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	❑	❑
HMO 3000 Flex	❑	❑

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

Standard Connector	Only offered with Pedi Dental
	With
Standard Platinum-Flex	❑
Standard High Gold-Flex	❑
HMO 2000 Low-Flex	❑
Standard Silver	❑
Standard Low Silver HSA-Flex	❑
Standard High Bronze HSA-Flex	❑
HMO 3500-Flex	❑

PPO HSA Plans	Pedi Dental	
	With	Without
PPO HSA 3400-Flex	❑	❑
PPO HSA 5000-Flex	❑	❑

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

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:_____

Clear Form

Harvard Pilgrim Health Care

REASONS FOR SUBMISSION (PLEASE CHECK ONE)	**QUALIFYING EVENT DATE:**_________________
☐NEW ENROLLMENT/CONTRACT ☐CHANGE TO CONTRACT ☐TERMINATE CONTRACT	☐ OPEN ENROLLMENT ☐NEW HIRE ☐COBRA ☐LOSS OF INSURANCE ☐COURT ORDER ☐BIRTH/ADOPTION ☐P/T TO F/T ☐MARRIAGE/DIVORCE ☐MOVED IN/OUT OF SERVICE AREA ☐DEATH ☐VOLUNTARY CANCELLATION

REASON FOR CHANGES (CHECK ALL THAT APPLY)

☐CHANGE COVERAGE TYPE ☐ADD DEPENDENT LISTED ☐TERMINATE DEPENDENT LISTED ☐TRANSFER/RE-ENROLL TO COBRA

☐OTHER:____

EMPLOYER/GROUP INFO (TO BE COMPLETED BY EMPLOYER)

EMPLOYER/GROUP NAME	*GROUP #DIVISION*	*DATE OF HIRE*	*EFFECTIVE DATE OF COVERAGE*

SUBSCRIBER INFORMATION

HP ID	*PRODUCT:* ☐HMO ☐PPO ☐POS ☐ACCESS AMERICA	*PLAN NAME*

SUBSCRIBER FIRST NAME	*MI*	*LAST NAME*	*DOB*	*GENDER* ☐M ☐F

SSN	*HOME PHONE*	*WORK PHONE*	*CELL PHONE*	*EMAIL*

STREET ADDRESS (NO PO BOX)	*APT #*	*CITY*	*STATE*	*ZIP*

PRIMARY LANGUAGE (OPTIONAL)	*PCP FULL NAME*	*PCP TOWN*	*CURRENT PATIENT* ☐YES ☐NO	*PCP ID #*

SPOUSE INFORMATION

SPOUSE FIRST NAME	*MI*	*LAST NAME*	*DOB*	*GENDER* ☐M ☐F

SSN	*MAILING ADDRESS (IF DIFFERENT)*	*RELATION CODE*

PCP FULL NAME	*PCP TOWN*	*CURRENT PATIENT* ☐YES ☐NO	*PCP ID #*

DEPENDENT INFORMATION

DEPENDENT FIRST NAME	*MI*	*LAST NAME*	*DOB*	*GENDER* ☐M ☐F	*RELATION CODE*

MAILING ADDRESS (IF DIFFERENT)	*SSN*

PCP FULL NAME	*PCP TOWN*	*CURRENT PATIENT* ☐YES ☐NO	*PCP ID#*

DEPENDENT INFORMATION

DEPENDENT FIRST NAME	*MI*	*LAST NAME*	*DOB*	*GENDER* ☐M ☐F	*RELATION CODE*

MAILING ADDRESS (IF DIFFERENT)	*SSN*

PCP FULL NAME	*PCP TOWN*	*CURRENT PATIENT* ☐YES ☐NO	*PCP ID#*

DEPENDENT INFORMATION

DEPENDENT FIRST NAME	*MI*	*LAST NAME*	*DOB*	*GENDER* ☐M ☐F	*RELATION CODE*

MAILING ADDRESS (IF DIFFERENT)	*SSN*

PCP FULL NAME	*PCP TOWN*	*CURRENT PATIENT* ☐YES ☐NO	*PCP ID#*

☐PLEASE CHECK IF USING ADDITIONAL MEMBERSHIP APPLICATIONS FOR DEPENDENT CHILDREN. BE SURE TO COMPLETE EMPLOYER AND SUBSCRIBER SECTIONS ON ADDITIONAL FORMS

OTHER INSURANCE – IF YOU HAVE NOT COMPLETED THIS SECTION, YOU MAY RECEIVE A FOLLOW-UP QUESTIONNAIRE AND CLAIMS MAY BE DELAYED.

ARE YOU OR ANYONE LISTED ABOVE COVERED BY ANOTHER HEALTH INSURANCE POLICY AT THE SAME TIME YOUR HPHC POLICY IS IN EFFECT? ☐YES. PLEASE COMPLETE ☐NO

NAME OF HEALTH PLAN	*HEALTH PLAN ID NUMBER*	*EFFECTIVE DATE*	*NAMES OF SUBSCRIBER*

MEMBERSHIP WILL BECOME EFFECTIVE UPON ACCEPTANCE BY HARVARD PILGRIM. BENEFITS UNDER THE PLAN WILL BE EXPLAINED IN YOUR EVIDENCE OF COVERAGE (EOC). I UNDERSTAND THAT HARVARD PILGRIM MAY OBTAIN PERSONAL AND MEDICAL INFORMATION TO ADMINSTER THE PLAN. FOR AN EXPLANATION OF HOW WE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION, PLEASE READ YOUR NOTICE OF PRIVACY PRACTICES. MAINE MEMBERS: YOU UNDERSTAND THAT YOUR EOC INCLUDES A SUBROGATION PROVISION THAT PERMITS SUBROGATION PAYMENTS TO US ON A JUST AND EQUITABLE BASIS. IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, IMCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPLANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR DENIAL OF INSURANCE BENEFITS.

EMPLOYEE SIGNATURE	*DATE*	*EMPLOYER SIGNATURE*	*DATE*

Thank you for choosing Harvard Pilgrim Health Care.

Please read the following instructions prior to completing this enrollment/change form. This form may be used for all enrollment transactions (Adding coverage, changing coverage, terminating coverage). In order to add, change or terminate coverage you must (1) experience a qualifying event, (2) complete this enrollment, and (3) provide the completed form to your employer within the allowed timeframe or approved retroactive period.

Qualifying Events:

New Enrollment	Contract change	Termination
Open Enrollment	Open Enrollment	Open Enrollment
New hire date	Marriage/Divorce	Voluntary Cancellation
Probationary Period (if applicable)	Birth/Adoption/Court Order	Left Employment
Loss of Insurance	Loss of Insurance	Moved from Area
Employment Status Change	Loss of Employer Premium contributions	No Longer Eligible (e.g. deceased, LOA, laid off, COBRA nonpayment)

Employer Section: Your Employer must fill out this section as well as the Reason for Submission in full for any transactions that this form is used for.

Member Section: Please complete all of the employee sections of this membership application in full. Failure to do so could delay enrollment. You will receive your ID card(s) and member benefit documents after your enrollment has been fully processed. If you are adding or removing a dependent(s), just include the details about the dependent(s) that you are adding or removing off the plan.

- **Product/Plan Name:** Please be sure to fill in the correct product code for the plan you have selected. Your options are HMO, POS, PPO and Access America. If your employer offers multiple Harvard Pilgrim Plans, please indicate the Plan name as listed on the enrollment materials to help clearly differentiate the plan you are choosing. If you know the Plan MD # (MD0000016670) the number to identify the plan/product please include the information.
- **Personal Information:** In addition to yourself, please include the personal information for every dependent that will be enrolled on the Plan. ***IMPORTANT: Social security numbers (or personal tax identification number) for each member on the plan are needed to ensure that federal regulatory reporting requirements are met. Social security numbers are not displayed on the member's ID card.***
- **Primary Care Provider:** If your plan is an HMO or POS, you will need to select a primary care provider (PCP). If your plan requires one, it is important that you choose a PCP right away. Be sure to fill out this section for all members, including dependents. Write the Harvard Pilgrim PCP ID (not the phone number) and the full name of the doctor you have chosen to coordinate your health care without a PCP assignment, your in-network benefits may be limited to emergency services only. To find a PCP or lookup the PCP ID, visit www.harvardpilgrim.org, and use the doctor search feature available in the Member Section.
- **Relation Code:** Please use one of the following codes to designate the dependent's relationship to the Employee:
  - 02 Spouse/Civil Union
  - 03 Child up to age 26
  - 06 Disabled (verification required)
  - 07 Ex-spouse
  - DP Domestic Partner
  - SE Spousal Equivalent

When this application is complete: Please sign the enrollment form and provide it to your employer. Your employer will need to sign this form and will forward this application to Harvard Pilgrim Health Care for processing. If you need additional assistance completing this form or selecting a PCP, please call a member services coordinator at 1-888-333-4742.

Coverage underwritten or administered by Harvard Pilgrim Health Care. Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

Harvard Pilgrim Health Care

2023 Harvard Pilgrim Health Care Plans for SBSB

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

Effective January 1, 2023 – December 31, 2023 Small Group

For employers with 1 to 5 eligible employees

Plan Name	Office Visit (PCP/Specialist)	Deductible (Individual/ Family)	Out-of-Pocket Maximum (Individual/ Family)	Co-insurance	ER	Urgent Care	Inpatient	Day Surgery	Laboratory	X-Rays	Scans: CT, MRI, PET	PT/OT/ST	Acupuncture & Chiropractic	Rx Cost Sharing[1]	
														Retail	Mail
Open Plans															
HMO															
HMO 25 - Flex Metal level - Platinum MD0000200289 RX0000200171 DN0000200108	$20 copay/$40 copay Copay waived for first non-routine PCP visit	None	$2,500/$5,000 Embedded	None	$125 copay	$40 copay	$400 copay	Flex Provider: $150 copay Other: $500 copay	Flex Provider: Covered in full Other: $40 copay	$30 copay	Non-hospital based: $100 copay Hospital based: $200 copay	Non-hospital based: $20 copay, Hospital based: $40 copay	$40 copay	5/$25/$40/$60/20% (T5: $250 coinsurance max)	10/$50/$80/$180/20% (T5: $750 coinsurance max)
HMO 500 - Flex Metal level - Gold MD0000200290 RX0000200172 DN0000200108	$25 copay/$50 copay Copay waived for first non-routine PCP visit	$500/$1,000 Embedded	$7,000/$14,000 Embedded	None	$300 copay	$50 copay	Deductible then $250 copay	Flex Provider: $50 copay Other: Deductible then $300 copay	Flex Provider: Covered in full Other: Deductible then $45 copay	Deductible then $50 copay	Non-hospital based: $200 copay Hospital based: Deductible then $300 copay	Non-hospital based: $25 copay, Hospital based: Deductible then $50 copay	$50 copay	5/$30/$60/$100/20% (T5: $250 coinsurance max)	10/$60/$120/$300/20% (T5: $750 coinsurance max)
HMO 1000 - Flex Metal level - Gold MD0000200291 RX0000200172 DN0000200108	$25 copay/$50 copay Copay waived for first non-routine PCP visit	$1,000/$2,000 Embedded	$7,000/$14,000 Embedded	None	$300 copay	$50 copay	Deductible then $250 copay	Flex Provider: $50 copay Other: Deductible then $300 copay	Flex Provider: Covered in full Other: Deductible then $45 copay	Deductible then $50 copay	Non-hospital based: $200 copay Hospital based: Deductible then $300 copay	Non-hospital based: $25 copay, Hospital based: Deductible then $50 copay	$50 copay	5/$30/$60/$100/20% (T5: $250 coinsurance max)	10/$60/$120/$300/20% (T5: $750 coinsurance max)
HMO 1500 - Flex Metal level - Gold MD0000200292 RX0000200172 DN0000200108	$25 copay/$50 copay Copay waived for first non-routine PCP visit	$1,500/$3,000 Embedded	$7,000/$14,000 Embedded	None	$300 copay	$50 copay	Deductible then $250 copay	Flex Provider: $50 copay Other: Deductible then $300 copay	Flex Provider: Covered in full Other: Deductible then $45 copay	Deductible then $50 copay	Non-hospital based: $200 copay Hospital based: Deductible then $300 copay	Non-hospital based: $25 copay, Hospital based: Deductible then $50 copay	$50 copay	5/$30/$60/$100/20% (T5: $250 coinsurance max)	10/$60/$120/$300/20% (T5: $750 coinsurance max)
HMO 2000 - Flex Metal level - Gold MD0000200293 RX0000200172 DN0000200108	$25 copay/$50 copay Copay waived for first non-routine PCP visit	$2,000/$4,000 Embedded	$7,000/$14,000 Embedded	None	$300 copay	$50 copay	Deductible then $250 copay	Flex Provider: $50 copay Other: Deductible then $300 copay	Flex Provider: Covered in full Other: Deductible then $45 copay	Deductible then $50 copay	Non-hospital based: $200 copay Hospital based: Deductible then $300 copay	Non-hospital based: $25 copay, Hospital based: Deductible then $50 copay	$50 copay	5/$30/$60/$100/20% (T5: $250 coinsurance max)	10/$60/$120/$300/20% (T5: $750 coinsurance max)
HMO 2000 with Coinsurance - Flex Metal level - Gold MD0000200296 RX0000200173 DN0000200109	$40 copay/$75 copay	$2,000/$4,000 Embedded	$8,700/$17,400 Embedded	20%	Deductible then 20%	$75 copay	Deductible then 20%	Flex Provider: $200 copay Other: Deductible then 20%	Flex Provider: Covered in full Other: Deductible then 20%	Deductible then 20%	Non-hospital based: $250 copay Hospital based: Deductible then 20%	Non-hospital based: $35 copay Hospital based: Deductible then 20%	$50 copay	5/$30/$60/$100/20% (T5: $250 coinsurance max)	10/$60/$120/$300/20% (T5: $750 coinsurance max)
HMO 2000 Value - Flex Metal level - Silver MD0000200297 RX0000200182 DN0000200110	$55 copay/$75 copay	$2,000/$4,000 Embedded	$9,100/$18,200 Embedded	None	Deductible then $1,000 copay	$75 copay	Deductible then $1,000 copay	Flex Provider: $250 copay Other: Deductible then $1,000 copay	Flex Provider: $25 copay Other: Deductible then $75 copay	Deductible then $100 copay	Non-hospital based: $750 copay Hospital based: Deductible then $1,000 copay	Non-hospital based: $50 copay Hospital based: Deductible then $75 copay	$50 copay	5/$30/Deductible then $80/Deductible then $120/Deductible then 20% (T5: $500 coinsurance max)	10/$60/Deductible then $160/Deductible then $360/Deductible then 20% (T5: $1,500 coinsurance max)
														Rx Deductible: $250/$500	
HMO 3000 - Flex Metal level - Silver MD0000200298 RX0000200174 DN0000200110	$55 copay/$75 copay Copay waived for first non-routine PCP visit	$3,000/$6,000 Embedded	$9,100/$18,200 Embedded	None	Deductible then $1,000 copay	$75 copay	Deductible then $1,000 copay	Flex Provider: $500 copay Other: Deductible then $1,000 copay	Flex Provider: Covered in full Other: Deductible then $100 copay	Deductible then $100 copay	Non-hospital based: $300 copay Hospital based: Deductible then $1,000 copay	Non-hospital based: $45 copay Hospital based: Deductible then $75 copay	$50 copay	5/$30/$80/$120/20% (T5: $500 coinsurance max)	10/$60/$160/$360/20% (T5: $1,500 coinsurance max)

[1] Preventive Rx applies for all HSA plans.

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

Plan Name	Office Visit (PCP/Specialist)	Deductible (Individual/ Family)	Out-of-Pocket Maximum (Individual/ Family)	Co-insurance	ER	Urgent Care	Inpatient	Day Surgery	Laboratory	X-Rays	Scans: CT, MRI, PET	PT/OT/ST	Acupuncture & Chiropractic	Rx Cost Sharing[1]	
														Retail	Mail
HMO HSA															
HMO HSA 2000 - Flex Metal level - Silver MD0000200301 RX0000200175 DN0000200111	Deductible then $35 copay/Deductible then $55 copay	$2,000/$4,000 Non-embedded	$7,500/$15,000 Embedded	None	Deductible then $400 copay	Deductible then $55 copay	Deductible then $400 copay	Flex Provider: Deductible then Covered in full Other: Deductible then $250 copay	Flex Provider: Deductible then Covered in full Other: Deductible then $75 copay	Deductible then $55 copay	Non-hospital based: Deductible then $200 copay Hospital based: Deductible then $400 copay	Non-hospital based: Deductible then $35 copay Hospital based: Deductible then $55 copay	Deductible then $50 copay	Deductible then $5/Deductible then $30/Deductible then $80/Deductible then $120/Deductible then 20% (T5: $500 coinsurance max)	Deductible then $10/Deductible then $60/Deductible then $160/Deductible then $360/Deductible then 20% (T5: $1,500 coinsurance max)
HMO HSA 3000 - Flex Metal level - Silver MD0000200303 RX0000200177 DN0000200111	Deductible then $35 copay/Deductible then $55 copay	$3,000/$6,000 Embedded	$7,500/$15,000 Embedded	None	Deductible then $400 copay	Deductible then $55 copay	Deductible then $400 copay	Flex Provider: Deductible then Covered in full Other: Deductible then $250 copay	Flex Provider: Deductible then Covered in full Other: Deductible then $75 copay	Deductible then $55 copay	Non-hospital based: Deductible then $200 copay Hospital based: Deductible then $400 copay	Non-hospital based: Deductible then $35 copay Hospital based: Deductible then $55 copay	Deductible then $50 copay	Deductible then $5/Deductible then $30/Deductible then $80/Deductible then $120/Deductible then 20% (T5: $500 coinsurance max)	Deductible then $10/Deductible then $60/Deductible then $160/Deductible then $360/Deductible then 20% (T5: $1,500 coinsurance max)
HMO HSA 3400 - Flex Metal level - Silver MD0000200304 RX0000200178 DN0000200111	Deductible then $35 copay/Deductible then $55 copay	$3,400/$6,800 Non-embedded	$7,500/$15,000 Embedded	20%	Deductible then $400 copay	Deductible then $55 copay	Deductible then 20%	Flex Provider: Deductible then Covered in full Other: Deductible then $250 copay	Flex Provider: Deductible then Covered in full Other: Deductible then $75 copay	Deductible then $55 copay Per Visit	Non-hospital based: Deductible then $200 copay Hospital based: Deductible then $400 copay	Non-hospital based: Deductible then $35 copay Hospital based: Deductible then $55 copay	Deductible then $50 copay	Deductible then $5/Deductible then $30/Deductible then $80/Deductible then $120/Deductible then 20% (T5: $500 coinsurance max)	Deductible then $10/Deductible then $60/Deductible then $160/Deductible then $360/Deductible then 20% (T5: $1,500 coinsurance max)
PPO															
PPO HSA 3400 - Flex Metal level - Silver MD0000200322 RX0000200178 DN0000200114	IN: Deductible then $35 copay/Deductible then $55 copay OON: Deductible then 20%	IN: $3,400/6,800 OON: $6,800/$13,600 Non-embedded	IN: $7,500/$15,000 OON: $15,000/$30,000 Embedded	IN: 20% OON: 20%	IN: Deductible then $400 copay OON: Same as IN	IN: Deductible then $55 copay OON: Deductible then 20%	IN: Deductible then 20% OON: Deductible then 20%	IN: Flex Provider: Deductible then Covered in full Other: Deductible then $250 copay OON: Deductible then 20%	IN: Flex Provider: Deductible then Covered in full Other: Deductible then $75 copay OON: Deductible then 20%	IN: Deductible then $55 copay OON: Deductible then 20%	IN: Non-hospital based: Deductible then $200 copay, Hospital based: Deductible then $400 copay OON: Deductible then 20%	IN: Non-hospital based: Deductible then $35 copay Hospital based: Deductible then $55 copay OON: Deductible then 20%	IN: Deductible then $50 copay OON: Deductible then 20%	Deductible then $5/Deductible then $30/Deductible then $80/Deductible then $120/Deductible then 20% (T5: $500 coinsurance max)	Deductible then $10/Deductible then $60/Deductible then $160/Deductible then $360/Deductible then 20% (T5: $1,500 coinsurance max)
PPO HSA 5000 - Flex Metal level - Bronze MD0000200323 RX0000200180 DN0000200116	IN: Deductible then $75 copay/Deductible then $150 copay OON: Deductible then 20%	IN: $5,000/$10,000 OON: $8,000/$16,000 Embedded	IN: $7,500/$15,000 OON: $15,000/$30,000 Embedded	IN: None OON: 20%	IN: Deductible then $1,500 copay OON: Same as IN	IN: Deductible then $150 copay OON: Deductible then 20%	IN: Deductible then $1,500 copay OON: Deductible then 20%	IN: Flex Provider: Deductible then $500 copay Other: Deductible then $1,000 copay OON: Deductible then 20%	IN: Flex Provider: Deductible then $25 copay Other: Deductible then $75 copay OON: Deductible then 20%	IN: Deductible then $150 copay OON: Deductible then 20%	IN: Non-hospital based: Deductible then $500 copay, Hospital based: Deductible then $1,000 copay OON: Deductible then 20%	IN: Non-hospital based: Deductible then $40 copay Hospital based: Deductible then $65 copay OON: Deductible then 20%	IN: Deductible then $50 copay OON: Deductible then 20%	Deductible then $5/Deductible then $30/Deductible then 50%/Deductible then 50% (T3: $125/coinsurance max T4: $250 coinsurance max T5: $500 coinsurance max)	Deductible then $10/Deductible then $60/Deductible then 50%/Deductible then 50% (T3: $250 coinsurance max T4: $750 coinsurance max T5: $1,500 coinsurance max)
Connector															
Standard Platinum - Flex MD0000200230 RX0000200125 DN0000200093	$20 copay/$40 copay	None	$3,000/$6,000 Embedded	None	$150 copay	$40 copay	$500 copay	Flex Provider: $100 copay Other: $250 copay	Covered in full	Covered in full	Non-hospital based: $50 copay Hospital based: $150 copay	Non-hospital based: $20 copay Hospital based: $40 copay	$40 copay	$10/$25/$50	$20/$50/$150
Standard High Gold MD0000200269 RX0000200127 DN0000200095	$30 copay/$55 copay	None	$5,000/$10,000 Embedded	None	$350 copay	$55 copay	$750 copay	$500 copay	$25 copay	$75 copay	$250 copay	$55 copay	$50 copay	$30/$60/$90	$60/$120/$270
HMO 2000 Low - Flex Metal level - Gold MD0000200233 RX0000200128 DN0000200096	$30 copay/$55 copay	$2,000/$4,000 Embedded	$5,650/$11,300 Embedded	None	Deductible then $350 copay	$55 copay	Deductible then $750 copay	Flex Provider: $250 copay Other: Deductible then $500 copay	Flex Provider: $20 copay Other: Deductible then $50 copay	Deductible then $75 copay	Non-hospital based: $200 copay Hospital based: Deductible then $300 copay	Non-hospital based: $25 copay Hospital based: $55 copay	$50 copay	$30/Deductible then $60/Deductible then $125 Rx Deductible: $250/$500	$60/Deductible then $120/Deductible then $375
Standard Silver MD0000200234 RX0000200129 DN0000200097	$30 copay/$60 copay	$2,000/$4,000 Embedded	$9,100/$18,200 Embedded	None	Deductible then $350 copay	$60 copay	Deductible then $1,000 copay	Deductible then $500 copay	Deductible then $50 copay	Deductible then $75 copay	Deductible then $350 copay	$60 copay	$50 copay	$30/Deductible then $60/Deductible then $90	$60/Deductible then $120/Deductible then $270
Standard Low Silver HSA - Flex MD0000200235 RX0000200130 DN0000200098	Deductible then $30 copay/Deductible then $60 copay	$2,000/$4,000 Non-embedded	$7,050/$14,100 Embedded	None	Deductible then $300 copay	Deductible then $60 copay	Deductible then $750 copay	Flex Provider: Deductible then $250 copay Other: Deductible then $500 copay	Flex Provider: Deductible then $20 copay Other: Deductible then $60 copay	Deductible then $75 copay	Non-hospital based: Deductible then $200 copay Hospital based: Deductible then $500 copay	Non-hospital based: Deductible then $30 copay Hospital based: Deductible then $60 copay	Deductible then $50 copay	Deductible then $30/Deductible then $60/Deductible then $105	Deductible then $60/Deductible then $120/Deductible then $315
Standard High Bronze HSA - Flex MD0000200236 RX0000200131 DN0000200099	Deductible then $60 copay/Deductible then $90 copay	$3,300/$6,600 Embedded	$7,500/$15,000 Embedded	None	Deductible then $875 copay	Deductible then $90 copay	Deductible then $1,500 copay	Flex Provider: Deductible then $250 copay Other: Deductible then $500 copay	Flex Provider: Deductible then $25 copay Other: Deductible then $55 copay	Deductible then $135 copay	Non-hospital based: Deductible then $350 copay Hospital based: Deductible then $750 copay	Non-hospital based: Deductible then $40 copay Hospital based: Deductible then $90 copay	Deductible then $50 copay	Deductible then $30/Deductible then $120/Deductible then $200	Deductible then $60/Deductible then $240/Deductible then $600
HMO 3500 - Flex Metal level - Bronze MD0000200238 RX0000200133 DN0000200101	Deductible then $40 copay/Deductible then $65 copay	$3,500/$7,000 Embedded	$8,500/$17,000 Embedded	20%	Deductible then $750 copay	Deductible then $65 copay	Deductible then 20%	Flex Provider: Deductible then $250 copay Other: Deductible then $1,000 copay	Flex Provider: Ded then $25 Others: Deductible then $75	Deductible then $75 copay	Non-hospital based: Deductible then $500 Hospital-based: Deductible then $1,000	Non-hospital based: Deductible then $40 copay, Hospital based: Deductible then $65 copay	Deductible then $50 copay	$5/$30/Deductible then 50%/Deductible then 50% (T3: $125/coinsurance max T4: $250 coinsurance max T5: $500 coinsurance max)	$10/$60/Deductible then 50%/Deductible then 50%/Deductible then 50% (T3: $250 coinsurance max T4: $750 coinsurance max T5: $1,500 coinsurance max)

[1] Preventive Rx applies for all HSA plans.

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

Plan Name	Office Visit (PCP/Specialist)	Deductible (Individual/ Family)	Out-of-Pocket Maximum (Individual/ Family)	Co-insurance	ER	Urgent Care	Inpatient	Day Surgery	Laboratory	X-Rays	Scans: CT, MRI, PET	PT/OT/ST	Acupuncture & Chiropractic	Rx Cost Sharing[1]	
														Retail	Mail
Closed Plans – Only for existing groups on 2022 version															
Focus HMO															
Focus HMO 1000 Metal level - Gold MD0000200307 RX0000200172 DN0000200108	$25 copay/$50 copay Copay waived for first non-routine PCP visit	$1,000/$2,000 Embedded	$7,000/$14,000 Embedded	None	$300 copay	$50 copay	Deductible then $250 copay	Deductible then $300 copay	Deductible then $25 copay	Deductible then $50 copay	Deductible then $250 copay	$50 copay	$50 copay	5/$30/$60/$100/20% (T5: $250 coinsurance max)	10/$60/$120/$300/20% (T5: $750 coinsurance max)
Focus HMO 2000 Metal level - Gold MD0000200309 RX0000200172 DN0000200108	$25 copay/$50 copay Copay waived for first non-routine PCP visit	$2,000/$4,000 Embedded	$7,000/$14,000 Embedded	None	$300 copay	$50 copay	Deductible then $250 copay	Deductible then $300 copay	Deductible then $25 copay	Deductible then $50 copay	Deductible then $250 copay	$50 copay	$50 copay	5/$30/$60/$100/20% (T5: $250 coinsurance max)	10/$60/$120/$300/20% (T5: $750 coinsurance max)
Focus HMO 3000 Metal level - Silver MD0000200311 RX0000200174 DN0000200110	$50 copay/$75 copay Copay waived for first non-routine PCP visit	$3,000/$6,000 Embedded	$9,100/$18,200 Embedded	None	Deductible then $850 copay	$75 copay	Deductible then $1,000 copay	Deductible then $500 copay	Deductible then $75 copay	Deductible then $75 copay	Deductible then $300 copay	Deductible then $75 copay	$50 copay	5/$30/$80/$120/20% (T5: $500 coinsurance max)	10/$60/$160/$360/20% (T5: $1,500 coinsurance max)
HMO															
HMO 1500 with Coinsurance - Flex Metal level - Gold MD0000200295 RX0000200173 DN0000200109	$40 copay/$75 copay	$1,500/$3,000 Embedded	$8,700/$17,400 Embedded	20%	Deductible then 20%	$75 copay	Deductible then 20%	Flex Provider: $200 copay Other: Deductible then 20%	Flex Provider: Covered in full Other: Deductible then 20%	Deductible then 20%	Non-hospital based: $250 copay Hospital based: Deductible then 20%	Non-hospital based: $35 copay Hospital based: Deductible then 20%	$50 copay	5/$30/$60/$100/20% (T5: $250 coinsurance max)	10/$60/$120/$300/20% (T5: $750 coinsurance max)
HMO 4000 - Flex Metal level - Silver MD0000200299 RX0000200174 DN0000200110	$45 copay/$75 copay Copay waived for first non-routine PCP visit	$4,000/$8,000 Embedded	$9,100/$18,200 Embedded	None	Deductible then $350 copay	$75 copay	Deductible then $750 copay	Flex Provider: $350 copay Other: Deductible then $750 copay	Flex Provider: Covered in full Other: Deductible then $75 copay	Deductible then $75 copay	Non-hospital based: $300 copay Hospital based: Deductible then $750 copay	Non-hospital based: $45 copay Hospital based: Deductible then $75 copay	$50 copay	5/$30/$80/$120/20% (T5: $500 coinsurance max)	10/$60/$160/$360/20% (T5: $1,500 coinsurance max)
HMO HSA															
HMO HSA 2500 - Flex Metal level - Silver MD0000200302 RX0000200176 DN0000200111	Deductible then $35 copay/Deductible then $55 copay	$2,500/$5,000 Non-embedded	$7,500/$15,000 Embedded	None	Deductible then $400 copay	Deductible then $55 copay	Deductible then $400 copay	Flex Provider: Deductible then Covered in full Other: Deductible then $250 copay	Flex Provider: Deductible then Covered in full Other: Deductible then $75 copay	Deductible then $55 copay	Non-hospital based: Deductible then $200 copay Hospital based: Deductible then $400 copay	Non-hospital based: Deductible then $35 copay Hospital based: Deductible then $55 copay	Deductible then $50 copay	Deductible then $5/Deductible then $30/Deductible then $80/Deductible then $120/Deductible then 20% (T5: $500 coinsurance max)	Deductible then $10/Deductible then $60/Deductible then $160/Deductible then $360/Deductible then 20% (T5: $1,500 coinsurance max)
HMO HSA 3600 - Flex Metal level - Bronze MD0000200305 RX0000200179 DN0000200111	Deductible then $75 copay/Deductible then $150 copay	$3,600/$7,200 Embedded	$7,500/$15,000 Embedded	None	Deductible then $1,500 copay	Deductible then $150 copay	Deductible then $1,500 copay	Flex Provider: Deductible then $500 copay Other: Deductible then $1,000 copay	Flex Provider: Deductible then $25 copay Other: Deductible then $75 copay	Deductible then $150 copay Per Visit	Non-hospital based: Deductible then $500 copay Hospital based: Deductible then $1,000 copay	Non-hospital based: Deductible then $40 copay Hospital based: Deductible then $150 copay	Deductible then $50 copay	Deductible then $5/Deductible then $30/Deductible then 50%/Deductible then 50% (T3: $125/coinsurance max T4: $250 coinsurance max T5: $500 coinsurance max)	Deductible then $10/Deductible then $60/Deductible then 50%/Deductible then 50% (T3: $250 coinsurance max T4: $750 coinsurance max T5: $1,500 coinsurance max)

[1] Preventive Rx applies for all HSA plans.