

Schedule of Benefits

Complete HMO HSA 2000 25/45/350 Enhanced FlexRxSM

For Individuals and Small Group Employers

This plan is a Health Savings Account (HSA) compatible high deductible health plan (HDHP). An HSA is a tax exempt fund that you and/or your employer can establish to pay for medical expenses associated with a qualified HDHP or you can use to save for your future health needs. By choosing an HSA-compatible plan, you are able to set up and contribute to an HSA and use the funds to pay for qualified medical expenses without federal tax liability or penalty. Check with your employer to find out whether they have an administrator to manage HSAs for their employees. Or contact our preferred HSA administrator, Benefit Strategies, at 603-232-8037 to learn how you may establish and fund an HSA. Once you set up an HSA, you should contact your HSA administrator to find out how to get the most from your account.



This health plan meets Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance. Please see the last page for additional information.

Schedule of Benefits

This Schedule of Benefits is a general description of your coverage as a member of Mass General Brigham Health Plan. For more information about your benefits, log into Member.MassGeneralBrighamHealthPlan.org to see your plan documents and get personalized information about your plan or call Customer Service at 866-414-5533 (TTY 711).

All covered services must be medically necessary and some may require prior authorization. Please check with your PCP or treating provider to determine if a prior authorization is necessary. Your Member Handbook may include additional coverage and/or exclusions not listed on the Schedule of Benefits.

DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM

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|-------------------------------|---|
| Deductible per benefit period | Medical/Dental/Vision/Behavioral Health/Prescription Drug (Combined): \$2,000 Individual /\$4,000 Family |
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With family coverage, the individual deductible does not apply. The entire family deductible must be met before benefits are payable for anyone in the family. Deductible doesn't apply to preventive services.

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| Out-of-Pocket Maximum per benefit period | Medical/Dental/Vision/Behavioral Health/Prescription Drug (Combined): \$7,000 Individual /\$14,000 Family |
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With family coverage, the family out-of-pocket maximum is satisfied by combining the deductibles, coinsurance, and copayment amounts paid by covered family members. A covered member will not exceed the Individual maximum out-of-pocket amount.

The Deductible, Coinsurance and Copayments for Medical, Dental, Vision, Behavioral Health, and Prescription Drugs apply to the annual Out-of-Pocket Maximum. This Schedule of Benefits and the Member Handbook comprise the Evidence of Coverage for members covered on this health plan.

OUTPATIENT MEDICAL CARE

Preventive Services

| | |
|---|------------------------|
| Annual Physical Exams ¹ | No Member Cost-Sharing |
| Annual Gynecological Exams ¹ | No Member Cost-Sharing |
| Family Planning Services | No Member Cost-Sharing |
| Immunizations & Vaccinations | No Member Cost-Sharing |
| Preventive Laboratory Tests | No Member Cost-Sharing |
| Screening Colonoscopy | No Member Cost-Sharing |
| Screening Mammography | No Member Cost-Sharing |
| Well Child Visits | No Member Cost-Sharing |

¹Services for specific conditions during an annual exam may be subject to cost sharing.

Other Primary & Specialty Care Office Visits

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| Office Visits for Other Primary Care | Subject to deductible, then \$25 copayment/Visit |
| Telemedicine (Virtual Visits) - PCP | Subject to deductible, then \$25 copayment/Visit |
| Telemedicine (Virtual Visits) - On Demand | Subject to deductible, then \$25 copayment/Visit |
| Office Visits for Other Specialty Care | Subject to deductible, then \$45 copayment/Visit |
| Telemedicine (Virtual Visits) - Specialist | Subject to deductible, then \$45 copayment/Visit |
| Allergy Shots | No charge after deductible |
| Cardiac Rehabilitation Service | Subject to deductible, then \$45 copayment/Visit |
| Chiropractic Care | Subject to deductible, then \$25 copayment/Visit |
| Routine Adult Eye Exam (1 visit(s) per member age 19 and over, every 12 months) | Subject to deductible, then \$45 copayment/Visit |
| Routine Foot Care (covered for diabetes and some circulatory diseases) | Subject to deductible, then \$45 copayment/Visit |
| Hearing Exams | Subject to deductible, then \$45 copayment/Visit |
| Infertility Services | Subject to deductible, then \$45 copayment/Visit |
| Physical Therapy/Occupational Therapy (Covered up to 60 combined visits for rehabilitation and habilitation each per benefit period) ² | Subject to deductible, then \$45 copayment/Visit |
| Speech Therapy | Subject to deductible, then \$45 copayment/Visit |
| Routine Prenatal and Postnatal Care | No charge after deductible |

²No benefit limit when covered services are furnished to treat autism spectrum disorders.

Other Outpatient Services

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| Diagnostic, Imaging and X-ray | Subject to deductible, then \$45 copayment/Visit |
| Laboratory | Subject to deductible, then \$45 copayment/Visit |
| High-tech Radiology (MRI, CT, PET Scan, Nuclear Cardiac Imaging) | Non-Hospital and other designated sites: Subject to deductible, then \$150 copayment/Visit Hospital-based: Subject to deductible, then \$300 copayment/Visit |
| Outpatient Surgery—Facility Fee | Non-Hospital and other designated sites: Subject to deductible, then \$250 copayment/Visit Hospital-based: Subject to deductible, then \$500 copayment/Visit |
| Outpatient Surgery—Professional Fee | No charge after deductible |

INPATIENT MEDICAL CARE

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| Inpatient Medical Services (including Maternity) - Facility Fee | Subject to deductible, then \$500 copayment/Stay |
| Inpatient Medical Services - Professional Fee | No charge after deductible |
| Inpatient Care in a Skilled Nursing Facility - Facility Fee (Covered up to 100 days per benefit period) | Subject to deductible, then \$500 copayment/Stay |
| Inpatient Care in a Skilled Nursing Facility - Professional Fee | No charge after deductible |
| Inpatient Care in a Rehabilitation Facility - Facility Fee (Covered up to 60 days per benefit period) | Subject to deductible, then \$500 copayment/Stay |
| Inpatient Care in a Rehabilitation Facility - Professional Fee | No charge after deductible |
| Routine Nursery and Newborn Care | No Member Cost-Sharing |

BEHAVIORAL HEALTH - OUTPATIENT

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| Mental Health Care or Substance Use Care | Subject to deductible, then \$25 copayment/Visit |
| Telemedicine (Virtual Visits) - Mental Health Care or Substance Use Care | Subject to deductible, then \$25 copayment/Visit |

BEHAVIORAL HEALTH - INPATIENT

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|---|--|
| Mental Health Care - Facility Fee | Subject to deductible, then \$500 copayment/Stay |
| Mental Health Care - Professional Fee | No charge after deductible |
| Substance Use Detoxification or Rehabilitation - Facility Fee | Subject to deductible, then \$500 copayment/Stay |
| Substance Use Detoxification or Rehabilitation - Professional Fee | No charge after deductible |

URGENT CARE

Care for an illness, injury, or condition serious enough that a person would seek immediate care, but not so severe as to require Emergency room care.

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| Urgent Care | Subject to deductible, then \$45 copayment/Visit |
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EMERGENCY CARE

If you require emergency medical care, go to the nearest emergency room or call 911. You or a family member should notify your PCP within 48 hours of an emergency visit.

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| Care you receive in an emergency room, in or out of Mass General Brigham Health Plan Service Area | Subject to deductible, then \$350 copayment/Visit (Copayment waived if admitted to hospital for inpatient care) |
| Ambulance Services (emergency transport only) | No charge after deductible |
| Emergency Dental Care (within 72 hours of accident or injury) | Subject to deductible, then \$350 copayment/Visit (Copayment waived if admitted to hospital for inpatient care) |

PEDIATRIC DENTAL and VISION CARE BENEFITS³

Dental

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| Preventive and Diagnostic (oral exams, X-rays, cleanings) | No charge after deductible |
| Basic Restorative (fillings, root canal, treatment) | Subject to deductible, then 25% coinsurance |
| Major Restorative (dentures, crowns) | Subject to deductible, then 50% coinsurance |
| Orthodontic Services (medically necessary) | Subject to deductible, then 50% coinsurance |

Vision

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| Routine Eye Exams (1 every 12 months per child up to the age of 19) | No charge after deductible |
| Frames and Lenses (provider designated frames and lenses) | No charge after deductible |

³This policy does include coverage of pediatric dental and vision services for children up to age 19 as required under the Federal Patient Protection and Affordable Care Act. Please see the sections later in this Schedule of Benefits for additional coverage information.

PRESCRIPTION DRUGS (6-Tier)

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| With a valid prescription and purchased at a participating pharmacy for up to a 30-day supply | <p>Tier 1 - Low-Cost Generic: Subject to deductible, then \$10 copayment/Prescription</p> <p>Tier 2 - Other generic and some brand name: Subject to deductible, then \$30 copayment/Prescription</p> <p>Tier 3 - High costing generic and preferred brand name: Subject to deductible, then \$50 copayment/Prescription</p> <p>Tier 4 - Higher cost generics and non-preferred brand name: Subject to deductible, then \$200 copayment/Prescription</p> <p>Tier 5 - Generic specialty and preferred specialty: Subject to deductible, then \$250 copayment/Prescription</p> <p>Tier 6 - Non-preferred Specialty: Subject to deductible, then \$500 copayment/Prescription</p> |
| Access90: With a valid prescription for a 90-day supply of a maintenance medication and purchased through the mail or at a participating pharmacy | <p>Tier 1 - Low-Cost Generic: Subject to deductible, then \$20 copayment/Prescription</p> <p>Tier 2 - Other generic and some brand name: Subject to deductible, then \$60 copayment/Prescription</p> <p>Tier 3 - High costing generic and preferred brand name: Subject to deductible, then \$100 copayment/Prescription</p> <p>Tier 4 - Higher cost generics and non-preferred brand name: Subject to deductible, then \$600 copayment/Prescription</p> |

OVER-THE-COUNTER DRUGS

For a complete list of over-the-counter drugs, visit MassGeneralBrighamHealthPlan.org or call Customer Service at 866-414-5533 (TTY 711).

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| Select over-the-counter medicines and products with a valid prescription and purchased at a participating pharmacy. | \$0-Subject to deductible, then \$50 copayment/Prescription (depending on drug prescribed) |
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ADDITIONAL SERVICES

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| Diabetic Supplies | No charge after deductible |
| Disposable Medical Supplies | No charge after deductible |
| Durable Medical Equipment | Subject to deductible, then 20% coinsurance |
| Early Intervention (from birth up to age three) | No charge after deductible |
| Fitness Program Reimbursement | Up to \$150/Individual, \$300/Family per calendar year (see MassGeneralBrighamHealthPlan.org for qualifications) |
| Hearing Aids (age 21 and under) (Covered up to \$2,000 for each affected ear every 36 months) | No charge after deductible |
| Home Health Care | No charge after deductible |
| Hospice Care | No charge after deductible |
| Oxygen Supplies and Therapy | No charge after deductible |
| Weight Loss Program Benefit | Coverage for up to six months of membership fees per calendar year in a qualified weight-loss program for either a covered Subscriber or one covered Dependent (see MassGeneralBrighamHealthPlan.org for qualifications) |
| Wigs (when medically necessary for hair loss due to cancer treatment or other conditions) | Subject to deductible, then 20% coinsurance |

ABOUT YOUR MASS GENERAL BRIGHAM HEALTH PLAN MEMBERSHIP

For questions or concerns about your coverage, call Customer Service at 866-414-5533 (TTY 711). Representatives are available Monday through Friday, 8:00 a.m.–6:00 p.m. (Thursday 8:00 a.m.– 8:00 p.m.)

Benefit Period

If you have non-group coverage, your benefit period resets on January 1. If you are enrolled through employer sponsored group coverage, your benefit period resets on your employer's anniversary date.

Copayments, Coinsurance, or Deductibles Required for Certain Services

Before coverage begins for certain services, you pay a deductible each benefit period. Your plan deductible is an amount you pay for certain services each year before Mass General Brigham Health Plan starts to pay for those certain covered services.

Your Health Savings Account (HSA) Compatible plan uses an Aggregate Deductible and Embedded Out-of-Pocket Maximum.

If you have individual coverage, you only need to satisfy the individual deductible and out-of-pocket maximum amounts. Family amounts do not apply to you. If you have family coverage, the individual deductible does not apply. Your entire family deductible must be met before benefits are payable for anyone in the family (unless otherwise noted). With family coverage, the family out-of-pocket maximum is satisfied by combining the deductibles, coinsurance, and copayment amounts paid by covered family members. A covered member will not exceed the Individual out-of-pocket maximum before the plan starts to pay 100% for covered services.

As a reminder, under HSA-compatible plans, all covered services except covered preventive services apply toward satisfaction of the deductible.

Your Primary Care Provider (PCP)

Your PCP arranges your health care and is the first person you call when you need medical care. Be sure to check with your PCP to find out office hours and whether urgent care is offered.

Mass General Brigham Health Plan requires the designation of a PCP. You have the right to designate any PCP who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the PCP.

For information on how to select a PCP, or a list of the most up-to date provider information, or a list of participating health care professionals who specialize in obstetrics or gynecology, visit MassGeneralBrighamHealthPlan.org or call Customer Service.

Preventive Care Services

Mass General Brigham Health Plan covers eligible preventive services for adults, women (including pregnant women) and children, which includes coverage for annual physical exams, immunizations, well child visits and annual gynecological exams. For a complete list of eligible preventive care services, please visit MassGeneralBrighamHealthPlan.org or call Customer Service.

Primary Care Provider (PCP) and Obstetrical Rights

You do not need prior authorization from Mass General Brigham Health Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. However, the health care professional may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

Urgent Care

If you need urgent care, call your PCP to arrange where you will receive treatment. Examples of conditions requiring urgent care include, but are not limited to, fever, sore throat or an earache.

Emergency Care

In an emergency, go to the nearest emergency facility, or call 911. Please refer to this Schedule of Benefits for your cost sharing amount. All follow-up care must be arranged by your PCP.

Referrals

Mass General Brigham Health Plan requires referral for specialist services provided by in-network Providers, except the following: Gynecologist or Obstetrician for routine, preventive or urgent care; Family Planning services; Outpatient and Diversionary Behavioral Health Services; Physical Therapy; Occupational Therapy; Speech Therapy; Routine Eye exam; and Emergency Services.

Utilization Review Program

The Utilization Review standards Mass General Brigham Health Plan uses were created to assure our members consistently receive high quality, appropriate medical care. To determine coverage, specific criteria are used to make Utilization Review decisions. These criteria are developed by physicians and meet the standards of national accreditation organizations. As new treatments and technologies become available, we update our Utilization Review standards annually.

To make utilization decisions the health plan conducts prospective, concurrent, and retrospective reviews of the health care services our members use.

Initial Determination (Prospective Review or Prior Authorization)

Determines in advance if a procedure or treatment either you or your doctor is requesting is both medically appropriate and medically necessary.

Concurrent Review

During the course of treatment, such as hospitalization, concurrent review monitors the progress of treatment and determines for how long it will be deemed medically necessary.

Retrospective Review

After care has been provided, we review treatment outcomes to ensure that the health care services provided to you met certain quality standards.

Care Management

When members have a severe or chronic illness or condition, they may qualify for Care Management. Care managers work one-on-one with members and their providers to find the most appropriate and cost-effective ways to manage a condition. Together, a treatment plan that best meets the member's needs is developed with the goal of promoting patient education, self-care, and providing access to the right kinds of health care services and options.

To learn more about Utilization Review or Care Management at Mass General Brigham Health Plan, please refer to your Member Handbook or call Customer Service.

Benefit Exclusions

Services or supplies that Mass General Brigham Health Plan does not cover include: Acupuncture; Benefits from other sources; Diet foods; Educational testing and evaluations; Massage therapy; Out-of-network providers; Non-emergency care when traveling outside the U.S.

Additional benefit exclusions apply, for a complete list please refer to your plan's Benefit Handbook.

Pediatric Dental Care Benefits

Members up to age 19 (through the end of the month the member turns 19 years of age) are eligible for the coverage below, when provided by an in-network Dental Provider. You must always verify the participation status of a Dental Provider prior to seeking services.

How to find a Dental Care Provider:

To find a participating provider, go to MassGeneralBrighamHealthPlan.org or call Delta Dental Customer Services at 855-264-7898 (TTY 711).

| Preventive and Diagnostic (oral exams, X-rays, cleanings) | |
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| Topical fluoride treatment (1 per 90 days) | No charge after deductible |
| Periodic oral exams (2 per benefit period) | No charge after deductible |
| Routine cleanings (2 per benefit period) | No charge after deductible |
| Bitewing x-rays (2 per benefit period) | No charge after deductible |
| Panoramic x-rays (1 every 3 years) | No charge after deductible |
| Sealants (1 every 3 years) | No charge after deductible |
| Space maintainers | No charge after deductible |
| Basic Restorative (fillings, root canal treatment) | |
| Fillings (1 per 12 months) | Subject to deductible, then 25% coinsurance |
| Simple tooth extractions (1 per tooth) | Subject to deductible, then 25% coinsurance |
| Surgical extractions | Subject to deductible, then 25% coinsurance |
| General Anesthesia or Minor treatment for pain relief | Subject to deductible, then 25% coinsurance |
| Root canals (1 per permanent tooth) | Subject to deductible, then 25% coinsurance |
| Periodontal services (limits vary) | Subject to deductible, then 25% coinsurance |
| Endodontic services (limits vary) | Subject to deductible, then 25% coinsurance |
| Repair of crowns (limits vary) | Subject to deductible, then 25% coinsurance |
| Palliative treatment of dental pain (limits vary) | Subject to deductible, then 25% coinsurance |
| Adjustment of dentures (limits vary) | Subject to deductible, then 25% coinsurance |
| Major Restorative (dentures, crowns) | |
| Dentures (1 per 84 months) | Subject to deductible, then 50% coinsurance |
| Crowns (1 per 60 months) | Subject to deductible, then 50% coinsurance |
| Orthodontic Services - All Orthodontic Treatment Requires Preauthorization | |
| Only medically necessary orthodontic treatment is covered | Subject to deductible, then 50% coinsurance |

Pediatric Vision Care Benefits

Members up to age 19 (through the end of the month the member turns 19 years of age) are eligible for the coverage below, when provided by an in-network vision provider.

How to find a Vision Care Provider:

To find a participating provider, go to MassGeneralBrighamHealthPlan.org or call EyeMed Customer Services at 844-201-3993 (TTY 711).

| Frequency | |
|--|---|
| Examinations | Once every 12 months |
| Frames | Once every 12 months |
| Lenses or Contact Lenses | Once every 12 months |
| Exams | |
| Routine Eye Exam, with dilation as necessary | No charge after deductible |
| Frames | |
| Collection (provider designated frames) | No charge after deductible |
| Lenses | |
| <i>Standard Plastic Lenses</i> | |
| Single Vision | No charge after deductible |
| Conventional (Lined) Bifocal | No charge after deductible |
| Conventional (Lined) Trifocal | No charge after deductible |
| Lenticular | No charge after deductible |
| Standard Progressive Lens | No charge after deductible |
| <i>Additional Lens Options</i> | |
| UV Treatment | No charge after deductible |
| Tint (Solid and Gradient) | No charge after deductible |
| Standard Plastic Scratch Coating | No charge after deductible |
| Photochromatic/ Transitions Lens | No charge after deductible |
| Contact Lenses | |
| Contact lenses (provider designated lenses) | No charge after deductible |
| Extended Wear Disposables | Up to 6-month supply of monthly or 2-week disposable, single vision spherical or toric contact lenses |
| Daily Wear/ Disposables | Up to 3-month supply of daily disposable, single vision spherical contact lenses |
| Conventional | 1 pair from selection of provider designated contact lenses |

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This health plan meets Minimum Creditable Coverage standards that are effective January 1, 2022 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards.

This disclosure is for minimum creditable coverage standards that are effective January 1, 2022. Because these standards may change, review your health plan material each year to determine whether your plan meets the latest standards.

If you have questions about this notice, you may contact the Division of Insurance by calling 617-521-7794 or visiting its website at mass.gov/doi.



This plan is underwritten by Mass General Brigham Health Plan, Inc.