

Care and coverage. Better together.



Enrollment kit:

The Governor's Academy

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Get to know Mass General Brigham Health Plan

Introducing Mass General Brigham Health Plan, a valuable option when it comes to health insurance for The Governor's Academy. As a health plan that puts you first, you get the best of value, innovation, and customer care. With our plan, you'll enjoy comprehensive coverage, access to world-class doctors and hospitals, and personalized care and customer service.

Choose from two plans with access to national networks of top doctors and hospitals

<p>The Governor's Academy Complete Access EPO 20%</p>	<p>This plan provides access to Mass General Brigham Health Plan's full network in Massachusetts and New Hampshire, plus the UnitedHealthcare Options PPO network outside of MA and NH. Members are required to designate their Mass General Brigham Health Plan PCPs located in MA and NH. Referrals are needed for most specialty services.</p>
<p>The Governor's Academy Complete PPO Plus HSA 2000 Enhanced FlexRx</p>	<p>This plan's network includes Mass General Brigham Health Plan's full network in Massachusetts and New Hampshire, plus the UnitedHealthcare Options PPO network outside of MA and NH. No PCP is required, and no referrals are necessary. Members can access in OR out-of-network services. All covered services except certain preventive care and preventive drugs are subject to the deductible. This plan's Enhanced Rx prescription drug coverage includes an expanded list of preventive drugs that are not subject to the deductible.</p>

Easier, smarter, and more member-focused benefits

<p>Prescription drug benefit</p>	<p>No matter which plan you choose, you'll have 4-tier coverage for a wide variety of prescription drugs. The pharmacy network includes thousands of participating pharmacies nationwide, including CVS Pharmacy®, independent pharmacies, and chains like Walgreens® and Rite Aid®. See your plan documents for tiering and cost details. Visit MGBHP.org/pharmacy to search for covered drugs.</p>
<p>Over-the-counter drug benefit</p>	<p>Lower or no-cost coverage for many over-the-counter drugs with a prescription at a participating pharmacy.</p>
<p>Behavioral health</p>	<p>Optum is our behavioral health partner and offers one of the largest behavioral health networks in the nation. Optum providers offer treatments that include outpatient services, day programs, residential programs, autism care and support, substance and recovery services, and more. In addition, Lyra Health provides a range of mental health services with virtual and in-person options, including on-demand resources, mental health coaching, therapy, and medication management. Members can get personalized provider matching and quickly schedule appointments, often within one to three days.</p>

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Member wellness programs

Wellness hub	The wellness hub helps you set personalized health goals, choose activities that match your interests and well-being needs, and join challenges to build healthy habits. Designed to meet you where you are and support a broad range of wellness priorities, the wellness hub makes it easier to explore, track, and stay engaged with everyday health and preventive care.
Health coaching	Health coaches are available by phone to assist you in sustainable behavior changes in the areas of healthy eating/weight management, physical activity, stress management, and tobacco cessation.
Tobacco cessation support	Member-focused telephonic tobacco cessation counseling with a certified tobacco treatment specialist.

Ways to save

DoctorSmartSM	An integrated suite of helpful tools available in our secure Member Portal and through the member app. Using DoctorSmart, you can find participating providers and hospitals. You can also access cost information for certain procedures and services that you can use to make informed decisions on where to receive care.
Fitness and weight loss reimbursement	Fitness reimbursement: Up to \$150 for individual coverage or \$300 for family coverage per calendar year including small group personal training through SplitFit and virtual subscriptions. Weight loss reimbursement: Flexible one-to-six-month weight-loss program benefit through WW [®] , Jenny Craig [®] , or Noom [®] . <small>Terms and conditions apply.</small>
EyeMed vision discount	Discounts on vision care and services with access to one of the nation's largest networks of independent providers and top retail providers such as LensCrafters [®] , Pearle Vision SM , and Target Optical SM .

Programs that focus on and support you

LiteSwitchSM	We're here to ensure a smooth transition to your new plan — even before coverage starts. Our specially trained Customer Service professionals are available to discuss any current or planned health care needs to help ensure your care is uninterrupted and you get all the services you need on day one.
Care management	A suite of programs to help members be as well as they can be, including asthma management, diabetes management, cardiovascular disease, and maternal child health. We also have a special care program for members with more complex medical needs, where a team of experts will work with members to reach their health goals.
DSC2U - Down Syndrome Clinic to You	Offers parents and/or caregivers of members with Down syndrome personalized care reports that include best practices and health-related information (for example, recommended lab tests and therapies, nutrition information, and other wellness resources).
Nurse advice line	24-hour toll-free nurse advice line for all covered members.



Want to know more?

To learn more, please refer to the Schedule of Benefits or visit our website at [MGBHP.org](https://www.MGBHP.org).



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.

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

Continued

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

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

Fax: 617-586-1799

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.

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Schedule of Benefits

The Governor's Academy Complete Access EPO 20%

For Self-Insured 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 1-855-833-2619 (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): None Prescription Drug: None
Out-of-Pocket Maximum per benefit period	Medical/Behavioral Health/Prescription Drug (Combined): \$1,000 Individual /\$2,000 Family

With family coverage, the individual Out-of-Pocket Maximum does not apply. The entire family out-of-pocket maximum is satisfied by combining the deductibles, coinsurance, and copayment amounts paid by covered family members.

The Deductible, Coinsurance and Copayments for Medical, Behavioral Health, and Prescription Drugs 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	\$20 copayment/Visit
Telemedicine (Virtual Visits) - PCP	\$20 copayment/Visit
Office Visits for Other Specialty Care	\$20 copayment/Visit
Telemedicine (Virtual Visits) - Specialist	\$20 copayment/Visit
Acupuncture (Covered up to 20 visits per benefit period)	\$20 copayment/Visit
Allergy Shots	No Member Cost-Sharing
Cardiac Rehabilitation Service	\$20 copayment/Visit
Chiropractic Care	\$20 copayment/Visit
Routine Eye Exam (1 visit(s) per member every 12 months)	\$20 copayment/Visit (waived for members diagnosed with diabetes)
Routine Foot Care (covered for diabetes and some circulatory diseases)	\$20 copayment/Visit
Hearing Exams	\$20 copayment/Visit
Infertility Services	\$20 copayment/Visit
Physical Therapy/Occupational Therapy (Covered up to 100 combined PT/OT visits per benefit period)	\$20 copayment/Visit
Speech Therapy	\$20 copayment/Visit
Routine Prenatal and Postnatal Care	No Member Cost-Sharing

Other Outpatient Services

Diagnostic, Imaging and X-ray	No Member Cost-Sharing
Laboratory	No Member Cost-Sharing
High-tech Radiology (MRI, CT, PET Scan, Nuclear Cardiac Imaging)	20% coinsurance
Outpatient Surgery—Facility Fee	20% coinsurance
Outpatient Surgery—Professional Fee	20% coinsurance

INPATIENT MEDICAL CARE

Inpatient Medical Services (including Maternity) - Facility Fee	20% coinsurance
Inpatient Medical Services - Professional Fee	20% coinsurance
Inpatient Care in a Skilled Nursing Facility - Facility Fee (Covered up to 100 days per benefit period)	20% coinsurance
Inpatient Care in a Skilled Nursing Facility - Professional Fee	20% coinsurance
Inpatient Care in a Rehabilitation Facility - Facility Fee (Covered up to 60 days per benefit period)	20% coinsurance
Inpatient Care in a Rehabilitation Facility - Professional Fee	20% coinsurance
Routine Nursery and Newborn Care	No Member Cost-Sharing

BEHAVIORAL HEALTH - OUTPATIENT

Mental Health Care or Substance Use Care	\$20 copayment/Visit
Telemedicine (Virtual Visits) - Mental Health Care or Substance Use Care	\$20 copayment/Visit

BEHAVIORAL HEALTH - INPATIENT

Mental Health Care - Facility Fee	20% coinsurance
Mental Health Care - Professional Fee	20% coinsurance
Substance Use Detoxification or Rehabilitation - Facility Fee	20% coinsurance
Substance Use Detoxification or Rehabilitation - Professional Fee	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.

Urgent Care	\$20 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	20% coinsurance
Ambulance Services (emergency transport only)	No Member Cost-Sharing
Emergency Dental Care (within 72 hours of accident or injury)	20% coinsurance

DENTAL CARE

Preventive Dental Care ** for children under 12 (one visit every 6 months)	No Member Cost-Sharing
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**Preventive dental services must be provided by a Delta Dental Premier Network participating dentist. To locate a Delta Dental Premier Network provider, please visit deltadentalma.com or call 800-872-0500.

PRESCRIPTION DRUGS (4-Tier)

30-day Retail: With a valid prescription and purchased at a participating pharmacy for up to a 30-day supply

Tier 1 - Low-Cost Generic: \$5 copayment/Prescription
Tier 2 - Other generic and some brand name: \$20 copayment/Prescription
Tier 3 - Higher costing generic, preferred brand name and specialty medications: \$30 copayment/Prescription
Tier 4 - Non-preferred brand name and specialty medications: 20% coinsurance/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 1 - Low-Cost Generic: \$5 copayment/Prescription
Tier 2 - Other generic and some brand name: \$20 copayment/Prescription
Tier 3 - High costing generic and preferred brand name: \$30 copayment/Prescription
Tier 4 - Higher cost generics and non-preferred brand name: 20% coinsurance/Prescription

90-day Retail:

Tier 1 - Low-Cost Generic: \$15 copayment/Prescription
Tier 2 - Other generic and some brand name: \$60 copayment/Prescription
Tier 3 - High costing generic and preferred brand name: \$90 copayment/Prescription
Tier 4 - Higher cost generics and non-preferred brand name: 20% coinsurance/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.massgeneralbrighamhealthplan.org) or call Customer Service at 1-855-833-2619 (TTY 711).

Select over-the-counter medicines and products with a valid prescription and purchased at a participating pharmacy.

\$0- \$30 copayment/Prescription (depending on drug prescribed)

ADDITIONAL SERVICES

Diabetic Supplies	No Member Cost-Sharing
Disposable Medical Supplies	20% coinsurance
Durable Medical Equipment	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)	20% coinsurance

ABOUT YOUR MASS GENERAL BRIGHAM HEALTH PLAN MEMBERSHIP

For questions or concerns about your coverage, call Customer Service at 1-855-833-2619 (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 or Coinsurance Required for Certain Services

All medical and behavioral health and prescription drug copayments and coinsurance 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 coinsurance and copayment 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 administered by Mass General Brigham Health Insurance Company which processes claims for payment but does not assume financial risk for claims.



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 1-855-833-2619 (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 1-855-833-2619 (toll free) or 711 (TTY) to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes.	See the Common Medical Events Chart below for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this plan?	\$1,000/Individual, \$2,000/Family per benefit period.	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, the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u> ?	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 <u>network provider</u> ?	Yes. For a list of in-network providers, see MassGeneralBrighamHealthPlan.org or call 1-855-833-2619.	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 <u>referral</u> to see a <u>specialist</u> ?	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.

 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	\$20 copayment/Visit	Not covered	None.
	Specialist visit	\$20 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 Member Cost-Sharing Blood work: No Member Cost-Sharing	Not covered	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	May require prior authorization.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at MassGeneralBrighamHealthPlan.org	Tier 1 – Low-Cost Generic	30-day Retail: \$5 copayment/Prescription 90-day Mail: \$5 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.
	Tier 2 – Other generic and some brand name	30-day Retail: \$20 copayment/Prescription 90-day Mail: \$20 copayment/Prescription	Not covered	
	Tier 3 – Higher costing generic, preferred brand name and specialty medications	30-day Retail: \$30 copayment/Prescription 90-day Mail: \$30 copayment/Prescription	Not covered	No charge for birth control and smoking cessation drugs.
	Tier 4 – Non-preferred brand name and specialty medications	30-day Retail: 20% coinsurance/Prescription 90-day Mail: 20% coinsurance/Prescription	Not covered	May require prior authorization.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network	Out of Network	
	Specialty drugs	Limited to a 30-day supply with appropriate tier copay (see above)	Not covered	Prescription must be filled through our specialty pharmacy and a prior authorization may be required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	May require prior authorization.
	Physician/surgeon fees	20% coinsurance	Not covered	None.
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	None.
	Emergency medical transportation	No Member Cost-Sharing	No Member Cost-Sharing	None.
	Urgent care	\$20 copayment/Visit	\$20 copayment/Visit	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	May require prior authorization.
	Physician/surgeon fee	20% coinsurance	Not covered	None.
If you need mental health, behavioral health, or substance use services	Mental/behavioral health/substance use outpatient services	\$20 copayment/Visit	Not covered	None.
	Mental/behavioral health/substance use inpatient services	20% coinsurance	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	20% coinsurance	Not covered	May require prior authorization.
	Childbirth/delivery professional services	20% coinsurance	Not covered	May require prior authorization.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network	Out of Network	
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: \$20 copayment/Visit Inpatient: 20% coinsurance	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: \$20 copayment/Visit Inpatient: 20% coinsurance	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.
	Skilled nursing care	20% coinsurance	Not covered	Covered up to 100 days per benefit period. May require prior authorization.
	Durable medical equipment	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	\$20 copayment/Visit	Not covered
Children's glasses		Not covered	Not covered	None.
Children's dental check-up		No Member Cost-Sharing	Not covered	One dental check-up every 6 months per child under age 12 covered under this plan.

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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 (adult age 12 and older) 	<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 **1-855-833-2619 (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 **1-855-833-2619**.

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

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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)
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<ul style="list-style-type: none"> ■ The plan's overall deductible \$0 ■ Specialist copayment \$20 ■ Hospital (facility) coinsurance 20% 	<ul style="list-style-type: none"> ■ The plan's overall deductible \$0 ■ Specialist copayment \$20 ■ Hospital (facility) coinsurance 20% 	<ul style="list-style-type: none"> ■ The plan's overall deductible \$0 ■ Specialist copayment \$20 ■ Hospital (facility) coinsurance 20%
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<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>
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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	\$0	Deductibles	\$0	Deductibles	\$0
Copayments	\$40	Copayments	\$600	Copayments	\$100
Coinsurance	\$1,000	Coinsurance	\$0	Coinsurance	\$200
<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	\$1,040	The total Joe would pay is	\$600	The total Mia would pay is	\$300

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

The Governor's Academy Complete PPO Plus HSA 2000 Enhanced FlexRxSM

For Self-Insured Large Group Employers

This plan is a Health Savings Account (HSA) compatible high deductible health plan (HDHP). An HSA is a tax exempt fund that you and/or your employer can establish to pay for medical expenses associated with a qualified HDHP or you can use to save for your future health needs. By choosing an HSA-compatible plan, you are able to set up and contribute to an HSA and use the funds to pay for qualified medical expenses without federal tax liability or penalty. Check with your employer to find out whether they have an administrator to manage HSAs for their employees. Or contact our preferred HSA administrator, Benefit Strategies, at 603-232-8037 to learn how you may establish and fund an HSA. Once you set up an HSA, you should contact your HSA administrator to find out how to get the most from your account.



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.

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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 1-855-833-2619 (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

	In Network	Out of Network
Deductible per benefit period	Medical/Behavioral Health/Prescription Drug (Combined): \$2,000 Individual /\$4,000 Family	Medical/Behavioral Health (Combined): \$4,000 Individual /\$8,000 Family
With family coverage, the individual deductible does not apply. The entire family deductible must be met before benefits are payable for anyone in the family. Deductible doesn't apply to preventive services.		
Out-of-Pocket Maximum per benefit period	Medical/Behavioral Health/Prescription Drug (Combined): \$4,000 Individual /\$8,000 Family	Medical/Behavioral Health (Combined): \$8,000 Individual /\$16,000 Family
With family coverage, the family out-of-pocket maximum is satisfied by combining the deductibles, coinsurance, and copayment amounts paid by covered family members. A covered member will not exceed the Individual maximum out-of-pocket amount.		

The Deductible, Coinsurance and Copayments for Medical, Behavioral Health, and Prescription Drugs 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.)

OUTPATIENT MEDICAL CARE

<i>Preventive Services</i>	In Network	Out of Network
Annual Physical Exams ¹	No Member Cost-Sharing	Subject to OON deductible, then 20% coinsurance
Annual Gynecological Exams ¹	No Member Cost-Sharing	Subject to OON deductible, then 20% coinsurance
Family Planning Services	No Member Cost-Sharing	Subject to OON deductible, then 20% coinsurance
Immunizations & Vaccinations	No Member Cost-Sharing	Subject to OON deductible, then 20% coinsurance
Preventive Laboratory Tests	No Member Cost-Sharing	Subject to OON deductible, then 20% coinsurance
Screening Colonoscopy	No Member Cost-Sharing	Subject to OON deductible, then 20% coinsurance
Screening Mammography	No Member Cost-Sharing	Subject to OON deductible, then 20% coinsurance
Well Child Visits	No Member Cost-Sharing	Subject to OON 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	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance
Telemedicine (Virtual Visits) - PCP	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance
Office Visits for Other Specialty Care	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance
Telemedicine (Virtual Visits) - Specialist	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance
Acupuncture (Covered up to 20 visits per benefit period)	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance
Allergy Shots	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance
Cardiac Rehabilitation Service	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance
Chiropractic Care	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance
Routine Eye Exam (1 visit(s) per member every 12 months)	No Member Cost-Sharing	Subject to OON deductible, then 20% coinsurance
Routine Foot Care (covered for diabetes and some circulatory diseases)	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance
Hearing Exams	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance
Infertility Services	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance
Physical Therapy/Occupational Therapy (Covered up to 100 combined PT/OT visits per benefit period)	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance
Speech Therapy	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance
Routine Prenatal and Postnatal Care	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance

Other Outpatient Services

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

INPATIENT MEDICAL CARE

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

BEHAVIORAL HEALTH - OUTPATIENT

	In Network	Out of Network
Mental Health Care or Substance Use Care	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance
Telemedicine (Virtual Visits) - Mental Health Care or Substance Use Care	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance

BEHAVIORAL HEALTH - INPATIENT

	In Network	Out of Network
Mental Health Care - Facility Fee	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance
Mental Health Care - Professional Fee	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance
Substance Use Detoxification or Rehabilitation - Facility Fee	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance
Substance Use Detoxification or Rehabilitation - Professional Fee	No charge after IN deductible	Subject to OON 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	No charge after IN deductible	Subject to OON 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	No charge after IN deductible
Ambulance Services (emergency transport only)	No charge after IN deductible
Emergency Dental Care (within 72 hours of accident or injury)	No charge after IN deductible

DENTAL CARE

Preventive Dental Care ** for children under 12 (one visit every 6 months)	No Member Cost-Sharing
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**Preventive dental services must be provided by a Delta Dental Premier Network participating dentist. To locate a Delta Dental Premier Network provider, please visit deltadentalma.com or call 800-872-0500.

PRESCRIPTION DRUGS (4-Tier)

30-day Retail: With a valid prescription and purchased at a participating pharmacy for up to a 30-day supply	Tier 1 - Low-Cost Generic: Subject to IN deductible, then \$5 copayment/Prescription Tier 2 - Other generic and some brand name: Subject to IN deductible, then \$20 copayment/Prescription Tier 3 - Higher costing generic, preferred brand name and specialty medications: Subject to IN deductible, then \$30 copayment/Prescription Tier 4 - Non-preferred brand name and specialty medications: Subject to IN deductible, then 20% coinsurance up to \$250 per script max
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 1 - Low-Cost Generic: Subject to IN deductible, then \$5 copayment/Prescription Tier 2 - Other generic and some brand name: Subject to IN deductible, then \$20 copayment/Prescription Tier 3 - High costing generic and preferred brand name: Subject to IN deductible, then \$30 copayment/Prescription Tier 4 - Higher cost generics and non-preferred brand name: Subject to IN deductible, then 20% coinsurance up to \$250 per script max
90-day Retail:	Tier 1 - Low-Cost Generic: Subject to IN deductible, then \$15 copayment/Prescription Tier 2 - Other generic and some brand name: Subject to IN deductible, then \$60 copayment/Prescription Tier 3 - High costing generic and preferred brand name: Subject to IN deductible, then \$90 copayment/Prescription Tier 4 - Higher cost generics and non-preferred brand name: Subject to IN deductible, then 20% coinsurance up to \$250 per script max

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 or call Customer Service at 1-855-833-2619 (TTY 711).

Select over-the-counter medicines and products with a valid prescription and purchased at a participating pharmacy.	\$0-Subject to IN deductible, then \$30 copayment/Prescription (depending on drug prescribed)
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ADDITIONAL SERVICES

	In Network	Out of Network
Diabetic Supplies	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance
Disposable Medical Supplies	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance
Durable Medical Equipment	Subject to IN deductible, then 20% coinsurance	Subject to OON deductible, then 20% coinsurance
Early Intervention (from birth up to age three)	No charge after IN deductible	No charge after OON deductible
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 charge after IN deductible	Subject to OON deductible, then 20% coinsurance
Home Health Care	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance
Hospice Care	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance
Medical Drugs (drugs that cannot be self-administered)	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance
Oxygen Supplies and Therapy	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance
Radiation Therapy and Chemotherapy	No charge after IN deductible	Subject to OON 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 IN deductible, then 20% coinsurance	Subject to OON deductible, then 20% coinsurance

ABOUT YOUR MASS GENERAL BRIGHAM HEALTH PLAN MEMBERSHIP

For questions or concerns about your coverage, call Customer Service at 1-855-833-2619 (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 year before the health plan starts to pay for those certain covered services.

Your Health Savings Account (HSA) Compatible plan uses an Aggregate Deductible and Embedded Out-of-Pocket Maximum.

If you have individual coverage, you only need to satisfy the individual deductible and out-of-pocket maximum amounts. Family amounts do not apply to you. If you have family coverage, the individual deductible does not apply. Your entire family deductible must be met before benefits are payable for anyone in the family (unless otherwise noted). With family coverage, the family out-of-pocket maximum is satisfied by combining the deductibles, coinsurance, and copayment amounts paid by covered family members. A covered member will not exceed the Individual out-of-pocket maximum before the plan starts to pay 100% for covered services.

As a reminder, under HSA-compatible plans, all covered services except covered preventive services apply toward satisfaction of the deductible.

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 1-855-833-2619 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 administered by Mass General Brigham Health Insurance Company which processes claims for payment but does not assume financial risk for claims.

for self-insured 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

 **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 1-855-833-2619 (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 1-855-833-2619 (toll free) or 711 (TTY) to request a copy.

Important Questions	Answers	Why This Matters
What is the overall <u>deductible</u>?	In Network: \$2,000/Individual, \$4,000/Family per benefit period. Out of Network: \$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 policy, the overall family <u>deductible</u> must be met before the plan begins to pay.
Are there services covered before you meet your <u>deductible</u>?	Yes. In-Network Preventive 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 <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this plan?	In Network: \$4,000/Individual, \$8,000/Family per benefit period. Out of Network: \$8,000/Individual, \$16,000/Family per benefit period.	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 <u>out-of-pocket limit</u>?	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 <u>network provider</u>?	Yes. For a list of in-network providers, see MassGeneralBrighamHealthPlan.org or call 1-855-833-2619.	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 <u>referral</u> to see a <u>specialist</u>?	No.	You can see the specialist you choose without a referral.

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for self-insured 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	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance	None.
	Specialist visit	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance	None.
	Preventive care/screening/immunization	No Member Cost-Sharing	Subject to OON 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 IN deductible Blood work: No charge after IN deductible	X-ray: Subject to OON deductible, then 20% coinsurance Blood work: Subject to OON deductible, then 20% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	No charge after IN deductible	Subject to OON 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: Subject to IN deductible, then \$5 copayment/Prescription 90-day Mail: Subject to IN deductible, then \$5 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.

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for self-insured 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	
More information about prescription drug coverage is available at MassGeneralBrighamHealthPlan.org	Tier 2 – Other generic and some brand name	30-day Retail: Subject to IN deductible, then \$20 copayment/Prescription 90-day Mail: Subject to IN deductible, then \$20 copayment/Prescription	Not covered	No charge for birth control and smoking cessation drugs. May require prior authorization.
	Tier 3 – Higher costing generic, preferred brand name and specialty medications	30-day Retail: Subject to IN deductible, then \$30 copayment/Prescription 90-day Mail: Subject to IN deductible, then \$30 copayment/Prescription	Not covered	
	Tier 4 – Non-preferred brand name and specialty medications	30-day Retail: Subject to IN deductible, then 20% coinsurance up to \$250 per script max 90-day Mail: Subject to IN deductible, then 20% coinsurance up to \$250 per script max	Not covered	
	Specialty drugs	Limited to a 30-day supply with appropriate tier copay (see above)	Not covered	Prescription must be filled through our specialty pharmacy and a prior authorization may be required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance	May require prior authorization.
	Physician/surgeon fees	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance	None.
If you need immediate medical attention	Emergency room services	No charge after IN deductible	No charge after IN deductible	None.

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for self-insured 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	
	Emergency medical transportation	No charge after IN deductible	No charge after IN deductible	None.
	Urgent care	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance	May require prior authorization.
	Physician/surgeon fee	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance	None.
If you need mental health, behavioral health, or substance use services	Mental/behavioral health/substance use outpatient services	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance	None.
	Mental/behavioral health/substance use inpatient services	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance	May require prior authorization.
If you are pregnant	Office visits for prenatal and postnatal care	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance	None.
	Childbirth/delivery facility services	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance	May require prior authorization.
	Childbirth/delivery professional services	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance	May require prior authorization.
If you need help recovering or have other special health needs	Home health care	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance	May require prior authorization.

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for self-insured 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	
	Rehabilitation services	Outpatient: No charge after IN deductible Inpatient: No charge after IN deductible	Outpatient: Subject to OON deductible, then 20% coinsurance Inpatient: Subject to OON 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.
	Habilitation services	Outpatient: No charge after IN deductible Inpatient: No charge after IN deductible	Outpatient: Subject to OON deductible, then 20% coinsurance Inpatient: Subject to OON 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 IN deductible	Subject to OON deductible, then 20% coinsurance	Covered up to 100 days per benefit period. May require prior authorization.
	Durable medical equipment	Subject to IN deductible, then 20% coinsurance	Subject to OON deductible, then 20% coinsurance	May require prior authorization. No charge for electric breast pump (one per birth).
	Hospice service	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance	May require prior authorization.

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for self-insured 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	
If your child needs dental or eye care	Children's eye exam	No Member Cost-Sharing	Subject to OON 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	No Member Cost-Sharing	Not covered	One dental check-up every 6 months per child under age 12 covered under this plan.

for self-insured 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

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 (adult age 12 and older) 	<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 **1-855-833-2619 (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 **1-855-833-2619**.

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

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for self-insured 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)
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<ul style="list-style-type: none"> ■ The plan's overall deductible \$2,000 ■ Specialist \$0 after IN deductible ■ Hospital (facility) \$0 after IN deductible 	<ul style="list-style-type: none"> ■ The plan's overall deductible \$2,000 ■ Specialist \$0 after IN deductible ■ Hospital (facility) \$0 after IN deductible 	<ul style="list-style-type: none"> ■ The plan's overall deductible \$2,000 ■ Specialist \$0 after IN deductible ■ Hospital (facility) \$0 after IN deductible
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<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>
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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	\$2,000	Deductibles	\$2,000	Deductibles	\$2,000
Copayments	\$30	Copayments	\$300	Copayments	\$0
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$10
<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	\$2,030	The total Joe would pay is	\$2,300	The total Mia would pay is	\$2,010

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.



The enhanced preventive drug benefit

A benefit for members enrolled in an HSA-compliant plan

Your prescription drug coverage includes an expanded list of preventive medications that are not subject to your deductible. This lets you get the most out of your FlexRxSM benefits from your very first day of coverage. When you fill a prescription for the drugs listed below, you'll pay only the applicable copay and/or coinsurance, depending on your plan.

Our members can get the most up-to-date list of qualifying drugs—along with personalized cost-sharing information—on the Member Portal at Member.MGBHP.org.

Drug list

Anaphylaxis/Adrenergic agents

Epinephrine Injections
Epinephrine Solutions

Anticoagulants

Aspirin/Dipyridamole Cap
Eliquis Tab
Enoxaparin Inj
Warfarin Tab
Xarelto Tab

Antimalarial

Atovaquone-Proguanil Tab
Chloroquine Phosphate
Mefloquine
Primaquine Phosphate

Antineoplastics

Anastrozole
Exemestane
Letrozole
Tamoxifen Citrate

Antisera

Cytomegalovirus Immune Globulin
Hepatitis B Immune Globulin
Immune Globulin
Oseltamivir Phosphate
Rabies Immune Globulin
Relenza Diskhaler
Rimantadine Hydrochloride
Varicella-Zoster Immune Globulin

Asthma/COPD

Advair HFA Aer
Albuterol HFA Aer
Albuterol Neb
Albuterol Syb
Albuterol Tab
Anoro Ellipta Aer
Arformoterol Neb
Arnuity Ellipta Inh
Atrovent HFA Aer
Breo Ellipta Inh
Budesonide Inh Sus
Combivent Aer
Cromolyn Sod Neb
Formoterol Neb
Incruse Ellipta Inh
Ipratropium/Albuterol Sol
Pulmicort Flexhaler
Qvar Redihaler
Roflumilast Tab

Drug list

Asthma/COPD (continued)

Serevent Dis Aer
Spiriva Aer
Stiolto Aer
Striverdi Aer
Symbicort Aer
Terbutaline Tab
Theophylline Elix
Theophylline Sol
Theophylline Tab ER
Trelegy Ellipta
Zafirlukast Tab

Depression

Amitriptyline Tab
Amoxapine Tab
Bupropion Tab
Bupropion Tab ER
Citalopram Tab
Clomipramine Cap
Desipramine Tab
Desvenlafaxine Tab ER
Doxepin hcl Cap
Duloxetine Cap
Escitalopram Sol
Fluoxetine Cap
Fluvoxamine Tab
Imipramine Hcl Tab
Imipramine Pam Cap
Lithium Carbonate Cap
Mirtazapine Tab
Mirtazapine Tab ODT
Nefazodone Tab
Nortriptyline Cap
Paroxetine
Phenelzine Tab
Protriptyline Tab
Sertraline Tab
Tranylcypromine Tab
Trazodone Tab
Trimipramine Cap
Venlafaxine Cap ER
Venlafaxine Tab

Diabetes

Acetone (Urine) Test Strip
Alogliptin Tab
Alogliptin/Metformin Tab
Alogliptin/Pioglitazone Tab
Blood Glucose Calibration-Liquid

Blood Glucose Monitoring Kit
with Device
Farxiga
Glimepiride Tab
Glipizide ER Tab
Glipizide Tab
Glipizide/Metformin Tab
Glucose Blood Test Strip
Glucose Urine Test-
(Glucose Oxidase) Strip
Glyburide Micronized Tab
Glyburide Tab
Glyburide/Metformin Tab
Glyxambi Tab
Insulin Infusion Disposable
Pump Kit
Insulin Pen Needles
Insulin Syringe/Needles
Humalog Inj
Humalog KwikPen
Humalog KwikPen Junior
Humalog Mix
Humulin Inj
Humulin Mix Inj
Humulin Mix KwikPen
Humulin N Inj
Humulin R Inj
Insulin Lispro Inj
Insulin Lispro KwikPen
Insulin Lispro KwikPen Junior
Insulin Lispro Protamine KwikPen
Janumet Tab
Janumet XR Tab
Januvia Tab
Jardiance Tab
Lancets
Lancet Devices
Lancets Kit
Lancets Misc.
Lantus Inj
Lantus Inj Solostar
Liraglutide Inj (generic Victoza)
Lyumjev Inj
Lyumjev KwikPen
Metformin Tab
Metformin Tab ER
Mounjaro
Nateglinide Tab
Ozempic Inj
Pioglitazone Tab

Repaglinide Tab
Rybelsus
Synjardy Tab
Synjardy XR Tab
Toujeo Solostar Inj
Trulicity Inj
Urine Glucose-
Ketones Test Strips
Xigduo

Folic acid

Folic Acid

High blood pressure

Acebutolol Cap
Amlodipine Tab
Amlodipine/Atorvastatin Tab
Amlodipine/Benzapril Cap
Amlodipine/Valsartan/Hctz Tab
Atenolol Tab
Atenolol/Chlorthalidone Tab
Benazepril Tab
Benazepril/Hctz Tab
Betaxolol Tab
Bisoprol Fum Tab
Bisoprolol/Hctz Tab
Candesartan Tab
Candesartan/Hctz Tab
Captopril Tab
Cartia Xt Cap
Carvedilol Tab
Clonidine Tab
Diltiazem Cap ER
Diltiazem Tab
Doxazosin Tab
Enalapril Tab
Enalapril/Hctz Tab
Eplerenone Tab
Felodipine Tab ER
Fosinopril Tab
Fosinopril/Hctz Tab
Guanfacine Tab
Hydralazine Tab
Irbesartan/Hctz Tab
Irbesartan Tab
Isradipine Cap
Labetalol Tab
Lisinopril/Hctz Tab
Losartan Pot Tab
Losartan/Hct Tab

Drug list

High blood pressure (continued)

Matzim LA Tab
Methyldopa Tab
Methyldopa/Hctz Tab
Metoprol Succinate Tab ER
Metoprol Tartrate Tab
Metoprolol/Hctz Tab
Metyrosine Cap
Minoxidil Tab
Moexipril Tab
Nadolol Tab
Nebivolol
Nicardipine Cap
Nifedipine Cap
Nifedipine Tab ER
Nimodipine Cap
Nisoldipine Tab ER
Olmesartan Tab
Olmesartan/Amlodipine/Hctz Tab
Olmesartan/Hctz Tab
Perindopril Tab
Phenoxybenza Cap
Pindolol Tab
Prazosin Hcl Cap
Propranolol Cap ER
Propranolol Tab
Propranolol/Hctz Tab
Quinapril Tab
Quinapril/Hctz Tab
Ramipril Cap
Sotalol Hcl Tab
Taztia Xt Cap
Telmisartan Tab
Telmisartan/Amlodipine Tab
Telmisartan/Hctz Tab
Terazosin Cap
Trandolapril Tab
Trandolapril/Verapamil Tab ER
Valsartan Tab
Valsartan/Hctz Tab
Verapamil Tab

High cholesterol

Cholestyramine Pow
Colesevelam Tab
Colestipol Tab
Ezetimibe Tab
Fenofibrate Cap
Fenofibric Cap
Fluvastatin Cap
Fluvastatin ER Tab
Gemfibrozil Tab
Lovastatin Tab
Niacin ER Tab
Pravastatin Tab
Rosuvastatin Tab
Simvastatin Tab

Osteoporosis

Alendronate Tab
Calcitonin Spr
Forteo Sol
Ibandronate Tab
Raloxifene Tab
Risedronate Tab
Teriparatide
Tymlos Inj
Zoledronic Inj

Prenatal vitamins

Generic Prenatal Vitamins

Vaccines

Anthrax Vaccine
Cholera Vaccine
Diph, Acellular Pert & Tet Tox Inj
Diph-Tetanus
Diphtheria-Tetanus Tox
Haemophilus B Polysaccharide
Conj Vaccine
Hepatitis A
Hepatitis B
Human Papillomavirus (HPV)
Influenza Virus
Influenza Virus Vaccine
Japanese Encephalitis Vaccine
Measles, Mumps & Rubella Virus
Vaccines
Meningococcal
Pneumococcal
Poliovirus Vaccine
Rabies Vaccine
Rotavirus Vaccine
Tetanus-Diphtheria Toxoids (TD)
Tet Tox-Diph-Acell Pertuss Ad Inj
Typhoid
Varicella Virus Vaccine
Yellow Fever Vaccine
Zoster Vaccine

Effective March 1, 2026

This list is subject to change.
Check the drug look-up tool for coverage.



For full details about your plan, log in to Member.MGBHP.org or call the customer service number on the back of your member ID card.