Mass General Brigham

2024 Medical Plan Comparison

Services shaded teal are subject to the annual deductible
Coinsurance amounts listed below represent the portion paid by the member

	Premium EPO Plan	Core PPO Plan		HDHP PPO Plan with HSA[2]	
	In-network	In-network	Out-of-network	In-network	Out-of-network
General Provisions					
HSA seed (employer contribution)	None	None		$500/individual; $1,000/family	
Annual deductible (individual/family)	$0/$0	$500/$1,000	$3,000/$6,000	$2,000/$4,000	$4,000/$8,000
Out-of-pocket maximum (individual/family)	$2,000/$4,000	$3,000/$6,000	$6,000/$12,000	$4,000/$8,000	$7,500/$15,000
Inpatient covered services					
Medical, surgical (per admission)	$250 copay	10%	40%	20%	40%
Mental health and substance use (per admission)	$250 copay	10%		20%	
Outpatient covered services					
Primary care physician visits (in-office and virtual)	$15 copay	$25 copay	40%	20%	40%
Pediatric primary care visits (in-office and virtual; age 18 or under)	$15 copay	$25 copay			
Specialist visits (in-office and virtual)	$30 copay	$40 copay			
Preventive care (adult and pediatric)	**Covered at 100%**	**Covered at 100%**	Not covered	**Covered at 100%**	Not covered
Routine eye exam (one visit per member every 12 months)			Not covered		Not covered
Immunizations and inoculations			40%		40%
Pap smear					
Screening mammogram, colonoscopy					
Diagnostic imaging, x-rays, and lab services		10%		20%	
Telemedicine (virtual visits through On Demand)	$10 copay	$10 copay	Not covered	20%	Not covered
Urgent care	$30 copay	$40 copay	40%	20%	40%
Emergency room	$200 copay (waived if admitted)	$300 copay (waived if admitted)		$300 copay (waived if admitted)	
Outpatient day surgery	$100 copay	10%	40%	20%	40%
Hi-tech imaging (MRI, CT, PET)	$50 copay	10%		20%	
Physical therapy/occupational therapy/speech therapy/ chiropractic/acupuncture[3]	$30 copay	$40 copay	40%	20%	40%
Mental health/SUD (in-office and virtual)	$15 copay for in-office $10 copay for virtual	$25 copay for in-office $10 copay for virtual	40%	20%	40%
Durable medical equipment (DME)	20%	20%	40%	20%	40%
Ambulance service (emergency only)	**Covered at 100%**	10%		20%	
Maternity coverage					
In-hospital (delivery)	$250 copay	10%	40%	20%	40%
Prenatal care	**Covered at 100%**	**Covered at 100%**			
Prescription drug coverage					
Retail pharmacy (30-day supply – generic/preferred brand/ non-preferred brand)	$10/$40/$70 copay	$10/$50/$100 copay	Not covered	$10/$50/$100 copay	Not covered
Maintenance choice[1] (90-day supply – generic/preferred brand/non-preferred brand)	$25/$100/$175 copay	$25/$125/$250 copay	Not covered	$25/$125/$250 copay	Not covered

[1]CVS Caremark Mail Order, CVS, MGB pharmacies or participating on-island pharmacy for employees at MVH, Windemere and NCH
[2]The HDHP includes an aggregate deductible and out-of-pocket maximum. For individual policies, only the individual deductible and out-of-pocket maximum (OOPM) amounts apply to the plan. For family policies with an aggregate plan, the entire family deductible must be met before benefits are payable for anyone in the family, and the entire family OOPM must be satisfied before the plan pays 100%.
[3]PT/OT up to 100 combined visits per calendar year, no limit for Autism Spectrum Disorders. Acupuncture up to 40 visits per member per calendar year.

Disclaimer: In the event there is any conflict between the information in this summary/communication and the provisions in the policy, plan or program documents, the policy, plan or program documents will govern.