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:** $3,000/Individual, $6,000/Family per benefit period. **Out of Network:** $6,000/Individual, $12,000/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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-Network Preventive 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:** $8,700/Individual, $17,400/Family per benefit period. **Out of Network:** $17,400/Individual, $34,800/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.

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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	Subject to IN deductible, then $40 copayment/Visit	Subject to OON deductible, then 20% coinsurance	None.
	Specialist visit	Subject to IN deductible, then $65 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:** Subject to IN deductible, then $65 copayment/Visit **Blood work:** Subject to IN deductible, then $65 copayment/Visit	**X-ray:** Subject to OON deductible, then 20% coinsurance **Blood work:** Subject to OON deductible, then 20% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	**Non-Hospital and other designated sites:** Subject to IN deductible, then $200 copayment/Visit **Hospital-based:** Subject to IN deductible, then $400 copayment/Visit	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 drugs to treat your illness or condition More information about 6-tier Prescription drug coverage is available at MGBHP.org/members/pharmacy	Tier 1 – Low-Cost Generic	30-day Retail: Subject to IN deductible, then $10 copayment/Prescription 90-day Mail: Subject to IN deductible, then $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. No charge for birth control and smoking cessation drugs. May require prior authorization.
	Tier 2 – Other generic and some brand name	30-day Retail: Subject to IN deductible, then $40 copayment/Prescription 90-day Mail: Subject to IN deductible, then $80 copayment/Prescription	Not covered	
	Tier 3 – High costing generic and preferred brand name	30-day Retail: Subject to IN deductible, then $100 copayment/Prescription 90-day Mail: Subject to IN deductible, then $200 copayment/Prescription	Not covered	
	Tier 4 – Higher cost generics and non-preferred brand name	30-day Retail: Subject to IN deductible, then $200 copayment/Prescription 90-day Mail: Subject to IN deductible, then $600 copayment/Prescription	Not covered	
	Tier 5 – Generic specialty and preferred specialty	Subject to IN deductible, then $250 copayment/Prescription	Not covered	Prescription must be filled through our specialty pharmacy and a prior authorization may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network	Out of Network	
	Tier 6 – Non-preferred specialty	Subject to IN deductible, then $500 copayment/Prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**Non-Hospital and other designated sites:** Subject to IN deductible, then $250 copayment/Visit **Hospital-based:** Subject to IN deductible, then $500 copayment/Visit	Subject to OON deductible, then 20% coinsurance	May require prior authorization.
	Physician/surgeon fees	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance	None.
If you need immediate medical attention	Emergency room services	Subject to IN deductible, then $600 copayment/Visit	Subject to IN deductible, then $600 copayment/Visit	Emergency room copay waived if admitted to hospital for inpatient care.
	Emergency medical transportation	No charge after IN deductible	No charge after IN deductible	None.
	Urgent care	Subject to IN deductible, then $65 copayment/Visit	Subject to OON deductible, then 20% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	Subject to IN deductible, then $500 copayment/Stay	Subject to OON deductible, then 20% coinsurance	May require prior authorization.
	Physician/surgeon fee	No charge after IN deductible	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	
If you need mental health, behavioral health, or substance use services	Mental/behavioral health/substance use outpatient services	Subject to IN deductible, then $40 copayment/Visit	Subject to OON deductible, then 20% coinsurance	None.
	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 charge after IN deductible	Subject to OON deductible, then 20% coinsurance	None.
	Childbirth/delivery facility services	Subject to IN deductible, then $500 copayment/Stay	Subject to OON deductible, then 20% coinsurance	May require prior authorization.
	Childbirth/delivery professional services	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance	May require prior authorization.
If you need help recovering or have other special health needs	Home health care	No charge after IN deductible	Subject to OON deductible, then 20% coinsurance	May require prior authorization.
	Rehabilitation services	**Outpatient:** Subject to IN deductible, then $65 copayment/Visit **Inpatient:** Subject to IN deductible, then $500 copayment/Stay	**Outpatient:** Subject to OON deductible, then 20% coinsurance **Inpatient:** Subject to OON deductible, then 20% coinsurance	**Outpatient:** Covered up to 60 combined PT/OT visits per benefit period. **Inpatient:** Covered up to 60 days per benefit period. Prior authorization required.
	Habilitation services	**Outpatient:** Subject to IN deductible, then $65 copayment/Visit **Inpatient:** Subject to IN deductible, then $500 copayment/Stay	**Outpatient:** Subject to OON deductible, then 20% coinsurance **Inpatient:** Subject to OON deductible, then 20% coinsurance	**Outpatient:** Covered up to 60 combined PT/OT visits per benefit period. **Inpatient:** Covered up to 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 charge after IN deductible	Subject to OON deductible, then 20% coinsurance	May require prior authorization.
If your child needs dental or eye care	Children's eye exam	No charge after IN deductible	Not covered	1 eye exam every 12 months
	Children's glasses	No charge after IN deductible	Not covered	Provider designated frames.
	Children's dental check-up	No charge after IN deductible	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** **$3,000**
- **Specialist copayment** **$65 after IN deductible**
- **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	$3,000
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,800**

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

- **The plan's overall deductible** **$3,000**
- **Specialist copayment** **$65 after IN deductible**
- **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	$3,000
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,300**

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

- **The plan's overall deductible** **$3,000**
- **Specialist copayment** **$65 after IN deductible**
- **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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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.

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.