Mass General Brigham
Health Plan

Value HMO *for Self-Insured, ERISA-Exempt Members*

Member Handbook

Effective July 1, 2024

IMPORTANT NOTICE: This plan includes a limited provider network called Value HMO. This plan provides access to a network that is smaller than Mass General Brigham Health Plan's full commercial HMO provider network. In this plan, members have access to network benefits only from the providers in the Value HMO network. Please consult the Value HMO provider directory at MassGeneralBrighamHealthPlan.org to determine which providers are included in the Value HMO network.

Your Value HMO Member Handbook

for Self-Insured, ERISA-Exempt Members

Welcome! Mass General Brigham Health Insurance Company (Mass General Brigham Health Plan) has been designated by your Employer Group (or Plan Sponsor) to provide administrative services for this self-funded Value HMO Plan (The Plan), including Claims processing, quality assurance, case management, Claim review and other related services.

Any time you need assistance understanding your Health Insurance benefits or membership, call Customer Service at 1-866-567-9175 (TTY 711). Our hours of operation are 8:00 a.m. to 6:00 p.m., Monday through Friday, and Thursday from 8:00 a.m. to 8:00 p.m.

This Handbook contains important information about your Benefits which are provided through your Plan Sponsor and administered by Mass General Brigham Health Plan. The Plan Sponsor is responsible for the benefit design and payment of all benefits for state, participating municipalities and other governmental entities' employees. Your Plan Sponsor is the funding source, Plan Administrator, and is an ERISA-exempt governmental entity meaning that ERISA does not apply to the benefits described in this Handbook. This Handbook contains some technical terms you may be unfamiliar with. If you need help understanding this Handbook, Customer Service Representatives are available to help you. We also provide Members with free translation services.

Mass General Brigham
Health Plan

Translation Services

English
ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-462-5449 (TTY: 711).

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al. 1-800-462-5449 (TTY: 711).

Português (Portuguese)
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-462-5449 (TTY: 711).

Italiano (Italian)
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-462-5449 (TTY: 711).

Kreyòl Ayisyen (Haitian/French Creole)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-462-5449 (TTY: 711).

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-462-5449 (TTY: 711)。

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-462-5449 (TTY: 711).

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-462-5449 (TTY: 711).

ខ្មែរ (Khmer/Cambodian)
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-462-5449 (TTY: 711).

ພາສາລາວ (Laotian)
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການ ຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ ທ່ານ. ໂທຣ 1-800-462-5449 (TTY: 711).

Ελληνικά (Greek)
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-462-5449 (TTY: 711).

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-462-5449
(رقم هاتف الصم والبكم:711).

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-462-5449 (ATS : 711).

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-462-5449 (TTY: 711).

Polski (Polish)
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-462-5449 (TTY: 711).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-462-5449 (TTY: 711) 번으로 전화해 주십시오.

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-462-5449 (TTY: 711) **पर कॉल करें।**

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Section 1.

Your Plan Document

Mass General Brigham Health Plan has certain obligations to you as part of our agreement with your Plan Sponsor. These requirements and obligations are described in your Plan Document which consists of two (2) documents: the Member Handbook and the Schedule of Benefits. Your Plan Document is available on our member portal at Member.MassGeneralBrighamHealthPlan.org. If we make changes to the clinical review criteria or if your Plan Sponsor makes a material change to your Plan Document, we will notify you at least 60 days in advance of the change. We will do this by providing an amendment to your Plan Document and will make it available on our secure member portal.

Your Member Handbook is an important document and explains how your membership works. It's also your guide to the most important things you need know, including:

- Covered Benefits
- Exclusions
- The requirement to receive services from an In-Network Plan Provider
- The requirement to go to your PCP for most services

To review a copy of this Member Handbook online, please visit Member.MassGeneralBrighamHealthPlan.org. For assistance, interpretation, or to request a Member Handbook or other documents, please contact:

Mass General Brigham Health Plan
Customer Service
399 Revolution Drive
Somerville, MA 02145

1-866-567-9175 (TTY 711)

Health Savings Accounts

A Health Savings Account (HSA) is a fund you can establish to pay for medical expenses that come with a High Deductible Health Plan or that you can use to save for your future health needs. Under federal rules, you need to enroll in a High Deductible Health Plan to be able to set up an HSA. If your Plan is a qualified High Deductible Health Plan,* you may be able to set up and contribute to an HSA. Check with your Plan Sponsor to find out whether they have planned for an administrator to manage HSAs. Once you set up an HSA, you should contact your HSA administrator to find out how to get the most from your account.

*The Plan is an HSA compatible High Deductible Health Plan if the product name at the top of your Schedule of Benefits contains "HSA."

Words with Special Meaning

Some words in this Member Handbook have special meaning. These words will be capitalized throughout the Handbook and defined in the Glossary at the end of the Handbook. For the purposes of this Member Handbook, the word "you" means "Members of Mass General Brigham Health Plan" and "the Plan", "us", "we", or "our" means "Mass General Brigham Health Plan".

The Value HMO Provider Directory

Mass General Brigham Health Plan requires Members, with certain exceptions as described in your Member Handbook, to obtain services from Value HMO Providers. Unless explicitly authorized by us, services that are obtained from Out-of-Network providers, except in emergencies, may not be covered by the Plan. To determine if a provider is contracted with the Value HMO network, please visit Member.MassGeneralBrighamHealthPlan.org and go to Find doctors & care. This will enable you to search for Providers by name, geographic location, specialty, gender, languages spoken, and hospital affiliation.

The web-based Provider Directory contains the most up-to-date information about our Value HMO network. For assistance, interpretation, or to request a copy of your Provider Directory, please contact Customer Service.

Information about Providers

More information about physicians, Nurse Practitioners, and Physician Assistants licensed to practice in Massachusetts is available from the Board of Registration in Medicine. Visit: **mass.gov/orgs/board-of-registration-in-medicine** to find information on your Provider's education, hospital affiliations, board certification status, and more. You can find information about nurse practitioners at the Massachusetts Division of Health Professionals Licensure website at mass.gov. Information on Physician Assistants can be found at mass.gov/orgs/board-of-registration-of-physician-assistants.

The following websites also provide useful information in selecting quality health care Providers:

- **Leapfrog—**leapfroggroup.org (for information on health care quality, so you can compare hospitals)
- **Massachusetts Health Quality Partners—**mhqp.org (to learn how different medical groups treat the same type of illness, allowing you to make comparisons)
- **Joint Commission for the Accreditation of Healthcare Organizations (JCAHO)—**qualitycheck.org (for information that allows you to compare quality of care at many hospitals, home care agencies, laboratories, nursing homes, and behavioral health programs)

For information about Mass General Brigham Health Plan, you may contact the Office of Patient Protection (OPP) at any time:

Office of Patient Protection
1-800-436-7757
Fax 617-624-5046
mass.gov/hpc/opp

The following information is available to you from the OPP:

- A list of sources of independently-published information rating insurance plan Members' satisfaction about the quality of Covered Health Care Services offered by us;
- The percentage of physicians who voluntarily and involuntarily ended contracts with us during the last calendar year, plus the three most common reasons why they left;
- The medical loss ratio, which is the percentage of Premium revenue spent by us for Health Care Services provided to Members for the most recent year for which information is available;
- A report detailing, for the previous calendar year, the total number of filed Grievances, the type of medical or Behavioral Health treatment at issue where applicable, the number of Grievances that were approved internally, the number of Grievances that were denied internally, and the number of Grievances that were withdrawn before resolution;
- The number of Grievances which resulted from an Adverse Determination, the type of medical or Behavioral Health Treatment at issue, and the outcomes of those Grievances;
- The percentage of Members who filed internal Grievances with us;
- The total number of internal Grievances that were reconsidered, the number of reconsidered Grievances that were approved internally, the number of reconsidered Grievances that were denied internally, and the number of reconsidered Grievances that were withdrawn before resolution; and
- The total number of external reviews pursued after exhausting the internal Grievance process and the resolution of all such external reviews.

Member Portal

Visit Member.MassGeneralBrighamHealthPlan.org to register and log into your own secure, Member portal which has everything you need to manage your plan 24 hours a day, 7 days a week. You can:

- Access your Benefits, coverage, and out of pocket costs
- Select or change your Primary Care Provider
- Manage your pharmacy Benefits
- Order or print a temporary ID card
- Estimate the cost of services

Section 2.

Eligibility and Enrollment

Enrollment

There is no pre-existing condition limitation or exclusion when enrolling with Mass General Brigham Health Plan. For questions concerning a waiting period before you can become enrolled with the Plan, please see your Plan Sponsor's benefits administrator. Once enrolled with the Plan, there is no waiting period. In addition, the Plan does not use the results of genetic testing in making any decisions about enrollment, renewal, payment or coverage of health care services nor do we consider any history of domestic abuse or actual or suspected exposure to diethylstilbestrol (DES) in making such decisions.

We will accept you into our plan regardless of your income status, source of income, physical or mental condition; age, expected length of life, sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)), religion, creed, personal appearance, national origin, English proficiency, ancestry, ethnicity, color, or race; marital status, veteran's status, occupation or political affiliation; claims experience, physical or mental disability, duration of medical coverage, pre-existing conditions, need for health care services, ultimate payer for your services, or your actual or expected health status as a Member.

Upon receipt of your completed Enrollment, the Plan will mail you a Member ID Card which you should use to access Covered Services from In-Network Providers. We are not responsible for any services you receive prior to your Effective Date of Enrollment with the Plan.

The Value HMO Service Area

As an Eligible Employee, you may enroll if you are actively working for an employer who is based in the Value HMO Service Area and are enrolling through your Plan Sponsor's group plan.

The Value HMO Service Area consists of the following Massachusetts counties:

- Bristol
- Dukes
- Essex
- Middlesex
- Nantucket
- Norfolk
- Plymouth
- Suffolk

Subscriber Eligibility

This section describes requirements concerning eligibility under the Plan. It is important to understand that eligibility of subscribers and dependents and effective dates of coverage are determined by the Plan Sponsor.

To be eligible to enroll as a Subscriber a person must:

- Be an Employee of a firm, corporation, partnership or association actively engaged in a business that is based within the Service Area.
- Meet all eligibility guidelines approved by the Plan Sponsor and the Plan, and
- Be enrolled through a Plan Sponsor that is up-to-date in the payment of the applicable payments for coverage or administrative services.

Dependent Eligibility

Unless your Plan Sponsor has elected different types of coverage for Dependents, a Dependent must meet one of the requirements for coverage listed below to be eligible for coverage under the Plan.

Plan Sponsors may elect different coverage for Dependents and different ages for the termination of Dependents and student Dependents. Please consult your Plan Sponsor's Benefits Office to determine the specific Dependent eligibility requirements that apply to your Plan.

- The Subscriber's legally married spouse. A legal spouse means the same sex or opposite sex spouse of the subscriber who has entered into a legally valid marriage or civil union in a jurisdiction where such marriage or civil union is legal. We recognize same-sex spouses and partners in a civil union subject to the Plan Sponsor's eligibility policies.
- The former spouse of a Subscriber, until the Subscriber or the former spouse remarries or until such time as may be specified in the divorce judgment consistent with state law, whichever occurs first, or subject to your Plan Sponsor's eligibility policies.
- A child of the Subscriber or the Subscriber's spouse, by birth, legal adoption (including a child for whom legal adoption proceedings have been initiated), under custody pursuant to a court order, or under legal guardianship, until the age of twenty-six (26) in accordance with the Patient Protection and Affordable Care Act: or
- A child who is under legal guardianship with the Subscriber or Subscriber's spouse is eligible for coverage as a dependent up to the Dependent's 26th birthday. Documentation must be provided that includes a court document signed by a judge indicating the child's name, the appointed legal guardian(s), the temporary or permanent designation, the effective date and, if temporary legal guardianship, the termination date
- A child who has been residing in the home as a foster child and for whom the subscriber has received foster care payments.
- A child of a Dependent of the Subscriber or Subscriber's spouse is eligible for coverage as a dependent up to the child's 26th birthday. However, when the parent of such child is no longer an eligible Dependent of the Subscriber or Subscriber's spouse, the child shall no longer be covered.
- Children who are recognized under a qualified medical child support order as having the right to enroll for coverage under the plan are eligible for coverage as dependents up to the Dependent's 26th birthday.
- A mentally or physically disabled child who is incapable of earning his or her own living and who is enrolled under the Subscriber's plan will continue to be covered after he or she would otherwise lose dependent eligibility, so long as the child continues to be mentally or physically incapable of earning his or her own living. Dependents at age 26 who are mentally or physically incapable of earning their own living may be eligible for handicapped dependent coverage.

Please contact the Plan for the Handicapped Dependent Application to apply for this coverage. Your dependent's application will be reviewed and once enrolled the child's coverage will be continued to the extent permitted per your Plan Sponsor's eligibility policies.

Effective Date and Enrollment Requirements

Persons who meet the requirements of the section titled "Eligibility" and subsections titled "Subscriber," and "Dependent," may enroll in the Plan. Please see your Plan Sponsor's Benefit Administrator to confirm your enrollment and Effective Dates of coverage. To be enrolled in the Plan, your Plan Sponsor must be up-to-date in the payments required under the contract.

At the time of Enrollment, each Member will need to choose a PCP to whom he or she must go to for primary care. Members of a family may each choose a different PCP for their care. You can change your PCP at Member.MassGeneralBrighamHealthPlan.org.

Effective Date

Under the Health Insurance Portability and Accountability Act (HIPAA), individuals may enroll in the Plan within 30 days of losing other coverage if:

1. The Subscriber's spouse or eligible Dependent has lost other insurance.
2. The Subscriber marries.
3. The Subscriber has a newborn or adopts a child.
4. The Plan Sponsor's contributions toward the Dependent's coverage are terminated.

For items 1, 2, and 4, the Effective Date must be no later than the first day of the first month after we receive the Enrollment request. For item 3, the Effective Date will be the date of birth in the case of a newborn Dependent or in the case of an adoptive Dependent the Effective Date will be the date of adoption or placement for adoption.

Status Changes

It is your responsibility to notify your Plan Sponsor about any changes that may affect your or your dependents' eligibility for coverage, such as:

- An addition to the family
- The marriage of a Dependent
- An address change
- Death of a Member
- Change in marital status

We must have your current address and telephone number on file so that we can contact you when necessary and to correctly process Claims for care outside the Service Area. Call your Plan Sponsor's Benefit Administrator to make any changes or corrections to your address and telephone number.

Disenrollment

Voluntary Termination by the Subscriber

A Subscriber who is enrolled in the Plan may terminate coverage following the Plan Sponsor's approval. Your Plan Sponsor must notify the Plan of your termination within sixty (60) days of the date you want your Membership to end.

Termination for Loss of Eligibility

The Plan may end or refuse to renew a Member's coverage for failing to meet any of the eligibility requirements. The enrolled Subscriber will be notified in writing if coverage ends for loss of eligibility. You may be eligible for continued coverage under federal or state law, if your membership is terminated under certain circumstances. See "Continuation of Group Coverage" for more information.

Membership Termination for Cause

The Plan may terminate or refuse to renew a Member's coverage only for the following reasons:

- The failure by the Member or other responsible party to make payments required under the contract.
- Making an intentional misrepresentation of a material fact or performing an act, practice, or omission that constitutes fraud.
- The commission of acts of physical or verbal abuse by a Member that pose a threat to Providers, staff at Providers' offices, or other Members and that are unrelated to the Member's physical or mental condition.
- Relocation of an individual to outside the Service Area.
- Non-renewal or cancellation of the group contract through which an eligible subscriber receives coverage.

- Termination of Membership for intentional misrepresentation of fraud will be made retroactive to the date of the misrepresentation, act, practice, or omission. You will be provided with written notification 30 days in advance of the retroactive termination taking place. Premiums paid for periods after the effective date of termination will not be refunded until the Plan rescinds any payments made on your behalf for covered health care services.

Termination for Non-payment by the Plan Sponsor

A Member's coverage will end under this Plan if the Plan Sponsor contract through which the Member receives coverage is terminated for non-payment. We will notify you in writing, if your coverage is terminated due to your Plan Sponsor failing to pay its administrative costs. You may enroll in any other individual plan offered by the Plan. For more information about individual coverage call Customer Service.

Continuation of Employer Group Coverage

Eligible members who were covered through a qualified Massachusetts employer group of 20 or more employees may be eligible for continuation of group coverage under the Federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA). Under COBRA, if you or your family members are covered by the plan on the day before coverage is lost due to one of the events noted below, coverage may be continued for up to the length of time associated with the event. You should contact your Plan Sponsor within 60 days of the event for more information if health coverage ends due to:

- **Plant closing—**As a covered employee, you have a 90-day eligibility for continued coverage in the event of a plant closing or partial plant closing;
- **Loss of employment** (other than for gross misconduct)—18 months;
- **Divorced Spouses—**In the event of divorce or legal separation, a former spouse is eligible to keep coverage under the employee's membership. This is the case only until the employee is no longer required by law to provide health insurance for the former spouse whichever comes first. The former spouse's eligibility for continued coverage will start on the date of divorce, even if he or she continues coverage under the employee's membership.
- **Loss of dependency status**—Maximum 36 months
- **Reduction of work hours**—Maximum 18 months

Continuation of coverage may not be extended beyond the applicable time allowed under federal law. The size of your Plan Sponsor will determine whether you select your continuation of coverage rights under state or federal law. Please also note that Mass General Brigham Health Plan may not have current information concerning Membership status. Plan Sponsors may notify us of Enrollment changes retroactively. Only your Plan Sponsor can confirm Membership status.

Individual Coverage

If your coverage with your Plan Sponsor ends, you may be eligible to enroll in an individual plan offered us. The Benefits and premium charges for these plans may differ from your coverage provided under your Plan Sponsor. For more information about individual coverage call Customer Service.

Your Member Identification Card

We will mail you an Identification Card following receipt of a complete and accurate Enrollment. Your Member ID Card has important information about you and your coverage. It also informs Providers and pharmacists that you are a Member of Mass General Brigham Health Plan and how much your cost-sharing for services should be. Additional cost-sharing may apply and may not be reflected on your ID card. Your Plan Document will show your cost-sharing amounts due for services. Be sure to show your Member ID Card whenever you get health care or fill a prescription. Carry your Member ID card with you so it will be handy when you need care.

Please read your card carefully to make sure all the information is correct. If you have questions or concerns about your Member ID Card, or if you lose it, call Customer Service. You may order a new ID card by logging on to Member.MassGeneralBrighamHealthPlan.org. Do not let anyone else use your Member ID Card for any purpose, including obtaining health care services.

Section 3.

Your Plan Providers

Your Primary Care Provider (PCP)

All members must choose a PCP upon Enrollment in the Plan. Your PCP provides or arranges all of your health care. The PCP you select can be a Doctor, Physician Assistant or Nurse Practitioner. You have the right to designate any 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 a PCP.

To select or choose a PCP or Primary Care Site, go to our secure member portal Member.MassGeneralBrighamHealthPlan.org or call Customer Service.

Concierge Services

Some physicians charge an annual fee to patients as a condition to be part of the physician's panel of patients and to receive special customer service from the provider (e.g., access to the provider's cellular telephone, more personalized service). Members who use physicians who provide additional customer service for a fee (also known as concierge service) should be advised that those concierge services are not part of your health plan coverage.

Why It's Best to Call Your Primary Care Site

Calling your Primary Care Site first can save you a needless trip to the Emergency room—and hours of waiting and worrying. You will get the quickest and best advice from people who know you well. For example, your Primary Care Site's doctor or nurse on call may tell you how to treat your problem at home. If the Doctor, Physician Assistant or Nurse thinks that you need to go to the Emergency room, he or she will tell you exactly where to go. The Doctor, Physician Assistant or Nurse can also let the Emergency room know you are coming.

Changing Your PCP

Your PCP can provide better care when he or she knows you and your medical history. For this reason, we encourage you to have an ongoing relationship with your PCP. If you need to change your PCP, you may do so at any time, for any reason, including changing your PCP to a Physician Assistant or Nurse Practitioner.

To change your PCP, go to our secure member portal Member.MassGeneralBrighamHealthPlan.org or call Customer Service. A Customer Service Representative can assist you with your selection and process the change. If you choose a new PCP and/or Primary Care Site, your change(s) are effective immediately or a future date you choose. If your PCP leaves the Provider Network, Mass General Brigham Health Plan or your PCP will notify you in writing. When you are notified, call Customer Service to select a new PCP. If Your PCP is Disenrolled from the HMO network, we will make every effort to notify you at least thirty (30) days before the disenrollment of your PCP.

For the most current information about any Provider in our Network, visit Member.MassGeneralBrighamHealthPlan.org or call the number on the back of your Member ID card.

Get to Know Your PCP

It is a good idea to meet your new PCP before you need care. To make an appointment, call your Primary Care Site. When you call, be sure to say that you are a Mass General Brigham Health Plan Member. You should ask your prior PCP to send your health records to your new Primary Care Site before this visit.

When you go to your appointment, show your Member ID card. You and your PCP can use this appointment to get to know each other. After this first appointment, call your Primary Care Site whenever you need health care. In an Emergency, seek immediate care at the nearest facility.

Behavioral Health (Mental Health and Substance Use) Providers

Members have access to a full range of Behavioral Health (mental health and substance use) services. Optum is the company that manages our Behavioral Health program.

Some examples of Behavioral Health services are individual, group, and family counseling and medication management. For a complete listing of Behavioral Health services, see "Section 8: Behavioral Health Services." If you need Behavioral Health services, you may choose any Provider in our Behavioral Health Network.

You can make the appointment on your own or call Optum's Clinical Department at 1-844-875-5722 (TTY 711) to help you find a Provider. You may also ask your PCP for help.

For information about our Behavioral Health Network Providers:

- See the "Behavioral Health Services" section of the Provider Directory
- Call Optum's Clinical Department at 1-844-875-5722 (TTY 711)
- Call Customer Service at 1-866-567-9175 (TTY 711).

Specialty Providers

Referrals are required for visits to In-Network Specialists, except for the following services:

- Gynecologist or Obstetrician for routine, preventive, or urgent Care
- Family planning services
- Outpatient and diversionary Behavioral Health services
- Emergency services
- Routine eye exams
- Physical therapy
- Speech therapy
- Occupational therapy

Before making your appointment with an In-Network Specialist, your PCP can discuss the situation, consider options and help decide where you can get the services you need. Some specialty care providers will require a clinical summary from your doctor before they see you. For example, a neurologist may want to obtain your PCP's opinion. These specialists require a Referral ID number from us prior to rendering services.

Relationship of Mass General Brigham Health Plan to Providers

Providers are independent contractors. Mass General Brigham's relationships with its Providers are governed by separate contracts. Providers may not change the Plan Document or create or imply any obligation for Mass General Brigham Health Plan. We are not liable for statements about this agreement made by Providers, their employees, or agents. We cannot guarantee the availability of individual Providers or Provider groups. We may change arrangements with Providers, including the addition or removal of Providers.

All Providers listed in any of the provider directory are available to Members at the time the directories were accessed. For the most up-to-date information on Network Providers, refer to online Provider Directory located at Member.MassGeneralBrighamHealthPlan.org.

Continuity of Medical and Behavioral Health Care

In order to ensure continuity of care, there are some circumstances when we will provide coverage for health services from a Provider (including Nurse Practitioners and Physician Assistants) who is not participating in the Plan's network.

- If you are enrolling as a new Member and your Plan Sponsor only offered you a choice of Carriers in which your existing PCP or an actively Treating Provider was not a participating provider, we will provide coverage for up to ninety (90) calendar days from the Effective Date of coverage. With respect to a Member in her second or third trimester of pregnancy, this provision applies to services rendered through the first postpartum visit by the Provider caring for her pregnancy. With respect to a Member with a terminal illness, this provision applies to services rendered until death.
- If your Provider has been disenrolled from the network, for reasons unrelated to quality of care or fraud, we will provide coverage for up to ninety (90) calendar days if they are providing you with active treatment for a chronic or acute medical condition or until that active treatment is completed, whichever comes first. For any pregnant Member who is in her second or third trimester this coverage will continue through the first postpartum visit. For any Member who is terminally ill, this coverage will continue through the Member's death if he or she remains covered under the plan until death.

To continue care in the above situation, the Provider must adhere to the quality assurance standards of Mass General Brigham Health Plan and provide us with the necessary medical information related to the care provided. The Provider must adhere to our policies and procedures, including procedures regarding prior Authorizations and providing services pursuant to a treatment plan, if any, approved by us. In the case of disenrolled Providers, they must also agree to accept reimbursement from us at the rates applicable prior to notice of disenrollment as payment in full, and not to impose cost-sharing with respect to the Insured in an amount that would exceed the cost-sharing that could have been imposed if the Provider had not been disenrolled. Failure of a Provider to agree to these conditions may result in a denial of coverage for the provided service.

If you have any questions, please call Customer Service.

Section 4.

Accessing Medically Necessary Care

Emergency Care

In an Emergency, go to the nearest Emergency facility, call 911, or call your local Community Behavioral Health Center*. You are always covered for care in an Emergency.

*Community Behavioral Health Centers may only be available in certain states.

An Emergency is defined as a medical condition, whether physical, behavioral, related to substance use disorder, or a mental disorder, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part. With respect to a pregnant woman who is having contractions, an emergency also includes having inadequate time to affect a safe transfer to another hospital before delivery or a threat to the safety of the member or her unborn child in the event of transfer to another hospital before delivery.

You or your representative (such as another member of your family) must call your Primary Care Site for emergency medical conditions within 48 hours of any Emergency care. Notification by the attending Emergency physician to the Plan or to your PCP within 48 hours of receiving Emergency services will also satisfy this requirement. Your PCP will arrange for any follow-up care you may need. You will not be denied coverage for reasonable and necessary medical and transportation expenses incurred as a result of any such Emergency.

If you are admitted to the hospital as a result of an emergency visit, your Treating Provider or the Hospital Emergency department must notify the plan within 24 hours of being admitted.

After you have been stabilized for discharge or transfer, we may require a Hospital Emergency department to contact a physician on-call designated by Mass General Brigham Health Plan, Optum, or its designee for Authorization of post-stabilization services to be provided. The Hospital Emergency department shall take all reasonable steps to initiate contact with Mass General Brigham Health Plan, Optum, or its designee within 30 minutes of stabilization. Such Authorization shall be deemed granted if Mass General Brigham Health Plan, Optum, or its designee has not responded to said call within 30 minutes. In the event the attending physician and on-call physician do not agree on what constitutes appropriate medical treatment, the opinion of attending physician will prevail and treatment shall be considered appropriate treatment for an Emergency medical condition, provided, that such treatment is consistent with general accepted principles of professional medical practice and is a Covered Health Care Service under the policy or contract with us.

Urgent Care

Urgent Care is care for a health problem that needs medical attention right away, but you do not think it is an Emergency. For an Urgent Care visit, call your PCP first as there may be an Urgent Care Center at your Primary Care Site. You can contact your Primary Care Site 24 hours a day, seven days a week. Urgent Care does not include care that is elective, Emergency, preventive, or health maintenance. Examples of conditions requiring Urgent Care include but are not limited to fever, sore throat, and earache.

Specialty Care

At times, your PCP may suggest that you see a Specialist. Specialists are Doctors who focus on one area of medicine. Examples of Specialists are cardiologists, dermatologists, and allergists. Referrals are required for visits to In-Network Specialists, except for the following services:

- Gynecologist or Obstetrician for routine, preventive, or Urgent Care
- Family planning services
- Outpatient and Diversionary Behavioral Health Services

- Emergency services
- Routine Eye Exams (ophthalmologist or optometrist)
- Physical Therapy
- Occupational Therapy
- Speech Therapy

Before making your appointment with an In-Network Specialist, your PCP can discuss the situation, consider options and help decide where you can get the services you need. Some specialty care providers will require a clinical summary from your doctor before they see you. For example, a neurologist may want to obtain your PCP's opinion. These Specialists require a Referral ID number from us prior to rendering services. When you have an established connection with your PCP, he or she can help you address all aspects of your health care and assist you in coordinating all the services you need. If necessary and your PCP approves, your PCP can authorize a standing Referral for an In-network Provider. A standing approval allows you to continue to see a Specialist without getting a new Referral for each visit once the initial specialty visit is approved by your PCP. In the event you require a standing Referral, the Specialist must adhere to our policies and agree to a treatment plan for you and provide the PCP with all necessary clinical and administrative information on a regular basis. The Specialist must also provide care consistent with the terms of your Plan Document and the Specialist cannot authorize any additional Referrals to other providers without our approval.

It is your responsibility to make sure that the Specialist you wish to see participates with Mass General Brigham Health Plan and is available in the Network. When you use In-Network Providers, you know that they have been credentialed by us and that they will work with our medical staff to help ensure you get the care you need. If you have a medically necessary service at an In-Network location but it is performed by an out-of-network provider, you will not be responsible to pay more than the amount required for In-Network services.

However, we may not cover the service if you had a reasonable opportunity to choose to have the service performed by an In-Network Provider. For example, if your In-Network Provider refers you to a dermatologist, you must ensure that the dermatologist is in the Network. This process helps the Plan ensure that the PCP is coordinating the Member's care. It is the Member's responsibility to ensure they have a Referral prior to seeing a Specialist. It is a good idea after you have received confirmation from your PCP that a Referral was sent by checking with the Specialist office at the time of your appointment. If you don't have a Referral, you can ask the Specialist's office to contact your PCP's office to send the Referral while you wait. Failure to obtain a Referral can result in you being financially responsible for your appointment.

Sometimes a Specialist will recommend you see another Specialist. Always check with your PCP before seeing a Specialist because your PCP needs to issue the Referral. A Specialist isn't able to refer you to another Specialist.

You may search our Provider Directory or call Customer Service at 1-866-567-9175 (TTY 711).

If, at any time, you or your PCP has trouble finding needed medical services in the Network, you or your PCP can call Customer Service for Referral help.

Out-of-Network Specialty Care

You may visit an Out-of-Network Specialist only if we approve it in advance. Services provided by Out-of-Network Specialists require prior Authorization. If there are In-Network providers who offer the service, we will usually deny the request to cover services provided by an Out- of-Network Specialists. Before you schedule an appointment or seek medical care from Out-of-Network Specialist, ask your PCP or treating doctor to send an Authorization request to Mass General Brigham Health Plan. After reviewing the request, we will notify you and your doctor of our decision in writing.

If you do not receive written approval from us for Out-of-Network specialty care, the plan will not cover the services. If you do receive Authorization for Out-of-Network specialty care, cost-sharing, if any, will remain the same.

Non-Emergency Hospital Care

If you need hospital care and it's not an Emergency, your PCP will make the arrangements for your hospital stay. You must go to the hospital specified by your PCP in order for us to cover your hospital care. The Plan will cover hospital care only if your PCP or Primary Care Site arranges such care. The only exception is for Emergency care. If you change your PCP, your new PCP must arrange for any further hospital care.

Behavioral Health Hospital Care

If you need Inpatient hospital care for Behavioral Health needs, call 911 or go to the nearest emergency room, or contact the Community Behavioral Health Center, if available, in your area. A Behavioral Health clinician at the Community Behavioral Health Center or the Emergency room will screen and evaluate you for a potential admission. For a listing of Emergency Rooms in your area, refer to your online Provider Directory. You can also call your PCP or Optum's Clinical Department.

Intermediate or Diversionary Behavioral Health Services

The Plan offers an array of Behavioral Health services to our Members. "Section 8: Behavioral Health Services" provides detailed information on Behavioral Health services that we cover and how to access these services.

In addition to traditional outpatient services (which include individual, couples, family and group counseling as well as medication management), several diversionary services are available to our Members. Examples of diversionary Behavioral Health Services include: Partial Hospitalization Programs (PHP); and Community Support Services (CSP). PHPs have structured intensive therapeutic services for up to six hours a day, and CSPs offer outreach and support to assist a Member/Family in accessing their mental health or substance use treatment in the community.

Diversionary services above do not require a Referral, but these services do require a Provider to obtain prior Authorization from Optum. You may learn more about these services by calling Optum at 1-844-875-5722 (or TTY 711) or speaking to your outpatient therapist if you have one.

Structured Outpatient Addiction Programs (SOAPs) provide short-term, clinically intensive structured day and/or evening addiction treatment services, usually provided in half- or full-day units, up to six or seven days per week. This program is designed to enhance continuity for Members being discharged from Level III or Level IV detoxification programs as they return to their homes and communities. These services do not require a prior Authorization.

After-hours Care

No matter when you are sick—day or night, any day of the year—call your Primary Care Site. All Primary Care Sites have a doctor, Physician Assistant or nurse on call 24 hours a day, seven days a week. The doctor, physician assistant or nurse on call is there to help with urgent health problems. When you call your Primary Care Site after-hours, the site's answering service will answer your call. The service will take your name and phone number and contact the doctor, physician assistant or nurse on call. That doctor, physician assistant or nurse will call you back to talk about your problem and help you decide what to do next.

For Behavioral Health after-hours care, call your Behavioral Health Provider first. You may also call Optum's clinical department 24 hours a day, seven days.

If you think your health problem is an Emergency and needs immediate attention, call 911 or the Community Behavioral Health Center in your area at once or go to the nearest Emergency room.

Care When Outside the Service Area

When Members are traveling or temporarily residing outside the Service Area, including dependents living outside the Service Area, the Plan will cover only Emergency and Urgent Care services. To ensure coverage, be sure to take care of your routine health care needs before traveling outside of the Service Area. If you need Emergency Care or Urgent Care while you are temporarily outside the Service Area, go to the nearest doctor or Emergency room. You do not have to call your PCP before seeking Emergency or Urgent Care while outside the Service Area. You or a family member should call your Primary Care Site within 48 hours of receiving out- of-area care and before

receiving any follow-up services related to your urgent or emergent need. Except for Emergency or Urgent Care, failure to obtain prior Authorization for services outside the Service Area may result in Member liability for payment.

The Plan will not cover:

- Tests or treatment you receive outside the Service Area that was requested by your PCP before you left the Service Area
- Routine Care or follow-up care that can wait until your return to the Service Area, such as physical exams, flu shots, stitch removal, mental health counseling
- Care that could have been foreseen prior to leaving the Service Area such as elective surgery
- Care for childbirth or problems with pregnancy beyond the 37th week of pregnancy, or after being told that you were at risk for early delivery

A Provider may ask you to pay for care received outside of the Service Area at the time of service. If you pay for Emergency or Urgent Care you received while outside of the Service Area, you may submit a Claim to us for reimbursement. See "Section 12 If You Receive a Bill in the Mail" for more information and instructions on how to submit a Claim. You may also call Customer Service for help with any bills that you may receive from a health care Provider.

Family Planning Services

Family Planning Services include birth control methods as well as exams, counseling, pregnancy testing, and some lab tests. You may call any In-Network Family Planning clinic for an appointment. You may also see your PCP for Family Planning Services. Call Customer Service if you need help finding a Network Provider for Family Planning Services.

Maternity Care

The Plan covers many services to help you have a healthy pregnancy and a healthy baby. If you think you might be pregnant, call your Primary Care Site. Your provider will schedule an appointment for a pregnancy test. If you are pregnant, your Primary Care Provider will arrange your maternity care with an obstetrician or nurse midwife.

You will be scheduled for regular checkups during your pregnancy. It is important to keep these appointments even if you feel well. During these appointments, your obstetrician or nurse midwife will check your baby's progress. He or she will tell you how to take good care of yourself and your baby during your pregnancy. He or she will also take care of you when you have your baby.

For information about Maternal & Child Health Clinical Nurse Specialist, see "Section 11: Care Management and Disease Management Programs."

Section 5.

Prior Authorizations

An Authorization is a special approval by Mass General Brigham Health Plan or Optum (our designated Behavioral Health Manager) for coverage of certain services. Not all services require Authorization. If a service does require an Authorization, Authorizations must occur before you receive the service in order for the service to be covered. Your PCP or the Specialist treating you will request an Authorization from Mass General Brigham Health Plan or Optum if it is necessary. Examples of services that may require Authorization from Mass General Brigham Health Plan are surgical procedures and elective admissions, Inpatient psychiatric care, etc. Mass General Brigham Health Plan and Optum give Authorizations as soon as possible.

For an initial or prior Authorization regarding a proposed elective admission, procedure or service, Authorization decisions are made within two (2) business days of obtaining all necessary information has been received and no longer than 14 calendar days. Once the decision is made, Providers are verbally notified of the decision within 24 hours. The Provider and the Member are sent written notification of the decision within one (1) business day of the verbal notification for denied or reduced Benefits (an "Adverse Determination"), and within two (2) business days for approvals.

Initial Authorization decisions determined by Mass General Brigham Health Plan or Optum as urgent are made within 72 hours/three (3) calendar days of receipt of the request and Providers are informed of the decision within 24 hours. The Provider and the Member are sent written notification of the decision within one (1) business day of the notification for denied or reduced Benefits (an "Adverse Determination"), and within two (2) business days for approvals.

Emergency care through the hospital Emergency department, Emergency admissions and care that must be provided during non-business hours (e.g. home skilled nursing) require notification by the next business day.

Concurrent Authorization decisions categorized by Mass General Brigham Health Plan or Optum as urgent are made within 24 hours. Concurrent Authorization decisions categorized by Mass General Brigham Health or Optum as non-urgent are made within one (1) business day of obtaining all necessary information and no longer than 14 calendar days. Providers are verbally informed of an urgent decision within twenty-four (24) hours and one (1) business day for non-urgent requests. Written or electronic confirmation of approval is sent to the Provider and Member within one (1) business day thereafter. Written or electronic notification includes the number of extended days, visits or service approved in a service date range. In the case of an Adverse Determination, written notification is sent to the Provider and Member within one (1) business day thereafter.

Once Mass General Brigham Health Plan or Optum reviews the request for service(s), we will inform your Provider of our decision. If we authorize the service(s), we will send you and your Provider an Authorization letter. When you get the letter, you can call your Provider to make an appointment. The Authorization letter will state the service(s) the plan has approved for coverage. Make sure you have this Authorization letter before any service(s) requiring Authorization are provided to you. If your Provider feels that you need a service(s) beyond those authorized, he or she will ask for Authorization directly from Mass General Brigham Health Plan or Optum.

If we approve the request for more service(s), we will send both you and your Provider an additional Authorization letter.

If we do not authorize any of the services requested, authorize only some of the services requested, or do not authorize the full amount, duration or scope of services requested, Mass General Brigham Health Plan or Optum will send you and your Provider a denial letter. Mass General Brigham Health Plan or Optum will not pay for any services that were not authorized. Mass General Brigham Health Plan or Optum will also send you and your Provider a notice if we decide to reduce, suspend, or end previously authorized service(s). If you disagree with any of these decisions, you can file a Grievance. For complete details on filing a Grievance, please see "Section 15: Complaint and Grievance Process" or contact Customer Service for more information.

It is your responsibility to make sure that you have written Authorization for coverage prior to receiving services that require Authorization. You may confirm the need for Authorization by contacting Customer Service.

Section 6.

Pharmacy Benefit

Your coverage includes a variety of prescription drug programs that are designed to make paying for your medications and premiums affordable. Your Pharmacy Benefit places all covered drugs into tiers. Depending on your Plan, you may have three, four, or six tiers. Described below is how covered drugs are placed into the appropriate tier structure. Cost-sharing (e.g., Copays, Deductibles and/or Coinsurance) applies to each tier and is listed in your Schedule of Benefits. More information about your financial obligations are included in "Section 13: Financial Obligations."

3 Tier Placement

- Tier 1 includes most generic medications and may also include some brand name medications. Generic medications contain the same active ingredients as their brand name counterparts.
- Tier 2 includes preferred brand name medications and may also include some high-cost generic medications.
- Tier 3 includes non-preferred brand name medications.

4 Tier Placement

- Tier 1 includes lower cost generic medications. Generic drugs contain the same active ingredients as their brand name counterparts.
- Tier 2 includes other generics and may include some brand name medications.
- Tier 3 includes higher costing generics, preferred brand name and specialty medications.
- Tier 4 includes non-preferred brand name and specialty medications.

6 Tier Placement

- Tier 1 includes lower cost generic medications. Generic drugs contain the same active ingredients as their brand name counterparts.
- Tier 2 includes other generics and may include some brand name medications.
- Tier 3 includes high costing generic and preferred brand name medications.
- Tier 4 includes higher cost generics and non-preferred brand name medications.
- Tier 5 includes generic specialty and preferred specialty medications.
- Tier 6 includes non-preferred specialty medications.

Each tier has a level of cost-sharing. Your member cost sharing may include a Copay, Deductible, Coinsurance, or a combination of these. Please refer to your Schedule of Benefits for those amounts. In many cases, your cost-sharing responsibility represents a fraction of the total cost for a prescription.

The Drug List includes a list of medicines covered by your plan. Doctors and pharmacists have reviewed the medications for safety, quality, effectiveness, and cost. You can determine the tier your drug is in by viewing the searchable Drug Lookup Tool at Member.MassGeneralBrighamHealthPlan.org.

Copayments (Copays)
Copayments are fixed dollar amounts you must pay for covered medications. Copayments are paid to the pharmacy at the time of purchase. Your copayment amounts are listed on your Schedule of Benefits.

Coinsurance
Coinsurance refers to a percentage of the cost of the drug that you are required to pay. The coinsurance percentage is listed in your Schedule of Benefits or Pharmacy Benefit Rider.

Per Script Maximum (Max)
The Plan may have a per script max for a specific tier. The per script max is the maximum amount you will have to pay at the pharmacy for each prescription fill. The per script max dollar amount is listed in your Schedule of Benefits or Pharmacy Benefit Rider.

Deductibles
The Plan may have a Deductible. A Deductible is a specific dollar amount that you must pay for certain covered services before any coverage is available for those services. If a Deductible applies to your coverage, you must first pay the deductible amount for the purchase of prescription drugs before any coverage for drugs begins. The deductible may apply to drugs on any tier. Please see your Schedule of Benefits or Pharmacy Benefit Rider for the amount of your Deductible and the tiers to which it applies. Once the Deductible is satisfied, the applicable Copay or Coinsurance amount applies.

Out-of-Pocket Maximum
The Plan includes an out-of-pocket maximum. It may apply to both medical and pharmacy cost sharing. This is the total amount you are required to pay in cost sharing. Please refer to your Schedule of Benefits or Pharmacy Benefit Rider to determine if you have a combined medical and pharmacy out of pocket maximum or a separate pharmacy out-of-pocket maximum.

Filling Prescriptions

To fill a prescription, bring it to one of the pharmacies in the Network. Be sure to show your Member ID Card so the pharmacist will know you are a Member of the Plan. For a listing of pharmacies, refer to Member.MassGeneralBrighamHealthPlan.org. Some prescription drugs need an Authorization. Your Provider can ask for an Authorization so you can have the prescriptions you need.

If you have any questions about which drugs do require Authorization, visit Member.MassGeneralBrighamHealthPlan.org, or call Pharmacy Customer Service at 1-866-567-9175 (TTY 711).

Self-Injectable/Administered Drugs

The plan covers drugs that are used for treating medical conditions are covered as part of your prescription drug benefit. These will be covered under your prescription drug benefit, not your medical benefit, when prescribed by a Network Provider and bought through an in-network or specialty, if required, pharmacy even if you get the drug during your covered visit with a Network provider.

Mail Order Pharmacy

For members who prefer the convenience of receiving prescriptions through the mail, certain maintenance medications (such as drugs used for asthma, blood pressure, high cholesterol, and arthritis) are available through our pharmacy vendor. This service provides members with a 90-day supply of prescription medicines at a reduced cost. To find out your cost sharing for 90-day supplies, please see your Schedule of Benefits or Pharmacy Benefit Rider.

To order your prescriptions through the mail, please visit Member.MassGeneralBrighamHealthPlan.org to download the registration form. Members only need to complete the form once. Refills can be ordered by calling Pharmacy Customer Service at 1-866-567-9175 (TTY 711).

Access90

Access90 provides members with a 90-day supply of certain maintenance medications when purchased through participating pharmacies. For a list of pharmacies, refer to Member.MassGeneralBrighamHealthPlan.org. This service provides members with a 90-day supply of most prescription medicines at a reduced cost.

Over-the-Counter Drug Benefit

Some over-the-counter (OTC) medications (including cough, cold, and allergy) are covered by the pharmacy benefit with a valid prescription from your doctor. Some may be available up to a 90-day supply. Cost sharing may vary depending on drug prescribed.

For a complete listing of the OTC drugs, applicable cost sharing amounts and quantity limitations, please visit: Member.MassGeneralBrighamHealthPlan.org.

Quantity Limit

The Plan may limit the number of units for a specific medication you may receive in a given time period to ensure safe and appropriate use. These limits are based on recommended dosing schedules, and the availability of several strengths of the medication. Quantity limits automatically apply at the time the prescriptions are purchased.

Mandatory Generic Policy

The Plan's mandatory generic policy requires a generic version of a medication be tried before the brand name medication is considered for coverage. A generic drug is the same medication and works in the same way as the brand name medication. Generic medications are approved by the US Food and Drug Administration (FDA) as safe and are the equivalent of the original brand name medication. In addition, there are usually multiple manufacturers of a generic medication that may result with a lower cost compared to the branded alternative. Prior Authorization is required for an exception to our mandatory generic medication pharmacy benefit. If you have already tried a generic equivalent, and wish to appeal the mandatory generic policy, you may call Pharmacy Customer Service. Some exceptions may apply.

Prior Authorization

Prior Authorization is a process in which a clinical review is required before a specific medication may be dispensed to a covered member. The review entails the application of criteria approved by the Plan's Pharmacy and Therapeutics Committee of physicians and pharmacists and is designed to assure the safe, effective, and appropriate use of a medication. These criteria are based on clinical studies and standards of care. The Prior Authorization process may entail a delay in your ability to fill the prescription until the clinical review based on all required information provided by your physician (or his/her designee) has occurred. The clinical review process may take up to 48 hours after complete information has been received.

Exception Request for Non-Formulary Drugs

Members, their authorized representative on file, or Provider may request that we perform a review process (within 72 hours) in order to make a coverage determination for a non-covered/non-formulary drug. The Plan will provide the Member, his/her authorized representative, and Provider notification of the coverage determination for the non-covered/non-formulary drug within 72 hours. If an expedited review process is requested due to an exigent (emergent) circumstance, we will provide the coverage determination for the non-covered/non-formulary drug within 24 hours.

To initiate the review process, a Member, his/her authorized representative, or Provider must call Pharmacy Customer Service at 1-866-567-9175 (TTY 711) and provide the following information:

- Member Name
- Member Contact Information
- Diagnosis
- Provider Name
- Provider Contact Information
- Medication Requested

We have a number of online tools to help you understand your prescription drug benefits. Please visit Member.MassGeneralBrighamHealthPlan.org for detailed information about your pharmacy coverage and information on each medication, including a list of covered drugs, and whether any tier, restrictions, or limitations that applies.

Grievance Review for Coverage of Non-Formulary Drugs

If your initial request for coverage of a non-covered/non-formulary drug is denied, you have the right to submit a Grievance to us. You may request in your Grievance that a coverage determination be performed by Mass General Brigham Health Plan or an Independent Review Organization (IRO). To submit a Grievance, you or your authorized representative on file or your Provider must contact us and state if you wish to have Mass General Brigham Health Plan or an IRO render a decision on your Grievance.

The Plan will provide notification of the coverage determination for the non-covered/non-formulary drug within 72 hours of your request. If an expedited review process is requested due to an exigent (emergent) circumstance, we will provide notification of the coverage determination for the non-covered/non-formulary drug within 24 hours of your request.

If you choose to have your Grievance performed by us, and we deny coverage, you have the right to request a second review by an IRO.

Step Therapy

The Plan automates the Prior Authorization criteria for certain drugs. Members who qualify for this program get immediate coverage without the need for a clinical review based on the drugs already filled through the Plan.

If your prescription records do not indicate the use of a first-step medication, or if you are a newly enrolled member with no prescription history, your doctor may contact us to request an exception to our step therapy program.

For more information, call Pharmacy Customer Service.

Specialty Pharmacy Program

Our Specialty Pharmacy Program offers a less costly method to buy expensive drugs used to treat complex medical conditions. We will cover certain drugs when you get them from our preferred list of Specialty Pharmacies. Specialty drugs are limited to a 30-day supply, unless noted otherwise.

A list of drugs included in the Specialty Pharmacy program is in the searchable Drug Lookup Tool on our Member Portal.

Your Network Provider can help you with buying the covered specialty drugs. Our Specialty Pharmacies have expertise in the delivery of the drugs and offer special services not available at a traditional retail pharmacy This includes:

- All necessary drugs and supplies needed for administration (at no extra charge).
- Convenient delivery options to your home or office with overnight or same day delivery available when Medically Necessary.
- Access to nurses, pharmacists and care coordinators specializing in the treatment of your condition, who are available 24 hours a day, seven (7) days a week, to give support and educational information about your medications.
- Compliance monitoring, adherence counseling and clinical follow-up.
- Educational resources about drug use, side effects, and injection administration.

If you need help or have questions about our Specialty Pharmacy Program, please call Pharmacy Customer Service.

Limitations

There are a number of prescription drugs that are either not covered or for which coverage is limited. The Plan only covers drugs that are Medically Necessary for Preventive Care or for treating illness, injury, or pregnancy.

Exclusions

The prescription drug benefit features a Preferred Drug List, in which the following drugs or services are excluded:

- Dietary supplements*
- Therapeutic devices or appliances (except where noted)*
- Biologicals, immunization agents or vaccines that are obtained through the medical benefit
- Blood or blood plasma**
- Medications which are to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed Hospital, nursing home, or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals**
- Charges for the administration or injection of any drug**
- If an FDA approved generic drug is available, the brand name equivalent is not covered, unless medically necessary***
- Drugs that are not FDA approved
- Progesterone supplements
- Fluoride supplements/vitamins for members over age 13 except for prenatal vitamins
- Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only
- Drugs labeled “Caution-limited by federal law to investigational use,” or experimental drugs, even though a charge is made to the individual
- Medications for which the cost is recoverable under Worker’s Compensation or Occupational Disease Law or any state or Governmental Agency, or medication furnished by any other Drug or Medical service for which no charge is made to the Member
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician’s original order
- Schedule 1 controlled substances (e.g. marijuana)
- Products and/or kits co-packaged with OTC products

For more information about our Preferred Drug List, call Pharmacy Customer Service or visit Member.MassGeneralBrighamHealthPlan.org. Please refer to your Schedule of Benefits as there may be additional exclusions applicable to your specific Plan design.

*Covered in certain circumstances under the Durable Medical Equipment (DME) benefit.
**Covered in certain circumstances under medical benefit.
***Some exceptions may apply.

Section 7.

Your Covered Health Care Services

To be covered, all Health Care Services and supplies must be:

- Provided by or arranged by the Member's PCP or an In-Network Specialist, unless noted otherwise in this Handbook
- Medically Necessary, as defined in this Handbook
- Listed as a Covered Health Care Service in this Handbook
- Provided by a Network Provider, unless prior Authorization has been obtained from the Plan to see an Out-of-Network Provider
- Provided to an eligible Member enrolled in the Plan. The Plan is not responsible for payment of any services provided prior to a Member's Eligibility date or after your disenrollment date
- Authorized by the Plan when Authorization is required. For more information on Authorization requirements, see Section 5, check with your PCP, your Treating Provider, or call Customer Service.

If you have questions about your, please call Customer Service.

Abortion and Abortion Related Care

The Plan covers abortion and abortion related care obtained from a Network Provider. You do not need a Referral from your PCP for abortion services. Abortion-related care is defined as services that are provided in conjunction with an abortion-related procedure, such as pre-operative evaluations and examinations, pre-operative counseling, laboratory services, Rh (D) immune globulin medication, anesthesia (general or local), post-operative care, follow-up, and advice on contraception or referral to family planning services. Services are provided at no member cost sharing except if the member is enrolled in an HSA qualified health plan as defined in 'Section 1. Your Plan Document – Health Savings Accounts'.

Acupuncture

Acupuncture may be covered depending upon your specific plan. See your Schedule of Benefits or call Customer Service.

Acute Hospital Care

The Plan covers acute care Hospital services when Medically Necessary. Your PCP must arrange for acute care Hospital services.

Ambulance Transportation

Emergency ambulance transportation, including air ambulance, is covered. The Plan covers such ambulance transport to the nearest Hospital that can provide the care you need. Ambulance calls for transportation that is refused is not covered. Except in an Emergency, ambulance transportation is covered only when arranged by a Network Provider. Medically Necessary transfer from one health care facility to another is also covered.

Ambulatory/Day Surgery

The Plan covers Medically Necessary Outpatient surgical and related diagnostic and medical services. Your PCP must arrange Ambulatory/ Day Surgery services.

Assisted Reproductive Services, Infertility, and Treatment for Infertility

The Plan provides coverage for medically necessary Assisted Reproductive Services, Infertility, and Treatment for Infertility. Infertility is defined as the condition of an individual who is unable to conceive or produce conception during a period of one year if the female is age 35 or younger or during a period of six months if the female is over the age of 35.

For purposes of meeting the criteria for Infertility, if a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the one-year or six-month period, as applicable.

The Plan will cover Medically Necessary expenses for Assisted Reproductive Services including the diagnosis and non-experimental treatment of Infertility to the same extent that Benefits are provided for other Medically Necessary services and prescription medications.

The following procedures are covered, but are not limited to:

- Artificial Insemination (AI) and Intrauterine Insemination (IUI)
- In Vitro Fertilization and Embryo Transfer (IVF-ET)
- Gamete Intrafallopian Transfer (GIFT)
- Zygote Intra-fallopian Transfer (ZIFT)
- Intracytoplasmic Sperm Injection (ICSI) for the treatment of male factor infertility
- Sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any (insurers may not limit Coverage to sperm provided by the spouse)
- Assisted Hatching
- Cryopreservation of embryos, eggs, and sperm when the Member is undergoing authorized infertility services.
- Cryopreservation of eggs and sperm is covered when authorized for a Member undergoing a medical treatment that may result in infertility.

The Plan does not provide coverage for:

- Any experimental infertility procedure
- Surrogacy/gestational carrier
- Reversal of voluntary sterilization
- Fees associated with obtaining egg donors such as screenings, agency fees, and donor compensation

Autism

The Plan covers the Diagnosis and Treatment of Autism Spectrum Disorders (ASD) when Medically Necessary. Diagnosis includes Medically Necessary assessments, evaluations including neuropsychological evaluations, genetic testing, or other tests to diagnose whether an individual has ASD. Autism Spectrum Disorders are defined as any of the pervasive developmental disorders as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, including autistic disorder, Asperger's Disorder, and pervasive developmental disorders not otherwise specified.

Treatment for autism includes habilitative or rehabilitative care, pharmacy care, psychiatric care, psychological care, and therapeutic care. Services for autism are provided by Autism Service Providers available in the Network.

Habilitative or rehabilitative care includes professional, counseling, and guidance services and treatment programs, including, but not limited to, Applied Behavior Analysis supervised by a Board-Certified Behavior Analyst, that are necessary to develop, maintain, and restore, to the maximum extent practicable, the functioning of an individual.

Applied Behavior Analysis includes the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences to produce socially significant improvement in human behavior including in the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. Pharmacy care is defined as medications prescribed by a licensed physician and health-related services deemed Medically Necessary to determine the need or effectiveness of the medications, to the same extent that pharmacy care is provided by the policy for other medical conditions.

Therapeutic care is defined as services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or social workers. The Plan's coverage for the treatment of Autism Spectrum Disorder does not affect an obligation to provide services to an individual under an individualized family service plan, an individualized education program, or an individualized service plan. The Plan's coverage excludes services provided by school personnel under an individualized education program.

Behavioral Health Services

Please see "Section 8: Behavioral Health Services."

Blood and Blood Products

The Plan covers administrative fees, supplies for administration, and self-donations for whole blood and its derivatives, including Factor 8, Factor 9, and immunoglobulin.

Cardiac Rehabilitation Coverage

The Plan covers outpatient cardiac rehabilitation when Medically Necessary. Cardiac rehabilitation is defined as multidisciplinary, Medically Necessary treatment of persons with documented cardiovascular disease, which is provided in either a Hospital or other setting which meets the standards set by the Commissioner of the Department of Public Health. Your PCP and/or Treating Provider must arrange for cardiac rehabilitation.

Chiropractic Care

Chiropractic care may be covered depending upon your specific plan. See your Schedule of Benefits or contact Customer Service.

Cleft Lip and Cleft Palate Treatment for Children

The Plan provides coverage of cleft lip and cleft palate treatment for children under the age of 18, including oral and maxillofacial surgery, plastic surgery, speech therapy, audiology, and nutrition services as Medically Necessary. We also cover preventive and restorative dentistry and orthodontic treatment related to the treatment of cleft lip or palate. When dental and orthodontic services are covered by both Mass General Brigham Health Plan and a Member's dental plan, Mass General Brigham Health Plan and the dental plan may elect to coordinate benefits. (See "Section 10: When You Have Other Coverage" for more information on coordination of benefits.)

Clinical Trials

If you participate in an approved clinical trial while you are a Member, we will cover the medically necessary Covered Health Services listed in this Section during the period of the clinical trial that you are a Member of the Plan as long as you meet certain requirements.

Members must qualify to participate in an approved clinical trial for the treatment of cancer or other life-threatening medical condition and have been referred to the clinical trial by a Network Provider or have provided medical and scientific information to us proving they meet the conditions for participation in the clinical trial.

An approved clinical trial is defined as (a) having been funded or approved by at least one of the following entities: National Institutes of Health (NIH); Center for Disease Control and Prevention; Agency for Health Care Research and Quality; Centers for Medicare & Medicaid Services; a cooperative group or center of any of the above or the Department of Defense, Veterans Affairs or the Department of Energy; or a qualified non-governmental research entity identified in NIH guidelines for grants; or (b) a study or trial under a Food and Drug Administration approved

investigational new drug application; or (c) a drug trial that is exempt from investigational new drug application requirements.

The Plan's coverage during approved clinical trials excludes the investigational item, device, or service; items and services solely for data collection and analysis; and services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis. Coverage is provided when services are rendered by Network Providers; prior authorization must be obtained in order to receive coverage of services rendered by Out-of-Network Providers.

Cytological Screening (Pap Smears)

The Plan covers cytological screening for women as recommended by your provider.

Dental Services (Emergency)

An emergency dental service is covered only when there is a traumatic injury to sound/natural and permanent teeth caused by a source external to the mouth and the emergency dental services are provided by a physician in a hospital emergency room or operating room within 72 hours following the injury.

In these cases, go to the nearest Emergency facility or call 911 or the Emergency phone number in your area.

Dental Services (Other)

The extraction of impacted wisdom teeth is only covered when the plan determines that the Member has a serious medical condition that makes it essential for the Member to be admitted to an acute care hospital or to a surgical day care setting in order for wisdom teeth to be extracted safely. Prior Authorization is required.

Diabetic Services and Supplies

The Plan provides coverage for Medically Necessary services and supplies used in the treatment of insulin-dependent, insulin-using, gestational and non-insulin dependent diabetes. Services and supplies must be prescribed by an authorized health care professional. The following services and supplies are covered within the following categories of Benefits:

- Outpatient services: outpatient diabetes self-management training and education
- Laboratory/radiological services: all laboratory tests and urinary profiles
- Durable medical equipment: blood glucose monitors, voice-synthesizers, visual magnifying aids, and continuous glucose monitors
- Prosthetics: therapeutic/molded shoes and shoe inserts
- Pharmacy: blood glucose monitoring strips, urine glucose strips, ketone strips, lancets, insulin syringes, insulin pumps and insulin pump supplies, insulin pens, insulin and oral medications, and continuous glucose monitors and supplies.

Refer to your Schedule of Benefits for applicable member cost-sharing and limitations based on services provided. Durable Medical Equipment noted above will take Diabetic Supplies cost-sharing, except Prosthetics which will take Durable Medical Equipment member cost-sharing. When diabetic medications, continuous glucose monitors/supplies, and insulin pumps/supplies are obtained through the prescription drug benefit, applicable cost sharing and/or restrictions may apply.

Dialysis

The Plan covers kidney dialysis on an Inpatient or Outpatient basis, or at home. You must apply for Medicare when federal law permits Medicare to be the primary payor for dialysis. You must also pay any Medicare premium. When Medicare is primary (or would be primary if the Member were timely enrolled) the Plan will pay for services only to the extent payments would exceed what would be payable by Medicare.

Your PCP must arrange dialysis services. If you are temporarily outside the Service Area, the Plan covers limited dialysis services. You must make prior arrangements with your PCP, who must obtain approval from us for this coverage except in an Emergency.

Disposable Medical Supplies

The Plan covers disposable medical supplies that are necessary to meet a medical or surgical purpose and are non-reusable and disposable. This includes hypodermic syringes or needles. Your PCP must order disposable medical supplies.

Durable Medical Equipment (DME)

The Plan covers Durable Medical Equipment that is: used to fulfill a medical purpose; generally not useful in the absence of illness or injury; can withstand repeated use over an extended period of time; and is appropriate for home use.

Coverage includes but is not limited to the purchase of medical equipment, replacement parts, and repairs. Your treating provider must order Durable Medical Equipment. Examples of equipment not covered includes but is not limited to: assisted listening devises, power wheelchair and/or accessories and components when used for community mobility only, exercise equipment that is appropriate for a professional setting, but is not medically necessary for home use and includes Functional Electrical Stimulation, physiotherapy equipment and foot orthotics except for children 15 and under with symptomatic flat feet and pronation.

Early Intervention Services

The Plan covers Early Intervention services for Members under the age of three (3) when the Member meets established criteria. Such Medically Necessary Services may be provided by early intervention Specialists who are working in early intervention programs approved by the Massachusetts Department of Public Health. You do not need a Referral from your PCP for Early Intervention services. You may go to any Early Intervention Provider in the Network for these services.

The Plan reimburses for Medically Necessary Applied Behavioral Analysis provided as part of an Early Intervention plan—Applied Behavior Analysis (EI-ABA) for children, up to age three years, who have a clinically determined diagnosis within the Autism Spectrum Disorders and are currently receiving services through an Early Intervention provider. EI-ABA services must be rendered by a qualified Massachusetts Department of Public Health (MDPH) Specialty Services Program (SSP). ABA services beyond age three may be covered through Optum (the organization that manages the Plan's Behavioral Health program) and may require Prior Authorization.

Emergency Services

The Plan covers Emergency services including ambulance services needed for transportation to the nearest hospital that can provide the care you need. If you need Emergency care, the Plan will cover those services even when they are furnished by a Provider who is not an In-Network provider. You also do not need a Referral from your PCP for Emergency Services. Simply go to the nearest Emergency facility or call 911 or the emergency phone number in your area.

An Emergency is defined as a medical condition, whether physical, behavioral, related to substance use disorder, or a mental disorder, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B). You do not need a Referral from your Primary Care Provider for Emergency Services. Go to the nearest Emergency facility or call 911 or the emergency phone number in your area.

Eye Care/Examinations (Vision Care)

The Plan covers routine eye exams for Members; please see your Schedule of Benefits for benefit limits. You may use any Network ophthalmologist or optometrist for routine eye exams, and you do not need a Referral from your PCP. For all other non-routine eye care services (difficult vision, blurry vision, loss of vision), you must see your PCP who will arrange a Referral to an ophthalmologist (eye care specialist). There is no coverage for eyeglasses or contact lenses (except when Medically Necessary for certain eye conditions such as treatment of keratoconus and following cataract surgery), low vision aids (except for visual magnifying aids used by legally blind members with diabetes) or ocular prostheses.

Family Planning Services

The Plan covers consultations, examinations, procedures, and other medical services provided on an outpatient basis and related to the use of all FDA approved contraceptive methods including but not limited to lab tests, birth control counseling, pregnancy testing, voluntary sterilization, IUDs, diaphragms, and Norplant. You can obtain services from your PCP, OB/GYN, Planned Parenthood, or any other Network Provider who offers these services. All FDA-approved prescription contraceptive methods are covered.

Fitness Programs

Fitness programs may be covered depending upon your specific plan. See your Schedule of Benefits or call Customer Service.

Gender Affirming

The Plan covers gender affirming procedures for individuals when it is recommended by the member's providers and when medically necessary. Covered services include, but are not limited to, Facial Feminization/Masculinization, breast reconstruction surgery/mastectomy, and cryopreservation of eggs/embryos, and sperm. For a more complete list of Covered services, please refer to the Gender Affirming medical policy at Member.MassGeneralBrighamHealthPlan.org.

Gynecologic/Obstetric Care

The Plan covers Medically Necessary Gynecological and Obstetrical services. You are not required to obtain a Referral or Prior Authorization for Gynecological or Obstetric care provided by an obstetrician, gynecologist, certified nurse midwife or family practitioner participating in the Network. However, the health care professional may be required to obtain Prior Authorization for certain services and to follow procedures for making Referrals. The Plan does not require higher Copays, Coinsurance, Deductibles, or other cost-sharing arrangements for these services.

Habilitation Services

The Plan covers Medically Necessary habilitation services for qualified members with certain conditions. See your Schedule of Benefits for benefit limits.

Hearing Aids for Children

The Plan provides coverage of hearing aids for children 21 years old or younger, including the initial hearing aid evaluation, fitting and adjustments, and supplies, including ear molds, when prescribed by a Network Provider. Please see your Schedule of Benefits for limitations. If you choose a higher-priced hearing aid, you must pay the difference between the cost and the Plan's coverage limit. Batteries and assistive listening devices are not covered.

Hearing Examinations

The Plan covers comprehensive exams and evaluations performed by a hearing Specialist. You may use any Network Provider for these services. The Plan also provides coverage for the cost of a newborn hearing-screening test performed before the infant is discharged from the hospital or birthing center.

HIV-Associated Lipodystrophy Treatment

The Plan covers medically necessary medical or drug treatments to correct or repair disturbances of body composition related to HIV-associated lipodystrophy syndrome when prior authorized. Coverage includes, but not limited to, reconstructive surgery, such as suction assisted lipectomy, approved medically necessary restorative procedures and dermal injections or fillers for reversal of facial lipoatrophy syndrome. Your Treating Provider must arrange for these services.

Home Health Care

The Plan covers home health care according to a physician-approved home health care plan when such care is an essential part of medical treatment and there is a defined goal. Home health care services are provided in a patient's residence by a public or private home health agency.

Services include, but are not limited to, nursing and Physical, Occupational, Speech Therapy, medical social work, and nutritional consultation, the services of a home health aide and the use of Durable Medical Equipment (DME) and supplies if medically necessary.

No limits other than medical necessity and being part of a physician approved home health services plan are placed on home care services (e.g., a policy may have an annual or lifetime cap on Durable Medical Equipment (DME); however, if the equipment is prescribed as part of a physician-approved home health services plan, its use is not subject to limit). Your PCP or Treating Provider must arrange services.

Home Infusion

The Plan covers home infusion services. Your PCP or Treating Provider must arrange home infusion services.

Hormone Replacement Therapy

The Plan provides coverage for hormone replacement therapy services including outpatient prescription drugs for pre- and post-menopausal women under the same terms and conditions as for other outpatient services and prescription drugs. (See "Section 6: Pharmacy Benefit" for more information.)

Hospice

The Plan covers hospice care for terminally ill Members with a life expectancy of six months or less, provided such services are determined to be appropriate and authorized by the Member's PCP and are equivalent to those services provided by a licensed hospice program regulated by the Department of Public Health.

House Calls

The Plan covers house calls within the Service Area when Medically Necessary. Providers include Physicians, Nurse Practitioners and Physician Assistants. Your PCP must arrange for house calls.

Immunizations and Vaccinations

The Plan covers immunizations and vaccinations, including travel vaccines. When rendered by Network Providers, these services are covered with no Copayments, Coinsurance, Deductibles, or dollar limits.

Laboratory Services

The Plan covers services that are Medically Necessary for the diagnosis, treatment, and prevention of disease and for the maintenance of the health of the Member, when ordered by a provider from an In-Network laboratory.

Long-Term Antibiotic Therapy for the Treatment of Lyme Disease

The Plan provides coverage for long-term antibiotic therapy for a member with Lyme disease. Your Treating Provider must arrange for this coverage.

Mammographic Examination (Mammogram)

The Plan covers Preventive breast cancer screening by mammogram is covered, including 3D mammograms. Women must be age 40 or older. Follow-up breast ultrasounds are also covered as preventive breast cancer screenings (instead of or in addition to a screening mammogram). Breast MRIs are covered as preventive breast cancer screenings when criteria are met.

Maternity Services (General Coverage)

The Plan provides inpatient and outpatient maternity benefits for prenatal care, childbirth, and post-partum care to the same extent as is provided for medical conditions not related to pregnancy. The Plan provides coverage for services rendered by an obstetrician, pediatrician, or certified nurse midwife attending the mother and child.

Maternity Services (Inpatient)

The Plan covers inpatient maternity care provided by an attending obstetrician, pediatrician, or certified nurse midwife for a mother and newborn child for at least 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If the mother and physician agree to an early discharge, Covered Health Care Services include one home visit by a registered nurse, physician, or certified midwife, and additional home visits when Medically Necessary and provided by a Network Provider. There is no coverage for delivery outside the Service Area within 30 days of the expected delivery date, or after the Member has been told that she is at risk for early delivery. Your PCP, obstetrician, or certified nurse midwife must arrange for services.

Maternity Services (Outpatient)

The Plan covers prenatal and postpartum care for Members when care is received from a Network Provider. Services include: prenatal exams; diagnostic tests; prenatal nutrition; health care counseling; risk assessment; and postpartum exams. Routine prenatal care includes your visits to the provider managing your pregnancy and a postpartum visit. These routine prenatal care services have cost sharing as outlined on your Schedule of Benefits. All other services provided may be subject to cost sharing including labs, obstetrical ultrasounds, and other diagnostic tests.

There is no coverage for obstetrical care outside the Service Area within thirty (30) days of expected delivery date. Your PCP, obstetrician, or certified nurse midwife will order medically necessary tests and must arrange for outpatient maternity services.

Mental Health Wellness Exam

The Plan provides coverage of an annual screening or assessment that seeks to identify any behavioral or mental health needs and appropriate resources for treatment. The examination may include: (i) observation, a behavioral health screening, education and consultation on health lifestyle changes, referrals to ongoing treatment, mental health services and other necessary supports, and discussion of potential options for medication; and (ii) age-appropriate screenings or observations to understand a covered person's mental health history, personal history and mental or cognitive state and, when appropriate, relevant adult input through screenings, interviews and questions. Services are provided at no member cost sharing except if the member is enrolled in an HSA qualified health plan as defined in 'Section 1. Your Plan Document – Health Savings Accounts'.

Newborn Care

The Plan covers all Medically Necessary newborn care. Your PCP must arrange newborn care.

Non-Durable Medical Equipment and Supplies

Non-Durable Medical Equipment and supplies are covered only when used in the course of diagnosis or treatment in a medical facility or in the course of authorized home care.

Nutritional Formulas

The Plan provides coverage for nutritional formula in the following situations:

- Formulas, approved by the Commissioner of the Department of Public Health, for the treatment of infants and children with specific inborn errors of metabolism of amino acids and organic acids such as phenylketonuria (PKU), tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia and methylmalonic acidemia
- Formulas, approved by the Commissioner of the Department of Public Health as Medically Necessary to protect the unborn fetuses of pregnant women with phenylketonuria
- Formulas for the treatment of malabsorption caused by disorders affecting the absorptive surface, functional length, gastrointestinal tract motility, such as Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility and chronic intestinal false obstruction
- Formulas for the treatment of members with an anatomic or structural problem that prevents food from reaching the stomach (e.g. esophageal cancer), or a neuromuscular problem that results in swallowing or chewing problems (e.g. muscular dystrophy)
- Formulas for the treatment of members with a serious medical condition that either directly or indirectly impacts their ability to normally ingest regular foods and places them at substantial risk of malnutrition (e.g. cancer, AIDS, organ failure, etc.)
- Formulas for the treatment of pediatric members diagnosed with failure to thrive
- Coverage for inherited diseases of amino acids and organic acids includes food products modified to be low protein

Obstetrical Services

See "Gynecologic/Obstetric Care," above.

Off-label Use of Drugs for the Treatment of Cancer

The Plan provides coverage for use of off-label drugs in the treatment of cancer as it would for any covered prescription drug. The drug must be recognized for treatment of cancer in one of the standard reference compendia, or in the medical literature, or by the Commissioner of Insurance. In addition, the Plan will provide coverage for a drug indicated for the treatment of cancer within the Association of Community Cancer Centers Compendia-Based Drug Bulletin. Your PCP or Specialist must arrange for this service. The Plan provides coverage for prescribed, orally administered anticancer medication used to eliminate or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected cancer medications that are covered as medical benefits.

Off-Label Use of Drugs for the Treatment of HIV/AIDS

The Plan provides coverage for use of off-label drugs in the treatment of HIV/AIDS as it would for any covered prescription drug. The drug must be recognized for treatment of HIV/AIDS in one of the standard reference compendia, or in the medical literature, or by the Commissioner of Insurance. Your PCP or Specialist must arrange for this service.

Off-label use of Drugs for the Treatment of Lyme Disease

The Plan provides coverage for off-label use of drugs in the treatment of Lyme disease if the drug has been approved by the FDA. Your Treating Provider must arrange for this coverage.

Optometric/Ophthalmologic Care

See "Eye Care/Examinations (Vision Care)" above.

Oral Cancer Therapy

The Plan provides coverage for prescribed, orally administered anticancer medication used to eliminate or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected cancer medications that are covered as medical Benefits.

Orthotics

The Plan covers non-dental braces and other mechanical or molded devices when Medically Necessary to support or correct any defects of form or function of the human body due to surgery, disease, or injury. Your PCP must arrange these services. Orthotics/ Support Devices for Feet: Support devices for the feet and corrective shoes are only covered for children fifteen (15) and under with certain medical conditions such as pronation or when prescribed by the Member's PCP and authorized by the Plan.

Outpatient Surgery

The Plan covers Medically Necessary surgical procedures in an outpatient surgical setting. These services are subject to outpatient surgery cost sharing. The Plan also covers Medically Necessary outpatient surgery that occurs in an office setting; these services would be subject to cost sharing associated with the office in which it was performed (PCP or Specialty).

Oxygen Supplies and Therapy

The Plan covers oxygen therapy for Members when Medically Necessary. Coverage includes oxygen and equipment rental and supplies required to deliver the oxygen. Your Treating Provider must arrange oxygen therapy services.

PANDAS (Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections) and PANS (Pediatric Acute-Onset Neuropsychiatric Syndrome)

The Plan covers the treatment of PANDAS and PANS including but not limited to the use of intravenous immunoglobulin therapy.

Pediatric Specialty Care

The Plan provides Coverage of pediatric specialty care, including mental health care, by persons with recognized expertise in providing specialty pediatric care. Your PCP must arrange for specialty care.

Pharmacy

See "Section 6: Pharmacy Benefit."

Physician Services

The Plan covers diagnosis, treatment, consultation, nutrition counseling, health education, and minor surgery when provided by the Member's PCP or In-Network Specialist.

Podiatry Services

The Plan covers Medically Necessary podiatry services performed by a physician or duly licensed podiatrist.

Preventive Care Services and Tests

The Plan covers select preventive care services and tests for adults, women (including pregnant women) and children, including coverage for annual physical exams as appropriate for the Member's age and gender, immunization visits, well child visits and annual gynecological exams. Routine cytological screening (Pap smears) and mammographic examinations are covered as Preventive Care. You may use any Network Provider for these services. Preventive care required by the Affordable Care Act (ACA) is covered to the extent required by the ACA.

For a complete list of eligible Preventive Care services, please visit Member.MassGeneralBrighamHealthPlan.org or contact Customer Service.

Covered preventive services reflect the United States Preventive Services Task Force (USPSTF) grade "A" and "B" recommendations, the Advisory Committee on Immunization Practices (ACIP) recommendations, the Women's Preventive Task Force, and the Health Resources and Services Administration for Infants, Children and Adolescents. Preventive service descriptions have been adopted from content on the healthcare.gov website.

The Plan will cover the following services for a Dependent from their date of birth through age six (6): physical examinations; history, measurement, sensory screening, neuropsychiatric evaluations and development screening, and assessment at the following intervals: six times during the child's first year after birth, three (3) times during the next year, and annually until age six (6). Covered services include: hereditary and metabolic screening at birth; appropriate immunizations; tuberculin test, hematocrit, hemoglobin, or other appropriate blood tests and urinalysis, as recommended by the physician; and lead screening.

Prosthetic Devices

The Plan covers prosthetic devices, including evaluation, fabrication, and fitting: some prosthetics may require a prior authorization. Coverage includes prosthetic devices which replace in whole or in part, an arm or leg, and includes repairs. Your PCP must arrange prosthetic device services.

Psychiatric Collaborative Care

The Plan provides coverage for an evidence-based, integrated behavioral health service delivery method in which a primary care team consisting of a primary care provider and a care manager provides structured care management to a patient, and that works in collaboration with a psychiatric consultant that provides regular consultations to the primary care team to review the clinical status and care of patients and to make recommendations.

Radiation and Chemotherapy

The Plan covers radiation and chemotherapy. The Plan also provides coverage for prescribed, orally administered anticancer medication used to eliminate or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected cancer medications that are covered as medical benefits.

Radiology

The Plan covers all Medically Necessary radiological services including x-rays, MRIs and CAT scans. Your PCP must arrange radiology services.

Reconstructive/Restorative Surgery

Reconstructive surgery is any procedure to repair, improve, restore or correct bodily function caused by an accidental injury, congenital anomaly or a previous surgical procedure or disease. The Plan covers surgery for post-mastectomy coverage including:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce symmetrical appearance
- Prostheses and physical complications for all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient

Your PCP must arrange reconstructive/restorative surgery services.

Registered Nurse or Nurse Practitioner

The Plan covers services rendered by a registered nurse, nurse practitioner, nurse midwife, or nurse anesthetist if such services are within the nurse's scope of practice. Your PCP must arrange these services.

Rehabilitation Hospital Care (Including Physical, Occupational, and Speech Therapy)

The Plan covers rehabilitative care on an Inpatient basis. Coverage is provided only when you need rehabilitative care that must be provided in an Inpatient setting. Rehabilitative care includes physical, speech, and occupational therapies. Services must be arranged through your Treating Provider. See your Schedule of Benefits for limitations on Inpatient rehabilitation hospital care.

Rehabilitation Therapy—Outpatient (Including Physical, Occupational, and Speech Therapy)

The Plan covers evaluation and restorative, short term treatment when needed to improve the ability to perform activities of daily living and when there is likely to be significant improvement in the Member's level of function after illness or injury. See your Schedule of Benefits for limitations on physical or occupational therapy Benefits.

Second Opinions

The Plan covers second opinions when provided by another Network Provider. A Referral from your PCP is needed when seeking a Second Opinion from another Network Provider. Second opinions from Out-of-Network Providers are covered only when the specific expertise requested is not available within the Network. Prior Authorization from the Plan is required. If you have selected a PCP that is affiliated with Harvard Vanguard Medical Associates (HVMA), you are required to obtain a Referral if you choose to receive a second opinion from a Network Specialist who is not affiliated with HVMA.

Skilled Nursing Facility Care

The Plan covers admissions to a skilled nursing facility. Coverage is provided only when you need daily skilled nursing care or rehabilitative services that must be provided in an inpatient setting. Services must be arranged through your PCP. Please see your Schedule of Benefits for limitations on Skilled Nursing Facility Care.

Specialty Care

The Plan covers Specialty Care when arranged by a Member's PCP. A Referral is required for Specialty Care; without a Referral, the Plan will not reimburse for the Specialist visit and you could be liable for the cost. You are not required to obtain a Referral or Prior Authorization for the following care provided by an obstetrician, gynecologist, certified nurse midwife, or family practitioner participating in the Network:

- Annual Preventive gynecologic health examinations
- Medically Necessary follow-up
- Maternity care
- Acute or Emergency gynecologic examinations
- Routine eye exams
- Physical therapy
- Speech therapy
- Occupational therapy

Speech, Hearing and Language Disorders

The Plan provides coverage for the diagnosis and treatment of speech, hearing, and language disorders by individuals licensed as speech-language pathologists or audiologists. Coverage is provided if services are rendered within the lawful scope of practice for such speech-language pathologists or audiologists, regardless of whether the services are provided in a hospital, clinic, or a private office. Coverage does not extend to the diagnosis or treatment of speech, hearing, and language disorders in a school-based setting. Benefits provided are subject to the same terms and conditions established for any other Health Care Service covered by the plan. You may use any Network Provider for these services.

Surgery

The Plan provides coverage for Medically Necessary surgery including related anesthesia. Surgery, including oral maxillofacial and reconstructive may require prior Authorization.

Telemedicine

This Plan may include audiovisual visits through a national network of U.S. board-certified doctors 24/7 to discuss non-emergency physical or mental health conditions accessed by smartphone, mobile device, or online via computer. Refer to your Schedule of Benefits to determine if On Demand is included in your plan.

Network Providers may also offer this type of service. Doctors can diagnose and treat many common illnesses. Member cost will depend on the types of services provided as noted in your Schedule of Benefits. Telephone (voice only), facsimile or email communications with your provider are not considered telemedicine. To find a Telemedicine provider visit Member.MassGeneralBrighamHealthPlan.org or talk with your Provider directly.

Temporomandibular Joint Syndrome (TMJ) Dysfunction Services

The Plan covers Medically Necessary services to diagnose and treat TMJ that is caused by a specific medical condition. Coverage is limited to medical services only and includes:

- Medical and Surgical consultation and treatment;
- Surgery;
- Diagnostic imaging;
- Physical therapy, subject to the visit limit for outpatient physical therapy provided by a licensed physical therapist; and
- Splint therapy

The Plan does not cover: services of a dentist, services associated with orthodontic care, oral appliances, or Arthroscopy for diagnostic purposes only.

Transplants

The Plan covers transplants as follows:

- Bone marrow transplants are covered when provided within the Network and approved by the Plan. Coverage includes but is not limited to Members with breast cancer that has progressed to metastatic disease, provided that the Member meets criteria established by the Department of Public Health.
- Human organ transplants are covered. Transplants must be non-experimental surgical procedures provided by a Network Provider. Coverage includes donor's costs for both living and nonliving transplant donors to the extent that another insurer does not cover the charges. Your provider will contact Mass General Brigham Health Plan.
- Coverage for human leukocyte antigen testing for certain individuals and patients. The Plan will provide for coverage of the cost of human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to establish such Member's bone marrow transplant donor suitability. The coverage includes the cost of testing for A, B, or DR antigens, or any combination thereof, consistent with rules, regulations and criteria established by the Department of Public Health. Your PCP must arrange all services.

Urgent Care

The Plan covers Urgent Care inside and outside the Service Area. Urgent Care does not include care that is provided in an emergency room or care that is elective, Emergency, preventive, or health maintenance. Examples of Urgent Care conditions include but are not limited to fever, sore throat, earache, and acute pain.

Vision Care

See "Eye Care/Examinations (Vision Care)."

Weight Loss Programs

Weight Loss programs may be covered depending upon your specific plan. See your Schedule of Benefits or contact Customer Service.

Wigs (Scalp Hair Prosthesis for Cancer Patients)

The Plan covers Wigs for hair loss due to the treatment of any form of cancer or leukemia, or when hair loss is due to another underlying medical condition. A written statement by the treating physician that the wig is Medically Necessary is required for conditions other than the treatment of cancer.

Section 8.

Behavioral Health Services

Behavioral Health (General)

The Plan's Behavioral Health treatment benefits includes non-custodial, inpatient, intermediate and outpatient services based on medical necessity criteria for treatment in the least restrictive, clinically appropriate setting for both mental health and substance use services. The Plan does not apply any Copays, Deductibles, Coinsurance, or maximum lifetime benefits to Behavioral Health services that are not equally applied to other Covered health care Services. Please see your Schedule of Benefits for more information on your Behavioral Health benefits or call Customer Service.

Optum is the Plan's delegated managed behavioral health organization (MBHO). Any decisions to deny behavioral health services are made only by the appropriately licensed mental health professionals. Optum has established contracts with a network of clinicians, groups, clinics, and practices to provide Behavioral Health treatment services within the Service Area.

All Behavioral Health services must be provided by an In-Network provider. You may call Optum for immediate information and assistance in locating the services you are seeking. You can also ask your PCP to refer you to a Network Provider.

Authorization is not required for routine outpatient Behavioral Health therapy office visits or Behavioral Health medical office visits (for example: psychopharmacology). Prior Authorization of Substance Use Disorder treatment (outpatient treatment and structured outpatient additions program) is not required. Acute Treatment Services and Clinical Stabilization Services will be covered for up to a total of 14 days without authorization. Facilities should provide notification to Optum within 48 hours of admission and medical necessity review may begin on the 7th day.

For the most up to date list of services that require a Prior Authorization, please visit Optum's providerexpress.com site and click on Mass General Brigham Health Plan's Provider Manual.

The Plan provides benefits for the diagnosis and treatment of Behavioral Health disorders described in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and American Society of Addiction Medicine (ASAM) criteria. The amount and type of treatment provided under the Plan's benefits are determined by medical necessity and may be subject to Authorization requirements. All cost-sharing and coverage limits are described in your Schedule of Benefits.

The Plan provides coverage for the diagnosis and treatment of:

- Biologically-based mental, behavioral or emotional disorders including schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia, panic disorder, obsessive-compulsive disorder, delirium and dementia, affective disorders, eating disorders, post-traumatic stress disorder, substance use disorders, autism, and other psychotic disorders or other biologically-based mental disorders appearing in the DSM that are scientifically recognized.
- Rape-related mental or emotional disorders among victims of rape or victims of assault with intent to commit rape. Rape-related mental health treatment is based on medical need for the service without any annual or lifetime dollar or unit limitation.
- Non–biologically-based mental, behavioral or emotional disorders, in children and adolescents under the age of 19, which substantially interfere with or substantially limit the functioning and social interactions of such a child or adolescent; provided, that said interference or limitation is documented by and the Referral for said diagnosis and treatment is made by the Primary Care Physician, primary pediatrician or a licensed mental health professional of such a child or adolescent or is evidenced by conduct, including, but not limited to: an inability to attend school as a result of such a disorder; the need to hospitalize the child or adolescent as a result of such a disorder; or a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others. The Plan will continue to provide such benefits to any adolescent who is engaged in an ongoing course of treatment beyond the adolescent's nineteenth birthday

until said course of treatment is completed and while the benefit contract under which such benefits first became available remains in effect, or subject to a subsequent benefits contract which is in effect. Treatment is based on medical need for the service without any annual or lifetime dollar or unit limitation.

- All other non–biologically-based mental health conditions.

Psychopharmacological and neuropsychological assessments are covered when Medically Necessary.

Behavioral Health Services (Outpatient)

Members may directly seek outpatient mental health and substance use counseling or medication services from any licensed clinician in the Network. The Network includes physicians with a specialty in psychiatry, licensed psychologists, licensed alcohol and drug counselor I, licensed independent clinical social workers, licensed marriage and family therapists, licensed mental health clinical nurse specialists or licensed mental health counselors. Members may directly contact In-Network providers of these services for treatment. Please use the online Provider Directory at MassGeneralBrighamHealthPlan.org, to locate a Behavioral Health clinician nearby. A Referral from your PCP is not required. Please see your Schedule of Benefits for specific benefit information.

Your mental health provider is required to contact Optum for any Authorizations needed. All Authorizations are based on Medical Necessity and the Member's clinical needs. All cost-sharing for outpatient mental health or substance use services, if applicable, are included in your Schedule of Benefits. Biologically based mental health services are provided without annual, lifetime or visit/unit/day limitations. No other limitations, Coinsurance, Copay, Deductible, or other cost-sharing may be applied toward these benefits except as are applied to covered medical services within the Plan.

Services may be provided in a licensed hospital; a mental health or substance use clinic licensed by the Department of Mental Health or Public Health; a community mental health center; a professional office or home-based service, provided, however, services are rendered by a licensed mental health professional acting within the scope of his or her license.

Behavioral Health Services (Intermediate)

The Plan covers Medically Necessary Intermediate Behavioral Health Services including:

- Partial Hospitalization
- Day Treatment
- Acute Residential Treatment
- Clinically managed detoxification Services
- Crisis stabilization
- Intensive Outpatient Programs (IOP)

Mobile crisis intervention - services will be provided at community-based sites through mobile response. The objective of these services is to respond rapidly, assess effectively, and deliver a course of treatment intended to promote recovery, ensure safety, and stabilize the crisis. For individuals who do not require inpatient services or another 24-hour level of care, Mobile Crisis intervention provides up to three days of daily post-stabilization follow-up. Mobile crisis intervention provides crisis assessment and crisis stabilization intervention to youth under the age of 21. Each encounter, including ongoing coordination following the crisis assessment and stabilization intervention and may last up to seven days. These services are available to both adults and youths.

Behavioral Health Help Line
Community Behavioral Health Centers are closely connected to the Massachusetts Behavioral Health Help Line. The Behavioral Health Help Line is a 24/7 clinical hotline staffed by trained behavioral health providers and peer coaches who offer clinical assessment, treatment referrals, and crisis triage services. When appropriate, Help Line staff directly connect callers with their nearest CBHC and perform a warm handoff.

The Help Line is available in more than 200 languages, 24/7, 365 days a year.

Visit: Community Behavioral Health Centers | Mass.gov
Call or Text: 833-773-2445
Web Chat: masshelpline.com

In addition, the following services are covered on a non-discriminatory basis to children and adolescents under the age of 19 for the diagnosis and treatment of non-biologically based mental, behavioral, or emotional disorders.

Community Based Acute Treatment (CBAT)
Mental health services provided in a staff-secure setting on a 24-hour basis, with sufficient clinical staffing to ensure safety for the child or adolescent, while providing intensive therapeutic services including, but not limited to: daily medication monitoring; psychiatric assessment; nursing availability; specialing (as needed); individual, group and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing, as needed. This service may be used as an alternative to or transition from inpatient services.

Intensive community-based treatment (ICBAT)
Provides the same services as CBAT for children and adolescents but of higher intensity, including more frequent psychiatric and psychopharmacological evaluation and treatment and more intensive staffing and service delivery. ICBAT programs have the capability to admit children and adolescents with more acute symptoms than those admitted to CBAT. ICBAT programs are able to treat children and adolescents with clinical presentations similar to those referred to inpatient mental health services but who are able to be cared for safely in an unlocked setting. Children and adolescents may be admitted to an ICBAT as an alternative to inpatient hospitalization; ICBAT is not used as a step-down placement following discharge from a locked, 24-hour setting.

In-home Therapy services including Family Stabilization Treatment
Medically necessary therapeutic clinical intervention or ongoing training, as well as therapeutic support shall be provided where the child resides, including: in the child's home, a foster home, a therapeutic foster home, or another community setting.

- Therapeutic clinical intervention includes: (i) a structured and consistent therapeutic relationship between a licensed clinician and a child and the child's family to treat the child's mental health needs, including improvement of the family's ability to provide effective support for the child and promotion of healthy functioning of the child within the family; (ii) the development of a treatment plan; and (iii) the use of established psychotherapeutic techniques, working with the family or a subset of the family to enhance problem solving, limit setting, communication, emotional support or other family or individual functions.
- Ongoing therapeutic training and support of a treatment plan pursuant to therapeutic clinical intervention that shall include, but not be limited to, teaching the child to understand, direct, interpret, manage and control feelings and emotional responses to situations and assisting the family in supporting the child and addressing the child's emotional and mental health needs.

Intensive Care Coordination (ICC)
A collaborative service that provides targeted care coordination services to children and adolescents with a serious emotional disturbance, including individuals with co-occurring conditions, in order to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual's family, while promoting quality, cost effective outcomes. Medically necessary coverage includes an assessment, the development of an individualized care plan, referrals to appropriate levels of care, monitoring of goals, and coordinating with other services and supports. Coverage is based on a system of care philosophy and the individualized care plan is tailored to meet the needs of the individual. Medically necessary coverage can include both face-to face and telephonic meetings, as indicated and as clinically appropriate. ICC is delivered in office, home or other settings, as medically necessary.

In-home behavioral services - a combination of medically necessary behavior management therapy and behavior management monitoring; such services shall be available, where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. In-home behavioral services include:

- Monitoring of a child's behavior, the implementation of a behavior plan and reinforcing implementation of a behavior plan by the child's parent or other caregiver.
- Therapy that addresses challenging behaviors that interfere with a child's successful functioning; including a functional behavioral assessment and observation of the youth in the home and/or community setting, development of a behavior plan, and supervision and coordination of interventions to address specific behavioral objectives or performance, including the development of a crisis-response strategy; and may include short-term counseling and assistance.

Family Support and Training
The Plan covers medically necessary services to a parent or other caregiver of a child to improve the capacity of the parent or caregiver to manage the child's emotional or behavioral needs. Coverage can be provided where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. Family support and training addresses one or more goals on the youth's behavioral health treatment plan and may include educating parents/caregivers about the youth's behavioral health needs and resiliency factors, teaching parents/caregivers how to navigate services on behalf of the child and how to identify formal and informal services and supports in their communities, including parent support and self-help groups.

Therapeutic Mentoring Services
The Plan covers medically necessary services provided to a child, designed to support age-appropriate social functioning resulting from a behavioral health diagnosis. This service may include supporting, coaching, and training the child in age-appropriate behaviors, interpersonal communication, problem solving, conflict resolution, and relating appropriately to other children and adolescents and to adults. Such services shall be provided, when indicated, where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. Therapeutic mentoring is a skill building service addressing one or more goals on the youth's behavioral health treatment plan. It may also be delivered in the community, to allow the youth to practice desired skills in appropriate settings.

You or your Behavioral Health Provider must get Prior Authorization from Optum or provide notification to Optum for these services except for SOAP, community-based detoxification, Community Based Acute Treatment, Intensive Community Based Acute Treatment, and addiction day treatment program for pregnant women. Notification is still required within 72 hours for Community Based Acute Treatment and Intensive Community Based Acute Treatment.

To obtain services, call Optum at 1-844-875-5721 (TTY 711). You may also contact your PCP for help.

Behavioral Health Services (Inpatient)

Services may be provided in a general hospital licensed to provide such services; in a facility under the direction and supervision of the Department of Mental Health; in a private mental hospital licensed by the Department of Mental Health; or in a substance use facility licensed by the Department of Public Health. Inpatient services are a 24-hour service, delivered in a licensed hospital setting for mental health or substance use treatment.

To obtain services, call Optum at 844-875-5722 (TTY 711). You may also contact your PCP or Community Behavioral Health Center for assistance. Prior Authorization is not required for inpatient mental health or substance use services. You or your Behavioral Health Provider must, however, notify Optum of your admission within 72 hours. Biologically based inpatient services are provided without annual, lifetime or day limitations.

Development of Behavioral Health Clinical Guidelines and Utilization Review Criteria

Behavioral Health Clinical Guidelines and Utilization Review Criteria are developed with input from practicing physicians and Optum in accordance with standards adopted by national accreditation organizations. Guidelines are evidence-based wherever possible, are applied in a manner that considers the individual's Behavioral Health needs and are otherwise compliant with applicable state and federal law.

Program exclusions:

No coverage is provided for programs that are not based on an individualized treatment Plan or that are not licensed as noted above. The Plan does not cover services provided by a program that is not licensed by the relevant state agency regulating the delivery of health and/or mental health services for that state. The Plan does not cover services provided by a program that will not accept direct payment from us. Programs that are based on pre-defined lengths of treatment are not covered. Programs that are provided in an educational or vocational setting or in a setting that provides primarily supportive services, including wilderness programs, outbound programs, halfway houses, sober living homes, resocialization programs, therapeutic communities, and similar programs are not covered even when some of the services are provided by licensed behavioral health clinicians. A "wilderness program" includes any program that the Plan, in its or their discretion, determines as involving adventure or challenge experiences in an outdoor setting.

Section 9.

Benefit Exclusions and Limitations

The Plan does not cover the following services or supplies.

Acupuncture

The Plan does not cover services that are not in the scope of acupuncture care.

Ambulance

The Plan does not cover for ambulance costs to transport you to a facility of your choice or to return you to the United States from another Country, also referred to as repatriation or medical evacuation.

Benefits from Other Sources

Benefits from other sources are Health Care Services and supplies to treat an illness or injury for which you have the right to benefits under government programs. These include:

- Veterans Administration for an illness or injury connected to military service.
- Programs set up by other local, state, federal or foreign laws or regulations that provide or pay for Health Care Services and supplies or that require care or treatment to be furnished in a public facility. In addition, no Benefits are provided if you could have received governmental benefits by applying for them on time.
- Services for which payment is required to be made by a Workers' Compensation plan.
- Employers under state or federal law are also considered benefits from other sources.

Biofeedback

The Plan does not provide coverage for biofeedback.

Blood and Related Fees

Blood or blood products except as specified under "Section 7: Your Covered Health Care Services."

Charges for Missed Appointments

The Plan does not provide coverage for charges for missed appointments.

Concierge Services

The Plan does not provide coverage for Concierge Services. Some physicians charge an annual fee to patients as a condition to be part of the physician's panel of patients and to receive special customer service from the Provider (e.g., access to the Provider's cellular telephone, more personalized service). Members who use physicians who provide additional customer service for a fee (also known as concierge service) should be advised that those concierge services are not part of the Plan's coverage.

Cosmetic Services and Procedures

The Plan does not provide coverage for Cosmetic Services that are performed solely for the purpose of making you look better, whether or not these services are meant to make you feel better about yourself or treat a mental condition, such as surgery to treat acne lesions or remove tattoos, and medications for cosmetic purposes to treat hair loss or wrinkles.

Reconstructive surgery is covered; please see "Section 7: Your Covered Health Care Services" for details.

Custodial Care or Rest Care

The Plan does not provide coverage for Custodial or Rest Care: this is care that is furnished mainly to help a person in the activities of daily living and does not require day-to-day attention by medically- trained persons.

Dental Care

The Plan does not provide coverage for Dental Care that is routine, preventive, and restorative unless selected by your Plan Sponsor.

Dentures

The Plan does not provide coverage for dentures.

Diet Foods

The plan does not provide coverage for the purchase of special foods to support any type of diet, except for those nutritional supplements/formulas specifically listed as a Covered Health Care Service in this Handbook.

Educational Testing and Evaluations

The Plan does not provide coverage for educational services or testing except such services covered under the Early Intervention Services and Outpatient Mental Health and Substance Use benefit. No benefits are provided for educational services intended solely to enhance educational achievement (e.g., subject achievement testing) or to resolve problems regarding school performance.

Exams Required by a Third Party

The Plan does not provide coverage for physical, psychiatric and psychological examinations or testing required by a third party, including but not limited to employment; insurance; licensing and court-ordered or school-ordered exams and drug testing that are not Medically Necessary or are considered evaluations for work-related performance.

Experimental Services and Procedures

The benefits described in this Handbook are provided only when covered services are furnished in accordance with the Plan's medical technology assessment guidelines. The Plan does not provide coverage for health care charges that are received for, or related to, care that the Plan considers experimental services or procedures. The fact that a treatment is offered as a last resort does not mean that benefits will be provided for it.

There are exceptions to this exclusion. As required by law, the Plan does provide benefits for:

- One or more stem cell (bone marrow) transplants for a member who has been diagnosed with breast cancer that has spread. The Member must meet the eligibility standards that have been set by the Massachusetts Department of Public Health.
- Certain drugs used on an off-label basis. Examples are drugs used to treat cancer and drugs used to treat HIV/AIDS.
- Coverage of patient care services furnished pursuant to qualified clinical trials intended to treat cancer.
- Services, procedures, devices, biologic products, drugs (collectively "treatment") and programs when there is sufficient scientific evidence to support their use.

Eyewear/Laser Eyesight Correction

The Plan does not provide coverage for eyeglasses or contact lenses. Benefits are also not provided for eye surgery to treat conditions which can be corrected by means other than surgery. An example of eye surgery that is excluded is laser surgery for conditions such as nearsighted vision.

There is an exception to this exclusion. The Plan does provide benefits for eyeglasses or contact lenses when Medically Necessary for certain eye conditions, such as use for post-cataract surgery and the treatment of keratoconus.

Foot Care

The Plan does not provide coverage for routine foot care services such as trimming of corns, trimming of nails and other hygienic care, except when your care is Medically Necessary due to a medical condition such as diabetes or a circulatory disease.

Hearing Aids for Adults Aged 22 and Older

The Plan does not provide coverage for Hearing Aids for Adults Aged 22 and Older unless otherwise noted on your Schedule of Benefits.

Long-term Care

The Plan does not provide coverage for medical or behavioral health Long-Term Care.

Massage Therapy

The Plan does not provide coverage for Massage Therapy.

Other Non-covered Services

The Plan does not provide coverage for any service or supply that is not described as a Covered Benefit in this Handbook. Including, but not limited to:

- Any service or supply that is not Medically Necessary
- All institutional charges over the semi-private room rate, except when a private room is Medically Necessary
- A Provider's charge for shipping and handling or taxes
- Medications, devices, treatments and procedures that have not been demonstrated to be medically effective
- Routine care, including routine prenatal care, when the Member is traveling outside the Service Area
- Services for which there would be no charge in the absence of insurance
- Special equipment needed for sports or job purposes.
- No coverage for delivery of a baby outside the Service Area within thirty (30) days of the expected delivery date, or after the Member has been told that she is at risk for early delivery
- Work rehabilitation

Out-of-Network Providers

The Plan does not provide coverage for any service provided, arranged, or approved by a Provider other than the Member's PCP or another Network Provider. Also, Medications or supplies prescribed by Providers not authorized to provide care by the Plan, except as covered outside the Service Area.

Personal Comfort Items

The Plan does not provide coverage for personal comfort or convenience items or services that are furnished for your personal care or for the convenience of your family. Some examples of non-covered items or services include telephones, radios, televisions, and personal care services. The following items are generally deemed convenience items:

- Air conditioners
- Air purifiers
- Chair lifts
- Dehumidifiers

- Dentures
- Elevators
- “Spare” or “back-up” equipment
- Bath/bathing equipment such as aqua massagers and turbo jets
- Whirlpool equipment generally used for soothing or comfort measures
- Home type bed baths requiring installation (such as Schmidt or Century Bed Bath).
- Non-medical equipment otherwise available to the member that does not serve a primary medical purpose
- Bed lifters not primarily medical in nature
- Beds and mattresses, non-hospital type (e.g., Beautyrest or Craftmatic brand adjustable beds)
- Full, queen and king size hospital Beds
- Cushions, pads, and pillows except those described as covered
- Pulse tachometers

Planned Home Births

The Plan does not provide coverage for planned home births.

Private-duty Nursing

The Plan does not provide coverage for private-duty nursing.

Reversal of Voluntary Sterilization

The Plan does not provide coverage for the reversal of voluntary sterilization.

Self-Monitoring Devices

The Plan does not provide coverage for self-monitoring devices , except:

- Blood glucose monitoring devises used by members with insulin-dependent, insulin-using, gestational, or non-insulin dependent diabetes
- Certain devices that the Plan decides would give a Member having particular symptoms the ability to detect or stop the onset of a sudden life-threatening condition
- Peak flow meters used in the monitoring of asthma control

Wilderness Therapy

The plan does not provide coverage for a wilderness program where an element of the program involves adventure, challenge experience or similar activities in an outdoor setting.

Section 10.

When You Have Other Coverage

The following information explains how Benefits under this policy will be coordinated with other health benefits available to pay for Health Care Services that a Member has received. Benefits are coordinated among payors, such as insurance Carriers, to prevent duplicate payment for the same service.

Nothing in this section should be interpreted to provide coverage for any service or supply that is not expressly covered under this Handbook or to increase the level of coverage provided.

Coordination of Benefits

Benefits in the Plan Document will be coordinated to the extent permitted by law with other plans covering health Benefits including but not limited to homeowner's insurance, motor vehicle insurance, group and/or non-group health insurance, and governmental Benefits (including Medicare).

Coordination of Benefits will be based upon the Massachusetts Regulation 211 CMR 38.00 for a service that is covered at least in part by any of the plans involved. Under no circumstance will the Plan be a primary payor when it can be a secondary payor under this Regulation or other applicable law. The Plan's reimbursement shall not exceed the maximum allowable under the Plan.

Primary vs. Secondary Coverage

When a Member is covered by two or more health benefit plans, one plan will be "primary" and the other plan (or plans) will be "secondary." The Benefits of the primary plan are determined before those of the secondary plan(s) and without considering the benefits of the secondary plan(s). The benefits of the secondary plan(s) are determined after those of the primary plan and may be reduced because of the primary plan's Benefits. In the case of health benefit plans that contain provisions for the Coordination of Benefits, the following rules shall decide which health benefit plans are primary or secondary based upon the Massachusetts Regulation 211 CMR 38.00:

Dependent/Non-Dependent

- The benefits of the plan that covers the person as an employee or Subscriber are determined before those of the plan that covers the person as a Dependent.

A Dependent child whose parents/guardians are not separated or divorced

The order of benefits is determined as follows:

- The Benefits of the plan of the parent/guardian whose birthday falls earlier in a year are determined before those of the plan of the parent or guardian whose birthday falls later in that year. If both parents or guardians have the same birthday, the plan covering the parent or guardian for the longer time is primary.
- When the other plan does not have the same rules of priority as those listed above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine order of Benefits.

A Dependent child whose parents are separated or divorced

Unless a court order, of which Mass General Brigham Health Plan has knowledge, specifies one of the parents as responsible for the health care benefits of the child, the order of benefits is determined as follows:

1. First, the plan of the parent with custody of the child
2. Then, the plan of the spouse of the parent with custody of the child
3. Finally, the plan of the parent not having custody of the child

Active/Inactive Employee

The Benefits of the plan that covers the person as an active employee are determined before those of the plan that covers the person as a laid-off or retired employee. COBRA coverage will always be secondary to other coverage.

Longer/Shorter Length of Coverage

If none of the above rules determines the order of Benefits, the Benefits of the plan that covered the employee, Member or Subscriber longer are determined before those of the plan that covered that person for the shorter time.

Provider Payment When Mass General Brigham Health Plan Coverage is Secondary

When the Plan's coverage is secondary to a Member's coverage under another health Benefit plan, we may suspend payment to a Provider of services until the Provider has properly submitted a Claim to the primary plan and the Claim has been processed and paid, in whole or in part, or denied by the primary plan. We may recover any payments made for services in excess of our liability as the secondary plan, either before or after payment by the primary plan.

Worker's Compensation/Government Programs

If we have information indicating that services provided to a Member are covered under Worker's Compensation, employer's liability, or another program of similar purpose, or by a federal, state or other government agency, we may suspend payment for such services until a determination is made whether payment will be made by such program. If we provide or pay for services for an illness or injury covered under Worker's Compensation, employer's liability, or another program of similar purpose, or by a federal, state or other government agency, we will be entitled to recovery of our expenses from the Provider of services or the party or parties legally obligated to pay for such services.

Subrogation

If you are or allegedly are injured by any act or omission of another person, the coverage under this contract will be subrogated. This means that Mass General Brigham Health Plan, on behalf of your Plan Sponsor, may use your right to recover money from the person(s) who caused or allegedly caused the injury or from any insurance company or other party. If you recover money, from any source (including but not limited to your own uninsured or underinsured motorist coverage), you must promptly reimburse Mass General Brigham Health Plan on behalf of your Plan Sponsor up to the amount of the payments that it has made. This is true even if you do not recover the total amount of your claim against the other person(s) or your recovery does not make you whole in relation to your total damages.

This is also true if the payment you receive is described as payment for other than healthcare expenses and Mass General Brigham Health Plan is not bound by any allocation to consortium or otherwise. Mass General Brigham Health Plan's subrogation rights also extend to consortium recoveries in connection with the injury (or alleged injury). The amount you must reimburse us will not be reduced by any attorneys' fees or expenses you incur.

You must give us information and help. This means you must complete and sign all necessary documents to help us get this money back.

This also means that you must give us notice before settling any claim arising out of injuries you sustained by an act or omission of another person(s) for which we provide coverage. You must not do anything that might limit our right to full reimbursement. The subrogation and recovery provisions in this Plan Document apply whether or not the Member recovering money is a minor. To enforce its subrogation rights under this policy, Mass General Brigham Health Plan will have the right to take legal action, with or without the Member's consent, against any party to secure recovery of the value of services provided or paid for by the Plan for which such party is, or may be, liable.

Member Cooperation

As a Member of the Plan, you agree to cooperate with Mass General Brigham Health Plan (on behalf of your Plan Sponsor) in exercising your Plan Sponsor's rights of subrogation and coordination of benefits under the Plan Document. Such cooperation will include, but not be limited to:

- The provision of all information and documents requested by the Plan
- The execution of any instruments deemed necessary by the Plan to protect its right
- The prompt assignment to the Plan of any monies received for services provided or paid for by the Plan
- The prompt notification to the Plan of any instances that may give rise to our rights

The Member further agrees to do nothing to prejudice or interfere with the Plan's rights to subrogation or coordination of Benefits. Failure of the Member to perform the obligations stated in this section shall render the Member liable to the Plan for any expenses we may incur, including reasonable attorneys' fees, in enforcing its rights under this Plan and without limiting Mass General Brigham Health Plan's or your Plan Sponsor's rights. We may offset any unreimbursed amounts due Mass General Brigham Health Plan against future claims for Benefits by you or any of your covered dependents.

Nothing in this Handbook may be interpreted to limit our right to use any means provided by law to enforce its rights to subrogation or Coordination of Benefits under this plan. Massachusetts law will apply to subrogation regardless of where the injury occurs.

Members Eligible for Medicare – Medicare Primary Where Permitted by law

When you receive Covered Benefits that are eligible for coverage by Medicare as the primary payer, the claim must be submitted to Medicare before payment by the Plan. Medicare is primary in all circumstances as permitted by law. The Plan may be liable for any amount eligible for coverage that is not paid by Medicare. You shall take such action as is required to assure payment by Medicare.

If you are eligible for Medicare by reason of End Stage Renal Disease, the Plan will be the primary payor for Covered Benefits during the "coordination period" specified by federal regulations at 42 CFR Section 411.62. Thereafter, Medicare will be the primary payor. When Medicare is primary (or would be primary if you were timely enrolled) the Plan will pay for services only to the extent payments would exceed what would be payable by Medicare. To avoid such a gap in coverage, if eligible, you must enroll timely in Medicare.

When the plan provides Benefits to a Member for which the Member is eligible under Medicare, the Plan shall be entitled to reimbursement from Medicare for such services to the extent permitted by law. The member shall take such action as is required to assure this reimbursement.

Section 11.

Care Management and Disease Management Programs

Our Care Management Programs

If you have a complex health concern, the Plan's care managers can support you and your health care Provider. Our care managers are nursing professionals who have expertise in helping individuals with a range of health care needs. Telephonic care management can be provided for physical problems, Behavioral Health needs (mental health and substance use), complex care needs, injuries requiring rehabilitation, organ transplants, social needs, and chronic illnesses.

Members may join any of the care management programs listed below. For more information on these or other programs contact:

- Call Customer Service at 1-866-567-9175 (TTY 711).

Behavioral Health Care Management Program

The Plan provides care for members who may have mental health and substance use concerns. The Plan's Behavioral Health Management program is managed by Optum. In addition, the Plan offers a complex care management program focusing on members with complex, comorbid Behavioral Health and medical conditions.

They can help find a counselor near you, make recommendations, and explain your treatment options. A Referral from your doctor is not needed for these services. For more information about Behavioral Health care management contact:

- Optum at 1-844-875-5722 (TTY: 711).
- Customer Service at 1-866-567-9175 (TTY 711).

Clinical Care Partners

If you have complex care needs, or the potential for complex care needs, care managers work with you on developing health and wellness action plans, coaching and education and collaborate with your Providers to coordinate your health care needs.

Your Care Circle Program

A care management program that offers child, adolescent, and adult members of who may have complex behavioral or health related needs a collaborative, interdisciplinary team who work with members to reach their goals and increase their health and well-being. The team consists of independently licensed behavioral health clinicians, licensed nurses, and peer support specialists including community health workers and recovery coaches. Key features of the program are:

• The team works within the members community

• Conduct comprehensive assessments

• Develop member centered care plans

• Works with natural supports, as well as providers to direct care around the member

• Address Social Determinants of Health (SDoH)

• Ensure communication with providers

Pediatric Care Management

The Plan's Pediatric Care Management program focuses on Members under age 19 who may have special health care needs. As a service to parents, this program coordinates a child's medical and Behavioral Health care and other needs.

Health Coaching

The Plan's Health & Wellness Coaches provide telephonic health coaching to help members gain the knowledge, skills, tools, and self-efficacy to achieve their health goals using strategies such as motivational interviewing and goal planning.

Motivational Interviewing is a member-centered and collaborative method to help members explore and resolve ambivalence about behavior change. Health coaches are trained to assist members in a variety of health and wellness topics including: healthy eating/weight management, physical activity, and stress management. Health Coaches also perform outreach calls to members that have gaps in care, as identified by HEDIS data and our interactive text messaging service, Health Crowd.

Our Disease and Condition Management Programs

Our specialized Disease and condition management programs provide comprehensive support, education and outcomes measurement for a number of conditions and diseases that frequently affect our Members. Members with these conditions are identified and offered the opportunity to participate in unique programming to meet the needs of individuals living with these conditions. The Plan's Clinicians with expertise in these programs work to develop tools and materials to help Members achieve improved health status and quality of life. These programs include the following:

Asthma Management Program

The Plan's Asthma Program helps you better manage your asthma by making sure you get all the care you need. An Asthma Care Manager will work with you and your health care Provider to come up with a treatment plan that works for you. A respiratory therapist can also visit you at home to help you understand how to use your medication, and help you identify what could be triggering asthma episodes.

Chronic Obstructive Pulmonary Disease (COPD) Program

There are many forms of lung conditions that are defined as COPD that affect Members. If you have one of these conditions, you may benefit from the extra care and education that our COPD care management program provides. COPD care managers work with Network Providers and reach out to Members considered to be at-risk for respiratory-related complications by providing education and support.

Diabetes Management Program

If you have diabetes, you may benefit from the extra care and education our Diabetes Care Management Program provides. Diabetes care managers reach out to Members considered to be at-risk for diabetes-related complications by providing education and support.

Maternal & Child Health Clinical Nurse Specialist

If you are pregnant, the Plan's Maternal & Child Health Clinical Nurse Specialist provides you with information about pregnancy, plus educational material, and extra support for moms-to-be. The program is free and offers you:

- Help from our care manager
- Rental or purchase of an electric breast pump
- Access to our Tobacco Treatment Specialist
- Access to mental health or substance use services

- Immunization information, schedules, and reminders

Childbirth education classes are available to you and your partner or support person free of charge at many primary care sites and hospitals. Speak to the Provider caring for you during your pregnancy or the facility where you plan to deliver, about enrolling. If they do not offer a childbirth education program, the Plan will reimburse you for the cost of these classes up to $130 per pregnancy. For more information, call Customer Service.

Cardiovascular Disease (CVD) Program

The Plan offers a CVD Program to Members. Members with documented CVD are potentially eligible for this program to help participants with condition management and reduction of Secondary Cardiovascular risk factors through education, coaching and lifestyle changes. For more information on the CVD program, please call Customer Service.

The Quit for Life Tobacco Cessation Program

The Plan provides support for Members trying to quit tobacco. Research shows that a combination of counseling and use of tobacco cessation medications doubles your chances of quitting successfully.

A Certified Tobacco Treatment Specialist (CTTS) can help you create a quit plan, discuss treatment option, choose a quit day, deal with cravings, and live with other tobacco users in your life who are not ready to quit. The CTTS is available to call your Provider with you to discuss obtaining a prescription for a tobacco cessation medication. The Plan's pharmacy benefit covers certain over the counter and prescription cessation medications at $0 cost with a prescription from your provider. The program also includes free educational materials.

For more information about quitting tobacco, contact:

Certified Tobacco Treatment Specialist
857-282-3096

Massachusetts Quitline
800-TRY-TO-STOP

Section 12.

Member Rights and Responsibilities

Your Rights as a Member

As a valued Member, you have the right to:

- Receive information about Mass General Brigham Health Plan, our services, our Providers and practitioners, your covered Benefits, and your rights and responsibilities as a Member.
- Receive documents in alternative formats and/or oral interpretation services free of charge for any materials in any language.
- Have your questions and concerns answered completely and courteously.
- Be treated with respect and with consideration for your dignity.
- Have privacy during treatment and expect confidentiality of all records and communications.
- Discuss and receive information regarding your treatment options, regardless of cost or benefit coverage, with your Provider in a way which is understood by you.
- Be included in all decisions about your health care, including the right to refuse treatment.
- Change your Primary Care Provider (PCP).
- Access Emergency care 24 hours/day, 7 days a week.
- Access an easy process to voice your concerns and expect follow-up by the Plan.
- File a Complaint or Appeal if you have had an unsatisfactory experience with the Plan or with any of our In-Network Providers or if you disagree with certain decisions made by the Plan.
- Make recommendations regarding the Plan's Member rights and responsibilities.
- Create and apply an Advance Directive, such as a will or health care proxy, if you are over 18 years of age.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Freely apply your rights without negatively affecting the way the Plan and/or your Provider treats you.
- Ask for and receive a copy of your medical record and request that it be changed or corrected, as explained in the Notice of Privacy Practices.

  The form is available at MassGeneralBrighamHealthPlan.org under Member resources & forms.
  For your convenience, you may mail, fax or email your request as follows:
  Mail: Mass General Brigham Health Plan Customer Service Department
  399 Revolution Drive – Suite 820
  Somerville, MA 02145
  Email: HealthPlanCustomerService-Members@mgb.org
  Fax: 617-526-1985

- Receive the Covered Health Care Services you are eligible for as outlined in this Handbook.

Your Responsibilities as a Member

As a Member, you also have responsibilities. It is your responsibility to:

- Choose a Primary Care Provider (PCP), the Provider responsible for your care and who participates in the Network.
- Call your PCP when you need health care.
- Tell any health care Providers who are treating you that you are a Mass General Brigham Health Plan Member.

- Give complete and accurate health information that we or your Provider needs in order to provide care.
- Understand the role of your PCP in providing your care and arranging other medical services that you may need.
- As much as possible, understand your health problems and take part in making decisions about your health care and in developing treatment goals with your Provider.
- Follow the plans and instructions agreed to by you and your Provider.
- Understand your Benefits—what's covered and what's not covered.
- Understand your network of Providers. As a Member of the Value HMO Network you are required, with certain exceptions as described in this *Member Handbook*, to obtain services from a Value HMO network Provider.
- Call your PCP within forty-eight (48) hours of any Emergency or out-of-area treatment. If you experienced a Behavioral Health (mental health and substance use) Emergency you should contact your Behavioral Health Provider, if you have one.
- Notify your Plan Sponsor of any changes in personal information such as address, telephone, marriage, additions to the family, eligibility of other health insurance coverage, etc.
- Understand that you may be responsible for payment of services you receive that are not included in the Covered Services list for your coverage type.

Reporting Health Care Fraud

If you know of anyone trying to commit health care fraud, please call our confidential Compliance Helpline at 1-844-556-2925. You do not need to identify yourself.

Examples of health care fraud include:

- Receiving bills for health care services you never received
- Individuals loaning their health insurance ID card to others for the purpose of receiving health care services or prescription drugs
- Being asked to provide false or misleading health care information

Member Satisfaction

Our Customer Service Representatives want you to get the most from your membership. Call us if you:

- Have any questions about your covered benefits
- Need help choosing a PCP
- Receive a bill from a Provider, Primary Care Site, or hospital
- Lose your Member ID Card
- Want to file a Grievance or make a Complaint

Please notify your Plan Sponsor if you:

- Move/relocate
- Get a new telephone number
- Have any changes to your policy (e.g., marriage, new baby, etc.)

If You Receive a Bill in the Mail or If You Paid for a Covered Service

Network Providers should not bill you for any service included in the description of Covered Health Care Services that exceeds Deductibles, Copayments or Coinsurance specified in your Schedule of Benefits. Your Summary of Payments, which is a monthly statement that we mail you, shows what the Plan has paid the provider and what your cost-sharing obligations to a Provider are for Covered Services. If you believe you have

overpaid or received a bill from a Provider in error for any service included on the Covered Health Care Services list, you should contact Customer Service.

If you need Emergency or Urgent Care while traveling abroad or out-of-state, the Plan will pay the Provider directly. Ask the Provider to contact us to discuss payment if the Provider asks you for money. If you do pay for Emergency or Urgent Care while traveling, the Plan will reimburse your out-of-pocket cost minus any Cost-Sharing you are required to pay according to the Plan you were enrolled in at the time of service.
Please send a copy of the bill and proper receipts indicating payment to:

Mass General Brigham Health Plan
Attn: Claims
399 Revolution Drive, Suite 810
Somerville, MA 02145

Be sure to include the following information:

- Member's full name
- Member's date of birth
- Member's identification number
- Date the health care service was provided
- A brief description of the illness or injury

For pharmacy items, you must include:

- A dated drug store receipt stating the name of the drug or medical supply, the prescription number, and the amount paid for the item

Limits on Claims

The Plan will pay or reimburse you only for services that are Emergency or Urgent Care Benefits. You must send any bills or receipts to us within twelve (12) months of the Date of Service. The Plan is not required to pay bills or reimburse you for Claims received later than twelve (12) months after the Date of Service. The Plan will pay or reimburse you only for services that are Covered Health Care Services and that are obtained in accordance with our policies.

Section 13.

Financial Obligations

Under the Plan, you have certain financial obligations with respect to paying for Covered Health Care Services in addition to your contribution for coverage. Below are descriptions of Member Cost-Sharing that may apply.

- **Deductibles—**Some plans require you to pay a Deductible. Your Schedule of Benefits indicates if you have any Deductible amounts and how that Deductible amount is calculated. A Deductible is a specific annual dollar amount you must pay each Benefit Period for certain services. You may have a Deductible for medical expenses, and a separate Deductible for pharmacy expenses. Once you meet your Deductible, you may still be responsible for Copayments and any applicable Coinsurance responsibilities.
- **Copayments (Copays) and Coinsurance—**In some cases, you will be asked to pay a Copay when receiving a covered health care benefit, such as a visit to the doctor, or a prescription. Copays are fixed dollar amounts that are due at the time the service is received or when billed by the provider. Your Schedule of Benefits identifies what your Copay should be for various health care Benefits. Some plans also provide coverage with Coinsurance. If your coverage requires payment of Coinsurance, the applicable Coinsurance percentages are listed in your Schedule of Benefits. After you have met any applicable Deductible amount, you may be responsible for a specified percentage of the cost of a covered health care Benefit you receive, and the Plan will be responsible for the remainder of the cost.
- **Out-of-Pocket Maximum—**All plans have an Out-of-Pocket Maximum dollar amount. Your Schedule of Benefits indicates the amount of your Out-of-Pocket Maximum and details how your amount is calculated. The Out-of-Pocket Maximum represents the most you are required to pay out-of-pocket each Calendar or Plan year (depending on the Plan), including deductible, Copay and Coinsurance amounts.

In order to ensure that you are not held responsible for amounts in excess of your Copays, Deductibles, Coinsurance, or Out-of-Pocket Maximum, your health care services (except as specified in this Handbook) must be provided by a Network Provider; arranged by your PCP; authorized by us, if prior Authorization is required, and that the services must be received during your active enrollment with the Plan. Failure to ensure that all of these requirements have been satisfied may result in you being held financially responsible for the total cost of the service provided to you.

When seeing a Network Provider, you should never be asked to pay more than your Copay, Deductible or Coinsurance limits allow, as specified by your Schedule of Benefits. If you receive a bill from a Network Provider that exceeds these allowed amounts, please call Customer Service.

You will receive a monthly *Summary of Payments* (SOP) in the mail or available through the member portal from us which indicates what a provider has billed, what the Plan has paid, and what you are responsible for paying (i.e., for Deductible, Copays and Coinsurance) based on Claims recently received by the Plan. Please retain all SOPs for your records and contact Customer Service if you have any questions about the information shown in the SOP.

Medical Cost Estimator

The Plan can help you estimate your Cost-Sharing obligations before you receive a Covered Service from an In-Network Provider. To get an estimate, log into Member.MassGeneralBrighamHealthPlan.org and under the 'Costs & claims' tab, select the link "Estimate Medical Costs". The tool will allow you to select the name of your doctor or facility as well as the medical service you want to estimate. A real time estimate will be provided to you for the service specific to the site and/or provider you selected.

If you are unable to request it on-line then please call Customer Service number on the back of your Member ID card, or for the hearing impaired, 711.

The information provided is an estimate based on the information supplied to the Plan at the time of the request. It represents best efforts to assist Members in anticipating Cost-Sharing prior to services being rendered and/or facilitating a dialogue between Members and Providers as to financial responsibilities and treatment options. This estimate does not guarantee coverage and/or pre-approval. The estimated amount may change due to several factors, including but not limited to: changes to your plan design; additional Claims received for processing subsequent to this estimate being provided; other services rendered in conjunction with these procedures; and changes to a Provider's contract with Mass General Brigham Health Plan.

Section 14.

Your Confidentiality and Privacy of Information

Confidentiality

We take our obligation to protect your personal and health information seriously. To help in maintaining your privacy, we have instituted the following practices:

- Mass General Brigham Health Plan employees do not discuss your personal information in public areas.
- Electronic information is kept secure through the use of passwords, automatic screen savers and limiting access to only those employees with a "need to know."
- Written information is kept secure by storing it in locked file cabinets, enforcing "clean-desk" practices and using secured shredding bins for its destruction.
- All employees and contractors, as part of their initial orientation, receive training on our confidentiality and privacy practices. In addition, as part of every employee's annual performance appraisal, they are required to sign a statement affirming that they have reviewed and agree to abide by Mass General Brigham Health Plan's confidentiality policy.
- All providers and other entities with whom we need to share information are required to sign agreements in which they agree to maintain confidentiality.
- We only collect information about you that we need to have in order to provide you with the services you have agreed to receive by enrolling in the Plan or as otherwise required by law.

In accordance with state law, we take special precautions to protect any information concerning mental health or substance use, HIV status, sexually transmitted diseases, pregnancy, or termination of pregnancy.

Section 15.

Complaint and Grievance Process

Mass General Brigham Health Plan tries to meet and go beyond what our Members expect of us. If an experience with us did not meet with your expectations, we want to know about it so we can understand your needs and provide better service.

Complaints

Members have the right to voice concerns and file Complaints. If you file a Complaint, our staff will be courteous and professional, and all information about the Complaint will be kept confidential. Filing a Complaint will not affect your coverage in a negative way.

To file a Complaint, call, write, or fax Mass General Brigham Health Plan:

Mass General Brigham Health Plan
Attn: Member Appeals and Grievance Department
399 Revolution Drive, Suite 810
Somerville, MA 02145
Fax: 617-526-1980
email: healthplanappealsgrievance@mgb.org

Customer Service
1-866-567-9175 (TTY 711)
Monday–Friday, 8 a.m.–6 p.m.
Thursday 8 a.m.– 8 p.m.

How the Complaint Process Works

A Customer Service Representative will ask for information about the Complaint, and, if possible, solve the problem over the telephone at the time of your call. If the Customer Service Representative cannot resolve the situation to your satisfaction at the time of your call, we will make every effort to resolve your Complaint within three (3) business days (called the “internal inquiry period”). If we are unable to satisfactorily resolve your Complaint within three (3) business days, we will, at your request, continue to investigate and resolve the matter through our internal Grievance process.

Grievances

If you are not satisfied with the way we have responded to your Complaint or with any decision made by us about your health care or service, you have the right to file a Grievance. A Grievance is a request that we reconsider a decision or investigate a Complaint regarding the quality of care or services that you have received or any aspect of the Plan’s administrative operations.

If your Grievance is about a decision we have made to deny coverage of health care or services, you must file your Grievance within 180 calendar days of your being notified of the decision. Filing a Grievance will not affect your coverage in a negative way. The time period for the Plan to resolve your Grievance will begin on the earliest of: on the date required by law, on the day after the Internal Inquiry Period, or at any time during the Internal Inquiry Period if you notify us that you are not satisfied with the response thus far to your inquiry. Time limits may only be waived or extended by mutual written agreement between you or an authorized representative and Mass General Brigham Health Plan. Any such agreement shall state the additional time limits, which shall not exceed fifteen (15) business days from the date of the agreement.

You may designate an authorized representative (a friend, relative, health care Provider, etc.) to act as your representative during the Grievance process. The authorized representative has the same rights and responsibilities as the Member.

Frequently Asked Questions about the Grievance Process

How do I file a Grievance?

You may file a Grievance by telephone, in person, by mail, by fax or by email.

The Plan will send you a written acknowledgement of receipt of your Grievance within one business day. If you telephone us or stop by in person, your Grievance will be transcribed by the Plan and a copy forwarded to you or your authorized representative within 24 hours (except where this time limit is waived or extended by mutual written agreement between you or your authorized representative and Mass General Brigham Health Plan). We request that you read, sign, and return to us this written transcription of your oral Complaint. This helps to ensure that we fully understand the nature of your complaint.

You may contact the Plan in writing or by phone or electronically to initiate the Grievance process. (See address, telephone, email, and fax number above in "Complaints.")

How do I designate an Authorized Representative?

An Authorized Representative is anyone you choose to act on your behalf in filing a Grievance with us. An Authorized Representative can be a family member, a friend, a Provider or anyone else you choose. Your Authorized Representative will have the same rights as you do in filing your Grievance. If you wish to choose an Authorized Representative, you must sign and return an Authorized Personal Representative Designation Request Form to the Plan. To get this form, please visit the forms section of Member.MassGeneralBrighamHealthPlan.org. If your Grievance involves Urgent Care, your provider can act as your Authorized Representative without having to complete this form.

What if my Grievance is about my health care or services?

If your Grievance pertains to a decision the plan has made about your health care or services, you or your authorized representative may be asked to sign and return a release of medical information to us. The form can be sent to you by email and is also available at MassGeneralBrighamHealthPlan.org under Member resources & forms. The form can be returned to us by mail, by fax or email to the addresses on the form.

After receipt of all necessary releases, your medical information will be requested by us. You or your authorized representative will have access to any medical information and records relevant to the Grievance which are in the possession of the plan. If we requested that you provide us with a signed authorization and you (or your authorized representative) do not provide the signed authorization for release of medical information within thirty (30) calendar days of the receipt of the Grievance, the plan, may issue a resolution of the Grievance without review of some or all of the medical records.

What if my Grievance is about a behavioral health care service?

The Plan has delegated the management of Grievances involving behavioral health or substance use services to Optum.

To initiate a Grievance with Optum you may contact them in writing or by phone:

Optum
Attn: Grievance/Complaints
425 Market Street
San Francisco, CA 94105
Fax: 877-384-1179
844-875-5722 (TTY 711)

If you prefer, you can request that we, instead of Optum, review your grievance regarding a behavioral health or substance use service.

What if resolution of my Grievance does not require review of my medical records?

If resolution of your Grievance does not require review of your medical records, the Grievance resolution process will begin on the day immediately after the internal inquiry period or sooner if you notify us that you are not satisfied with the Plan's response during the internal inquiry period.

Who will review my Grievance?

Grievances are reviewed by an individual or individuals who are knowledgeable about the matters at issue in the Grievance. Grievances of Adverse Determinations will be reviewed by an individual or individuals that did not participate in any of the prior decisions regarding the matter of the Grievance. These individuals are actively practicing health care professionals in the same or similar specialty who typically treat the medical condition, perform the procedure, or provide the same treatment that is the subject of the Grievance.

How will the decision on my Grievance be explained?

When we send you a written decision on your Grievance, we will include complete identification of the specific information considered and an explanation of the basis for the decision. In the case of a Grievance that involves an Adverse Determination, the written resolution will include a substantive clinical justification that is consistent with generally accepted principles of professional medical practice, and will, at a minimum:

- State the date of service, treating provider, diagnosis and treatment codes and their meanings.
- Identify the specific information upon which the adverse determination was based.
- Discuss the presenting symptoms or condition, diagnosis and treatment interventions, and the specific reasons such medical evidence fails to meet the relevant medical review criteria.
- Specify alternative treatment options covered by the Plan, if any, and a list of Providers currently accepting new patients that offer the alternative treatment.
- Reference and include applicable clinical practice guidelines and review criteria.
- Include a summary of the reviewer's professional qualifications and a signed statement that the reviewer did not participate in any previous reviews related to the Grievance, is not under the supervision of the reviewer who issued the Adverse Determination and has no conflict of interest in making the decision.
- Notify you (or your Authorized Representative) of the procedure for reconsideration of the appeal decision made by the plan and the procedures for requesting external review, including an expedited review and the opportunity to request continuation of services.

When will I hear from Mass General Brigham Health Plan about my Grievance?

The Plan will contact you in writing within thirty (30) calendar days with the outcome of your Grievance review, unless you and the Plan agreed to an extension.

Continuation of Services During the Grievance Process

If the subject matter of the Grievance involves the termination of ongoing services, the disputed coverage or treatment will remain in effect, without liability to you, until you or your Authorized Representative has been informed of our decision provided that you have filed your grievance on a timely basis. This continuation of coverage or treatment applies only to those services which, at the time of their initiation, were approved by us and which were not terminated pursuant to an exhaustion of your benefit coverage.

Reconsideration

The Plan may offer you (or your Authorized Representative) the opportunity for reconsideration of a Final Adverse Determination where relevant medical information was:

- Received too late to review within the thirty (30) calendar days time limit,
- Not received, but is expected to become available within a reasonable time period following the written resolution, or

- For other good cause offered by the Member or Member's Authorized Representative.

If you choose to request reconsideration, the Plan must agree in writing to a new time period for review, but in no event greater than thirty (30) calendar days from the agreement to reconsider the Grievance. The time period for requesting external review begins the date of resolution of the reconsidered Grievance.

Expedited Grievance Review for Special Circumstances

If you or your health care Provider believe your health, life, or ability to regain maximum functioning may be put at risk by waiting thirty (30) calendar days, you or your doctor can request an expedited Grievance review.

An expedited Grievance will be reviewed and resolved as soon as possible consistent with the medical requirements involved but in no event later than seventy-two (72) hours. You have the right to apply for an expedited external review at the same time you apply for an expedited internal review.

The Plan will provide an automatic reversal of the denial for services or durable medical equipment, pending the outcome of the expedited internal appeal, within forty-eight (48) hours of receiving written certification by the Member's physician which states the service or durable medical equipment is: (1) Medically Necessary; (2) that a denial of coverage would create substantial risk of serious harm; and (3) that the risk of such harm is so immediate that services or durable medical equipment should not await the outcome of the normal appeal process. For durable medical equipment, the treating physician must further certify as to the specific, immediate, and severe harm that will result to the Member if such equipment is not provided within forty-eight (48) hours.

Expedited Grievance Review for Persons Who are Hospitalized

A Grievance made while a Member is hospitalized will be resolved as expeditiously as possible, taking into consideration the medical and safety needs of the Member.

A written resolution will be provided before the Member's discharge from the hospital. During a Member's hospitalization, and only during hospitalization, a health care professional or a representative of the hospital may act as the Member's Authorized Representative without written authorization by the Member.

Expedited Grievance Review for Persons with Terminal Illness

When a Grievance is submitted by a Member with a terminal illness, or his or her Authorized Representative, resolution will be provided to the Member or Authorized Representative within five (5) business days from the receipt of the Grievance, except for Grievances regarding urgently needed services, which will be resolved within seventy-two (72) hours. If the Expedited Review process affirms the denial of coverage or treatment to a Member with a terminal illness, the Plan will provide the Member or the Member's Authorized Representative, within five (5) business days of the decision:

- A statement, setting forth the specific medical and scientific reasons for denying coverage or treatment, and
- A description of alternative treatment, services, or supplies covered or provided by the Plan, if any.

If the Expedited Review process affirms the denial of coverage or treatment to a Member with a terminal illness, the Plan will allow the Member, or the Member's Authorized Representative to request a conference. The conference will be scheduled within ten (10) days of receiving a request from a Member; provided however that the conference shall be held within five (5) business days of the request if the treating physician determines, after consultation with the Plan's medical director or his designee, and based on standard medical practice, that the effectiveness of either the proposed treatment, services, or supplies or any alternative treatment, services, or supplies covered by the Plan would be materially reduced if not provided at the earliest possible date.

At the conference we will permit attendance of the Member, the Authorized Representatives of the Member, or both, as well as the Member's treating health care professional or other Providers. A representative of the Plan, who has authority to determine the disposition of the Grievance, will conduct the review.

Mass General Brigham Health Plan's Obligation to Timely Resolution of Grievances

If we do not act upon your Grievance within the prescribed time frames or the agreed upon extended time frame, the Grievance will be decided in your favor. Any extension deemed necessary to complete the review of your Grievance must be authorized by mutual written agreement between you or your authorized representative and Mass General Brigham Health Plan.

Independent External Review

In the case of a denial of covered services, if you are not satisfied with the final outcome of the Grievance review you receive, you have the right to apply for an independent external review with an Independent Review Organization (IRO). Please contact Customer Service for information on how to file an Independent External review.

If the external review agency overturns the Plan's decision in whole or in part, we shall issue a written notice to the Member within five (5) business days of receipt of the written decision. Such notice shall:

- Acknowledge the decision of the IRO
- Advise the Member of any additional procedures for obtaining the requested coverage or services
- Advise the Member of the date by which the payment will be made or the Authorization for services will be issued by the Plan
- Advise the Member of the name and phone number of the person at the Plan who will assist the Member with final resolution of the Grievance

Expedited External Review and Continuation of Coverage

You or your Authorized Representative may request to have your request for review processed as an expedited external review.

Any request for an expedited external review must contain a certification, in writing, from your physician, that a delay in the providing or continuation of Health Care Services that are the subject of a Final Adverse Determination would pose a serious and immediate threat to your health. If the subject matter of the external review involves the termination of ongoing services, you may apply to the external review panel to seek continuation of coverage for the terminated service during the period the review is pending.

Any such request must be made by the end of the second business day following receipt of the Final Adverse Determination.

The review panel may order the continuation of coverage or treatment where it determines that substantial harm to your health may result in the absence of such continuation or for such other good cause, as the review panel shall determine. Any such continuation of coverage will be at your Plan Sponsor's expense regardless of the final external review determination.

Section 17.

Utilization Review and Quality Assurance

Utilization Review

The mission of the Utilization Review (UR) program is to ensure that the highest standards of care are provided to our Members. Our commitment to providing high quality, cost effective care is assured through the use of evidence-based criteria for determining the medical necessity of services and treatments.

The UR program promotes the appropriate level of care and intensity of services provided to our Members across the healthcare continuum. The program continually evaluates new therapies and services for quality and safety while investigating the proper application of these treatments.

The Plan recognizes that the under-utilization of medically appropriate services can harm our Members' health and wellness. For this reason, we promote appropriate use of services. UR decisions are based only on appropriateness of care and service in conjunction with the Member's individual coverage. We do not specifically reward practitioners or other individuals conducting Utilization Review for issuing denials of coverage or service, nor does the Plan provide financial rewards to UR decision makers to encourage decisions that cause underutilization.

The Plan may delegate the review of certain specialized services to accredited external specialty review organizations alongside our clinical team (examples may include sleep studies, genetic testing, and high-tech radiology).

For Behavioral Health or Substance Use services, the Plan has delegated Utilization Review to Optum.

Adverse Determinations

Decisions made by us or a designated Utilization Review organization to deny, reduce, modify, or terminate an admission, continued Inpatient stay, or the availability of any other services, for failure to meet the requirements for coverage based on Medical Necessity, appropriateness of health care setting and level of care or effectiveness are considered Adverse Determinations. Written notification of Adverse Determinations will include a substantive clinical justification that is consistent with generally accepted principles of professional medical practice, and will, at a minimum:

- Identify the specific information upon which the Adverse Determination was based.
- Discuss the presenting symptoms or condition, diagnosis and treatment interventions, and the specific reasons such medical evidence fails to meet the relevant medical review criteria.
- Specify alternative treatment options covered by the Plan, if any.
- Reference and include applicable clinical practice guidelines and review criteria.
- Notify you (or your Authorized Representative) of our internal Grievance process and the procedures for requesting external review.

The Plan engages in prospective review and concurrent review with discharge planning, and care management of Health Care Services as part of its Utilization Review Program.

Initial Determination (Also known as Prospective Review or Prior Authorization)

Prior Authorization is required on certain services to ensure the efficient and appropriate use of Covered Health Care services. Prior authorization is obtained by the provider before you receive the service. Decisions are made by the Plan or a designated Utilization Review organization within two (2) working days of obtaining all necessary information, including any necessary evaluations and/or second opinions. Providers and Members are notified of the decision within twenty-four (24) hours. Both providers and members are sent written notification of prospective approvals within two (2) working days of the initial notification and within one (1) working day for prospective denials.

Concurrent Review

During the course of treatment, such as a hospitalization, concurrent review monitors the progress of treatment and determines for how long it will be deemed medically necessary. Concurrent review decisions are made within one (1) working day after receiving all required information. Providers are told of the decision within twenty-four (24) hours of the concurrent review decision. Providers and Members are sent written notice within one (1) working day of the initial notice. The notice will include number of extended days, next review date, the new total number of days or services approved, and date of admission or initiation of services.

Services subject to concurrent review are continued without liability to the member until the member has been notified of the decision.

Reconsideration

The Plan offers a treating Provider an opportunity to seek reconsideration of a "not approved" Determination from a clinical peer reviewer in any case involving a prospective or in-process review. The treating Provider is informed of this opportunity within the written denial letter. The reconsideration process will occur within one working day of the Provider's request and will be conducted between the Provider and a Mass General Brigham Health Plan peer reviewer. If the reconsideration process does not reverse the "not approved" Determination, the Member or Provider, on behalf of the Member, may pursue the Plan's Grievance process. The reconsideration process is not a prerequisite to the Plan's Grievance process or an expedited appeal. Members can call Customer Service to determine the status or outcome of Utilization Review decisions.

Care Management

Care Management allows for coordination of quality Health Care Services to meet an individual's specific health care needs while facilitating care across agencies and organizations (home health, skilled nursing, hospitals are examples) and creating cost effective alternatives for catastrophic, chronically ill or injured Members on a case-by-case basis. Examples of circumstances where Care Management may be beneficial include organ transplantation, asthma, congestive heart failure, diabetes, smoking or major traumatic injury such as burns.

Quality Assurance Program

We are committed to improving the health of our Members by providing the highest quality health care through the design, use and continuous improvement of the most appropriate and effective delivery systems. The scope of our Quality Assurance Program includes:

- Member satisfaction
- Access to care and services
- Continuity of care
- Provider credentialing
- Preventive health services
- Patient safety
- Health care outcomes

If you are concerned about the quality of care you have received by a Network Provider or the Service provided by us, please contact the Quality Services Department at 800-433-5556.

Development of Clinical Guidelines and Utilization Review Criteria

Mass General Brigham Health Plan utilizes a nationally recognized criterion set provided InterQual® to assess medical necessity for a number of inpatient and outpatient services. For medical therapies not addressed by the InterQual® policy, we may develop evidence based medical polices to address these therapies.

Medical policy criteria developed by the Plan are created with input from local practicing physicians who are specialists in each subject area and comply with standards of national accreditation organizations.

Our Medical policies are evidence based and are applied in a way that considers the member's health care needs and are compliant with applicable state and federal law.

Our Medical policies are reviewed once a year, or more often, as new treatments, and technologies become generally accepted medical practice.

Mass General Brigham Health Plan makes their Utilization Review criteria available online at MassGeneralBrighamHealthPlan.org under Clinical Resources in the Provider Tab, or by request. To make a request, call 1-866-567-9175 and please be sure to include the specific diagnosis and treatment in question. We will provide applicable criteria and protocols within thirty (30) days of your request.

Optum makes their clinical policies available online at providerexpress.com. Or call the telephone number on the back of your Member ID card for more information.

Evaluation of New Technology

We strive to ensure that our Members have access to safe and effective medical care. With the rapid advancement of technology and pharmaceuticals, the Plan has a process to evaluate new technology on a case-by-case basis as well as on a benefit level.

The Plan reviews and evaluates new and emerging technologies, including diagnostics, surgical procedures, medical therapies, equipment, and pharmaceuticals to determine their safety and effectiveness. We use information gathered from varied sources including peer reviewed scientific literature, policy statements from professional medical organizations, national consensus guidelines, FDA reviews, and internal and external expert consultants in its evaluation efforts. We may also analyze market trends and legal and ethical issues in its evaluations as appropriate. Technologies are selected for review based on actual or potential demand.

The Chief Medical Officer or Medical Director is responsible for making medical necessity decisions on urgent requests for new technologies that have not been evaluated and approved through the Plan's technology assessment process. In making this decision, the Chief Medical Officer or Medical Director reviews any available literature and consults with internal and external expert consultants as needed.

New technologies are incorporated into our benefit structure based upon the strength of the safety and efficacy evidence, market analysis and the relevance to the Plan's Membership.

Access and Utilization

We are accessible to Members seeking information about the Utilization Review process and Authorization requests and decisions from 8:30 a.m. to 5:30 p.m., Monday through Friday by calling Customer Service Professionals at 1-866-567-9175 (TTY 711). For after-hours Utilization Review issues, you may leave a message or fax. All requests and messages left after-hours will be retrieved the next business day.

In cases regarding behavioral health or substance use services, the Plan has delegated Utilization Review to Optum and Harvard Vanguard Medical Associates for all HVMA Members.

Section 18.

Glossary

Acute Treatment Services

24-hour medically supervised addiction treatment for adults or adolescents provided in a medically managed or medically monitored inpatient facility, as defined by the department of public health, that provides evaluation and withdrawal management, and which may include biopsychosocial assessment, individual and group counseling, psychoeducational groups, and discharge planning.

Adverse Determination

A determination, based upon a review of information provided by the Plan or its designated Utilization Review organization, to deny, reduce, modify, or terminate an admission, continued Inpatient stay, or the availability of any other services, for failure to meet the requirements for coverage based on Medical Necessity, appropriateness of health care setting, and level of care or effectiveness, including a determination that a requested or recommended Health Care Service or treatment is experimental or investigational.

Applied Behavior Analysis (ABA)

The design, implementation, and evaluation of environment modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Authorization

An Authorization is a special approval by the Plan for payment of certain services.

Authorized Representative

A Member's guardian, conservator, power of attorney, health care agent, family member, or other person authorized by the Member that we can document has been authorized by the Member in writing to act on the Member's behalf with respect to a Complaint or Grievance.

Autism Services Provider/Networks

A person, entity, or group that provides treatment of Autism Spectrum Disorders. This includes: board certified behavior analysts, psychiatrists and psychologists, licensed or certified speech therapists, occupational therapists, physical therapists, social workers, and pharmacies.

Autism Spectrum Disorders

Any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, Asperger's disorder and pervasive developmental disorders not otherwise specified.

Behavioral Health Manager

A company organized under the law of the Commonwealth or organized under the laws of another state and qualified to do business in the Commonwealth that has entered into a contractual arrangement with a carrier to pro- vide or arrange for the provision of behavioral, substance use disorder, and mental health services to voluntarily enrolled member of the carrier. Optum is the Plan's delegated Behavioral Health Manager.

Behavioral Health Services

Care and services for the evaluation, diagnosis, treatment, consultation, prescribing, monitoring or management of mental health, developmental, or substance use disorders. Such care and services may be provided by any Health Care Professional for whom such services are within the scope of licensure for such Health Care Professional. Behavioral Health Services shall also include but not be limited to Partial Hospital Programs and Intensive Outpatient Programs.

Behavioral Health Treatment

Mental health and substance use treatment.

Benefit

A specific area of plan coverage, such as outpatient visits or hospitalization, that make up the range of medical services available to Members. Also, a contractual agreement, specified in the Plan Document, determining covered services provided to Members.

Benefit Period

Your benefit period resets on your Plan Sponsor's anniversary date.

Board Certified Behavior Analyst

A behavior analyst credentialed by the behavior analyst certification board as a board-certified behavior analyst.

Chronic Disease Management

Care and services for the management of chronic conditions, including (1) conditions, defined by the federal Centers for Medicare and Medicaid Services that include, but are not limited to, diabetes, chronic obstructive pulmonary disease, asthma, congestive heart failure, hypertension, history of stroke, cancer, and coronary artery disease; (2) congenital anomalies and hereditary conditions; and (3) other chronic conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both.

Claim

An invoice from a Provider that describes the services that have been provided for a Member or a request that qualifies as a claim under applicable law. All claim determinations (including but not limited to: claim appeal decisions) by the Plan and/or Optum shall be final and binding in the absence of clear and convincing evidence that the determination was arbitrary and capricious.

Clinical Stabilization Services

24-hour clinically managed post detoxification treatment for adults or adolescents, as defined by the department of public health, usually following acute treatment services for substance use, which may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others and aftercare planning, for individuals beginning to engage in recovery from addiction.

Coinsurance

A percentage of the medical or pharmacy cost that the Member is financially responsible for instead of a fixed dollar amount.

Community-Based Acute Treatment

Is defined as 24-hour clinically managed mental health diversionary or step-down services for children and adolescents that is usually provided as an alternative to mental health acute treatment.

Community Behavioral Health Centers

Community Behavioral Health Centers will supplement the broad array of existing behavioral health providers that offer coordinated and integrated mental health and substance use disorder treatment, including new and enhanced behavioral health services. These services are provided on a non-discriminatory basis and include:

- Routine and urgent outpatient services, including same-day evaluation and referral to treatment, evening and weekend hours, timely follow-up appointments, and evidence-based behavioral health treatment. Services may be provided in-person, at CBHC and community-based locations, and via telehealth;
- Mobile crisis intervention services for adults and youth, including 24/7 site- and community-based mobile crisis assessment, intervention and stabilization, as an alternative to hospital emergency departments; and
- Community crisis stabilization services for adults and youth, offering short-term, 24/7, staff-secure, safe, and structured crisis treatment services in a community-based program that serves as a medically necessary, less-restrictive, and voluntary alternative to inpatient psychiatric hospitalization.

Complaint

Any Inquiry made by, or on behalf of a Member, to the Plan or one of our Utilization Review designees that is not explained or resolved to the Member's satisfaction within three (3) business days of the Inquiry including any matter concerning an Adverse Determination.

Copayment (Copay)

A fixed amount paid by a Member for applicable covered services or for prescription medications. A Copayment is paid to a Provider at the time Covered Services are rendered. A Covered Service may require other member cost-sharing (such as a Deductible and/or Coinsurance) before or after a Copayment is required.

Cost-Sharing

The general term that refers to the share of costs for services covered by a plan or health insurance that you must pay out of your own pocket (sometimes called "out-of-pocket costs").

Some examples of types of cost sharing include copayments, deductibles, and coinsurance. Other costs, including your contribution for coverage, penalties you may have to pay, or the cost of care not covered by a plan or policy are usually not considered cost sharing.

Coverage Date

The date medical coverage becomes effective for a Plan Member.

Covered Benefits/Covered Services

The services and supplies covered by the Plan described in this Handbook.

Day

A calendar day (unless business day is specified).

Deductible

The amount you are required to pay to Providers for covered Health Care services before we begin to pay for these services. Please see your Schedule of Benefits to determine if your plan has a Deductible.

Diagnosis of Autism Spectrum Disorders

Medically necessary assessments, evaluations including neuropsychological evaluations, genetic testing or other tests to diagnose whether an individual has one of the Autism Spectrum Disorders.

Disenrollment

The process by which a Member's coverage ends.

Effective Date

The date on which an individual becomes a Member of the Plan and is eligible for Covered Services.

Eligible Individuals

Eligible Individuals are individuals who are employees of a firm, corporation, partnership or association actively engaged in a business that is based within the Service Area. See "Section 2: Eligibility and Enrollment" for what qualifies an Individual as eligible.

Emergency Medical Condition

A medical condition, whether physical, behavioral, related to substance use disorder, or a mental disorder, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part. With respect to a pregnant woman who is having contractions, an emergency also includes having an inadequate time to affect a safe transfer to another hospital before delivery or a threat to the safety of the member or her unborn child in the event of transfer to another hospital before delivery. For further information, refer to section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).

Enrollment

The process by which the Plan registers eligible Employees for membership.

Enrollment Date

The first day on which the Plan is responsible for providing Covered Services to a Member.

Essential Community Provider

An Essential Community Provider (ECP) is a health care provider that serves high-risk, special needs and underserved individuals.

Facility

A licensed institution providing Health Care Services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

Family Planning Services

Services directly related to the prevention of conception. Services include: birth control counseling, education about Family Planning, examination and treatment, laboratory examinations and tests, medically approved methods and procedures, pharmacy supplies and devices, sterilization, including tubal ligation. (Abortion is not a Family Planning Service.) Vasectomies are considered a family planning service but will apply appropriate cost sharing depending on where the service is performed.

Final Adverse Determination

An adverse determination made after a Member has exhausted all remedies available through our internal Grievance process.

Formulary

The schedule of prescription drugs approved for use which will be covered by the plan and dispensed through participating pharmacies.

Grievance

Any oral or written Complaint submitted to us or one of our Utilization Review designees that has been initiated by a Member, or the Member's Authorized Representative, concerning any aspect or action of the Plan relative to the Member, including, but not limited to, review of Adverse Determinations regarding scope of coverage, denial of services, rescission of coverage, quality of care and administrative operations.

Habilitation Services

Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Care Agent

The individual responsible for making health care decisions for a person in the event of that person's incapacitation.

Health Care Provider

A Health Care Professional or Facility that is contracted with or a delegated entity and has agreed to provide health care services to members of Mass General Brigham Health Plan with an expectation of receiving payment, other than Coinsurance, Copays or Deductibles, directly or indirectly from us.

All covered services except Urgent and Emergent Services must be with Health Care providers that participate in the plan's network.

Health Care Services

Services for the evaluation, consultation, prescribing, diagnosis, prevention, treatment, management, cure, or relief of a physical, behavioral, substance use disorder or mental health condition, illness, injury, or disease.

Health Savings Account (HSA)

A Health Savings Account is a fund you can establish to pay for medical expenses associated with a qualified High Deductible Health Plan or invest for your future health needs. We do not administer these accounts, so please contact your Plan Sponsor for more information.

Hearing Aid

A wearable aid or device, typically worn in the ear, which improves a Member's ability to hear sound. A hearing aid may include parts, attachments, accessories, and supplies. Hearing aid batteries are not part of the hearing aid Benefit.

High Deductible Health Plan

A High Deductible Health Plan is a health insurance plan that meets certain government requirements with respect to Deductibles and Out-of-Pocket Maximums.

HMO

A health maintenance organization licensed pursuant to M.G.L. c. 176G or self-insured HMO plan (such as this plan) providing similar (but not identical) benefits than those provided by such a licensed HMO.

Independent Review Organization (IRO)

A company contracted to conduct independent external reviews of Adverse Determinations specific to members of this Plan, involving appropriateness of care, medical necessity criteria, level of care, and effectiveness of a requested service. The Plan contracts with several IROs to perform external reviews.

In-Network Provider

A Provider who is contracted with the Plan to provide services to members. All covered services except Emergency Services must be with In-Network Providers.

Inpatient

Care in a hospital that requires admission and requires at least one overnight stay. As over- night stay in an observation bed is considered outpatient.

Inquiry

Any communication by or on behalf of a Member to the Plan that has not been the subject of an Adverse Determination and that requests redress of an action, omission or policy of the Plan.

Intensive community-based acute treatment

Is defined as intensive 24-hour clinically managed mental health diversionary or step-down services for children and adolescents that is usually provided as an alternative to mental health acute treatment.

Licensed Mental Health Professional

Includes a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed certified social worker, a licensed mental health counselor, a licensed supervised mental health counselor, a licensed psychiatric nurse mental health clinical specialist, a licensed psychiatric mental health nurse practitioner, a licensed physician assistant who practices in the area of psychiatry, a licensed alcohol and drug counselor I, or a licensed marriage and family therapist within the lawful scope of practice for such therapist. Includes a clinician practicing under the supervision of a licensed professional and working towards licensure in a clinic licensed under chapter 111.

Limited Provider Network

A reduced or selective Provider Network, not a Regional Provider Network, which is smaller than a Carrier's General Provider Network and from which the Carrier may choose to exclude from participation other providers who participate in the Carrier's Regional Provider Network or General Provider Network.

Managed Care

A system of health care delivery that is provided and coordinated by a PCP. The goal is a system that delivers value by providing access to quality, cost-effective health care.

Mass General Brigham Health Plan

Mass General Brigham Health Plan is a Massachusetts licensed, not-for-profit Health Maintenance Organization (HMO) founded in 1986 by the Massachusetts League of Community Health Centers and the Greater Boston Forum for Health Action. Our mission is to provide accessible health care delivery systems, which are Member-focused, quality-driven, and culturally responsive to our Members' needs.

Medically Necessary Services

Medically Necessary or Medical Necessity describes health care services that the Plan, in its discretion, determine be consistent with generally accepted principles of professional medical practice as determined by whether: (a) the service is the most appropriate available supply or level of service for the Member in question considering potential benefits and harms to the individual; (b) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or (c) for services and interventions not in widespread use, is based on scientific evidence.

Member

An Eligible subscriber or dependent actively enrolled in the Plan.

Member Financial Responsibility

The member's financial responsibility, if any, for any contribution for coverage, Coinsurance, Copays, or Deductibles.

Member ID Card

The card that identifies an individual as a Member of the Plan. The Member ID Card includes the Member's identification number and information about the Member's coverage. The Member ID Card must be shown to Providers prior to receipt of services.

Mental Health Acute Treatment

Is defined as 24-hour medically supervised mental health services provided in an inpatient facility, licensed by the department of mental health, that provides psychiatric evaluation, management, treatment and discharge planning in a structured treatment milieu. See Section 8 - Behavioral Health Services, Behavioral Health Services (Inpatient) for additional details.

Network

The group of Providers contracted by Mass General Brigham Health Plan to provide health care services to our Members.

Network Provider

A Provider who, under contract with Mass General Brigham Health Plan or a delegated entity, has agreed to provide health care services to insureds with an expectation of receiving payment, other than Coinsurance, Copays or Deductibles, directly or indirectly from the plan.

Non-discriminatory Basis Coverage

The Plan's coverage policies do not contain any annual or lifetime dollar or unit of service limitations imposed on coverage for care provided by Nurse Practitioners that are less than any annual or lifetime dollar or unit of service limitation imposed on coverage for the same services by other providers.

Nurse Practitioner

A registered nurse who holds authorization in advance nursing practice as a nurse practitioner under M.G.L. c. 112, 80B and regulations promulgated thereunder. A Nurse Practitioner may serve as a Primary Care Provider.

Optum

Optum is the organization contracted by Mass General Brigham Health Plan to work in collaboration with the Plan's Behavioral Health Department to administer our Behavioral Health program.

Out-of-Network Provider

A Provider who is not contracted with us to provide services to Members. Services with Out-of-Network Providers are not covered unless authorized by the Plan before you have the service or in an Emergency or Urgent situation.

Out-of-Pocket Maximum

The amount a member is required to pay during a benefit period before the Plan begins to pay 100% of the allowed amount. The limit does not include your contribution of coverage or a service the Plan does not cover.

Physician Assistant

A health care professional who meets the requirements for registration as set forth in M.G.L. c. 112 § 9I and who may provide medical services appropriate to his or her training, experience, and skills and under the supervision of a registered physician.

Plan Document

The legal document, made up of this Handbook and your Schedule of Benefits, which sets forth the services covered by the Plan, the exclusions from coverage, and the conditions of coverage for Members.

Plan Sponsor

Typically your employer, the state agency with which Mass General Brigham Health Plan enters into an Agreement to provide health care Coverage for eligible members and their Dependents.

Preventive Care

Care such as annual physical exams, immunizations, mammograms, and other screening tests which are generally provided by your PCP.

Primary Care Provider (PCP)

A health care professional qualified to give general medical care for common health care problems who: supervises, coordinates, prescribes, or otherwise gives or proposes Health Care services; initiates Referrals for Specialty care; and maintains continuity of care within the scope of practice. Primary Care Provider may include but not be limited to medical doctors and Nurse Practitioners and Physician Assistants who concentrate in primary care, pediatric primary care, and/or gynecological and reproductive health.

Primary Care Site

The location where a PCP provides care to the Plan's Members. A Primary Care Site may be a health center, an outpatient department of a hospital, or a physician group practice.

Prior Authorization

A process that the Plan requires in order to (1) verify that certain Covered Services are and continue to be Medically Necessary and provided in an appropriate and cost-effective manner, and (2) to arrange for the payment of Benefits. In-Network Providers are responsible for obtaining Prior Authorization on behalf of the Member.

Provider

A health care professional or facility licensed as required by state law. Providers include doctors, hospitals, laboratories, pharmacies, skilled nursing facilities, nurse practitioners, registered nurses, physician assistants, psychiatrists, social workers, licensed marriage and family therapists, licensed mental health counselors, clinical Specialists in psychiatric and mental health nursing, and others. The Plan will only cover services of a Provider if those services are Covered Benefits and within the scope of the Provider's license.

Provider Directory

A list of the Plan's In-Network medical and behavioral health facilities and professionals, including PCPs, Specialists, hospitals and Urgent Care centers. The Provider Directory is available online at Member.MassGeneralBrighamHealthPlan.org.

Referral

A recommendation by a PCP for a Member to receive care from a different Provider. In most cases, the Plan requires Referrals for specialist services provided by In-Network Providers. Please see "Section 4: Accessing Medically Necessary Care" for more information.

Rehabilitation Services

Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Schedule of Benefits

The Schedule of Benefits is a general description of your coverage. It also lists the Deductible, Copayment, Coinsurance, and Out-of-Pocket Maximum amounts, where applicable, on services your policy covers. The Schedule of Benefits is not the same as the Member ID Card (see Member ID Card).

Service Area

The geographical area where the Plan has developed a Network of Providers to provide adequate access to Covered Services.

Specialist

A Provider who is trained and certified by his/her state to provide specialty services. Examples include but are not limited to cardiologists, obstetricians, and dermatologists.

Summary of Payments (SOP)

A Summary of Payments (SOP) is a statement sent by the Plan to members which explains what medical treatments and/or services were paid for on their behalf. The SOP also contains information on member cost-sharing amounts such as deductible, copay and coinsurance amounts. The Plan makes these statements available on Member.MassGeneralBrighamHealthPlan.org or mails these statements to members once a month.

Telemedicine (Virtual Visit)

A visit through the use of interactive audio, video or other electronic media for a diagnosis, consultation or treatment of a patient's physical or mental health. Telemedicine does not include audio-only telephone, facsimile machine, online questionnaires, texting, or text-only e-mail.

Treating Provider

See "Network Provider" above.

Treatment of Autism Spectrum Disorders

Includes the following care prescribed, provided or ordered for an individual diagnosed with one of the Autism Spectrum Disorders by a licensed physician or a licensed psychologist who determines the care to be medically necessary; habilitative or rehabilitative care; pharmacy care; psychiatric care; and therapeutic care.

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.

Utilization Review

A set of formal review techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness or efficiency of Covered Health Care Services, procedures, or settings.

Such review techniques may include, but are not limited to, ambulatory review, prospective review/Prior Authorization, second opinion, certification, concurrent review, care management, discharge planning or retrospective review.

Workers Compensation

Insurance coverage maintained by employers under federal law to cover employees' injuries and illnesses under certain conditions.

Customer Service

Whenever you have a question or concern about your Membership or Benefits, our highly trained Customer Service Representatives are available to help you.

Just call **1-866-567-9175** (TTY 711) and a representative will assist you. Our hours of operation are Monday–Friday 8 a.m.–6 p.m., and Thursday 8 a.m.–8 p.m.

This plan is administered by Mass General Brigham Health Insurance Company which processes claims for payment but does not assume financial risk for claims.