Mass General Brigham

2026 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[1]	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
General Provisions						
HSA seed (employer contribution)	N/A		N/A		$500/individual; $1,000/family	
Annual deductible (individual/family)	$0/$0	N/A	$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	Not covered	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	Not covered	$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[2]	**Covered at 100%**	Not covered[2]
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 and x-rays			$30 copay		20%	
Diagnostic lab services			10%			
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)	Refer to the Summary of Benefits	$300 copay (waived if admitted)		$300 copay (waived if admitted)	
Outpatient day surgery	$100 copay	Not covered	10%	40%	20%	40%
Hi-tech imaging (MRI, CT, PET)	$50 copay		$150 copay		20%	
Physical therapy/occupational therapy/speech therapy for all conditions excluding primary behavioral health condition; chiropractor/acupuncture[3]	$30 copay		$40 copay	40%	20%	40%
Physical therapy/occupational therapy/speech therapy for a primary behavioral health condition	**Covered at 100%**		10%	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%**		$100 copay		20%	
Maternity coverage						
In-hospital (delivery)	$250 copay	Not covered	10%	40%	20%	40%
Prenatal care office visits	**Covered at 100%**		**Covered at 100%**			
Prescription drug coverage						
Retail pharmacy (30-day supply – generic/preferred brand/ non-preferred brand)	$10/$40/$70 copay	Not covered	$10/$50/$100 copay	Not covered	$10/$50/$100 copay	Not covered
Maintenance choice[4] (90-day supply – generic/preferred brand/non-preferred brand)	$25/$100/$175 copay		$25/$125/$250 copay		$25/$125/$250 copay	

[1] 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%.

[2] Some pediatric preventive care services are covered out-of-network.

[3] Non-primary behavioral health PT/OT up to 100 combined visits per calendar year. Acupuncture up to 40 visits per member per calendar year.

[4] CVS Caremark Mail Order, CVS, MGB pharmacies or participating on-island pharmacy for employees at MVH, Windemere and NCH.

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.