### Important Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why This Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>In Network: $2,500/Individual, $5,000/Family per benefit period.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible</td>
</tr>
<tr>
<td></td>
<td>Out of Network: $5,000/Individual, $10,000/Family per benefit period.</td>
<td>amount before this plan begins to pay. If you have other family members on the</td>
</tr>
<tr>
<td></td>
<td></td>
<td>plan, the overall family deductible must be met before the plan begins to pay.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. In-Network Preventive care, does not apply towards the deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the annual</td>
</tr>
<tr>
<td></td>
<td></td>
<td>deductible amount. But a copayment or coinsurance may apply. For example, this</td>
</tr>
<tr>
<td></td>
<td></td>
<td>plan covers certain preventive services without cost-sharing and before you meet</td>
</tr>
<tr>
<td></td>
<td></td>
<td>your deductible. See a list of covered preventive services at MassGeneralBrigham</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HealthPlan.org.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don't have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>In Network: $7,000/Individual, $14,000/Family per benefit period.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services.</td>
</tr>
<tr>
<td></td>
<td>Out of Network: $14,000/Individual, $28,000/Family per benefit period.</td>
<td>If you have other family members in this plan, they have to meet their own</td>
</tr>
<tr>
<td></td>
<td></td>
<td>out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, Out-of-Network penalties for failure to obtain prior authorization, Out-of-Network charges above the allowed amount, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they do not count toward the out-of-pocket</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. For a list of in-network providers, see MassGeneralBrighamHealthPlan.org or call 866-414-5533.</td>
<td>limit.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the</td>
</tr>
<tr>
<td></td>
<td></td>
<td>plan’s network. You will pay the most if you use an out-of-network provider, and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (a balance bill). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**

- The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
- This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to Member.MassGeneralBrighamHealthPlan.org or call Customer Services at 866-414-5533 (toll free) or 711 (TTY). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at MassGeneralBrighamHealthPlan.org or call 866-414-5533 (toll free) or 711 (TTY) to request a copy.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In Network</td>
<td>Out of Network</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Subject to IN deductible, then $30 copayment/Visit</td>
<td>Subject to OON deductible, then 20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Subject to IN deductible, then $45 copayment/Visit</td>
<td>Subject to OON deductible, then 20% coinsurance</td>
</tr>
<tr>
<td>If you visit a health care provider’s</td>
<td>Primary care visit to treat an injury or illness</td>
<td></td>
<td>None.</td>
</tr>
<tr>
<td>office or clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Member Cost-Sharing</td>
<td>Subject to OON deductible, then 20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Services for specific conditions during an annual exam may be subject to cost sharing.</td>
</tr>
<tr>
<td></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>X-ray: Subject to IN deductible, then $45 copayment/Visit</td>
<td>X-ray: Subject to OON deductible, then 20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Blood work: Subject to IN deductible, then $45 copayment/Visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-Hospital and other designated sites: Subject to IN deductible, then $150 copayment/Visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hospital-based: Subject to IN deductible, then $300 copayment/Visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>May require prior authorization.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Coverage Period:
On or after 01/01/2023

---

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage for:** All Coverage Tiers | **Plan Type:** PPO

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tier 1 – Low-Cost Generic</td>
<td>Retail: Subject to IN deductible, then $10 copayment/Prescription Maintenance 90: Subject to IN deductible, then $20 copayment/Prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 2 – Other generic and some brand name</td>
<td>Retail: Subject to IN deductible, then $30 copayment/Prescription Maintenance 90: Subject to IN deductible, then $60 copayment/Prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 3 – High costing generic and preferred brand name</td>
<td>Retail: Subject to IN deductible, then $60 copayment/Prescription Maintenance 90: Subject to IN deductible, then $120 copayment/Prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 4 – Higher cost generics and non-preferred brand name</td>
<td>Retail: Subject to IN deductible, then $200 copayment/Prescription Maintenance 90: Subject to IN deductible, then $600 copayment/Prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 5 – Generic specialty and preferred specialty</td>
<td>Subject to IN deductible, then $250 copayment/Prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 6 – Non-preferred specialty</td>
<td>Subject to IN deductible, then $500 copayment/Prescription</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

**If you need drugs to treat your illness or condition**

More information about prescription drug coverage is available at MassGeneralBrighamHealthPlan.org

- No charge for birth control and smoking cessation drugs.
- May require prior authorization.
- Prescription must be filled through our specialty pharmacy and a prior authorization may be required.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>In Network</strong></td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td><strong>Non-Hospital and other designated sites:</strong> Subject to IN deductible, then $250 copayment/Visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Hospital-based:</strong> Subject to IN deductible, then $500 copayment/Visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Out of Network</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Subject to OON deductible, then 20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>Subject to IN deductible, then $350 copayment/Visit</td>
<td>Emergency room copay waived if admitted to hospital for inpatient care.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge after IN deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>Subject to OON deductible, then $45 copayment/Visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Out of Network</strong></td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>Subject to OON deductible, then 20% coinsurance</td>
<td>May require prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>Subject to OON deductible, then 20% coinsurance</td>
<td></td>
</tr>
</tbody>
</table>
### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage for:** All Coverage Tiers  |  **Plan Type:** PPO

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Out of Network</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need mental health, behavioral health, or substance use services</td>
<td>Mental/behavioral health/substance use outpatient services</td>
<td>Subject to IN deductible, then $30 copayment/Visit</td>
<td>Subject to OON deductible, then 20% coinsurance</td>
<td>None.</td>
</tr>
<tr>
<td></td>
<td>Mental/behavioral health/substance use inpatient services</td>
<td>Subject to IN deductible, then $500 copayment/Stay</td>
<td>Subject to OON deductible, then 20% coinsurance</td>
<td>May require prior authorization.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits for prenatal and postnatal care</td>
<td>No charge after IN deductible</td>
<td>Subject to OON deductible, then 20% coinsurance</td>
<td>None.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>Subject to IN deductible, then $500 copayment/Stay</td>
<td>Subject to OON deductible, then 20% coinsurance</td>
<td>May require prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge after IN deductible</td>
<td>Subject to OON deductible, then 20% coinsurance</td>
<td>May require prior authorization.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge after IN deductible</td>
<td>Subject to OON deductible, then 20% coinsurance</td>
<td>May require prior authorization.</td>
</tr>
</tbody>
</table>
## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>In Network</strong></td>
<td><strong>Out of Network</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Outpatient</strong>: Subject to IN deductible, then $45 copayment/Visit</td>
<td><strong>Outpatient</strong>: Subject to OON deductible, then 20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Inpatient</strong>: Subject to IN deductible, then $500 copayment/Stay</td>
<td><strong>Inpatient</strong>: Subject to OON deductible, then 20% coinsurance</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td></td>
<td></td>
<td><strong>Outpatient</strong>: Covered up to 60 combined PT/OT visits per benefit period. <strong>Inpatient</strong>: Covered up to 60 days per benefit period. Prior authorization required.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td></td>
<td><strong>Outpatient</strong>: Subject to IN deductible, then $45 copayment/Visit</td>
<td><strong>Outpatient</strong>: Subject to OON deductible, then 20% coinsurance <strong>Inpatient</strong>: Subject to OON deductible, then 20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Inpatient</strong>: Subject to IN deductible, then $500 copayment/Stay</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>Subject to IN deductible, then $500 copayment/Stay</td>
<td>Subject to OON deductible, then 20% coinsurance</td>
<td>Covered up to 100 days per benefit period. May require prior authorization.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>Subject to IN deductible, then 20% coinsurance</td>
<td>Subject to OON deductible, then 20% coinsurance</td>
<td>May require prior authorization. No charge for electric breast pump (one per birth).</td>
</tr>
<tr>
<td>Hospice service</td>
<td>No charge after IN deductible</td>
<td>Subject to OON deductible, then 20% coinsurance</td>
<td>May require prior authorization.</td>
</tr>
</tbody>
</table>
### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage Period:** On or after 01/01/2023  
**Coverage for:** All Coverage Tiers | **Plan Type:** PPO

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>No charge after IN deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>No charge after IN deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>No charge after IN deductible</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
Excluded Services & Other Covered Services:

| Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.) |
|------|-----------------------------------------------------|-----------------------------------------------------|
| •   | Acupuncture                                         | Extraction of infected or impacted wisdom teeth (except when in a hospital setting) |
|     | Cosmetic Surgery                                    | Long-term care                                       |
|     | Dental care-adult (you may have coverage under a separate dental plan) | Non-emergency care when traveling outside the U.S. |

Other Covered Services (This isn't a complete list. Check your policy or Plan document for other covered services and your costs for these services.)

<table>
<thead>
<tr>
<th>Services</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Abortion</td>
<td>Hearing aids (age 21 and younger)-Covered up to $2,000 for each affected ear every 36 months</td>
</tr>
<tr>
<td>• Bariatric surgery</td>
<td>Infertility treatment</td>
</tr>
<tr>
<td>• Chiropractic care</td>
<td>Routine foot care (covered for diabetes and some circulatory diseases)</td>
</tr>
<tr>
<td></td>
<td>Weight loss program (coverage for up to six months of membership fees in a qualified weight-loss program for either a covered Subscriber or one covered Dependent)</td>
</tr>
<tr>
<td></td>
<td>Routine eye exam (adult)</td>
</tr>
</tbody>
</table>

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies are: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Customer Service at 866-414-5533 (toll free) or 711 (TTY).

Does this Coverage Provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this Coverage Meet the Minimum Value Standard? Yes
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Para obtener asistencia en Español, llame al 866-414-5533.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.
**Complete PPO Plus HSA 2500 30/45/350**  
**Enhanced FlexRxSM** for individuals and small group employers  

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs  
**Coverage Period:** On or after 01/01/2023  

**Coverage for:** All Coverage Tiers | **Plan Type:** PPO

---

**About these Coverage Examples:**

*This is not a cost estimator.* Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

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### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Total Example Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$800</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td><strong>$0</strong></td>
</tr>
<tr>
<td><strong>Total Peg would pay is</strong></td>
<td><strong>$3,300</strong></td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:  
- Specialist office visits (prenatal care)  
- Childbirth/Delivery Professional Services  
- Childbirth/Delivery Facility Services  
- Diagnostic tests (ultrasounds and blood work)  
- Specialist visit (anesthesia)

**Total Example Cost:** $12,700

**In this example, Peg would pay:**

- **Deductibles:** $2,500
- **Copayments:** $800
- **Coinsurance:** $0
- **What isn’t covered:** $0
- **The total Peg would pay is:** $3,300

---

### Managing Joe’s type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Total Example Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$400</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td><strong>$0</strong></td>
</tr>
<tr>
<td><strong>Total Joe would pay is</strong></td>
<td><strong>$2,900</strong></td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:  
- Primary care physician office visits (including disease education)  
- Diagnostic tests (blood work)  
- Prescription drugs  
- Durable medical equipment (glucose meter)

**Total Example Cost:** $5,600

**In this example, Joe would pay:**

- **Deductibles:** $2,500
- **Copayments:** $400
- **Coinsurance:** $0
- **What isn’t covered:** $0
- **The total Joe would pay is:** $2,900

---

### Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Total Example Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$100</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td><strong>$0</strong></td>
</tr>
<tr>
<td><strong>Total Mia would pay is</strong></td>
<td><strong>$2,600</strong></td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:  
- Emergency room care (including medical supplies)  
- Diagnostic test (x-ray)  
- Durable medical equipment (crutches)  
- Rehabilitation services (physical therapy)

**Total Example Cost:** $2,800

**In this example, Mia would pay:**

- **Deductibles:** $2,500
- **Copayments:** $100
- **Coinsurance:** $0
- **What isn’t covered:** $0
- **The total Mia would pay is:** $2,600

---

The plan would be responsible for the other costs of these EXAMPLE covered services.

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

This health plan meets Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance.