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 1000 with Coinsurance-Flex	❑	❑
HMO 1500-Flex	❑	❑
HMO 2000-Flex	❑	❑
HMO 2000 with Coinsurance-Flex	❑	❑
HMO 2000 with Copayment-Flex	❑	❑
HMO 3250-Flex **(only offered with Pedi Dental)**		❑

Core HMO Plans (only offered with Pedi Dental)	**Pedi Dental**
	With
HMO 1750 Core - Flex	❑
HMO 3250 Core - Flex	❑

HSA HMO Plans	**Pedi Dental**	
	With	Without
HSA HMO 2000-Flex	❑	❑
HSA HMO 2000 with Coinsurance-Flex	❑	❑
HSA HMO 3000-Flex	❑	❑
HSA HMO 3100-Flex	❑	❑

3 Tier Pharmacy Plans (only offered with Pedi Dental)	**Pedi Dental**
	With
Standard Platinum	❑
Standard High Gold	❑
Standard Low Gold	❑
Standard Silver	❑
Standard Low Silver HSA	❑
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

"I want a local partner that understands my needs."

Guiding Massachusetts to better health.

From Cape Cod to Boston and the Berkshires, Harvard Pilgrim's Massachusetts team has a deep-rooted history and strong relationships that span the state. As a not-for-profit company, our mission lets us focus on what matters most: healthier people and healthier communities.

Massachusetts Small Group
2019 Q2 Intermediaries Benefit Designs

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

The individual shown is representative only. The comment is a composite of sentiments often expressed by our members.

HMO														
Product Name	**Office Visit**	**Deductible**	**Annual Out Of Pocket Max**	**Co-insurance**	**ER**	**Urgent Care**	**Inpatient/ Day Surgery**	**Labs/ X-Rays**	**Scans: CT, MRI, PET**	**PT/OT/ ST**	**Acupuncture**	**RX Cost Share (Value Formulary)**	**Dental Cost Sharing**	**MA MCC Compliant?**
HMO 25 - Flex Platinum MD0000004934 RX0000001291	$25/$40	None/None	$1,700/$3,400	None	$125	Hosp: $40 Free: $40 Conv: $25	IP: $1,000 Per Admit Day: Flex Provider: $150 Others: $500	Labs: Flex Provider: CIF Others: $40 X-Rays: $40	$125	$25	$40	Retail: $5/$25/$40/$60/20% (T5 $250/script max) Mail: $12.50/$62.50/$100/$180/20% (T5 $750/script max)	CIF/20%/50%/50% No Deductible Dental OOPM: $1,350/$2,700 DN0000000453	Yes
HMO 500 - Flex Gold MD0000004935 RX0000001774	$25/$45	$500/$1,250	$6,000/$12,000	None	$300	Hosp: $45 Free: $45 Conv: $25	IP: Ded then $200 Per Admit Day: Flex Provider: $50 Others: Ded then $200	Labs: Flex Provider: CIF Others: Ded then $45 X-Rays: Ded then $45	Ded then $200	Ded then $25	$45	Retail: $5/$30/$60/$100/20% (T5 $250/script max) Mail: $12.50/$75/$150/$300/20% (T5 $750/script max)	CIF/20%/50%/50% No Deductible Dental OOPM: $1,350/$2,700 DN0000000456	Yes
HMO 1000 - Flex Gold MD0000004936 RX0000001775	$25/$45	$1,000/$2,500	$6,000/$12,000	None	$300	Hosp: $45 Free: $45 Conv: $25	IP: Ded then $200 Per Admit Day: Flex Provider: $50 Others: Ded then $200	Labs: Flex Provider: CIF Others: Ded then $45 X-Rays: Ded then $45	Ded then $200	Ded then $25	$45	Retail: $5/$30/$60/$100/20% (T5 $250/script max) Mail: $12.50/$75/$150/$300/20% (T5 $750/script max)	CIF/20%/50%/50% No Deductible Dental OOPM: $1,350/$2,700 DN0000000456	Yes
HMO 1000 with Coinsurance - Flex Gold MD0000004937 RX0000001775	$30/$55	$1,000/$2,500	$6,000/$12,000	20%	$400	Hosp: $55 Free: $55 Conv: $30	IP: Ded then 20% Day: Flex Provider: $150 Others: Ded then 20%	Labs: Flex Provider: CIF Others: Ded then 20% X-Rays: Ded then 20%	Ded then 20%	Ded then 20%	$55	Retail: $5/$30/$60/$100/20% (T5 $250/script max) Mail: $12.50/$75/$150/$300/20% (T5 $750/script max)	CIF/20%/50%/50% No Deductible Dental OOPM: $1,350/$2,700 DN0000000456	Yes
HMO 1500 - Flex Gold MD0000004938 RX0000001775	$25/$45	$1,500/$3,750	$6,000/$12,000	None	$300	Hosp: $45 Free: $45 Conv: $25	IP: Ded then $250 Per Admit Day: Flex Provider: $75 Others: Ded then $200	Labs: Flex Provider: CIF Others: Ded then $45 X-Rays: Ded then $45	Ded then $200	Ded then $25	$45	Retail: $5/$30/$60/$100/20% (T5 $250/script max) Mail: $12.50/$75/$150/$300/20% (T5 $750/script max)	CIF/20%/50%/50% No Deductible Dental OOPM: $1,350/$2,700 DN0000000456	Yes
HMO 2000 - Flex Gold MD0000004939 RX0000001775	$25/$45	$2,000/$5,000	$6,000/$12,000	None	$300	Hosp: $45 Free: $45 Conv: $25	IP: Ded then $250 Per Admit Day: Flex Provider: $75 Others: Ded then $200	Labs: Flex Provider: CIF Others: Ded then $45 X-Rays: Ded then $45	Ded then $200	Ded then $25	$45	Retail: $5/$30/$60/$100/20% (T5 $250/script max) Mail: $12.50/$75/$150/$300/20% (T5 $750/script max)	CIF/20%/50%/50% No Deductible Dental OOPM: $1,350/$2,700 DN0000000456	Yes
HMO 2000 with Coinsurance - Flex Gold MD0000004940 RX0000001775	$35/$70	$2,000/$5,000	$6,000/$12,000	20%	$500	Hosp: $70 Free: $70 Conv: $35	IP: Ded then 20% Day: Flex Provider: $150 Others: Ded then 20%	Labs: Flex Provider: CIF Others: Ded then 20% X-Rays: Ded then 20%	Ded then 20%	Ded then 20%	$50	Retail: $5/$30/$60/$100/20% (T5 $250/script max) Mail: $12.50/$75/$150/$300/20% (T5 $750/script max)	CIF/20%/50%/50% No Deductible Dental OOPM: $1,350/$2,700 DN0000000456	Yes

HMO														
Product Name	**Office Visit**	**Deductible**	**Annual Out Of Pocket Max**	**Co-insurance**	**ER**	**Urgent Care**	**Inpatient/ Day Surgery**	**Labs/ X-Rays**	**Scans: CT, MRI, PET**	**PT/OT/ ST**	**Acupuncture**	**RX Cost Share (Value Formulary)**	**Dental Cost Sharing**	**MA MCC Compliant?**
HMO 2000 with Copayment - Flex Silver MD0000004941 RX0000001777	$40/$65	$2,000/$5,000	$7,500/$15,000	None	$1,000	Hosp: $65 Free: $65 Conv: $40	IP: Ded then $1,000 Per Admit Day: Flex Provider: $250 Others: Ded then $1,000	Labs: Flex Provider: CIF Others: Ded then $65 X-Rays: Ded then $65	Ded then $1,000	Ded then $40	$50	Retail: $5/$30/$80/$120/20% (T5 $500/script max) Mail: $12.50/$75/$200/$360/20% (T5 $1,500/script max)	CIF/20%/50%/50% No Deductible Dental OOPM: $550/$1,100 DN0000000464	Yes
HMO 3250 - Flex Silver MD0000004942 RX0000001777	$40/$65	$3,250/$6,500	$7,500/$15,000	None	$650	Hosp: $65 Free: $65 Conv: $40	IP: Ded then $1,000 Per Admit Day: Flex Provider: $250 Others: Ded then $750	Labs: Flex Provider: CIF Others: Ded then $65 X-Rays: Ded then $65	Ded then $650	Ded then $40	$50	Retail: $5/$30/$80/$120/20% (T5 $500/script max) Mail: $12.50/$75/$200/$360/20% (T5 $1,500/script max)	CIF/20%/50%/50% No Deductible Dental OOPM: Medical OOPM applies DN0000000458	Yes
HMO 1750 Core - Flex Gold MD0000004943 RX0000001776	$35 for the first 3 visits per mem (6 per fam). All other visits Ded then 20%	$1,750/$3,500	$7,500/$15,000	20%	Ded then $250	Hosp: $35 for the first 3 visits per mem (6 per fam). All other visits Ded then 20% Free: $35 for the first 3 visits per mem (6 per fam). All other visits Ded then 20% Conv: $35 for the first 3 visits per mem (6 per fam). All other visits Ded then 20%	IP: Ded then 20% Day: Freestanding: $150 Others: Ded then 20%	Labs: Flex: CIF Others: Ded then 20% X-Rays: Ded then 20%	Ded then 20%	$35 for the first 3 visits per mem (6 per fam). All other visits Ded then 20%	$35 for the first 3 visits per mem (6 per fam). All other visits Ded then 20%	Retail: $5/$30/$60/$100/20% (T5 $250/script max) Mail: $12.50/$75/$150/$300/20% (T5 $750/script max)	CIF/20%/50%/50% No Deductible Dental OOPM: Medical OOPM applies DN0000000458	Yes

HMO														
Product Name	**Office Visit**	**Deductible**	**Annual Out Of Pocket Max**	**Co-insurance**	**ER**	**Urgent Care**	**Inpatient/ Day Surgery**	**Labs/ X-Rays**	**Scans: CT, MRI, PET**	**PT/OT/ ST**	**Acupuncture**	**RX Cost Share (Value Formulary)**	**Dental Cost Sharing**	**MA MCC Compliant?**
HMO 3250 Core - Flex	$35 for the first 3 visits per mem (6 per fam). All other visits Ded then 30%	$3,250/$6,500	$7,500/$15,000	30%	Ded then $250	Hosp: $35 for the first 3 visits per mem (6 per fam). All other visits Ded then 30%	IP: Ded then 30%	Labs: Flex Provider: CIF Others: Ded then 30%	Ded then 30%	$35 for the first 3 visits per mem (6 per fam). All other visits Ded then 30%	$35 for the first 3 visits per mem (6 per fam). All other visits Ded then 30%	Retail: $5/$30/$80/$120/20% (T5 $500/script max)	CIF/20%/50%/50%	Yes
Silver						Free: $35 for the first 3 visits per mem (6 per fam). All other visits Ded then 30%	Day: Flex Provider: $150 Others: Ded then 30%	X-Rays: Ded then 30%				Mail: $12.50/$75/$200/$360/20% (T5 $1,500/script max)	No Deductible	
MD0000004944						Conv: $35 for the first 3 visits per mem (6 per fam). All other visits Ded then 30%							Dental OOPM: Medical OOPM applies	
RX0000001777													DN0000000458	

HMO HSA

Product Name	Office Visit	Deductible	Annual Out Of Pocket Max	Co-insurance	ER	Urgent Care	Inpatient/ Day Surgery	Labs/ X-Rays	Scans: CT, MRI, PET	PT/OT/ ST	Acupuncture	RX Cost Share (Value Formulary)	Dental Cost Sharing	MA MCC Compliant?
HMO HSA 2000 - Flex Silver MD0000004945 RX0000001778	Ded then $35/$55	$2,000/$5,000	$6,500/$13,000	None	Ded then $400	Hosp: Ded then $55 Free: Ded then $55 Conv: Ded then $35	IP: Ded then $500 Per Admit Day: Flex Provider: Ded then CIF Others: Ded then $250	Labs: Flex Provider: Ded then CIF Others: Ded then $55 X-Rays: Ded then $55	Ded then $200	Ded then $35	Ded then $50	Retail: Ded then $5/$30/$80/$120/20% (T5 $500/script max) Mail: Ded then $12.50/$75/$200/$360/20% (T5 $1,500/script max)	Ded then CIF/Ded then 20%/Ded then 50%/Ded then 50% Medical Ded Applies Dental OOPM: $650/$1,300 DN0000000465	Yes
HMO HSA 2000 with Coinsurance - Flex Silver MD0000004946 RX0000001778	Ded then $30/$55	$2,000/$5,000	$6,500/$13,000	20%	Ded then $400	Hosp: Ded then $55 Free: Ded then $55 Conv: Ded then $30	IP: Ded then 20% Day: Flex Provider: Ded then CIF Others: Ded then 20%	Labs: Flex Provider: Ded then CIF Others: Ded then 20% X-Rays: Ded then 20%	Ded then 20%	Ded then 20%	Ded then 20%	Retail: Ded then $5/$30/$80/$120/20% (T5 $500/script max) Mail: Ded then $12.50/$75/$200/$360/20% (T5 $1,500/script max)	Ded then CIF/Ded then 20%/Ded then 50%/Ded then 50% Medical Ded Applies Dental OOPM: $650/$1,300 DN0000000465	Yes
HMO HSA 3000 - Flex Silver MD0000004947 RX0000001779	Ded then $35/$55	$3,000/$6,000	$6,500/$13,000	None	Ded then $400	Hosp: Ded then $55 Free: Ded then $55 Conv: Ded then $35	IP: Ded then $500 Per Admit Day: Flex Provider: Ded then CIF Others: Ded then $250	Labs: Flex Provider: Ded then CIF Others: Ded then $55 X-Rays: Ded then $55	Ded then $200	Ded then $35	Ded then $50	Retail: Ded then $5/$30/$80/$120/20% (T5 $500/script max) Mail: Ded then $12.50/$75/$200/$360/20% (T5 $1,500/script max)	Ded then CIF/Ded then 20%/Ded then 50%/Ded then 50% Medical Ded Applies Dental OOPM: $650/$1,300 DN0000000467	Yes
HMO HSA 3100 - Flex Bronze MD0000004948 RX0000001606	Ded then $40/$65	$3,100/$6,200	$6,400/$12,800	20%	Ded then $750	Hosp: Ded then $65 Free: Ded then $65 Conv: Ded then $40	IP: Ded then 20% Day: Flex Provider: Ded then $250 Others: Ded then $1,000	Labs: Flex Provider: Ded then CIF Others: Ded then $65 X-Rays: Ded then $65	Ded then $750	Ded then $40	Ded then $50	Retail: Ded then $5/$30/50%/50%/50% (T3 $125/script max, T4 $250/script max, T5 $500/script max) Mail: Ded then $12.50/$75/50%/50%/50% (T3 $312.50/script max, T4 $750/script max, T5 $1,500/script max)	Ded then CIF/Ded then 20%/Ded then 50%/Ded then 50% Medical Ded Applies Dental OOPM: $250/$500 DN0000000462	Yes

Standard Connector (3-Tier Pharmacy) Plans

Product Name	Office Visit	Deductible	Annual Out Of Pocket Max	Co-insurance	ER	Urgent Care	Inpatient/ Day Surgery	Labs/ X-Rays	Scans: CT, MRI, PET	PT/OT/ ST	Acupuncture	RX Cost Share (Value Formulary)	Dental Cost Sharing	MA MCC Compliant?
Standard Platinum Platinum MD0000004922 RX0000001592	$20/$40	None/None	$3,000/$6,000	None	$150	Hosp: $40 Free: $40 Conv: $20	IP: $500 Per Admit Day: $250	CIF	$150	$40	$40	Retail: $10/$25/$50 Mail: $20/$50/$150	CIF/20%/50%/50% No Deductible Dental OOPM: Medical OOPM applies DN0000000451	Yes
Standard High Gold Gold MD0000004924 RX0000001765	$25/$45	$1,000/$2,000	$5,000/$10,000	None	Ded then $150	Hosp: $45 Free: $45 Conv: $25	IP: Ded then $500 Per Admit Day: Ded then $250	Ded then $25	Ded then $200	$45	$45	Retail: $20/$40/$60 Mail: $40/$80/$180	CIF/20%/50%/50% No Deductible Dental OOPM: Medical OOPM applies DN0000000452	Yes
Standard Low Gold Gold MD0000004925 RX0000001766	$30/$50	$2,000/$4,000	$5,500/$11,000	None	$350	Hosp: $50 Free: $50 Conv: $30	IP: Ded then $750 Per Admit Day: Ded then $500	Ded then $50	Ded then $250	$50	$50	Retail: $25/$50/$100 (Ded applies to T2 & T3) Mail: $50/$100/$300 (Ded applies to T2 & T3)	CIF/20%/50%/50% No Deductible Dental OOPM: Medical OOPM applies DN0000000444	Yes
Standard Silver Silver MD0000004926 RX0000001767	$30/$55	$2,000/$4,000	$7,900/$15,800	None	Ded then $300	Hosp: $55 Free: $55 Conv: $30	IP: Ded then $1,000 Per Admit Day: Ded then $500	Ded then $50	Ded then $500	$55	$55	Retail: $25/$50/$75 (Ded applies to T3) Mail: $50/$100/$225 (Ded applies to T3)	CIF/20%/50%/50% No Deductible Dental OOPM: Medical OOPM applies DN0000000445	Yes
Standard Low Silver HSA Silver MD0000004927 RX0000001768	Ded then $25/$50	$2,000/$4,000	$6,700/$13,400	None	Ded then $250	Hosp: Ded then $50 Free: Ded then $50 Conv: Ded then $25	IP: Ded then $500 Per Admit Day: Ded then $250	Ded then $50	Ded then $250	Ded then $50	Ded then $50	Retail: Ded then $25/$50/$100 Mail: Ded then $50/$100/$300	Ded then CIF/Ded then 20%/Ded then 50%/Ded then 50% Medical Ded Applies Dental OOPM: Medical OOPM applies DN0000000446	Yes
Standard High Bronze Bronze MD0000004928 RX0000001769	Ded then $25/$50	$2,750/$5,500	$7,900/$15,800	None	Ded then $250	Hosp: Ded then $50 Free: Ded then $50 Conv: Ded then $25	IP: Ded then $750 Per Admit Day: Ded then $500	Ded then $50	Ded then $500	Ded then $50	$50	Retail: $25/$50/$100 (Ded applies to T2 and T3) Mail: $50/$100/$300 (Ded applies to T2 and T3)	CIF/20%/50%/50% No Deductible Dental OOPM: Medical OOPM applies DN0000000445	Yes