

Schedule of Benefits

Leader Bank Complete PPO Plus HSA Combined 1750 Enhanced FlexRx

For 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.

Schedule of Benefits

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

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

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

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

DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM

Deductible per benefit period	Medical/Behavioral Health/Prescription Drug (Combined): \$1,750 Individual /\$3,500 Family
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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): \$5,000 Individual /\$10,000 Family
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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 deductible, then 20% coinsurance
Annual Gynecological Exams ¹	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance
Family Planning Services	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance
Immunizations & Vaccinations	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance
Preventive Laboratory Tests	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance
Screening Colonoscopy	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance
Screening Mammography	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance
Well Child Visits	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance

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

Other Primary & Specialty Care Office Visits

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

Other Outpatient Services

	In Network	Out of Network
Diagnostic, Imaging and X-ray	No charge after deductible	Subject to deductible, then 20% coinsurance
Laboratory	No charge after deductible	Subject to deductible, then 20% coinsurance
High-tech Radiology (MRI, CT, PET Scan, Nuclear Cardiac Imaging)	No charge after deductible	Subject to deductible, then 20% coinsurance
Outpatient Surgery—Facility Fee	Subject to deductible, then \$150 copayment/Visit	Subject to deductible, then 20% coinsurance
Outpatient Surgery—Professional Fee	No charge after deductible	Subject to deductible, then 20% coinsurance

INPATIENT MEDICAL CARE

	In Network	Out of Network
Inpatient Medical Services (including Maternity) - Facility Fee	Subject to deductible, then \$250 copayment/Stay	Subject to deductible, then 20% coinsurance
Inpatient Medical Services - Professional Fee	No charge after deductible	Subject to deductible, then 20% coinsurance
Inpatient Care in a Skilled Nursing Facility - Facility Fee (Covered up to 100 days per benefit period)	Subject to deductible, then \$250 copayment/Stay	Subject to deductible, then 20% coinsurance
Inpatient Care in a Skilled Nursing Facility - Professional Fee	No charge after deductible	Subject to deductible, then 20% coinsurance
Inpatient Care in a Rehabilitation Facility - Facility Fee (Covered up to 60 days per benefit period)	Subject to deductible, then \$250 copayment/Stay	Subject to deductible, then 20% coinsurance
Inpatient Care in a Rehabilitation Facility - Professional Fee	No charge after deductible	Subject to deductible, then 20% coinsurance
Routine Nursery and Newborn Care	No Member Cost-Sharing	Subject to deductible, then 20% coinsurance

BEHAVIORAL HEALTH - OUTPATIENT

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

BEHAVIORAL HEALTH - INPATIENT

	In Network	Out of Network
Mental Health Care - Facility Fee	Subject to deductible, then \$250 copayment/Stay	Subject to deductible, then 20% coinsurance
Mental Health Care - Professional Fee	No charge after deductible	Subject to deductible, then 20% coinsurance
Substance Use Detoxification or Rehabilitation - Facility Fee	Subject to deductible, then \$250 copayment/Stay	Subject to deductible, then 20% coinsurance
Substance Use Detoxification or Rehabilitation - Professional Fee	No charge after deductible	Subject to deductible, then 20% coinsurance

URGENT CARE

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

	In Network	Out of Network
Urgent Care	No charge after deductible	Subject to deductible, then 20% coinsurance

EMERGENCY CARE

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

Care you receive in an emergency room, in or out of the Service Area	Subject to deductible, then \$200 copayment/Visit (Copayment waived if admitted to hospital for inpatient care)
Ambulance Services (emergency transport only)	No charge after deductible
Emergency Dental Care (within 72 hours of accident or injury)	Subject to deductible, then \$200 copayment/Visit (Copayment waived if admitted to hospital for inpatient care)

PRESCRIPTION DRUGS (6-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 deductible, then \$5 copayment/Prescription Tier 2 - Other generic and some brand name: Subject to deductible, then \$15 copayment/Prescription Tier 3 - High costing generic and preferred brand name: Subject to deductible, then \$30 copayment/Prescription Tier 4 - Higher cost generics and non-preferred brand name: Subject to deductible, then \$50 copayment/Prescription Tier 5 - Generic specialty and preferred specialty: Subject to deductible, then \$30 copayment/Prescription Tier 6 - Non-preferred Specialty: Subject to deductible, then \$50 copayment/Prescription
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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 deductible, then \$10 copayment/Prescription Tier 2 - Other generic and some brand name: Subject to deductible, then \$30 copayment/Prescription Tier 3 - High costing generic and preferred brand name: Subject to deductible, then \$60 copayment/Prescription Tier 4 - Higher cost generics and non-preferred brand name: Subject to deductible, then \$150 copayment/Prescription
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90-day Retail:	Tier 1 - Low-Cost Generic: Subject to deductible, then \$10 copayment/Prescription Tier 2 - Other generic and some brand name: Subject to deductible, then \$30 copayment/Prescription Tier 3 - High costing generic and preferred brand name: Subject to deductible, then \$60 copayment/Prescription Tier 4 - Higher cost generics and non-preferred brand name: Subject to deductible, then \$150 copayment/Prescription
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OVER-THE-COUNTER DRUGS

For a complete list of over-the-counter drugs, visit MassGeneralBrighamHealthPlan.org or call Customer Service at 866-414-5533 (TTY 711).

Select over-the-counter medicines and products with a valid prescription and purchased at a participating pharmacy.	\$0-Subject to 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 deductible	Subject to deductible, then 20% coinsurance
Disposable Medical Supplies	No charge after deductible	Subject to deductible, then 20% coinsurance
Durable Medical Equipment	Subject to deductible, then 20% coinsurance	Subject to deductible, then 20% coinsurance
Early Intervention (from birth up to age three)	No charge after deductible	No charge after 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 deductible	Subject to deductible, then 20% coinsurance
Home Health Care	No charge after deductible	Subject to deductible, then 20% coinsurance
Hospice Care	No charge after deductible	Subject to deductible, then 20% coinsurance
Oxygen Supplies and Therapy	No charge after deductible	Subject to deductible, then 20% coinsurance
Weight Loss Program Benefit	Coverage for up to six months of membership fees per calendar year in a qualified weight-loss program for either a covered Subscriber or one covered Dependent (see MassGeneralBrighamHealthPlan.org for qualifications)	
Wigs (when medically necessary for hair loss due to cancer treatment or other conditions)	Subject to deductible, then 20% coinsurance	Subject to deductible, then 20% coinsurance

ABOUT YOUR MASS GENERAL BRIGHAM HEALTH PLAN MEMBERSHIP

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

Benefit Period

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

Copayments, Coinsurance, or Deductibles Required for Certain Services

Before coverage begins for certain services, you pay a deductible each benefit period. Your plan deductible is an amount you pay for certain services each 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 866-414-5533 for a list of Out-of-Network services that require Prior Authorization.

Concurrent Review

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

Retrospective Review

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

Care Management

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

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

Benefit Exclusions

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

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

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

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

This health plan meets Minimum Creditable Coverage standards that are effective January 1, 2025 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, 2025. Because these standards may change, review your health plan material each year to determine whether your plan meets the latest standards.

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



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