Gallagher

CHOICE (ICHRA) 2027 How to Enroll

Nye Health Services
Open Enrollment: November 10 – November 24
Medicare Open Enrollment: October 27 – November 24
Effective Date: January 1, 2027



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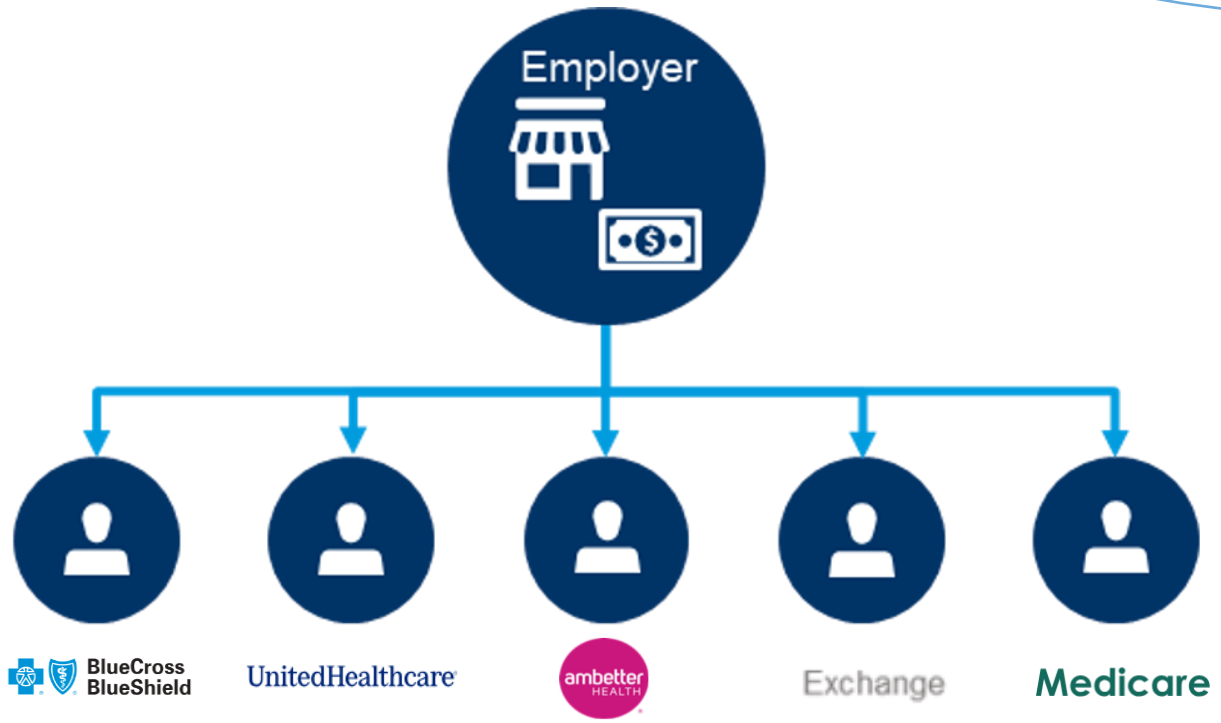
CHOICE: How it works - SIMPLIFIED

Employer provides monthly medical defined contribution to employees

Employees use the employer contribution in the benefitbay platform to purchase their own medical plan with the carrier and plan design to fit their needs.

Any employee responsibility beyond the employer contribution is deducted via payroll (similar to group insurance)



Non-Group Rates Based On:

- ❑ Rating Area – within each state by zip code
- ❑ Member age and age of oldest three dependents

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Agenda

1. How to get started
2. Enrolling in Medicare
3. How to waive coverage
4. Healthcare 101

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1

How to get started



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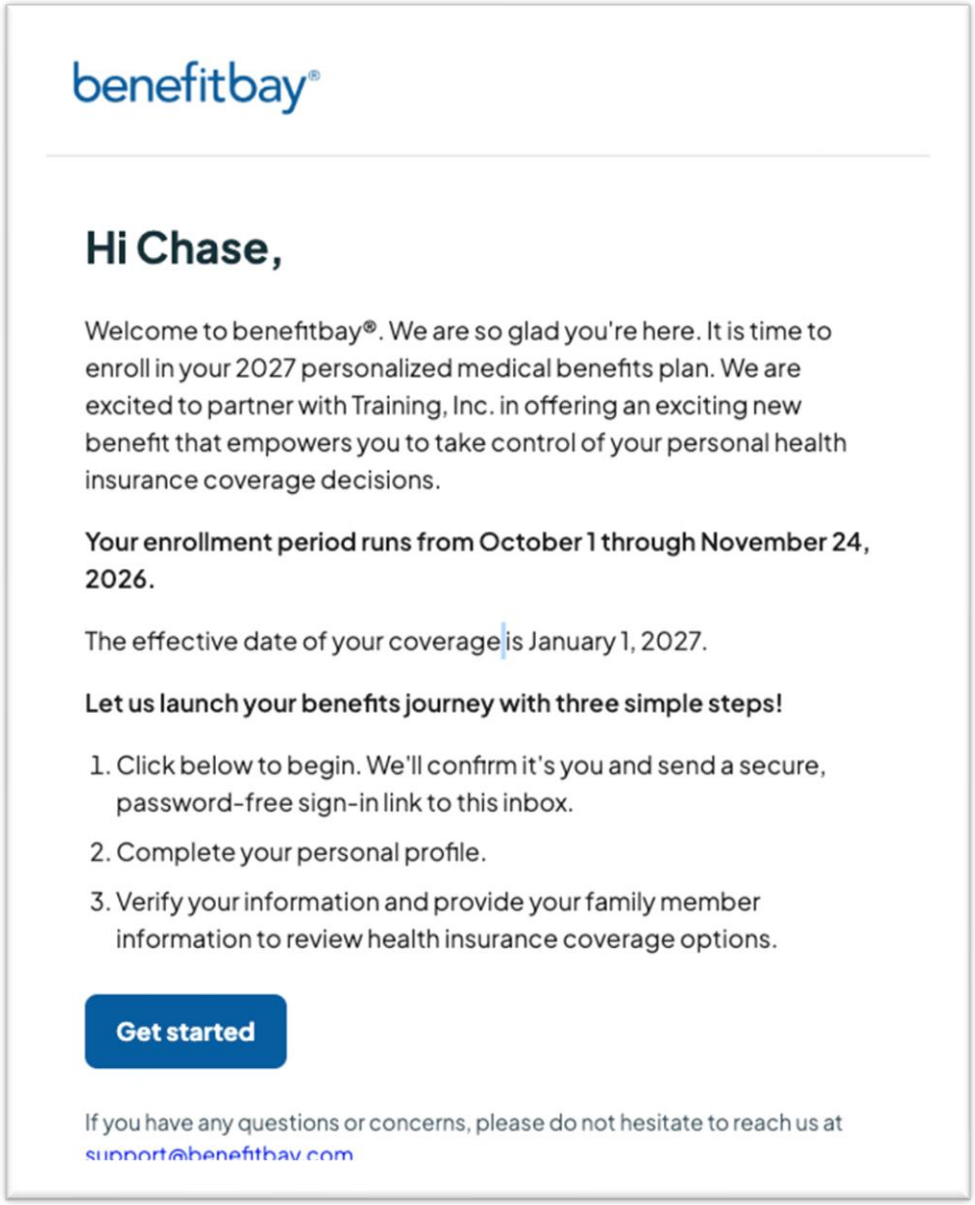
Welcome to Open Enrollment

Employees will receive an invite to log into app.benefitbay.com. It is important to note that any time during the enrollment process you can chat with a Customer Support representative at benefitbay during business hours by clicking on the online chat logo in the lower left-hand corner of the screen



benefitbay®

Hi Chase,

Welcome to benefitbay®. We are so glad you're here. It is time to enroll in your 2027 personalized medical benefits plan. We are excited to partner with Training, Inc. in offering an exciting new benefit that empowers you to take control of your personal health insurance coverage decisions.

Your enrollment period runs from October 1 through November 24, 2026.

The effective date of your coverage is January 1, 2027.

Let us launch your benefits journey with three simple steps!

1. Click below to begin. We'll confirm it's you and send a secure, password-free sign-in link to this inbox.
2. Complete your personal profile.
3. Verify your information and provide your family member information to review health insurance coverage options.

Get started

If you have any questions or concerns, please do not hesitate to reach us at support@benefitbay.com

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Welcome to Open Enrollment

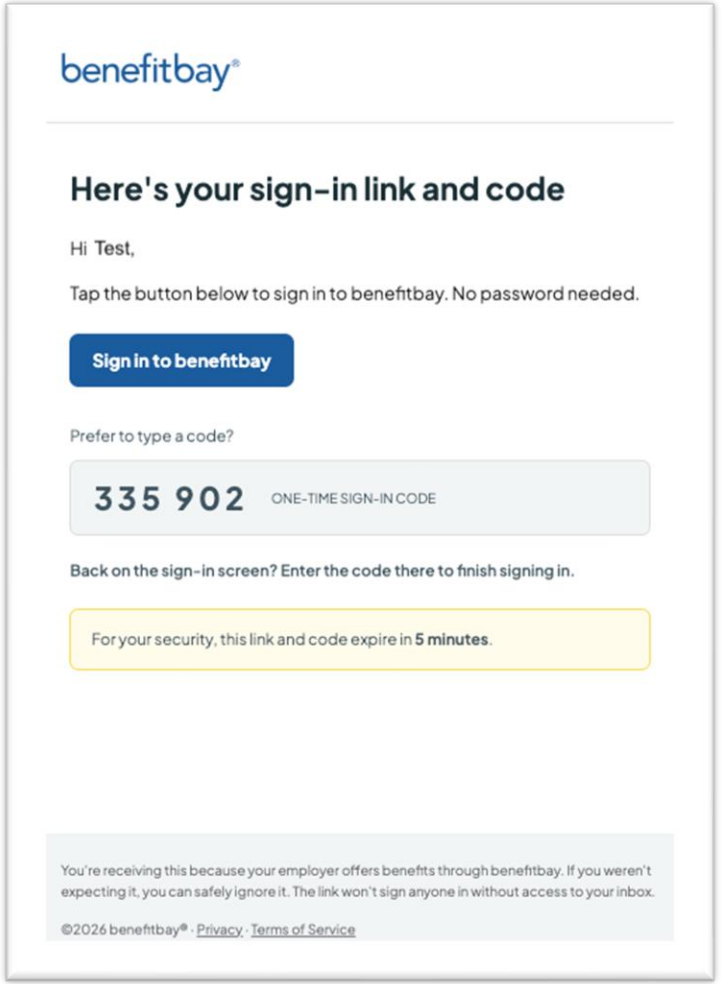
NO PASSWORD NEEDED!

Enter your email

- Type your email address into the prompt. Nothing else to remember, no password to reset. Magic link will be sent to your email address

Open the magic link from your email

- benefitbay sends a single-use link to bring you right into your account. (Or an optional verification code can be used, if preferred)



Use the same process for additional logins at the benefitbay website: app.benefitbay.com

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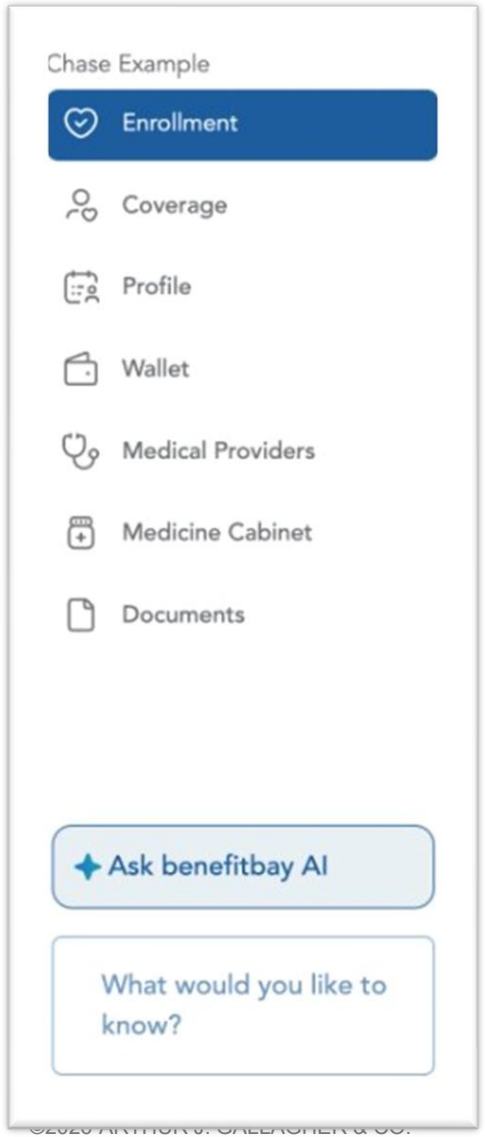
benefitbay – Navigation Overview



Your Employee Enrollment will be the place where you begin your journey. You can always navigate to Enrollment by clicking on "Enrollment" in your menu bar at the top left of the page.

OTHER SECTIONS INCLUDE:

Coverage: shows your Current or Pending medical insurance coverage

Profile: shows your personal & employment information, home address and family members

Wallet: shows your benefitbay ARC account information to provide to your carrier

Medical Providers: you will be able to add your physicians and medical providers

Medicine Cabinet: you will be able to add your medications to review coverage

Documents: contains your Individual Coverage HRA notice which your insurance carrier may need, your HIPAA Authorization and SBC for your current plan

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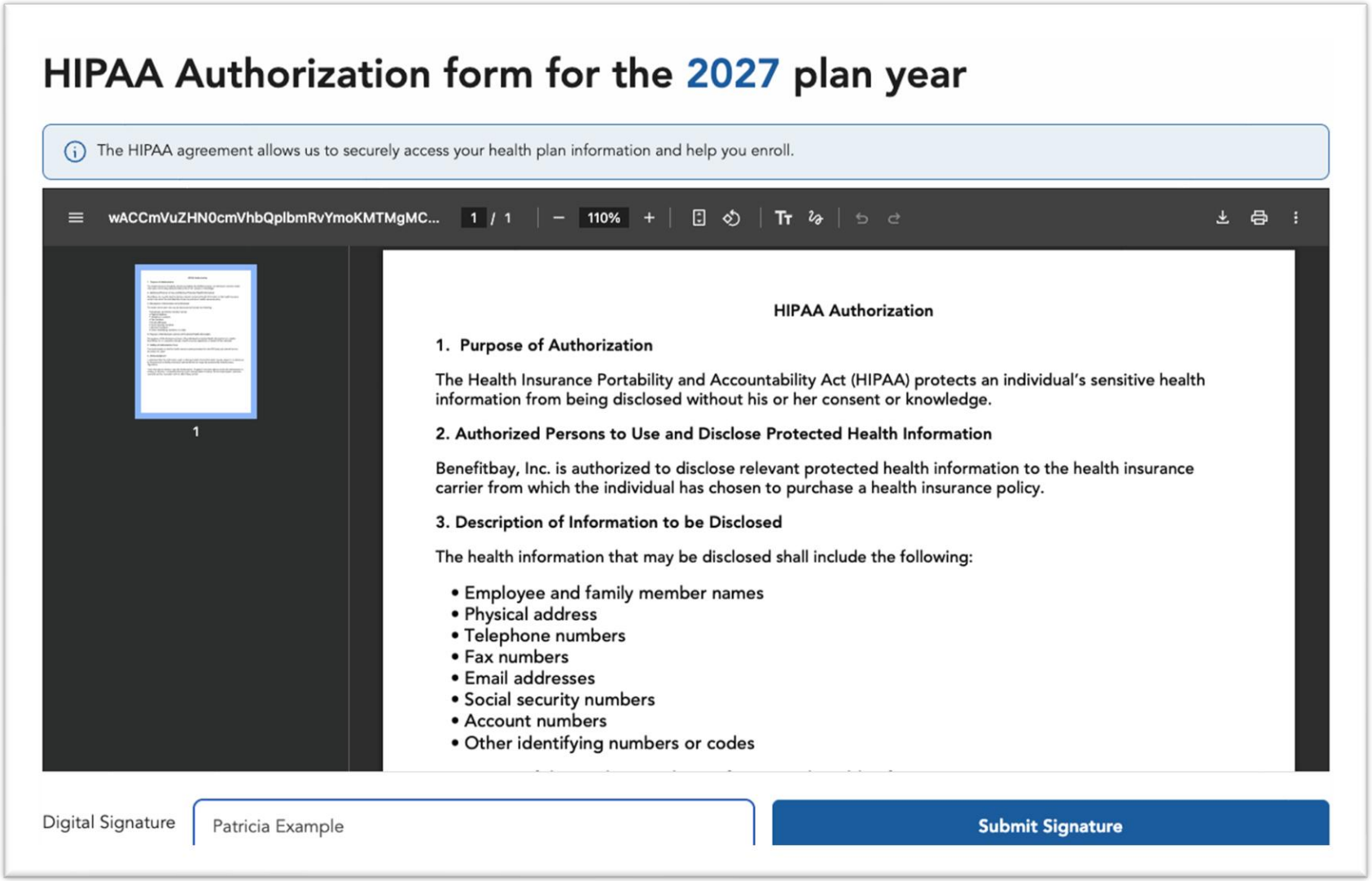
benefitbay – HIPAA Authorization

HIPAA Authorization:

This MUST be completed to start your shopping for coverage, enrolling or waiving your coverage.

Your name will populate in the “digital signature” box. Click “submit signature”



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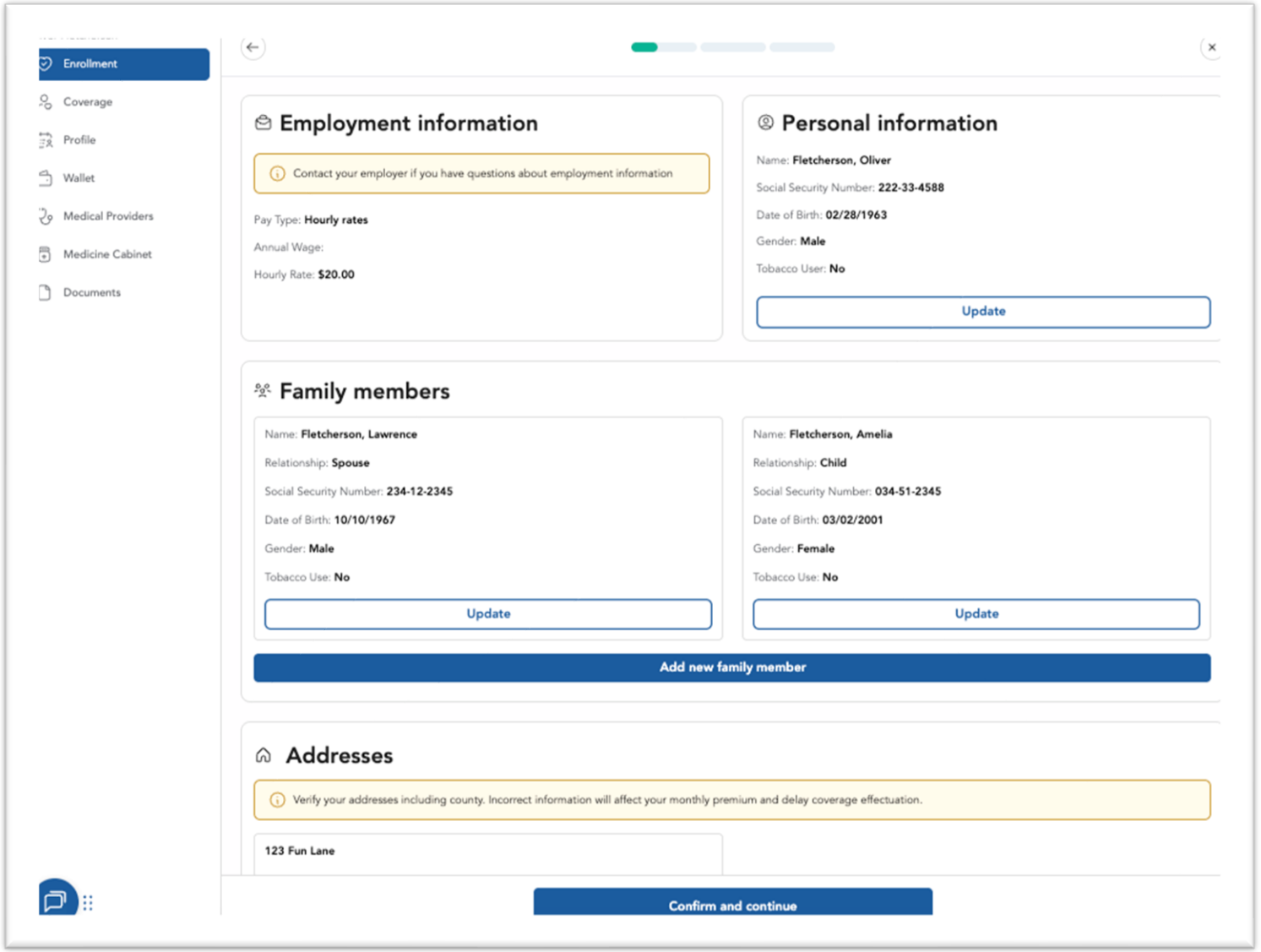
Benefitbay Enrollment – Information Verification

Update any incorrect or missing information. If any employment information is incorrect, reach out to HR to have updated.

Click "Confirm & continue" OR add family members if needed.

Adding Family Members:

To add family members – click "Add new family member" if you want to cover your dependents or add a new dependent. If your dependent has other medical insurance, then there is no need to add them.



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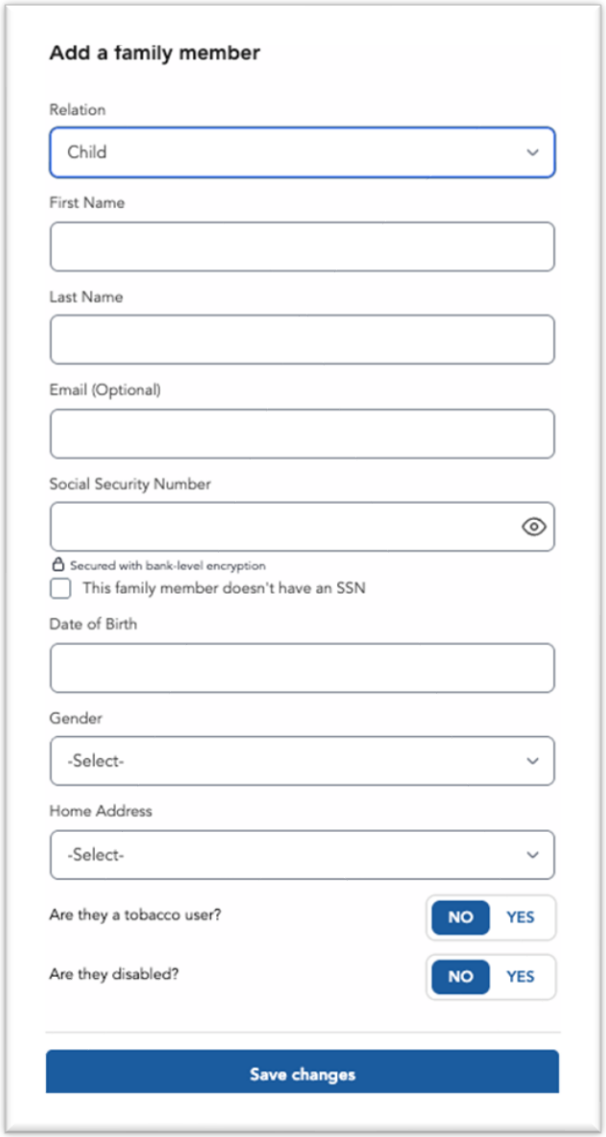
Benefitbay Enrollment – Add family member(s)

Adding Family Members:

To add family members – click "Add new family member" if you want to cover your dependents or add a new dependent. If your dependent has other medical insurance, then there is no need to add them.



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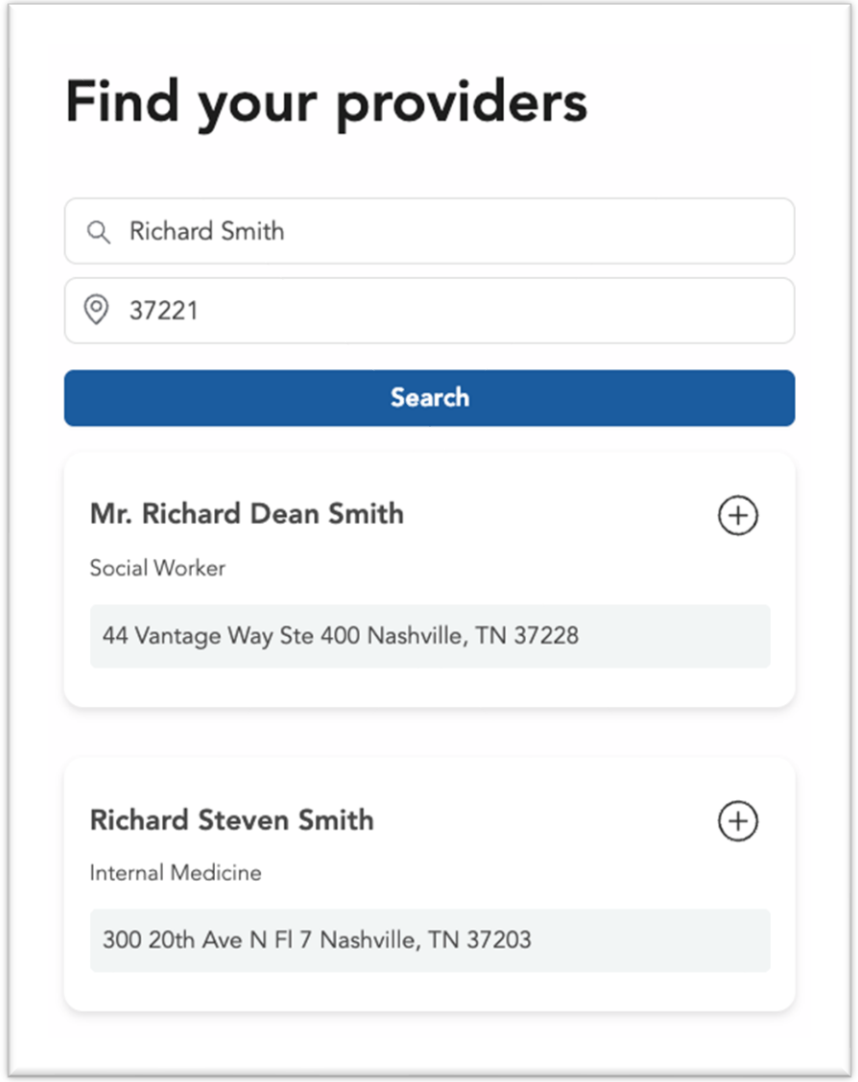
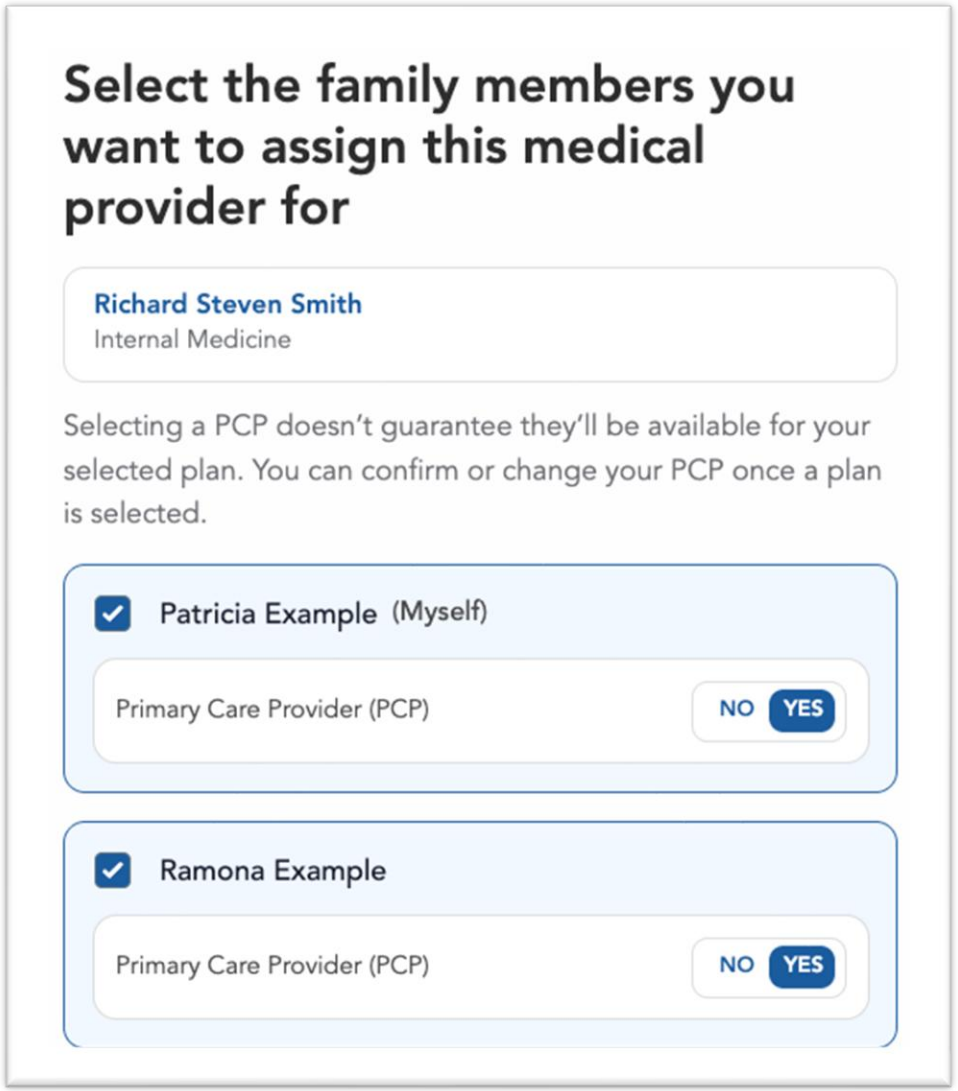
benefitbay – Provider Search

If you selected to "Add a Provider", you can search by provider name and zip code.

You are then able to assign that provider to a specific family member.

You may also indicate if they should be labeled as a PCP.





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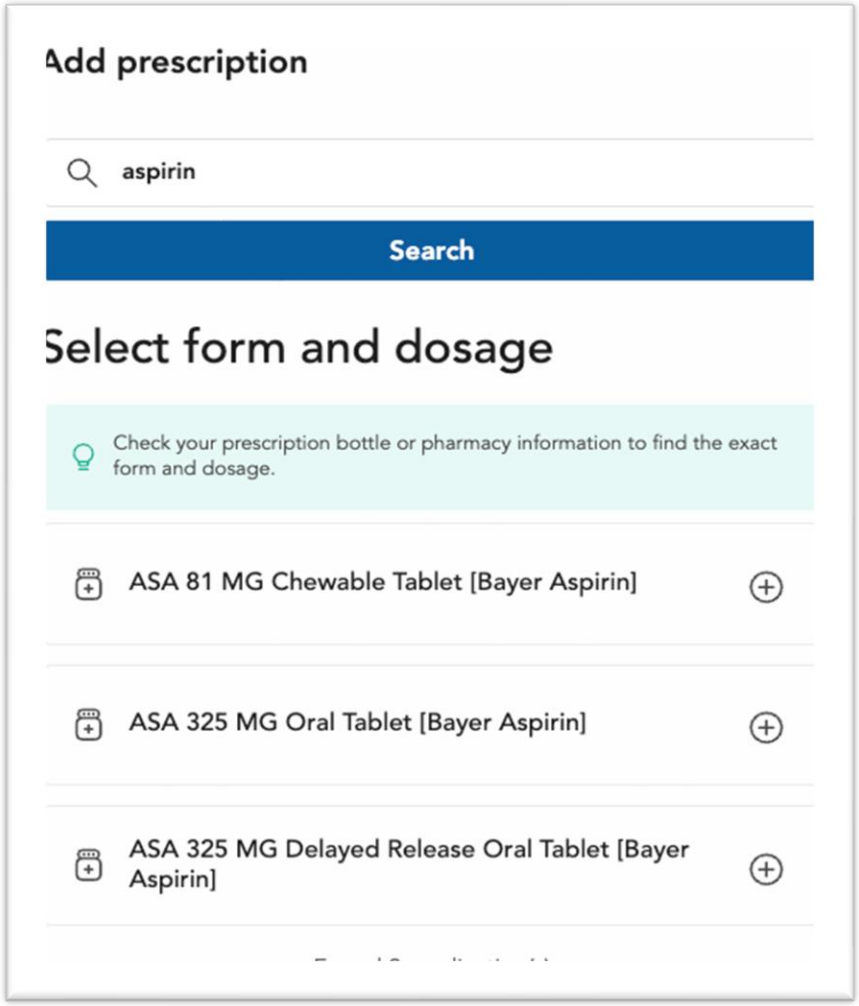
benefitbay – Prescription Search

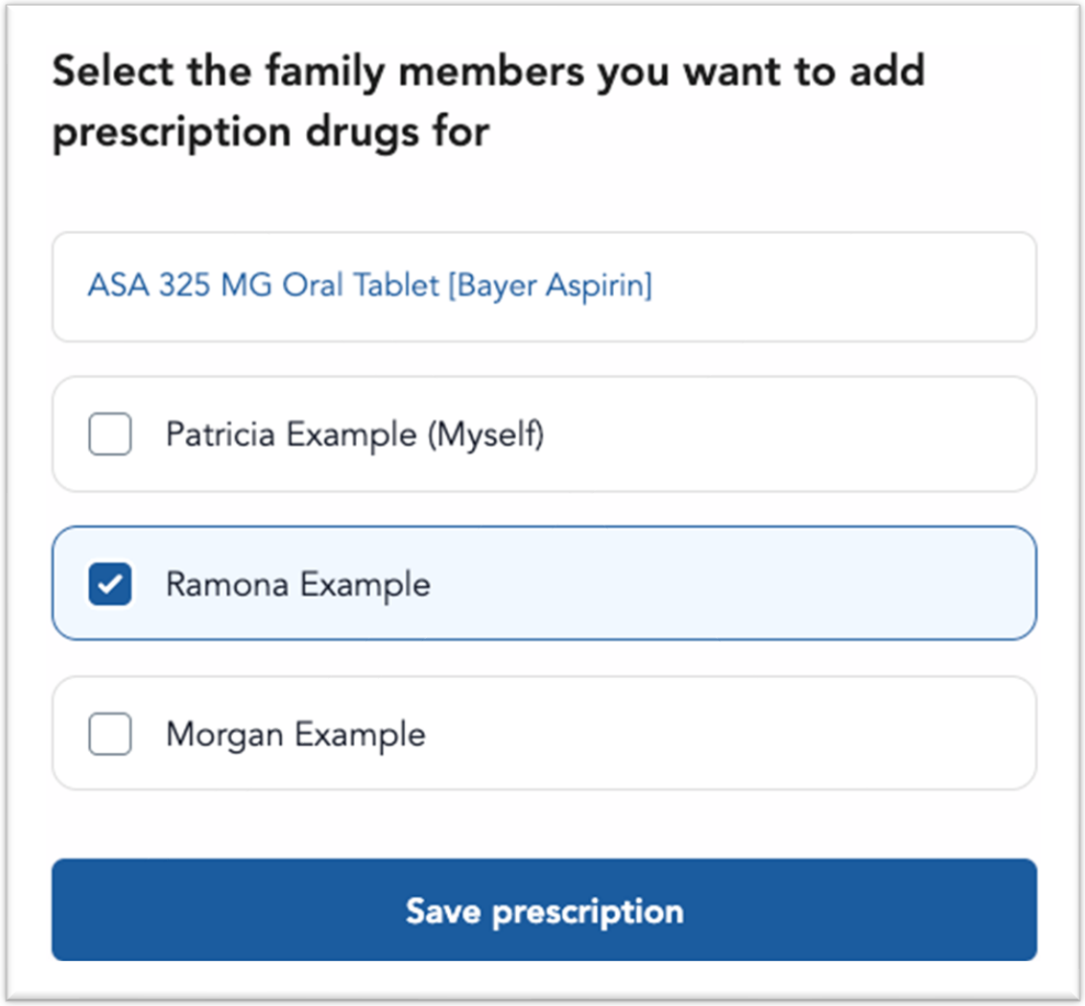
Click "Yes, add prescriptions" OR select "I'll do it later" if you would like to move on and shop for coverage.

You can Search for the prescription name and Select the medication form and dosage.

Select family members to add to prescriptions.

You may also add additional medications if needed.





You may not search plans by prescription coverage, however, you may work with a benefitbay advisor to confirm rx coverages.

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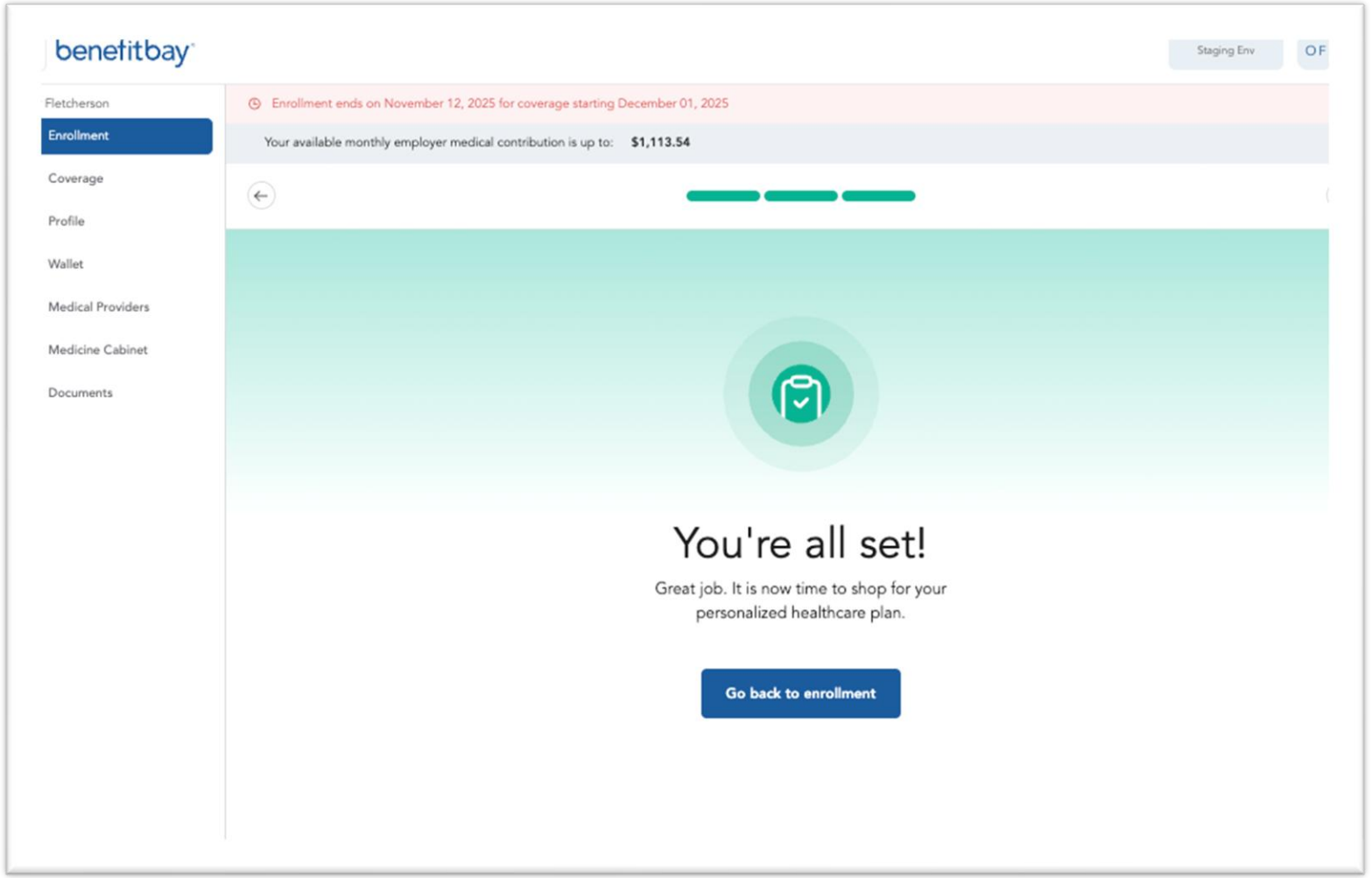
benefitbay –Enrollment

Once you have verified all your information you will see “You’re all set”.

Click “Go back to enrollment” to start your medical plan shopping experience.



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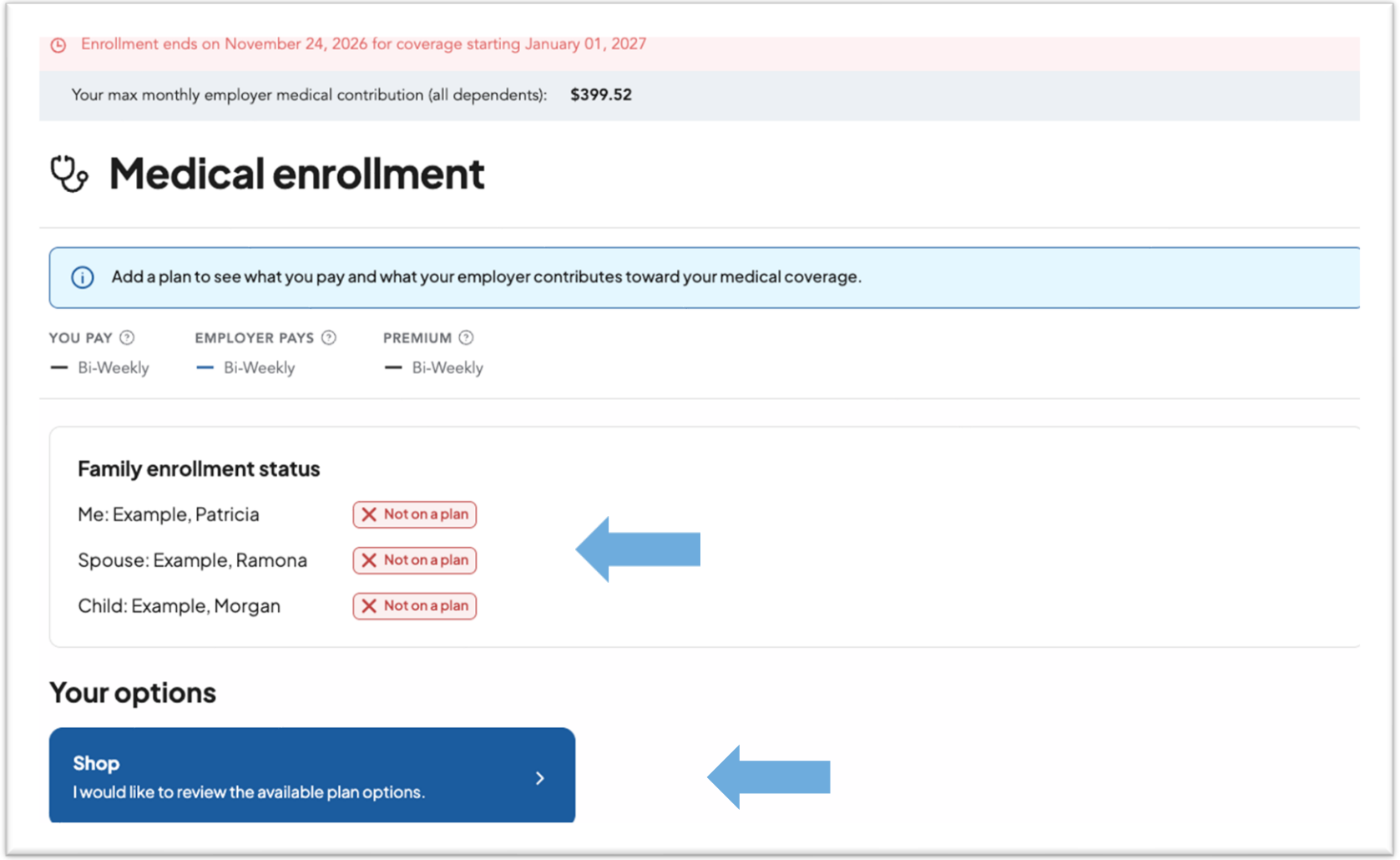
benefitbay – Enrollment

You can see the "Family enrollment status" shows "Not on a plan". When complete, these Red icons will change to green, indicating that you have selected and enrolled in a plan.

Click the "Shop" button to continue to shop plans.



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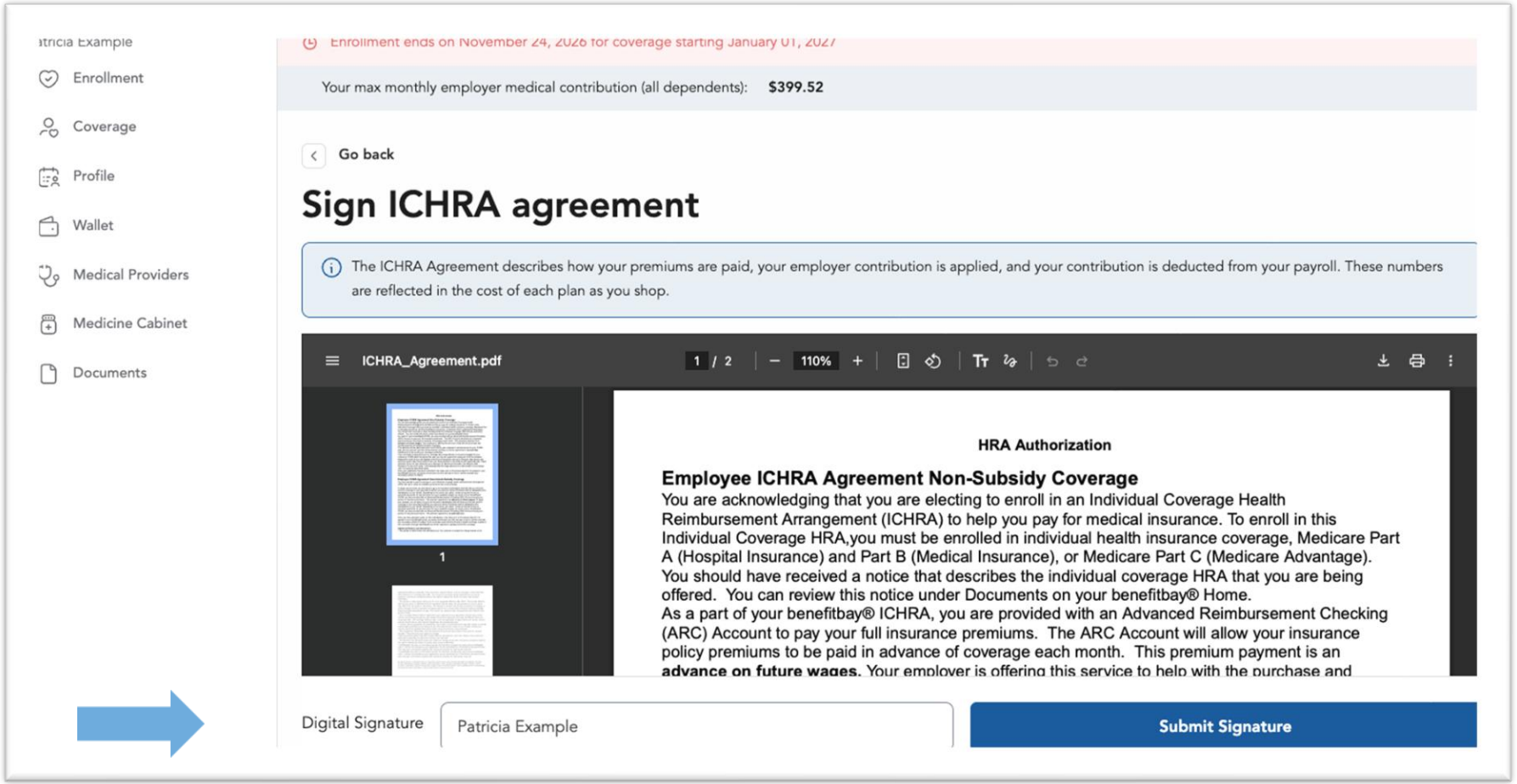
benefitbay – ICHRA Agreement

To start shopping you will first need to complete the ICHRA Agreement. Click on the document to review and sign.

Your name will populate in the “digital signature” box. Click “submit signature”



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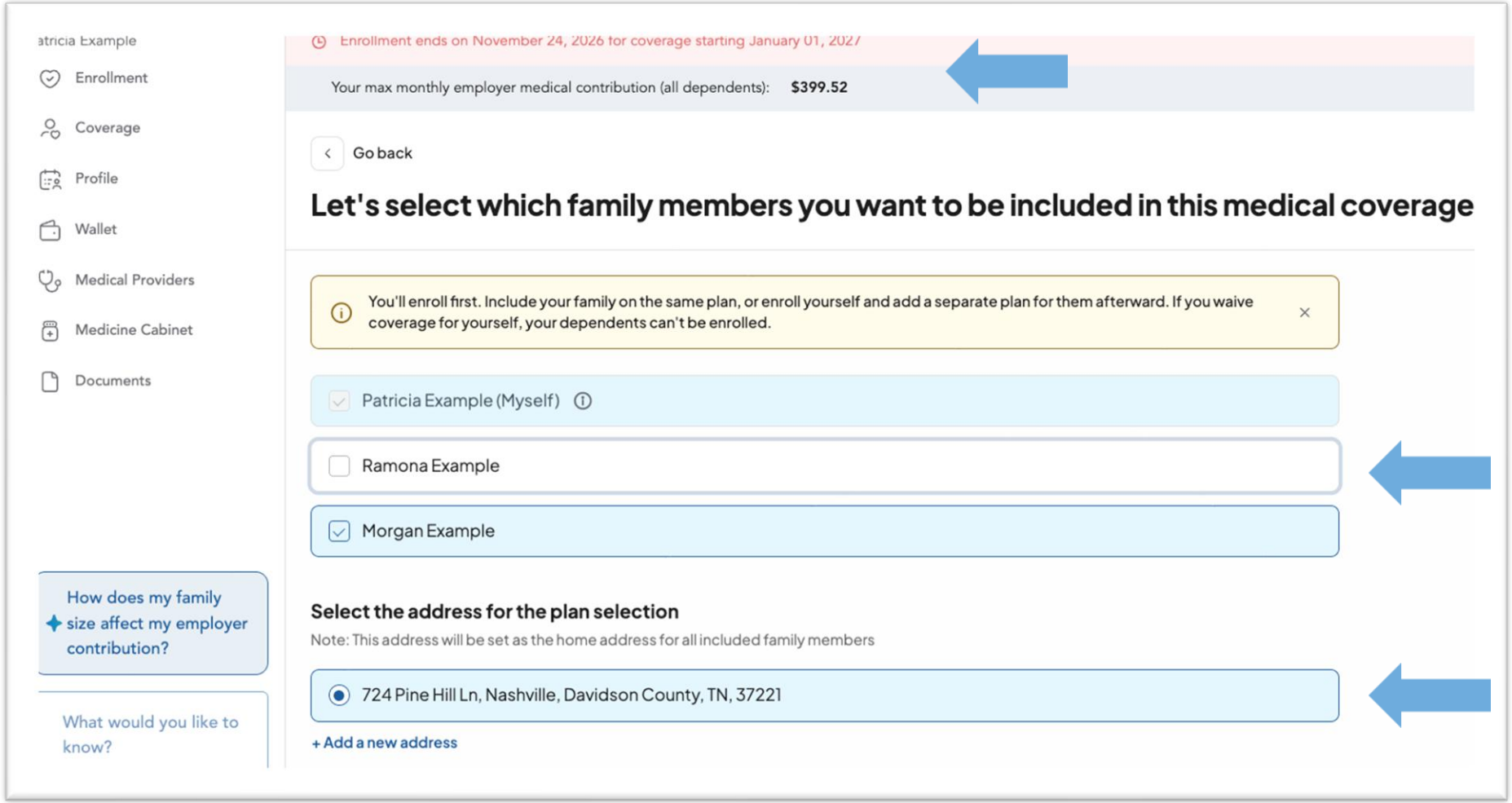
benefitbay – Enrollment

1. Your open enrollment period and available contribution
2. Select family members you would like to shop for
3. Confirm the address – **COUNTY & ZIP CODE**
4. Save and continue to shop!



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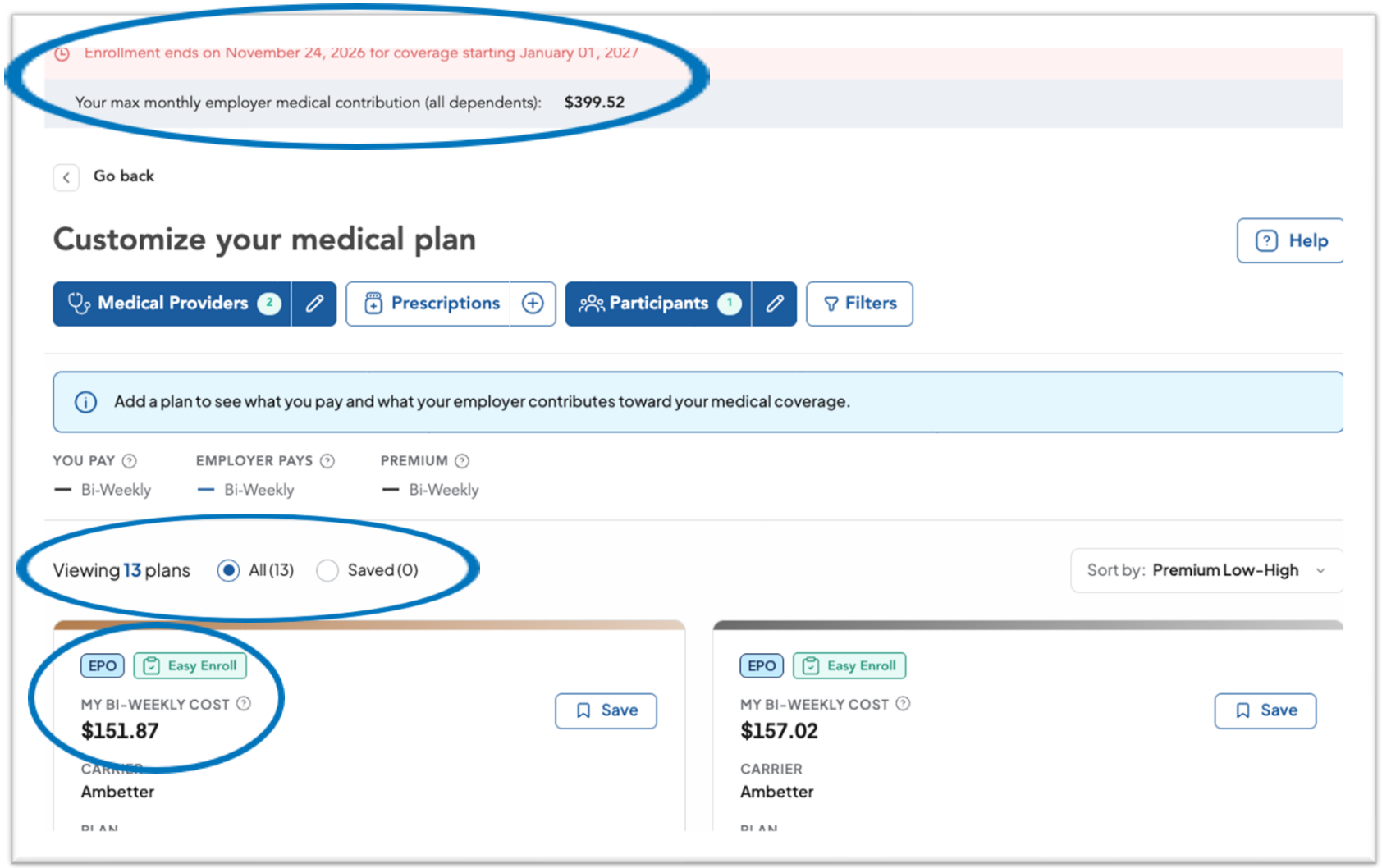
benefitbay – Shopping Screen

Enrollment Period and Employer maximum monthly contributions is available at the top of each page.

The number of plans available can be found at the top of the plan section.

Each plan includes your cost per pay period and enrollment designation.



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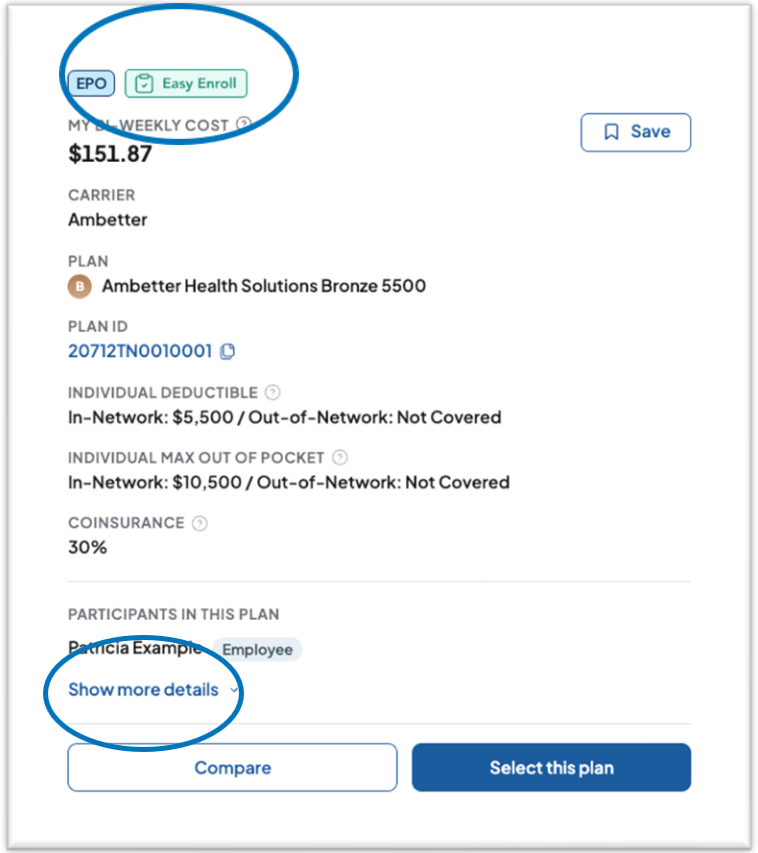
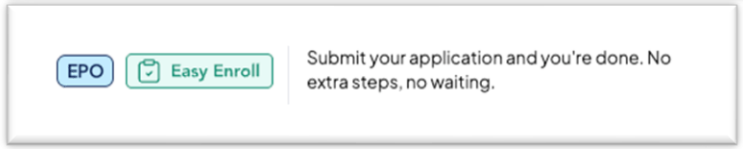
benefitbay – Shopping Screen

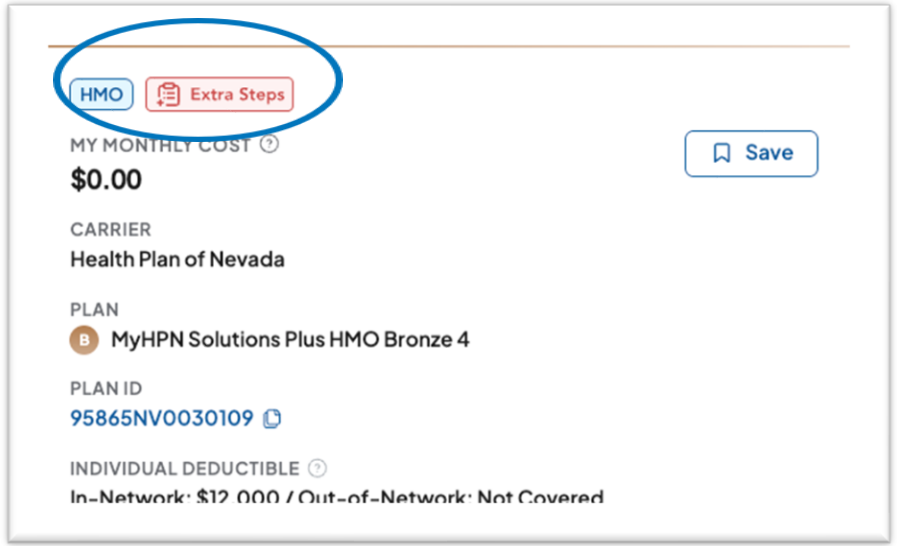
"Easy Enroll" plans will have application directly sent to the carrier with no additional steps needed.

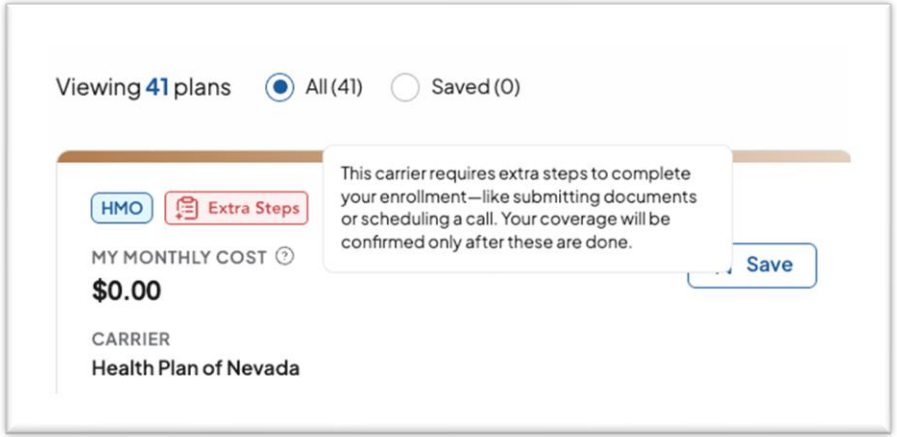
"Extra Steps" plans will require additional information. Be on the lookout for email from benefitbay.

To find out more information on the plan you can click "Show more details" to expand the information regarding the plan, access the summary of benefits, providers and drug formulary









"Extra Steps" May include but not be limited to wet signature on application or proof of residency documentation.

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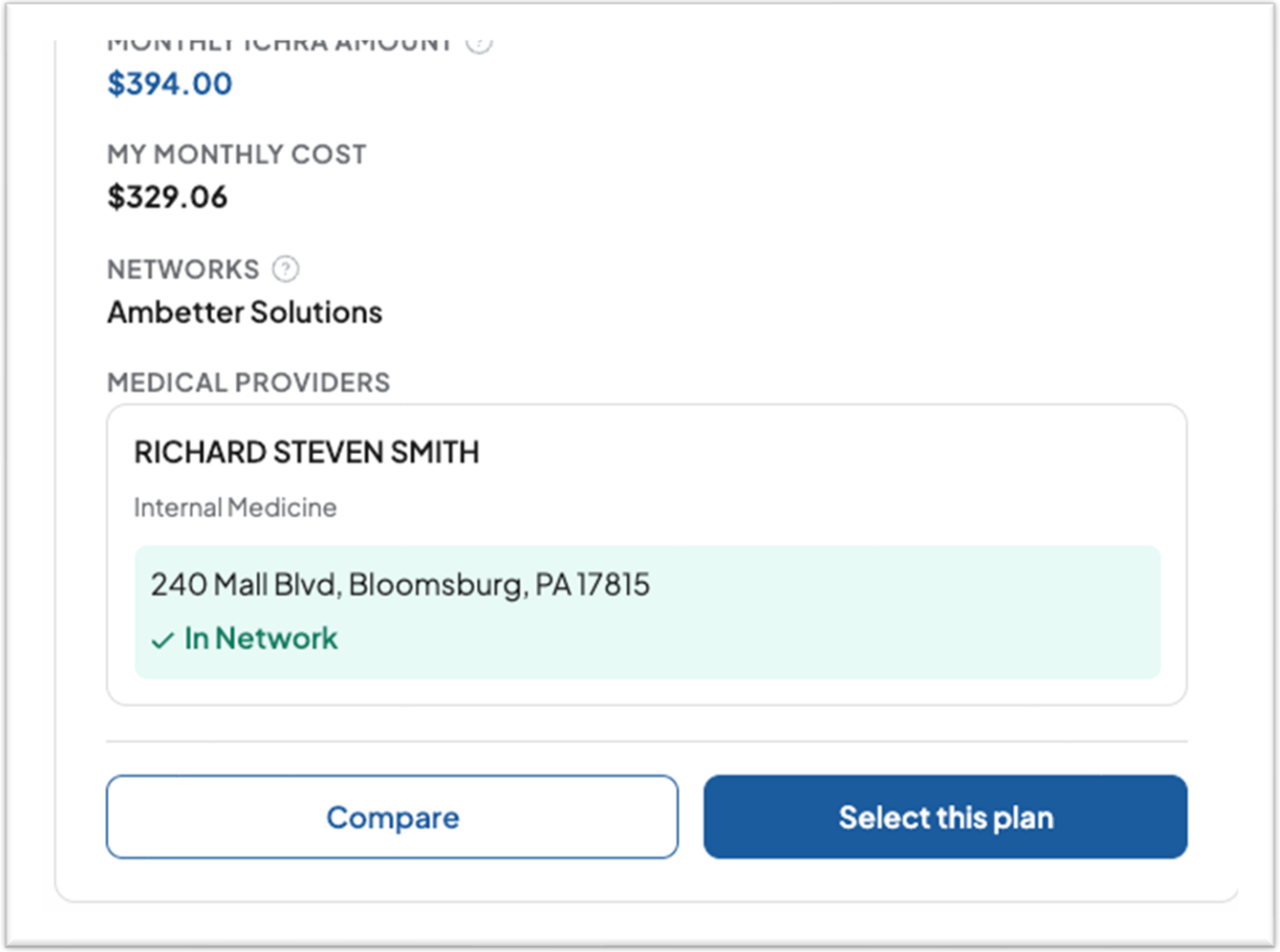
benefitbay – Plan Details

Scroll to the bottom of Plan Details section to view Summary of Benefits and confirm if your providers are covered under the plan.

Those highlighted in green are likely covered under the plan. Those highlighted in red may not be contracted.

Please Note: If there are provider(s) that are very important to you or your family, we recommend confirming with the provider directly they accept your selected plan. Provider contracts are negotiated by insurance carriers throughout the year and are subject to change.



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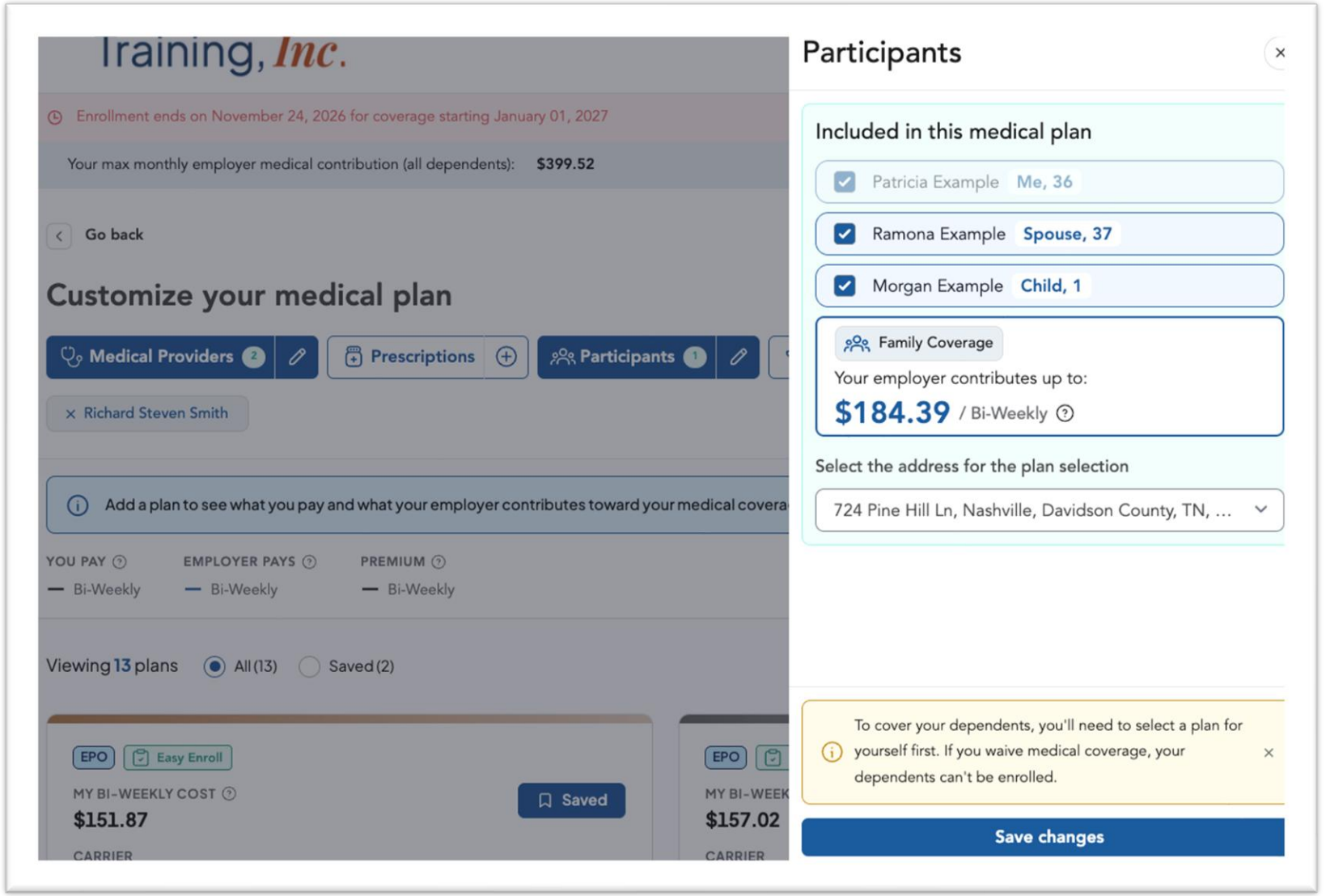
benefitbay – Plan Costs by participant

You may view the participants you have chosen to shop for and update plan enrollment to view updated costs.

If searching for different plans for different adult family members, please choose a member plan first.



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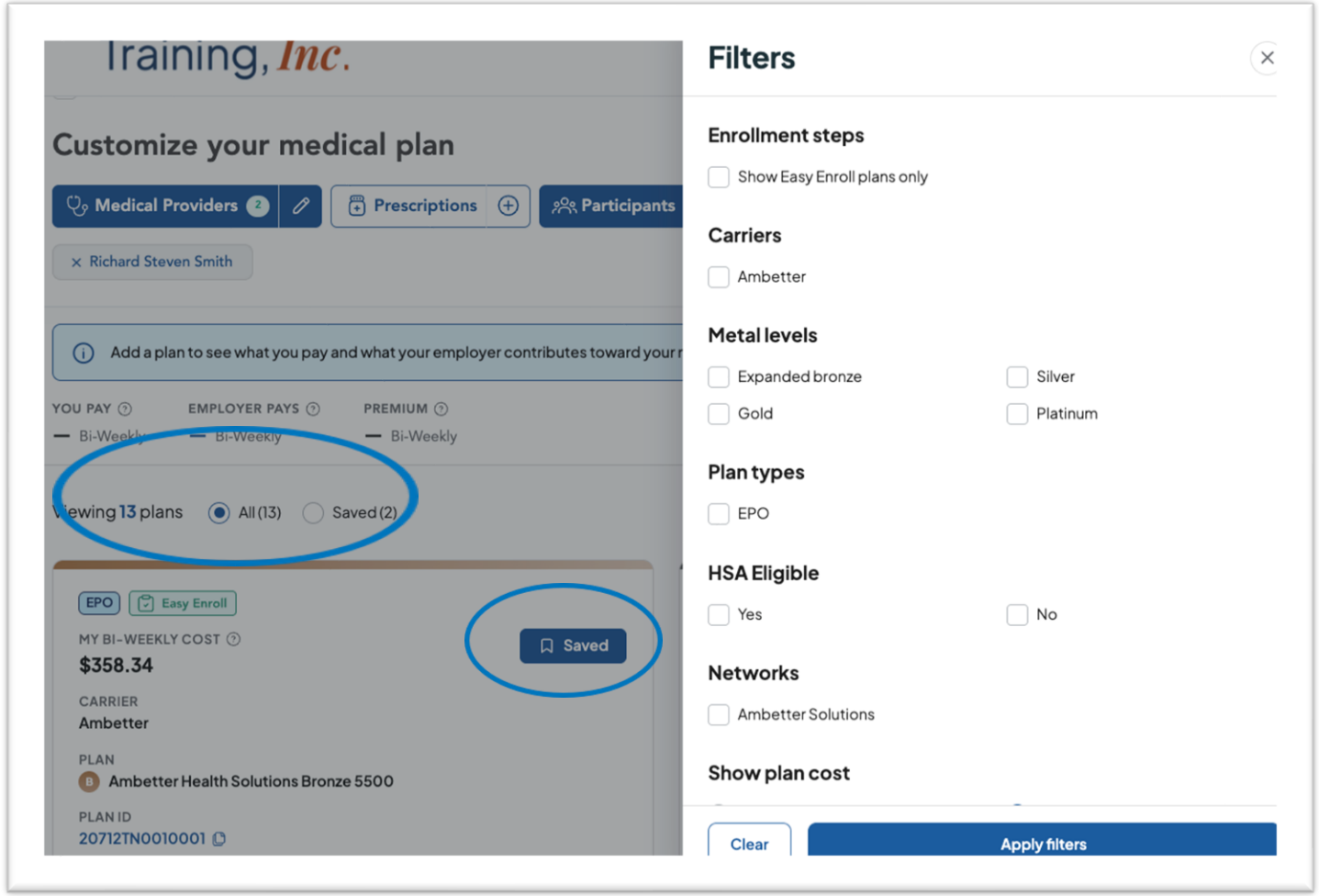
benefitbay – Shopping Filters

The Shopping Section will display the number of plans available. You may select to view all plans or saved plans.

To save a plan click "Save" to review plans later. This is helpful when narrowing down your options or meeting with a Support Team member to discuss your options

"Filters" are used to easily reduce the available plan options to only plans that meet your specific criteria including:

- Easy Enroll Plans
- Carrier
- Metal levels
- Plan type
- HSA Eligible
- Network
- Providers



You can also use the "Sort by" options to display premium & deductible in your preferred order.

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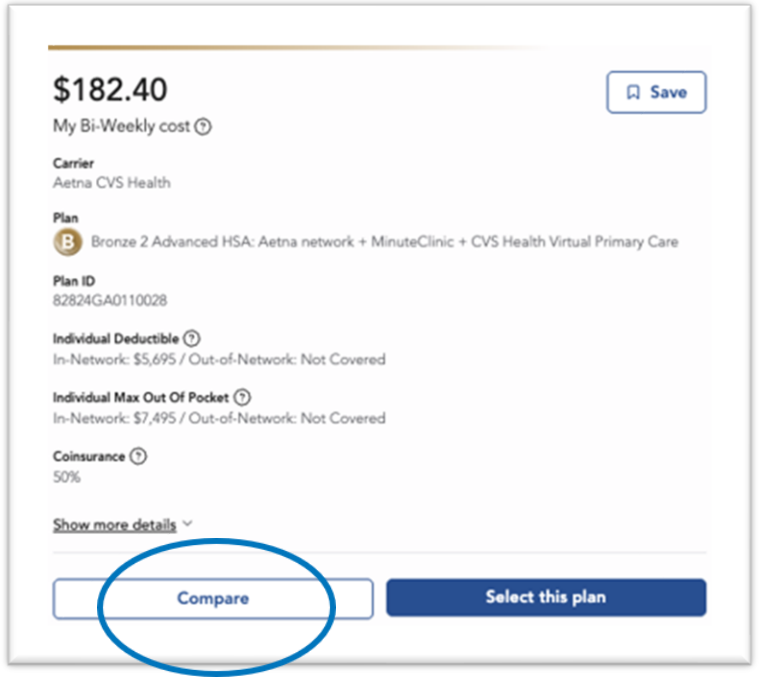
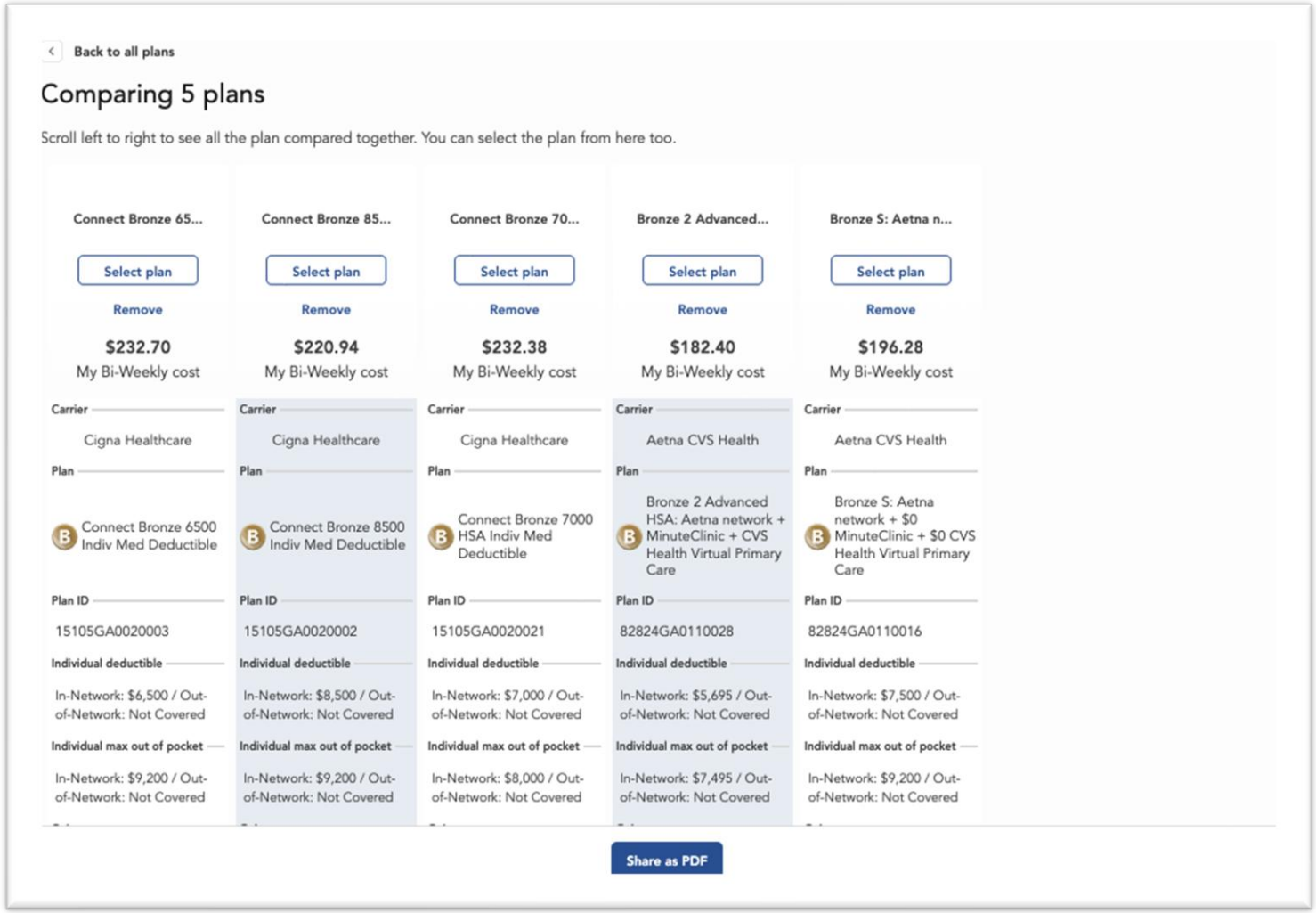
benefitbay – Plan Comparison

You may compare up to five plans by clicking "Compare" on each of the plan options you select.





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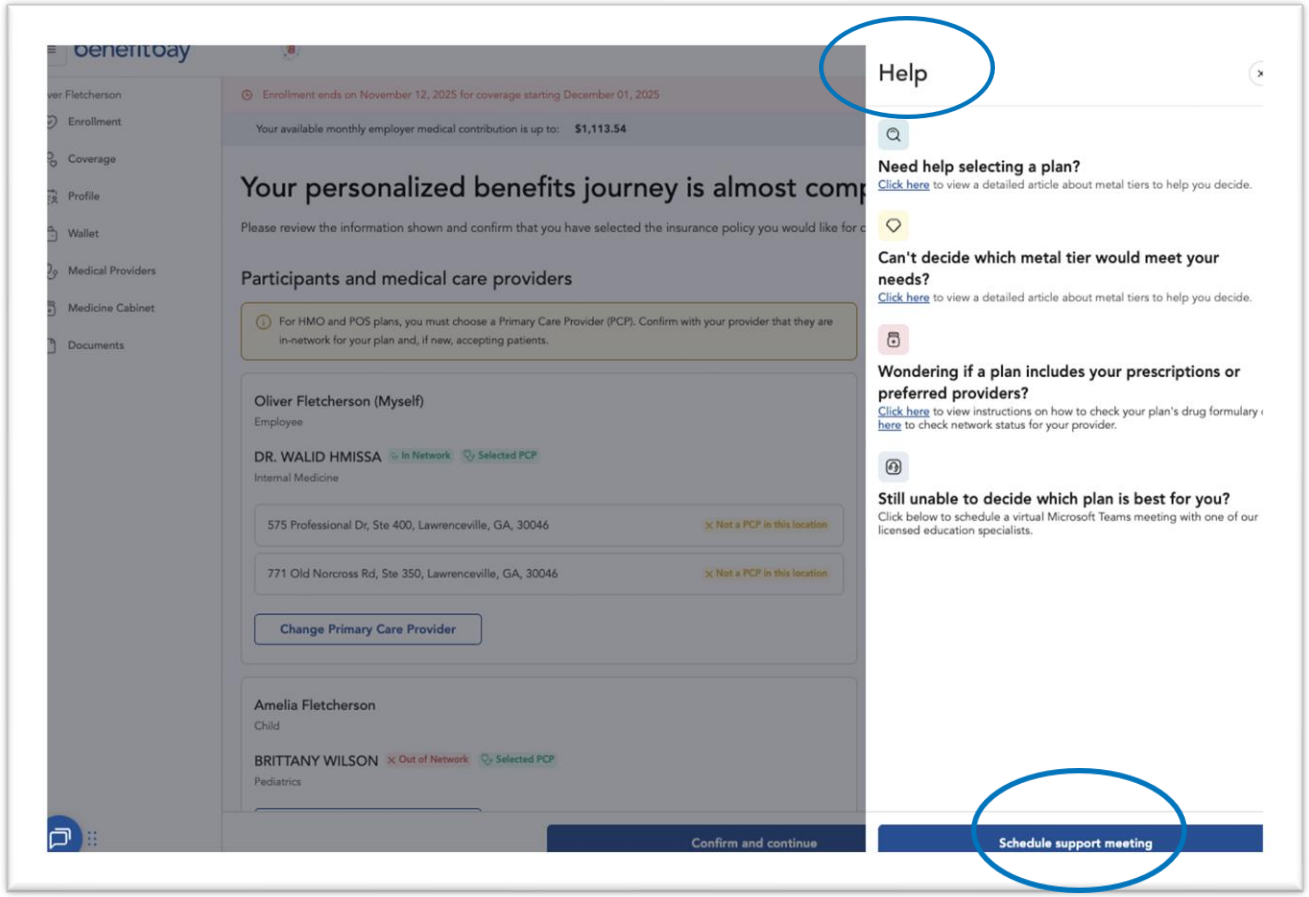
benefitbay – Schedule Support Meeting (available in shopping screen)

If you need assistance choosing a plan or enrolling in a plan, click “Help” in the upper right-hand corner of the SHOPPING screen for additional resources.

Click “Schedule Support Meeting” in the bottom of the help section to schedule a time to speak with a licensed support team member. All appointments are set for virtual call.

Best Practice: Be prepared before contacting a benefitbay licensed representative for support with plan selection. Verify information and add doctors and prescriptions to your portal. Schedule only one meeting. If follow-up support is needed, your representative will work with you to schedule an additional meeting.



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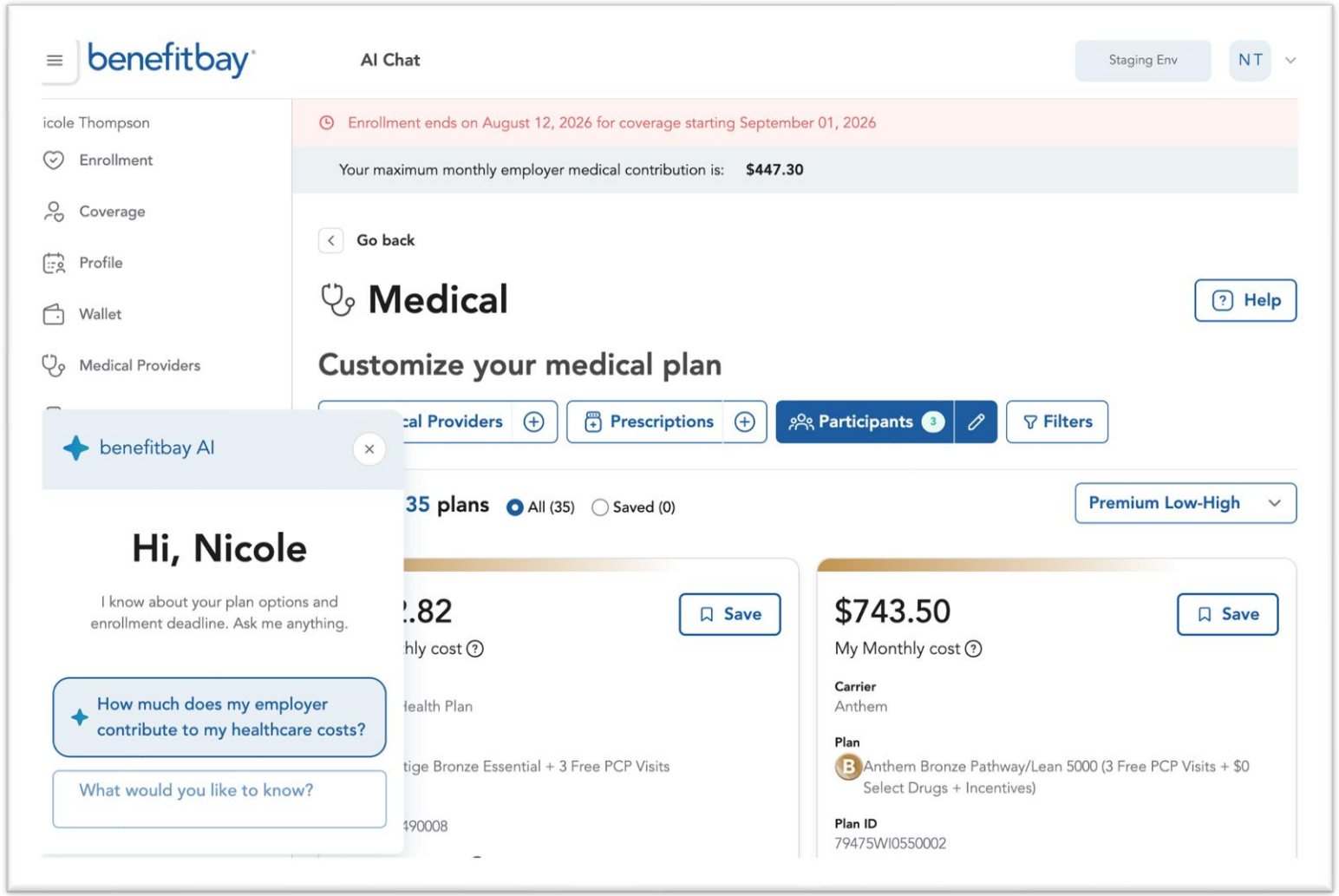
benefitbay – AI Chat Assistant

HIPAA-compliant, and aware of the employee's dependents, ICHRA contribution, and the step of enrollment you're on. It suggests questions people actually asked at that stage during last year’s open enrollment.

It can apply filters on the your behalf, and escalates to a real person on the benefitbay support team when needed.



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benefitbay – Support

Support Team Extended Hours
(National Open Enrollment)

Monday – Friday
8am - 10pm EST

Saturday & Sunday
9am - 6pm EST

Closed: Thanksgiving Day



Schedule a 1-1 meeting with a licensed support team member



Access the chat icon in benefitbay to chat with a support team member



Email the support team at:
support@benefitbay.com

Employee Knowledge Base: Employee knowledge base

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benefitbay – Plan Submission

Once you have decided you will click “Select Plan”

What happens next

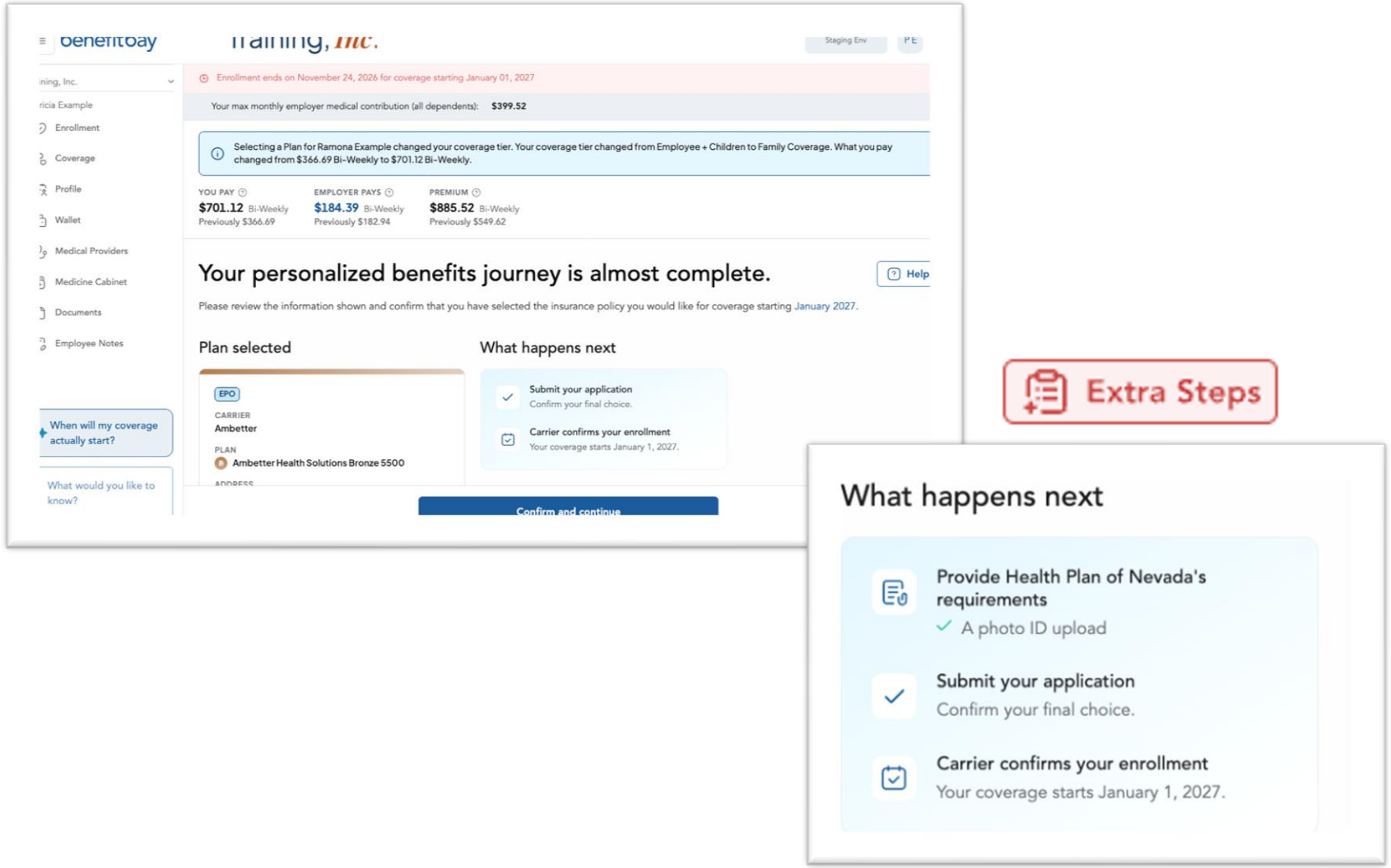
“Easy Enroll” – Submit your application and carrier confirms your enrollment.

“Extra Steps” –

Additional steps identified

Submit your application and carrier confirms your enrollment.

If everything is correct, click “Confirm and continue”



Extra Steps

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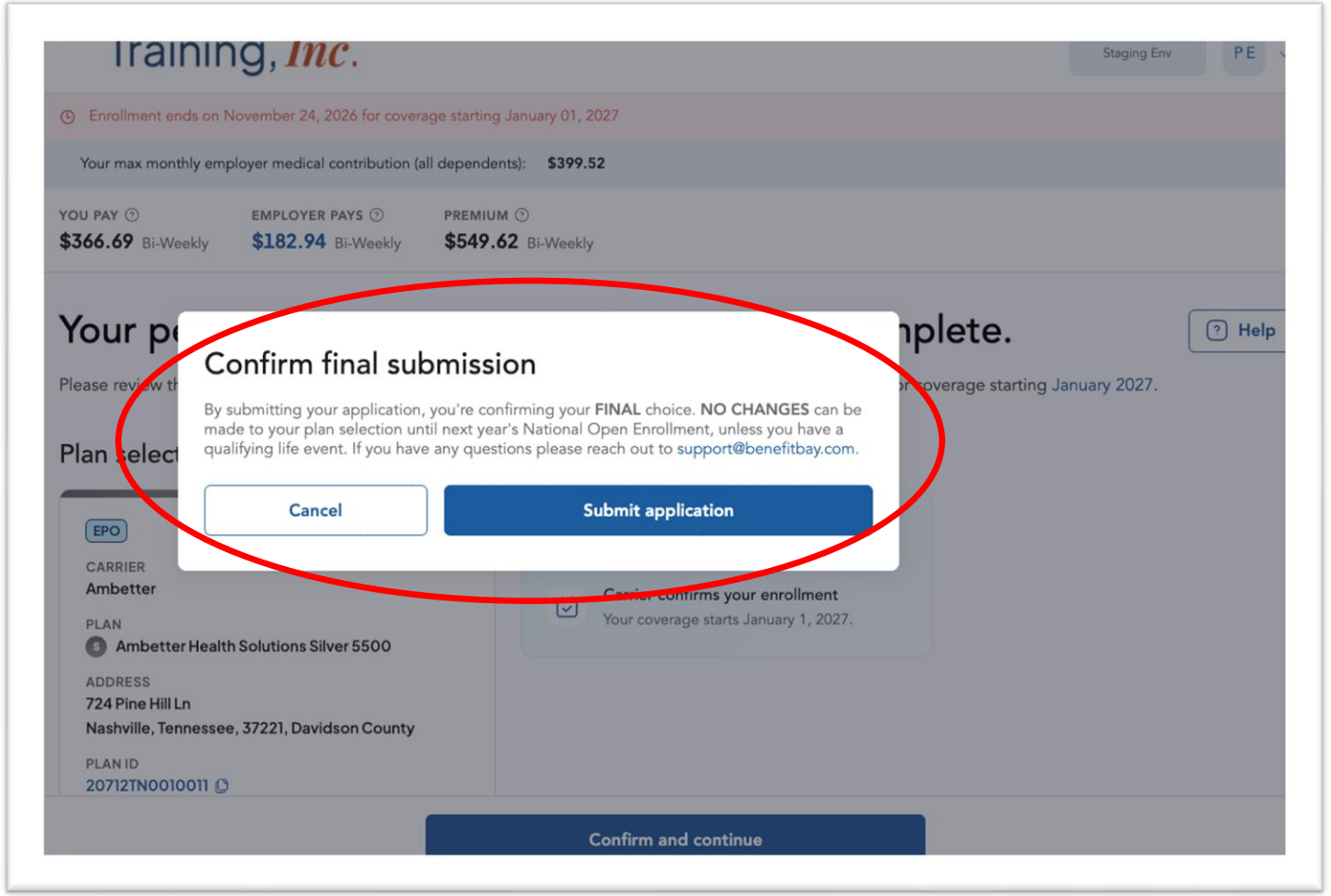
benefitbay – Plan Submission WARNING

You will be asked to confirm that this is your **FINAL** submission.

Your **Open Enrollment** period for the selected members **will end**. There will be no changes to the plan selection after this step is completed unless you have a qualifying event throughout the year.

You will not be able to re-shop!

When you are ready to make your final selection, click "Submit application"



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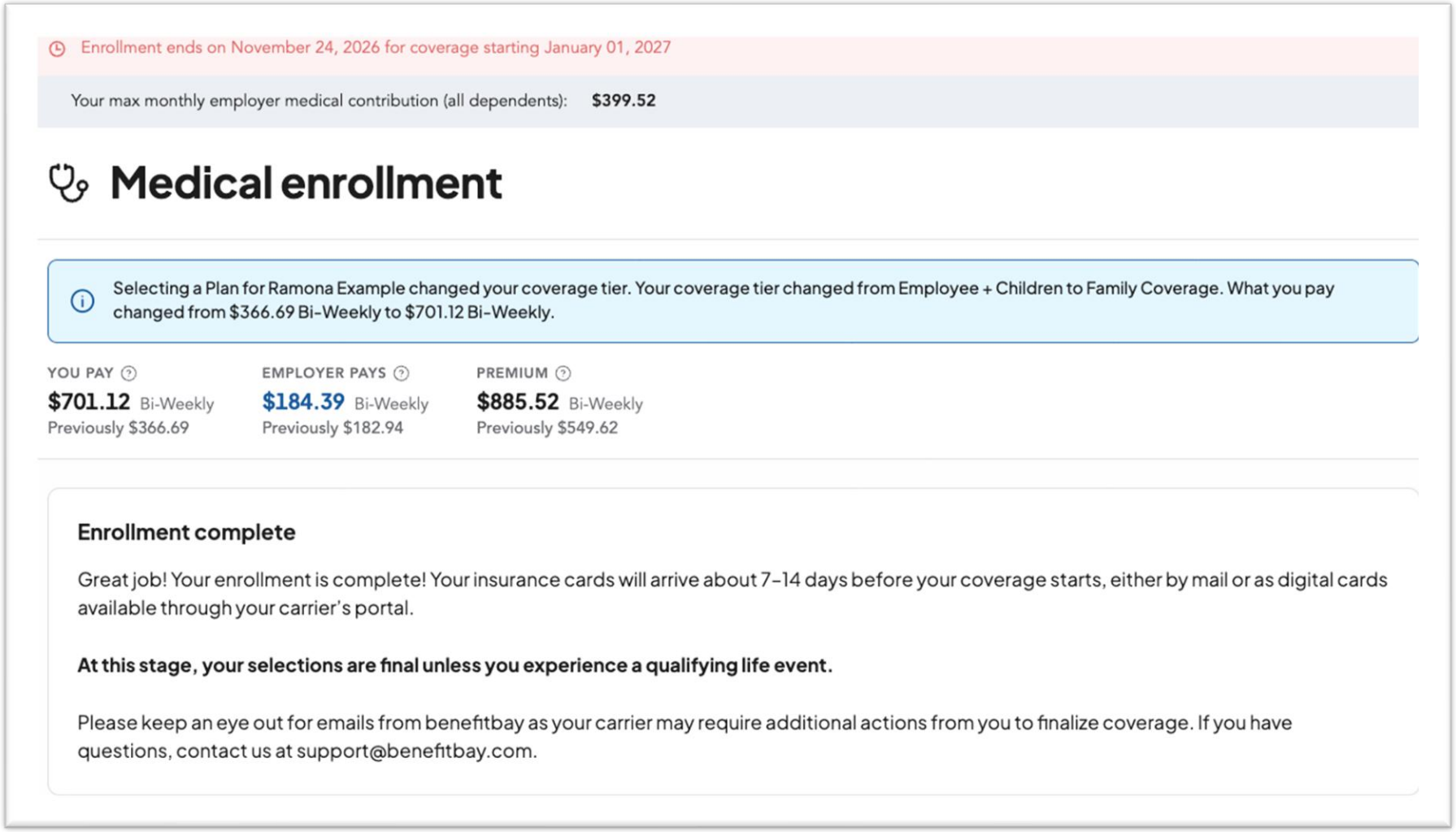
benefitbay – Enrollment Complete!



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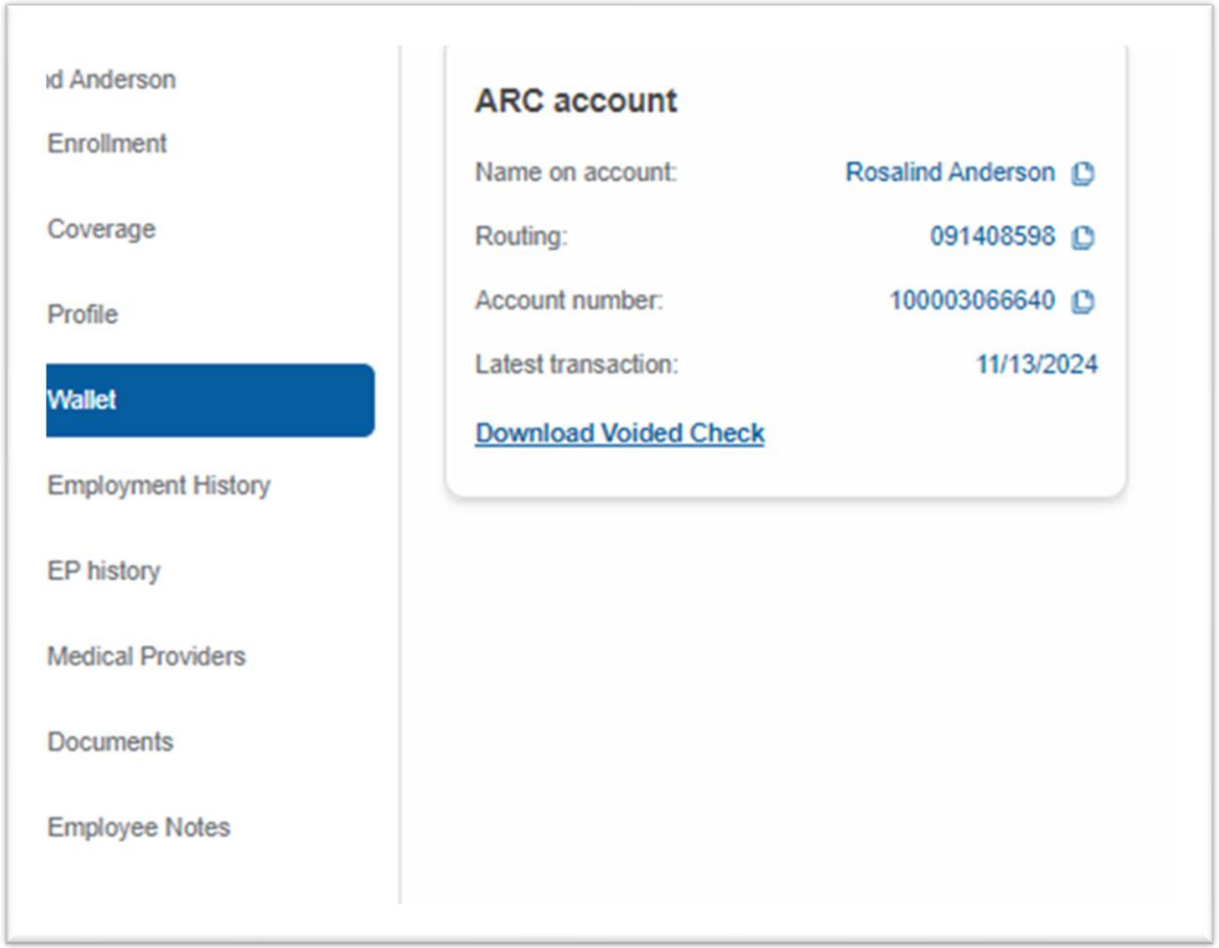
benefitbay – Managing Premiums

Your premiums are paid by benefitbay to your insurance carrier using funds from your employer. Each month your employer submits their contribution and any employee contribution to benefitbay for distribution to your insurance carrier(s).

Each employee is setup with an Advanced Reimbursement Checking (ARC) Account to use for payment of your insurance premiums. Details can be found under the "Wallet" tab.

When possible, benefitbay sets up this recurring payment on your behalf. Some carriers require employee involvement. If you receive communications from your carrier to make a payment for your medical plan, please contact support@benefitbay.com for next steps.

If benefitbay support requests your assistance with setting up reoccurring payments with the carrier, please always use your ARC Account information.



Never enter your personal bank account information!

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Important Reminders!

📞 One Scheduled Call Per Employee

- Each employee should schedule just one enrollment call
- Employees can always reach out via email or in-platform chat

📝 Come Prepared

- Log into benefitbay before the enrollment call, review profile information, and review available plans.
- Bring a list of doctors, providers, and medications to the call.

🚫 No Plan Changes After Selection

- Once a plan has been selected and approved by the employee, no changes can be made.

🚫 No Extensions

- All renewals, enrollments, changes and terms MUST be completed during the Open Enrollment window

🚫 No Passive Renewals

- All renewals, enrollments, changes and terms **MUST** be completed during the Open Enrollment window

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2

Enrolling in Medicare



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benefitbay –Medicare Action Steps

Required steps to receive your employer contribution

Open Enrollment: October 27 – November 24

- Login to benefitbay
- Sign HIPAA Authorization
- Verify Personal Information **UPDATE** Doctors & Prescriptions
- Click SHOP
- Sign ICHRA Agreement
- **REQUIRED: Click SHOP again to schedule a meeting with your benefitbay Medicare Advisor to complete your shopping journey**

Questions? email support@benefitbay.com



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3

Waiving Coverage



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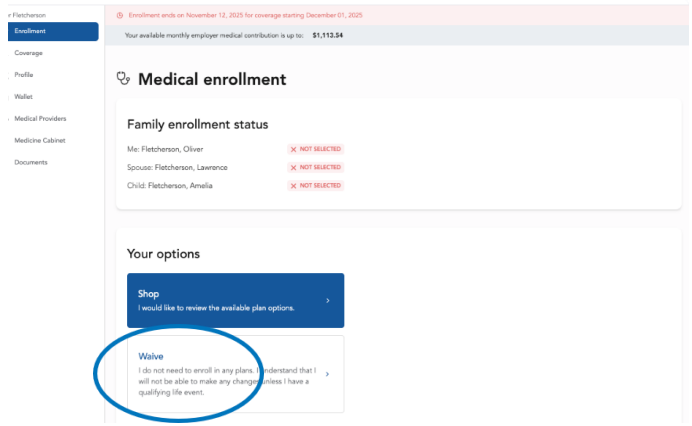
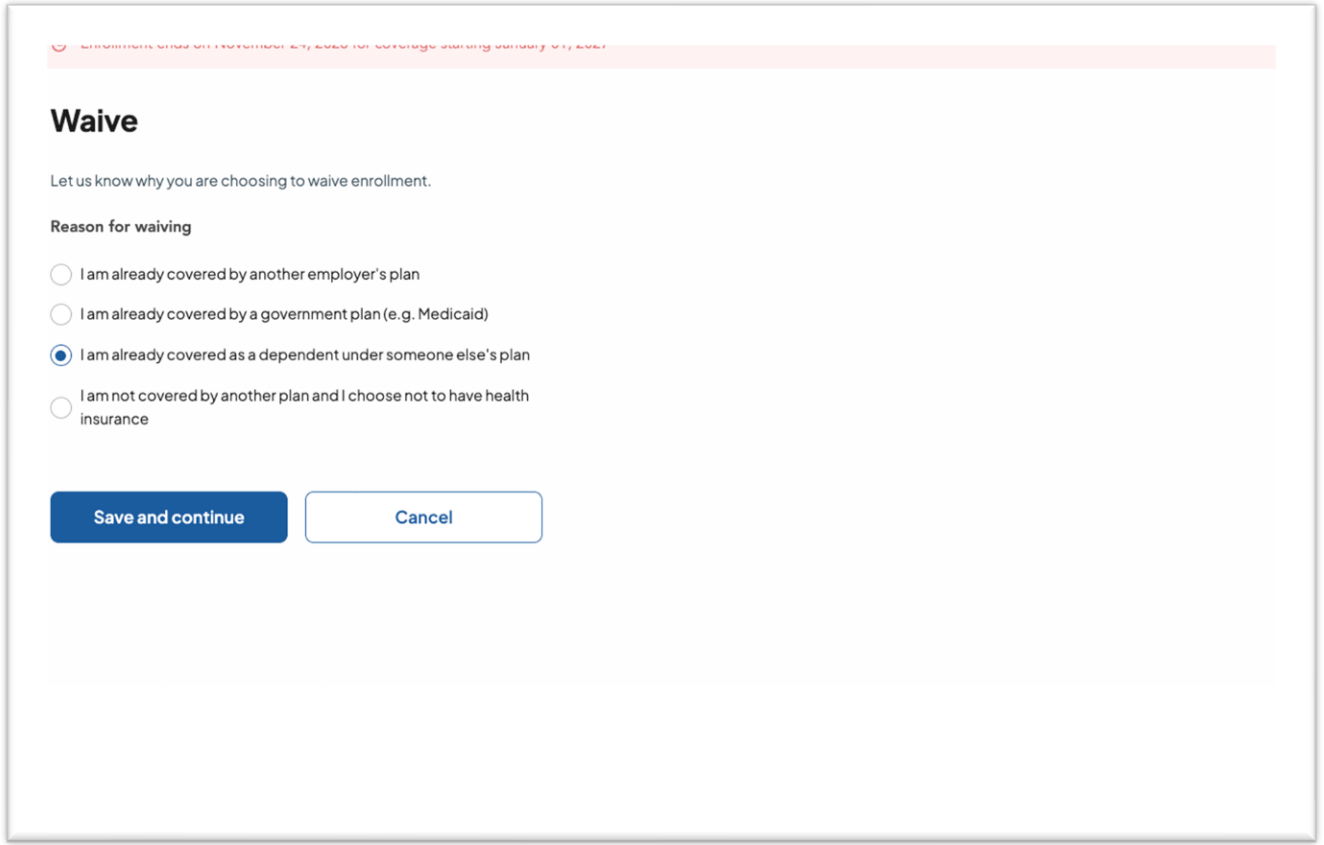
benefitbay – How To Waive Coverage

After logging in with the welcome email and signing your HIPAA Authorization, you will verify your information.

Click the “Waive” button at the bottom of the screen





Select the reason you are waiving, and click “Save and continue”

It will bring you back to your Enrollment page and show that you are waiving. You may remove waiver to shop.

Your journey is complete!

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4

Healthcare 101



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Healthcare 101

Plan Types

HMO Health Maintenance Organization	POS Point of Service	EPO Exclusive Provider Organization	PPO Preferred Provider Organization
❖ **Cost:** Generally lower premiums and deductibles. Fixed copays are common. Coinsurance may apply.	❖ **Cost:** Slightly higher premiums than an HMO.	❖ **Cost:** Premiums fall between HMO and PPO plans.	❖ **Cost:** Higher premiums than HMO, POS or EPO plans.
❖ **Doctors**: Use the HMO network and choose a primary care physician (PCP).	❖ **Doctors:** Coverage includes out-of-network doctors, but you pay more to see them.	❖ **Doctors**: In-network care only. Networks are generally larger than HMO networks.	❖ **Doctors:** See providers in or out of network. You pay less for in-network care.
❖ **Specialists**: A referral from your PCP is required. .	❖ **Specialists**: A referral from your PCP may be required.	❖ **Specialists:** Referral requirements vary by plan.	❖ **Specialists**: No referral required.

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Healthcare 101

Metal Tiers

ICHRA Medical Plans are identified as Bronze, Silver, Gold, and Platinum Metal Tiers. These metal tiers differentiate each plan and determine how you and your insurance carrier will share the medical costs for your health care. They have nothing to do with the quality of care or coverage.

Bronze	Silver	Gold	Platinum
❖ Lowest monthly premiums when compared to the other plan levels. ❖ Typically have high deductibles and qualify as high-deductible health plans (HDHPs). ❖ Pay approximately 60% of an individual's covered medical costs. ❖ Those who might benefit from this plan: • few medical services • few medications • Little to no healthcare needs	❖ Slightly higher premiums than Bronze plans. ❖ Usually have lower deductibles than bronze plans and do not always qualify as high-deductible health plans (HDHPs). ❖ Pay approximately 70% of an individual's covered medical costs. ❖ Those who might benefit from this plan: • some medical services • Some medications • Some healthcare needs	❖ Higher premiums than Silver plans ❖ Usually have lower deductibles than silver plans and do not usually qualify as high-deductible health plans (HDHPs). ❖ Pay approximately 80% of an individual's covered medical costs. ❖ Those who might benefit from this plan: • Moderate medical services • Moderate medications • Moderate healthcare needs	❖ Highest monthly premiums of all plans. ❖ Usually have lowest or no deductibles and do not qualify as high-deductible ❖ Pay approximately 90% of an individual's covered medical costs. ❖ Those who might benefit from this plan: • Frequent medical services • Frequent medications • Frequent healthcare needs

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Healthcare 101

Terms and Definitions

Deductible
What you pay before your plan starts paying for medical services.

Coinsurance
Your share after the deductible. Typically 10%–40%, based on your plan.

Copayment
A fixed amount you pay for certain medical services.

Out-of-pocket maximum

Your spending limit for the policy period, usually a year.

After you reach the limit, your plan pays 100% of covered procedures.

Premium
A fixed monthly payment to keep your plan, even when you do not use care.

Your employer sends its contribution and any employee deduction to benefitbay to pay premiums.

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Healthcare 101

High Deductible Health Plan (HDHP)

Usually lower premiums. Higher deductible.

Compared with a traditional plan, you pay more for care before insurance starts paying its share.

The HSA option

An HDHP can pair with a health savings account (HSA).

Use money free from federal taxes to pay certain medical expenses.

When it may fit

You are healthy and rarely need care.

You can cover an unexpected deductible upfront or within 30 days of receiving the bill.

You can contribute substantially to an HSA each month and want to use it to save or invest.

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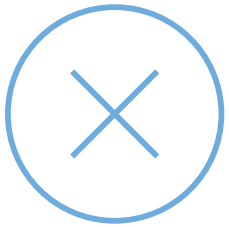
Healthcare 101

Health Savings Account

A health savings account (HSA), allows you to pay for certain medical, dental, vision and over the counter expenses with money free from federal taxes. To be eligible to participate in an HSA you **must** be enrolled in an HSA eligible plan.



You are NOT eligible if you:

Are covered by any other health insurance (including Tricare)

Are enrolled in Medicare or Medicaid

Are claimed as a dependent on someone else's tax return

Are covered under a general purpose Flexible Spending Account Program



2027 Calendar Year HSA Contribution Maximums*

Single: $4,500

Non-Single: $9,000

If you are age 55 or older, you may make an additional "catch-up" contribution of $1,000.

*prorate based on months insured by an HSA plan

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Healthcare 101

Flexible Spending Account

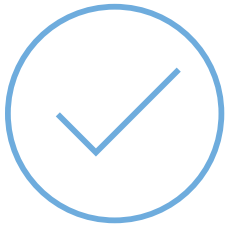
A Flexible Spending Account, allows you to pay for certain medical, dental, vision and over the counter expenses with money free from federal taxes.

Check with your employer if one is available to you and how much you may contribute



Entire elected amount is available on day 1

Amount must be used to pay qualified medical, dental, vision and over the counter expenses



Rollover or Grace Period

Check with your employer, your plan may include a rollover maximum or grace period

Unused funds will be forfeited

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Sample – How to Read an SBC (Found in plan details)

Mass General Brigham Health Plan

Complete HMO 2500 30/55/500
with Care Complement℠ for individuals and small group employers

Coverage Period: On or after 01/01/2026

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services **Coverage for: All Coverage Tiers** | **Plan Type: HMO**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to Member.MassGeneralBrighamHealthPlan.org or call Customer Services at 866-414-5533 (toll free) or 711 (TTY). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at MassGeneralBrighamHealthPlan.org or call 866-414-5533 (toll free) or 711 (TTY) to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	$2,500/Individual, $5,000/Family per benefit period.	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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, most outpatient visits (including mental/behavioral health and substance use disorder), and urgent care does not apply towards the deductible.	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.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$10,000/Individual, $20,000/Family per benefit period.	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.
What is not included in the out-of-pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they do not count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of in-network providers, see MassGeneralBrighamHealthPlan.org or call 866-414-5533.	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.
Do you need a referral to see a specialist?	Yes.	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.

Coverage year:
there is a different SBC for each coverage year.

Plan Type:
EPO, HMO, PPO, POS, etc. For definitions of plan types, see: https://www.healthcare.gov/glossary

Plan name:
There is a different SBC for each plan at each metal tier and each Silver cost-sharing level.

Separate deductibles:
A separate may apply before the plan begins sharing the cost of covered medications or services.

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Sample – How to Read an SBC

Mass General Brigham Health Plan — Complete HMO 2500 30/55/500 with Care Complement℠ for individuals and small group employers — Coverage Period: On or after 01/01/2026

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services **Coverage for: All Coverage Tiers | Plan Type: HMO**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to Member.MassGeneralBrighamHealthPlan.org or call Customer Services at 866-414-5533 (toll free) or 711 (TTY). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at MassGeneralBrighamHealthPlan.org or call 866-414-5533 (toll free) or 711 (TTY) to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	$2,500/Individual, $5,000/Family per benefit period.	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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, most outpatient visits (including mental/behavioral health and substance use disorder), and urgent care does not apply towards the deductible.	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.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$10,000/Individual, $20,000/Family per benefit period.	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.
What is not included in the out-of-pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they do not count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of in-network providers, see MassGeneralBrighamHealthPlan.org or call 866-414-5533.	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.
Do you need a referral to see a specialist?	Yes.	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.

Page 1 of the SBC contains important questions, answers and explanations about the health plan.

Overall deductible - Individual & Family

Services covered pre-deductible

Deductibles for specific services
Some plans have a separate drug deductible

Out-of-pocket limit - Individual & Family

Costs not included in the out-of-pocket limit

Provider network information

Required referrals
Many HMOs require referrals, but some do not.

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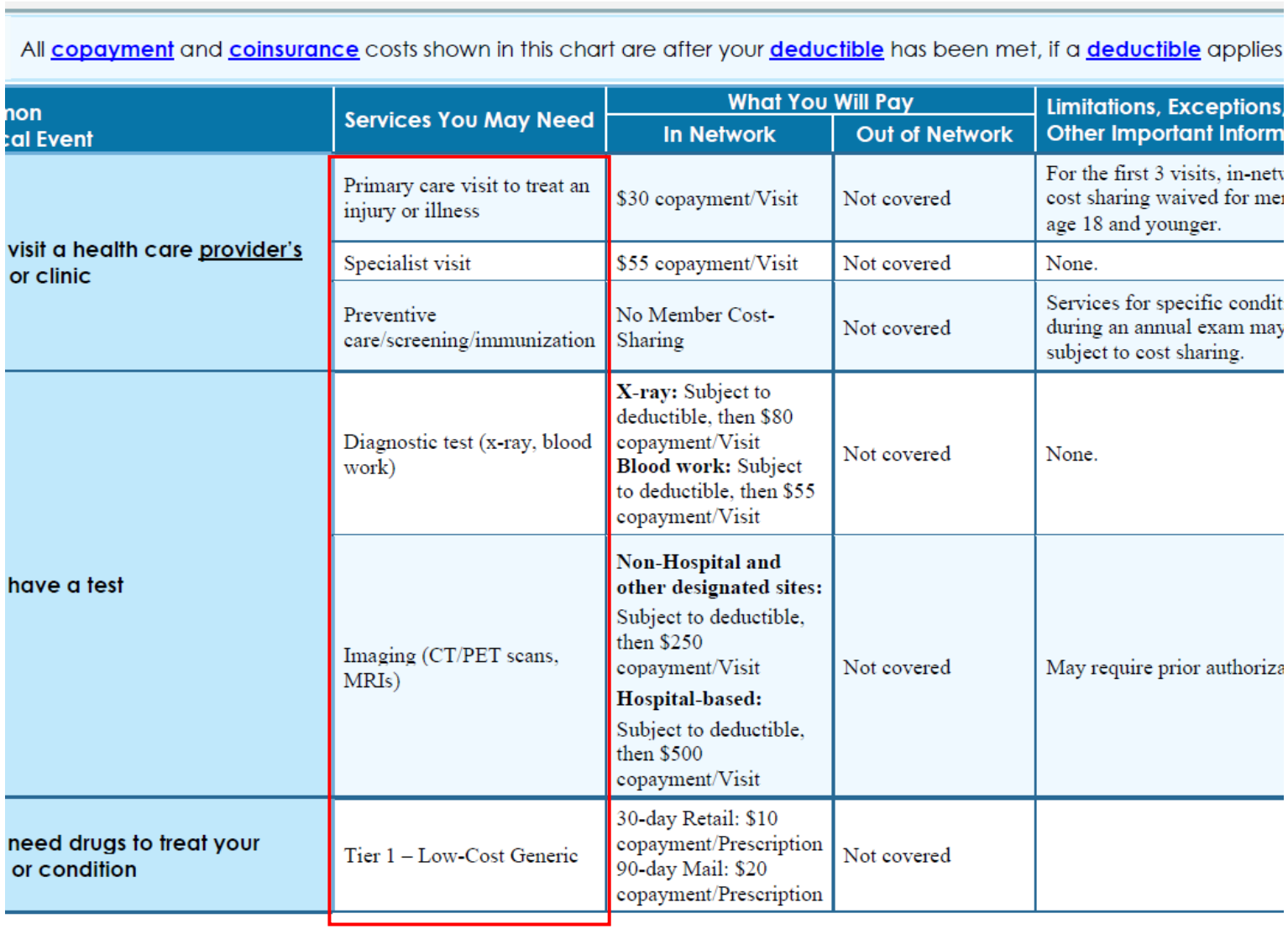
Sample – How to Read an SBC



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

non cal Event	Services You May Need	What You Will Pay		Limitations, Exceptions, Other Important Inform
		In Network	Out of Network	
visit a health care provider's or clinic	Primary care visit to treat an injury or illness	$30 copayment/Visit	Not covered	For the first 3 visits, in-netv cost sharing waived for mer age 18 and younger.
	Specialist visit	$55 copayment/Visit	Not covered	None.
	Preventive care/screening/immunization	No Member Cost-Sharing	Not covered	Services for specific condit during an annual exam may subject to cost sharing.
have a test	Diagnostic test (x-ray, blood work)	**X-ray:** Subject to deductible, then $80 copayment/Visit **Blood work:** Subject to deductible, then $55 copayment/Visit	Not covered	None.
	Imaging (CT/PET scans, MRIs)	**Non-Hospital and other designated sites:** Subject to deductible, then $250 copayment/Visit **Hospital-based:** Subject to deductible, then $500 copayment/Visit	Not covered	May require prior authoriza
need drugs to treat your or condition	Tier 1 – Low-Cost Generic	30-day Retail: $10 copayment/Prescription 90-day Mail: $20 copayment/Prescription	Not covered	

Page 2 of the SBC contains copayment and coinsurance information for:

- **Primary care visits**
- **Specialist visits**
- **Preventive care/screening/immunization**
- **Tests**
- **Prescription Drug Coverage**

Information that does not fit on the first page may instead appear at the top of the second page.

For some plans, drug cost information may appear on page 3.

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Sample – How to Read an SBC

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network	Out of Network	
More information about prescription drug coverage is available at MassGeneralBrighamHealthPlan.org	Tier 2 – Other generic and some brand name	30-day Retail: $35 copayment/Prescription 90-day Mail: $70 copayment/Prescription	Not covered	Your plan does not include coverage for GLP-1 medications (e.g., Wegovy, Zepbound, Saxenda) that share an indication of obesity/weight management. No charge for birth control and smoking cessation drugs. May require prior authorization.
	Tier 3 – High costing generic and preferred brand name	30-day Retail: Subject to deductible, then $75 copayment/Prescription 90-day Mail: Subject to deductible, then $150 copayment/Prescription	Not covered	
	Tier 4 – Higher cost generics and non-preferred brand name	30-day Retail: Subject to deductible, then $300 copayment/Prescription 90-day Mail: Subject to deductible, then $900 copayment/Prescription	Not covered	
	Tier 5 – Generic specialty and preferred specialty	Subject to deductible, then $350	Not covered	Prescription must be filled
	Tier 6 – Non-preferred specialty			
If you have outpatient surgery	Facility fee (e.g., surgery center)			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network	Out of Network	
	Physician/surgeon fees	No charge after deductible	Not covered	None.
If you need immediate medical attention	Emergency room services	Subject to deductible, then $500 copayment/Visit	Subject to deductible, then $500 copayment/Visit	Emergency room copay waived if admitted to hospital for inpatient care.
	Emergency medical transportation	No Member Cost-Sharing	No Member Cost-Sharing	None.
	Urgent care	$55 copayment/Visit	$55 copayment/Visit	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	Subject to deductible, then $500 copayment/Stay	Not covered	May require prior authorization.
	Physician/surgeon fee	No charge after deductible	Not covered	None.
If you need mental health, behavioral health, or substance use services	Mental/behavioral health/substance use outpatient services	$30 copayment/Visit	Not covered	For the first 3 visits, in-network cost sharing waived for members age 18 and younger.
	Mental/behavioral health/substance use inpatient services	Subject to deductible, then $500 copayment/Stay	Not covered	May require prior authorization.
If you are pregnant	Office visits for prenatal and postnatal care	No Member Cost-Sharing	Not covered	None.
	Childbirth/delivery facility services	Subject to deductible, then $500 copayment/Stay	Not covered	May require prior authorization.
	Childbirth/delivery professional services	No charge after deductible	Not covered	May require prior authorization.

The next several pages of the SBC provide information on the costs of:

- **Prescription drugs** (may appear on page 2 if space allows)

Outpatient surgery

Immediate medical needs
- Emergency room care
- Emergency transportation
- Urgent care

Hospital stay (including physicians' fees and hospital facility fees)

Mental, behavioral, and substance abuse services (inpatient and outpatient)

Pregnancy-related services

Recovery or other special health needs

Pediatric dental and vision services

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Excluded & Other Covered Services

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic Surgery
- Dental care-adult (you may have coverage under a separate dental plan)
- Extraction of infected or impacted wisdom teeth (except when in a hospital setting)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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.)

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

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.

The final substantive pages of the SBC will include information on:

- **Excluded services**
- **Other covered services**

Services like bariatric surgery, chiropractic visits, infertility treatment, and weight loss services are often listed on these final pages.

Some state laws require health plans to either cover or exclude these health services; otherwise, coverage will vary by plan.

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Next steps… prepare for open enrollment



Gallagher

How to prepare for Open Enrollment

Gather information that is important to you and your family

What Matters Most!		
Providers (name & zip code)	Prescriptions (name & dosage)	Utilization

Monthly premium *Deductible* *Provider network* *Prescription coverage* *HSA eligibility*

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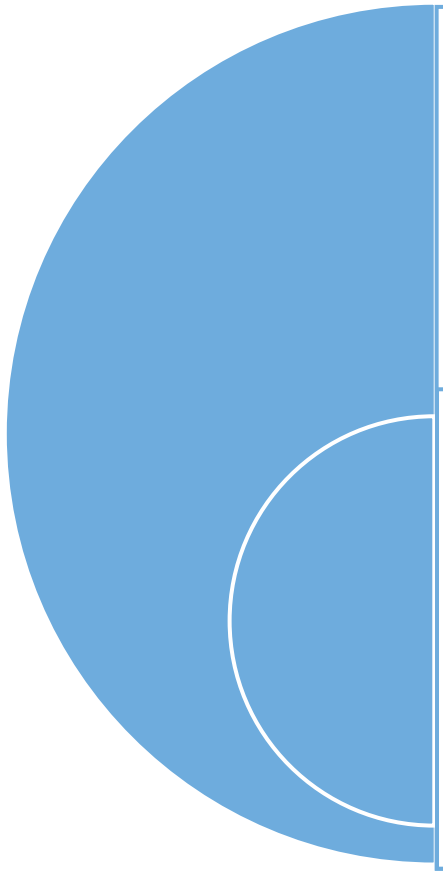
Open Enrollment Steps

ADP & benefitbay



Active Enrollment (REQUIRED)

- Medical (benefitbay)
- Medicare Renewal (meet with benefitbay advisor)
- HSA - $4500/9000 (ADP)
- Healthcare FSA - $3500 Max* (ADP)
- Dependent Care FSA (ADP)

Passive Enrollment (ADP – Changes Only)

- Dental
- Vision
- Voluntary Life (subject to EOI)
- Long Term Disability (subject to EOI)
- Accident Plan
- Critical Illness
- 401(k) Savings Plan

Open Enrollment: November 10 – November 24
Medicare Open Enrollment: October 27 – November 24

*** Awaiting final approval from the IRS**

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Q&A

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Thank you

Get in touch to let us know how we can help.

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