Complete HMO 1000 25/50/350 with Care ComplementSM for individuals and small group employers

Coverage Period: On or after 01/01/2024

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>$1,000/Individual, $2,000/Family per benefit period.</td>
<td>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, they have to meet their own individual deductible until the overall family deductible amount has been met.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. 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.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>$9,000/Individual, $18,000/Family per benefit period.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they do not count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. For a list of in-network providers, see MassGeneralBrighamHealthPlan.org or call 866-414-5533.</td>
<td>If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. 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.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>Yes.</td>
<td>This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan’s permission before you see the specialist.</td>
</tr>
</tbody>
</table>
### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage Period:** On or after 01/01/2024

**Coverage for:** All Coverage Tiers  |  **Plan Type:** HMO

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

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>$25 copayment/Visit</td>
<td>Not covered</td>
<td>For the first 3 visits, in-network cost sharing waived for members age 18 and younger.</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$50 copayment/Visit</td>
<td>Not covered</td>
<td>None.</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No Member Cost-Sharing</td>
<td>Not covered</td>
<td>Services for specific conditions during an annual exam may be subject to cost sharing.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>X-ray: Subject to deductible, then $50 copayment/Visit Blood work: No charge after deductible</td>
<td>Not covered</td>
<td>None.</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Non-Hospital and other designated sites: Subject to deductible, then $250 copayment/Visit Hospital-based: Subject to deductible, then $500 copayment/Visit</td>
<td>Not covered</td>
<td>May require prior authorization.</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Tier 1 – Low-Cost Generic</td>
<td>Retail: $10 copayment/Prescription Maintenance 90: $20 copayment/Prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------------</td>
<td>-------------------</td>
<td>---------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In Network</td>
<td>Out of Network</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at MassGeneralBrighamHealthPlan.org</td>
<td>Tier 2 – Other generic and some brand name</td>
<td>Retail: $30 copayment/Prescription Maintenance 90: $60 copayment/Prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 3 – High costing generic and preferred brand name</td>
<td>Retail: $75 copayment/Prescription Maintenance 90: $150 copayment/Prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 4 – Higher cost generics and non-preferred brand name</td>
<td>Retail: $200 copayment/Prescription Maintenance 90: $600 copayment/Prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 5 – Generic specialty and preferred specialty</td>
<td>$250 copayment/Prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 6 – Non-preferred specialty</td>
<td>$500 copayment/Prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at MassGeneralBrighamHealthPlan.org</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Non-Hospital and other designated sites: Subject to deductible, then $250 copayment/Visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hospital-based: Subject to deductible, then $500 copayment/Visit</td>
<td>May require prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Emergency room services</td>
<td>$350 copayment/Visit</td>
<td>Emergency room copay waived if admitted to hospital for inpatient care.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td></td>
<td>$350 copayment/Visit</td>
<td>None.</td>
</tr>
</tbody>
</table>
## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage Period:** On or after 01/01/2024

**Coverage for:** All Coverage Tiers  |  **Plan Type:** HMO

### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency medical transportation</strong></td>
<td>No Member Cost-Sharing</td>
<td>No Member Cost-Sharing</td>
</tr>
<tr>
<td><strong>Urgent care</strong></td>
<td>$50 copayment/Visit</td>
<td>$50 copayment/Visit</td>
</tr>
<tr>
<td><strong>Facility fee (e.g., hospital room)</strong></td>
<td>Subject to deductible, then $500 copayment/Stay</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Physician/surgeon fee</strong></td>
<td>No charge after deductible</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### If you have a hospital stay

<table>
<thead>
<tr>
<th>Mental/behavioral health/substance use outpatient services</th>
<th>$25 copayment/Visit</th>
<th>Not covered</th>
<th>For the first 3 visits, in-network cost sharing waived for members age 18 and younger.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental/behavioral health/substance use inpatient services</td>
<td>Subject to deductible, then $500 copayment/Stay</td>
<td>Not covered</td>
<td>May require prior authorization.</td>
</tr>
</tbody>
</table>

### If you need mental health, behavioral health, or substance use services

<table>
<thead>
<tr>
<th>Office visits for prenatal and postnatal care</th>
<th>No Member Cost-Sharing</th>
<th>Not covered</th>
<th>None.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childbirth/delivery facility services</td>
<td>Subject to deductible, then $500 copayment/Stay</td>
<td>Not covered</td>
<td>May require prior authorization.</td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>No charge after deductible</td>
<td>Not covered</td>
<td>May require prior authorization.</td>
</tr>
</tbody>
</table>

### If you are pregnant

| Home health care | No Member Cost-Sharing | Not covered | May require prior authorization. |
### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage Period:** On or after 01/01/2024

#### Plan Type: HMO

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In Network</th>
<th>Out of Network</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Rehabilitation services</strong></td>
<td><strong>Outpatient:</strong> Visit 1-6: No Member Cost-Sharing</td>
<td>Not covered</td>
<td><strong>Outpatient:</strong> Covered up to 60 combined PT/OT visits per benefit period. <strong>Inpatient:</strong> Covered up to 60 days per benefit period. Prior authorization required.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Visit 7-60: $50 copayment/Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Inpatient:</strong> Subject to deductible, then $500 copayment/Stay</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Habilitation services</strong></td>
<td><strong>Outpatient:</strong> Visit 1-6: No Member Cost-Sharing</td>
<td>Not covered</td>
<td><strong>Outpatient:</strong> Covered up to 60 combined PT/OT visits per benefit period. <strong>Inpatient:</strong> Covered up to 60 days per benefit period. Prior authorization required.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Visit 7-60: $50 copayment/Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Inpatient:</strong> Subject to deductible, then $500 copayment/Stay</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Skilled nursing care</strong></td>
<td>Subject to deductible, then $500 copayment/Stay</td>
<td>Not covered</td>
<td>Covered up to 100 days per benefit period. May require prior authorization.</td>
</tr>
<tr>
<td></td>
<td><strong>Durable medical equipment</strong></td>
<td>Subject to deductible, then 20% coinsurance</td>
<td>Not covered</td>
<td>May require prior authorization. No charge for electric breast pump (one per birth).</td>
</tr>
<tr>
<td></td>
<td><strong>Hospice service</strong></td>
<td>No Member Cost-Sharing</td>
<td>Not covered</td>
<td>May require prior authorization.</td>
</tr>
</tbody>
</table>

#### 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 |
Coverage Period: On or after 01/01/2024

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: All Coverage Tiers | Plan Type: HMO

Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)</th>
<th>Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cosmetic Surgery</td>
<td>• Extraction of infected or impacted wisdom teeth (except when in a hospital setting)</td>
</tr>
<tr>
<td>• Dental care-adult (you may have coverage under a separate dental plan)</td>
<td>• Long-term care</td>
</tr>
<tr>
<td></td>
<td>• Non-emergency care when traveling outside the U.S.</td>
</tr>
<tr>
<td></td>
<td>• Private-duty nursing</td>
</tr>
</tbody>
</table>

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.)

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

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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe's type 2 Diabetes</th>
<th>Mia's Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
<tr>
<td><strong>The plan’s overall deductible</strong></td>
<td><strong>The plan’s overall deductible</strong></td>
<td><strong>The plan’s overall deductible</strong></td>
</tr>
<tr>
<td>$1,000</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>Specialist copayment</strong></td>
<td><strong>Specialist copayment</strong></td>
<td><strong>Specialist copayment</strong></td>
</tr>
<tr>
<td>$50</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td><strong>Hospital (facility) copayment</strong></td>
<td><strong>Hospital (facility) copayment</strong></td>
<td><strong>Hospital (facility) copayment</strong></td>
</tr>
<tr>
<td>$500 after deductible</td>
<td>$500 after deductible</td>
<td>$500 after deductible</td>
</tr>
</tbody>
</table>

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)

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)

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage for:** All Coverage Tiers | **Plan Type:** HMO

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Total Example Cost</th>
<th>In this example, Peg would pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,000</td>
<td>$1,700</td>
</tr>
<tr>
<td>Copayments</td>
<td>$700</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>

Total Example Cost: $12,700

In this example, Peg would pay:

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

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Total Example Cost</th>
<th>In this example, Joe would pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$100</td>
<td><strong>$900</strong></td>
</tr>
<tr>
<td>Copayments</td>
<td>$800</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>

Total Example Cost: $5,600

In this example, Joe would pay:

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

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Total Example Cost</th>
<th>In this example, Mia would pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$400</td>
<td><strong>$900</strong></td>
</tr>
<tr>
<td>Copayments</td>
<td>$500</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>

Total Example Cost: $2,800

In this example, Mia would pay:

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

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