HealthConnector CommonwealthCare

Commonwealth Care Health Benefits and Copayments (Copays)

This lists the services covered and costs for each of the different plan types (effective July 1, 2012- June 30, 2013).

Plan Type 1

Copayment amounts are the same for all health plans.

Benefit	Copay
Outpatient care	
Preventive services	$0
Office visit to your primary care provider (PCP)	$0
Office visit to a specialist	$0
Radiology, imaging (x-rays), lab work	$0
Outpatient surgery at a hospital or ambulatory surgery center	$0
Abortion	$0
Inpatient care	
Hospital stay, may include surgery, x-rays, lab services, and room and board (copay is per stay)	$0
Emergency care	
Emergency room visit	$0
Prescription drugs	
30 day supply from a pharmacy	
• Generic drug	$1*/3.65
• Drug on your plan's preferred list	$3.65
• Drug not on your plan's preferred list	$3.65
Contraceptive prescriptions (medication and devices)	$0
Alcohol, drug abuse and mental health care	
Outpatient or office visit	$0
Inpatient care (copay is per stay)	$0
Methadone maintenance (dosing, counseling, screens)	$0
Dental Preventive and emergency dental services only	
• Diagnostic (Exams, xrays), Preventive (cleanings, fluoride), extractions, emergency care visits, treatment of complication – surgery, anesthesia, professional visit	$0
Vision	
Eye exam every 24 months	$0
Free glasses every 24 months	$0
Diabetes care	
Office visit to PCP or podiatrist for routine foot care (may include foot orthotics)	$0
Visit to specialist (may include foot orthotics)	$0
Rehabilitation services	
Extended inpatient care (100 total days per year)	$0
• In a skilled nursing facility	$0
• In a rehabilitation hospital or chronic disease hospital (copay is per stay)	$0
Physical therapy, speech or hearing therapy, pulmonary or occupational therapy (need plan approval for more than 20 visits)	$0
Cardiac rehabilitation	$0
Home health care	$0
Maternity and family planning	
Outpatient office visit	$0
Other benefits	
Ambulance (emergency only)	$0
Prosthetics, oxygen and respiratory therapy equipment, other durable medical equipment	$0
Hospice	$0
Maximum copays	
Maximum amount a member will need to pay for all prescriptions in a benefit year **	$250
Maximum amount a member will need to pay for services excluding prescription drugs in a benefit year **	$0

** Limited to generic prescription drugs for high blood pressure, high cholesterol and diabetes*

*** The benefit year is from July 1, 2012 – June 30, 2013.*

HealthConnector CommonwealthCare

Commonwealth Care Health Benefits and Copayments (Copays)

This lists the services covered and costs for each of the different plan types (effective July 1, 2012- June 30, 2013).

Plan Type 2

Copayment amounts are the same for all health plans.

Benefit	Copay
Outpatient care	
Preventive services	$0
Office visit to your primary care provider (PCP)	$10
Office visit to a specialist	$18
Radiology, x-rays, lab work	$0
Imaging (MRI, CAT and PET)	$30
Outpatient surgery at a hospital or ambulatory surgery center	$50
Abortion	$50
Inpatient care	
Hospital stay, may include surgery, x-rays, lab services, and room and board (copay is per stay)	$50 *
Emergency care	
Emergency room visit (no copay if you are admitted to the hospital)	$50
Prescription drugs	
30 day supply from a pharmacy	
• Generic drug	$10
• Drug on your plan's preferred list	$20
• Drug not on your plan's preferred list	$40
3-month supply, by mail	
• Generic drug	$20
• Drug on your plan's preferred list	$40
• Drug not on your plan's preferred list	$120
Contraceptive prescriptions (medication and devices)	$0
Alcohol, drug abuse and mental health care	
Outpatient or office visit	$10
Inpatient care (copay is per stay)	$50 *
Methadone maintenance (dosing, counseling, screens)	$0
Vision	
Eye exam every 24 months	$10
Free glasses every 24 months	$0
Diabetes care	
Office visit to PCP or podiatrist for routine foot care (may include foot orthotics)	$5
Visit to specialist (may include foot orthotics)	$10
Rehabilitation services	
Extended inpatient care (100 total days per year)	
• In a skilled nursing facility	$0
• In a rehabilitation hospital or chronic disease hospital (copay is per stay)	$50 *
Physical therapy, speech or hearing therapy, pulmonary or occupational therapy (need plan approval for more than 20 visits)	$10
Cardiac rehabilitation	$0
Home health care	$0
Maternity and family planning	
Outpatient office visit	$0
Other benefits	
Ambulance (emergency only)	$0
Prosthetics, oxygen and respiratory therapy equipment, other durable medical equipment	$0
Hospice	$0
Maximum copays	
Maximum amount a member will need to pay for all prescriptions in a benefit year **	$500
Maximum amount a member will need to pay for services excluding prescription drugs in a benefit year **	$750

** Copay waived if transferred from another inpatient unit*

*** The benefit year is from July 1, 2012 – June 30, 2013.*

HealthConnector CommonwealthCare

Commonwealth Care Health Benefits and Copayments (Copays)

This lists the services covered and costs for each of the different plan types.
(effective July 1, 2012-June 30, 2013).

Plan Type 3

Copayment amounts are the same for all health plans.

Benefit	Copay
Outpatient care	
Preventive services	$0
Office visit to your primary care provider (PCP)	$15
Office visit to a specialist	$22
Radiology, x-rays, lab work	$0
Imaging (MRI, CAT and PET)	$60
Outpatient surgery at a hospital or ambulatory surgery center	$125
Abortion	$100
Inpatient care	
Hospital stay, may include surgery, x-rays, lab services, and room and board (copay is per stay)	$250 *
Emergency care	
Emergency room visit (no copay if you are admitted to the hospital)	$100
Prescription drugs	
30 day supply from a pharmacy	
• Generic drug	$12.50
• Drug on your plan's preferred list	$25
• Drug not on your plan's preferred list	$50
3-month supply, by mail	
• Generic drug	$25
• Drug on your plan's preferred list	$50
• Drug not on your plan's preferred list	$150
Contraceptive prescriptions (medication and devices)	$0
Alcohol, drug abuse and mental health care	
Outpatient or office visit	$15
Inpatient care (copay is per stay)	$250 *
Methadone maintenance (dosing, counseling, screens)	$0
Vision	
Eye exam every 24 months	$20
Free glasses every 24 months	$0
Diabetes care	
Office visit to PCP or podiatrist for routine foot care (may include foot orthotics)	$10
Visit to specialist (may include foot orthotics)	$20
Rehabilitation services	
Extended inpatient care (100 total days per year)	
• In a skilled nursing facility	$0
• In a rehabilitation hospital or chronic disease hospital (copay is per stay)	$250 *
Physical therapy, speech or hearing therapy, pulmonary or occupational therapy (need plan approval for more than 20 visits)	$20
Cardiac rehabilitation	$0
Home health care	$0
Maternity and family planning	
Outpatient office visit	$0
Other benefits	
Ambulance (emergency only)	$0
Prosthetics, oxygen and respiratory therapy equipment, other durable medical equipment	10%
Hospice	$0
Maximum copays	
Maximum amount a member will need to pay for all prescriptions in a benefit year **	$800
Maximum amount a member will need to pay for services excluding prescription drugs in a benefit year **	$1500

** Copay waived if transferred from another inpatient unit*

*** The benefit year is from July 1, 2012– June 30, 2013.*