**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services **Coverage for: All Coverage Tiers | Plan Type: PPO**

**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.

| Important Questions | Answers | Why This Matters |
|---|---|---|
| **What is the overall deductible?** | **In-Network (INN):** $1,500/Individual, $3,000/Family per benefit period. **Out-of-Network (OON):** $3,000/Individual, $6,000/Family per benefit period. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. In-Network Preventive care, most outpatient visits (including mental/behavioral health and substance use disorder), prescription drug coverage, and urgent care does not apply towards the deductible. | This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at MassGeneralBrighamHealthPlan.org. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | **In-Network (INN):** $11,000/Individual, $22,000/Family per benefit period. **Out-of-Network (OON):** $22,000/Individual, $44,000/Family per benefit period. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | 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. | Even though you pay these expenses, they do not count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. For a list of in-network providers, see MassGeneralBrighamHealthPlan.org or call 866-414-5533. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and 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. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In Network | Out of Network | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $30 copayment/Visit | Subject to OON deductible, then 20% coinsurance | For the first 3 visits, in-network cost sharing waived for members age 18 and younger. |
| | Specialist visit | $60 copayment/Visit | Subject to OON deductible, then 20% coinsurance | None. |
| | Preventive care/screening/immunization | No Member Cost-Sharing | Subject to OON deductible, then 20% coinsurance | Services for specific conditions during an annual exam may be subject to cost sharing. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | **X-ray:**<br>**Tier 1:** Subject to IN deductible, then $55 copayment/Visit<br>**Tier 2:** Subject to IN deductible, then $150 copayment/Visit<br>**Tier 3:** Subject to IN deductible, then $300 copayment/Visit<br>**Blood work:**<br>Subject to IN deductible, then $30 copayment/Visit | **X-ray:** Subject to OON deductible, then 20% coinsurance<br>**Blood work:** Subject to OON deductible, then 20% coinsurance | None. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In Network | Out of Network | |
| | Imaging (CT/PET scans, MRIs) | **Tier 1:** Subject to IN deductible, then $150 copayment/Visit<br>**Tier 2:** Subject to IN deductible, then $600 copayment/Visit<br>**Tier 3:** Subject to IN deductible, then $1,000 copayment/Visit | Subject to OON deductible, then 20% coinsurance | May require prior authorization. |
| **If you need drugs to treat your illness or condition**<br><br>More information about 6-tier Prescription drug coverage is available at MGBHP.org/members/pharmacy | Tier 1 – Low-Cost Generic | 30-day Retail: $10 copayment/Prescription<br>90-day Mail: $20 copayment/Prescription | Not covered | Your plan does not include coverage for GLP-1 medications (e.g., Wegovy, Zepbound, Saxenda) that share an indication of obesity/weight management.<br><br>No charge for birth control and smoking cessation drugs.<br><br>May require prior authorization. |
| | Tier 2 – Other generic and some brand name | 30-day Retail: $40 copayment/Prescription<br>90-day Mail: $80 copayment/Prescription | Not covered | |
| | Tier 3 – High costing generic and preferred brand name | 30-day Retail: $100 copayment/Prescription<br>90-day Mail: $200 copayment/Prescription | Not covered | |
| | Tier 4 – Higher cost generics and non-preferred brand name | 30-day Retail: $200 copayment/Prescription<br>90-day Mail: $600 copayment/Prescription | Not covered | |
| | Tier 5 – Generic specialty and preferred specialty | $300 copayment/Prescription | Not covered | Prescription must be filled through our specialty pharmacy and a prior authorization may be required. |
| | Tier 6 – Non-preferred specialty | $500 copayment/Prescription | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In Network | Out of Network | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | **Tier 1:** Subject to IN deductible, then $250 copayment/Visit<br>**Tier 2:** Subject to IN deductible, then $1,500 copayment/Visit<br>**Tier 3:** Subject to IN deductible, then $2,500 copayment/Visit | Subject to OON deductible, then 20% coinsurance | May require prior authorization. |
| | Physician/surgeon fees | **Tier 1:** No charge after IN deductible<br>**Tier 2:** No charge after IN deductible<br>**Tier 3:** No charge after IN deductible | Subject to OON deductible, then 20% coinsurance | None. |
| **If you need immediate medical attention** | Emergency room services | $450 copayment/Visit | $450 copayment/Visit | Emergency room copay waived if admitted to hospital for inpatient care. |
| | Emergency medical transportation | No Member Cost-Sharing | No Member Cost-Sharing | None. |
| | Urgent care | $60 copayment/Visit | Subject to OON deductible, then 20% coinsurance | None. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | **Tier 1:** Subject to IN deductible, then $500 copayment/Stay<br>**Tier 2:** Subject to IN deductible, then $2,000 copayment/Stay<br>**Tier 3:** Subject to IN deductible, then $3,500 copayment/Stay | Subject to OON deductible, then 20% coinsurance | May require prior authorization. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In Network | Out of Network | |
| | Physician/surgeon fee | **Tier 1:** No charge after IN deductible<br>**Tier 2:** No charge after IN deductible<br>**Tier 3:** No charge after IN deductible | Subject to OON deductible, then 20% coinsurance | None. |
| **If you need mental health, behavioral health, or substance use services** | Mental/behavioral health/substance use outpatient services | $30 copayment/Visit | Subject to OON deductible, then 20% coinsurance | For the first 3 visits, in-network cost sharing waived for members age 18 and younger. |
| | Mental/behavioral health/substance use inpatient services | Subject to IN deductible, then $500 copayment/Stay | Subject to OON deductible, then 20% coinsurance | May require prior authorization. |
| **If you are pregnant** | Office visits for prenatal and postnatal care | No Member Cost-Sharing | Subject to OON deductible, then 20% coinsurance | None. |
| | Childbirth/delivery facility services | **Tier 1:** Subject to IN deductible, then $500 copayment/Stay<br>**Tier 2:** Subject to IN deductible, then $2,000 copayment/Stay<br>**Tier 3:** Subject to IN deductible, then $3,500 copayment/Stay | Subject to OON deductible, then 20% coinsurance | May require prior authorization. |
| | Childbirth/delivery professional services | **Tier 1:** No charge after IN deductible<br>**Tier 2:** No charge after IN deductible<br>**Tier 3:** No charge after IN deductible | Subject to OON deductible, then 20% coinsurance | May require prior authorization. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In Network | Out of Network | |
| If you need help recovering or have other special health needs | Home health care | No Member Cost-Sharing | Subject to OON deductible, then 20% coinsurance | May require prior authorization. |
| | Rehabilitation services | **Outpatient:**<br>**Tier 1:**<br>Visit 1-6: No Member Cost-Sharing<br>Visit 7-60: Subject to IN deductible, then $60 copayment/Visit<br>**Tier 2:** Subject to IN deductible, then $75 copayment/Visit<br>**Tier 3:** Subject to IN deductible, then $150 copayment/Visit<br>**Inpatient:** Subject to IN deductible, then $500 copayment/Stay | **Outpatient:** Subject to OON deductible, then 20% coinsurance<br>**Inpatient:** Subject to OON deductible, then 20% coinsurance | **Outpatient:** Covered up to 60 combined PT/OT visits per benefit period.<br>**Inpatient:** 60 days per benefit period. Prior authorization required. |
| | Habilitation services | **Outpatient:**<br>**Tier 1:**<br>Visit 1-6: No Member Cost-Sharing<br>Visit 7-60: Subject to IN deductible, then $60 copayment/Visit<br>**Tier 2:** Subject to IN deductible, then $75 copayment/Visit<br>**Tier 3:** Subject to IN deductible, then $150 copayment/Visit<br>**Inpatient:** Subject to IN deductible, then $500 copayment/Stay | **Outpatient:** Subject to OON deductible, then 20% coinsurance<br>**Inpatient:** Subject to OON deductible, then 20% coinsurance | **Outpatient:** Covered up to 60 combined PT/OT visits per benefit period.<br>**Inpatient:** 60 days per benefit period. Prior authorization required. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In Network | Out of Network | |
| | Skilled nursing care | Subject to IN deductible, then $500 copayment/Stay | Subject to OON deductible, then 20% coinsurance | Covered up to 100 days per benefit period. May require prior authorization. |
| | Durable medical equipment | Subject to IN deductible, then 20% coinsurance | Subject to OON deductible, then 20% coinsurance | May require prior authorization. No charge for electric breast pump (one per birth). |
| | Hospice service | No Member Cost-Sharing | Subject to OON deductible, then 20% coinsurance | May require prior authorization. |
| **If your child needs dental or eye care** | Children's eye exam | No Member Cost-Sharing | Not covered | 1 eye exam every 12 months |
| | Children's glasses | No Member Cost-Sharing | Not covered | Provider designated frames. |
| | Children's dental check-up | No Member Cost-Sharing | Not covered | 2 preventive exam(s) per benefit period per child up to the age of 19 |

## 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.)**

- Cosmetic Surgery
- Dental care-adult (you may have coverage under a separate dental plan)
- Extraction of infected or impacted wisdom teeth (except when in a hospital setting)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

**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.)**

- Abortion
- Acupuncture- Covered up to 20 visits per benefit period
- Bariatric surgery
- Chiropractic care
- Hearing aids (age 21 and younger)- Covered up to $2,000 for each affected ear every 36 months
- Infertility treatment
- Routine eye exam (adult)
- Routine foot care (covered for diabetes and some circulatory diseases)
- 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)

**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.*

## 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.

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

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$60**
- **Hospital (facility) copayment** **$500 after IN deductible**

**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:** | |
| *Cost Sharing* | |
| Deductibles | $1,500 |
| Copayments | $600 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$2,100** |

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

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$60**
- **Hospital (facility) copayment** **$500 after IN deductible**

**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:** | |
| *Cost Sharing* | |
| Deductibles | $100 |
| Copayments | $1,000 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,100** |

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

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$60**
- **Hospital (facility) copayment** **$500 after IN deductible**

**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:** | |
| *Cost Sharing* | |
| Deductibles | $400 |
| Copayments | $600 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,000** |

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



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

# Important Information About This Plan

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 In-Network 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 In-Network providers.

Mass General Brigham
Health Plan

# MCC Compliance



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