Mass General Brigham
Health Plan

Schedule of Benefits

Complete HMO 20/40 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).

All covered services must be medically necessary and some may require prior authorization. Please check with your PCP or treating provider to determine if a prior authorization is necessary. Your Member Handbook may include additional coverage and/or exclusions not listed on the Schedule of Benefits.

DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM

Deductible per benefit period	**Medical/Dental/Behavioral Health/Prescription Drug (Combined):** **None**
Out-of-Pocket Maximum per benefit period	**Medical/Dental/Behavioral Health/Prescription Drug (Combined):** **$3,500 Individual /$7,000 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.

OUTPATIENT MEDICAL CARE

Preventive Services

Annual Physical Exams[1]	No Member Cost-Sharing
Annual Gynecological Exams[1]	No Member Cost-Sharing
Family Planning Services	No Member Cost-Sharing
Immunizations & Vaccinations	No Member Cost-Sharing
Preventive Laboratory Tests	No Member Cost-Sharing
Screening Colonoscopy	No Member Cost-Sharing
Screening Mammography	No Member Cost-Sharing
Well Child Visits	No Member Cost-Sharing

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

Other Primary & Specialty Care Office Visits

Office Visits for Other Primary Care	$20 copayment/Visit (waived for members age 18 and younger for the first 3 visits)
Telemedicine (Virtual Visits) - PCP	$20 copayment/Visit
Telemedicine (Virtual Visits) - On Demand	$20 copayment/Visit
Office Visits for Other Specialty Care	$40 copayment/Visit
Telemedicine (Virtual Visits) - Specialist	$40 copayment/Visit
Acupuncture (Covered up to 20 visits per benefit period)	Visit 1-6: No Member Cost-Sharing Visit 7-20: $40 copayment/Visit
Allergy Shots	No Member Cost-Sharing
Cardiac Rehabilitation Service	No Member Cost-Sharing
Chiropractic Care	Visit 1-6: No Member Cost-Sharing Visit 7 and after: $20 copayment/Visit
Routine Adult Eye Exam (1 visit(s) per member age 19 and over, every 12 months)	$40 copayment/Visit (waived for members diagnosed with diabetes)
Routine Foot Care (covered for diabetes and some circulatory diseases)	$40 copayment/Visit
Hearing Exams	$40 copayment/Visit
Infertility Services	$40 copayment/Visit
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: $40 copayment/Visit
Speech Therapy	$40 copayment/Visit
Routine Prenatal and Postnatal Care	No Member Cost-Sharing

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

Other Outpatient Services

Diagnostic, Imaging and X-ray	No Member Cost-Sharing
Laboratory	No Member Cost-Sharing
High-tech Radiology (MRI, CT, PET Scan, Nuclear Cardiac Imaging)	**Non-Hospital and other designated sites:** $150 copayment/Visit **Hospital-based:** $300 copayment/Visit
Outpatient Surgery—Facility Fee	**Non-Hospital and other designated sites:** $250 copayment/Visit **Hospital-based:** $500 copayment/Visit
Outpatient Surgery—Professional Fee	No Member Cost-Sharing

INPATIENT MEDICAL CARE	
Inpatient Medical Services (including Maternity) - Facility Fee	$500 copayment/Stay
Inpatient Medical Services - Professional Fee	No Member Cost-Sharing
Inpatient Care in a Skilled Nursing Facility - Facility Fee (Covered up to 100 days per benefit period)	$500 copayment/Stay
Inpatient Care in a Skilled Nursing Facility - Professional Fee	No Member Cost-Sharing
Inpatient Care in a Rehabilitation Facility - Facility Fee (Covered up to 60 days per benefit period)	$500 copayment/Stay
Inpatient Care in a Rehabilitation Facility - Professional Fee	No Member Cost-Sharing
Routine Nursery and Newborn Care	No Member Cost-Sharing

BEHAVIORAL HEALTH - OUTPATIENT	
Mental Health Care or Substance Use Care	$20 copayment/Visit (waived for members age 18 and younger for the first 3 visits)
Telemedicine (Virtual Visits) - Mental Health Care or Substance Use Care	$20 copayment/Visit

BEHAVIORAL HEALTH - INPATIENT	
Mental Health Care - Facility Fee	$500 copayment/Stay
Mental Health Care - Professional Fee	No Member Cost-Sharing
Substance Use Detoxification or Rehabilitation - Facility Fee	$500 copayment/Stay
Substance Use Detoxification or Rehabilitation - Professional Fee	No Member Cost-Sharing

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.

Urgent Care	$40 copayment/Visit

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	$150 copayment/Visit (waived if admitted to hospital for inpatient care)
Ambulance Services (emergency transport only)	No Member Cost-Sharing
Emergency Dental Care (within 72 hours of accident or injury)	$150 copayment/Visit (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)	25% coinsurance
Major Restorative (dentures, crowns)	50% coinsurance
Orthodontic Services (medically necessary)	50% coinsurance

Vision	
Routine Eye Exams (1 every 12 months per child up to the age of 19)	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: $20 copayment/Prescription Tier 3 - High costing generic and preferred brand name: $45 copayment/Prescription Tier 4 - Higher cost generics and non-preferred brand name: $160 copayment/Prescription Tier 5 - Generic specialty and preferred specialty: $200 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: $40 copayment/Prescription Tier 3 - High costing generic and preferred brand name: $90 copayment/Prescription Tier 4 - Higher cost generics and non-preferred brand name: $480 copayment/Prescription
90-day Retail:	Tier 1 - Low-Cost Generic: $30 copayment/Prescription Tier 2 - Other generic and some brand name: $60 copayment/Prescription Tier 3 - High costing generic and preferred brand name: $135 copayment/Prescription Tier 4 - Higher cost generics and non-preferred brand name: $480 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- $45 copayment/Prescription (depending on drug prescribed)

ADDITIONAL SERVICES

Diabetic Supplies	No Member Cost-Sharing
Disposable Medical Supplies	20% coinsurance
Durable Medical Equipment	20% coinsurance
Early Intervention (from birth up to age three)	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
Home Health Care	No Member Cost-Sharing
Hospice Care	No Member Cost-Sharing
Medical Drugs (drugs that cannot be self-administered)	$160 copayment/Visit
Oxygen Supplies and Therapy	No Member Cost-Sharing
Radiation Therapy and Chemotherapy	$75 copayment/Visit
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)	20% 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 or Coinsurance Required for Certain Services
All medical, dental, behavioral health and prescription drug copayments and coinsurance 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 coinsurance and copayment 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.

Your Primary Care Provider (PCP)
Your PCP arranges your health care and is the first person you call when you need medical care. Be sure to check with your PCP to find out office hours and whether urgent care is offered.

Mass General Brigham Health Plan requires the designation of a PCP. You have the right to designate a PCP who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the PCP.

For information on how to select a PCP, or a list of the most up-to date provider information, or a list of participating health care professionals who specialize in obstetrics or gynecology, visit MassGeneralBrighamHealthPlan.org or call Customer Service.

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.

Primary Care Provider (PCP) and Obstetrical Rights
You do not need a referral from Mass General Brigham Health Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. However, the health care professional may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan.

Urgent Care
If you need urgent care, call your PCP to arrange where you will receive treatment. 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 amount. All follow-up care must be arranged by your PCP.

Referrals
Mass General Brigham Health Plan requires referral for specialist services provided by in-network Providers, except the following: Gynecologist or Obstetrician for routine, preventive or urgent care; Family Planning services; Outpatient and Diversionary Behavioral Health Services; Physical Therapy; Occupational Therapy; Speech Therapy; Routine Eye exam; and Emergency Services.

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)*
Determines in advance if a procedure or treatment either you or your doctor is requesting is both medically appropriate and medically necessary.

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; Out-of-network providers; Non-emergency care when traveling outside the U.S.

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)	25% coinsurance
Simple tooth extractions (1 per tooth)	25% coinsurance
Surgical extractions	25% coinsurance
General Anesthesia or Minor treatment for pain relief	25% coinsurance
Root canals (1 per permanent tooth)	25% coinsurance
Periodontal services (limits vary)	25% coinsurance
Endodontic services (limits vary)	25% coinsurance
Repair of crowns (limits vary)	25% coinsurance
Palliative treatment of dental pain (limits vary)	25% coinsurance
Adjustment of dentures (limits vary)	25% coinsurance
Major Restorative (dentures, crowns)	
Dentures (1 per 84 months)	50% coinsurance
Crowns (1 per 60 months)	50% coinsurance
Orthodontic Services - All Orthodontic Treatment Requires Preauthorization	
Only medically necessary orthodontic treatment is covered	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, 2026 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, 2026. 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.

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