Mass General Brigham
Health Plan

# Schedule of Benefits

## Complete PPO Plus 4000 40/60 with Care Complement℠

### For Individuals and Small Group Employers



**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).

There are two levels of coverage associated with this Plan: In-Network coverage and Out-of-Network coverage. In-Network coverage applies when you use a Preferred (In-Network) Provider to obtain Covered Services. To access the Complete PPO Plus Provider Directory, visit MassGeneralBrighamHealthPlan.org or call Customer Service.

Out-of-Network coverage applies when you use a Non-Preferred (Out-of-Network) Provider that is not contracted with the Complete PPO Plus network to obtain Covered Services. When using Out-of-Network Providers, the Plan pays only a percentage of the cost of the care you receive up to the Allowed Amount for the service. (Please see your Member Handbook for information on how the Allowed Amount is determined by Mass General Brigham Health Plan.) If an Out-of-Network Provider charges any amount in excess of the Allowed Amount, you are responsible for the excess amount.

All covered services must be medically necessary and some may require Prior Authorization. For a full list of medical and surgical services that require a Prior Authorization, please go to MassGeneralBrighamHealthPlan.org, or call Customer Service. Please visit this site often as services can be added and updated to the list at any time. Your Member Handbook may also include additional coverage and/or exclusions not listed on the Schedule of Benefits.

## DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM

| | In Network | Out of Network |
|---|---|---|
| Deductible per benefit period | **Medical/Dental/Behavioral Health (Combined):**<br>**$4,000 Individual /$8,000 Family**<br>**Prescription Drug: None** | **Medical/Behavioral Health (Combined):**<br>**$8,000 Individual /$16,000 Family** |
| Out-of-Pocket Maximum per benefit period | **Medical/Dental/Behavioral Health/Prescription Drug (Combined):**<br>**$11,300 Individual /$22,600 Family** | **Medical/Behavioral Health (Combined):**<br>**$22,600 Individual /$45,200 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.

## OUT OF NETWORK PENALTY

| | |
|---|---|
| Penalty | $500 |

The Penalty is the amount that a Member may be responsible for paying for certain Out-of-Network services when Prior Authorization has not been received before obtaining the services. The Penalty charge is in addition to any Member Cost-sharing amounts. (Does not count towards the deductible or out-of-pocket maximum.)

## OUTPATIENT MEDICAL CARE

| *Preventive Services* | In Network | Out of Network |
|---|---|---|
| Annual Physical Exams[1] | No Member Cost-Sharing | Subject to OON deductible, then 20% coinsurance |
| Annual Gynecological Exams[1] | No Member Cost-Sharing | Subject to OON deductible, then 20% coinsurance |
| Family Planning Services | No Member Cost-Sharing | Subject to OON deductible, then 20% coinsurance |
| Immunizations & Vaccinations | No Member Cost-Sharing | Subject to OON deductible, then 20% coinsurance |
| Preventive Laboratory Tests | No Member Cost-Sharing | Subject to OON deductible, then 20% coinsurance |
| Screening Colonoscopy | No Member Cost-Sharing | Subject to OON deductible, then 20% coinsurance |
| Screening Mammography | No Member Cost-Sharing | Subject to OON deductible, then 20% coinsurance |
| Well Child Visits | No Member Cost-Sharing | Subject to OON deductible, then 20% coinsurance |

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

| *Other Primary & Specialty Care Office Visits* | In Network | Out of Network |
|---|---|---|
| Office Visits for Other Primary Care | Subject to IN deductible, then $40 copayment/Visit (waived for members age 18 and younger for the first 3 visits) | Subject to OON deductible, then 20% coinsurance |
| Telemedicine (Virtual Visits) - PCP | Subject to IN deductible, then $40 copayment/Visit | Subject to OON deductible, then 20% coinsurance |
| Telemedicine (Virtual Visits) - On Demand | Subject to IN deductible, then $40 copayment/Visit | |
| Office Visits for Other Specialty Care | Subject to IN deductible, then $60 copayment/Visit | Subject to OON deductible, then 20% coinsurance |
| Telemedicine (Virtual Visits) - Specialist | Subject to IN deductible, then $60 copayment/Visit | Subject to OON deductible, then 20% coinsurance |
| Acupuncture<br>(Covered up to 20 visits per benefit period) | Visit 1-6: No Member Cost-Sharing<br>Visit 7-20: Subject to IN deductible, then $60 copayment/Visit | Subject to OON deductible, then 20% coinsurance |
| Allergy Shots | No Member Cost-Sharing | Subject to OON deductible, then 20% coinsurance |
| Cardiac Rehabilitation Service | No Member Cost-Sharing | Subject to OON deductible, then 20% coinsurance |
| Chiropractic Care | Visit 1-6: No Member Cost-Sharing<br>Visit 7 and after: Subject to IN deductible, then $40 copayment/Visit | Subject to OON deductible, then 20% coinsurance |
| Routine Adult Eye Exam<br>(1 visit(s) per member age 19 and over, every 12 months) | Subject to IN deductible, then $60 copayment/Visit (waived for members diagnosed with diabetes) | Subject to OON deductible, then 20% coinsurance |
| Routine Foot Care (covered for diabetes and some circulatory diseases) | Subject to IN deductible, then $60 copayment/Visit | Subject to OON deductible, then 20% coinsurance |
| Hearing Exams | Subject to IN deductible, then $60 copayment/Visit | Subject to OON deductible, then 20% coinsurance |
| Infertility Services | Subject to IN deductible, then $60 copayment/Visit | Subject to OON deductible, then 20% coinsurance |

| | | |
|---|---|---|
| Physical Therapy/Occupational Therapy (Covered up to 60 combined visits for rehabilitation and habilitation each per benefit period)[2] | Visit 1-6: No Member Cost-Sharing<br>Visit 7-60: Subject to IN deductible, then $60 copayment/Visit | Subject to OON deductible, then 20% coinsurance |
| Speech Therapy | Subject to IN deductible, then $60 copayment/Visit | Subject to OON deductible, then 20% coinsurance |
| Routine Prenatal and Postnatal Care | No Member Cost-Sharing | Subject to OON deductible, then 20% coinsurance |

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

***Other Outpatient Services***

| | **In Network** | **Out of Network** |
|---|---|---|
| Diagnostic, Imaging and X-ray | Subject to IN deductible, then $100 copayment/Visit | Subject to OON deductible, then 20% coinsurance |
| Laboratory | Subject to IN deductible, then $60 copayment/Visit | Subject to OON deductible, then 20% coinsurance |
| High-tech Radiology (MRI, CT, PET Scan, Nuclear Cardiac Imaging) | **Non-Hospital and other designated sites:**<br>Subject to IN deductible, then $300 copayment/Visit<br>**Hospital-based:**<br>Subject to IN deductible, then $750 copayment/Visit | Subject to OON deductible, then 20% coinsurance |
| Outpatient Surgery—Facility Fee | **Non-Hospital and other designated sites:**<br>Subject to IN deductible, then $500 copayment/Visit<br>**Hospital-based:**<br>Subject to IN deductible, then $1,000 copayment/Visit | Subject to OON deductible, then 20% coinsurance |
| Outpatient Surgery—Professional Fee | No charge after IN deductible | Subject to OON deductible, then 20% coinsurance |

**INPATIENT MEDICAL CARE**

| | **In Network** | **Out of Network** |
|---|---|---|
| Inpatient Medical Services (including Maternity) - Facility Fee | Subject to IN deductible, then 10% coinsurance | Subject to OON deductible, then 30% coinsurance |
| Inpatient Medical Services - Professional Fee | Subject to IN deductible, then 10% coinsurance | Subject to OON deductible, then 30% coinsurance |
| Inpatient Care in a Skilled Nursing Facility - Facility Fee<br>(Covered up to 100 days per benefit period) | Subject to IN deductible, then 10% coinsurance | Subject to OON deductible, then 30% coinsurance |
| Inpatient Care in a Skilled Nursing Facility - Professional Fee | Subject to IN deductible, then 10% coinsurance | Subject to OON deductible, then 30% coinsurance |
| Inpatient Care in a Rehabilitation Facility - Facility Fee<br>(Covered up to 60 days per benefit period) | Subject to IN deductible, then 10% coinsurance | Subject to OON deductible, then 30% coinsurance |
| Inpatient Care in a Rehabilitation Facility - Professional Fee | Subject to IN deductible, then 10% coinsurance | Subject to OON deductible, then 30% coinsurance |
| Routine Nursery and Newborn Care | No Member Cost-Sharing | Subject to OON deductible, then 20% coinsurance |

**BEHAVIORAL HEALTH - OUTPATIENT**

| | In Network | Out of Network |
|---|---|---|
| Mental Health Care or Substance Use Care | Subject to IN deductible, then $40 copayment/Visit (waived for members age 18 and younger for the first 3 visits) | Subject to OON deductible, then 20% coinsurance |
| Telemedicine (Virtual Visits) - Mental Health Care or Substance Use Care | Subject to IN deductible, then $40 copayment/Visit | Subject to OON deductible, then 20% coinsurance |

**BEHAVIORAL HEALTH - INPATIENT**

| | In Network | Out of Network |
|---|---|---|
| Mental Health Care - Facility Fee | Subject to IN deductible, then 10% coinsurance | Subject to OON deductible, then 30% coinsurance |
| Mental Health Care - Professional Fee | Subject to IN deductible, then 10% coinsurance | Subject to OON deductible, then 30% coinsurance |
| Substance Use Detoxification or Rehabilitation - Facility Fee | Subject to IN deductible, then 10% coinsurance | Subject to OON deductible, then 30% coinsurance |
| Substance Use Detoxification or Rehabilitation - Professional Fee | Subject to IN deductible, then 10% coinsurance | Subject to OON deductible, then 30% coinsurance |

**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.

| | In Network | Out of Network |
|---|---|---|
| Urgent Care | Subject to IN deductible, then $60 copayment/Visit | Subject to OON deductible, then 20% coinsurance |

**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 | Subject to IN deductible, then $850 copayment/Visit (Copayment waived if admitted to hospital for inpatient care) |
| Ambulance Services (emergency transport only) | No charge after IN deductible |
| Emergency Dental Care (within 72 hours of accident or injury) | Subject to IN deductible, then $850 copayment/Visit (Copayment 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 IN deductible, then 25% coinsurance |
| Major Restorative (dentures, crowns) | Subject to IN deductible, then 50% coinsurance |
| Orthodontic Services (medically necessary) | Subject to IN 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: $50 copayment/Prescription<br>Tier 3 - High costing generic and preferred brand name: $175 copayment/Prescription<br>Tier 4 - Higher cost generics and non-preferred brand name: $250 copayment/Prescription<br>Tier 5 - Generic specialty and preferred specialty: $350 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: $100 copayment/Prescription<br>Tier 3 - High costing generic and preferred brand name: $350 copayment/Prescription<br>Tier 4 - Higher cost generics and non-preferred brand name: $750 copayment/Prescription |
| **90-day Retail:** | Tier 1 - Low-Cost Generic: $30 copayment/Prescription<br>Tier 2 - Other generic and some brand name: $150 copayment/Prescription<br>Tier 3 - High costing generic and preferred brand name: $525 copayment/Prescription<br>Tier 4 - Higher cost generics and non-preferred brand name: $750 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- $175 copayment/Prescription (depending on drug prescribed) |

**ADDITIONAL SERVICES**

| | In Network | Out of Network |
|---|---|---|
| Diabetic Supplies | No Member Cost-Sharing | Subject to OON deductible, then 20% coinsurance |
| Disposable Medical Supplies | No charge after IN deductible | Subject to OON deductible, then 20% coinsurance |
| Durable Medical Equipment | Subject to IN deductible, then 20% coinsurance | Subject to OON deductible, then 30% coinsurance |
| Early Intervention (from birth up to age three) | No Member Cost-Sharing | 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 | Subject to OON deductible, then 20% coinsurance |
| Home Health Care | No Member Cost-Sharing | Subject to OON deductible, then 20% coinsurance |
| Hospice Care | No Member Cost-Sharing | Subject to OON deductible, then 20% coinsurance |
| Medical Drugs (drugs that cannot be self-administered) | $250 copayment/Visit | Subject to OON deductible, then 20% coinsurance |
| Oxygen Supplies and Therapy | No Member Cost-Sharing | Subject to OON deductible, then 20% coinsurance |
| Radiation Therapy and Chemotherapy | $75 copayment/Visit | Subject to OON deductible, then 20% coinsurance |
| 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 IN deductible, then 20% coinsurance | Subject to OON deductible, then 30% 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.

**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.

**Urgent Care**
If you need urgent care, you can obtain In-Network coverage by seeking services from an In-Network Urgent Care Facility. To find an In-Network Urgent Care Facility near you, access the online Provider Directory at MassGeneralBrighamHealthPlan.org or call Customer Service. 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 amounts. If you need follow-up care after you are treated in an emergency room, you must get care from an In- Network Provider for coverage to be provided at the In-Network coverage level. If you are admitted to the hospital from an emergency visit, you or the attending physician must call the Plan at 866-414-5533 within 24 hours. This telephone number can also be found on your Member ID card.

**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)*
Prior Authorization determines in advance if a procedure or treatment either you or your doctor is requesting is both medically appropriate and medically necessary. Members are required to obtain Prior Authorization from Mass General Brigham Health Plan for certain services. Before you receive services from an Out-of-Network Provider, please refer to our website, MassGeneralBrighamHealthPlan.org, or contact Customer Service at 866-414-5533 for a list of Out-of- Network services that require Prior Authorization.

***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; Personal comfort items; Reversal of Voluntary Sterilization.

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 IN deductible, then 25% coinsurance |
| Simple tooth extractions<br>(1 per tooth) | Subject to IN deductible, then 25% coinsurance |
| Surgical extractions | Subject to IN deductible, then 25% coinsurance |
| General Anesthesia or Minor treatment for pain relief | Subject to IN deductible, then 25% coinsurance |
| Root canals<br>(1 per permanent tooth) | Subject to IN deductible, then 25% coinsurance |
| Periodontal services (limits vary) | Subject to IN deductible, then 25% coinsurance |
| Endodontic services (limits vary) | Subject to IN deductible, then 25% coinsurance |
| Repair of crowns (limits vary) | Subject to IN deductible, then 25% coinsurance |
| Palliative treatment of dental pain (limits vary) | Subject to IN deductible, then 25% coinsurance |
| Adjustment of dentures (limits vary) | Subject to IN deductible, then 25% coinsurance |
| | |
| **Major Restorative (dentures, crowns)** | |
| Dentures<br>(1 per 84 months) | Subject to IN deductible, then 50% coinsurance |
| Crowns<br>(1 per 60 months) | Subject to IN deductible, then 50% coinsurance |
| | |
| **Orthodontic Services - All Orthodontic Treatment Requires Preauthorization** | |
| Only medically necessary orthodontic treatment is covered | Subject to IN 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.**