




Mass General Brigham

A large, light blue heart outline is centered on the page. In the upper left, there is a pill icon with a diagonal line and a small square icon. In the lower right, there is a circular icon containing a stylized pulse line. A curved line connects the pill icon to the heart, and another curved line connects the pulse icon to the heart.

2025 Medical plan comparison chart

For out-of-area employees represented by unions and/or covered by collective bargaining agreements being offered Select and Plus health plans.

This chart is only a summary. For details, limitations, and exclusions, please contact the Mass General Brigham Benefits Center (Alight) at **1-833-885-5656** for the specific plan's benefit description. A full list of Tier 1 providers is available at mgbhealthplan.org/MGB-Directory. This chart applies to out-of-area coverage. For nationwide coverage, Mass General Brigham Health Plan leverages the UnitedHealthcare Options PPO network. To confirm if you live in- or out-of-area, see askmyHRportal.com (article KB0016477).


 Mass General Brigham Health Plan	Select
	In-network (MGB Health Plan/UnitedHealthcare)
General provisions	
Annual deductible (individual/family)	None
The plan's coinsurance	Covered in full, except DME as indicated below
Medical out-of-pocket maximum (individual/family) ¹	\$2,500/\$5,000
Inpatient medical, surgical, mental health and substance abuse services	
Per admission copay	\$250 copay
Semiprivate room and ancillary services	Covered in full
Inpatient physician/surgeon/anesthesia	Covered in full
Inpatient mental health and substance use	Covered in full
Outpatient covered services	
Primary care physician visits (in-office and virtual visits)	\$15 copay
Pediatric primary care visits (in-office and virtual visits age 18 or under)	\$15 copay
Specialist visits (in-office and virtual visits)	\$30 copay
Routine physicals ²	Covered in full
Chiropractic services	\$30 copay
Acupuncture (40 visits per member per calendar year)	\$30 copay
Telemedicine (virtual visits) through Doctors On Demand	\$10 copay
Urgent care	\$30 copay
Emergency room visit ³	\$200 copay (waived if admitted)
Outpatient surgery	\$100 copay
Routine pediatric care (birth through age 18) ²	Covered in full
Immunizations and inoculations (adult) ²	Covered in full
Routine eye exam (one visit per member every 24 months)	Covered in full
Pap smear ²	Covered in full
Routine mammogram (one baseline mammogram between ages 35–39; one mammogram per year after age 40) ²	Covered in full
Diagnostic x-ray and lab services	Covered in full
Ambulatory CT scan/MRI/PET	\$50 copay
Physical therapy and occupational therapy	\$30 copay per visit (100 visits per member per calendar year)
Speech therapy	\$30 copay per visit
Mental health/SUD (in office and virtual visits)	\$10 copay
Durable medical equipment (DME)	Plan pays 80% coverage
Ambulance service (emergency only)	Covered in full
Maternity coverage	
In-hospital (delivery)	\$250 copay
Out-of-hospital (prenatal care)	Covered in full

¹ A separate out-of-pocket maximum applies to the prescription drug plan, based on your salary and medical plan coverage level as of January 1. See the back page for details.

² No copay for in-network preventive care described under the Affordable Care Act; copay applies if regular office visit includes non-preventive care. "Preventive care" includes most routine physical exams and preventive screenings for adults and children; well-child care; preventive immunizations; preventive Pap smears and mammograms; routine gynecology visits; routine vision exams; routine hearing exam office visits and hearing tests; preventive lab tests; family planning services (including contraception); routine Prostate-Specific Antigen (PSA) testing; and routine sigmoidoscopies/colonoscopies, except where surgical removal takes place, which is subject to deductible, copay and/or coinsurance. Frequency of coverage for services will be based on preventive screening guidelines referenced by the Affordable Care Act.

³ If you are admitted directly from an Emergency visit at a general hospital for inpatient admission or outpatient surgery, you will pay the lowest cost share amount for covered services.

Please note: The services shaded in **green** count towards your annual deductible.

 Mass General Brigham Health Plan	Plus	
	In-network (MGB Health Plan/UnitedHealthcare)	Out-of-network
General provisions		
Annual deductible (individual/family)	None	\$2,000/\$4,000
The plan’s coinsurance	Covered in full, except DME as indicated below	Plan pays 70% coverage of the allowable charge. Amounts above may be subject to balance billing.
Medical out-of-pocket maximum (individual/family) ¹	\$2,500/\$5,000	\$5,000/\$10,000
Inpatient medical, surgical, mental health and substance abuse services		
Per admission copay	\$250 copay	Plan pays 70% coverage after deductible
Semiprivate room and ancillary services	Covered in full	Plan pays 70% coverage after deductible
Inpatient physician/surgeon/anesthesia	Covered in full	Plan pays 70% coverage after deductible
Inpatient mental health and substance use	Covered in full	Plan pays 70% coverage
Outpatient covered services		
Primary care physician visits (in-office and virtual visits)	\$15 copay	Plan pays 70% coverage after deductible
Pediatric primary care visits (in-office and virtual visits age 18 or under)	\$15 copay	Plan pays 70% coverage after deductible
Specialist visits (in-office and virtual visits)	\$30 copay	Plan pays 70% coverage after deductible
Routine physicals ²	Covered in full	Not covered
Chiropractic services	\$30 copay	Plan pays 70% coverage after deductible
Acupuncture (40 visits per member per calendar year)	\$30 copay	Plan pays 70% coverage after deductible
Telemedicine (virtual visits) through Doctors On Demand	\$10 copay	Not covered
Urgent care	\$30 copay	Plan pays 70% coverage after deductible
Emergency room visit ³	\$200 copay (waived if admitted)	
Outpatient surgery	\$100 copay	Plan pays 70% coverage after deductible
Routine pediatric care (birth through age 18) ²	Covered in full	Plan pays 70% coverage after deductible (to age 5 only)
Immunizations and inoculations (adult) ²	Covered in full	Plan pays 70% coverage after deductible
Routine eye exam (one visit per member every 24 months)	Covered in full	Not covered
Pap smear ²	Covered in full	Plan pays 70% coverage after deductible
Routine mammogram (one baseline mammogram between ages 35–39; one mammogram per year after age 40) ²	Covered in full	Plan pays 70% coverage after deductible
Diagnostic x-ray and lab services	Covered in full	Plan pays 70% coverage after deductible
Ambulatory CT scan/MRI/PET	\$50 copay	Plan pays 70% coverage after deductible
Physical therapy and occupational therapy	\$30 copay per visit (100 visits per member per calendar year)	Plan pays 70% coverage after deductible
Speech therapy	\$30 copay per visit	Plan pays 70% coverage after deductible
Mental health/SUD (in office and virtual visits)	\$10 copay	Plan pays 70% coverage
Durable medical equipment (DME)	Plan pays 80% coverage	Plan pays 70% coverage after deductible
Ambulance service (emergency only)	Covered in full	
Maternity coverage		
In-hospital (delivery)	\$250 copay	Plan pays 70% coverage after deductible
Out-of-hospital (prenatal care)	Covered in full	Plan pays 70% coverage after deductible

¹ A separate out-of-pocket maximum applies to the prescription drug plan, based on your salary and medical plan coverage level as of January 1. See the back page for details.

² No copay for in-network preventive care described under the Affordable Care Act; copay applies if regular office visit includes non-preventive care. "Preventive care" includes most routine physical exams and preventive screenings for adults and children; well-child care; preventive immunizations; preventive Pap smears and mammograms; routine gynecology visits; routine vision exams; routine hearing exam office visits and hearing tests; preventive lab tests; family planning services (including contraception); routine Prostate-Specific Antigen (PSA) testing; and routine sigmoidoscopies/colonoscopies, except where surgical removal takes place, which is subject to deductible, copay and/or coinsurance. Frequency of coverage for services will be based on preventive screening guidelines referenced by the Affordable Care Act.

³ If you are admitted directly from an Emergency visit at a general hospital for inpatient admission or outpatient surgery, you will pay the lowest cost share amount for covered services.

Prescription drug coverage (CVS/Caremark or participating pharmacies)

Reminder: You can pick up 90-day maintenance drugs at Mass General Brigham pharmacies in addition to CVS pharmacies.

Up to a 30-day supply			90-day maintenance drug supply		
\$10 copay Generic drugs	\$40 copay Preferred brand-name	\$70 copay Non-preferred brand-name	\$20 copay Generic drugs	\$80 copay Preferred brand-name	\$140 copay Non-preferred brand-name

Specialty medications treat complex and often chronic health conditions. These medications may need special storage and can be expensive. All specialty medications must be received through either a Mass General Brigham or CVS Specialty Pharmacy.*

Prescription drug out-of-pocket maximum

Your prescription drug plan includes an out-of-pocket maximum that limits how much you have to pay in prescription drug copay expenses during the calendar year. Your prescription drug out-of-pocket maximum depends on your level of medical coverage (for example, individual or family) and your salary as of January 1, 2025:

	Salary level	Out-of-pocket maximum levels
Annual prescription drug out-of-pocket maximum	Under \$50,000	\$300 individual coverage/ \$600 for all other levels
	\$50,000 to \$100,000	\$1,000 individual coverage/ \$2,000 for all other levels
	Above \$100,000	\$2,000 individual coverage/ \$4,800 for all other levels

The prescription drug out-of-pocket maximum is embedded for individuals. This means that no one member will pay more than the designated individual amount out of pocket.

Example: An employee earns under \$50,000 annually and is enrolled in the Select family tier. Once the first covered member reaches \$300, that person no longer has a prescription drug out-of-pocket maximum for the rest of the plan year. The \$600 prescription drug out-of-pocket maximum is satisfied when individuals spend up to \$300 in prescriptions and collectively the family's out-of-pocket cash for prescriptions totals \$600.

*Select exclusions apply for certain medications

Medical coverage terms to understand



Coinsurance: The plan's share of the charges that are paid after you have met any deductibles. If a plan pays 80%, for example, you would pay the remaining 20%, up to the plan's annual out-of-pocket maximum. Coinsurance only applies to the allowable amount. Costs above the allowable charge may be subject to balanced billing.



Copay: The amount you pay per service received, such as office visits, emergency care, prescription drugs, etc. Copays range from \$10 to \$250.



Deductible: The amount you pay before a plan pays any benefits.



Primary care physician (PCP): The doctor you select to provide your medical care and help you find a specialist. Each covered family member may select his or her own PCP.



Out-of-pocket maximum: The most you would have to pay in copays, deductibles, and coinsurance in a calendar year before the plan pays 100% of covered services. Only allowable amounts are attributed to the out-of-pocket maximum. A separate out-of-pocket maximum applies to your prescription drug plan, based on your annual salary and level of medical coverage (individual or family, for example).