

Care and coverage. Better together.



Enrollment kit:
Alma del Mar

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**Complete Access EPO 4000 30/50 ER350 with Care Complement
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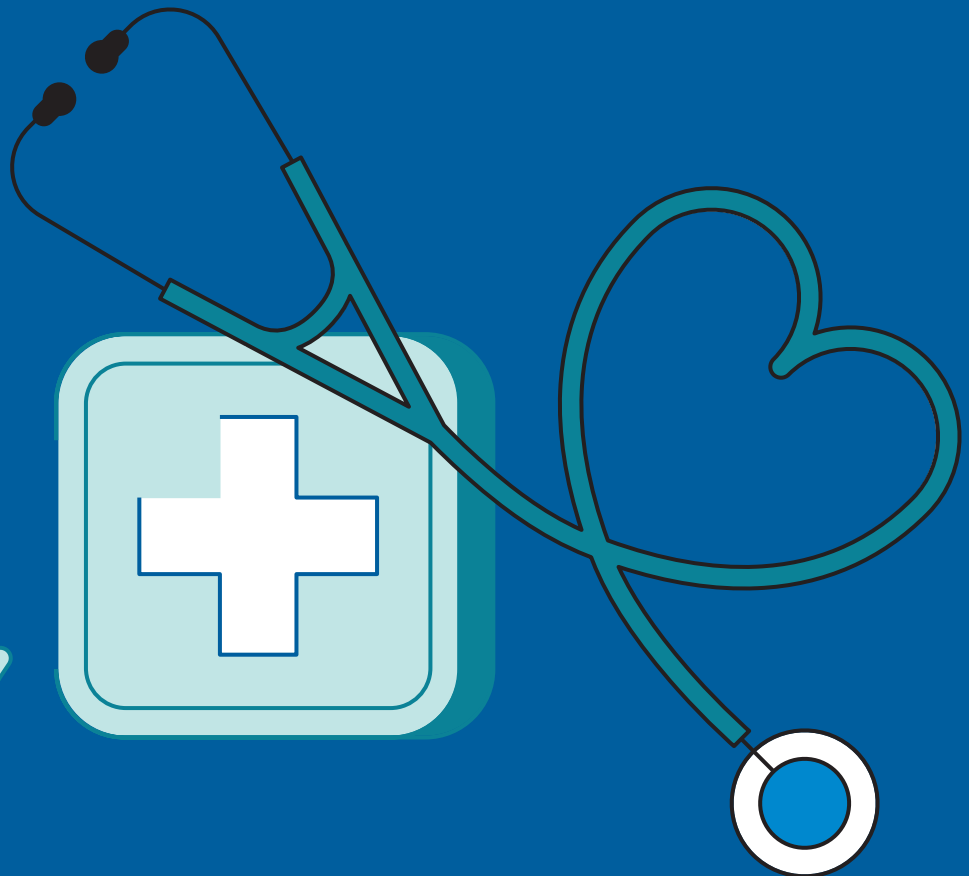
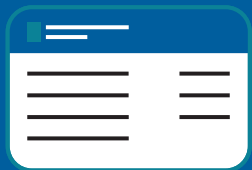
**Complete Access EPO 4000 30/50 ER350 with Care Complement
Summary of Benefits and Coverage**

**Complete PPO Plus Combined 4000 20/35 ER 350 with Care Complement
Schedule of Benefits**

**Complete PPO Plus Combined 4000 20/35 ER 350 with Care Complement
Summary of Benefits and Coverage**

Welcome to Mass General Brigham Health Plan

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Let's get started!

First things first: What's important to you?

1

Is my doctor in network?

Our network includes access to world-class doctors, specialists, and hospitals. The provider directory lets you find and compare doctors, hospitals, and more. Easily search and filter your results based on what's important to you, such as gender, language, and location.

2

Is my medication on the drug list?

We partner with Optum Rx® to offer great pharmacy benefits and a vast nationwide network.* To search the drug list, get cost information, and see FAQs for starting prescription drug coverage, scan the QR code.

3

What if I'm currently receiving care—how will that continue?

If you're receiving ongoing care for certain complex health conditions, our team can help transition your care—simply fill out a transition of care form and we'll help ensure the transition of your care.



To find these answers and more helpful resources, visit MGBHP.org/new.

What's covered?

- Routine and preventive care
- Specialty care
- Routine eye exam
- Behavioral health
- Help for common and complex healthcare needs
- Urgent and emergency care, even when you travel
- Pharmacy*

Let's talk about the basics. Your benefits include the essentials of a comprehensive health plan.



For specific details about this plan's network, covered benefits, and cost sharing, see the **Schedule of Benefits** included in your enrollment materials.

*Pharmacy coverage is included in most plans. To determine what's covered, check your plan documents or confirm with your employer.

Care options for every step of your journey

Your plan is thoughtfully designed to help you get the care you need, where and when you want it.



Primary and specialty care

Your care begins with your primary care provider (PCP). In-person office visits and virtual visits are available.



Urgent care center

Ideal when you need immediate, in-person help for a non-life-threatening condition.



Virtual visit for non-emergency conditions

Included in most plans, On Demand connects you to a U.S.-based doctor 24/7 using live video via smartphone, tablet, or computer.



24/7 Nurse Advice Line

We make it easy to connect with a registered nurse to get nursing advice on any subject.



Behavioral health support

Our network gives access to the care and support you need.



Retail or limited services clinic

For when you're experiencing mild symptoms or need a vaccine.



Care teams

Members with certain chronic conditions can get help with accessing or coordinating care from our team of licensed professionals.



Emergency room

Call 911 or go to the nearest emergency room if you're having an emergency and your life is in danger.



A plan to help you feel your best

Wellness programs

- A wellness hub that covers all dimensions of your well-being and encourages you to set goals and choose activities based on your interests and level of health. Provides group challenges and tracking tools to keep you coming back and working on healthy habits.
- One-on-one telephonic health coaching to help you eat better, manage weight, reduce stress, and reduce your risk of chronic conditions like diabetes and heart disease. Our Health Coaches can also help you make the most of your benefits.
- Quit for Life nicotine cessation program with 1:1 support from a Certified Tobacco Treatment Specialist. Most plans include quit medications at no cost sharing.



Mind, body, and spirit— they're all important to a person's overall well-being.

Discounts and savings

- Fitness reimbursement: Up to \$150 for individual coverage or \$300 for family coverage per calendar year. Amounts may vary (terms and conditions apply).
- Up to 6 month weight-loss program benefit through WW®, Jenny Craig®, or Noom®. Terms and conditions apply.
- Discounted eyewear, powered by EyeMed.
- Up to \$130 reimbursement for childbirth education.
- Reimbursement for breastfeeding classes.
- Partial reimbursements on bike helmets.
- No member cost sharing for first three sick visits and first three behavioral health visits for members aged 18 or younger.*
- Low- or no-cost cost sharing for many over-the-counter (OTC) drugs with a prescription at a participating pharmacy.

Innovative programs to help members optimize their care

Care Complement

Care Complement features give you access to more affordable care options by removing cost sharing for certain services, medications, and therapies. Applies to most plans.**

Recovery coaches

Coaches guide and support members who are recovering from addiction.

* Included in most plans but does not apply to Health Savings Account (HSA)-compliant plans.

** Care Complement is available on your plan if it's in the plan name.

How will I access my plan information?

Here's a peek at your key plan materials and tools that we developed for ease of use.



Schedule of Benefits

An easy-to-read document of your plan's coverage and cost sharing responsibilities. Once enrolled, you can find it in the Member Portal.



Member guide and ID card

You'll receive your member ID card and guide after enrollment. You can get a digital copy at Member.MGBHP.org.



Member Portal

Sign in to the Member Portal to manage your account and access resources, wellness programs, perks, claims history, accumulations, and important plan documents.



Member app

You can also download the app for iOS and Android to access your ID card and plan information at any time.



The Member Portal is active for you on your plan's effective date. Find it at Member.MGBHP.org.

How to get more from the plan

Once you become a member, we encourage you to take these next steps:

1

Set up your plan to work for you

- Review your member welcome guide and save the ID card(s) you receive by mail.
- Enroll in the Member Portal.
- Download the app.
- Read your plan documents and learn about all the services included in your plan.

2

Use your plan

- Present your ID card wherever you receive care.
- Optimize your wellness program.
- Take advantage of your member discounts and savings.
- Access preventive services, such as your annual exam.
- Find providers in your network.

Access care personalized for you

Women's health programs

Our women's health programs offer comprehensive resources and support for all stages of life, including menopause, pregnancy, postpartum, or pelvic health.

Mass General Brigham Home Hospital

This innovative approach to bringing hospital-level care to the home offers direct coordination with health plan care managers to improve member experience.

Our plans are built with insights from world-renowned researchers and clinicians at Mass General Brigham.

Behavioral health support

Lyra Health is a virtual-first behavioral health platform that offers personalized recommendations and fast appointment options, in addition to our Optum network of providers.



Not all plans will include these benefits. Please speak with your employer to confirm.



Let us know if we can help



Get answers fast with live chat

Even before you're a member, you can live chat with us during business hours.



Call or email Customer Service

You're also welcome to call **866-643-8392** or email **MGBHPCS@mgb.org** with any questions.

The Customer Service team is committed to your satisfaction.

Hours: Monday through Friday, 8 a.m. to 6 p.m., and Thursdays, 8 a.m. to 8 p.m.

"The Customer Service team is here for you if you have questions or concerns. The team is committed to your satisfaction, and I'm proud to say that they work very hard to make sure your experience with us is exceptional."

— Jonathan Biron, Director, Customer Service

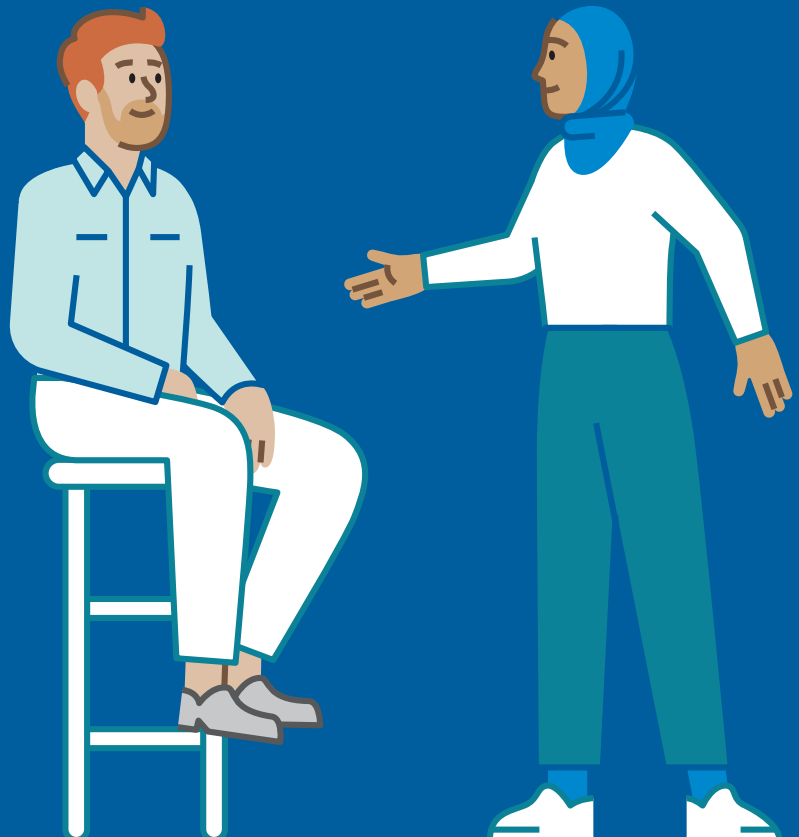
Visit our new members page

Learn more about our plan at **MGBHP.org/new**



- Find a doctor.
- See if your medications are covered.
- Get help with transition of care questions.
- See member benefits and resources.
- Contact Customer Service by phone, email, or live chat.

Thank you for taking the time to learn more about Mass General Brigham Health Plan and the ways we can meet your needs and help you live a healthier life.



Pharmacy coverage with convenience, choice, and savings



Get more from our FlexRx program with benefits that include:

- Savings on a 90-day supply of certain medications by mail order, depending on the benefit plan
- Low-cost drug tier for many common medications*
- Coverage for many common over-the-counter drugs
- Online tools to help members manage their plan and save money
- National pharmacy network

We partner with Optum Rx[®] to manage pharmacy benefits for our members. Members can fill prescription medications at any pharmacy in our national network which includes most major chains like CVS Pharmacy[®], Walgreens[®], and Rite Aid[®], as well as grocery store and independent pharmacies across the United States.

Check your benefit plan information for specifics on your coverage, including tiering and cost sharing.



Members can call the number on the back of their member ID card. Not a member yet? Call **866-643-8392**.

*Not available on 3-Tier pharmacy benefit plans.

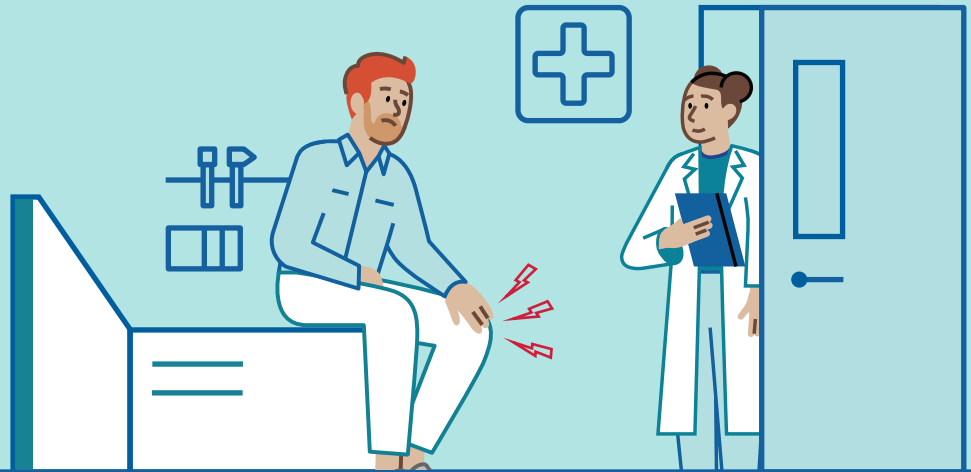
Questions?

Visit MGBHP.org/pharmacy where you'll find important information regarding your pharmacy benefits, such as:

- A searchable drug lookup tool
- Mail order information
- Pharmacy management program and procedures, including prior authorizations, step-therapy programs, medication coverage, restrictions, and quantity limits
- A description of the exceptions process for nonformulary pharmaceuticals
- And more

MGBHP.org

Easier access to care at no cost to you



Care Complement provides access to affordable care options by removing cost sharing for certain services, therapies, and medications

Save money on treatments that lead to a healthier you

The following services/therapies are included at \$0 member cost:

- First six acupuncture visits (20 visit limit)
- First six chiropractor visits
- First six physical therapy or occupational therapy visits
- First three sick visits and first three behavioral health visits for members aged 18 or younger
- Cardiac rehabilitation therapy
- Certain services that reduce the risk of complications from diabetes, including an annual routine eye exam, diabetic education, and nutritional counseling



Care Complement benefits are available in all plans with Care Complement in the name.

No member cost for chronic condition medications:

Depression

- Fluoxetine 10mg, 20mg capsules

Diabetes

- Metformin, regular release tablets

High cholesterol

- Atorvastatin tablets
- Simvastatin tablets

Heart and high blood pressure

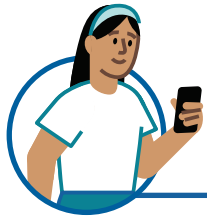
- Amlodipine besylate tablets
- Atenolol tablets
- Furosemide tablets
- Lisinopril tablets
- Losartan tablets
- Hydrochlorothiazide 25mg and 50mg tablets and 12.5mg capsules
- Metoprolol succinate SR tablets

Get expanded access to substance use disorder therapies and medication

- Free recovery coaching
- \$0 cost for the medication-assisted therapy (MAT) office visits
- \$0 cost for certain MAT prescriptions*:
 - Buprenorphine HCL-naloxone HCL sublingual film or tablet
 - Buprenorphine HCL sublingual tablet
 - Naloxone vial, tablet, or nasal spray (prescription)
 - Narcan nasal spray (prescription)
 - Vivitrol
 - Zubsolv sublingual tablet

Our care management teams offer personalized care

- Made up of nurses, doctors, pharmacists, social care managers, and behavioral health experts, our integrated care management teams deliver customized care that meets your unique needs.



For more information about plan benefits, members can log in to Member.MGBHP.org or call the customer service number on the back of your member ID card.

*Additional products may be available at \$0 based on your plan.

MGBHP.org

Mass General Brigham Health Plan includes Mass General Brigham Health Plan, Inc. and Mass General Brigham Health Insurance Company

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Routine healthcare services delivered by network providers at no cost sharing

The listed preventive services, as required by the Affordable Care Act (ACA), reflect routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems. You do not have to pay for these covered services when delivered by a network provider. Additional services may be added.

Please refer to [MGBHP.org](https://www.massgeneralbrigham.org/health-plan) for the most up-to-date listing.

Adults and children

- Alcohol and substance misuse screening and counseling
- Alcohol and drug use assessment
- Cholesterol screening
- Depression screening
- Hepatitis B screening
- Hepatitis C screening
- HIV screening and counseling
- Immunizations and vaccines, including flu shots
- Pre-exposure prophylaxis (or PrEP) for members who are at very high risk of getting HIV to prevent HIV infection
- Sexually transmitted disease (STD) prevention, screening, and counseling (including gonorrhea, chlamydia, and syphilis)
- Tobacco use screening and counseling
- Tuberculosis infection screening for all patients at higher risk
- Weight management screening and counseling
- Well visits and regular preventive care (medical history and physical examination) including blood pressure screening, height, weight, and body mass index (BMI), screening and counseling for interpersonal and domestic violence

Adults only

- Ambulatory or home blood pressure monitoring services and devices are covered for adults without hypertension
- Aspirin use counseling at your well visit, for members at risk of heart disease or colon cancer
- Colorectal cancer screenings (including lab testing, sigmoidoscopy, or colonoscopy)
- Diabetic screening
- For members 65 and older: fall-prevention counseling at your well visit and vitamin D supplements through your pharmacy benefit
- Intensive behavioral counseling about diet and physical activity for adults who are overweight and have other risk factors for cardiovascular disease
- Lung cancer screening for adults age 50-80 at risk of developing lung cancer
- Tobacco use nicotine replacement therapy

Men only

- Abdominal aortic aneurysm: one-time screening for men of specified ages who have ever smoked (age 65-75)

Women only

- Annual GYN exam including screening for urinary incontinence
- Aspirin use for preeclampsia prevention through your pharmacy benefit
- Bacteriuria screening for pregnant women
- Breast cancer chemoprevention counseling for women at higher risk
- Breastfeeding support, breast pump, supplies, and counseling
- Cervical cancer screening including human papilloma virus (HPV) testing
- Diabetes screening for women during and after pregnancy
- FDA-approved contraceptive methods and counseling (contraceptives covered with no member cost sharing include: generics, brand name drugs with no generic alternative, and emergency contraceptives)
- Folic acid supplements for women who may become pregnant, through your pharmacy benefit
- Hepatitis B screening for pregnant women
- Osteoporosis screening for women 50 and older and for younger women with increased risk of fracture
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Screening mammogram, ultrasound or MRI for breast cancer screening. Counseling and BRCA genetic testing
- Sterilization procedures

Children only

- Behavioral assessments throughout childhood (includes depression screening)
- Developmental screening and surveillance throughout childhood
- Fluoride varnish for children ages 6 months to 18 years
- Hearing screening for children and adolescents up to age 21*
- Hematocrit or hemoglobin screening for children
- Iron supplements for children ages 6-12 months at risk for anemia (over-the-counter with prescription) and high blood pressure
- Lead screening for children at risk of exposure
- Oral fluoride supplements for children without fluoride in their water (over the counter with prescription)
- Oral health risk assessment for young children
- Vision screening for all children**
- Newborn screening and tests
- Congenital hypothyroidism screening for newborns
- Gonococcal infection preventive medication for the eyes of all newborns
- Hearing screening
- Hemoglobinopathies or sickle cell screening for newborns
- Phenylketonuria (PKU) screening

* This service is not the same as a hearing exam.

** This service is not the same as a routine or comprehensive eye exam.

Notice of privacy practices

This notice describes how health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. Mass General Brigham Health Plan provides health insurance coverage to you. Because you get health benefits from Mass General Brigham Health Plan, we have protected health information (PHI) about you. By law, Mass General Brigham Health Plan must protect the privacy of your health information.

This notice explains:

- When Mass General Brigham Health Plan may use and share your health information.
- What your rights are regarding your health information.

Mass General Brigham Health Plan may use or share your health information:

- When the U.S. Department of Health and Human Services needs it to make sure your privacy is protected.
- When required by law or a law enforcement agency.
- For payment activities, such as checking if you are eligible for health benefits, and paying your healthcare providers for services you get.
- To operate programs, such as evaluating the quality of healthcare services you get, providing care management and disease management services and performing studies to reduce healthcare costs.
- With your healthcare providers to coordinate your treatment and the services you get.
- With health-oversight agencies, such as the Federal Centers for Medicare and Medicaid Services, and for oversight activities authorized by law, including fraud and abuse investigations.
- For health research.
- With government agencies that give you benefits or services.
- With plan sponsors of employer group health plans, but only if they agree to protect that information. Disclosures to plan sponsors occur

only in accordance with HIPAA requirements (45 CFR §164.504(f)), including amendments to plan documents restricting the sponsor's use and disclosure of PHI and ensuring appropriate safeguards.

- To prevent or respond to an immediate and serious health or safety emergency.
- To remind you of appointments, benefits, treatment options or other health-related choices you have.
- If we contact you to raise funds for our organization, you have the right to opt out of receiving such fundraising communications.
- With entities that provide services or perform functions on behalf of Mass General Brigham Health Plan (Business Associates), provided that they have agreed to safeguard your information.

When a federal or state privacy law provides for stricter safeguards of your PHI, Mass General Brigham Health Plan will follow the stricter law. Except as described above, Mass General Brigham Health Plan cannot use or share your health information with anyone without your written permission. You may cancel your permission at any time, as long as you tell us in writing. Please note: We cannot take back any health information we used or shared when we had your permission. Certain uses and disclosures require your written authorization, including most marketing communications and any sale of your protected health information. Other uses and disclosures not described in this notice will be made only with your written authorization. You may revoke an authorization in writing; we will honor your revocation as provided by applicable law, but cannot undo uses or disclosures already made under your authorization.

For purposes of underwriting, Mass General Brigham Health Plan is prohibited from using or disclosing any genetic information.

Mass General Brigham Health Plan does not use your health information for any marketing purposes and will not sell your health information to anyone.

You have the right to:

- See and get a copy of your health information that is contained in a “designated record set.” You must ask for this in writing. To the extent your information is held in an electronic health record, you may be able to receive the information in electronic form. In some cases, we may deny your request to see and get a copy of your health information. Mass General Brigham Health Plan may charge you to cover certain costs, such as copying and postage.
- Ask Mass General Brigham Health Plan to change your health information that is in a “designated record set” if you think it is wrong or incomplete. You must tell us in writing which health information you want us to change, and why. If we deny your request, you may file a statement of disagreement with us that will be included in any future disclosures of the disputed information.
- Ask Mass General Brigham Health Plan to limit its use or sharing of your health information. You must ask for this in writing. Mass General Brigham Health Plan may not be able to grant this request. We must agree to your request to restrict disclosure of PHI to a health plan when the disclosure is for payment or health care operations and relates to an item or service for which you have paid in full, unless the disclosure is otherwise required by law.
- Ask Mass General Brigham Health Plan to get in touch with you in some other way, if by contacting you at the address or telephone number we have on file, you believe you would be harmed. You may request to receive communications of PHI by alternative means or at alternative locations (for example, at a different mailing address), as permitted by law.
- Get a list of when and with whom Mass General Brigham Health Plan has shared your health information. You must ask for this in writing.
- Be notified in the event that we or one of our Business Associates discovers a breach of your protected health information.
- Get a paper copy of this notice at any time.
- These rights may not apply in certain situations.

This notice, effective as of February 16, 2026, will remain in effect until we change it. By law, Mass General Brigham Health Plan must give you notice explaining that we protect your health information, and that we must follow the terms of this notice. If Mass General Brigham Health Plan does make important changes, we will send you a new notice and post an updated notice on our website. That new notice will apply to all of the health information that Mass General Brigham Health Plan has about you. Mass General Brigham Health Plan takes your privacy very seriously. If you would like to exercise any of the rights we describe in this notice, or if you feel that Mass General Brigham Health Plan has violated your privacy rights, contact our Privacy Officer in writing at the following address: At least once every three years, we will notify individuals then covered by the plan of the availability of this notice and how to obtain a copy. If you agree, we may send this notice to you by email. If we learn that an email transmission has failed, we will provide you with a paper copy. You retain the right to receive a paper copy upon request.

To contact Customer Service, please call the number on the back of your member ID Card.

Mass General Brigham Health Plan Privacy Officer
399 Revolution Drive, Suite 810
Somerville, MA 02145

Filing a complaint or exercising your rights will not affect your benefits.

You may also file a complaint with the U.S. Secretary of Health and Human Services at:

The U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
Toll-free: **877-696-6775 (TTY 711)**

Mass General Brigham Health Plan will not retaliate against you if you file a complaint either with Mass General Brigham Health Plan or the U.S. Secretary of Health and Human Services. For more information, or if you need help understanding this notice, call Customer Service at the number on the back of your ID card, Monday through Friday, 8 a.m. to 6 p.m. ET (Thursdays, 8 a.m. to 6 p.m. ET). If Mass General Brigham Health Plan receives or maintains any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, Mass General Brigham Health Plan may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us. To contact Customer Service, please call the number on the back of your member ID Card.

[MGBHP.org](https://www.massgeneralbrigham.org)

Mass General Brigham Health Plan includes Mass General Brigham Health Plan, Inc. and Mass General Brigham Health Insurance Company

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Confidentiality

Mass General Brigham Health Plan takes seriously our obligation to protect your personal and health information. To help maintain your privacy, we have instituted the following practices:

- Mass General Brigham Health Plan employees do not discuss your personal information in public areas such as the cafeteria, on elevators or when outside of the office.
- Electronic information is kept secure through the use of passwords, automatic screen savers and limiting access to only those employees with a "need to know."
- Written information is kept secure by storing it in locked file cabinets, enforcing "clean-desk" practices, and using secured shredding bins for its destruction.
- All employees, as part of their initial orientation, receive training on our confidentiality and privacy practices. In addition, as part of every employee's annual performance appraisal, they are required to sign a statement affirming that they have reviewed and agree to abide by our confidentiality policy.
- All providers and other entities with whom we need to share information are required to sign agreements in which they agree to maintain confidentiality.
- Mass General Brigham Health Plan only collects information about you that we need in order to provide you with the services you have agreed to receive by enrolling in Mass General Brigham Health Plan or as otherwise required by law.

In accordance with state law, Mass General Brigham Health Plan takes special precautions to protect any information concerning mental health or substance use, HIV status, sexually transmitted diseases, pregnancy or termination of pregnancy.

14721-0126-04

New member transition of care

Form and instructions

We're here to help! Our Customer Service professionals will work with you and your providers so you can access medically necessary services, behavioral health services, and prescriptions. For example: medication infusions or scheduled surgery.

To be eligible for consideration, you or your dependent must:

- Be receiving ongoing care for specific health conditions* (See section 1 for typical medical conditions)
- Be receiving care that started prior to enrollment with Mass General Brigham Health Plan

Member information

First name (member receiving care)		M.I.	Last name
Phone	Email address		
Member ID number (if received)		Name of employer	

Contact preferences

What's the best way to reach you during business hours?	Email	Telephone
Do you give us permission to leave a message?	Yes	No

Section 1: Medical services

To request transition of care support for medical services, please select one or more of the following conditions:

- | | | |
|---|--|--|
| Pregnancy | Recent heart attack | Specialty pharmacy/home infusion |
| Sick newborn requiring intensive care | Specialty referral | Enrollment in a care management/disease management program |
| Rare medical condition (please specify details below) | Scheduled or approved outpatient surgery | Cancer: newly diagnosed/ongoing cancer treatment |

*Examples of chronic medical conditions that typically are not eligible for transition of care program (unless the condition is not stable OR the member receives IV medication infusions for a chronic condition) include arthritis, asthma, allergies, diabetes, hypertension, and COPD/emphysema.

Section 1: Medical services (continued)

Please provide full provider contact information for conditions and treatment indicated above, next scheduled office visit(s), procedure or scheduled follow up appointment dates.

What is the name of the provider(s) you or your dependent receive care from?

Provider name	Phone	Provider address
Provider name	Phone	Provider address
Provider name	Phone	Provider address

When was the last time you or your dependent saw this provider(s) for the conditions noted?

When is the next office visit, scheduled procedure, or follow up appointment with this provider(s)?

Please complete the section below with any other relevant information that may help us better understand and support you with coordinating the medical care that you need.

Section 2: Prescription (Rx) services

To request transition of care support for prescription services, please specify the medications that you or your dependent take and the frequency with which they are taken:

Medication name	Dosing/frequency	Last fill date
Medication name	Dosing/frequency	Last fill date
Medication name	Dosing/frequency	Last fill date
Medication name	Dosing/frequency	Last fill date

Section 3: Behavioral health services

To request transition of care support for outpatient behavioral health services with a provider that does not participate within our behavioral health provider network, please list your provider(s) below:

Provider name	Phone	Provider address	
Provider name	Phone	Provider address	
Provider name	Phone	Provider address	
Do you receive care with this provider(s) in-person or virtually via Telehealth?	In-person	Telehealth	
How often do you see this provider(s) for care?	Weekly	Monthly	Other
Member signature (Parent or legal guardian for members under age 18)	Date		

Return completed form by email, mail, or fax. A Customer Service professional will reach out to help you make a smooth transition. If you have questions, call Customer Service at **866-643-8392** (*option 1*).

Email: MGBHPCS@mgb.org

Fax: **617-586-1799**

Mail: Mass General Brigham Health Plan
Customer Service
399 Revolution Drive, Suite 820
Somerville, MA 02145

	Complete Access EPO 4000 30/50 ER350 with Care Complement	Complete PPO Plus Combined 4000 20/35 ER350 with Care Complement**				
Deductible (Individual/Family)	\$4,000 / \$8,000	\$4,000 / \$8,000				
Medical Out-of-Pocket Maximum (Individual/Family)	\$5,450 / \$10,900	\$5,450 / \$10,900				
Preventive Visit-Primary Care Provider (Includes a Routine Eye Exam, once a year)	Covered in Full	Covered in Full				
Primary Care Provider Visits	\$30 copayment*	Deductible applies first, then \$20 copayment*				
Specialist Visits	\$50 copayment	Deductible applies first, then \$35 copayment				
Physical Therapy Visits	Visits 1-6: \$0 Visits 7-100: Deductible, then \$50	Visits 1-6: \$0 Visits 7-100: Deductible, then \$35				
Chiropractic Care Visits	Visits 1-6: \$0 Visits 7 and after: \$30 copayment	Visits 1-6: \$0 Visits 7 and after: Deductible applies first, then \$20 copayment				
Acupuncture Visits	Visits 1-6: \$0 Visits 7-20: \$50 copayment	Visits 1-6: \$0 Visits 7-20: Deductible applies first, then \$35 copayment				
Diagnostics, Imaging, X-Ray	Subject to the Deductible	Subject to the Deductible				
Lab Tests	Subject to the Deductible	Subject to the Deductible				
High-Tech Radiology	Subject to the Deductible	Subject to the Deductible				
Outpatient Surgery	Subject to the Deductible	Subject to the Deductible				
Outpatient Mental Health / Substance Use	\$30 copayment	Deductible applies first, then \$20 copayment				
Inpatient Hospital Care	Subject to the Deductible	Subject to the Deductible				
Urgent Care	\$50 copayment	Deductible applies first, then \$35 copayment				
Emergency Room Visit	\$350 copayment	Deductible applies first, then \$350 copayment				
Pharmacy Benefit (same for both plans)						
Pharmacy Out-of-Pocket Maximum	\$1,000 Individual / \$2,000 Family					
	Tier 1 <i>Preferred Generic</i>	Tier 2 <i>Non-Preferred Generic</i>	Tier 3 <i>Preferred Brand</i>	Tier 4 <i>Non-Preferred Brand</i>	Tier 5 <i>Preferred Specialty</i>	Tier 6 <i>Non-Preferred Specialty</i>
Retail Pharmacy, 30-Day Supply	\$15	\$30	\$60	\$120	\$60	\$120
Mail Order Pharmacy, 90-Day Supply	\$30	\$60	\$120	\$360	N/A***	N/A***

*Please see Care Complement benefits (there is \$0 cost share for the first 3 pediatric sick visits to the PCP and first 3 behavioral health visits for children under the age of 18)

**In-Network PPO Benefits are noted above. If care is accessed outside of the network, most benefits are subject to the deductible and 20% coinsurance

***Tiers 5 and 6 (Preferred and Non-Preferred Specialty medications) are not available through Mail Order

FlexRxSM Prescription Drug Cost Sharing

Your plan has a combined deductible, which is listed on the *Schedule of Benefits*. The combined deductible is the amount you pay for certain services each benefit period and applies to your prescription drug coverage as indicated on this document.

Prescription Drug Out-of-Pocket Maximum per benefit period: \$1,000 Individual/ \$2,000 Family

Your plan has a separate prescription drug out-of-pocket maximum which is listed above. Once the prescription drug out-of-pocket maximum is satisfied (including applicable Deductible, Copayment, and Coinsurance amounts), your prescription drugs are covered in full for the rest of the benefit period with no other cost sharing required.

Retail

With a valid prescription at a participating pharmacy for up to a 30-day supply

Tier	Member cost share
Tier 1 - Low-Cost Generic	\$15 copayment/Prescription
Tier 2 - Other generic and some brand name	\$30 copayment/Prescription
Tier 3 - High costing generic and preferred brand name	\$60 copayment/Prescription
Tier 4 - Higher cost generics and non-preferred brand name	\$120 copayment/Prescription
Tier 5 - Generic specialty and preferred specialty	\$60 copayment/Prescription
Tier 6 - Non-preferred Specialty	\$120 copayment/Prescription

Access90

With a valid prescription for a 90-day supply of a maintenance medication and purchased through the mail or at a participating retail pharmacy

90-day Mail

Tier	Member cost share
Tier 1 - Low-Cost Generic	\$30 copayment/Prescription
Tier 2 - Other generic and some brand name	\$60 copayment/Prescription
Tier 3 - High costing generic and preferred brand name	\$120 copayment/Prescription
Tier 4 - Higher cost generics and non-preferred brand name	\$360 copayment/Prescription

90-day Retail

Tier	Member cost share
Tier 1 - Low-Cost Generic	\$45 copayment/Prescription
Tier 2 - Other generic and some brand name	\$90 copayment/Prescription
Tier 3 - High costing generic and preferred brand name	\$180 copayment/Prescription
Tier 4 - Higher cost generics and non-preferred brand name	\$360 copayment/Prescription

Your plan does not include coverage for GLP-1 medications (e.g., Wegovy, Zepbound, Saxenda) that share an indication of obesity/weight management.

Over-the-Counter Drugs

For a complete list of over-the-counter drugs, visit [MassGeneralBrighamHealthPlan.org](https://www.massgeneralbrigham.org/healthplan) or call Customer Service at 866-414-5533 (TTY 711).

	Member cost share
Select over-the-counter medicines and products with a valid prescription and purchased at a participating pharmacy	\$0- \$60 copayment/Prescription (depending on the drug prescribed)

Mass General Brigham Health Plan includes Mass General Brigham Health Plan, Inc. and Mass General Brigham Health Insurance Company.

Effective: 07/01/2026

DLEI2 |

15710-0526-00

Visit MassGeneralBrighamHealthPlan.org for pharmacy benefit information, including the Drug Lookup tool which will assist in determining covered drugs and tier designation.

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Schedule of Benefits

Complete Access EPO 4000 30/50 ER350 with Care ComplementSM

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This health plan meets Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance. Please see the last page for additional information.

Schedule of Benefits

This Schedule of Benefits is a general description of your coverage as a member of Mass General Brigham Health Plan. For more information about your benefits, log into Member.MassGeneralBrighamHealthPlan.org to see your plan documents and get personalized information about your plan or call Customer Service at 866-414-5533 (TTY 711).

To search Providers in the Complete Access EPO Provider Directory, please visit MassGeneralBrighamHealthPlan.org.

All covered services must be medically necessary and some may require prior authorization. Please check with your PCP or treating provider to determine if a prior authorization is necessary. Your Member Handbook may include additional coverage and/or exclusions not listed on the Schedule of Benefits.

DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM

Deductible per benefit period	Medical/Behavioral Health (Combined): \$4,000 Individual /\$8,000 Family
Out-of-Pocket Maximum per benefit period	Medical/Behavioral Health (Combined): \$5,450 Individual /\$10,900 Family

The Deductible, Coinsurance and Copayments for Medical and Behavioral Health apply to the annual Out-of-Pocket Maximum. This Schedule of Benefits and the Member Handbook comprise the Evidence of Coverage for members covered on this health plan.

OUTPATIENT MEDICAL CARE

Annual Physical Exams ¹	No Member Cost-Sharing
Annual Gynecological Exams ¹	No Member Cost-Sharing
Family Planning Services	No Member Cost-Sharing
Immunizations & Vaccinations	No Member Cost-Sharing
Preventive Laboratory Tests	No Member Cost-Sharing
Screening Colonoscopy	No Member Cost-Sharing
Screening Mammography	No Member Cost-Sharing
Well Child Visits	No Member Cost-Sharing

¹Services for specific conditions during an annual exam may be subject to cost sharing.

Other Primary & Specialty Care Office Visits

Office Visits for Other Primary Care	\$30 copayment/Visit (waived for members age 18 and younger for the first 3 visits)
Telemedicine (Virtual Visits) - PCP	\$30 copayment/Visit
Telemedicine (Virtual Visits) - On Demand	\$30 copayment/Visit
Office Visits for Other Specialty Care	\$50 copayment/Visit
Telemedicine (Virtual Visits) - Specialist	\$50 copayment/Visit
Acupuncture (Covered up to 20 visits per benefit period)	Visit 1-6: No Member Cost-Sharing Visit 7-20: \$50 copayment/Visit
Allergy Shots	No Member Cost-Sharing
Cardiac Rehabilitation Service	No Member Cost-Sharing
Chiropractic Care	Visit 1-6: No Member Cost-Sharing Visit 7 and after: \$30 copayment/Visit
Routine Eye Exam (1 visit(s) per member every 12 months)	No Member Cost-Sharing
Routine Foot Care (covered for diabetes and some circulatory diseases)	\$50 copayment/Visit
Hearing Exams	\$50 copayment/Visit
Infertility Services	\$50 copayment/Visit
Physical Therapy/Occupational Therapy (Covered up to 100 combined PT/OT visits per benefit period)	Visit 1-6: No Member Cost-Sharing Visit 7-100: Subject to deductible, then \$50 copayment/Visit
Speech Therapy	Subject to deductible, then \$50 copayment/Visit
Routine Prenatal and Postnatal Care	No Member Cost-Sharing

Other Outpatient Services

Diagnostic, Imaging and X-ray	No charge after deductible
Laboratory	No charge after deductible
High-tech Radiology (MRI, CT, PET Scan, Nuclear Cardiac Imaging)	No charge after deductible
Outpatient Surgery—Facility Fee	No charge after deductible
Outpatient Surgery—Professional Fee	No charge after deductible

INPATIENT MEDICAL CARE

Inpatient Medical Services (including Maternity) - Facility Fee	No charge after deductible
Inpatient Medical Services - Professional Fee	No charge after deductible
Inpatient Care in a Skilled Nursing Facility - Facility Fee (Covered up to 100 days per benefit period)	No charge after deductible
Inpatient Care in a Skilled Nursing Facility - Professional Fee	No charge after deductible
Inpatient Care in a Rehabilitation Facility - Facility Fee (Covered up to 60 days per benefit period)	No charge after deductible
Inpatient Care in a Rehabilitation Facility - Professional Fee	No charge after deductible
Routine Nursery and Newborn Care	No Member Cost-Sharing

BEHAVIORAL HEALTH - OUTPATIENT

Mental Health Care or Substance Use Care	\$30 copayment/Visit (waived for members age 18 and younger for the first 3 visits)
Telemedicine (Virtual Visits) - Mental Health Care or Substance Use Care	\$30 copayment/Visit

BEHAVIORAL HEALTH - INPATIENT

Mental Health Care - Facility Fee	No charge after deductible
Mental Health Care - Professional Fee	No charge after deductible
Substance Use Detoxification or Rehabilitation - Facility Fee	No charge after deductible
Substance Use Detoxification or Rehabilitation - Professional Fee	No charge after deductible

URGENT CARE

Care for an illness, injury, or condition serious enough that a person would seek immediate care, but not so severe as to require Emergency room care.

Urgent Care	\$50 copayment/Visit
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EMERGENCY CARE

If you require emergency medical care, go to the nearest emergency room or call 911. You or a family member should notify your PCP within 48 hours of an emergency visit.

Care you receive in an emergency room, in or out of the Service Area	\$350 copayment/Visit (waived if admitted to hospital for inpatient care)
Ambulance Services (emergency transport only)	No charge after deductible
Emergency Dental Care (within 72 hours of accident or injury)	\$350 copayment/Visit (waived if admitted to hospital for inpatient care)

ADDITIONAL SERVICES

Diabetic Supplies	No Member Cost-Sharing
Disposable Medical Supplies	No charge after deductible
Durable Medical Equipment	Subject to deductible, then 20% coinsurance
Early Intervention (from birth up to age three)	No Member Cost-Sharing
Fitness Program Reimbursement	Up to \$150/Individual, \$300/Family per calendar year (see MassGeneralBrighamHealthPlan.org for qualifications).
Hearing Aids (age 21 and under) (Covered up to \$2,000 for each affected ear every 36 months)	No Member Cost-Sharing
Home Health Care	No Member Cost-Sharing
Hospice Care	No Member Cost-Sharing
Medical Drugs (drugs that cannot be self-administered)	\$50 copayment/Visit
Oxygen Supplies and Therapy	No Member Cost-Sharing
Radiation Therapy and Chemotherapy	\$75 copayment/Visit
Weight Loss Program Benefit	Coverage for up to six months of membership fees per calendar year in a qualified weight-loss program for either a covered Subscriber or one covered Dependent (see MassGeneralBrighamHealthPlan.org for qualifications)
Wigs (when medically necessary for hair loss due to cancer treatment or other conditions)	Subject to deductible, then 20% coinsurance

ABOUT YOUR MASS GENERAL BRIGHAM HEALTH PLAN MEMBERSHIP

For questions or concerns about your coverage, call Customer Service at 866-414-5533 (TTY 711). Representatives are available Monday through Friday, 8:00 a.m.–6:00 p.m. (Thursday 8:00 a.m.– 8:00 p.m.)

Benefit Period

Your benefit period resets on your employer's anniversary date.

Copayments, Coinsurance, or Deductibles Required for Certain Services

Before coverage begins for certain services, you pay a deductible each benefit period. Your Plan deductible is an amount you pay for certain services each benefit period. For some services, after the deductible is satisfied, members may be required to pay a copayment and/or coinsurance before coverage begins.

All members are responsible for the individual deductible per benefit period. Family member's deductible payments contribute toward the family deductible per benefit period. The family deductible can be satisfied by combining the deductibles paid for by covered family members. Each family member's contribution will not exceed the amount set for an individual deductible.

All medical and behavioral health amounts paid apply toward the out-of-pocket maximum. Once the individual out-of-pocket maximum is satisfied, these services are covered for the member in full through the remainder of the benefit period. The family out-of-pocket maximum is satisfied by combining the copayments, coinsurance and deductible amounts paid by covered family members. Once the family out-of-pocket maximum is satisfied, these services are covered for all family members in full through the remainder of the benefit period.

Your Primary Care Provider (PCP)

Your PCP arranges your health care and is the first person you call when you need medical care. Be sure to check with your PCP to find out office hours and whether urgent care is offered.

For members in Massachusetts and New Hampshire, Mass General Brigham Health Plan requires the designation of a PCP. You have the right to designate a PCP who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the PCP.

For information on how to select a PCP, or a list of the most up-to date provider information, or a list of participating health care professionals who specialize in obstetrics or gynecology, visit MassGeneralBrighamHealthPlan.org or call Customer Service.

Preventive Care Services

Mass General Brigham Health Plan covers eligible preventive services for adults, women (including pregnant women) and children, which includes coverage for annual physical exams, immunizations, well child visits and annual gynecological exams. For a complete list of eligible preventive care services, please visit MassGeneralBrighamHealthPlan.org or call Customer Service.

Primary Care Provider (PCP) and Obstetrical Rights

You do not need a referral from Mass General Brigham Health Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. However, the health care professional may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan.

Urgent Care

If you need urgent care, call your PCP to arrange where you will receive treatment. Examples of conditions requiring urgent care include, but are not limited to, fever, sore throat or an earache.

Emergency Care

In an emergency, go to the nearest emergency facility, or call 911. Please refer to this Schedule of Benefits for your cost sharing amount. All follow-up care must be arranged by your PCP.

Referrals

For members in Massachusetts and New Hampshire, Mass General Brigham Health Plan requires referral for specialist services provided by in-network Providers, except the following: Gynecologist or Obstetrician for routine, preventive or urgent care; Family Planning services; Outpatient and Diversionary Behavioral Health Services; Physical Therapy; Occupational Therapy; Speech Therapy; Routine Eye exam; and Emergency Services.

Utilization Review Program

The Utilization Review standards Mass General Brigham Health Plan uses were created to assure our members consistently receive high quality, appropriate medical care. To determine coverage, specific criteria are used to make Utilization Review decisions. These criteria are developed by physicians and meet the standards of national accreditation organizations. As new treatments and technologies become available, we update our Utilization Review standards annually.

To make utilization decisions the health plan conducts prospective, concurrent, and retrospective reviews of the health care services our members use.

Initial Determination (Prospective Review or Prior Authorization)

Determines in advance if a procedure or treatment either you or your doctor is requesting is both medically appropriate and medically necessary.

Concurrent Review

During the course of treatment, such as hospitalization, concurrent review monitors the progress of treatment and determines for how long it will be deemed medically necessary.

Retrospective Review

After care has been provided, we review treatment outcomes to ensure that the health care services provided to you met certain quality standards.

Care Management

When members have a severe or chronic illness or condition, they may qualify for Care Management. Care managers work one-on-one with members and their providers to find the most appropriate and cost-effective ways to manage a condition. Together, a treatment plan that best meets the member's needs is developed with the goal of promoting patient education, self-care, and providing access to the right kinds of health care services and options.

To learn more about Utilization Review or Care Management at Mass General Brigham Health Plan, please refer to your Member Handbook or call Customer Service.

Benefit Exclusions

Services or supplies that Mass General Brigham Health Plan does not cover include: Benefits from other sources; Diet foods; Educational testing and evaluations; Massage therapy; Out-of-network providers; Non-emergency care when traveling outside the U.S.

Additional benefit exclusions apply, for a complete list please refer to your plan's Benefit Handbook.

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This health plan meets Minimum Creditable Coverage standards that are effective January 1, 2026 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards.

This disclosure is for minimum creditable coverage standards that are effective January 1, 2026. Because these standards may change, review your health plan material each year to determine whether your plan meets the latest standards.


If you have questions about this notice, you may contact the Division of Insurance by calling 617-521-7794 or visiting its website at mass.gov/doi.



This plan is underwritten by Mass General Brigham Health Plan, Inc.

for large group employers

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services Coverage for: All Coverage Tiers | Plan Type: EPO

 **The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to Member.MassGeneralBrighamHealthPlan.org or call Customer Services at 866-414-5533 (toll free) or 711 (TTY). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at MassGeneralBrighamHealthPlan.org or call 866-414-5533 (toll free) or 711 (TTY) to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	\$4,000/Individual, \$8,000/Family per benefit period.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Preventive care, most outpatient visits (including mental/behavioral health and substance use disorder), prescription drug coverage, and urgent care does not apply towards the deductible.	This plan covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your <u>deductible</u> . See a list of covered preventive services at MassGeneralBrighamHealthPlan.org .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	\$5,450/Individual, \$10,900/Family per benefit period for Medical and Behavioral Health combined. \$1,000/Individual, \$2,000/Family per benefit period for Prescription drug.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they do not count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. For a list of in-network providers, see MassGeneralBrighamHealthPlan.org or call 866-414-5533.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes, for members in Massachusetts and New Hampshire.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist.

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for large group employers

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services Coverage for: All Coverage Tiers | Plan Type: EPO

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network	Out of Network	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 copayment/Visit	Not covered	For the first 3 visits, in-network cost sharing waived for members age 18 and younger.
	Specialist visit	\$50 copayment/Visit	Not covered	None.
	Preventive care/screening/immunization	No Member Cost-Sharing	Not covered	Services for specific conditions during an annual exam may be subject to cost sharing.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: No charge after deductible Blood work: No charge after deductible	Not covered	None.
	Imaging (CT/PET scans, MRIs)	No charge after deductible	Not covered	May require prior authorization.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at MassGeneralBrighamHealthPlan.org	Tier 1 – Low-Cost Generic	30-day Retail: \$15 copayment/Prescription 90-day Mail: \$30 copayment/Prescription	Not covered	Your plan does not include coverage for GLP-1 medications (e.g., Wegovy, Zepbound, Saxenda) that share an indication of obesity/weight management. No charge for birth control and smoking cessation drugs. May require prior authorization.
	Tier 2 – Other generic and some brand name	30-day Retail: \$30 copayment/Prescription 90-day Mail: \$60 copayment/Prescription	Not covered	
	Tier 3 – High costing generic and preferred brand name	30-day Retail: \$60 copayment/Prescription 90-day Mail: \$120 copayment/Prescription	Not covered	

for large group employers

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services **Coverage for: All Coverage Tiers | Plan Type: EPO**

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network	Out of Network	
	Tier 4 – Higher cost generics and non-preferred brand name	30-day Retail: \$120 copayment/Prescription 90-day Mail: \$360 copayment/Prescription	Not covered	
	Tier 5 – Generic specialty and preferred specialty	\$60 copayment/Prescription	Not covered	Prescription must be filled through our specialty pharmacy and a prior authorization may be required.
	Tier 6 – Non-preferred specialty	\$120 copayment/Prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	Not covered	May require prior authorization.
	Physician/surgeon fees	No charge after deductible	Not covered	None.
If you need immediate medical attention	Emergency room services	\$350 copayment/Visit	\$350 copayment/Visit	Emergency room copay waived if admitted to hospital for inpatient care.
	Emergency medical transportation	No charge after deductible	No charge after deductible	None.
	Urgent care	\$50 copayment/Visit	\$50 copayment/Visit	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	Not covered	May require prior authorization.
	Physician/surgeon fee	No charge after deductible	Not covered	None.

for large group employers

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services Coverage for: All Coverage Tiers | Plan Type: EPO

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network	Out of Network	
If you need mental health, behavioral health, or substance use services	Mental/behavioral health/substance use outpatient services	\$30 copayment/Visit	Not covered	For the first 3 visits, in-network cost sharing waived for members age 18 and younger.
	Mental/behavioral health/substance use inpatient services	No charge after deductible	Not covered	May require prior authorization.
If you are pregnant	Office visits for prenatal and postnatal care	No Member Cost-Sharing	Not covered	None.
	Childbirth/delivery facility services	No charge after deductible	Not covered	May require prior authorization.
	Childbirth/delivery professional services	No charge after deductible	Not covered	May require prior authorization.
If you need help recovering or have other special health needs	Home health care	No Member Cost-Sharing	Not covered	May require prior authorization.
	Rehabilitation services	Outpatient: Visit 1-6: No Member Cost-Sharing Visit 7-100: Subject to deductible, then \$50 copayment/Visit Inpatient: No charge after deductible	Not covered	Outpatient: Covered up to 100 combined PT/OT visits per benefit period. Inpatient: Covered up to 60 days per benefit period. Prior authorization required.
	Habilitation services	Outpatient: Visit 1-6: No Member Cost-Sharing Visit 7-100: Subject to deductible, then \$50 copayment/Visit Inpatient: No charge after deductible	Not covered	Outpatient: Covered up to 100 combined PT/OT visits per benefit period. Inpatient: Covered up to 60 days per benefit period. Prior authorization required.

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for large group employers

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services **Coverage for: All Coverage Tiers | Plan Type: EPO**

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network	Out of Network	
	Skilled nursing care	No charge after deductible	Not covered	Covered up to 100 days per benefit period. May require prior authorization.
	Durable medical equipment	Subject to deductible, then 20% coinsurance	Not covered	May require prior authorization. No charge for electric breast pump (one per birth).
	Hospice service	No Member Cost-Sharing	Not covered	May require prior authorization.
If your child needs dental or eye care	Children's eye exam	No Member Cost-Sharing	Not covered	1 eye exam(s) every 12 months per child
	Children's glasses	Not covered	Not covered	None.
	Children's dental check-up	Not covered	Not covered	Limited to children under age 18 with a cleft palate/cleft lip condition. You may have coverage under a separate dental plan.

for large group employers

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services Coverage for: All Coverage Tiers | Plan Type: EPO

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
<ul style="list-style-type: none">• Cosmetic Surgery	<ul style="list-style-type: none">• Extraction of infected or impacted wisdom teeth (except when in a hospital setting)• Long-term care	<ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S.• Private-duty nursing
Other Covered Services (This isn't a complete list. Check your policy or Plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none">• Abortion• Acupuncture- Covered up to 20 visits per benefit period• Bariatric surgery	<ul style="list-style-type: none">• Chiropractic care• Hearing aids (age 21 and younger)- Covered up to \$2,000 for each affected ear every 36 months• Infertility treatment	<ul style="list-style-type: none">• Routine eye exam (adult)• Routine foot care (covered for diabetes and some circulatory diseases)• Weight loss program (coverage for up to six months of membership fees in a qualified weight-loss program for either a covered Subscriber or one covered Dependent)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies are: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Customer Service at **866-414-5533 (toll free) or 711 (TTY)**.

Does this Coverage Provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this Coverage Meet the Minimum Value Standard? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Para obtener asistencia en Español, llame al **866-414-5533**.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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for large group employers

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services Coverage for: All Coverage Tiers | Plan Type: EPO

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$4,000	■ The plan's overall deductible	\$4,000	■ The plan's overall deductible	\$4,000
■ Specialist copayment	\$50	■ Specialist copayment	\$50	■ Specialist copayment	\$50
■ Hospital (facility)	\$0 after deductible	■ Hospital (facility)	\$0 after deductible	■ Hospital (facility)	\$0 after deductible
<p>This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)</p>	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$4,000	Deductibles	\$100	Deductibles	\$1,300
Copayments	\$70	Copayments	\$800	Copayments	\$500
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$0	Limits or exclusions	\$0	Limits or exclusions	\$0
The total Peg would pay is	\$4,070	The total Joe would pay is	\$900	The total Mia would pay is	\$1,800

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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MCC Compliance



This health plan meets Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance.

Schedule of Benefits

Complete PPO Plus Combined 4000 20/35 ER350 with Care ComplementSM

For Large Group Employers

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This health plan meets Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance. Please see the last page for additional information.

Schedule of Benefits

This Schedule of Benefits is a general description of your coverage as a member of Mass General Brigham Health Plan. For more information about your benefits, log into Member.MassGeneralBrighamHealthPlan.org to see your plan documents and get personalized information about your plan or call Customer Service at 866-414-5533 (TTY 711).

There are two levels of coverage associated with this Plan: In-Network coverage and Out-of-Network coverage. In-Network coverage applies when you use a Preferred (In-Network) Provider to obtain Covered Services. To access the Complete PPO Plus Provider Directory, visit MassGeneralBrighamHealthPlan.org or call Customer Service.

Out-of-Network coverage applies when you use a Non-Preferred (Out-of-Network) Provider that is not contracted with the Complete PPO Plus network to obtain Covered Services. When using Out-of-Network Providers, the Plan pays only a percentage of the cost of the care you receive up to the Allowed Amount for the service. (Please see your Member Handbook for information on how the Allowed Amount is determined by Mass General Brigham Health Plan.) If an Out-of-Network Provider charges any amount in excess of the Allowed Amount, you are responsible for the excess amount.

All covered services must be medically necessary and some may require Prior Authorization. For a full list of medical and surgical services that require a Prior Authorization, please go to MassGeneralBrighamHealthPlan.org, or call Customer Service. Please visit this site often as services can be added and updated to the list at any time. Your Member Handbook may also include additional coverage and/or exclusions not listed on the Schedule of Benefits.

DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM

Deductible per benefit period	Medical/Behavioral Health (Combined): \$4,000 Individual /\$8,000 Family
Out-of-Pocket Maximum per benefit period	Medical/Behavioral Health (Combined): \$5,450 Individual /\$10,900 Family

The Deductible, Coinsurance and Copayments for Medical and Behavioral Health apply to the annual Out-of-Pocket Maximum. This Schedule of Benefits and the Mass General Brigham Health Plan Member Handbook comprise the Evidence of Coverage for members covered on this health plan.

OUT OF NETWORK PENALTY

Penalty	\$500
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The Penalty is the amount that a Member may be responsible for paying for certain Out-of-Network services when Prior Authorization has not been received before obtaining the services. The Penalty charge is in addition to any Member Cost-sharing amounts. (Does not count towards the deductible or out-of-pocket maximum.)

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OUTPATIENT MEDICAL CARE

<i>Preventive Services</i>	In Network	Out of Network
Annual Physical Exams ¹	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance
Annual Gynecological Exams ¹	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance
Family Planning Services	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance
Immunizations & Vaccinations	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance
Preventive Laboratory Tests	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance
Screening Colonoscopy	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance
Screening Mammography	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance
Well Child Visits	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance

¹Services for specific conditions during an annual exam may be subject to cost sharing.

Other Primary & Specialty Care Office Visits

	In Network	Out of Network
Office Visits for Other Primary Care	Subject to deductible, then \$20 copayment/Visit (waived for members age 18 and younger for the first 3 visits)	Subject to deductible, then 20% coinsurance
Telemedicine (Virtual Visits) - PCP	Subject to deductible, then \$20 copayment/Visit	Subject to deductible, then 20% coinsurance
Telemedicine (Virtual Visits) - On Demand	Subject to deductible, then \$20 copayment/Visit	
Office Visits for Other Specialty Care	Subject to deductible, then \$35 copayment/Visit	Subject to deductible, then 20% coinsurance
Telemedicine (Virtual Visits) - Specialist	Subject to deductible, then \$35 copayment/Visit	Subject to deductible, then 20% coinsurance
Acupuncture (Covered up to 20 visits per benefit period)	Visit 1-6: No Member Cost-Sharing Visit 7-20: Subject to deductible, then \$35 copayment/Visit	Subject to deductible, then 20% coinsurance
Allergy Shots	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance
Cardiac Rehabilitation Service	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance
Chiropractic Care	Visit 1-6: No Member Cost-Sharing Visit 7 and after: Subject to deductible, then \$20 copayment/Visit	Subject to deductible, then 20% coinsurance
Routine Eye Exam (1 visit(s) per member every 12 months)	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance
Routine Foot Care (covered for diabetes and some circulatory diseases)	Subject to deductible, then \$35 copayment/Visit	Subject to deductible, then 20% coinsurance
Hearing Exams	Subject to deductible, then \$35 copayment/Visit	Subject to deductible, then 20% coinsurance
Infertility Services	Subject to deductible, then \$35 copayment/Visit	Subject to deductible, then 20% coinsurance
Physical Therapy/Occupational Therapy (Covered up to 100 combined PT/OT visits per benefit period)	Visit 1-6: No Member Cost-Sharing Visit 7-100: Subject to deductible, then \$35 copayment/Visit	Subject to deductible, then 20% coinsurance
Speech Therapy	Subject to deductible, then \$35 copayment/Visit	Subject to deductible, then 20% coinsurance
Routine Prenatal and Postnatal Care	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance

Other Outpatient Services

	In Network	Out of Network
Diagnostic, Imaging and X-ray	No charge after deductible	Subject to deductible, then 20% coinsurance
Laboratory	No charge after deductible	Subject to deductible, then 20% coinsurance
High-tech Radiology (MRI, CT, PET Scan, Nuclear Cardiac Imaging)	No charge after deductible	Subject to deductible, then 20% coinsurance
Outpatient Surgery—Facility Fee	No charge after deductible	Subject to deductible, then 20% coinsurance
Outpatient Surgery—Professional Fee	No charge after deductible	Subject to deductible, then 20% coinsurance

INPATIENT MEDICAL CARE

	In Network	Out of Network
Inpatient Medical Services (including Maternity) - Facility Fee	No charge after deductible	Subject to deductible, then 20% coinsurance
Inpatient Medical Services - Professional Fee	No charge after deductible	Subject to deductible, then 20% coinsurance
Inpatient Care in a Skilled Nursing Facility - Facility Fee (Covered up to 100 days per benefit period)	No charge after deductible	Subject to deductible, then 20% coinsurance
Inpatient Care in a Skilled Nursing Facility - Professional Fee	No charge after deductible	Subject to deductible, then 20% coinsurance
Inpatient Care in a Rehabilitation Facility - Facility Fee (Covered up to 60 days per benefit period)	No charge after deductible	Subject to deductible, then 20% coinsurance
Inpatient Care in a Rehabilitation Facility - Professional Fee	No charge after deductible	Subject to deductible, then 20% coinsurance
Routine Nursery and Newborn Care	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance

BEHAVIORAL HEALTH - OUTPATIENT

	In Network	Out of Network
Mental Health Care or Substance Use Care	Subject to deductible, then \$20 copayment/Visit (waived for members age 18 and younger for the first 3 visits)	Subject to deductible, then 20% coinsurance
Telemedicine (Virtual Visits) - Mental Health Care or Substance Use Care	Subject to deductible, then \$20 copayment/Visit	Subject to deductible, then 20% coinsurance

BEHAVIORAL HEALTH - INPATIENT

	In Network	Out of Network
Mental Health Care - Facility Fee	No charge after deductible	Subject to deductible, then 20% coinsurance
Mental Health Care - Professional Fee	No charge after deductible	Subject to deductible, then 20% coinsurance
Substance Use Detoxification or Rehabilitation - Facility Fee	No charge after deductible	Subject to deductible, then 20% coinsurance
Substance Use Detoxification or Rehabilitation - Professional Fee	No charge after deductible	Subject to deductible, then 20% coinsurance

URGENT CARE

Care for an illness, injury, or condition serious enough that a person would seek immediate care, but not so severe as to require Emergency room care.

	In Network	Out of Network
Urgent Care	Subject to deductible, then \$35 copayment/Visit	Subject to deductible, then 20% coinsurance

EMERGENCY CARE

If you require emergency medical care, go to the nearest emergency room or call 911. You or a family member should notify your PCP within 48 hours of an emergency visit.

Care you receive in an emergency room, in or out of the Service Area	Subject to deductible, then \$350 copayment/Visit (Copayment waived if admitted to hospital for inpatient care)
Ambulance Services (emergency transport only)	No charge after deductible
Emergency Dental Care (within 72 hours of accident or injury)	Subject to deductible, then \$350 copayment/Visit (Copayment waived if admitted to hospital for inpatient care)

ADDITIONAL SERVICES

	In Network	Out of Network
Diabetic Supplies	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance
Disposable Medical Supplies	No charge after deductible	Subject to deductible, then 20% coinsurance
Durable Medical Equipment	Subject to deductible, then 20% coinsurance	Subject to deductible, then 40% coinsurance
Early Intervention (from birth up to age three)	No Member Cost-Sharing	No Member Cost-Sharing
Fitness Program Reimbursement	Up to \$150/Individual, \$300/Family per calendar year (see MassGeneralBrighamHealthPlan.org for qualifications).	
Hearing Aids (age 21 and under) (Covered up to \$2,000 for each affected ear every 36 months)	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance
Home Health Care	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance
Hospice Care	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance
Medical Drugs (drugs that cannot be self-administered)	\$50 copayment/Visit	Subject to deductible, then 20% coinsurance
Oxygen Supplies and Therapy	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance
Radiation Therapy and Chemotherapy	\$75 copayment/Visit	Subject to deductible, then 20% coinsurance
Weight Loss Program Benefit	Coverage for up to six months of membership fees per calendar year in a qualified weight-loss program for either a covered Subscriber or one covered Dependent (see MassGeneralBrighamHealthPlan.org for qualifications)	
Wigs (when medically necessary for hair loss due to cancer treatment or other conditions)	Subject to deductible, then 20% coinsurance	Subject to deductible, then 40% coinsurance

ABOUT YOUR MASS GENERAL BRIGHAM HEALTH PLAN MEMBERSHIP

For questions or concerns about your coverage, call Customer Service at 866-414-5533 (TTY 711). Representatives are available Monday through Friday, 8:00 a.m.–6:00 p.m. (Thursday 8:00 a.m.– 8:00 p.m.)

Benefit Period

Your benefit period resets on your employer's anniversary date.

Copayments, Coinsurance, or Deductibles Required for Certain Services

Before coverage begins for certain services, you pay a deductible each benefit period. Your Plan deductible is an amount you pay for certain services each benefit period. For some services, after the deductible is satisfied, members may be required to pay a copayment and/or coinsurance before coverage begins.

All members are responsible for the individual deductible per benefit period. Family member's deductible payments contribute toward the family deductible per benefit period. The family deductible can be satisfied by combining the deductibles paid for by covered family members. Each family member's contribution will not exceed the amount set for an individual deductible.

All medical and behavioral health amounts paid apply toward the out-of-pocket maximum. Once the individual out-of-pocket maximum is satisfied, these services are covered for the member in full through the remainder of the benefit period. The family out-of-pocket maximum is satisfied by combining the copayments, coinsurance and deductible amounts paid by covered family members. Once the family out-of-pocket maximum is satisfied, these services are covered for all family members in full through the remainder of the benefit period.

Preventive Care Services

Mass General Brigham Health Plan covers eligible preventive services for adults, women (including pregnant women) and children, which includes coverage for annual physical exams, immunizations, well child visits and annual gynecological exams. For a complete list of eligible preventive care services, please visit MassGeneralBrighamHealthPlan.org or call Customer Service.

Urgent Care

If you need urgent care, you can obtain In-Network coverage by seeking services from an In-Network Urgent Care Facility. To find an In-Network Urgent Care Facility near you, access the online Provider Directory at MassGeneralBrighamHealthPlan.org or call Customer Service. Examples of conditions requiring urgent care include, but are not limited to, fever, sore throat or an earache.

Emergency Care

In an emergency, go to the nearest emergency facility, or call 911. Please refer to this Schedule of Benefits for your cost sharing amounts. If you need follow-up care after you are treated in an emergency room, you must get care from an In-Network Provider for coverage to be provided at the In-Network coverage level. If you are admitted to the hospital from an emergency visit, you or the attending physician must call the Plan at 866-414-5533 within 24 hours. This telephone number can also be found on your Member ID card.

Utilization Review Program

The Utilization Review standards Mass General Brigham Health Plan uses were created to assure our members consistently receive high quality, appropriate medical care. To determine coverage, specific criteria are used to make Utilization Review decisions. These criteria are developed by physicians and meet the standards of national accreditation organizations. As new treatments and technologies become available, we update our Utilization Review standards annually.

To make utilization decisions the health plan conducts prospective, concurrent, and retrospective reviews of the health care services our members use.

Initial Determination (Prospective Review or Prior Authorization)

Prior Authorization determines in advance if a procedure or treatment either you or your doctor is requesting is both medically appropriate and medically necessary. Members are required to obtain Prior Authorization from Mass General Brigham Health Plan for certain services. Before you receive services from an Out-of-Network Provider, please refer to our website, MassGeneralBrighamHealthPlan.org, or contact Customer Service at 866-414-5533 for a list of Out-of-Network services that require Prior Authorization.

Concurrent Review

During the course of treatment, such as hospitalization, concurrent review monitors the progress of treatment and determines for how long it will be deemed medically necessary.

Retrospective Review

After care has been provided, we review treatment outcomes to ensure that the health care services provided to you met certain quality standards.

Care Management

When members have a severe or chronic illness or condition, they may qualify for Care Management. Care managers work one-on-one with members and their providers to find the most appropriate and cost-effective ways to manage a condition. Together, a treatment plan that best meets the member's needs is developed with the goal of promoting patient education, self-care, and providing access to the right kinds of health care services and options.

To learn more about Utilization Review or Care Management at Mass General Brigham Health Plan, please refer to your Member Handbook or call Customer Service.

Benefit Exclusions

Services or supplies that Mass General Brigham Health Plan does not cover include: Benefits from other sources; Diet foods; Educational testing and evaluations; Massage therapy; Personal comfort items; Reversal of Voluntary Sterilization.

Additional benefit exclusions apply, for a complete list please refer to your plan's Benefit Handbook.

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This health plan meets Minimum Creditable Coverage standards that are effective January 1, 2026 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards.


This disclosure is for minimum creditable coverage standards that are effective January 1, 2026. Because these standards may change, review your health plan material each year to determine whether your plan meets the latest standards.

If you have questions about this notice, you may contact the Division of Insurance by calling 617-521-7794 or visiting its website at mass.gov/doi.



This plan is underwritten by Mass General Brigham Health Insurance Company.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services **Coverage for: All Coverage Tiers | Plan Type: PPO**

 **The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to Member.MassGeneralBrighamHealthPlan.org or call Customer Services at 866-414-5533 (toll free) or 711 (TTY). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at MassGeneralBrighamHealthPlan.org or call 866-414-5533 (toll free) or 711 (TTY) to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	\$4,000/Individual, \$8,000/Family per benefit period.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. In-Network Preventive care, prescription drug coverage, does not apply towards the deductible.	This plan covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your <u>deductible</u> . See a list of covered preventive services at MassGeneralBrighamHealthPlan.org .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	\$5,450/Individual, \$10,900/Family per benefit period for Medical and Behavioral Health combined. \$1,000/Individual, \$2,000/Family per benefit period for Prescription drug.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Premiums, Out-of-Network penalties for failure to obtain prior authorization, Out-of-Network charges above the allowed amount, and health care this plan doesn't cover.	Even though you pay these expenses, they do not count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. For a list of in-network providers, see MassGeneralBrighamHealthPlan.org or call 866-414-5533.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (a balance bill). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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for large group employers

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services Coverage for: All Coverage Tiers | Plan Type: PPO

All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network	Out of Network	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	Subject to deductible, then \$20 copayment/Visit	Subject to deductible, then 20% coinsurance	For the first 3 visits, in-network cost sharing waived for members age 18 and younger.
	Specialist visit	Subject to deductible, then \$35 copayment/Visit	Subject to deductible, then 20% coinsurance	None.
	Preventive care/screening/immunization	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance	Services for specific conditions during an annual exam may be subject to cost sharing.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: No charge after deductible Blood work: No charge after deductible	X-ray: Subject to deductible, then 20% coinsurance Blood work: Subject to deductible, then 20% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	No charge after deductible	Subject to deductible, then 20% coinsurance	May require prior authorization.
If you need drugs to treat your illness or condition	Tier 1 – Low-Cost Generic	30-day Retail: \$15 copayment/Prescription 90-day Mail: \$30 copayment/Prescription	Not covered	Your plan does not include coverage for GLP-1 medications (e.g., Wegovy, Zepbound, Saxenda) that share an indication of obesity/weight management. No charge for birth control and smoking cessation drugs.
	More information about prescription drug coverage is available at MassGeneralBrighamHealthPlan.org	Tier 2 – Other generic and some brand name	30-day Retail: \$30 copayment/Prescription 90-day Mail: \$60 copayment/Prescription	

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for large group employers

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services **Coverage for: All Coverage Tiers | Plan Type: PPO**

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network	Out of Network	
	Tier 3 – High costing generic and preferred brand name	30-day Retail: \$60 copayment/Prescription 90-day Mail: \$120 copayment/Prescription	Not covered	May require prior authorization.
	Tier 4 – Higher cost generics and non-preferred brand name	30-day Retail: \$120 copayment/Prescription 90-day Mail: \$360 copayment/Prescription	Not covered	
	Tier 5 – Generic specialty and preferred specialty	\$60 copayment/Prescription	Not covered	Prescription must be filled through our specialty pharmacy and a prior authorization may be required.
	Tier 6 – Non-preferred specialty	\$120 copayment/Prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	Subject to deductible, then 20% coinsurance	May require prior authorization.
	Physician/surgeon fees	No charge after deductible	Subject to deductible, then 20% coinsurance	None.
If you need immediate medical attention	Emergency room services	Subject to deductible, then \$350 copayment/Visit	Subject to deductible, then \$350 copayment/Visit	Emergency room copay waived if admitted to hospital for inpatient care.
	Emergency medical transportation	No charge after deductible	No charge after deductible	None.
	Urgent care	Subject to deductible, then \$35 copayment/Visit	Subject to deductible, then 20% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	Subject to deductible, then 20% coinsurance	May require prior authorization.

for large group employers

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services Coverage for: All Coverage Tiers | Plan Type: PPO

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network	Out of Network	
	Physician/surgeon fee	No charge after deductible	Subject to deductible, then 20% coinsurance	None.
If you need mental health, behavioral health, or substance use services	Mental/behavioral health/substance use outpatient services	Subject to deductible, then \$20 copayment/Visit	Subject to deductible, then 20% coinsurance	For the first 3 visits, in-network cost sharing waived for members age 18 and younger.
	Mental/behavioral health/substance use inpatient services	No charge after deductible	Subject to deductible, then 20% coinsurance	May require prior authorization.
If you are pregnant	Office visits for prenatal and postnatal care	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance	None.
	Childbirth/delivery facility services	No charge after deductible	Subject to deductible, then 20% coinsurance	May require prior authorization.
	Childbirth/delivery professional services	No charge after deductible	Subject to deductible, then 20% coinsurance	May require prior authorization.
If you need help recovering or have other special health needs	Home health care	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance	May require prior authorization.
	Rehabilitation services	Outpatient: Visit 1-6: No Member Cost-Sharing Visit 7-100: Subject to deductible, then \$35 copayment/Visit Inpatient: No charge after deductible	Outpatient: Subject to deductible, then 20% coinsurance Inpatient: Subject to deductible, then 20% coinsurance	Outpatient: Covered up to 100 combined PT/OT visits per benefit period. Inpatient: Covered up to 60 days per benefit period. Prior authorization required.

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for large group employers

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services Coverage for: All Coverage Tiers | Plan Type: PPO

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network	Out of Network	
	Habilitation services	Outpatient: Visit 1-6: No Member Cost-Sharing Visit 7-100: Subject to deductible, then \$35 copayment/Visit Inpatient: No charge after deductible	Outpatient: Subject to deductible, then 20% coinsurance Inpatient: Subject to deductible, then 20% coinsurance	Outpatient: Covered up to 100 combined PT/OT visits per benefit period. Inpatient: Covered up to 60 days per benefit period. Prior authorization required.
	Skilled nursing care	No charge after deductible	Subject to deductible, then 20% coinsurance	Covered up to 100 days per benefit period. May require prior authorization.
	Durable medical equipment	Subject to deductible, then 20% coinsurance	Subject to deductible, then 40% coinsurance	May require prior authorization. No charge for electric breast pump (one per birth).
	Hospice service	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance	May require prior authorization.
If your child needs dental or eye care	Children's eye exam	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance	1 eye exam(s) every 12 months per child
	Children's glasses	Not covered	Not covered	None.
	Children's dental check-up	Not covered	Not covered	Limited to children under age 18 with a cleft palate/cleft lip condition. You may have coverage under a separate dental plan.

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Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services **Coverage for: All Coverage Tiers | Plan Type: PPO**

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u>.)		
<ul style="list-style-type: none"> • Cosmetic Surgery • Dental care (you may have coverage under a separate dental plan) 	<ul style="list-style-type: none"> • Extraction of infected or impacted wisdom teeth (except when in a hospital setting) • Long-term care 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Private-duty nursing
Other Covered Services (This isn't a complete list. Check your policy or Plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> • Abortion • Acupuncture- Covered up to 20 visits per benefit period • Bariatric surgery 	<ul style="list-style-type: none"> • Chiropractic care • Hearing aids (age 21 and younger)- Covered up to \$2,000 for each affected ear every 36 months • Infertility treatment 	<ul style="list-style-type: none"> • Routine eye exam (adult) • Routine foot care (covered for diabetes and some circulatory diseases) • Weight loss program (coverage for up to six months of membership fees in a qualified weight-loss program for either a covered Subscriber or one covered Dependent)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies are: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Customer Service at **866-414-5533 (toll free) or 711 (TTY)**.

Does this Coverage Provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this Coverage Meet the Minimum Value Standard? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Para obtener asistencia en Español, llame al **866-414-5533**.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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for large group employers

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services Coverage for: All Coverage Tiers | Plan Type: PPO

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$4,000	■ The plan's overall deductible	\$4,000	■ The plan's overall deductible	\$4,000
■ Specialist copayment	\$35 after deductible	■ Specialist copayment	\$35 after deductible	■ Specialist copayment	\$35 after deductible
■ Hospital (facility)	\$0 after deductible	■ Hospital (facility)	\$0 after deductible	■ Hospital (facility)	\$0 after deductible
<p>This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)</p>	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$4,000	Deductibles	\$900	Deductibles	\$2,400
Copayments	\$70	Copayments	\$600	Copayments	\$10
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$0	Limits or exclusions	\$0	Limits or exclusions	\$0
The total Peg would pay is	\$4,070	The total Joe would pay is	\$1,500	The total Mia would pay is	\$2,410

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

MCC Compliance



This health plan meets Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance.