Mass General Brigham
Health Plan

# Schedule of Benefits

## Choice Easy Tier HMO 500 30/55 with Care Complement℠

### For Individuals and Small Group Employers

**IMPORTANT NOTICE:** This plan includes a Tiered Provider Network called Choice Easy Tier. In this plan, members pay different levels of Copayments, Coinsurance, and/or Deductibles depending on the tier of the provider delivering a covered service or supply. This plan may make changes to a provider's benefit tier annually on January 1. Please consult the 2026/2027 Choice Easy Tier provider directory or visit the provider search tool at MassGeneralBrighamHealthPlan.org to determine the tier of providers.



**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).

As a member of the Choice Easy Tier plan, you will pay different levels of copayments, coinsurance, and/or deductibles depending on the tier of the hospital delivering a covered service or supply. Hospitals must meet the standards for quality and cost based on our benchmark.

Participating hospitals are classified into three tiers as described below:

- **Tier 1 (lowest member cost-sharing):** Hospitals assigned to this tier offer the most value relative to cost-efficiency and have the lowest member cost-sharing for certain covered services as indicated below. Outpatient services at a freestanding/independent (non-hospital affiliated) facility are included in this tier.
- **Tier 2 (middle member cost-sharing):** Hospitals and affiliated facilities assigned to this tier still have moderate cost relative to our benchmark and have moderate member cost-sharing for certain covered services as indicated below.
- **Tier 3 (highest member cost-sharing):** Hospitals and affiliated facilities assigned to this tier have the highest cost relative to our benchmark and have the highest member cost-sharing for certain covered services as indicated below.

If your PCP refers you to a provider for covered services such as a specialist, it is important to check the tier of the hospital that the provider is affiliated with. Your cost for certain services will be the highest when you receive certain services at or by Tier 3 hospitals, even if your PCP refers you. For assistance in finding providers in the 2026/2027 Choice Easy Tier network and tier information of the providers, please visit the online provider search tool at MassGeneralBrighamHealthPlan.org

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

| | |
|---|---|
| Deductible per benefit period | **Medical/Dental/Behavioral Health (Combined):**<br>**$500 Individual /$1,000 Family**<br>**Prescription Drug: None** |
| Out-of-Pocket Maximum per benefit period | **Medical/Dental/Behavioral Health/Prescription Drug (Combined):**<br>**$10,500 Individual /$21,000 Family** |

The Deductible, Coinsurance and Copayments for Medical, Dental, 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 |

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

***Other Primary & Specialty Care Office Visits***

| | |
|---|---|
| Office Visits for Other Primary Care | $30 copayment/Visit (waived for members age 18 and younger for the first 3 visits) |
| Telemedicine (Virtual Visits) - PCP | $30 copayment/Visit |
| Telemedicine (Virtual Visits) - On Demand | $30 copayment/Visit |
| Office Visits for Other Specialty Care | $55 copayment/Visit |
| Telemedicine (Virtual Visits) - Specialist | $55 copayment/Visit |
| Acupuncture<br>(For up to 20 visits per benefit period) | Visit 1-6: No Member Cost-Sharing<br>Visit 7-20: $55 copayment/Visit |
| Allergy Shots | No Member Cost-Sharing |
| Cardiac Rehabilitation Service | **Tier 1:** No Member Cost-Sharing<br>**Tier 2:** Subject to deductible, then $75 copayment/Visit<br>**Tier 3:** Subject to deductible, then $150 copayment/Visit |
| Chiropractic Care | Visit 1-6: No Member Cost-Sharing<br>Visit 7 and after: $30 copayment/Visit |
| Routine Adult Eye Exam<br>(1 visit(s) per member age 19 and over, every 12 months) | $55 copayment/Visit (waived for members diagnosed with diabetes) |
| Routine Foot Care (covered for diabetes and some circulatory diseases) | $55 copayment/Visit |
| Hearing Exams | $55 copayment/Visit |
| Infertility Services | $55 copayment/Visit |
| Physical Therapy/Occupational Therapy<br>(Covered up to 60 combined visits for rehabilitation and habilitation each per benefit period)[2] | **Tier 1:**<br>Visit 1-6: No Member Cost-Sharing<br>Visit 7-60: Subject to deductible, then $55 copayment/Visit<br>**Tier 2:** Subject to deductible, then $75 copayment/Visit<br>**Tier 3:** Subject to deductible, then $150 copayment/Visit |
| Speech Therapy | **Tier 1:** Subject to deductible, then $55 copayment/Visit<br>**Tier 2:** Subject to deductible, then $75 copayment/Visit<br>**Tier 3:** Subject to deductible, then $150 copayment/Visit |
| Routine Prenatal and Postnatal Care | No Member Cost-Sharing |

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

***Other Outpatient Services***

| | |
|---|---|
| Diagnostic, Imaging and X-ray | **Tier 1:** Subject to deductible, then $55 copayment/Visit<br>**Tier 2:** Subject to deductible, then $150 copayment/Visit<br>**Tier 3:** Subject to deductible, then $300 copayment/Visit |
| Laboratory | $55 copayment/Visit |

| | |
|---|---|
| High-tech Radiology (MRI, CT, PET Scan, Nuclear Cardiac Imaging) | **Tier 1:** Subject to deductible, then $75 copayment/Visit<br>**Tier 2:** Subject to deductible, then $525 copayment/Visit<br>**Tier 3:** Subject to deductible, then $1,000 copayment/Visit |
| Outpatient Surgery—Facility Fee | **Tier 1:** Subject to deductible, then $250 copayment/Visit<br>**Tier 2:** Subject to deductible, then $1,500 copayment/Visit<br>**Tier 3:** Subject to deductible, then $2,500 copayment/Visit |
| Outpatient Surgery—Professional Fee | **Tier 1:** No charge after deductible<br>**Tier 2:** No charge after deductible<br>**Tier 3:** No charge after deductible |

**INPATIENT MEDICAL CARE**

| | |
|---|---|
| Inpatient Medical Services (including Maternity) - Facility Fee | **Tier 1:** Subject to deductible, then $500 copayment/Stay<br>**Tier 2:** Subject to deductible, then $2,000 copayment/Stay<br>**Tier 3:** Subject to deductible, then $3,500 copayment/Stay |
| Inpatient Medical Services - Professional Fee | **Tier 1:** No charge after deductible<br>**Tier 2:** No charge after deductible<br>**Tier 3:** No charge after deductible |
| Inpatient Care in a Skilled Nursing Facility - Facility Fee<br>(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<br>(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**

| | |
|---|---|
| Mental Health Care or Substance Use Care | $30 copayment/Visit (waived for members age 18 and younger for the first 3 visits) |
| Telemedicine (Virtual Visits) - Mental Health Care or Substance Use Care | $30 copayment/Visit |

**BEHAVIORAL HEALTH - INPATIENT**

| | |
|---|---|
| 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.

| | |
|---|---|
| Urgent Care | $55 copayment/Visit |

**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.

| | |
|---|---|
| Care you receive in an emergency room, in or out of the Service Area | $500 copayment/Visit (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) | $500 copayment/Visit (waived if admitted to hospital for inpatient care) |

**PEDIATRIC DENTAL and VISION CARE BENEFITS[3]**

| | |
|---|---|
| *Dental* | |
| Preventive and Diagnostic (oral exams, X-rays, cleanings) | No Member Cost-Sharing |
| 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*** | |
| Routine Eye Exams (1 every 12 months) | No Member Cost-Sharing |
| Frames and Lenses (provider designated frames and lenses) | No Member Cost-Sharing |

[3]This 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**

| | |
|---|---|
| **30-day Retail:** With a valid prescription and purchased at a participating pharmacy for up to a 30-day supply | Tier 1 - Low-Cost Generic: $10 copayment/Prescription<br>Tier 2 - Other generic and some brand name: $40 copayment/Prescription<br>Tier 3 - High costing generic and preferred brand name: $100 copayment/Prescription<br>Tier 4 - Higher cost generics and non-preferred brand name: $200 copayment/Prescription<br>Tier 5 - Generic specialty and preferred specialty: $300 copayment/Prescription<br>Tier 6 - Non-preferred Specialty: $500 copayment/Prescription |
| **Access90** With a valid prescription for a 90-day supply of a maintenance medication and purchased through the mail or at a participating retail pharmacy | |
| **90-day Mail:** | Tier 1 - Low-Cost Generic: $20 copayment/Prescription<br>Tier 2 - Other generic and some brand name: $80 copayment/Prescription<br>Tier 3 - High costing generic and preferred brand name: $200 copayment/Prescription<br>Tier 4 - Higher cost generics and non-preferred brand name: $600 copayment/Prescription |
| **90-day Retail:** | Tier 1 - Low-Cost Generic: $30 copayment/Prescription<br>Tier 2 - Other generic and some brand name: $120 copayment/Prescription<br>Tier 3 - High costing generic and preferred brand name: $300 copayment/Prescription<br>Tier 4 - Higher cost generics and non-preferred brand name: $600 copayment/Prescription |

Your plan does not include coverage for GLP-1 medications (e.g., Wegovy, Zepbound, Saxenda) that share an indication of obesity/weight management.

**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).

| | |
|---|---|
| Select over-the-counter medicines and products with a valid prescription and purchased at a participating pharmacy. | $0- $100 copayment/Prescription (depending on drug prescribed) |

**ADDITIONAL SERVICES**

| | |
|---|---|
| Diabetic Supplies | No Member Cost-Sharing |
| Disposable Medical Supplies | Subject to deductible, then 20% coinsurance |
| Durable Medical Equipment | Subject to deductible, then 20% coinsurance |
| Early Intervention (from birth up to age three) | No Member Cost-Sharing |
| 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 Member Cost-Sharing |
| Home Health Care | No Member Cost-Sharing |
| Hospice Care | No Member Cost-Sharing |
| Medical Drugs (drugs that cannot be self-administered) | $200 copayment/Visit |
| Oxygen Supplies and Therapy | No Member Cost-Sharing |
| Radiation Therapy and Chemotherapy | $75 copayment/Visit |
| 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 benefit period. For some services, after the deductible is satisfied, members may be required to pay a copayment and/or coinsurance before coverage begins.

All members are responsible for the individual deductible per benefit period. Family member's deductible payments contribute toward the family deductible per benefit period. The family deductible can be satisfied by combining the deductibles paid for by covered family members. Each family member's contribution will not exceed the amount set for an individual deductible.

All medical, dental, behavioral health, and prescription drug amounts paid apply toward the out-of-pocket maximum. Once the individual out-of-pocket maximum is satisfied, these services are covered for the member in full through the remainder of the benefit period. The family out-of-pocket maximum is satisfied by combining the copayments, coinsurance and deductible amounts paid by covered family members. Once the family out-of-pocket maximum is satisfied, these services are covered for all family members in full through the remainder of the benefit period.

**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 a 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 a referral 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.

**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. If you are admitted to the hospital for inpatient care, you will be responsible to pay Tier 1 member cost sharing. All follow-up care must be arranged by your PCP. If you receive follow-up care in a hospital setting, your member cost sharing will depend on the tier of the hospital that provides that care. Please refer to this Schedule of Benefits for your cost sharing amounts.

**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: 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)** | |
| Topical fluoride treatment<br>(1 per 90 days) | No Member Cost-Sharing |
| Periodic oral exams<br>(2 per benefit period) | No Member Cost-Sharing |
| Routine cleanings<br>(2 per benefit period) | No Member Cost-Sharing |
| Bitewing x-rays<br>(2 per benefit period) | No Member Cost-Sharing |
| Panoramic x-rays<br>(1 every 3 years) | No Member Cost-Sharing |
| Sealants<br>(1 every 3 years) | No Member Cost-Sharing |
| Space maintainers | No Member Cost-Sharing |
| | |
| **Basic Restorative (fillings, root canal treatment)** | |
| Fillings<br>(1 per 12 months) | Subject to deductible, then 25% coinsurance |
| Simple tooth extractions<br>(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<br>(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<br>(1 per 84 months) | Subject to deductible, then 50% coinsurance |
| Crowns<br>(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 Member Cost-Sharing |
| | |
| **Frames** | |
| Collection (provider designated frames) | No Member Cost-Sharing |
| | |
| **Lenses**<br>***Standard Plastic Lenses*** | |
| Single Vision | No Member Cost-Sharing |
| Conventional (Lined) Bifocal | No Member Cost-Sharing |
| Conventional (Lined) Trifocal | No Member Cost-Sharing |
| Lenticular | No Member Cost-Sharing |
| Standard Progressive Lens | No Member Cost-Sharing |
| | |
| ***Additional Lens Options*** | |
| UV Treatment | No Member Cost-Sharing |
| Tint (Solid and Gradient) | No Member Cost-Sharing |
| Standard Plastic Scratch Coating | No Member Cost-Sharing |
| Photochromatic/ Transitions Lens | No Member Cost-Sharing |
| | |
| **Contact Lenses** | |
| Contact lenses (provider designated lenses) | No Member Cost-Sharing |
| 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, 2027 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, 2027. 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.**

Mass General Brigham
Health Plan

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