MRI, PET	PT/OT/ST	Chiro & Acupuncture	Rx Cost Sharing	
														Retail	Mail
HMO 2000 with Coinsurance - Flex **Metal Tier: Gold** MD0000100152 RX0000100085 DN0000100046	$35/$70 Copay waived for first non-routine PCP visit	$2,000/ $4,000 Embedded	$7,000/ $14,000	20%	$500	Urgent care: $70 Convenience care: $35	Ded then 20%	Flex provider: $150 Other: Ded then 20%	Flex provider: CIF Other: Ded then 20%	Ded then 20%	Non-hospital-based: $150 per procedure Hospital-based: Ded then 20%	Non-hospital-based: $35 Hospital-based: Ded then 20%	$50	$5/$30/$60/ $100/20% (T5 $250/script max)	$10/$60/$120/ $300/20% (T5 $750/script max)
HMO 2000 Value - Flex **Metal Tier: Silver** MD0000100153 RX0000100087 DN0000100047	$50/$75 Copay waived for first non-routine PCP visit	$2,000/ $4,000 Embedded	$8,500/ $17,000	None	$1,000	Urgent care: $75 Convenience care: $50	Ded then $1,000 per admit	Flex provider: $250 Other: Ded then $1,000	Flex provider: $25 Other: Ded then $75	Ded then $100	Non-hospital-based: $750 per procedure Hospital-based: Ded then $1,000 per procedure	Non-hospital-based: $50 Hospital-based: Ded then $75	$50	$5/$30/$80/ $120/20% (T5 $500/script max)	$10/$60/$160/ $360/20% (T5 $1,500/script max)
HMO 2000 Low - Flex **Metal Tier: Gold** MD0000100142 RX0000100081 DN0000100040	$30/$55	$2,000/ $4,000 Embedded	$6,500/ $13,000	None	Ded then $350	Urgent care: $55 Convenience care: $30	Ded then $750 per admit	Flex provider: $250 Other: Ded then $500	Flex provider: $20 Other: Ded then $50	Ded then $75	Non-hospital-based: $200 per procedure Hospital-based: Ded then $300 per procedure	Non-hospital-based: $25 Hospital-based: $55	$50	$25/Ded then $50/ Ded then $125	$50/Ded then $100/ Ded then $375
HMO 3000 - Flex **Metal Tier: Silver** MD0000100154 RX0000100087 DN0000100047	$40/$65 Copay waived for first non-routine PCP visit	$3,000/ $6,000 Embedded	$8,500/ $17,000	None	Ded then $650	Urgent care: $65 Convenience care: $40	Ded then $1,000 per admit	Flex provider: $250 Other: Ded then $750	Flex provider: CIF Other: Ded then $65	Ded then $65	Non-hospital-based: $250 per procedure Hospital-based: Ded then $750 per procedure	Non-hospital-based: $40 Hospital-based: Ded then $65	$50	$5/$30/$80/ $120/20% (T5 $500/script max)	$10/$60/$160/ $360/20% (T5 $1,500/script max)
HMO 3500 - Flex **Metal Tier: Bronze** MD0000100155 RX0000100088 DN0000100048	Ded then $40/Ded then $65 Copay waived for first non-routine PCP visit	$3,500/ $7,000 Embedded	$8,500/ $17,000	20%	Ded then $750	Urgent care: Ded then $65 Convenience care: Ded then $40	Ded then 20%	Flex provider: Ded then $250 Other: Ded then $1,000	Flex provider: Ded then $25 Other: Ded then $75	Ded then $75	Non-hospital-based: Ded then $500 per procedure Hospital-based: Ded then $1,000 per procedure	Non-hospital-based: Ded then $40 Hospital-based: Ded then $65	Ded then $50	$5/$30/Ded then 50%/ Ded then 50%/ Ded then 50% (T3 $125/script max, T4 $250/script max, T5 $500/script max)	$10/$60/Ded then 50%/ Ded then 50%/ Ded then 50% (T3 $250/script max, T4 $750/script max, T5 $1,500/script max)

HMO and HMO HSA

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Product Name	Office Visit	Deductible	Out-of-Pocket Max	Co-insurance	ER	Urgent Care	Inpatient	Day Surgery	Labs	X-rays	Scans: CT, MRI, PET	PT/OT/ST	Chiro & Acupuncture	Rx Cost Sharing**	
														Retail	Mail
HMO 1750 Core - Flex **Metal Tier: Gold** MD0000100156 RX0000100089 DN0000100049	$35 copay for the first 3 visits per member* All other visits: Ded then 20%	$1,750/ $3,500 Embedded	$8,000/ $16,000	20%	Ded then $250	Urgent care and Convenience care: $35 copay for the first 3 visits per member* All other visits: Ded then 20%	Ded then 20%	Flex provider: $150 Other: Ded then 20%	Flex provider: CIF Other: Ded then 20%	Ded then 20%	Ded then 20%	$35 copay for the first 3 visits per member* All other visits: Ded then 20%	$35 copay for the first 3 visits per member* All other visits: Ded then 20%	$5/$30/$60/ $100/20% (T5 $250/script max)	$10/$60/$120/ $300/20% (T5 $750/script max)
HMO 3500 Core - Flex **Metal Tier: Silver** MD0000100157 RX0000100087 DN0000100047	$35 copay for the first 3 visits per member* All other visits: Ded then 30%	$3,500/ $7,000 Embedded	$8,500/ $17,000	30%	Ded then $250	Urgent care and Convenience care: $35 copay for the first 3 visits per member* All other visits: Ded then 30%	Ded then 30%	Flex provider: $150 Other: Ded then 30%	Flex provider: CIF Other: Ded then 30%	Ded then 30%	Ded then 30%	$35 copay for the first 3 visits per member* All other visits: Ded then 30%	$35 copay for the first 3 visits per member* All other visits: Ded then 30%	$5/$30/$80/ $120/20% (T5 $500/script max)	$10/$60/$160/ $360/20% (T5 $1,500/script max)
HMO HSA 2000 - Flex **Metal Tier: Silver** MD0000100158 RX0000100090 DN0000100050	Ded then $35/Ded then $55	$2,000/ $4,000 Non-embedded	$6,850/ $13,700	None	Ded then $400	Urgent care: Ded then $55 Convenience care: Ded then $35	Ded then $500 per admit	Flex provider: Ded then CIF Other: Ded then $250	Flex provider: Ded then CIF Other: Ded then $55	Ded then $55	Non-hospital-based: Ded then $200 per procedure Hospital-based: Ded then $400 per procedure	Non-hospital-based: Ded then $35 Hospital-based: Ded then $55	Ded then $50	Ded then $5/$30/$80/ $120/20% (T5 $500/script max)	Ded then $10/$60/$160/ $360/20% (T5 $1,500/script max)
HMO HSA 3000 - Flex **Metal Tier: Silver** MD0000100159 RX0000100091 DN0000100051	Ded then $35/Ded then $55	$3,000/ $6,000 Non-embedded	$6,850/ $13,700	None	Ded then $400	Urgent care: Ded then $55 Convenience care: Ded then $35	Ded then $500 per admit	Flex provider: Ded then CIF Other: Ded then $250	Flex provider: Ded then CIF Other: Ded then $55	Ded then $55	Non-hospital-based: Ded then $200 per procedure Hospital-based: Ded then $400 per procedure	Non-hospital-based: Ded then $35 Hospital-based: Ded then $55	Ded then $50	Ded then $5/$30/$80/ $120/20% (T5 $500/script max)	Ded then $10/$60/$160/ $360/20% (T5 $1,500/script max)
HMO HSA 3400 - Flex **Metal Tier: Silver** MD0000100160 RX0000100092 DN0000100052	Ded then $40/Ded then $75	$3,400/ $6,800 Non-embedded	$6,850/ $13,700	20%	Ded then $750	Urgent care: Ded then $75 Convenience care: Ded then $40	Ded then 20%	Flex provider: Ded then $250 Other: Ded then $1,000	Flex provider: Ded then $25 Other: Ded then $75	Ded then $100	Non-hospital-based: Ded then $500 per procedure Hospital-based: Ded then $1,000 per procedure	Non-hospital-based: Ded then $40 Hospital-based: Ded then $65	Ded then $50	Ded then $5/$30/$80/ $120/20% (T5 $500/script max)	Ded then $10/$60/$160/ $360/20% (T5 $1,500/script max)

* 6 per family.

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PPO HSA (No longer available for new business)

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														Retail	Mail
PPO HSA 3400 - Flex **Metal Tier: Silver** MD0000100172 RX0000100092 DN0000100057	IN: Ded then $40/Ded then $75 OON: Ded then 20%	IN: $3,400/ $6,800 OON: $6,800/ $13,600 Non-embedded	IN: $6,850/ $13,700 OON: $13,700/ $27,400	IN: 20% OON: 20%	Ded then $750	Urgent care: IN: Ded then $75 OON: Ded then 20% Convenience care: IN: Ded then $40 OON: Ded then 20%	IN: Ded then 20% OON: Ded then 20%	IN: Flex provider: Ded then $250 Other: Ded then $1,000 OON: Ded then 20%	IN: Flex provider: Ded then $25 Other: Ded then $75 OON: Ded then 20%	IN: Ded then $100 OON: Ded then 20%	IN: Non-hospital-based: Ded then $500 per procedure Hospital-based: Ded then $1,000 per procedure OON: Ded then 20%	IN: Non-hospital-based: Ded then $40 Hospital-based: Ded then $65 OON: Ded then 20%	IN: Ded then $50 OON: Ded then 20%	Ded then $5/$30/$80/ $120/20% (T5 $500/ script max)	Ded then $10/$60/$160/ $360/20% (T5 $1,500/ script max)
PPO HSA 5000 - Flex **Metal Tier: Bronze** MD0000100173 RX0000100093 DN0000100066	IN: Ded then $60/Ded then $150 OON: Ded then 20%	IN: $5,000/ $10,000 OON: $10,000/ $20,000 Embedded	IN: $7,000/ $14,000 OON: $14,000/ $28,000	IN: None OON: 20%	Ded then $1,500	Urgent care: IN: Ded then $150 OON: Ded then 20% Convenience care: IN: Ded then $60 OON: Ded then 20%	IN: Ded then $1,500 per admit OON: Ded then 20%	IN: Flex provider: Ded then $250 Other: Ded then $1,000 OON: Ded then 20%	IN: Flex provider: Ded then $25 Other: Ded then $75 OON: Ded then 20%	IN: Ded then $150 OON: Ded then 20%	IN: Non-hospital-based: Ded then $500 per procedure Hospital-based: Ded then $1,000 per procedure OON: Ded then 20%	IN: Non-hospital-based: Ded then $40 Hospital-based: Ded then $65 OON: Ded then 20%	IN: Ded then $50 OON: Ded then 20%	Ded then $5/$30/50%/ 50%/50% (T3 $125/script max, T4 $250/script max, T5 $500/script max)	Ded then $10/60/50%/ 50%/50% (T3 $250/script max, T4 $750/script max, T5 $1,500/script max)

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Connector plans

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														Retail	Mail
Standard Platinum - Flex **Metal Tier: Platinum** MD0000100140 RX0000100078 DN0000100037	$20/$40	None/ None	$3,000/ $6,000	None	$150	Urgent care: $40 Convenience care: $20	$500 per admit	Flex provider: $100 Other: $250	CIF	CIF	Non-hospital-based: $50 per procedure Hospital-based: $150 per procedure	Non-hospital-based: $20 Hospital-based: $40	$40	$10/$25/$50	$20/$50/$150
Standard High Gold - Flex **Metal Tier: Gold** MD0000100141 RX0000100080 DN0000100039	$25/$50	None/ None	$5,000/ $10,000	None	$300	Urgent care: $50 Convenience care: $25	$750 per admit	Flex provider: $100 Other: $500	Flex provider: CIF Other: $50	$75	Non-hospital-based: $100 per procedure Hospital-based: $400 per procedure	Non-hospital-based: $20 Hospital-based: $50	$50	$25/$50/$75	$50/$100/$225
HMO 2000 Low - Flex **Metal Tier: Gold** MD0000100142 RX0000100081 DN0000100040	$30/$55	$2,000/ $4,000 Embedded	$6,500/ $13,000	None	Ded then $350	Urgent care: $55 Convenience care: $30	Ded then $750 per admit	Flex provider: $250 Other: Ded then $500	Flex provider: $20 Other: Ded then $50	Ded then $75	Non-hospital-based: $200 per procedure Hospital-based: Ded then $300 per procedure	Non-hospital-based: $25 Hospital-based: $55	$50	$25/Ded then $50/ Ded then $125	$50/Ded then $100/ Ded then $375
Standard Silver **Metal Tier: Silver** MD0000100143 RX0000100082 DN0000100041	$25/$50	$2,000/ $4,000 Embedded	$8,550/ $17,100	None	Ded then $300	Urgent care: $50 Convenience care: $25	Ded then $1,000 per admit	Ded then $500	Ded then $50	Ded then $75	Ded then $400 per procedure	$50	$50	$25/$50/Ded then $75	$50/$100/Ded then $225

Connector plans

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														Retail	Mail
Standard Low Silver HSA - Flex **Metal Tier: Silver** MD0000100144 RX0000100083 DN0000100042	Ded then $30/Ded then $60	$2,000/ $4,000 Non-embedded	$6,850/ $13,700	None	Ded then $300	Urgent care: Ded then $60 Convenience care: Ded then $30	Ded then $750 per admit	Flex provider: Ded then $250 Other: Ded then $500	Flex provider: Ded then $20 Other: Ded then $60	Ded then $75	Non-hospital-based: Ded then $200 per procedure Hospital-based: Ded then $500 per procedure	Non-hospital-based: Ded then $30 Hospital-based: Ded then $60	Ded then $50	Ded then $30/ Ded then $60/ Ded then $105	Ded then $60/ Ded then $120/ Ded then $315
Standard High Bronze **Metal Tier: Bronze** MD0000100145 RX0000100084 DN0000100043	Ded then $40/Ded then $90	$2,700/ $5,400 Embedded	$8,550/ $17,100	None	Ded then $750	Urgent care: Ded then $90 Convenience care: Ded then $40	Ded then $1,200 per admit	Ded then $500	Ded then $75	Ded then $100	Ded then $1,000 per procedure	Ded then $90	$50	$30/Ded then $100/ Ded then $150	$60/Ded then $200/ Ded then $450

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