Mass General Brigham
Health Plan

Schedule of Benefits

Complete PPO Plus 5000 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): $5,000 Individual /$10,000 Family Prescription Drug: None**	**Medical/Behavioral Health (Combined): $10,000 Individual /$20,000 Family**
Out-of-Pocket Maximum per benefit period	**Medical/Dental/Behavioral Health/Prescription Drug (Combined): $10,500 Individual /$21,000 Family**	**Medical/Behavioral Health (Combined): $21,000 Individual /$42,000 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.

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 (Covered up to 20 visits per benefit period)	Visit 1-6: No Member Cost-Sharing 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 Visit 7 and after: Subject to IN deductible, then $40 copayment/Visit	Subject to OON deductible, then 20% coinsurance
Routine Adult Eye Exam (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 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:** Subject to IN deductible, then $300 copayment/Visit **Hospital-based:** 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:** Subject to IN deductible, then $500 copayment/Visit **Hospital-based:** 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 (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 (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 Tier 2 - Other generic and some brand name: $50 copayment/Prescription Tier 3 - High costing generic and preferred brand name: $175 copayment/Prescription Tier 4 - Higher cost generics and non-preferred brand name: $250 copayment/Prescription Tier 5 - Generic specialty and preferred specialty: $350 copayment/Prescription 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 Tier 2 - Other generic and some brand name: $100 copayment/Prescription Tier 3 - High costing generic and preferred brand name: $350 copayment/Prescription Tier 4 - Higher cost generics and non-preferred brand name: $750 copayment/Prescription
90-day Retail:	Tier 1 - Low-Cost Generic: $30 copayment/Prescription Tier 2 - Other generic and some brand name: $150 copayment/Prescription Tier 3 - High costing generic and preferred brand name: $525 copayment/Prescription 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 (1 per 90 days)	No Member Cost-Sharing
Periodic oral exams (2 per benefit period)	No Member Cost-Sharing
Routine cleanings (2 per benefit period)	No Member Cost-Sharing
Bitewing x-rays (2 per benefit period)	No Member Cost-Sharing
Panoramic x-rays (1 every 3 years)	No Member Cost-Sharing
Sealants (1 every 3 years)	No Member Cost-Sharing
Space maintainers	No Member Cost-Sharing
Basic Restorative (fillings, root canal treatment)	
Fillings (1 per 12 months)	Subject to IN deductible, then 25% coinsurance
Simple tooth extractions (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 (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 (1 per 84 months)	Subject to IN deductible, then 50% coinsurance
Crowns (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 ***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.