

2027 Summary of Benefits

Medicare Advantage Plans with Part D Prescription Drug Coverage

Mass General Brigham Advantage Core (HMO-POS)

Mass General Brigham Advantage Secure (HMO-POS)

Mass General Brigham Advantage Plus (HMO-POS)

January 1, 2027 – December 31, 2027

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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](https://www.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 Core (HMO-POS)**, **Mass General Brigham Advantage Secure (HMO-POS)** and **Mass General Brigham Advantage Plus (HMO-POS)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Mass General Brigham Advantage Core (HMO-POS)**, **Mass General Brigham Advantage Secure (HMO-POS)** and **Mass General Brigham Advantage Plus (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 Core (HMO-POS)**, **Mass General Brigham Advantage Secure (HMO-POS)** and **Mass General Brigham Advantage Plus (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 Core (HMO-POS), Mass General Brigham Advantage Secure (HMO-POS) and Mass General Brigham Advantage Plus (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 Core (HMO-POS)**, **Mass General Brigham Advantage Secure (HMO-POS)** and **Mass General Brigham Advantage Plus (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 Core (HMO-POS), **Mass General Brigham Advantage Secure (HMO-POS)** and **Mass General Brigham Advantage Plus (HMO-POS)** have a network of doctors, hospitals, pharmacies, and other providers. In general, you must receive services from an in-network provider. Most services you receive from an out-of-network provider will not be covered. There are covered services you can use out-of-network providers for, but your cost share may be more than with in-network providers. Please see your plan documents for specific coverage information. If you use the providers that are not in our network, you may pay more.

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

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

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

What do we cover?

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

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

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, MGBAdvantage.org.

- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

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

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SECTION II - SUMMARY OF BENEFITS

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

Benefits/Services	Mass General Brigham Advantage Core (HMO-POS)	Mass General Brigham Advantage Secure (HMO-POS)	Mass General Brigham Advantage Plus (HMO-POS)
Monthly Plan Premium (includes both medical and drugs)	You do not pay a separate monthly plan premium for Mass General Brigham Advantage Core (HMO-POS). You must continue to pay your Medicare Part B premium.	\$60 per month. In addition, you must continue to pay your Medicare Part B premium.	\$180 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: \$700 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.	Medical Deductible: This plan does not have a medical deductible. Prescription Drug Deductible: \$700 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.	Medical Deductible: This plan does not have a medical deductible. Prescription Drug Deductible: \$700 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: \$7,150 for services you receive from	Your yearly limit(s) in this plan: \$5,000 for services you receive from	Your yearly limit(s) in this plan: \$4,500 for services you receive from

	in-network providers. • \$7,150 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. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	in-network providers. • \$5,000 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. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	in-network providers. • \$4,500 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. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
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COVERED MEDICAL AND HOSPITAL BENEFITS

Benefits/Services	Mass General Brigham Advantage Core (HMO-POS)	Mass General Brigham Advantage Secure (HMO-POS)	Mass General Brigham Advantage Plus (HMO-POS)
Inpatient Hospital (See Mental Health Care section for Inpatient Mental Health Care)	<u>In-Network:</u> Days 1-5: \$550 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. May require prior authorization in-network.	<u>In-Network:</u> Days 1-5: \$275 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. May require prior authorization in-network.	<u>In-Network:</u> Days 1-5: \$235 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. May require prior authorization in-network.

Benefits/Services	Mass General Brigham Advantage Core (HMO-POS)	Mass General Brigham Advantage Secure (HMO-POS)	Mass General Brigham Advantage Plus (HMO-POS)
	<u>Out-of-Network:</u> Not Covered.	<u>Out-of-Network:</u> Not Covered.	<u>Out-of-Network:</u> Not Covered.
Outpatient Hospital	<u>In-Network:</u> Outpatient hospital: \$0 - \$475 copay. Outpatient Surgery: \$0 - \$475 copay. You pay \$0 copay for preventive colonoscopies that turn into diagnostic colonoscopies. All other procedures are a \$475 copay. May require prior authorization in-network. <u>Out-of-Network:</u> Outpatient hospital: Not Covered. Outpatient Surgery: Not Covered.	<u>In-Network:</u> 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. May require prior authorization in-network. <u>Out-of-Network:</u> Outpatient hospital: Not Covered. Outpatient Surgery: Not Covered.	<u>In-Network:</u> Outpatient hospital: \$0 - \$250 copay. Outpatient Surgery: \$0 - \$250 copay. You pay \$0 copay for preventive colonoscopies that turn into diagnostic colonoscopies. All other procedures are a \$250 copay. May require prior authorization in-network. <u>Out-of-Network:</u> Outpatient hospital: Not Covered. Outpatient Surgery: Not Covered.
Ambulatory Surgical Center	<u>In-Network:</u> Ambulatory Surgical Center: \$0 - \$475 copay. You pay \$0 copay for preventive colonoscopies that turn into diagnostic colonoscopies. All other	<u>In-Network:</u> Ambulatory Surgical Center: \$0 - \$300 copay. You pay \$0 copay for preventive colonoscopies that turn into diagnostic colonoscopies. All other	<u>In-Network:</u> Ambulatory Surgical Center: \$0 - \$250 copay. You pay \$0 copay for preventive colonoscopies that turn into diagnostic colonoscopies. All other

Benefits/Services	Mass General Brigham Advantage Core (HMO-POS)	Mass General Brigham Advantage Secure (HMO-POS)	Mass General Brigham Advantage Plus (HMO-POS)
	procedures are a \$475 copay. May require prior authorization in-network. <u>Out-of-Network:</u> Ambulatory Surgical Center: Not Covered.	procedures are a \$300 copay. May require prior authorization in-network. <u>Out-of-Network:</u> Ambulatory Surgical Center: Not Covered.	procedures are a \$250 copay. May require prior authorization in-network. <u>Out-of-Network:</u> Ambulatory Surgical Center: Not Covered.
Doctor's Office Visits	<u>In-Network:</u> Primary care physician visit: \$0 copay Specialist visit: \$60 copay. <u>Out-of-Network:</u> Primary care physician visit: \$30 copay. Specialist visit: \$85 copay. May require a referral from your primary care provider for specialist office visits.	<u>In-Network:</u> Primary care physician visit: \$0 copay Specialist visit: \$45 copay. <u>Out-of-Network:</u> Primary care physician visit: \$30 copay. Specialist visit: \$60 copay. May require a referral from your primary care provider for specialist office visits.	<u>In-Network:</u> Primary care physician visit: \$0 copay Specialist visit: \$35 copay. <u>Out-of-Network:</u> Primary care physician visit: \$30 copay. Specialist visit: \$60 copay. May require a referral from your primary care provider for specialist office visits.

Benefits/Services	Mass General Brigham Advantage Core (HMO-POS)	Mass General Brigham Advantage Secure (HMO-POS)	Mass General Brigham Advantage Plus (HMO-POS)
Preventive Care <i>(e.g., flu vaccine, diabetic screenings)</i>	<u>In-Network:</u> \$0 copay for all preventive services covered under Original Medicare. Any additional preventive services approved by Medicare during the contract year will be covered. <u>Out-of-Network:</u> \$30 copay for all preventive services covered under Original Medicare.	<u>In-Network:</u> \$0 copay for all preventive services covered under Original Medicare. Any additional preventive services approved by Medicare during the contract year will be covered. <u>Out-of-Network:</u> \$30 copay for all preventive services covered under Original Medicare.	<u>In-Network:</u> \$0 copay for all preventive services covered under Original Medicare. Any additional preventive services approved by Medicare during the contract year will be covered. <u>Out-of-Network:</u> \$30 copay for all preventive services covered under Original Medicare.
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 the hospital within 24 hours.	<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 the hospital within 24 hours.	<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 the hospital within 24 hours.

Benefits/Services	Mass General Brigham Advantage Core (HMO-POS)	Mass General Brigham Advantage Secure (HMO-POS)	Mass General Brigham Advantage Plus (HMO-POS)
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).	<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).	<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. May require prior authorization in-network. Lab services: \$0 copay May require prior authorization in-network. Diagnostic Radiology Services (such as MRI, CT Scan): \$150 copay - \$250 copay May require prior authorization in-network. X-rays: \$50 copay.	<u>In-Network:</u> Diagnostic tests and procedures: \$20 copay. May require prior authorization in-network. Lab services: \$0 copay May require prior authorization in-network. Diagnostic Radiology Services (such as MRI, CT Scan): \$75 copay - \$200 copay May require prior authorization in-network. X-rays: \$30 copay.	<u>In-Network:</u> Diagnostic tests and procedures: \$20 copay. May require prior authorization in-network. Lab services: \$0 copay May require prior authorization in-network. Diagnostic Radiology Services (such as MRI, CT Scan): \$100 copay - \$200 copay May require prior authorization in-network. X-rays: \$25 copay.

Benefits/Services	Mass General Brigham Advantage Core (HMO-POS)	Mass General Brigham Advantage Secure (HMO-POS)	Mass General Brigham Advantage Plus (HMO-POS)
	May require prior authorization in-network. Therapeutic radiology services (such as radiation treatment for cancer): \$60 copay. May require prior authorization in-network. <u>Out-of-Network:</u> Diagnostic tests and procedures: \$25 copay. May require prior authorization out-of-network. Lab services: \$25 copay. May require prior authorization out-of-network. Diagnostic Radiology Services (such as MRI, CT Scan): Not Covered. X-rays: Not Covered. Therapeutic radiology services (such as radiation treatment for cancer): Not Covered.	May require prior authorization in-network. Therapeutic radiology services (such as radiation treatment for cancer): \$60 copay. May require prior authorization in-network. <u>Out-of-Network:</u> Diagnostic tests and procedures: \$25 copay. May require prior authorization out-of-network. Lab services: \$25 copay. May require prior authorization out-of-network. Diagnostic Radiology Services (such as MRI, CT Scan): Not Covered. X-rays: Not Covered. Therapeutic radiology services (such as radiation treatment for cancer): Not Covered.	May require prior authorization in-network. Therapeutic radiology services (such as radiation treatment for cancer): \$30 copay. May require prior authorization in-network. <u>Out-of-Network:</u> Diagnostic tests and procedures: \$25 copay. May require prior authorization out-of-network. Lab services: \$25 copay. May require prior authorization out-of-network. Diagnostic Radiology Services (such as MRI, CT Scan): Not Covered. X-rays: Not Covered. Therapeutic radiology services (such as radiation treatment for cancer): Not Covered.

Benefits/Services	Mass General Brigham Advantage Core (HMO-POS)	Mass General Brigham Advantage Secure (HMO-POS)	Mass General Brigham Advantage Plus (HMO-POS)
Hearing Services	<u>In-Network:</u> 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. <u>Out-of-Network:</u> Medicare-covered hearing exam: Not Covered. Routine hearing exam: Not Covered. Hearing Aids: Not Covered.	<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. <u>Out-of-Network:</u> Medicare-covered hearing exam: Not Covered. Routine hearing exam: Not Covered. Hearing Aids: Not Covered.	<u>In-Network:</u> Medicare-covered hearing exam: \$30 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. <u>Out-of-Network:</u> Medicare-covered hearing exam: Not Covered. Routine hearing exam: Not Covered. Hearing Aids: Not Covered.
Dental Services	<u>In-Network:</u> Medicare-Covered dental exam: \$50 copay. Preventive Services: \$0 copay when using a DentaQuest provider.	<u>In-Network:</u> Medicare-Covered dental exam: \$45 copay. Preventive Services: \$0 copay when using a DentaQuest provider.	<u>In-Network:</u> Medicare-Covered dental exam: \$30 copay. Preventive Services: \$0 copay when using a DentaQuest provider.

Benefits/Services	Mass General Brigham Advantage Core (HMO-POS)	Mass General Brigham Advantage Secure (HMO-POS)	Mass General Brigham Advantage Plus (HMO-POS)
	Comprehensive Services: Not Covered. Clinical criteria guidelines are used when reviewing pre-treatment estimates, prior authorization requests and/or claims for in-network and out-of-network. The criteria used are generally accepted dental standards and information gathered from practicing dentists and dental organizations such as the American Dental Association. For list of preventive covered procedure codes, go to mgbadvantage.org/plans/benefits. <u>Out-of-Network:</u> Medicare-Covered dental exam: Not Covered. Preventive Services: 50% coinsurance* when using a non-DentaQuest provider. Comprehensive Services: Not Covered.	Comprehensive Services: \$0 copay when using a DentaQuest provider. 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. The criteria used are generally accepted dental standards and information gathered from practicing dentists and dental organizations such as the American Dental Association. For list of preventive covered procedure codes, go to mgbadvantage.org/plans/benefits. <u>Out-of-Network:</u> Medicare-Covered dental exam: Not Covered. Preventive Services: 50% coinsurance* when using	Comprehensive Services: \$0 copay when using a DentaQuest provider. 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. The criteria used are generally accepted dental standards and information gathered from practicing dentists and dental organizations such as the American Dental Association. For list of preventive covered procedure codes, go to mgbadvantage.org/plans/benefits. <u>Out-of-Network:</u> Medicare-Covered dental exam: Not Covered. Preventive Services: 50% coinsurance* when using

Benefits/Services	Mass General Brigham Advantage Core (HMO-POS)	Mass General Brigham Advantage Secure (HMO-POS)	Mass General Brigham Advantage Plus (HMO-POS)
	No combined in-network and out-of-network maximum per calendar year for comprehensive services. *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.	a non-DentaQuest provider. Comprehensive Services: 50% coinsurance* when using a non-DentaQuest provider. \$800 combined in-network and out-of-network maximum per calendar year for comprehensive services. *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.	a non-DentaQuest provider. Comprehensive Services: 50% coinsurance* when using a non-DentaQuest provider. \$1,000 combined in-network and out-of-network maximum per calendar year for comprehensive services. *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.
Vision Services	<u>In-Network:</u> 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-	<u>In-Network:</u> Medicare covered eye 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-	<u>In-Network:</u> Medicare covered eye exam to diagnose and treat diseases and conditions of the eye: \$30 copay. Routine eye exam (1 every calendar year): \$0 copay when using an EyeMed provider. Eyeglasses or contact lenses after cataract surgery (for Medicare-

Benefits/Services	Mass General Brigham Advantage Core (HMO-POS)	Mass General Brigham Advantage Secure (HMO-POS)	Mass General Brigham Advantage Plus (HMO-POS)
	covered standard eyewear): \$0 copay Routine eyewear: Up to \$150 per calendar year for prescription eyewear or contact lenses purchased from an EyeMed provider. <u>Out-of-Network:</u> Medicare covered eye exam to diagnose and treat diseases and conditions of the eye: Not Covered. Routine eye exam: Not Covered. Eyeglasses or contact lenses after cataract surgery (for Medicare-covered standard eyewear): Not Covered. Routine eyewear: Not Covered.	covered standard eyewear): \$0 copay Routine eyewear: Up to \$200 per calendar year for prescription eyewear or contact lenses purchased from an EyeMed provider. <u>Out-of-Network:</u> Medicare covered eye exam to diagnose and treat diseases and conditions of the eye: Not Covered. Routine eye exam: Not Covered. Eyeglasses or contact lenses after cataract surgery (for Medicare-covered standard eyewear): Not Covered. Routine eyewear: Not Covered.	covered standard eyewear): \$0 copay Routine eyewear: Up to \$250 per calendar year for prescription eyewear or contact lenses purchased from an EyeMed provider. <u>Out-of-Network:</u> Medicare covered eye exam to diagnose and treat diseases and conditions of the eye: Not Covered. Routine eye exam: Not Covered. Eyeglasses or contact lenses after cataract surgery (for Medicare-covered standard eyewear): Not Covered. Routine eyewear: Not Covered.
Mental Health Care	<u>In-Network:</u> Outpatient group therapy visit: \$35 copay. Individual therapy visit: \$35 copay. Inpatient Mental Health Care:	<u>In-Network:</u> Outpatient group therapy visit: \$20 copay. Individual therapy visit: \$20 copay. Inpatient Mental Health Care:	<u>In-Network:</u> Outpatient group therapy visit: \$15 copay. Individual therapy visit: \$15 copay. Inpatient Mental Health Care:

Benefits/Services	Mass General Brigham Advantage Core (HMO-POS)	Mass General Brigham Advantage Secure (HMO-POS)	Mass General Brigham Advantage Plus (HMO-POS)
	Days 1-5: \$425 copay per day for each admission. Days 6 and beyond: \$0 copay per day. <u>Out-of-Network:</u> Outpatient group therapy visit: \$85 copay. Individual therapy visit: \$85 copay. Inpatient Mental Health Care: Not Covered.	Days 1-5: \$275 copay per day for each admission. Days 6 and beyond: \$0 copay per day. <u>Out-of-Network:</u> Outpatient group therapy visit: \$60 copay. Individual therapy visit: \$60 copay. Inpatient Mental Health Care: Not Covered.	Days 1-5: \$235 copay per day for each admission. Days 6 and beyond: \$0 copay per day. <u>Out-of-Network:</u> Outpatient group therapy visit: \$60 copay. Individual therapy visit: \$60 copay. Inpatient Mental Health Care: Not Covered.
Skilled Nursing Facility (SNF)	<u>In-Network:</u> Days 1-20: \$0 copay per day. Days 21-44: \$200 copay per day. Days 45-100: \$0 copay per day. May require prior authorization in-network. <u>Out-of-Network:</u> Not Covered.	<u>In-Network:</u> Days 1-20: \$0 copay per day. Days 21-44: \$160 copay per day. Days 45-100: \$0 copay per day. May require prior authorization in-network. <u>Out-of-Network:</u> Not Covered.	<u>In-Network:</u> Days 1-20: \$0 copay per day. Days 21-44: \$150 copay per day. Days 45-100: \$0 copay per day. May require prior authorization in-network. <u>Out-of-Network:</u> Not Covered.
Outpatient Rehabilitation	<u>In-Network:</u> Occupational Therapy Visit: \$50 copay per visit. Physical therapy and speech and language therapy visit: \$65 copay.	<u>In-Network:</u> Occupational Therapy Visit: \$25 copay per visit. Physical therapy and speech and language therapy visit: \$25 copay.	<u>In-Network:</u> Occupational Therapy Visit: \$25 copay per visit. Physical therapy and speech and language therapy visit: \$25 copay.

Benefits/Services	Mass General Brigham Advantage Core (HMO-POS)	Mass General Brigham Advantage Secure (HMO-POS)	Mass General Brigham Advantage Plus (HMO-POS)
	Prior authorization is required after the 20th visit in-network. <u>Out-of-Network:</u> Occupational Therapy Visit, Physical Therapy Visit and Speech and Language Therapy Visit: Not Covered.	Prior authorization is required after the 20th visit in-network. <u>Out-of-Network:</u> Occupational Therapy Visit, Physical Therapy Visit and Speech and Language Therapy Visit: Not Covered.	Prior authorization is required after the 20th visit in-network. <u>Out-of-Network:</u> Occupational Therapy Visit, Physical Therapy Visit and Speech and Language Therapy Visit: Not Covered.
Ambulance	<u>In-Network:</u> Ground Ambulance: \$350 copay. Air Ambulance: \$350 copay. Worldwide Emergency Transportation: \$350 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. <u>Out-of-Network:</u> Non-emergency ambulance services: Not Covered.	<u>In-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. <u>Out-of-Network:</u> Non-emergency ambulance services: Not Covered.	<u>In-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. <u>Out-of-Network:</u> Non-emergency ambulance services: Not Covered.

Benefits/Services	Mass General Brigham Advantage Core (HMO-POS)	Mass General Brigham Advantage Secure (HMO-POS)	Mass General Brigham Advantage Plus (HMO-POS)
Transportation	Up to \$50 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.	Up to \$75 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.	Up to \$100 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.

Benefits/Services	Mass General Brigham Advantage Core (HMO-POS)	Mass General Brigham Advantage Secure (HMO-POS)	Mass General Brigham Advantage Plus (HMO-POS)
Medicare Part B Drugs (including chemotherapy)	<u>In-Network:</u> Part B drugs, such as Chemotherapy and other covered Part B medications: 0% - 20% of the total cost. Medicare Part B insulin: up to a \$35 copay. May require prior authorization for Part B drugs in-network. <u>Out-of-Network:</u> Part B drugs, such as Chemotherapy and other covered Part B medications: Not Covered. Medicare Part B insulin: Not Covered. 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	<u>In-Network:</u> Part B drugs, such as Chemotherapy and other covered Part B medications: 0% - 20% of the total cost. Medicare Part B insulin: up to a \$35 copay. May require prior authorization for Part B drugs in-network. <u>Out-of-Network:</u> Part B drugs, such as Chemotherapy and other covered Part B medications: Not Covered. Medicare Part B insulin: Not Covered. 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	<u>In-Network:</u> Part B drugs, such as Chemotherapy and other covered Part B medications: 0% - 20% of the total cost. Medicare Part B insulin: up to a \$35 copay. May require prior authorization for Part B drugs in-network. <u>Out-of-Network:</u> Part B drugs, such as Chemotherapy and other covered Part B medications: Not Covered. Medicare Part B insulin: Not Covered. 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

Benefits/Services	Mass General Brigham Advantage Core (HMO-POS)	Mass General Brigham Advantage Secure (HMO-POS)	Mass General Brigham Advantage Plus (HMO-POS)
	another drug for that same condition.	another drug for that same condition.	another drug for that same condition.
Over-the-Counter Items (OTC)	Not Covered	Up to \$30 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 their enrollment in the plan. Existing Medicare Advantage members continue to use their existing card until it expires or disenroll 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, phone or by mail.	Up to \$65 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 their enrollment in the plan. Existing Medicare Advantage members continue to use their existing card until it expires or disenroll 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, phone or by mail.
Wellness Benefit	Up to \$105 combined annual allowance to use towards eligible fitness programs, home fitness equipment or costs toward your prescription	Up to \$160 combined annual allowance to use towards eligible fitness programs, home fitness equipment or costs toward your prescription	Up to \$250 combined annual allowance to use towards eligible fitness programs, home fitness equipment or costs toward your prescription

Benefits/Services	Mass General Brigham Advantage Core (HMO-POS)	Mass General Brigham Advantage Secure (HMO-POS)	Mass General Brigham Advantage Plus (HMO-POS)
	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.	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.	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.
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.	\$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.	\$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.

Benefits/Services	Mass General Brigham Advantage Core (HMO-POS)	Mass General Brigham Advantage Secure (HMO-POS)	Mass General Brigham Advantage Plus (HMO-POS)
	*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.	*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.	*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, Worldwide Urgent Coverage and Worldwide Emergency Transportation	\$50,000 maximum coverage limit. Limited services classified as emergency or post stabilization care had they been provided in the US or its territories. Part D	\$50,000 maximum coverage limit. Limited services classified as emergency or post stabilization care had they been provided in the US or its territories. Part D	\$50,000 maximum coverage limit. Limited services classified as emergency or post stabilization care had they been provided in the US or its territories. Part D

Benefits/Services	Mass General Brigham Advantage Core (HMO-POS)	Mass General Brigham Advantage Secure (HMO-POS)	Mass General Brigham Advantage Plus (HMO-POS)
	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.	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.	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.

PRESCRIPTION DRUG BENEFITS

Benefits/Services	Mass General Brigham Advantage Core (HMO-POS)	Mass General Brigham Advantage Secure (HMO-POS)	Mass General Brigham Advantage Plus (HMO-POS)
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Deductible

Prescription Drug Deductible: \$700 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.

Initial Coverage

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach \$2,400. 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 (30-day supply)	One-month supply (30-day supply)	One-month supply (30-day supply)
Tier 1 (Preferred Generic)	\$0 copay	\$0 copay	\$0 copay
Tier 2 (Generic)	\$5 copay	\$5 copay	\$5 copay
Tier 3 (Preferred Brand)	17% Coinsurance	17% Coinsurance	17% Coinsurance
Tier 4 (Non-Preferred Drug)	22% Coinsurance	22% Coinsurance	22% Coinsurance
Tier 5 (Specialty Tier)	25% Coinsurance	25% Coinsurance	25% Coinsurance
Tier	Two-month supply (60-day supply)	Two-month supply (60-day supply)	Two-month supply (60-day supply)
Tier 1 (Preferred Generic)	\$0 copay	\$0 copay	\$0 copay
Tier 2 (Generic)	\$10 copay	\$10 copay	\$10 copay
Tier 3 (Preferred Brand)	17% Coinsurance	17% Coinsurance	17% Coinsurance
Tier 4 (Non-Preferred Drug)	22% Coinsurance	22% Coinsurance	22% Coinsurance
Tier 5 (Specialty Tier)	N/A	N/A	N/A
Tier	Three-month supply (90-day supply)	Three-month supply (90-day supply)	Three-month supply (90-day supply)

Tier 1 (Preferred Generic)	\$0 copay	\$0 copay	\$0 copay
Tier 2 (Generic)	\$15 copay	\$15 copay	\$15 copay
Tier 3 (Preferred Brand)	17% Coinsurance	17% Coinsurance	17% Coinsurance
Tier 4 (Non-Preferred Drug)	22% Coinsurance	22% Coinsurance	22% Coinsurance
Tier 5 (Specialty Tier)	N/A	N/A	N/A
	Standard Mail Order	Standard Mail Order	Standard Mail Order
Tier	One-month supply (30-day supply)	One-month supply (30-day supply)	One-month supply (30-day supply)
Tier 1 (Preferred Generic)	\$0 copay	\$0 copay	\$0 copay
Tier 2 (Generic)	\$5 copay	\$5 copay	\$5 copay
Tier 3 (Preferred Brand)	17% Coinsurance	17% Coinsurance	17% Coinsurance
Tier 4 (Non-Preferred Drug)	22% Coinsurance	22% Coinsurance	22% Coinsurance
Tier 5 (Specialty Tier)	25% Coinsurance	25% Coinsurance	25% Coinsurance
Tier	Two-month supply (60-day supply)	Two-month supply (60-day supply)	Two-month supply (60-day supply)
Tier 1 (Preferred Generic)	\$0 copay	\$0 copay	\$0 copay
Tier 2 (Generic)	\$10 copay	\$10 copay	\$10 copay
Tier 3 (Preferred Brand)	17% Coinsurance	17% Coinsurance	17% Coinsurance
Tier 4 (Non-Preferred Drug)	22% Coinsurance	22% Coinsurance	22% Coinsurance
Tier 5 (Specialty Tier)	N/A	N/A	N/A
Tier	Three-month supply (90-day supply)	Three-month supply (90-day supply)	Three-month supply (90-day supply)
Tier 1 (Preferred Generic)	\$0 copay	\$0 copay	\$0 copay
Tier 2 (Generic)	\$10 copay	\$10 copay	\$10 copay
Tier 3 (Preferred Brand)	17% Coinsurance	17% Coinsurance	17% Coinsurance

Tier 4 (Non-Preferred Drug)	22% Coinsurance	22% Coinsurance	22% Coinsurance
Tier 5 (Specialty Tier)	N/A	N/A	N/A

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 \$2,400, 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)
8:00 AM to 8:00 PM, EST	8:00 AM to 8:00 PM, EST
Monday through Sunday	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 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.