

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage for: All Coverage Tiers | **Plan Type:** HMO



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

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to Member.MassGeneralBrighamHealthPlan.org or call Customer Services at 866-567-9175 (toll free) or 711 (TTY). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at MassGeneralBrighamHealthPlan.org or call 866-567-9175 (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 out-of-pocket limit for this plan?	\$4,500/Individual, \$9,000/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 out-of-pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they do not count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. For a list of in-network providers, see MassGeneralBrighamHealthPlan.org or call 866-567-9175.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist.

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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 provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copayment/Visit	Not covered	None.
	Specialist visit	\$30 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)	\$50 copayment (maximum of one copayment per member per benefit period)	Not covered	May require prior authorization.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at MassGeneralBrighamHealthPlan.org	Tier 1	30-day Retail: \$10 copayment/Prescription 90-day Mail: \$20 copayment/Prescription	Not covered	No charge for birth control and smoking cessation drugs.
	Tier 2	30-day Retail: \$30 copayment/Prescription 90-day Mail: \$60 copayment/Prescription	Not covered	May require prior authorization.
	Tier 3	30-day Retail: \$55 copayment/Prescription 90-day Mail: \$135 copayment/Prescription	Not covered	May require prior authorization.
	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.



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		In Network	Out of Network	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$50 copayment (maximum of one copayment per member per benefit period)	Not covered	May require prior authorization.
	Physician/surgeon fees	No Member Cost-Sharing	Not covered	None.
If you need immediate medical attention	Emergency room services	\$100 copayment/Visit	\$100 copayment/Visit	Emergency room copay waived if admitted to hospital for inpatient care.
	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)	\$50 copayment (maximum of one copayment per member per benefit period)	Not covered	May require prior authorization.
	Physician/surgeon fee	No Member Cost-Sharing	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	No Member Cost-Sharing	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	\$50 copayment (maximum of one copayment per member per benefit period)	Not covered	May require prior authorization.



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	Childbirth/delivery professional services	No Member Cost-Sharing	Not covered	May require prior authorization.
If you need help recovering or have other special health needs	Home health care	No Member Cost-Sharing	Not covered	May require prior authorization.
	Rehabilitation services	Outpatient: \$20 copayment/Visit Inpatient: \$50 copayment (maximum of one copayment per member per benefit period)	Not covered	Outpatient: Covered up to 60 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: \$50 copayment (maximum of one copayment per member per benefit period)	Not covered	Outpatient: Covered up to 60 combined PT/OT visits per benefit period. Inpatient: Covered up to 60 days per benefit period. Prior authorization required. Cost and coverage limits are waived for early intervention services for eligible children.
	Skilled nursing care	\$50 copayment (maximum of one copayment per member per benefit period)	Not covered	Covered up to 100 days per benefit period. May require prior authorization.
	Durable medical equipment	No Member Cost-Sharing	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.



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If your child needs dental or eye care	Children's eye exam	\$30 copayment/Visit	Not covered	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.



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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>.)		
• Acupuncture • Cosmetic Surgery • Dental care (adult age 12 and older)	• Extraction of infected or impacted wisdom teeth (except when in a hospital setting) • Long-term care	• 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.)		
• Abortion • Bariatric surgery • Chiropractic care	• Hearing aids (age 21 and younger)- Covered up to \$2,000 for each affected ear every 36 months • Infertility treatment • 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 in a qualified weight loss program for either a covered Subscriber or one covered Dependent)

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Customer Service at **866-567-9175 (toll free) or 711 (TTY)**.

Does this Coverage Provide Minimum Essential Coverage? Yes

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

Does this Coverage Meet the Minimum Value Standard? Yes

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

Language Access Services:

Para obtener asistencia en Español, llame al **866-567-9175**.

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)	
■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0	■ The plan's overall deductible	\$0
■ Specialist copayment	\$30	■ Specialist copayment	\$30	■ Specialist copayment	\$30
■ Hospital (facility)	\$50	■ Hospital (facility)	\$50	■ Hospital (facility)	\$50
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>)		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>)		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>)	
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	\$100	Copayments	\$500	Copayments	\$300
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$0	Limits or exclusions	\$0	Limits or exclusions	\$0
The total Peg would pay is	\$100	The total Joe would pay is	\$500	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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Important Information About This Plan

This plan includes a limited provider network called Value HMO. This plan provides access to a network that is smaller than Mass General Brigham Health Plan's full commercial HMO provider network. In this plan, members have access to network benefits only from the providers in the Value HMO network. Please consult the provider directory at MassGeneralBrighamHealthPlan.org to determine which providers are included in the Value HMO network.

MCC Compliance



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