2026 Summary of Benefits

Medicare Advantage Plans with Part D Prescription Drug Coverage

Mass General Brigham Advantage Secure (HMO-POS)

January 1, 2026 – December 31, 2026

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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 at 1-855-833-3668 (TTY: 711) and ask for the "**Evidence of Coverage**." You can also see the Evidence of Coverage on our website, MGBAdvantage.org.

You have choices about how to get your Medicare benefits

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

Tips for comparing your Medicare choices

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

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

Sections in this booklet

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

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

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

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

Hours of Operation & Contact Information

- From October 1 to March 31, we're open 8 a.m. – 8 p.m., 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: MGBAdvantage.org.

Who can join?

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

Which doctors, hospitals, and pharmacies can I use?

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

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

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

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

What do we cover?

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

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

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

How will I determine my drug costs?

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

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Premiums and Benefits	**Mass General Brigham Advantage Secure (HMO-POS)**
Monthly Plan Premium (includes both medical and drugs)	$62 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: $350 for Tiers 3, 4 and 5 except for covered insulin products and most adult Part D vaccines. Deductible is not applicable on tiers 1 and 2.
Maximum Out-of-Pocket Responsibility (does not include Part D prescription drugs)	Your yearly limit(s) in this plan: • $3,350 for services you receive from in-network providers. • $7,000 for services you receive from in-network and out-of-network providers combined. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.
COVERED MEDICAL AND HOSPITAL BENEFITS	
Benefits/Services	**Mass General Brigham Advantage Secure (HMO-POS)**
Inpatient Hospital	**In-Network:** Days 1-5: $250 copay per day for each admission. Days 6 and beyond: $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 both in-network and out-of-network.

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

Emergency Care	**<u>In-Network and Out-of-Network:</u>** $130 copay per visit. Worldwide Emergency Coverage: $130 copay (see details on maximum coverage limit under **Worldwide Emergency Coverage, Worldwide Urgent Coverage and Worldwide Emergency Transportation**). Your copay is waived if you are admitted to a hospital within 24 hours.
Urgently Needed Services	**<u>In-Network and Out-of-Network:</u>** $50 copay per visit. Worldwide Urgent Coverage: $50 copay (see details on maximum coverage limit under **Worldwide Emergency Coverage, Worldwide Urgent Coverage and Worldwide Emergency Transportation**).
Diagnostic Services / Labs/ Imaging	**<u>In-Network:</u>** Diagnostic tests and procedures: $20 copay. Lab services: $0 copay Diagnostic Radiology Services (such as MRI, CAT Scan): $75 copay - $160 copay X-rays: $10 copay. Therapeutic radiology services (such as radiation treatment for cancer): $60 copay. **<u>Out-of-Network:</u>** Diagnostic tests and procedures: 20% of the total cost. Lab services: 20% of the total cost. Diagnostic Radiology Services (such as MRI, CAT Scan): 20% of the total cost. X-rays: 20% of the total cost. Therapeutic radiology services (such as radiation treatment for cancer): 20% of the total cost. Prior authorization may be required in-network and out-of-network.
Hearing Services	**<u>In-Network:</u>** Medicare-covered hearing exam: $45 copay. Routine hearing exam (1 every calendar year): $0 copay when using a TruHearing provider. Hearing Aids (up to 2 hearing aids every year): $699 copayment per aid for TruHearing Advanced Aids or a $999 copayment per aid for TruHearing Premium Aids.

	Out-of-Network: Medicare-covered hearing exam: $50 copay. Routine hearing exam: Not covered. Hearing Aids: Not covered.
Dental Services	**In-Network:** Medicare-Covered dental exam: $45 copay. Preventive Services: $0 copay when using a DentaQuest provider. Comprehensive Services: $0 copay when using a DentaQuest provider. **Out-of-Network:** Medicare-Covered dental exam: $50 copay. Preventive Services: $0 copay* when using a non-DentaQuest provider. Comprehensive Services: 20% coinsurance* when using a non-DentaQuest provider. *If an out of network provider is selected, you will be responsible for the applicable cost share plus the difference between the billed amount and the allowed amount. $2,000 combined in-network and out-of-network maximum per calendar year for comprehensive services. Preventive and Comprehensive dental services are provided through DentaQuest. Refer to the Evidence of Coverage for complete details. Prior authorization may be required for certain services in-network and out-of-network. Clinical criteria guidelines are used when reviewing pre-treatment estimates, prior authorization requests and/or claims for in-network and out of network services. The criteria used are generally accepted dental standards and information gathered from practicing dentists and dental organizations such as the American Dental Association.
Vision Services	**In-Network:** Medicare-covered exam to diagnose and treat diseases and conditions of the eye: $45 copay. Routine eye exam (1 every calendar year): $0 copay when using an EyeMed provider. Eyeglasses or contact lenses after cataract surgery (for Medicare-covered standard eyewear): $0 copay. Routine eyewear: Up to $250 per calendar year for prescription eyewear or contact lenses purchased from an EyeMed provider.

	Out-of-Network: Medicare-covered exam to diagnose and treat diseases and conditions of the eye: $50 copay. Routine eye exam (1 every calendar year): You will receive up to a $40 reimbursement for a routine vision exam received from an out-of-network provider. You will need to pay out of pocket and submit to EyeMed for reimbursement. Eyeglasses or contact lenses after cataract surgery (for Medicare-covered standard eyewear): $50 copay. Routine eyewear: You will receive up to a $250 reimbursement for prescription eyewear or contact lenses when purchased from an out-of-network provider. You will need to pay out of pocket and submit to EyeMed for reimbursement.
Mental Health Care	**In-Network:** Outpatient group therapy visit: $20 copay. Individual therapy visit: $20 copay. Inpatient Mental Health Care: Days 1-5: $250 copay per day for each admission. Days 6 and beyond: $0 copay per day. **Out-of-Network:** Outpatient group therapy visit: $50 copay. Individual therapy visit: $50 copay. Inpatient Mental Health Care: 30% of the total cost per stay. Notification is required within 72 hours of admission. Before you receive in-network or out-of network inpatient services (except emergency and urgently needed services), your provider must first obtain prior authorization.
Skilled Nursing Facility (SNF)	**In-Network:** Days 1-20: $0 copay per day. Days 21-44: $160 copay per day. Days 45-100: $0 copay per day. **Out-of-Network:** 30% of the total cost per stay.

	Prior authorization may be required in-network and out-of-network.
Outpatient Rehabilitation	**<u>In-Network:</u>** Occupational therapy visit: $15 copay. Physical therapy and speech and language therapy visit: $15 copay. **<u>Out-of-Network:</u>** Occupational therapy visit: $50 copay. Physical therapy and speech and language therapy visit: $50 copay. Prior authorization is required after the 20th visit in-network and out-of-network.
Ambulance	**<u>In-Network and Out-of-Network:</u>** Ground Ambulance: $300 copay. Air Ambulance: $300 copay. Worldwide Emergency Transportation: $300 copay (see details on maximum coverage limit under **Worldwide Emergency Coverage, Worldwide Urgent Coverage and Worldwide Emergency Transportation**). Prior authorization required for non-emergency ambulance services in-network and out-of-network.
Transportation	Up to $120 per quarter allowance for non-emergent transportation to medical visits and to pick up prescriptions from the pharmacy. Transportation includes but not limited to taxis, public transportation, rideshare and ferry boats. The quarterly allowance does not carry over quarter to quarter. The allowance will be automatically loaded onto your Flexible Benefit Mastercard. New members will receive their Flexible Benefit Mastercard upon their enrollment in the plan. Existing Medicare Advantage members continue to use their existing card until it expires or disenroll from the plan.
Medicare Part B Drugs (including chemotherapy)	**<u>In-Network:</u>** For Part B drugs such as chemotherapy drugs: 0% - 20% of the total cost. Medicare Part B insulin: up to a $35 copay. Other Part B drugs: 0% - 20% of the total cost. **<u>Out-of-Network:</u>** For Part B drugs such as chemotherapy drugs: 20% of the total cost. Medicare Part B insulin: up to a $35 copay. Other Part B drugs: 20% of the total cost. Prior authorization for Part B drugs may be required in-network and out-of-network.

	Certain Part B prescription drugs may be subject to Part B step therapy* Refer to the list of covered drugs (Formulary). Visit our website at MGBAdvantage.org or call Customer Service at 1-855-833-3668 (TTY: 711). *Trying certain drugs for your medical condition before coverage of another drug for that same condition.
Over-the-Counter Items (OTC)	Up to $95 per quarter allowance to purchase eligible OTC items at participating retailers. The quarterly allowance does not carry over quarter to quarter. The allowance is automatically loaded onto your Flexible Benefit Mastercard. New members will receive their Flexible Benefit Mastercard upon enrollment in the plan. Existing Medicare Advantage members continue to use their existing card until it expires or disenrolls from the plan. A mobile app is available to search for eligible products while shopping. Members may also ask to receive a catalog to purchase eligible items online, by phone or by mail.
Wellness Benefit	Up to $450 combined annual allowance to use towards eligible fitness, weight loss programs or costs toward your prescription hearing aids. The annual allowance does not carry over. The allowance will be automatically loaded onto your Flexible Benefit Mastercard. New members will receive their Flexible Benefit Mastercard upon their enrollment in the plan. Existing Medicare Advantage members continue to use their existing card until it expires or disenroll from the plan. Members can use their Flexible Benefit Card where Mastercard® is accepted.
Annual Wellness Visit Reward	$50 reward for completing your annual wellness visit*. The reward will be automatically loaded onto your Flexible Benefit Mastercard. New members will receive their Flexible Benefit Mastercard upon their enrollment in the plan. Existing Medicare Advantage members continue to use their existing card until it expires or disenroll from the plan. *Medicare-covered Annual Wellness Visit does not include your “Welcome to Medicare Visit.” The “Welcome to Medicare Visit” is a one-time appointment for new Medicare enrollees done in their first year. The Medicare-covered Annual Wellness Visit is scheduled every year, 12-months after your “Welcome to Medicare” visit. This exam is different from your physical because it focuses on preventative care and doesn’t include comprehensive examination which includes vital signs, blood tests and other diagnostic tests or valuation of other health concerns.
Worldwide Emergency Coverage,	$50,000 maximum coverage limit.

Worldwide Urgent Coverage and Worldwide Emergency Transportation	Limited services classified as emergency or post stabilization care had they been provided in the US or its territories. Part D prescription drugs obtained at a retail pharmacy not covered. Foreign taxes and fees (including but not limited to currency conversion or transaction fees) are not covered.

<table>
<tr><th colspan="2">PRESCRIPTION DRUG BENEFITS</th></tr>
<tr><td>Deductible</td><td>Prescription Drug Deductible: $350 for Tiers 3, 4 and 5 except for covered insulin products and most adult Part D vaccines. Deductible is not applicable on tiers 1 and 2.</td></tr>
<tr><td>Initial Coverage</td><td>You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $2,100. You then move on to the Catastrophic Coverage Stage.
<table>
<tr><th colspan="4">Standard Retail Cost-Sharing</th></tr>
<tr><th>Tier</th><th>One-month supply</th><th>Two-month supply</th><th>Three-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 copay</td><td>$0 copay</td><td>$0 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$5 copay</td><td>$10 copay</td><td>$15 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$47 copay</td><td>$94 copay</td><td>$141 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>25% coinsurance</td><td>25% coinsurance</td><td>25% coinsurance</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>29% coinsurance</td><td>N/A</td><td>N/A</td></tr>
<tr><th colspan="4">Standard Mail Order</th></tr>
<tr><th>Tier</th><th>One-month supply</th><th>Two-month supply</th><th>Three-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 copay</td><td>$0 copay</td><td>$0 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$5 copay</td><td>$10 copay</td><td>$10 copay</td></tr>
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<tr><td>Tier 5
(Specialty Tier)</td><td>29% coinsurance</td><td>N/A</td><td>N/A</td></tr>
</table>
If you reside in a long-term care facility, you pay the same as at a retail pharmacy.
</td></tr>
<tr><td>Catastrophic Coverage</td><td>After your yearly out-of-pocket drug costs reach $2,100, 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.</td></tr>
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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

Customer Service also has free language interpreter services available for non-English speakers.

This document is available in other alternate formats.

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

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

You must continue to pay your Medicare Part B premium.

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

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