


for large group employers

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

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](http://Member.MassGeneralBrighamHealthPlan.org) or call Customer Services at 866-414-5533 (toll free) or 711 (TTY). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [MassGeneralBrighamHealthPlan.org](http://MassGeneralBrighamHealthPlan.org) or call 866-414-5533 (toll free) or 711 (TTY) to request a copy.

Important Questions	Answers	Why This Matters
<b>What is the overall <u>deductible</u>?</b>	\$1,750/Individual, \$3,500/Family per benefit period.	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this plan 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.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	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 <a href="http://MassGeneralBrighamHealthPlan.org">MassGeneralBrighamHealthPlan.org</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this plan?</b>	\$5,000/Individual, \$10,000/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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	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> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. For a list of in-network providers, see <a href="http://MassGeneralBrighamHealthPlan.org">MassGeneralBrighamHealthPlan.org</a> or call 866-414-5533.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (a balance bill). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the specialist you choose without a referral.

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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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	No charge after deductible	Subject to deductible, then 20% coinsurance	None.
	Specialist visit	No charge after deductible	Subject to deductible, then 20% coinsurance	None.
	Preventive care/screening/immunization	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance	Services for specific conditions during an annual exam may be subject to cost sharing.
If you have a test	Diagnostic test (x-ray, blood work)	<b>X-ray:</b> No charge after deductible <b>Blood work:</b> No charge after deductible	<b>X-ray:</b> Subject to deductible, then 20% coinsurance <b>Blood work:</b> Subject to deductible, then 20% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	No charge after deductible	Subject to deductible, then 20% coinsurance	May require prior authorization.
If you need drugs to treat your illness or condition	Tier 1 – Low-Cost Generic	30-day Retail: Subject to deductible, then \$5 copayment/Prescription 90-day Mail: Subject to deductible, then \$10 copayment/Prescription	Not covered	No charge for birth control and smoking cessation drugs.



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		In Network	Out of Network	
More information about <a href="#">prescription drug coverage</a> is available at <a href="http://MassGeneralBrighamHealthPlan.org">MassGeneralBrighamHealthPlan.org</a>	Tier 2 – Other generic and some brand name	30-day Retail: Subject to deductible, then \$15 copayment/Prescription 90-day Mail: Subject to deductible, then \$30 copayment/Prescription	Not covered	
	Tier 3 – High costing generic and preferred brand name	30-day Retail: Subject to deductible, then \$30 copayment/Prescription 90-day Mail: Subject to deductible, then \$60 copayment/Prescription	Not covered	May require prior authorization.
	Tier 4 – Higher cost generics and non-preferred brand name	30-day Retail: Subject to deductible, then \$50 copayment/Prescription 90-day Mail: Subject to deductible, then \$150 copayment/Prescription	Not covered	May require prior authorization.
	Tier 5 – Generic specialty and preferred specialty	Subject to deductible, then \$30 copayment/Prescription	Not covered	Prescription must be filled through our specialty pharmacy and a prior authorization may be required.
	Tier 6 – Non-preferred specialty	Subject to deductible, then \$50 copayment/Prescription	Not covered	
	If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Subject to deductible, then \$150 copayment/Visit	Subject to deductible, then 20% coinsurance
Physician/surgeon fees		No charge after deductible	Subject to deductible, then 20% coinsurance	None.



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		In Network	Out of Network	
<b>If you need immediate medical attention</b>	Emergency room services	Subject to deductible, then \$200 copayment/Visit	Subject to deductible, then \$200 copayment/Visit	Emergency room copay waived if admitted to hospital for inpatient care.
	Emergency medical transportation	No charge after deductible	No charge after deductible	None.
	Urgent care	No charge after deductible	Subject to deductible, then 20% coinsurance	None.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Subject to deductible, then \$250 copayment/Stay	Subject to deductible, then 20% coinsurance	May require prior authorization.
	Physician/surgeon fee	No charge after deductible	Subject to deductible, then 20% coinsurance	None.
<b>If you need mental health, behavioral health, or substance use services</b>	Mental/behavioral health/substance use outpatient services	No charge after deductible	Subject to deductible, then 20% coinsurance	None.
	Mental/behavioral health/substance use inpatient services	Subject to deductible, then \$250 copayment/Stay	Subject to deductible, then 20% coinsurance	May require prior authorization.
<b>If you are pregnant</b>	Office visits for prenatal and postnatal care	No charge after deductible	Subject to deductible, then 20% coinsurance	None.
	Childbirth/delivery facility services	Subject to deductible, then \$250 copayment/Stay	Subject to deductible, then 20% coinsurance	May require prior authorization.
	Childbirth/delivery professional services	No charge after deductible	Subject to deductible, then 20% coinsurance	May require prior authorization.



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		In Network	Out of Network	
<b>If you need help recovering or have other special health needs</b>	Home health care	No charge after deductible	Subject to deductible, then 20% coinsurance	May require prior authorization.
	Rehabilitation services	<b>Outpatient:</b> No charge after deductible <b>Inpatient:</b> Subject to deductible, then \$250 copayment/Stay	<b>Outpatient:</b> Subject to deductible, then 20% coinsurance <b>Inpatient:</b> Subject to deductible, then 20% coinsurance	<b>Outpatient:</b> Covered up to 100 combined PT/OT visits per benefit period. <b>Inpatient:</b> Covered up to 60 days per benefit period. Prior authorization required.
	Habilitation services	<b>Outpatient:</b> No charge after deductible <b>Inpatient:</b> Subject to deductible, then \$250 copayment/Stay	<b>Outpatient:</b> Subject to deductible, then 20% coinsurance <b>Inpatient:</b> Subject to deductible, then 20% coinsurance	<b>Outpatient:</b> Covered up to 100 combined PT/OT visits per benefit period. <b>Inpatient:</b> 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	Subject to deductible, then \$250 copayment/Stay	Subject to deductible, then 20% coinsurance	Covered up to 100 days per benefit period. May require prior authorization.
	Durable medical equipment	Subject to deductible, then 20% coinsurance	Subject to deductible, then 20% coinsurance	May require prior authorization. No charge for electric breast pump (one per birth).
	Hospice service	No charge after deductible	Subject to deductible, then 20% coinsurance	May require prior authorization.

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		In Network	Out of Network	
<b>If your child needs dental or eye care</b>	Children’s eye exam	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance	1 eye exam(s) every 12 months per child
	Children’s glasses	Not covered	Not covered	None.
	Children’s dental check-up	Not covered	Not covered	Limited to children under age 18 with a cleft palate/cleft lip condition. You may have coverage under a separate dental plan.



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**Excluded Services & Other Covered Services:**

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

**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](http://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](http://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](http://www.HealthCare.gov) or call 1-800-318-2596.

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

**Does this Coverage Provide Minimum Essential Coverage? Yes**

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

**Does this Coverage Meet the Minimum Value Standard? Yes**

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

**Language Access Services:**

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

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

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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,750	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,750	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,750
■ <a href="#">Specialist</a>	\$0 after deductible	■ <a href="#">Specialist</a>	\$0 after deductible	■ <a href="#">Specialist</a>	\$0 after deductible
■ <a href="#">Hospital (facility) copayment</a>	\$250 after deductible	■ <a href="#">Hospital (facility) copayment</a>	\$250 after deductible	■ <a href="#">Hospital (facility) copayment</a>	\$250 after deductible
<p><b>This EXAMPLE event includes services like:</b>                      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><b>This EXAMPLE event includes services like:</b>                      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><b>This EXAMPLE event includes services like:</b>                      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>	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$1,750	Deductibles	\$1,750	Deductibles	\$1,750
Copayments	\$300	Copayments	\$200	Copayments	\$60
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$50
<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
<b>The total Peg would pay is</b>	<b>\$2,050</b>	<b>The total Joe would pay is</b>	<b>\$1,950</b>	<b>The total Mia would pay is</b>	<b>\$1,860</b>

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

## MCC Compliance

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