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 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 Medicare 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

SECTION II - SUMMARY OF BENEFITS

Mass Mass General
General General Brigham
Brigham Brigham Advantage
Advantage Advantage Signature

(PPO) Premier (PPO)

(PPO)

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

	\$0 per month.	\$140 per	\$299 per
Monthly Plan Premium	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.	month. In addition, you must continue to pay your Medicare Part B premium.	month. In addition, you must continue to pay your Medicare Part B premium.

	Medical	Medical	Medical
	Deductible:	Deductible:	Deductible:
	This plan does	This plan does	This plan does
	not have a	not have a	not have a
	medical	medical	medical
	deductible.	deductible.	deductible.
Deductible	Prescription	Prescription	Prescription
	Drug	Drug	Drug
	Deductible:	Deductible:	Deductible:
	This plan does	This plan does	This plan does
	not have a	not have a	not have a
	prescription	prescription	prescription
	deductible.	deductible.	deductible.
	Your yearly	Your yearly	Your yearly
	limit(s) in this	limit(s) in this	limit(s) in this
	plan:	plan:	plan:
	• \$5,500 for	• \$3,150 for	• \$0 for
	services you	services you	services you
Maximum Out-	receive from	receive from	receive from
of-Pocket	in-network	in-network	in- network
Responsibility	providers.	providers.	providers.
Responsibility	• \$9,550 for	• \$5,450 for	• \$0 for
	services you	services you	services you
	receive from	receive from	receive from
	in-network	in-network	in-network
	and out-of-	and out-of-	and out-of-
	network	network	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.
- 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.
- 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 /	Mass General	Mass General	Mass General
Services	Brigham	Brigham	Brigham
	Advantage	Advantage	Advantage
	(PPO)	Premier (PPO)	Signature
			(PPO)
Inpatient	In-Network:	In-Network:	In-Network:
Hospital	Days 1-5: \$350	Days 1-3: \$150	\$0 copay per
	copay per day	copay per day	stay.
	for each	for each	Out-of-
	admission.	admission.	Network:
	Days 6-90: \$0	Days 4-90: \$0	\$0 copay per
	copay per day.	copay per day.	stay.
	Our plan	Our plan	May require
	covers an	covers an	prior
	unlimited	unlimited	authorization
	number of days	number of days	in-network.
	for an inpatient	for an inpatient	
	hospital stay.	hospital stay.	
	Out-of-	Out-of-	
	Network:	Network:	
	30% of the total	20% of the total	
	cost per stay.	cost per stay.	
	May require	May require	
	prior	prior	
	authorization	authorization	
	in-network.	in-network.	

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

Benefits / Services	Mass General Brigham Advantage (PPO)	Mass General Brigham Advantage Premier (PPO)	Mass General Brigham Advantage Signature (PPO)
	May require prior authorization in-network.	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.	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.	In-Network: Ambulatory Surgical Center: \$0 copay Out-of- Network: Ambulatory Surgical Center: \$0 copay. May require prior authorization in-network.

Benefits / Services	Mass General Brigham Advantage (PPO)	Mass General Brigham Advantage Premier (PPO)	Mass General Brigham Advantage Signature (PPO)
	Out-of-	Out-of-	
	Network:	Network:	
	Ambulatory	Ambulatory	
	Surgical	Surgical	
	Center: 40% of	Center: 20% of	
	the total cost.	the total cost.	
	May require	May require	
	prior	prior	
	authorization	authorization	
	in-network.	in-network.	
	In-Network:	In-Network:	In-Network:
	Primary care	Primary care	Primary care
	physician visit:	physician visit:	physician visit:
	\$0 copay	\$0 copay	\$0 copay
	Specialist visit:	Specialist visit:	Specialist visit:
Doctor's	\$50 copay.	\$25 copay.	\$0 copay
Office Visits	Out-of-	Out-of-	Out-of-
	Network:	Network:	Network:
	Primary care	Primary care	Primary care
	physician visit:	physician	physician visit:
	\$20 copay.	visit: \$10	\$0 copay.
		copay.	

Benefits / Services	Mass General Brigham	Mass General Brigham	Mass General Brigham
	Advantage (PPO)	Advantage Premier (PPO)	Advantage Signature (PPO)
	Specialist visit: \$65 copay.	Specialist visit: \$40 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:	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:	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:

Benefits /	Mass General	Mass General	Mass General
Services	Brigham	Brigham	Brigham
	Advantage	Advantage	Advantage
	(PPO)	Premier (PPO)	Signature
			(PPO)
	\$0 copay for all	\$0 copay for all	\$0 copay for all
	preventive	preventive	preventive
	services	services	services
	covered under	covered under	covered under
	Original	Original	Original
	Medicare at	Medicare at	Medicare at
	zero cost	zero cost	zero cost
	sharing.	sharing.	sharing.
	<u>In-Network</u>	<u>In-Network</u>	<u>In-Network</u>
	and Out-of-	and Out-of-	and Out-of-
	Network:	Network:	Network:
			110011101111
	\$90 copay per	\$90 copay per	\$0 copay
	\$90 copay per visit.		<u> </u>
Emergency		\$90 copay per	\$0 copay
Emergency	visit.	\$90 copay per visit.	\$0 copay Worldwide
Emergency Care	visit. Worldwide	\$90 copay per visit. Worldwide	\$0 copay Worldwide Emergency
	visit. Worldwide Emergency	\$90 copay per visit. Worldwide Emergency	\$0 copay Worldwide Emergency Coverage: \$0
	visit. Worldwide Emergency Coverage: \$90	\$90 copay per visit. Worldwide Emergency Coverage: \$90	\$0 copay Worldwide Emergency Coverage: \$0
	visit. Worldwide Emergency Coverage: \$90 copay.	\$90 copay per visit. Worldwide Emergency Coverage: \$90 copay.	\$0 copay Worldwide Emergency Coverage: \$0
	visit. Worldwide Emergency Coverage: \$90 copay. Your copay is	\$90 copay per visit. Worldwide Emergency Coverage: \$90 copay. Your copay is	\$0 copay Worldwide Emergency Coverage: \$0

Benefits / Services	Mass General Brigham Advantage (PPO)	Mass General Brigham Advantage Premier (PPO)	Mass General Brigham Advantage Signature (PPO)
	within 24	within 24	
	hours.	hours.	
	In-Network	In-Network	In-Network
	and Out-of-	and Out-of-	and Out-of-
	Network:	Network:	Network:
Urgently	\$50 copay per	\$30 copay per	\$0 copay
Needed	visit.	visit.	Worldwide
Services	Worldwide	Worldwide	Urgent
	Urgent	Urgent	Coverage: \$0
	Coverage: \$50	Coverage: \$30	copay
	copay.	copay.	
	In-Network:	In-Network:	In-Network:
	Diagnostic	Diagnostic	Diagnostic
	tests and	tests and	tests and
	procedures:	procedures: \$0	procedures: \$0
Diagnostic	\$20 copay.	copay	copay
Services /	Lab services:	Lab services:	Lab services:
Labs/ Imaging	\$0 copay	\$0 copay.	\$0 copay
	Diagnostic	Diagnostic	Diagnostic
	Radiology	Radiology	Radiology
	Services (such	Services (such	Services (such
	as MRI, CAT	as MRI, CAT	as MRI, CAT

Benefits / Services	Mass General Brigham Advantage (PPO)	Mass General Brigham Advantage Premier (PPO)	Mass General Brigham Advantage Signature (PPO)
	Scan): \$75 copay - \$160 copay X-rays: \$15 copay. Therapeutic radiology services (such as radiation treatment for cancer): \$60 copay.	Scan): \$75 copay - \$150 copay X-rays: \$0 copay Therapeutic radiology services (such as radiation treatment for cancer): \$60 copay.	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: 40% of the total cost. Lab services: 40% of the total cost.	Out-of- Network: Diagnostic tests and procedures: \$10 copay. Lab services: \$10 copay.	Out-of- Network: Diagnostic tests and procedures: \$0 copay. Lab services: \$0 copay. Diagnostic Radiology

Benefits / Services	Mass General Brigham Advantage (PPO)	Mass General Brigham Advantage Premier (PPO)	Mass General Brigham Advantage Signature (PPO)
	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.	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.	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.

	In-Network:	In-Network:	In-Network:
	Medicare-	Medicare-	Medicare-
	covered	covered	covered
	hearing exam:	hearing exam:	hearing exam:
	\$50 copay.	\$25 copay.	\$0 copay.
	Routine	Routine	Routine
	hearing exam	hearing exam	hearing exam
	(1 every	(1 every	(1 every
	calendar year):	calendar year):	calendar year):
	\$0 copay when	\$0 copay when	\$0 copay when
	using a	using a	using a
	TruHearing	TruHearing	TruHearing
Hearing	provider.	provider.	provider.
Services	Hearing Aids	Hearing Aids	Hearing Aids
001 11000	(up to 2	(up to 2	(up to 2
	hearing aids	hearing aids	hearing aids
	every year):	every year):	every year):
	\$699	\$699	\$699
	copayment per	copayment per	copayment per
	aid for	aid for	aid for
	TruHearing	TruHearing	TruHearing
	Advanced Aids	Advanced Aids	Advanced Aids
	or a \$999	or a \$999	or a \$999
	copayment per	copayment per	copayment per
	aid for	aid for	aid for
	TruHearing	TruHearing	TruHearing
	Premium Aids.	Premium Aids.	Premium Aids.

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

Benefits /	Mass General	Mass General	Mass General
Services	Brigham	Brigham	Brigham
	Advantage	Advantage	Advantage
	(PPO)	Premier (PPO)	Signature
			(PPO)
	In-Network:	In-Network:	In-Network:
	Medicare-	Medicare-	Medicare-
	Covered dental	Covered dental	Covered dental
	exam: \$50	exam: \$25	exam: \$0
	copay.	copay.	copay.
	Preventive	Preventive	Preventive
	Services: \$0	Services: \$0	Services: \$0
	copay when	copay when	copay when
	using a	using a	using a
Dental	DentaQuest	DentaQuest	DentaQuest
Services	provider.	provider.	provider.
Sel Vices	Comprehensiv	Comprehensiv	Comprehensiv
	e Services: \$0	e Services: \$0	e Services: \$0
	copay when	copay when	copay when
	using a	using a	using a
	DentaQuest	DentaQuest	DentaQuest
	provider.	provider.	provider.
	May require	May require	May require
	prior	prior	prior
	authorization	authorization	authorization
	in-network.	in-network.	in-network.

Out-of-**Network:** Medicare-Covered dental exam: \$65 copay. Preventive Services: \$0 copay* when using a non-**DentaQuest** provider. Comprehensiv e Services: 20% coinsurance* when using a non-**DentaQuest** provider. *If an out of network provider is selected, you will be responsible for the applicable

Out-of-**Network:** Medicare-Covered dental exam: \$40 copay. Preventive Services: \$0 copay* when using a non-**DentaQuest** provider. Comprehensiv e Services: 20% coinsurance* when using a non-**DentaQuest** provider. *If an out of network provider is selected, you will be responsible for the applicable

Out-of-**Network:** Medicare-Covered dental exam: \$0 copay. Preventive Services: \$0 copay* when using a non-**DentaQuest** provider. Comprehensiv e Services: 20% coinsurance* when using a non-**DentaQuest** provider. *If an out of network provider is selected, you will be responsible for the applicable

Benefits / Services	Mass General Brigham Advantage (PPO)	Mass General Brigham Advantage Premier (PPO)	Mass General Brigham Advantage Signature (PPO)
	cost share 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 Comprehensiv e dental	cost share 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 Comprehensiv e dental	cost share 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 Comprehensiv e dental
	services are provided through	services are provided through	services are provided through

Benefits / Services	Mass General Brigham Advantage (PPO)	Mass General Brigham Advantage Premier (PPO)	Mass General Brigham Advantage Signature (PPO)
	DentaQuest.	DentaQuest.	DentaQuest.
	Refer to the	Refer to the	Refer to the
	Evidence of	Evidence of	Evidence of
	Coverage for	Coverage for	Coverage for
	complete	complete	complete
	details.	details.	details.

Benefits / Services	Mass General Brigham Advantage	Mass General Brigham Advantage	Mass General Brigham Advantage
	(PPO)	Premier (PPO)	Signature (PPO)
	In-Network:	In-Network:	In-Network:
	Medicare	Medicare	Medicare
	covered eye	covered eye	covered eye
	exam to	exam to	exam to
	diagnose and	diagnose and	diagnose and
	treat diseases	treat diseases	treat diseases
	and conditions	and conditions	and conditions
	of the eye: \$50	of the eye: \$25	of the eye: \$0
	copay.	copay.	copay
	Routine eye	Routine eye	Routine eye
Vision	exam (1 every	exam (1 every	exam (1 every
Services	calendar year):	calendar year):	calendar year):
	\$0 copay when	\$0 copay when	\$0 copay when
	using an	using an	using an
	EyeMed	EyeMed	EyeMed
	provider.	provider.	provider.
	Eyeglasses or	Eyeglasses or	Eyeglasses or
	contact lenses	contact lenses	contact lenses
	after cataract	after cataract	after cataract
	surgery (for	surgery (for	surgery (for
	Medicare-	Medicare-	Medicare-
	covered	covered	covered

Benefits / Services	Mass General Brigham Advantage (PPO)	Mass General Brigham Advantage Premier (PPO)	Mass General Brigham Advantage Signature (PPO)
	standard	standard	standard
	eyewear): \$0	eyewear): \$0	eyewear): \$0
	copay	copay	copay
	Eyewear: Up to	Eyewear: Up to	Eyewear: Up to
	\$200 per	\$300 per	\$300 per
	calendar year	calendar year	calendar year
	for prescription	for prescription	for prescription
	eyewear or	eyewear or	eyewear or
	contact lenses	contact lenses	contact lenses
	purchased from	purchased from	purchased from
	an EyeMed	an EyeMed	an EyeMed
	provider.	provider.	provider.
	Out-of-	Out-of-	Out-of-
	Network:	Network:	Network:
	Medicare	Medicare	Medicare
	covered eye	covered eye	covered eye
	exam to	exam to	exam to
	diagnose and	diagnose and	diagnose and
	treat diseases	treat diseases	treat diseases
	and conditions	and conditions	and conditions
	of the eye: \$65	of the eye: \$40	of the eye: \$0
	copay.	copay.	copay.

Benefits / Services	Mass General Brigham Advantage (PPO)	Mass General Brigham Advantage Premier (PPO)	Mass General Brigham Advantage Signature (PPO)
	Routine eye	Routine eye	Routine eye
	exam (1 every	exam (1 every	exam (1 every
	calendar year):	calendar year):	calendar year):
	You will receive	You will receive	You will receive
	up to a \$40	up to a \$40	up to a \$40
	reimbursement	reimbursement	reimbursement
	for a routine	for a routine	for a routine
	vision exam	vision exam	vision exam
	received from	received from	received from
	an out-of-	an out-of-	an out-of-
	network	network	network
	provider. You	provider. You	provider. You
	will need to pay	will need to pay	will need to pay
	out of pocket	out of pocket	out of pocket
	and submit to	and submit to	and submit to
	EyeMed for	EyeMed for	EyeMed for
	reimbursement.	reimbursement.	reimbursement.
	Eyeglasses or	Eyeglasses or	Eyeglasses or
	contact lenses	contact lenses	contact lenses
	after cataract	after cataract	after cataract
	surgery (for	surgery (for	surgery (for
	Medicare-	Medicare-	Medicare-

Benefits / Services	Mass General Brigham Advantage (PPO)	Mass General Brigham Advantage Premier (PPO)	Mass General Brigham Advantage Signature (PPO)
	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.	up to a \$300 reimbursement for prescription eyewear or contact lenses when	up to a \$300 reimbursement for prescription eyewear or contact lenses when

Benefits / Services	Mass General Brigham Advantage (PPO)	Mass General Brigham Advantage Premier (PPO)	Mass General Brigham Advantage Signature (PPO)
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	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	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. Individual therapy visit: \$0 copay. Inpatient Mental Health Care: \$0 copay

Benefits / Services	Mass General Brigham Advantage (PPO)	Mass General Brigham Advantage Premier (PPO)	Mass General Brigham Advantage Signature (PPO)
	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.	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.	Prior authorization may apply to Inpatient Mental Health Care innetwork.
Skilled Nursing Facility (SNF)	In-Network: Days 1-20: \$0 copay per day.	In-Network: Days 1-20: \$0 copay per day.	In-Network: \$0 copay per stay. Out-of- Network:

Benefits / Services	Mass General Brigham Advantage (PPO)	Mass General Brigham Advantage Premier (PPO)	Mass General Brigham Advantage Signature (PPO)
	Days 21-44: \$160 copay per day. Days 45-100: \$0 copay per day. Out-of- Network: 30% of the total cost per stay. May require prior	Days 21-44: \$160 copay per day. Days 45-100: \$0 copay per day. Out-of- Network: 20% of the total cost per stay. May require prior	\$0 copay per stay. May require prior authorization in-network.
	authorization in-network.	authorization in-network.	
Outpatient Rehabilitation	In-Network: Occupational therapy visit: \$40 copay. Physical therapy and speech and language	In-Network: Occupational therapy visit: \$20 copay. Physical therapy and speech and language	In-Network: Occupational therapy visit: \$0 copay Physical therapy and speech and language

Benefits / Services	Mass General Brigham Advantage (PPO)	Mass General Brigham Advantage Premier (PPO)	Mass General Brigham Advantage Signature (PPO)
	therapy visit:	therapy visit:	therapy visit:
	\$40 copay.	\$20 copay.	\$0 copay
	Out-of-	Out-of-	Out-of-
	Network:	Network:	Network:
	Occupational	Occupational	Occupational
	therapy visit:	therapy visit:	therapy visit:
	\$65 copay.	\$40 copay.	\$0 copay.
	Physical	Physical	Physical
	therapy and	therapy and	therapy and
	speech and	speech and	speech and
	language	language	language
	therapy visit:	therapy visit:	therapy visit:
	\$65 copay.	\$40 copay.	\$0 copay.
	Prior	Prior	Prior
	authorization is	authorization is	authorization is
	required after	required after	required after
	the 20 th visit in-	the 20 th visit in-	the 20 th visit in-
	network.	network.	network.

Benefits / Services	Mass General Brigham Advantage (PPO)	Mass General Brigham Advantage Premier (PPO)	Mass General Brigham Advantage Signature (PPO)
	In-Network	In-Network	In-Network
	and Out-of-	and Out-of-	and Out-of-
	Network:	Network:	Network:
	Ground	Ground	Ground
	Ambulance:	Ambulance:	Ambulance: \$0
	\$275 copay.	\$200 copay.	copay
	Air Ambulance:	Air Ambulance:	Air Ambulance:
Ambulance	\$275 copay.	\$200 copay.	\$0 copay
	Prior	Prior	Prior
	authorization	authorization	authorization
	required for	required for	required for
	non-emergency	non-emergency	non-emergency
	ambulance	ambulance	ambulance
	services in-	services in-	services in-
	network.	network.	network.
	Up to \$120 per	Up to \$120 per	Up to \$120 per
	quarter (no	quarter (no	quarter (no
	carry over) for	carry over) for	carry over) for
Transportation	non- emergent	non- emergent	non- emergent
	transportation,	transportation,	transportation,
	like taxis,	like taxis,	like taxis,
	public	public	public

Benefits / Services	Mass General Brigham Advantage (PPO)	Mass General Brigham Advantage Premier (PPO)	Mass General Brigham Advantage Signature (PPO)
	transportation	transportation	transportation
	or rideshare for	or rideshare for	or rideshare for
	medical visits.	medical visits.	medical visits.
	Members can use their	Members can use their	Members can use their
	Flexible Benefit	Flexible Benefit	Flexible Benefit
	Card where	Card where	Card where
	Mastercard is	Mastercard is	Mastercard is
	accepted.	accepted.	accepted.
	In-Network:	In-Network:	In-Network:
	For Part B	For Part B	For Part B
	drugs such as	drugs such as	drugs such as
	chemotherapy	chemotherapy	chemotherapy
	drugs: 0% -	drugs: 0% -	drugs: \$0
	20% of the total	20% of the total	copay
	cost.	cost.	Medicare Part
	Medicare Part	Medicare Part	B insulin: \$0
	B insulin: \$35	B insulin: \$35	copay
	copay.	copay.	Other Part B
	Other Part B	Other Part B	drugs: \$0
	drugs: 0% -	drugs: 0% -	copay

Benefits / Services	Mass General Brigham Advantage (PPO)	Mass General Brigham Advantage Premier (PPO)	Mass General Brigham Advantage Signature (PPO)
	20% of the total cost.	20% of the total cost.	
	Out-of- Network:	Out-of- Network:	Out-of- Network:
	For Part B drugs such as chemotherapy drugs: 40% of the total cost.	For Part B drugs such as chemotherapy drugs: 20% of the total cost.	For Part B drugs such as chemotherapy drugs: \$0 copay.
Medicare Part B Drugs (including chemotherapy	Medicare Part B insulin: \$35 copay. Other Part B	Medicare Part B insulin: \$35 copay. Other Part B	Medicare Part B insulin: \$0 copay. Other Part B
	drugs: 40% of the total cost. May require prior authorization for Part B drugs innetwork.	drugs: 20% of the total cost. May require prior authorization for Part B drugs innetwork.	drugs: \$0 copay. May require prior authorization for Part B drugs in- network.

	Up to \$85 per	Up to \$120 per	Up to \$130 per
	quarter (no	quarter (no	quarter (no
	carryover)	carryover)	carryover)
	toward over-	toward over-	toward over-
	the-counter	the-counter	the-counter
	health &	health &	health &
	wellness	wellness	wellness
	products.	products.	products.
	Members will	Members will	Members will
	receive a	receive a	receive a
	Flexible	Flexible	Flexible
Over-the-	Benefits Card	Benefits Card	Benefits Card
Counter Items	to purchase	to purchase	to purchase
(OTC)	eligible items at	eligible items at	eligible items at
(010)	participating	participating	participating
	retailers where	retailers where	retailers where
	Mastercard is	Mastercard is	Mastercard is
	accepted.	accepted.	accepted.
	Members may	Members may	Members may
	also ask to	also ask to	also ask to
	receive a	receive a	receive a
	catalog and	catalog and	catalog and
	purchase	purchase	purchase
	eligible items	eligible items	eligible items
	online, phone,	online, phone,	online, phone,
	or by mail.	or by mail.	or by mail.

Benefits /	Mass General	Mass General	Mass General
Services	Brigham	Brigham	Brigham
	Advantage	Advantage	Advantage
	(PPO)	Premier (PPO)	Signature
			(PPO)
	Up to a \$450	Up to a \$450	Up to a \$450
	combined	combined	combined
	annual	annual	annual
	allowance to	allowance to	allowance to
	use towards	use towards	use towards
	fitness, eligible	fitness, eligible	fitness, eligible
	weight loss	weight loss	weight loss
	programs or	programs or	programs or
	costs toward	costs toward	costs toward
Wellness	your	your	your
Benefit	prescription	prescription	prescription
	hearing aids	hearing aids	hearing aids
	using a Flexible	using a Flexible	using a Flexible
	Benefit card.	Benefit card.	Benefit card.
	All purchases	All purchases	All purchases
	must be done	must be done	must be done
	per your	per your	per your
	benefits where	benefits where	benefits where
	Mastercard® is	Mastercard® is	Mastercard® is
	accepted.	accepted.	accepted.

PRESCRIPTION DRUG BENEFITS

Benefits/Services Mass Mass Mass General General General Brigham Brigham **Brigham** Advantage Advantage Advantage (PPO) **Premier Signature** (PPO) (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	33%	33%	33%
Tier)	Coinsurance	Coinsurance	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	Not		
Tier)	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	Not		
Tier)	Applicable	Not Applicable	Not Applicable
	•	·	

	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	33%	33%	33%
Tier)	Coinsurance	Coinsurance	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	Not		
Tier)	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	Not		
Tier)	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 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)

15308-0725-01

8:00 AM to 8:00 PM, EST Monday through Sunday

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.