Mass General Brigham
Health Plan

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have questions, you can call and speak to a sales representative.

You can reach our Sales team by calling: **888-828-5500** (TTY: 711)

October 1 – March 31, 8:00 a.m. to 8:00 p.m. ET, Monday through Sunday

April 1 – September 30, 8:00 a.m. to 8:00 p.m. ET, Monday through Friday

Understanding the benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit **MGBAdvantage.org** or call **888-828-5500** (TTY 711) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding important rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2026.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.
- ☐ Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

2025 Summary of Benefits

Medicare Advantage Plans with Part D Prescription Drug Coverage

Mass General Brigham Advantage Secure (HMO-POS)

January 1, 2025 – December 31, 2025

SKUH001_2020_CMS Accepted H6487_1139PDT_M

15307-0924-00

1 SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "**Evidence of Coverage**." You can also see the Evidence of Coverage on our website, **MGBAdvantage.org**.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Mass General Brigham Advantage Secure (HMO-POS)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Mass General Brigham Advantage Secure (HMO-POS)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About **Mass General Brigham Advantage Secure (HMO-POS).**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services.
- Covered Medical and Hospital Benefits.
- Prescription Drug Benefits.

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at 1-855-833-3668 (TTY: 711).

Things to Know About Mass General Brigham Advantage Secure (HMO-POS)

Hours of Operation & Contact Information

- From October 1 to March 31, we're open 8 a.m. – 8 p.m. ET, 7 days a week.
- From April 1 to September 30, we're open 8 a.m. – 8 p.m. ET, Monday through Friday.
- If you are a member of this plan, call us at 1-855-833-3668, TTY: 711.
- If you are not a member of this plan, call us at 1-888-828-5500, TTY: 711.
- Our website: **MGBAdvantage.org**

Who can join?

To join **Mass General Brigham Advantage Secure (HMO-POS)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. Our service area includes these counties in Massachusetts: Bristol, Dukes, Essex, Middlesex, Nantucket, Norfolk, Plymouth, Suffolk, and Worcester.

Which doctors, hospitals, and pharmacies can I use?

Mass General Brigham Advantage Secure (HMO-POS) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, you may pay more.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directory at our website **MGBAdvantage.org**.

Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

We cover everything that Original Medicare covers – and *more*. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs including chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, **MGBAdvantage.org**
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact Mass General Brigham Health Plan

15307-0924-00

SECTION II - SUMMARY OF BENEFITS

Mass General Brigham Advantage Secure (HMO-POS)

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Premiums and Benefits	**Mass General Brigham Advantage Secure (HMO-POS)**
Monthly Plan Premium	$52 per month. In addition, you must continue to pay your Medicare Part B premium.
Deductible	Medical Deductible: This plan does not have a medical deductible. Prescription Drug Deductible: This plan does not have a prescription drug deductible.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $3,350 for services you receive from in-network providers. • $7,000 for services you receive from in-network and out-of-network providers combined. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.

COVERED MEDICAL AND HOSPITAL BENEFITS	
Benefits/Services	**Mass General Brigham Advantage Secure (HMO-POS)**
Inpatient Hospital	**In-Network:** Days 1-5: $250 copay per day for each admission. Days 6-90: $0 copay per day. Our plan covers an unlimited number of days for an inpatient hospital stay. **Out-of-Network:** 30% of the total cost per stay. Prior authorization is required in-network.

Outpatient Hospital	**In-Network:** Outpatient hospital: $0 - $200 copay. Outpatient Surgery: $0 - $200 copay. You pay $0 copay for preventive colonoscopies that turn into diagnostic colonoscopies. All other procedures and services are a $200 copay. **Out-of-Network:** Outpatient hospital: 30% of the total cost. Outpatient Surgery: 30% of the total cost. May require prior authorization in-network.
Ambulatory Surgical Center	**In-Network:** Ambulatory Surgical Center: $0 - $200 copay. You pay $0 copay for preventive colonoscopies that turn into diagnostic colonoscopies. All other procedures are a $200 copay. **Out-of-Network:** Ambulatory Surgical Center: 30% of the total cost. May require prior authorization in-network.
Doctor's Office Visits	**In-Network:** Primary care physician visit: $0 copay Specialist visit: $45 copay. **Out-of-Network:** Primary care physician visit: $20 copay. Specialist visit: $50 copay.
Preventive Care ***(e.g., flu vaccine, diabetic screenings)***	**In-Network:** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered. **Out-of-Network:** $0 copay for all preventive services covered under Original Medicare at zero cost sharing.

Emergency Care	**In-Network and Out-of-Network:** $105 copay per visit. Worldwide Emergency Coverage: $105 copay. Your copay is waived if you are admitted to a hospital within 24 hours.
Urgently Needed Services	**In-Network and Out-of-Network:** $50 copay per visit. Worldwide Urgent Coverage: $50 copay.
Diagnostic Services / Labs/ Imaging	**In-Network:** Diagnostic tests and procedures: $20 copay. Lab services: $0 copay Diagnostic Radiology Services (such as MRI, CAT Scan): $75 copay - $160 copay X-rays: $10 copay. Therapeutic radiology services (such as radiation treatment for cancer): $60 copay. **Out-of-Network:** Diagnostic tests and procedures: 20% of the total cost. Lab services: 20% of the total cost. Diagnostic Radiology Services (such as MRI, CAT Scan): 20% of the total cost. X-rays: 20% of the total cost. Therapeutic radiology services (such as radiation treatment for cancer): 20% of the total cost. May require prior authorization in-network.

Hearing Services	**In-Network:** Medicare-covered hearing exam: $45 copay. Routine hearing exam (1 every calendar year): $0 copay when using a TruHearing provider. Hearing Aids (up to 2 hearing aids every year): $699 copayment per aid for TruHearing Advanced Aids or a $999 copayment per aid for TruHearing Premium Aids. **Out-of-Network:** Medicare-Covered hearing exam: $50 copay. Routine hearing exam: Not covered. Hearing Aids Not covered.
Dental Services	**In-Network:** Medicare-Covered dental exam: $45 copay. Preventive Services: $0 copay when using a DentaQuest provider. Comprehensive Services: $0 copay when using a DentaQuest provider. May require prior authorization in-network. **Out-of-Network:** Medicare-Covered dental exam: $50 copay. Preventive Services: $0 copay when using a non-DentaQuest provider. Comprehensive Services: 20% coinsurance when using a non-DentaQuest provider. ($0 copayment for adjunctive services only). *If an out of network provider is selected, you will be responsible for the applicable coinsurance plus the difference between the billed amount and the allowed amount. $2,000 combined in-network and out-of-network maximum per calendar year for comprehensive services. Preventive and Comprehensive dental services are provided through DentaQuest. Refer to the Evidence of Coverage for complete details.

Vision Services	**In-Network:** Medicare-covered exam to diagnose and treat diseases and conditions of the eye: $45 copay. Routine eye exam (1 every calendar year): $0 copay when using an EyeMed provider. Eyeglasses or contact lenses after cataract surgery (for Medicare-covered standard eyewear): $0 copay. Eyewear: Up to $250 per calendar year for prescription eyewear or contact lenses purchased from an EyeMed provider. **Out-of-Network:** Medicare-covered exam to diagnose and treat diseases and conditions of the eye: $50 copay. Routine eye exam (1 every calendar year): You will receive up to a $40 reimbursement for a routine vision exam received from an out-of-network provider. You will need to pay out of pocket and submit to EyeMed for reimbursement. Eyeglasses or contact lenses after cataract surgery (for Medicare-covered standard eyewear): $50 copay. Eyewear: You will receive up to a $250 reimbursement for prescription eyewear or contact lenses when purchased from an out-of-network provider. You will need to pay out of pocket and submit to EyeMed for reimbursement.
Mental Health Care	**In-Network:** Outpatient group therapy visit: $20 copay. Individual therapy visit: $20 copay. Inpatient Mental Health Care: Days 1-5: $250 copay per day for each admission. Days 6-90: $0 copay per day. **Out-of-Network:** Outpatient group therapy visit: $50 copay. Individual therapy visit: $50 copay. Inpatient Mental Health Care: 30% of the total cost per stay. Prior Authorization may apply to Inpatient Mental Health Care in-network.

Skilled Nursing Facility (SNF)	**In-Network:** Days 1-20: $0 copay per day. Days 21-44: $160 copay per day. Days 45-100: $0 copay per day. **Out-of-Network:** 30% of the total cost per stay. Prior authorization is required in-network.
Outpatient Rehabilitation	**In-Network:** Occupational therapy visit: $15 copay. Physical therapy and speech and language therapy visit: $15 copay. **Out-of-Network:** Occupational therapy visit: $50 copay. Physical therapy and speech and language therapy visit: $50 copay. Prior authorization is required after the 20th visit in-network.
Ambulance	**In-Network and Out-of-Network:** Ground Ambulance: $200 copay. Air Ambulance: $200 copay. Prior authorization required for non-emergency ambulance services in-network.
Transportation	Up to $120 per quarter (no carry over) for non-emergent transportation, like taxis, public transportation or rideshare for medical visits. Members can use their Flexible Benefit Card where Mastercard® is accepted.
Medicare Part B Drugs (including chemotherapy)	**In-Network:** For Part B drugs such as chemotherapy drugs: 0% - 20% of the total cost. Medicare Part B insulin: $35 copay. Other Part B drugs: 0% - 20% of the total cost. **Out-of-Network:** For Part B drugs such as chemotherapy drugs: 20% of the total cost. Medicare Part B insulin: $35 copay. Other Part B drugs: 20% of the total cost. May require prior authorization for Part B drugs in-network.

Over-the-Counter Items (OTC)	Up to $95 per quarter (no carryover) toward over-the-counter health & wellness products. Members will receive a Flexible Benefits Card to purchase eligible items at participating retailers where Mastercard® is accepted. Members may also ask to receive a catalog and purchase eligible items online, phone, or by mail.
Wellness Benefit	Up to a $450 combined annual allowance to use towards fitness, eligible weight loss programs or costs toward your prescription hearing aids using a Flexible Benefit card. All purchases must be done per your benefits where Mastercard® is accepted.

PRESCRIPTION DRUG BENEFITS	
Deductible	Prescription Drug Deductible: This plan does not have a prescription drug deductible.
Initial Coverage	You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $2,000. You then move on to the Catastrophic Coverage Stage.

Standard Retail Cost-Sharing

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay
Tier 2 (Generic)	$5 copay	$10 copay	$15 copay
Tier 3 (Preferred Brand)	$47 copay	$94 copay	$141 copay
Tier 4 (Non-Preferred Drug)	$100 copay	$200 copay	$300 copay
Tier 5 (Specialty Tier)	33% coinsurance	N/A	N/A

Standard Mail Order

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay
Tier 2 (Generic)	$5 copay	$10 copay	$10 copay
Tier 3 (Preferred Brand)	$47 copay	$94 copay	$94 copay
Tier 4 (Non-Preferred Drug)	$100 copay	$200 copay	$200 copay
Tier 5 (Specialty Tier)	33% coinsurance	N/A	N/A

PRESCRIPTION DRUG BENEFITS	
	If you reside in a long-term care facility, you pay the same as at a retail pharmacy.
Catastrophic Coverage	After your yearly out-of-pocket drug costs reach $2,000, you reach the catastrophic coverage stage: • During this payment stage, you pay nothing for your covered Part D drugs. • You may have cost sharing for drugs that are covered under our enhanced benefit.

DISCLAIMERS

Mass General Brigham Health Plan Medicare Advantage
399 Revolution Drive, Suite 850
Somerville, MA 02145

Contact information and hours of operation:

Members

October 1-March 31
1-855-833-3668 (TTY: 711)
8:00 a.m. to 8:00 p.m., ET
Monday through Sunday

April 1-September 30
1-855-833-3668 (TTY: 711)
8:00 a.m. to 8:00 p.m., ET
Monday through Friday

If you call after business hours, you may leave a message that includes your name and phone number, and a representative will return your call no later than one business day after you leave a message. Customer Service also has free language interpreter services available for non-English speakers.

Non-Members

October 1-March 31
1-888-828-5500 (TTY: 711)
8:00 a.m. to 8:00 p.m., ET
Monday through Sunday

April 1-September 30
1-888-828-5500 (TTY: 711)
8:00 a.m. to 8:00 p.m., ET
Monday through Friday

This document is available in other alternate formats.

Mass General Brigham Advantage Health Plan is an HMO-POS/PPO plan with a Medicare contract. Enrollment in Mass General Brigham Advantage Health Plan depends on contract renewal.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat Mass General Brigham Health Plan members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Customer Service number or see your “Evidence of Coverage” for more information, including the cost-sharing that applies to out-of-network services.

2025 Summary of Benefits

Medicare Advantage Plans with Part D Prescription Drug Coverage

Mass General Brigham Advantage (PPO)
Mass General Brigham Advantage Premier (PPO)
Mass General Brigham Advantage Signature (PPO)

January 1, 2025 – December 31, 2025

SKUH001_2020_CMS Accepted H9485_1140PDT_M

15308-0924-00

1 SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "**Evidence of Coverage**." You can also see the Evidence of Coverage on our website, **MGBAdvantage.org**

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Mass General Brigham Advantage (PPO), Mass General Brigham Advantage Premier (PPO) and Mass General Brigham Advantage Signature (PPO)**).

Tips for comparing your Medcare choices

This Summary of Benefits booklet gives you a summary of what **Mass General Brigham Advantage (PPO), Mass General Brigham Advantage Premier (PPO)** and **Mass General Brigham Advantage Signature (PPO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About **Mass General Brigham Advantage (PPO), Mass General Brigham Advantage Premier (PPO)** and **Mass General Brigham Advantage Signature (PPO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print.
This document may be available in a non-English language. For additional information, call us at 1-855- 833-3668 (TTY: 711).

Things to Know About Mass General Brigham Advantage (PPO), Mass General Brigham Advantage Premier (PPO) and Mass General Brigham Advantage Signature (PPO)

Hours of Operation & Contact Information

- From October 1 to March 31 we're open 8 a.m. – 8 p.m. ET, 7 days a week.
- From April 1 to September 30, we're open 8 a.m. – 8 p.m. ET, Monday through Friday.
- If you are a member of this plan, call us at 1-855- 833-3668, TTY: 711.
- If you are not a member of this plan, call us at 1-888-828-5500, TTY: 711.
- Our website: **MGBAdvantage.org**

Who can join?

To join **Mass General Brigham Advantage (PPO), Mass General Brigham Advantage Premier (PPO) and Mass General Brigham Advantage Signature (PPO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. The service area for Mass General Brigham Advantage (PPO), Mass General Brigham Advantage Premier (PPO) and Mass General Brigham Advantage Signature (PPO) includes the following counties in Massachusetts: Bristol, Dukes, Essex, Middlesex, Nantucket, Norfolk, Plymouth, Suffolk and Worcester.

Which doctors, hospitals, and pharmacies can I use?

Mass General Brigham Advantage (PPO), Mass General Brigham Advantage Premier (PPO) and **Mass General Brigham Advantage Signature (PPO)** have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, you may pay more.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directory at our website at **MGBAdvantage.org.**

Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

We cover everything that Original Medicare covers – and *more*. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs including chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, **MGBAdvantage.org.**
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact Mass General Brigham Health Plan

2 SECTION II - SUMMARY OF BENEFITS

	Mass General Brigham Advantage (PPO)	Mass General Brigham Advantage Premier (PPO)	Mass General Brigham Advantage Signature (PPO)
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES			
Monthly Plan Premium	$0 per month. You do not pay a separate monthly plan premium for Mass General Brigham Advantage (PPO). You must continue to pay your Medicare Part B premium.	$140 per month. In addition, you must continue to pay your Medicare Part B premium	$299 per month. In addition, you must continue to pay your Medicare Part B premium.
Deductible	Medical Deductible: This plan does not have a medical deductible. Prescription Drug Deductible: This plan does not have a prescription deductible.	Medical Deductible: This plan does not have a medical deductible. Prescription Drug Deductible: This plan does not have a prescription deductible.	Medical Deductible: This plan does not have a medical deductible. Prescription Drug Deductible: This plan does not have a prescription deductible.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $5,500 for services you receive from in-network providers. • $9,550 for services you receive from in-network and out-of-network providers combined.	Your yearly limit(s) in this plan: • $3,150 for services you receive from in-network providers. • $5,450 for services you receive from in-network and out-of-network providers combined.	Your yearly limit(s) in this plan: • $0 for services you receive from in-network providers. • $0 for services you receive from in-network and out-of-network providers combined.

	If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.	If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.	If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.
COVERED MEDICAL AND HOSPITAL BENEFITS			
Benefits/Services	**Mass General Brigham Advantage (PPO)**	**Mass General Brigham Advantage Premier (PPO)**	**Mass General Brigham Advantage Signature (PPO)**
Inpatient Hospital	**In-Network:** Days 1-5: $350 copay per day for each admission. Days 6-90: $0 copay per day. Our plan covers an unlimited number of days for an inpatient hospital stay. **Out-of-Network:** 30% of the total cost per stay. Prior authorization is required in-network.	**In-Network:** Days 1-3: $150 copay per day for each admission. Days 4-90: $0 copay per day. Our plan covers an unlimited number of days for an inpatient hospital stay. **Out-of-Network:** 20% of the total cost per stay. Prior authorization is required in-network.	**In-Network:** $0 copay per stay **Out-of-Network:** $0 copay per stay. Prior authorization is required in-network.

Outpatient Hospital	**In-Network:** Outpatient hospital: $0 - $300 copay. Outpatient Surgery: $0 - $300 copay. You pay $0 copay for preventive colonoscopies that turn into diagnostic colonoscopies. All other procedures are a $300 copay. **Out-of-Network:** Outpatient hospital: 40% of the total cost. Outpatient Surgery: 40% of the total cost. May require prior authorization in-network.	**In-Network:** Outpatient hospital: $0 - $125 copay. Outpatient Surgery: $0 - $125 copay. You pay $0 copay for preventive colonoscopies that turn into diagnostic colonoscopies. All other procedures are a $125 copay. **Out-of-Network:** Outpatient hospital: 20% of the total cost. Outpatient Surgery: 20% of the total cost. May require prior authorization in-network.	**In-Network:** Outpatient hospital: $0 copay. Outpatient Surgery: $0 copay. **Out-of-Network:** Outpatient hospital: $0 copay. Outpatient Surgery: $0 copay. May require prior authorization in-network.

Ambulatory Surgical Center	**In-Network:** Ambulatory Surgical Center: $0 - $300 copay. You pay $0 copay for preventive colonoscopies that turn into diagnostic colonoscopies. All other procedures are a $300 copay. **Out-of-Network:** Ambulatory Surgical Center: 40% of the total cost. May require prior authorization in-network.	**In-Network:** Ambulatory Surgical Center: $0 - $125 copay. You pay $0 copay for preventive colonoscopies that turn into diagnostic colonoscopies. All other procedures are a $125 copay. **Out-of-Network:** Ambulatory Surgical Center: 20% of the total cost. May require prior authorization in-network.	**In-Network:** Ambulatory Surgical Center: $0 copay **Out-of-Network:** Ambulatory Surgical Center: $0 copay. May require prior authorization in-network.
Doctor's Office Visits	**In-Network:** Primary care physician visit: $0 copay Specialist visit: $50 copay. **Out-of-Network:** Primary care physician visit: $20 copay. Specialist visit: $65 copay.	**In-Network:** Primary care physician visit: $0 copay Specialist visit: $25 copay. **Out-of-Network:** Primary care physician visit: $10 copay. Specialist visit: $40 copay.	**In-Network:** Primary care physician visit: $0 copay Specialist visit: $0 copay **Out-of-Network:** Primary care physician visit: $0 copay. Specialist visit: $0 copay.

Preventive Care ***(e.g., flu vaccine, diabetic screenings)***	**In-Network:** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered. **Out-of-Network:** $0 copay for all preventive services covered under Original Medicare at zero cost sharing.	**In-Network:** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered. **Out-of-Network:** $0 copay for all preventive services covered under Original Medicare at zero cost sharing.	**In-Network:** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered. **Out-of-Network:** $0 copay for all preventive services covered under Original Medicare at zero cost sharing.
Emergency Care	**In-Network and Out-of-Network:** $90 copay per visit. Worldwide Emergency Coverage: $90 copay. Your copay is waived if you are admitted to the hospital within 24 hours.	**In-Network and Out-of-Network:** $90 copay per visit. Worldwide Emergency Coverage: $90 copay. Your copay is waived if you are admitted to the hospital within 24 hours.	**In-Network and Out-of-Network:** $0 copay Worldwide Emergency Coverage: $0 copay
Urgently Needed Services	**In-Network and Out-of-Network:** $50 copay per visit. Worldwide Urgent Coverage: $50 copay.	**In-Network and Out-of-Network:** $30 copay per visit. Worldwide Urgent Coverage: $30 copay.	**In-Network and Out-of-Network:** $0 copay Worldwide Urgent Coverage: $0 copay

Diagnostic Services / Labs/ Imaging	**In-Network:** Diagnostic tests and procedures: $20 copay. Lab services: $0 copay Diagnostic Radiology Services (such as MRI, CAT Scan): $75 copay - $160 copay X-rays: $15 copay. Therapeutic radiology services (such as radiation treatment for cancer): $60 copay. **Out-of-Network:** Diagnostic tests and procedures: 40% of the total cost. Lab services: 40% of the total cost. Diagnostic Radiology Services (such as MRI, CAT Scan): 40% of the total cost. X-rays: 40% of the total cost. Therapeutic radiology services (such as radiation treatment for cancer): 40% of the total cost. May require prior authorization in-network.	**In-Network:** Diagnostic tests and procedures: $0 copay Lab services: $0 copay. Diagnostic Radiology Services (such as MRI, CAT Scan): $75 copay - $150 copay X-rays: $0 copay Therapeutic radiology services (such as radiation treatment for cancer): $60 copay. **Out-of-Network:** Diagnostic tests and procedures: $10 copay. Lab services: $10 copay. Diagnostic Radiology Services (such as MRI, CAT Scan): 20% of the total cost. X-rays: $10 copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% of the total cost. May require prior authorization in-network.	**In-Network:** Diagnostic tests and procedures: $0 copay Lab services: $0 copay Diagnostic Radiology Services (such as MRI, CAT Scan): $0 copay X-rays: $0 copay Therapeutic radiology services (such as radiation treatment for cancer): $0 copay **Out-of-Network:** Diagnostic tests and procedures: $0 copay. Lab services: $0 copay. Diagnostic Radiology Services (such as MRI, CAT Scan): $0 copay. X-rays: $0 copay. Therapeutic radiology services (such as radiation treatment for cancer): $0 copay. May require prior authorization in-network.

Hearing Services	**In-Network:** Medicare- covered hearing exam: $50 copay. Routine hearing exam (1 every calendar year): $0 copay when using a TruHearing provider. Hearing Aids (up to 2 hearing aids every year): $699 copayment per aid for TruHearing Advanced Aids or a $999 copayment per aid for TruHearing Premium Aids. **Out-of-Network:** Medicare covered hearing exam: $65 copay. Routine hearing exam (1 every calendar year): $65 copay by a non TruHearing provider. Hearing Aids (up to 2 hearing aids every year): $699 copayment per aid for TruHearing Advanced Aids or a $999 copayment per aid for TruHearing Premium Aids.	**In-Network:** Medicare- covered hearing exam: $25 copay. Routine hearing exam (1 every calendar year): $0 copay when using a TruHearing provider. Hearing Aids (up to 2 hearing aids every year): $699 copayment per aid for TruHearing Advanced Aids or a $999 copayment per aid for TruHearing Premium Aids. **Out-of-Network:** Medicare covered hearing exam: $40 copay. Routine hearing exam (1 every calendar year): $40 copay by a non TruHearing provider. Hearing Aids (up to 2 hearing aids every year): $699 copayment per aid for TruHearing Advanced Aids or a $999 copayment per aid for TruHearing Premium Aids.	**In-Network:** Medicare- covered hearing exam: $0 copay. Routine hearing exam (1 every calendar year): $0 copay when using a TruHearing provider. Hearing Aids (up to 2 hearing aids every year): $699 copayment per aid for TruHearing Advanced Aids or a $999 copayment per aid for TruHearing Premium Aids. **Out-of-Network:** Medicare covered hearing: $0 copay. Routine hearing exam (1 every calendar year): $40 copay by a non TruHearing provider. Hearing Aids (up to 2 hearing aids every year): $699 copayment per aid for TruHearing Advanced Aids or a $999 copayment per aid for TruHearing Premium Aids.

Dental Services	**In-Network:** Medicare-Covered dental exam: $50 copay. Preventive Services: $0 copay when using a DentaQuest provider. Comprehensive Services: $0 copay when using a DentaQuest provider. May require prior authorization in-network. **Out-of-Network:** Medicare-Covered dental exam: $65 copay. Preventive Services: $0 copay when using a non-DentaQuest provider. Comprehensive Services: 20% coinsurance when using a non-DentaQuest provider. *If an out of network provider is selected, you will be responsible for the applicable coinsurance plus the difference between the billed amount and the allowed amount. $1,500 combined in-network and out-of-network maximum per calendar year for comprehensive services. Preventive and Comprehensive dental	**In-Network:** Medicare-Covered dental exam: $25 copay. Preventive Services: $0 copay when using a DentaQuest provider. Comprehensive Services: $0 copay when using a DentaQuest provider. May require prior authorization in-network. **Out-of-Network:** Medicare-Covered dental exam: $40 copay. Preventive Services: $0 copay when using a non-DentaQuest provider. Comprehensive Services: 20% coinsurance when using a non-DentaQuest provider. *If an out of network provider is selected, you will be responsible for the applicable coinsurance plus the difference between the billed amount and the allowed amount. $2,500 combined in-network and out-of-network maximum per calendar year for comprehensive services. Preventive and Comprehensive dental	**In-Network:** Medicare-Covered dental exam: $0 copay. Preventive Services: $0 copay when using a DentaQuest provider. Comprehensive Services: $0 copay when using a DentaQuest provider. May require prior authorization in-network. **Out-of-Network:** Medicare-Covered dental exam: $0 copay. Preventive Services: $0 copay when using a non-DentaQuest provider. Comprehensive Services: 20% coinsurance when using a non-DentaQuest provider. *If an out of network provider is selected, you will be responsible for the applicable coinsurance plus the difference between the billed amount and the allowed amount. $3,000 combined in-network and out-of-network maximum per calendar year for comprehensive services. Preventive and Comprehensive dental

	services are provided through DentaQuest. Refer to the Evidence of Coverage for complete details.	services are provided through DentaQuest. Refer to the Evidence of Coverage for complete details.	services are provided through DentaQuest. Refer to the Evidence of Coverage for complete details.
Vision Services	**In-Network:** Medicare covered eye exam to diagnose and treat diseases and conditions of the eye: $50 copay. Routine eye exam (1 every calendar year): $0 copay when using an EyeMed provider. Eyeglasses or contact lenses after cataract surgery (for Medicare-covered standard eyewear): $0 copay. Eyewear: Up to $200 per calendar year for prescription eyewear or contact lenses purchased from an EyeMed provider. **Out-of-Network:** Medicare covered eye exam to diagnose and treat diseases and conditions of the eye: $65 copay. Routine eye exam (1 every calendar year): You will receive up to a $40 reimbursement for a routine vision exam received from an out-of-	**In-Network:** Medicare covered eye exam to diagnose and treat diseases and conditions of the eye: $25 copay. Routine eye exam (1 every calendar year): $0 copay when using an EyeMed provider. Eyeglasses or contact lenses after cataract surgery (for Medicare-covered standard eyewear): $0 copay. Eyewear: Up to $300 per calendar year for prescription eyewear or contact lenses purchased from an EyeMed provider. **Out-of-Network:** Medicare covered eye exam to diagnose and treat diseases and conditions of the eye: $40 copay. Routine eye exam (1 every calendar year): You will receive up to a $40 reimbursement for a routine vision exam received from an out-of-	**In-Network:** Medicare covered eye exam to diagnose and treat diseases and conditions of the eye: $0 copay. Routine eye exam (1 every calendar year): $0 copay when using an EyeMed provider. Eyeglasses or contact lenses after cataract surgery (for Medicare-covered standard eyewear): $0 copay. Eyewear: Up to $300 per calendar year for prescription eyewear or contact lenses purchased from an EyeMed provider. **Out-of-Network:** Medicare covered eye exam to diagnose and treat diseases and conditions of the eye: $0 copay. Routine eye exam (1 every calendar year): You will receive up to a $40 reimbursement for a routine vision exam received from an out-of-

	network provider. You will need to pay out of pocket and submit to EyeMed for reimbursement. Eyeglasses or contact lenses after cataract surgery (for Medicare-covered standard eyewear): $65 copay. You will receive up to a $200 reimbursement for prescription eyewear or contact lenses when purchased from an out-of-network provider. You will need to pay out of pocket and submit to EyeMed for reimbursement.	network provider. You will need to pay out of pocket and submit to EyeMed for reimbursement. Eyeglasses or contact lenses after cataract surgery (for Medicare-covered standard eyewear): $40 copay. You will receive up to a $300 reimbursement for prescription eyewear or contact lenses when purchased from an out-of-network provider. You will need to pay out of pocket and submit to EyeMed for reimbursement.	network provider. You will need to pay out of pocket and submit to EyeMed for reimbursement. Eyeglasses or contact lenses after cataract surgery (for Medicare-covered standard eyewear): $0 copay. You will receive up to a $300 reimbursement for prescription eyewear or contact lenses when purchased from an out-of-network provider. You will need to pay out of pocket and submit to EyeMed for reimbursement.

Mental Health Care	**In-Network:** Outpatient group therapy visit: $30 copay. Individual therapy visit: $30 copay. Inpatient Mental Health Care: Days 1-5: $350 copay per day for each admission. Days 6-90: $0 copay per day. **Out-of-Network:** Outpatient group therapy visit: $65 copay. Individual therapy visit: $65 copay. Inpatient Mental Health Care: 30% of the total cost per stay. Prior authorization may apply to Inpatient Mental Health Care in-network.	**In-Network:** Outpatient group therapy visit: $10 copay. Individual therapy visit: $10 copay. Inpatient Mental Health Care: Days 1-3: $150 copay per day for each admission. Days 4-90: $0 copay per day. **Out-of-Network:** Outpatient group therapy visit: $40 copay. Individual therapy visit: $40 copay. Inpatient Mental Health Care: 20% of the total cost per stay. Prior authorization may apply to Inpatient Mental Health Care in-network.	**In-Network:** Outpatient group therapy visit: $0 copay Individual therapy visit: $0 copay Inpatient Mental Health Care: $0 copay **Out-of-Network:** Outpatient group therapy visit: $0 copay. Individual therapy visit: $0 copay. Inpatient Mental Health Care: $0 copay Prior authorization may apply to Inpatient Mental Health Care in-network.
Skilled Nursing Facility (SNF)	**In-Network:** Days 1-20: $0 copay per day. Days 21-44: $160 copay per day. Days 45-100: $0 copay per day. **Out-of-Network:** 30% of the total cost per stay.	**In-Network:** Days 1-20: $0 copay per day. Days 21-44: $160 copay per day. Days 45-100: $0 copay per day. **Out-of-Network:** 20% of the total cost per stay.	**In-Network:** $0 copay per stay **Out-of-Network:** $0 copay per stay. Prior authorization is required in-network.

	Prior authorization is required in-network.	Prior authorization is required in-network.	
Outpatient Rehabilitation	**In-Network:** Occupational therapy visit: $40 copay. Physical therapy and speech and language therapy visit: $40 copay. **Out-of-Network:** Occupational therapy visit: $65 copay. Physical therapy and speech and language therapy visit: $65 copay. Prior authorization is required after the 20th visit in-network.	**In-Network:** Occupational therapy visit: $20 copay. Physical therapy and speech and language therapy visit: $20 copay. **Out-of-Network:** Occupational therapy visit: $40 copay. Physical therapy and speech and language therapy visit: $40 copay. Prior authorization is required after the 20th visit in-network.	**In-Network:** Occupational therapy visit: $0 copay Physical therapy and speech and language therapy visit: $0 copay. **Out-of-Network:** Occupational therapy visit: $0 copay. Physical therapy and speech and language therapy visit: $0 copay. Prior authorization is required after the 20th visit in-network.
Ambulance	**In-Network and Out-of-Network:** Ground Ambulance: $275 copay. Air Ambulance: $275 copay. Prior authorization required for non-emergency ambulance services in-network.	**In-Network and Out-of-Network:** Ground Ambulance: $200 copay. Air Ambulance: $200 copay. Prior authorization required for non-emergency ambulance services in-network.	**In-Network and Out-of-Network:** Ground Ambulance: $0 copay. Air Ambulance: $0 Copay Prior authorization required for non-emergency ambulance services in-network.

Benefits/Services	Mass General Brigham Advantage (PPO)	Mass General Brigham Advantage Premier (PPO)	Mass General Brigham Advantage Signature (PPO)
Transportation	Up to $120 per quarter (no carry over) for non-emergent transportation, like taxis, public transportation or rideshare for medical visits. Members can use their Flexible Benefit Card where Mastercard is accepted.	Up to $120 per quarter (no carry over) for non-emergent transportation, like taxis, public transportation or rideshare for medical visits. Members can use their Flexible Benefit Card where Mastercard is accepted.	Up to $120 per quarter (no carry over) for non-emergent transportation, like taxis, public transportation or rideshare for medical visits. Members can use their Flexible Benefit Card where Mastercard is accepted.
Medicare Part B Drugs (including chemotherapy)	**In-Network:** For Part B drugs such as chemotherapy drugs: 0% - 20% of the total cost. Medicare Part B insulin: $35 copay. Other Part B drugs: 0% - 20% of the total cost. **Out-of-Network:** For Part B drugs such as chemotherapy drugs: 40% of the total cost. Medicare Part B insulin: $35 copay. Other Part B drugs: 40% of the total cost. May require prior authorization for Part B drugs in-network.	**In-Network:** For Part B drugs such as chemotherapy drugs: 0% - 20% of the total cost. Medicare Part B insulin: $35 copay. Other Part B drugs: 0% - 20% of the total cost. **Out-of-Network:** For Part B drugs such as chemotherapy drugs: 20% of the total cost. Medicare Part B insulin: $35 copay. Other Part B drugs: 20% of the total cost copay. May require prior authorization for Part B drugs in-network.	**In-Network:** For Part B drugs such as chemotherapy drugs: $0 copay Medicare Part B insulin: $0 copay Other Part B drugs: $0 copay **Out-of-Network:** For Part B drugs such as chemotherapy drugs: $0 copay. Medicare Part B insulin: $0 copay Other Part B drugs: $0 copay. May require prior authorization for Part B drugs in-network.

Benefits/Services	Mass General Brigham Advantage (PPO)	Mass General Brigham Advantage Premier (PPO)	Mass General Brigham Advantage Signature (PPO)
Over-the-Counter Items (OTC)	Up to $85 per quarter (no carryover) toward over-the-counter health & wellness products. Members will receive a Flexible Benefits Card to purchase eligible items at participating retailers where Mastercard is accepted. Members may also ask to receive a catalog and purchase eligible items online, phone, or by mail.	Up to $120 per quarter (no carryover) toward over-the-counter health & wellness products. Members will receive a Flexible Benefits Card to purchase eligible items at participating retailers where Mastercard is accepted. Members may also ask to receive a catalog and purchase eligible items online, phone, or by mail.	Up to $130 per quarter (no carryover) toward over-the-counter health & wellness products. Members will receive a Flexible Benefits Card to purchase eligible items at participating retailers where Mastercard is accepted. Members may also ask to receive a catalog and purchase eligible items online, phone, or by mail.
Wellness Benefit	Up to a $450 combined annual allowance to use towards fitness, eligible weight loss programs or costs toward your prescription hearing aids using a Flexible Benefit card. All purchases must be done per your benefits where Mastercard® is accepted.	Up to a $450 combined annual allowance to use towards fitness, eligible weight loss programs or costs toward your prescription hearing aids using a Flexible Benefit card. All purchases must be done per your benefits where Mastercard® is accepted.	Up to a $450 combined annual allowance to use towards fitness, eligible weight loss programs or costs toward your prescription hearing aids using a Flexible Benefit card. All purchases must be done per your benefits where Mastercard® is accepted.

PRESCRIPTION DRUG BENEFITS			
Benefits/Services	**Mass General Brigham Advantage (PPO)**	**Mass General Brigham Advantage Premier (PPO)**	**Mass General Brigham Advantage Signature (PPO)**
Deductible This plan does not have a prescription drug deductible.			
Initial Coverage You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $2,000. You then move on to the Catastrophic Coverage Stage.			
	Standard Retail Cost-Sharing	**Standard Retail Cost-Sharing**	**Standard Retail Cost-Sharing**
Tier	**One-month supply**	**One-month supply**	**One-month supply**
Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay
Tier 2 (Generic)	$5 copay	$5 copay	$5 copay
Tier 3 (Preferred Brand)	$47 copay	$47 copay	$47 copay
Tier 4 (Non-Preferred Drug)	$100 copay	$100 copay	$100 copay
Tier 5 (Specialty Tier)	33% Coinsurance	33% Coinsurance	33% Coinsurance
Tier	**Two-month supply**	**Two-month supply**	**Two-month supply**
Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay
Tier 2 (Generic)	$10 copay	$10 copay	$10 copay
Tier 3 (Preferred Brand)	$94 copay	$94 copay	$94 copay
Tier 4 (Non-Preferred Drug)	$200 copay	$200 copay	$200 copay
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable	Not Applicable
Tier	**Three-month supply**	**Three-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay
Tier 2 (Generic)	$15 copay	$15 copay	$15 copay
Tier 3 (Preferred Brand)	$141 copay	$141 copay	$141 copay
Tier 4 (Non-Preferred Drug)	$300 copay	$300 copay	$300 copay
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable	Not Applicable

	Mass General Brigham Advantage (PPO)	Mass General Brigham Advantage Premier (PPO)	Mass General Brigham Advantage Signature (PPO)
	Standard Mail Order	**Standard Mail Order**	**Standard Mail Order**
Tier	**One-month supply**	**One-month supply**	**One-month supply**
Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay
Tier 2 (Generic)	$5 copay	$5 copay	$5 copay
Tier 3 (Preferred Brand)	$47 copay	$47 copay	$47 copay
Tier 4 (Non-Preferred Drug)	$100 copay	$100 copay	$100 copay
Tier 5 (Specialty Tier)	33% Coinsurance	33% Coinsurance	33% Coinsurance
Tier	**Two-month supply**	**Two-month supply**	**Two-month supply**
Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay
Tier 2 (Generic)	$10 copay	$10 copay	$10 copay
Tier 3 (Preferred Brand)	$94 copay	$94 copay	$94 copay
Tier 4 (Non-Preferred Drug)	$200 copay	$200 copay	$200 copay
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable	Not Applicable
Tier	**Three-month supply**	**Three-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay
Tier 2 (Generic)	$10 copay	$10 copay	$10 copay
Tier 3 (Preferred Brand)	$94 copay	$94 copay	$94 copay
Tier 4 (Non-Preferred Drug)	$200 copay	$200 copay	$200 copay
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable	Not Applicable
If you reside in a long-term care facility, you pay the same as at a retail pharmacy.			

Catastrophic Coverage

After your yearly out-of-pocket drug costs reach $2,000, you reach the catastrophic coverage stage:

- During this payment stage, you pay nothing for your covered Part D drugs,
- You may have cost sharing for drugs that are covered under our enhanced benefit.

DISCLAIMERS

Mass General Brigham Health Plan Medicare Advantage
399 Revolution Drive, Suite 850
Somerville, MA 02145

Contact information and hours of operation:

Members

October 1-March 31
1-855-833-3668 (TTY: 711)
8:00 a.m. to 8:00 p.m., ET
Monday through Sunday

April 1-September 30
1-855-833-3668 (TTY: 711)
8:00 a.m. to 8:00 p.m., ET
Monday through Friday

If you call after business hours, you may leave a message that includes your name and phone number, and a representative will return your call no later than one business day after you leave a message. Customer Service also has free language interpreter services available for non-English speakers.

Non-Members

October 1-March 31
1-888-828-5500 (TTY: 711)
8:00 a.m. to 8:00 p.m., ET
Monday through Sunday

April 1-September 30
1-888-828-5500 (TTY: 711)
8:00 a.m. to 8:00 p.m., ET
Monday through Friday

Mass General Brigham Health Plan is an HMO-POS/PPO plan with a Medicare contract. Enrollment in Mass General Brigham Advantage Health Plan depends on contract renewal.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat Mass General Brigham Health Plan members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Customer Service number or see your "Evidence of Coverage" for more information, including the cost-sharing that applies to out-of-network services.

Mass General Brigham Health Plan

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

IMPORTANT INFORMATION:

2025 Medicare Star Ratings

Mass General Brigham Health Plan - H6847

For 2025, Mass General Brigham Health Plan - H6847 received the following Star Ratings from Medicare:

Overall Star Rating:	Not enough data available*
Health Services Rating:	Not enough data available
Drug Services Rating:	Not enough data available

**Some plans do not have enough data to rate performance.*

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

The number of stars show how well a plan performs.

★★★★★ EXCELLENT
★★★★☆ ABOVE AVERAGE
★★★☆☆ AVERAGE
★★☆☆☆ BELOW AVERAGE
★☆☆☆☆ POOR

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at Medicare.gov/plan-compare.

Questions about this plan?

Contact Mass General Brigham Health Plan 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time at 888-828-5500 (toll-free) or 711 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time. Current members please call 855-833-3668 (toll-free) or 711 (TTY).

Mass General Brigham Health Plan

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

IMPORTANT INFORMATION:

2025 Medicare Star Ratings

Mass General Brigham Health Plan - H9485

For 2025, Mass General Brigham Health Plan - H9485 received the following Star Ratings from Medicare:

Overall Star Rating:	★★★½☆
Health Services Rating:	★★★★☆
Drug Services Rating:	★★★☆☆

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

The number of stars show how well a plan performs.

★★★★★	EXCELLENT
★★★★☆	ABOVE AVERAGE
★★★☆☆	AVERAGE
★★☆☆☆	BELOW AVERAGE
★☆☆☆☆	POOR

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at Medicare.gov/plan-compare.

Questions about this plan?

Contact Mass General Brigham Health Plan 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time at 888-828-5500 (toll-free) or 711 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time. Current members please call 855-833-3668 (toll-free) or 711 (TTY).

Mass General Brigham
Health Plan

Multi-language Interpreter Services

Form Approved OMG# 0938-1421

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-855-833-3668. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-855-833-3668. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-855-833-3668。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-855-833-3668。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-855-833-3668. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-855-833-3668. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-855-833-3668 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-855-833-3668. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-855-833-3668 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-855-833-3668. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم بمساعدتك. هذه خدمة مجانية فوري، ليس عليك سوى الاتصال بنا على [1-855-833-3668]. سيقوم شخص ما يتحدث العربية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-855-833-3668 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-855-833-3668. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-855-833-3668. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan

medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan
1-855-833-3668. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-855-833-3668. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには 1-855-833-3668 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Mass General Brigham
Health Plan

Mass General Brigham Health Plan Non-Discrimination Notice

Discrimination is Against the Law

Mass General Brigham Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). Mass General Brigham Health Plan does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Mass General Brigham Health Plan:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may inlude:
  - Qualified interpreters
  - Information written in other languages

If you need these services

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact **Medicare Advantage Customer Service**.

Mass General Brigham Health Plan
Medicare Advantage Customer Service
399 Revolution Drive, Suite 850
Somerville, MA 02145

You can reach our Customer Service team by calling: **855-833-3668** (TTY: 711)

October 1 – March 31
8:00 a.m. to 8:00 p.m. ET
Monday through Sunday

April 1 – September 30
8:00 a.m. to 8:00 p.m. ET
Monday through Friday

Email:
HealthPlanMedAdvCustomerService@mgb.org

If you believe that Mass General Brigham Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with **Appeals and Grievances Coordinator**.

MASS GENERAL BRIGHAM HEALTH PLAN
APPEALS AND GRIEVANCES DEPARTMENT
399 REVOLUTION DRIVE
SOMERVILLE, MA 02145

Phone: **855-833-3668** (TTY 711)
Fax: **617-526-1980**
Email: **HealthPlanAppealsGrievance@mgb.org**

You can file a grievance in person, or by mail, fax, or email. If you need help filing a grievance, **Appeals and Grievances Coordinator** is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

US DEPARTMENT OF HEALTH & HUMAN SERVICES
ROOM 509F, HHH BLDG
200 INDEPENDENCE AVE, SW
WASHINGTON DC 20201

Phone: **800-368-1019**
800-537-7697 (TDD)

Complaint forms are available at:
hhs.gov/ocr/office/file/index.html

This notice is available at Mass General Brigham Health Plan website: **MGBAdvantage.org**