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

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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, **MassGeneralBrighamAdvantage.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., 7 days a week.
- From April 1 to September 30, we're open 8 a.m. – 8 p.m., 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: **MassGeneralBrighamAdvantage.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 **MassGeneralBrighamAdvantage.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, **MassGeneralBrighamAdvantage.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	**<u>In-Network:</u>** 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	**<u>In-Network:</u>** 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	**<u>In-Network:</u>** 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	**<u>In-Network:</u>** Occupational therapy visit: $40 copay. Physical therapy and speech and language therapy visit: $40 copay. **<u>Out-of-Network:</u>** 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.	**<u>In-Network:</u>** Occupational therapy visit: $20 copay. Physical therapy and speech and language therapy visit: $20 copay. **<u>Out-of-Network:</u>** 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.	**<u>In-Network:</u>** Occupational therapy visit: $0 copay Physical therapy and speech and language therapy visit: $0 copay. **<u>Out-of-Network:</u>** 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	**<u>In-Network and Out-of-Network:</u>** Ground Ambulance: $275 copay. Air Ambulance: $275 copay. Prior authorization required for non-emergency ambulance services in-network.	**<u>In-Network and Out-of-Network:</u>** Ground Ambulance: $200 copay. Air Ambulance: $200 copay. Prior authorization required for non-emergency ambulance services in-network.	**<u>In-Network and Out-of-Network:</u>** 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 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

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.