Mass General Brigham
Health Plan

2024 Summary of Benefits

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

This Summary of Benefits covers plans in the following counties in Massachusetts: Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester.

H9485_0782PDT_M

This booklet gives you a summary of drug and health services covered by Mass General Brigham Advantage (PPO) and Mass General Brigham Advantage Premier (PPO), and what you pay.

This information is not a complete description of benefits.

Call **1-855-833-3668** (TTY: 711) for more information.

October 1 – March 31, 8:00 AM to 8:00 PM EST Monday through Sunday

April 1 – September 30, 8:00 AM to 8:00 PM EST Monday through Friday

To get a complete list of services covered by your plan, call our Customer Service department, and ask for the Evidence of Coverage. You can also access the Evidence of Coverage online at our website, **MassGeneralBrighamAdvantage.org**.

Summary of Benefits

January 1, 2024 – December 31, 2024

You have choices about how to get your Medicare benefits

You can 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) and Mass General Brigham Advantage Premier (PPO)).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you an overview of what Mass General Brigham Advantage (PPO) and Mass General Brigham Advantage Premier (PPO) cover and what you pay.

To compare our plan with other Medicare health plans, ask the other plans' representatives for their Summary of Benefits booklets or use the Medicare Plan Finder on **medicare.gov**.

To learn more about the coverage and costs of Original Medicare, look in your current *Medicare & You* handbook. View it online at 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**.

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 Customer Service at the number shown in the next section.

Things to know about our plans

Contact information and hours of operation	
Members	
October 1-March 31 **1-855-833-3668** (TTY: 711) 8:00 AM to 8:00 PM, EST Monday through Sunday	April 1–September 30 **1-855-833-3668** (TTY: 711) 8:00 AM to 8:00 PM, EST 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 AM to 8:00 PM, EST Monday through Sunday	April 1–September 30 **1-888-828-5500** (TTY: 711) 8:00 AM to 8:00 PM, EST Monday through Friday

Our website**: MassGeneralBrighamAdvantage.org**

Who can join?

To join Mass General Brigham Advantage (PPO) or Mass General Brigham Advantage Premier (PPO) you must be eligible for Medicare Part A, be enrolled in Medicare Part B, and live in our service area. You must continue to pay your Medicare Part B premium.

Our service area includes the following counties in Massachusetts: Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk, Worcester.

Which doctors, hospitals, and pharmacies can I use?

Mass General Brigham Advantage (PPO) and Mass General Brigham Advantage Premier (PPO) members have access to providers in the Mass General Brigham system, in addition to a wide network of doctors, hospitals, pharmacies, and other providers throughout Massachusetts. If you use the providers that are in our network, you will pay less for your covered services. But if you want to, you can also use providers that are not in our network and may pay more for your covered services.

You can see our plan's provider directory and pharmacy directory at **MassGeneralBrighamAdvantage.org** or call us and we will provide you with the provider and pharmacy directory information you need. The pharmacy network, and/or provider network may change at any time.

What do we cover?

We cover everything that Original Medicare covers — and more.

- Our plan members get all the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less.

- Our plan members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this booklet.

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

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions at **MassGeneralBrighamAdvantage.org** or call us and we'll send you a copy of the formulary. The formulary may change at any time. You will receive notice when necessary.

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, Coverage Gap, and Catastrophic Coverage.

Summary of Benefits

January 1, 2024 – December 31, 2024

	Mass General Brigham Advantage (PPO)	Mass General Brigham Advantage Premier (PPO)
Monthly plan premium	Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties: **$0 per month**	Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties: **$140 per month**
	You must continue to pay your Medicare Part B premium.	
Deductibles and Maximum Out of Pocket		
Medical	This plan does not have a medical deductible.	This plan does not have a medical deductible.
Prescription drugs	This plan does not have a prescription drug deductible.	This plan does not have a prescription drug deductible.
Maximum Out-of-Pocket responsibility (Does not include costs related to prescription drugs)	Your yearly limit(s) in this plan: $6,400 for services you receive from in-network providers. $9,700 for services you receive from out-of-network providers and in-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 out-of-network providers and in-network providers combined.
	The In-Network cost sharing will be applied to the In-Network and the Out- of-Network Maximum Out-of-Pocket amounts but the cost sharing for Out- of-Network will **not** apply to the In-Network Maximum Out-of-Pocket amount. 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 calendar year.	
	Please note that you will still need to pay your Medicare Part B premium, your plan premium, and any cost sharing for your Part D prescription drugs.	
Inpatient and Outpatient Hospital Services		
Inpatient hospital coverage	Our plan covers an unlimited number of days for an inpatient hospital stay	
	In-Network: $335 copay per day for days 1 to 5. $0 copay per day for day 6 through 90. $0 copay per day for days 91 and beyond. **Out-of-Network:** 40% of the cost per stay	**In-Network:** $125 copay per day for days 1 to 3. $0 copay per day for day 4 through 90. $0 copay per day for days 91 and beyond. **Out-of-Network:** 20% of the cost per stay
	Prior Authorization is required in-network.	

	Mass General Brigham Advantage (PPO)	Mass General Brigham Advantage Premier (PPO)
Outpatient hospital coverage	**In-Network:** $0 to $300 copay per visit You pay $0 for preventive colonoscopies that turn into diagnostic colonoscopies. All other procedures and services are a $300 copay. **Out-of-Network** 40% coinsurance per visit	**In-Network:** $0 to $125 copay per visit You pay $0 for preventive colonoscopies that turn into diagnostic colonoscopies. All other procedures and services are a $125 copay. **Out-of-Network** 20% coinsurance per visit
	Prior Authorization is required for certain services in-network. Please see your Evidence of Coverage for more information.	
Ambulatory surgery center	**In-Network:** $0 to $300 copay per visit You pay $0 for preventive colonoscopies that turn into diagnostic colonoscopies. All other procedures and services are a $300 copay. **Out-of-Network:**40% coinsurance per visit	**In-Network:** $0 to $125 copay per visit You pay $0 for preventive colonoscopies that turn into diagnostic colonoscopies. All other procedures and services are a $125 copay. **Out-of-Network:**20% coinsurance per visit
	Prior Authorization is required in-network.	
Doctor's office visits (including telehealth visits)		
Primary care physician	**In-Network:** $0 copay per visit **Out-of-Network:** $20 copay per visit	**In-Network:** $0 copay **Out-of-Network:** $10 copay
Specialist	**In-Network:** $45 copay **Out-of-Network:** $65 copay	**In-Network:** $20 copay **Out-of-Network:** $40 copay
Preventive Care	**In-Network and Out-of-Network**: $0 copay per visit	**In-Network and Out-of-Network**: $0 copay per visit
	Our plans cover many preventive services including	
	• Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) * • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling	• Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Lung cancer screening (low dose computed tomography [LDCT]) • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Flu shots, pneumococcal shots, Hepatitis B shots (limitations may apply) • "Welcome to Medicare" preventive visit (one-time) • Any additional preventive services approved by Medicare during the calendar year will be covered.
	*If any other medical condition including polyp or other tissue is found and removed during the procedure your cost sharing will remain $0 copay.	

	Mass General Brigham Advantage (PPO)	Mass General Brigham Advantage Premier (PPO)
Annual physical exam		
Annual physical exam	**In-Network:** $0 copay **Out-of-Network:** $20 copay	**In-Network:** $0 copay **Out-of-Network:** $10 copay
	This exam includes a detailed medical/family history and a head-to-toe assessment with hands-on examination of all body systems to assess overall general health.	
Emergency services		
Emergency care	**In- and Out-of-Network:** $90 copay	**In- and Out-of-Network:** $90 copay
	Your copay is waived if you are admitted to the hospital within 24 hours. Your plan includes worldwide coverage for emergency care.	
Urgently needed services	**In- and Out-of-Network:** $50 copay per visit	**In- and Out-of-Network:** $30 copay per visit
	Your plan includes worldwide coverage for urgently needed services.	
Diagnostic services/labs/imaging		
Diagnostic radiology (such as MRIs, CT scans)	**In-Network:** $75 - $160 copay per visit Ultrasounds are a $75 copay. Outpatient CT, PET, and MRI scans are a $160 copay **Out-of-Network:** 40% coinsurance per visit	**In-Network:** $75 - $150 copay visit Ultrasounds are a $75 copay. Outpatient CT, PET, and MRI scans are a $150 copay **Out-of-Network:** 20% coinsurance per visit
	Prior Authorization is required in-network.	
Diagnostic tests and procedure	**In-Network:** $20 copay per visit **Out-of-Network:** 40% coinsurance per visit	**In-Network:** $0 copay per visit **Out-of-Network:** $10 copay per visit
	Prior Authorization is required in-network.	
Lab services	**In-Network:** $0 copay per visit **Out-of-Network:** 40% coinsurance per visit	**In-Network:** $0 copay per visit **Out-of-Network:** $10 copay per visit
	Prior Authorization is required in-network.	
Outpatient x-ray	**In-Network:** $15 copay per visit **Out-of-Network:** 40% coinsurance per visit	**In-Network:** $0 copay per visit **Out-of-Network:** $10 copay per visit
	Prior Authorization is required in-network.	

	Mass General Brigham Advantage (PPO)	Mass General Brigham Advantage Premier (PPO)
Hearing services		
Medicare covered hearing exam	**In-Network:** $45 copay per visit **Out-of-Network:** $65 copay per visit	**In-Network:** $20 copay per visit **Out-of-Network:** $40 copay per visit
Routine hearing exam – up to one per calendar year	**In-Network:** $0 copay when using a TruHearing provider **Out-of-Network:** $65 copay for a routine hearing exam by an out-of-network (non TruHearing) hearing provider	**In-Network:** $0 copay when using a TruHearing provider **Out-of-Network:** $40 copay for a routine hearing exam by an out-of-network (non TruHearing) hearing provider
Hearing aids	**In-Network:** $699 - $999 copay per hearing aid per calendar year **Out-of-Network**: $699 - $999 copay per hearing aid per calendar year	**In-Network:** $699 - $999 copay per hearing aid per calendar year **Out-of-Network**: $699 - $999 copay per hearing aid per calendar year
	TruHearing provider must be used for in- and out-of-network hearing aid benefit.	
Dental services		
Limited Medicare-covered dental services	**In-Network:** $45 copay per visit **Out-of-Network:** $65 copay per visit	**In-Network:** $20 copay per visit **Out-of-Network:** $40 copay per visit
Non-Medicare-covered dental services	**Preventive Services: In- and Out-of-Network:** No copayment or coinsurance for covered preventive services **Comprehensive Services:** **In-Network:** No copayment or coinsurance for covered comprehensive services **Out-of-Network:** 20% coinsurance for covered comprehensive services 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 Services: In- and Out-of-Network:** No copayment or coinsurance for covered preventive services **Comprehensive Services:** **In-Network:** No copayment or coinsurance for covered comprehensive services. **Out-of-Network:** 20% coinsurance for covered comprehensive services 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 services are provided through Liberty Dental. Refer to the Evidence of Coverage for complete details.	

	Mass General Brigham Advantage (PPO)	Mass General Brigham Advantage Premier (PPO)
Vision services		
Medicare-covered eye exam	**In-Network:** $45 copay per visit **Out-of-Network:** $65 copay per visit	**In-Network:** $20 copay per visit **Out-of-Network:** $40 copay per visit
Eyewear after cataract surgery (for Medicare-covered standard eyewear)	**In-Network:** $0 copay **Out-of-Network:** $65 copay	**In-Network:** $0 copay **Out-of-Network:** $40 copay
Routine eye exam (1 every calendar year)	**In-Network:** $0 copay when using an EyeMed Provider **Out-of-Network:** You will receive 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 for reimbursement.	**In-Network:** $0 copay when using an EyeMed provider **Out-of-Network:** You will receive 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 for reimbursement.
	To receive reimbursement for an out-of-network routine vision exam, you must file a claim with EyeMed Vision Care. The claim form can be found on **MassGeneralBrighamAdvantage.org/forms** or by calling Customer Service for the claim form.	
Eyewear (for covered eyewear you pay any balance in excess of the limit)	**In-Network:** Up to $200 per calendar year for prescription eyewear or contact lenses purchased from an EyeMed provider **Out-of-Network:** 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 for reimbursement.	**In-Network:** Up to $300 per calendar year for prescription eyewear or contact lenses purchased from an EyeMed provider **Out-of-Network:** 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 for reimbursement.
	To receive reimbursement for eyewear purchased out-of-network (from a non-EyeMed provider), you must file a claim with EyeMed Vision Care. The claim form can be found on **MassGeneralBrighamAdvantage.org/forms** or by calling Customer Service for the claim form.	

	Mass General Brigham Advantage (PPO)	Mass General Brigham Advantage Premier (PPO)
Mental health services		
Inpatient mental health care	**In-Network:** $335 copay per day for days 1-5 $0 copay per day for days 6 to 90 $0 copay per day for days 91 and beyond **Out of Network:** 40% coinsurance per stay	**In-Network:** $125 copay per day for days 1 to 3 $0 copay per day for days 4 to 90 $0 copay per day for days 91 and beyond **Out-of-Network:** 20% coinsurance per stay
	Authorization rules may apply to in-network services. There is a Medicare 190-day lifetime limit for care in a free-standing psychiatric hospital for both in-network and out-of-network services. Please see your Evidence of Coverage for additional important information.	
Outpatient individual and group therapy	**In-Network:** $30 copay per visit **Out-of-Network:** $65 copay per visit	**In-Network:** $10 copay per visit **Out-of-Network:** $40 copay per visit
Additional services		
Skilled nursing facility (SNF) (covered up to 100 days)	**In-Network:** $0 copay per day for days 1 to 20 $160 copay per day for days 21 to 44 $0 copay per day for days 45 to 100 **Out-of-Network:** 40% coinsurance per stay.	**In-Network:** $0 copay per day for days 1 to 20 $160 copay per day for days 21 to 44 $0 copay per day for days 45 to 100 **Out-of-Network:** 20% coinsurance per stay
	Prior Authorization is required in-network.	
Physical therapy	**In-Network:** $40 copay per visit **Out-of-Network:** $65 copay per visit	**In-Network:** $20 copay per visit **Out-of-Network:** $40 copay per visit
	Prior Authorization is required in-network after the 20th visit.	
Ambulance	**In-Network and Out-of-Network:** $275 copay per trip	**In-Network and Out-of-Network:** $200 copay per trip
Transportation – nonemergency (including chair vans)	Not covered	Not covered
Medicare Part B drugs (including chemotherapy)	**In-Network:** Medicare Part B insulin: $35 All other Medicare Part B drugs: 0% to 20% coinsurance. Part B drugs that are rebate eligible may be subject to a lower coinsurance. **Out-of-Network:** 40% coinsurance	**In-Network:** Medicare Part B insulin: $35 All other Medicare Part B drugs: 0% to 20% coinsurance. Part B drugs that are rebate eligible may be subject to a lower coinsurance. **Out of Network**: 20% coinsurance
	Prior Authorization may apply for Part B drugs in-network.	

	Mass General Brigham Advantage (PPO)	Mass General Brigham Advantage Premier (PPO)
Foot care (Podiatry services)	**In-Network:** $40 copay **Out-of-Network:** $65 copay	**In-Network:** $20 copay **Out-of-Network:** $40 copay
	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.	
Over-the- counter-items (OTC)	**In-Network:** Up to $85 per quarter toward over-the-counter health & wellness products.	**In-Network:** Up to $120 per quarter toward over-the-counter health & wellness products.
	Convey Health Solutions will manage the OTC benefit. Convey Health Solutions will mail the OTC catalog for a list of eligible items. Purchase OTC items by mail, phone, or online. If you have questions or to order by phone please call: **1-800-695-5306** (TTY: 711) Monday – Friday 8 am to 11 pm, EST There is no coverage for out-of-network providers.	
Diabetes supplies and services		
Diabetes monitoring and supplies	**In-Network:** $0 copay **Out-of-Network:** 40% coinsurance	**In-Network:** $0 copay **Out-of-Network:** 20% coinsurance
	Authorization rules may apply in-network.	
Diabetes self-management training	**In-Network and Out-of-Network:** $0 copay	**In-Network and Out-of-Network:** $0 copay
Therapeutic shoes or inserts	**In-Network:** 20% coinsurance **Out-of-Network:** 40% coinsurance	**In-Network:** $0 copay **Out-of-Network:** 20% coinsurance
Durable medical equipment (wheelchairs, oxygen, etc.)	**In-Network:** 20% coinsurance **Out-of-Network:** 40% coinsurance	**In-Network:** 20% coinsurance **Out-of-Network:** 20% coinsurance
	Authorization rules may apply in-network	
Prosthetic devices (braces, artificial limbs, etc.)		
Prosthetic devices	**In-Network:** 20% coinsurance **Out-of-Network:** 40% coinsurance	**In-Network:** 20% coinsurance **Out-of-Network:** 20% coinsurance
	Authorization rules may apply in-network	
Related medical supplies	**In-Network:** 20% coinsurance **Out-of-Network:** 40% coinsurance	**In-Network:** 20% coinsurance **Out-of-Network:** 20% coinsurance
	Authorization rules may apply in-network	
Wellness programs (see back of booklet for more details)		
Fitness	Up to $300 reimbursement per calendar year	Up to $300 reimbursement per calendar year
Weight loss	Up to $150 reimbursement per calendar year	Up to $150 reimbursement per calendar year

Wellness programs

Take control of your health with our fitness and weight-loss benefits

What is the fitness benefit?

Enroll in a qualified fitness facility, program, or activity and receive up to $300 per calendar year toward your club membership fees.

What programs qualify?

- Virtual/online fitness memberships, subscriptions, programs, or classes that provide cardiovascular and strength training using a digital platform.
- Health clubs with a variety of cardiovascular and strength-training exercise equipment, e.g., traditional health clubs, YMCAs, YWCAs, and community fitness centers.
- Fitness classes at participating Councils on Aging (COA) facilities; fitness studios with instructor-led groups such as yoga, Pilates, Zumba®, kickboxing, CrossFit®, and indoor cycling/spinning and other exercise classes.
- Activity trackers, e.g., Fitbit, Garmin.
- Home fitness equipment such as weights, stationary bikes, or treadmills.

What is the weight-loss benefit?

Enroll in a qualified weight-loss program and receive up to $150 per calendar year toward your membership fees.

What kinds of programs qualify?

Traditional WW, (formerly known as Weight Watchers®) meetings, WW Online, Jenny Craig, NOOM, and hospital-based and other non-hospital-based weight-loss programs that combine healthy eating, exercise, and coaching sessions.

Programs that DO NOT qualify

For the fitness benefit, non-eligible facilities, programs, or activities include but are not limited to country clubs and social clubs, spas, and 1-on-1 sessions. DVDs, and YouTube subscriptions are not covered.

The weight loss program benefit does not cover food, nutritional supplements, or enrollment/registration fees.

Rewarding you for healthy choices

Get reimbursed up to $450 per year when you enroll in qualified fitness and weight-loss programs.

- $300 fitness reimbursement
- $150 weight-loss reimbursement

Prescription drug benefits

	Mass General Brigham Advantage (PPO)	Mass General Brigham Advantage Premier (PPO)
Deductible	This plan does not have a prescription drug deductible.	This plan does not have a prescription drug deductible.
Initial coverage	You pay the following until your total yearly drug costs reach $5,030. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.	

Tier 1: Preferred Generic
Tier 2: Generic
Tier 3: Preferred Brand
Tier 4: Non-Preferred Drug
Tier 5: Specialty Tier

Note: Cost sharing may differ based on the pharmacy type (retail pharmacy, mail order, long-term care (LTC)) or home infusion, and 30-day or 90-day supply.

Retail Cost Sharing Mass General Brigham Advantage (PPO) Mass General Brigham Advantage Premier (PPO)			
Drug tier	**30-day supply**	**60-day supply**	**90-day supply**
Tier 1 Preferred generic	$0 copay	$0 copay	$0 copay
Tier 2 Generic	$3 copay	$6 copay	$9 copay
Tier 3 Preferred brand	$37 copay	$74 copay	$111 copay
Tier 4 Non-preferred drug	$100 copay	$200 copay	$300 copay
Tier 5 Specialty tier	33% coinsurance	N/A	N/A

Mail Order Cost Sharing Mass General Brigham Advantage (PPO) Mass General Brigham Advantage Premier (PPO)			
Drug tier	**30-day supply**	**60-day supply**	**90-day supply**
Tier 1 Preferred generic	$0 copay	$0 copay	$0 copay
Tier 2 Generic	$3 copay	$6 copay	$6 copay
Tier 3 Preferred brand	$37 copay	$74 copay	$74 copay
Tier 4 Non-preferred drug	$100 copay	$200 copay	$200 copay
Tier 5 Specialty tier	33% coinsurance	N/A	N/A

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

Coverage gap	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand-name drugs and 25% of the plan's cost for covered generic drugs until your costs total $8,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.
Catastrophic coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $8,000, the plan pays the full cost for your covered Part D drugs. You pay nothing. For excluded drugs covered under our enhanced benefit, you pay the same cost sharing as in the Initial Coverage Phase. You may get your drugs at network retail pharmacies and mail order pharmacies.

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	April 1–September 30
1-855-833-3668 (TTY: 711)	**1-855-833-3668** (TTY: 711)
8:00 AM to 8:00 PM, EST	8:00 AM to 8:00 PM, EST
Monday through Sunday	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	April 1–September 30
1-888-828-5500 (TTY: 711)	**1-888-828-5500** (TTY: 711)
8:00 AM to 8:00 PM, EST	8:00 AM to 8:00 PM, EST
Monday through Sunday	Monday through Friday

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

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations.

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

This is not a complete description of benefits. Contact the plan for more information.

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 any questions, you can call and speak to a customer service representative.

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

October 1 – March 31, 8:00 AM to 8:00 PM EST, Monday through Sunday

April 1 – September 30, 8:00 AM to 8:00 PM EST, 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 **MassGeneralBrighamAdvantage.org** or call **855-833-3668** (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, 2025.
- ☐ 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.