Mass General Brigham
Health Plan

Complete PPO Plus *for Individuals and Small Group Employers*

Member Handbook

Effective January 1, 2023

Your Complete PPO Plus Member Handbook

Welcome to Mass General Brigham Health Plan.

Mass General Brigham Health Plan is a not-for-profit Health Maintenance Organization (HMO) based in Massachusetts. We are pleased to have you as a Member of one of our Preferred Provider Organization (PPO) plans, and we look forward to working with you to keep you healthy.

Any time you need help understanding your benefits or membership, you can view all of your Benefit information on Member.MassGeneralBrighamHealthPlan.org or call Customer Service at 866-414-5533 (TTY 711), Monday through Friday, 8:00 a.m. to 6:00 p.m., and Thursdays 8:00 a.m. to 8:00 p.m.

This handbook contains important information about your plan Benefits. It also has 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.

Issued and effective January 1, 2023 | CompletePPOPLUSMM_v3

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, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. 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 Evidence of Coverage

Your Member Handbook and Schedule of Benefits represent your complete Evidence of Coverage.

Mass General Brigham Health Plan is a Health Maintenance Organization (HMO) licensed by the Commonwealth of Massachusetts. The plan provides or arranges for health care Benefits to our Members through a network of physicians, specialists, and other Providers.

As a licensed HMO, we have certain requirements that you, as a Member, must meet in order to ensure coverage of Health Care Services you receive. Failure to meet these requirements, could jeopardize your coverage.

Mass General Brigham Health Plan has certain obligations to you that we must fulfill as part of our agreement with you. These requirements and obligations are described in your Evidence of Coverage (EOC). Your EOC contains two (2) documents: the Member Handbook and the *Schedule of Benefits*. Your Member Handbook and your *Schedule of Benefits* are available on our member portal at Member.MassGeneralBrighamHealthPlan.org.

If we make changes to any Covered Service, clinical review criteria, or what you must pay for covered services, or makes a change to your EOC, we will send you notice at least 60 days before the change is effective. We will do this by sending you an amendment to your Evidence of Coverage and ask that you keep it with this *Member Handbook*.

Member Handbook

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
- Differences in coverage when you get covered services from Preferred (In-Network) and Non-preferred (Out-of-Network) Providers, including how to access Emergency Services
- Any limits or special rules for coverage

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

Mass General Brigham Health Plan
Customer Service
399 Revolution Drive, Suite 810
Somerville, MA 02145

866-414-5533 (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 employer to find out whether they have planned for an administrator to manage HSAs, or call Customer Service for information about HSA administrators who can help you understand how you may establish and fund an HSA. Once you set up an HSA, you should contact your HSA administrator to find out how to get the most from your account.

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

Dental Care Coverage

This policy includes coverage of pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. For questions about the pediatric dental benefit, please call **1-855-264-7898**.

Vision Care Coverage

This policy includes coverage of pediatric vision services as required under the Federal Patient Protection and Affordable Care Act. For questions about the pediatric vision benefit, please call **1-844-201-3993** (TTY users dial 711)**.**

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" or "your" means "Members of Mass General Brigham Health Plan" and "the plan", "us'', "we", or "our" means "Mass General Brigham Health Plan."

Two Levels of Coverage

The plan gives you the choice of using any health care Provider. There are two levels of coverage based on the type of Provider you see:

- **In-Network** coverage is when you see a Preferred Provider
- **Out-of-Network** coverage is when you see a Non-preferred Provider

When you choose a Preferred (In-Network) Provider, you will pay less out-of-pocket costs, in most cases. When using Non-preferred (Out-of-Network) Providers, the plan pays only a percentage of the cost of the care you receive up to the Allowed Amount* for the service. If an Out-of-Network Provider charges any amount over the Allowed Amount for that service, you must pay the balance. Please see "Section 12: Your Financial Obligations" for more information about Out-of-Network charges over the Allowed Amount.

*The Allowed Amount is the maximum amount that we will pay for Covered Benefits minus any applicable Member Cost-sharing.

In-Network Complete PPO Plus Provider Directory

To determine if a Provider is an In-Network provider, please visit Member.MassGeneralBrighamHealthPlan.org and go to Find doctors & care. This will enable you to search for Providers by name, location, specialty, gender, languages spoken, and hospital affiliation.

The web-based Provider Directory contains the most up-to-date information about In-Network Providers. For assistance, interpretation or to request request a free copy of your Provider Directory, please contact Customer Service.

National Coverage

The plan gives you coverage wherever you go in the continental U.S. You may access the Provider Directory at Member.MassGeneralBrighamHealthPlan.org to locate In-Network Providers by state or contact Customer Service for assistance in locating In-Network Providers nationwide.

Information about Providers

More information about physicians 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 physician'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 below also provide helpful information about 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, so you can 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
800-436-7757
Fax 1-617-624-5046
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 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
- Manage your pharmacy Benefits
- Order or print a temporary ID card
- Estimate the cost of services
- Shop, compare, and earn incentives

Section 2.

Eligibility and Enrollment

Enrollment

There is no waiting period or pre-existing condition limitation when enrolling with Mass General Brigham Health Plan. 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, gender, gender identity, sexual orientation, 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. We are not responsible for any services you receive prior to your Effective Date of Enrollment with the plan.

The Service Area

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

The Service Area consists of the state of Massachusetts.

Subscriber Eligibility

Eligible Subscribers include:

- Individuals who have a permanent residence in the Service Area
- Employees of a sole proprietorship, firm, corporation, partnership, or association actively engaged in a business that is based within the Service Area. Eligible employees may enroll in the plan through their employer group if they:
    - Are enrolled through an employer group that is up-to-date in the payment of the applicable payments for coverage, and
    - Meet all employer eligibility requirements,
    - Reside in the continental United States.

Dependent Eligibility

Unless an employer 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.

Employers may elect different coverage for Dependents and different ages for the termination of Dependents and student Dependents. Please consult your Employer Group'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 sponsors 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 judgement consistent with state law, whichever occurs first.
- 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 a Subscriber or Subscriber's spouse is eligible for coverage as a dependent up to the Dependent's 26th birthday. Documentation must be supplied 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 Subscribers' 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 if approved, the child's coverage will continue on either a temporary or permanent basis.

Eligibility Rules for Dependent Children

Eligibility for dependent coverage, including adoptive children and newborns, has been extended to age 26. IRS dependents include the dependents who are claimed on the subscriber's or spouse's federal tax return, are eligible for coverage up to age 26. Non-IRS dependents are eligible for coverage up to two years following loss of IRS dependent status. The date on which your dependent loses dependent status is December 31st of the last federal tax year in which the person was claimed as a dependent on another person's tax return. On an annual basis, Mass General Brigham Health Plan will validate the dependent's eligibility.

- If your dependent age 19 or over is not a handicapped dependent, he or she is eligible for continued coverage under the Massachusetts Health Care Reform Act. IRS dependents are eligible for coverage up to age 26. Non-IRS dependents are eligible for coverage up to two years after losing IRS dependent status according to Internal Revenue Code rules, whichever occurs first.
- The insured must have family plan coverage.

Effective Date and Enrollment Requirements

For individuals enrolling directly with Mass General Brigham Health Plan

The Effective Date for an eligible individual and their dependents is usually the first of the month after we receive a completed enrollment application. Enrollment is subject to our verification of eligibility. Enrollment applications must be complete, accurate and true to the best of your knowledge. We may request more proof to verify your eligibility for enrollment.

For individuals enrolling through a qualified Massachusetts employer

Please see your employer group's Benefit Administrator to confirm your enrollment and Effective Dates of coverage. To be enrolled in the plan through an employer group, your employer must be up to date in the payment of applicable premium for coverage. We have the right to examine an employer groups' records, including payroll records, to verify eligibility and premium payments.

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. Call your employer group's Benefits Administrator or Plan Sponsor to make any changes or corrections to your address and telephone number.

Effective Date

Eligible individuals of a qualified Massachusetts employer group 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 Employer'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.

Disenrollment

Voluntary Termination

An individuals who is not enrolled through an employer group may elect to cancel their contract at any time and for any reason. You must notify us in writing, at least 15 days prior to the requested termination date. If no termination date is requested, or if the requested termination date is less than 15 days from the day we receive your written request, termination will be effective 15 days after receipt of the written request.

A Subscriber who is enrolled through an employer group may terminate coverage following your employer group's approval. Your employer group 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 an Individual's or Subscriber's coverage for failing to meet any of the specified eligibility requirements. The Member 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. See "Continuation of Employer 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, who is not enrolled through an employer group, to outside designated service area.
- Non-renewal or cancellation of the group contract through which an eligible subscriber receives coverage.
- For individuals not enrolled through an employer group, the full premium is due by the first of the month in which coverage is provided. The plan allows a 60-day grace period for any outstanding premium owed. If your premium is not received in full by the end of the month in which your premium is due, you will be notified of your delinquency in writing. If any outstanding premium is not paid in full by the end of the second month in which your premium is due, you will be terminated from coverage. You are responsible for claims incurred following the date of non-payment.
- If an individual Member enrolls and receives an Advance Premium Tax Credit, the Member will have a ninety (90) day grace period for any outstanding premium owed. If your premium is not received in full by the end of the month in which your premium is due, you will be notified of your delinquency in writing. If any outstanding premium is not paid in full by the end of the third month in which your premium is due, you will be terminated from coverage. You are responsible for claims incurred after day 31.
- Termination of Membership for intentional misrepresentation or 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 of Membership for all other causes will be effective fifteen (15) days after you are sent written notification. Premiums paid for periods after the effective date of termination will be refunded.

Continuation of Employer Group Coverage

Eligible employees who were covered through a qualified Massachusetts employer group may be eligible for continued Enrollment under state or federal law following their termination from the plan. Eligible members who were covered through a qualified Massachusetts employer group with 2–19 employees may be eligible for continuation of group coverage under the Massachusetts Small Group Continuation Coverage law. You should contact your employer group for more information about coverage under this law. In addition to the Small Group Continuation Coverage law, there are other state laws which may apply.

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 employer group within 60 days of the event for more information if your coverage ends due to:

- Termination of employment (other than for gross misconduct)—18 months
- Reduction of work-hours—18 months
- Dependent child's loss of eligibility—36 months
- Divorce or legal separation—36 months
- Death of covered employee—36 months
- Covered employee's entitlement to Medicare—36 months

If you are a terminated employee or if you lose coverage due to a reduction of work-hours your coverage may be extended from 18 months to 29 months if you become disabled. Notice of your disability must be provided to your employer within 60 days of the event and before the end of the 18-month continuation period. You must also notify your employer if your disability ends within 30 days of the date of a final determination that you are no longer disabled.

You or your covered Dependents have 60 days to decide to continue your coverage under the Massachusetts Small Group Continuation Coverage law. The election period runs 60 days from the later of the date on which coverage terminates, or the date the notice of your right to elect coverage is sent. To continue coverage, you or your dependents may be charged up to 102% of the premium cost to your employer. If you are disabled, you may also be charged up to 150% of the premium cost after the initial 18-month continuation period expires.

Instead of continuing coverage through the Massachusetts Small Group Continuation Coverage Law, you also have the right to continue your policy in the following circumstancesand 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 employer group within 60 days of the event for more information if your 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 or the employee or former spouse remarries, 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. After remarriage, under state and federal law, the former spouse may be eligible to continue coverage under an individual membership for which the former souse may be obligated to pay the necessary premium.
- Loss of dependency status—36 months
- Reduction of work hours—18 months

If you are a terminated employee or if you lose coverage due to a reduction of work-hours your coverage may be extended for up to 29 months following a disability determination by the Social Security Administration (SSA) or up to 36 months following a second COBRA qualifying event.

To be eligible for an extension, you or a family member must notify your employer within 60 days of the event date, SSA's determination of your disability, or upon receiving notice of the event by your employer. You or your covered dependents have 60 days to decide to continue your coverage under COBRA. The election period runs 60 days from the later of the date of the election notice, or the date you would lose coverage. The cost for continuing coverage is 102% of the premium cost to your employer. If you are disabled, the cost for continuing coverage during your extension period may be increased to 150% of the premium cost to your employer.

Continuation of coverage may not be extended beyond the applicable time allowed under federal law. The size of your employer group 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. Employer groups may notify us of Enrollment changes retroactively. As a result, if you are enrolled through your employer, the information we have may not be current. Only your employer group can confirm Membership status.

Individual Coverage

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

Your Member Identification Card

We will mail you a Member Identification Card (ID card) following receipt of a complete and accurate Enrollment. Your Member ID Card has important information about you and your Benefits. It informs Providers and pharmacists that you are a Member of Mass General Brigham Health Plan and how much your Cost-sharing for certain services should be. Additional cost-sharing may apply and may not be reflected on your ID card. Your *Schedule of Benefits* 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. Always 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.

Accessing Medically Necessary Care

Primary Care

You are not required to choose a Primary Care Provider to manage your Covered Services. However, the plan encourages you to select a Primary Care Provider from the online Provider Directory at Member.MassGeneralBrighamHealthPlan.org to help manage your care. You may choose any Provider to provide your Health Care Services. However, your choice of Provider is important because it will impact your out-of-pocket costs for Covered Services. Your out-of-pocket costs will be less when you see an In-Network Provider for covered Benefits. If you choose an Out-of-Network Provider for your care, you will usually pay more out-of-pocket.

In-Network Care

To access care from an In-Network Provider and receive In-Network Benefits, use the online Provider Directory located at Member.MassGeneralBrighamHealthPlan.org to search for In-Network physicians, hospitals, and other Providers. You can search for physicians and other practitioners by name, gender, specialty, hospital affiliation, languages spoken, and office locations.

In-Network Providers are under contract to provide Covered Services to Members of this plan. Members should contact the Provider directly to verify a Provider's status. Members are responsible for telling Providers of their Membership in the plan by showing them their ID card before receiving services.

Out-of-Network Care

Out-of-Network Benefits are available when you receive Covered Services from Out-of-Network Providers. Your Member out-of-pocket costs are generally higher for Out-of-Network services. However, you have more flexibility in getting care and may go to the licensed health care professional of your choice.

When receiving Out-of-Network Benefits, some services require prior approval by the plan. Please see "Section 4: Prior Authorization" for these requirements. To request Prior Authorization for medical and surgical services, please call Customer Service at 866-414-5533 (TTY 711). To request Prior Authorization for Behavioral Health (mental health and substance use) services, please call our Behavioral Health Manager, Optum, at 844-451-3518 (TTY 711).

Payments to In-Network Providers are usually based on a contracted rate between the Provider and the plan. Since there may not be a contract arrangement with certain Out-of-Network Providers, there is no limit on what certain Out-of-Network Providers can charge. You are responsible for any amount charged by an Out-of-Network Provider that is more than the Allowed Amount for the service. For more information on this rule, please see "Section 12: Your Financial Obligations."

You have the right to request assistance from the plan or Optum if your Primary Care or treating Provider has a hard time finding an In-Network Provider for medically necessary services. Please call Customer Service for assistance. Upon your request, the plan or Optum will identify and confirm the availability of these services and, if necessary, will arrange and pay for medically necessary Out-of-Network services at In-Network coverage levels if they are not available to you In-Network.

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 the plan or to your PCP within 48 hours of receiving Emergency services will also satisfy this requirement. Your treating provider will arrange for any follow-up care you may need. You will not be denied coverage for 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. To locate an In-Network Urgent Care Provider, use the online Provider Directory at Member.MassGeneralBrighamHealthPlan.org or call Customer Service. 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.

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 the online Provider Directory at Member.MassGeneralBrighamHealthPlan.org or contact Customer Service.

Prior Authorization must be obtained before receiving Inpatient Behavioral Health services. To obtain Prior Authorization for mental health or substance use services from an Out-of-Network Provider, you should call our Behavioral Health Manager, Optum, at 844-451-3518 (TTY: 711). In-Network Providers will contact Optum in order to obtain Prior Authorization on your behalf.

Intermediate or Diversionary Behavioral Health Services

The plan offers an array of Behavioral Health services to our Members. "Section 7: 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 includes 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.

Some Diversionary Behavioral Health services require prior Authorization. You or your provider may obtain prior Authorization by calling our Behavioral Health Manager, Optum, at 1-844-451-3518 (TTY 711).

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

If you choose an In-Network Provider from the Provider Directory as your Primary Care or treating Provider, then no matter when you are sick—day or night, any day of the year—your In-Network Provider or a covering Provider will be available to direct your care. Talk to your In-Network Provider to find out what arrangements are available for care after normal business hours.

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 a week at 1-844-451-3518 (TTY 711).

If you think your health problem is an Emergency and you need immediate attention, call 911 or go to the nearest Emergency room.

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 Family Planning clinic for an appointment. You may also see a PCP for Family Planning Services. Call Customer Service if you need help finding a 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 family doctor or 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 10: Care Management and Disease Management Programs."

You must obtain Prior Approval for Inpatient services when using an Out-of-Network Provider. The Prior Approval process is initiated by calling Customer Service at 866-414-5533. Further information about Prior Approval may be found in "Section 4: Prior Authorization."

Transplants

Transplant services are only covered at the In-Network Benefit level when you receive them from a designated In-Network Provider that has special training in that area. In order to receive In-Network Benefits for transplants, you must get the care at an In-Network facility. If you choose to receive treatment at a facility that is not In-Network, then your coverage will be at the Out-of-Network Benefit level. For more information, please contact 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.

Relationship of Mass General Brigham Health Plan to Providers

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

All In-Network Providers listed in 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 our online Provider Directory located at Member.MassGeneralBrighamHealthPlan.org.

Continuity of Medical Care 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 employer 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 In-Network 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 In-Network 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.

To continue care in the above situations, 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.

Prior Authorization

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 In-Network Provider will request an Authorization if it is necessary. However, if you receive care from an Out-of-Network Provider, you are responsible for getting the necessary Prior Authorization.

Examples of services that may require Prior Authorization are surgical procedures and elective admissions, Inpatient psychiatric care, etc. Mass General Brigham Health Plan and Optum give Authorizations as soon as possible.

For Initial or prior Authorization regarding a proposed elective admission, procedure, or service, Authorization decisions are made within two (2) business days after 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 (such as home skilled nursing) require notification by the next business day.

Concurrent Authorization decisions determined by Mass General Brigham Health Plan or Optum as urgent are made within 24 hours. Concurrent Authorization decisions determined by Mass General Brigham Health Plan 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 another 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 refer to “Section 14: 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.

Out-of-Network Prior Authorization Requirements

This section explains when Prior Authorization is needed and the process to follow to meet the requirements to receive medically necessary covered services from an Out-of-Network Provider. An Out-of-Network Provider is any Provider that is not part of the Network. If any of the requirements are not met, no coverage will be provided, and you may be responsible for the entire cost of these services.

When Prior Authorization is Required

Prior Authorization is required in advance of receiving specific medically necessary covered services. Providers and facilities in the Network are required to obtain Prior Authorization for you. If you visit an Out-of-Network Provider, it is your responsibility to obtain the Prior Authorization. The Out-of-Network Provider may also seek Prior Authorization on your behalf. Regardless of whether you visit an In-Network or Out-of-Network Provider, it is always a good idea to check with your Provider to see if the services have been authorized.

1) For Behavioral Health (Mental Health and Substance Use) specific services that require a prior authorization, please contact Optum at 1-844-451-3518 (TTY 711).
2) For a full list of medical and surgical services that require a Prior Authorization, please go to MassGeneralBrighamHealthPlan.org, or call Customer Service for assistance. Please visit this site often as services can be added and updated to the list at any time.

How to Obtain Prior Authorization

To seek Prior Authorization for medically necessary covered services received from an Out-of-Network Provider, you should call Customer Service at 866-414-5533 for medical/surgical services. You should call Optum at 1-844-451-3518 (TTY 711) to seek Prior Authorization for Behavioral Health services. The following information must be given at least ten (10) business days in advance when seeking Prior Authorization for medical/surgical and Behavioral Health services:

- The Member's name
- The Member's ID number
- The treating physician's name, address, and telephone number
- The diagnosis for which care is ordered
- The treatment ordered and the date it is expected to be performed

For Inpatient admission to an Out-of-Network Provider, the following additional information must be given:

- The name and address of the facility where care will be received
- The admitting physician's name, address, and telephone number
- The admitting diagnoses and date of admission
- The name of any procedure to be performed and the date it is expected to be performed

The Effect of Prior Authorization on Coverage

If you obtain Prior Authorization and receive approval from Mass General Brigham Health Plan or Optum, the plan will pay for services authorized according to this Member Handbook and your *Schedule of Benefits*. However, if you do not obtain Prior Authorization or receive approval from Mass General Brigham Health Plan or Optum when required, no coverage will be provided and you may be responsible for the entire cost of these services.

Non-medically Necessary Services

If Mass General Brigham Health Plan or Optum determines at any point that a service was not Medically Necessary, no coverage will be provided for these services at issue, and you will be responsible for the entire cost of these services.

Neither notification nor Prior Authorization entitles you to any Benefits not otherwise payable under this Member Handbook or the *Schedule of Benefits*.

If Mass General Brigham Health Plan or Optum denies a coverage request, Mass General Brigham Health Plan or Optum will send you a written notice that explains the decision, your Provider's right to obtain reconsideration of the decision, and your appeal rights. Please see "Section 15: Utilization Review and Quality Assurance" for information on the time limits for Prior Authorization decisions and reconsideration procedure for Providers if coverage is denied. Please see "Section 14: Complaint and Grievance Process" for a description of your appeal rights if coverage for a service is denied by Mass General Brigham Health Plan.

Major Disasters

Mass General Brigham Health Plan will try to provide or arrange for services in the case of major disasters. Major disasters might include war, riot, epidemic, public emergency, or natural disaster. Other causes include the partial or complete destruction of our facilities or the disability of service Providers. If we cannot provide or arrange services due to a major disaster, we are not responsible for the costs or outcome of its inability.

Section 5.

Pharmacy Benefit

We are committed to providing a high quality and cost-effective pharmacy benefit for our members. Your coverage includes a variety of prescription drug programs that are designed to make paying for your medications and premiums affordable. The pharmacy benefit places all covered drugs into tiers. Described below is how covered drugs are placed in the four or six 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 12: Your Financial Obligations."

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.

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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
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.

Deductibles
Your 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 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
Your 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* 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 866-414-5533 (TTY 711).

Self-Injectable/Administered Drugs

Self-injectable/administered drugs used for treating medical conditions are covered as part of your prescription drug benefit. Therefore, coverage will be provided under your prescription drug benefit (not your medical benefit) for these covered drugs only when the drugs are prescribed by a Treating provider and purchased through an in-network or specialty (if required) pharmacy even if it is administered during your covered visit with a health care provider.

Maintenance 90

Maintenance medications are those that treat chronic conditions such as high blood pressure, diabetes, etc. Short-term use medications (i.e., pain medication, antibiotics) do not have this requirement. To save money on your maintenance medications, the plan requires that you receive maintenance medications in a 90-day supply. To see if you must fill your medication with a 90-day supply, visit the Drug Lookup Tool on Member.MassGeneralBrighamHealthPlan.org.

In order to switch to 90-day supplies of your medication, you must ask your medication prescriber to write you a new prescription to allow 90 days of medication to be dispensed at a time. Besides the convenience of filling prescriptions less often, you may benefit from a reduced cost for most medications. Members can opt out of the 90-day program for one or more of their medicines. This can be done for twelve months at a time. If needed, a member can use a one-time deferral until they get a new prescription from their provider for a 90-day supply. For a shorter 30-day deferral or to opt-out for more than 30 days a member should call Pharmacy Customer Service.

If a Provider feels that it is Medically Necessary for a member to get just a 30-day supply at a time, opting out of 90-day prescription would be based on a provider request to reduce the duration and medication(s). This process would require information from the provider: the medication(s) listed; the proposed time frame for exclusion; and the reason for only a 30-day supply.

If you have any questions about the mandatory 90-day supply, please call Pharmacy Customer Service.

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, please see your *Schedule of Benefits*.

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 866-414-5533 (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 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.

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 Requests 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 designee, or Provider must call Pharmacy Customer Service at 866-414-5533 (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 some medications. Members who qualify for this program are provided immediate coverage without the requirement of a clinical review based on the prescriptions already filled through the plan. For more information, call Pharmacy Customer Service.

Specialty Pharmacy Program

The Specialty Pharmacy Program offers a less costly method to purchase expensive medications that are used to treat complex medical conditions. Certain medications are covered only when obtained from our preferred list of Specialty Pharmacies.

A list of prescriptions included in the Specialty Pharmacy program can be found through the searchable Drug Lookup Tool, at Member.MassGeneralBrighamHealthPlan.org.

Your prescribing Provider can help you with the purchase of the covered specialty medications. Our Specialty Pharmacies have expertise in the delivery of the medications they provide, and offer special services not available at a traditional retail pharmacy, including:

- All necessary medication 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 days a week, to provide support and educational information about your medications
- Compliance monitoring, adherence counseling and clinical follow-up
- Educational resources regarding medication use, side effects, and injection administration

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

Section 6.

Your Covered Health Care Services

The Affordable Care Act ensures Americans have access to quality, affordable health insurance. To achieve this, Mass General Brigham Health Plan offers a core package of items and services, known as Essential Health Benefits (EHB). Under the statute, the plan covers at a minimum the following 10 categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including Behavioral Health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

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

- Provided by a licensed health care Provider
- Authorized by the plan when Authorization is required. For more information on Authorization requirements, check with your Treating Provider or call Customer Service. You should always check with your Treating Provider to make sure that any required Notification or prior Authorizations have been obtained before the services are performed or the supplies are provided. Failure to submit necessary Notifications or receive Prior Authorizations for Out-of-Network coverage may result in Member liability for payment.
- Medically Necessary, as defined in this handbook
- Listed as a Covered Health Care Service in this handbook
- Provided by a licensed health care 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. If you have questions about your Benefits, please call Customer Service.

Abortion

The plan covers abortion when services are obtained by a licensed health care Provider. Cost-sharing may vary depending on the type of Provider selected.

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 treating Provider must arrange 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. We also cover Medically Necessary transfer from one health care facility to another.

Ambulatory/Day Surgery

The plan covers Medically Necessary Outpatient surgical and related diagnostic and medical services. Your treating Provider 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 6 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 1 year or 6-month period, as applicable.

The plan will cover Medically Necessary expenses for Assisted Reproductive Services including the diagnosis and nonexperimental 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 Intrafallopian 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 plans 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 7: Behavioral Health Services" of this handbook.

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 treating Provider must arrange for cardiac rehabilitation.

Chiropractic Care

The plan covers Chiropractic care. See your *Schedule of Benefits* or contact Customer Service for visit limitations that apply.

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 9: 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 an In-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. Prior Authorization is required.

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 will provide 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 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 treating Provider must arrange dialysis services.

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 treating Provider 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 devices, 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.

The plan reimburses for Medically Necessary Applied Behavioral Analysis provided as part of an Early Intervention plan—Applied Behavior Analysis (EI-ABA) for commercially insured 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 plans 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 from any licensed health care Provider. 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). 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 refer to your *Schedule of Benefits* for Benefit limits. You can find a list of In-Network Ophthalmologists or Optometrists in the Provider Directory which you can access at Member.MassGeneralBrighamHealthPlan.org. 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 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. Prior Authorization is not required for routine care but may be required for certain services such as surgery and infertility treatment. 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 your treating Provider. Please refer to 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 coverage limit. Batteries and assistive listening devices are not covered.

Hearing Examinations

The plan covers comprehensive exams and evaluations performed by a hearing Specialist. 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 is 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, and 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 treating Provider must arrange services.

Home Infusion

The plan covers home infusion services. Your treating Provider must arrange home infusion services.

Hormone Replacement Therapy

The plan provides coverage for hormone replacement therapy services including outpatient prescription drugs for peri- and post-menopausal women under the same terms and conditions as for other outpatient services and prescription drugs. (See "Section 5: 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 treating Provider 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 when Medically Necessary. Providers include Physicians, Nurse Practitioners and Physician Assistants. Your treating Provider must arrange for house calls.

Immunizations and Vaccinations

The plan covers immunizations and vaccinations, including travel vaccines. When rendered by In-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 your treating Provider from a licensed 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)

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 postpartum 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. Your treating Provider, obstetrician, or certified nurse midwife must arrange for services.

Maternity Services (Outpatient)

The plan covers prenatal and postpartum care for Members. 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.

Newborn Care

The plan covers all Medically Necessary 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 treating Provider must arrange for this service.

The plan provides coverage for prescribed, orally administered anticancer medication 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 treating Provider 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 treating Provider 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 treating Provider 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.

Pharmacy

See "Section 5: Pharmacy Benefit".

Physician and Physician Assistant Services

The plan covers diagnosis, treatment, consultation, nutrition counseling and health education when provided by a licensed physician or physician assistant.

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.

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 treating Provider must arrange prosthetic device services.

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 treating Provider 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 treating Provider 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.

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 that must be provided in an Inpatient setting. Rehabilitative care includes physical, speech, and occupational therapies. Services must be arranged through your treating Provider. Refer to 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 licensed physician regarding proposed treatment or diagnosis.

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 treating Provider. Please see your *Schedule of Benefits* for limitations on Skilled Nursing Facility Care.

Specialty Care

You may obtain specialty care from any licensed Provider. Coverage includes adult and pediatric specialty care. Pediatric specialty care, including mental health care, is available from Providers with recognized expertise in providing specialty pediatric care.

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 include 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 of any other Health Care Service covered by the plan.

Surgery

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

Telemedicine

The plan provides 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. Your provider may also offer this type of service. Doctors can diagnose and treat many common illnesses. Member cost will depend on the type 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) 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 include:

- 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

In order to receive In-Network Benefits for Transplants, you must obtain care at an In-Network Provider. If you choose to receive care at an Out-of-Network facility, you will receive Benefits at the Out-of-Network level. For a list of In-Network Providers, please contact Customer Service.

The plan covers transplants as follows:

- Bone marrow transplants are covered when 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. 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 must contact Mass General Brigham Health Plan.

- Coverage for human leukocyte antigen testing for certain individuals and patients. The plan will provide for coverage for 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 treating Provider must arrange all services.

Urgent Care

The plan covers Urgent Care. 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 call 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 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 7.

Behavioral Health Services

Behavioral Health Services (General)

The plan's Behavioral Health treatment benefits include 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 plans 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.

You may use the Provider Directory at Member.MassGeneralBrighamHealthPlan.org to search for an In-Network Behavioral Health Provider, or you may call Customer Service for immediate information and assistance in locating the services you are seeking.

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.

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 the plan Benefits are determined by Medical Necessity and may be subject to Authorization requirements. See "Section 4: Prior Authorization" for information on 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.

If your Behavioral Health Provider is not part of the Network, you are required to contact our Behavioral Health Manager, Optum, at 844-451-3518 (TTY 711) to obtain Prior Authorization for all services that require Prior Authorization. See "Section 4: Prior Authorization" for information on Behavioral Health Authorization requirements. All Authorizations are based on Medical Necessity and the Member's clinical needs.

Behavioral Health Services (Outpatient)

Members may directly seek outpatient mental health and substance use counseling or medication services from any licensed clinician, but your Cost-sharing will be less if you use an In-Network provider. The Network includes physicians with a specialty in psychiatry, a licensed alcohol and drug counselor I, licensed psychologists, 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 for these services for treatment. Please use the online Provider Directory at Member.MassGeneralBrighamHealthPlan.org, to locate a Behavioral Health clinician nearby. Please see your *Schedule of Benefits* for specific Benefit information.

Your In-Network mental health Provider (or you if your mental health Provider is not part of the Network 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)

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 directly from the community 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.

Mobile crisis intervention - a short-term, mobile, on-site, face-to-face therapeutic response service that is available 24 hours a day, 7 days a week to a child experiencing a behavioral health crisis. Mobile crisis intervention is used to identify, assess, treat, and stabilize a situation, to reduce the immediate risk of danger to the child or others, and to make referrals and linkages to all medically necessary behavioral health services and supports and the appropriate level of care. The intervention shall be consistent with the child's risk management or safety plan, if any. Mobile crisis intervention includes a crisis assessment and crisis planning, which may result in the development or update of a crisis safety plan.

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, and addiction day treatment program for pregnant women.

To obtain services, call Optum at 1-844-451-3518 (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 1-844-451-3518 (TTY 711). 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. Biologically-based inpatient services are provided without annual, lifetime or day limitations.

Federal and State Mental Health Parity Laws

Federal and state laws require that all Managed Care Organizations, including Mass General Brigham Health Plan, provide mental health and substance use services to Members in the same way they provide medical/surgical Health Services. This is what is referred to as “mental health parity.” Mental health parity laws are important because, in the past, patients who require mental health and substance use treatment may have faced higher deductibles, office visit limits, and other treatment limitations in comparison to patients who require medical/surgical treatments. The federal and state parity laws help limit these differences. The federal law is known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act.

Below is information regarding your rights and our obligations under the mental health parity laws as well as information on how to submit a formal complaint if you believe that we have not complied with these laws.

Your Rights and Obligations According to the Mental Health Parity Laws

- The plan must provide you with the same level of benefits for mental health and substance use problems you have as for other medical/surgical problems you may have.

- The plan must have similar Prior Authorization requirements and treatment limits for mental health and substance use services as we do for medical/surgical services.
- Upon your or your Provider's request, the plan must provide you or your Provider with a copy of the Medical Necessity criteria used by us for Prior Authorization.
- Within a reasonable time frame the plan must provide you with a written notice regarding any denial of Authorization for mental or substance use services. See "Section 16: Utilization Review and Quality Assurance" for more information.
- You have the right to receive a second medical opinion on a mental health or substance use problem when you are given a diagnosis or treatment option.
- Copayments, Coinsurance, Deductibles, unit of service limits (e.g., hospital days, outpatient visits), and/or annual or lifetime maximums are not greater for mental disorders than those required for physical conditions.
- Office visit Copayments are not greater than those required for primary care visits.

Submitting a Complaint About a Mental Health Parity Issue
If you believe that we have not complied with federal or state mental health parity laws, you may submit a complaint to us and/or to the Massachusetts Division of Insurance's Consumer Services Section.

Submitting a Complaint to Mass General Brigham Health Plan
To submit a complaint about a mental health parity issue to us, follow the instructions shown in "Section 14: Complaint and Grievance Process."

Submitting a Complaint to the Massachusetts Department of Insurance
Complaints alleging a Carrier's non-compliance with the mental health parity laws may be submitted verbally or in writing to the Division's Consumer Services Section for review. A written submission may be made using the Division's Insurance Complaint Form. A copy of the form may be requested by telephone or by mail, and the form can also be found on the Division's webpage at: mass.gov/how-to/filing-an-insurance-complaint.

Consumer complaints regarding alleged non-compliance with the mental health parity laws may also be submitted by telephone to the Division's Consumer Services section by calling 877-563-4467 or 617-521-7794. All complaints that are initially made verbally by telephone must be followed up by a written submission to the Consumer Services section, which must include but is not limited to the following information on the Insurance Complaint Form:

- The complainant's name and address
- The nature of the complaint
- The complainant's signature authorizing the release of any information regarding the complaint to help the Division with its review of the complaint

The plan and the Division of Insurance will attempt to resolve all consumer complaints regarding non-compliance with the mental health parity laws in a timely fashion.

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, and are applied in a manner that considers the individual's Behavioral Health needs, and are otherwise compliant with applicable state and federal law.

Section 8.

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

No benefits are provided 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 the Veterans Administration for an illness or injury connected to military service. They also include 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 or an employer 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 6: Your Covered Health Care Services."

Charges for Missed Appointments

No coverage is provided 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 refer to "Section 6: 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 dental services other than required Pediatric Dental coverage as indicated on your plans *Schedule of Benefits*.

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 Member 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 health 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.

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 Member 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
- Services for which there would be no charge in the absence of insurance
- Special equipment needed for sports or job purposes.
- Work rehabilitation

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
- Bed, hospital type in full, queen, and king sizes
- 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 9.

When You Have Other Coverage

The following information explains how Benefits under this policy will be coordinated with other insurance Benefits available to pay for Health Care Services that a Member has received. Benefits are coordinated among 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 under this Evidence of Coverage 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, Hospital indemnity Benefits that exceed $100 per day, 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. The plan 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 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.

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 a Member's Mass General Brigham Health Plan 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 has 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 its expenses from the Provider of services or the party or parties legally obligated to pay for such services.

Subrogation

If you are injured by any act or omission of another person, the coverage under this contract will be subrogated. This means that we may use your right to recover money from the person(s) who caused the injury or from any insurance company or other party. If you recover money, you must reimburse us 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).

This is also true if the payment you receive is described as payment for other than health care expenses. 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 Evidence of Coverage 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 in exercising its rights of subrogation and coordination of Benefits under the Evidence of Coverage. 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 plans 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 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 Member 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.

Members Eligible for Medicare

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. The plan will 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.

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. The member shall take such action as is required to assure this reimbursement.

Section 10.

Care Management and Disease Management Programs

Our Care Management Programs

If you have a complex health concern, the plan has care managers who can support you and your health care Provider during treatment. Our care managers are nursing and therapy (e.g. physical, respiratory, etc.) professionals who have expertise helping individuals with a range of health care needs. Telephonic care management can be provided for physical problems, Behavioral Health (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:

- Customer Service at 866-414-5533 (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 Care 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.
For more information about Behavioral Health care management, contact:

- Optum at 1-844-451-3518 (TTY 711)
- Customer Service at 866-414-5533 (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. Educational books, videos, and computer games that help children understand asthma are also available.

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 11.
Member Rights and Responsibilities

Your Rights as a Member

As a valued Member of Mass General Brigham Health Plan, 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 our 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.
- 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.
- 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.
- 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:

- 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.
- 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.
- Call your PCP within forty-eight (48) hours of any Emergency visit or treatment by an Out-of-Network Provider. 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 employer 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 Benefits
- Lose your Member ID Card
- Want to file a Grievance or make a Complaint

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

In-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 (SOP), which is a 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 an In-Network or Out-of-Network 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, 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 12.

Your Financial Obligations

As part of your contract, you have certain financial obligations with respect to paying for covered Health Care Services in addition to your premium. Below are descriptions of Member Cost-sharing that may apply when using In-Network and Out-of-Network Providers. Member Cost-sharing under your Plan may apply to services received In-Network, Out-of-Network, or both. See your *Schedule of Benefits* for Cost-sharing details that are specific to your Plan.

- **Copayments 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.
- **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 Copays and any applicable Coinsurance responsibilities.
- **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 Out-of-Pocket Maximum amount is calculated. The Out-of-Pocket Maximum represents the most you are required to pay out-of-pocket each Benefit Period, including deductible, copay and coinsurance amounts. Penalty amounts and charges above the Allowed Amount never apply to the Deductible or Out-of-Pocket Maximum.

Out-of-Network Charges in Excess of the Allowed Amount

On occasion, an Out-of-Network Provider may charge amounts in excess of the Allowed Amount. In those instances, you will be financially responsible for the difference between what the Provider charges and the Allowed Amount payable by the plan. This means that you will be responsible for paying the full amount above the Allowed Amount. Amounts charged by an Out-of-Network Provider in excess of the Allowed Amount do not count toward the Deductible or Out-of-Pocket Maximum. You may contact Customer Service at 866-414-5533 if you have questions about the maximum Allowed Amount that may be permitted by the plan for a service.

Penalty

The Penalty is the amount that a Member may be responsible for paying for certain Out-of-Network services when Prior Authorization has not been received before obtaining the services. The Penalty charge is in addition to any Member Cost-sharing amounts. Penalty charges do not count toward any Deductible or Out-of-Pocket Maximum. Please see “Section 4. Prior Authorization” for a detailed explanation of the Prior Authorization program.

Coverage Levels and Location of Service

It is your responsibility to determine if a Provider you wish to see is an In-Network Provider and is accepting new patients if you are a new patient. When you use In-Network Providers, you know that they meet the plan’s Provider quality standards and that they will work with us and Optum (our Behavioral Health Manager) to help ensure you get the care you need. If you have a Medically Necessary service at an In-Network Provider’s 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, the plan may not cover the service if you had a reasonable opportunity to choose to have the service performed by an In-Network Provider. You may search the Provider Directory or call Customer Service.

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 "Cost & Claims" tab, select the link "Estimate Medical Cost." 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 the 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 13.

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 and contractors do not discuss your personal information in public areas.
- Electronic information is kept secure through the use of passwords, automatic screen savers and giving limited 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 planor 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.

Notice of Privacy Practices

This section describes how health information about you may be used and disclosed, and how you can get access to this information. Mass General Brigham Health Plan provides health insurance coverage to you. Because you get health Benefits from us, we have personal health information (PHI) about you. By law, Mass General Brigham Health Plan must protect the privacy of your health information.

This section explains:

- When Mass General Brigham Health Plan may use and share your health information
- What your rights are regarding your health information

Mass General Brigham Health Plan may use or share your health information:

- When the U.S. Department of Health and Human Services needs it to make sure your privacy is protected
- When required by law or a law enforcement agency
- For payment activities, such as checking if you are eligible for health Benefits, and paying your health care Providers for services you get
- To operate programs, such as evaluating the quality of Health Care Services you get, providing care management and disease management services and performing studies to reduce health care costs
- With your health care Providers to coordinate your treatment and the services you get
- With health-oversight agencies, such as the Federal Centers for Medicare and Medicaid Services, and for oversight activities authorized by law, including fraud and abuse investigations
- For research projects that meet specific privacy requirements
- With government agencies that give you Benefits or services

- With plan sponsors of employer group health plans, but only if they agree to protect that information;
- To prevent or respond to an immediate and serious health or safety emergency
- To remind you of appointments, Benefits, treatment options or other health-related choices you have
- With entities that provide services or perform functions on behalf of Mass General Brigham Health Plan (Business Associates), provided that they have agreed to safeguard your information

Please also note:

- When a federal or state privacy law provides for stricter safeguards of your PHI, Mass General Brigham Health Plan will follow the stricter law. Except as described above, we cannot use or share your health information with anyone without your written permission. You may cancel your permission at any time, as long as you tell us in writing. Please note: We cannot take back any health information we used or shared when we had your permission.

- For purposes of underwriting, we are prohibited from using or disclosing any genetic information.

- We do not use your health information for any marketing purposes and will not sell your health information to anyone.

You have the right to:

- See and get a copy of your health information that is contained in a "designated record set." You must ask for this in writing. To the extent your information is held in an electronic health record, you may be able to receive the information in electronic form. In some cases, we may deny your request to see and get a copy of your health information. Mass General Brigham Health Plan may charge you to cover certain costs, such as copying and postage.
- Ask Mass General Brigham Health Plan to change your health information that is in a "designated record set" if you think it is wrong or incomplete. You must tell us in writing which health information you want us to change, and why. If we deny your request, you may file a statement of disagreement with us that will be included in any future disclosures of the disputed information.
- Ask Mass General Brigham Health Plan to limit its use or sharing of your health information. You must ask for this in writing. We may not always be able to grant this request.
- Ask Mass General Brigham Health Plan to get in touch with you in some other way, if by contacting you at the address or telephone number we have on file, you believe you would be harmed.
- Get a list of when and with whom Mass General Brigham Health Plan has shared your health information. You must ask for this in writing.
- Be notified in the event that we or one of our Business Associates discovers a breach of your unsecured protected health information.
- Get a paper copy of this notice at any time.

These rights may not apply in certain situations. This notice took effect on April 17, 2019 and will remain in effect until we change it. By law, Mass General Brigham Health Plan must give you notice explaining that we protect your health information, and that we must follow the terms of this notice. Mass General Brigham Health Plan can change how we use and share your health information. If we do make important changes, we will send you a new notice and post an updated notice on our website. That new notice will apply to all of the health information that Mass General Brigham Health Plan has about you. We take your privacy very seriously.

If you would like to exercise any of the rights we describe in this section, or if you feel that Mass General Brigham Health Plan has violated your privacy rights, contact our Privacy Officer in writing at the following address:

Mass General Brigham Health Plan, Privacy Officer
399 Revolution Drive, Suite 810
Somerville, MA 02145

Filing a Complaint or exercising your rights will not affect your Benefits. You may also file a Complaint with the U.S. Secretary of Health and Human Services:

The U.S. Department of Health and Human Service
200 Independence Avenue
SW Washington, DC 20201
877-696-6775

Mass General Brigham Health Plan will not retaliate against you if you file a complaint either with us or the U.S. Secretary of Health and Human Services. For more information, or if you need help understanding this information, call Customer Service.

Section 14.

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 to 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

Customer Service
866-414-5533 (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 plans 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 you 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 either 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 or by fax.

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 to initiate the Grievance process. (See address, telephone, 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.

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

If your Grievance is related 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. 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
844-451-3518 (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 my Grievance is about a pediatric dental service?

To initiate a Grievance regarding pediatric dental services, you can call or write:

Phone: **1-855-264-7898**
Complaints, Grievances, & Appeals Department
P.O. Box 969
Boston, MA 02129

What if my Grievance is about a pediatric vision service?

To initiate a Grievance regarding pediatric vision services, you can call or write:

Phone: **1-844-201-3993**
Fax: **1-513-492-3259**

FAA/EyeMed Vision Care
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, OH 45040

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 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 have 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 medical requirements involved but in no event later than seventy-two (72) hours. You have the right to apply for 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 soon 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

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 the Massachusetts Health Policy Commission's Office of Patient Protection. The Office of Patient Protection provides an independent review of Grievances not resolved at the plan level to your satisfaction. The External Review Organization will review the Grievance to determine if the service or treatment in question is Medically Necessary and a Covered Benefit. The decisions of the External Review Organization are final and binding.

You or your Authorized Representative is responsible to activate the External Review Process. To activate the review:

- Complete and submit the required application to the Health Policy Commission within four (4) months of receipt of our final Grievance decision.
- Submit applicable filing fees ($25.00) to the Health Policy Commission (The Office of Patient Protection may waive the fee in cases of extreme financial hardship). You will not be required to pay more than $75.00 in fees for external review requests per Benefit Period, regardless of the number of external review requests submitted.

For non-expedited reviews, a final decision will be issued within forty-five (45) calendar days from the receipt of the appeal at the Office of Patient Protection. For expedited reviews, a final decision will be issued within seventy-two (72) hours from the receipt of the appeal at the Office of Patient Protection.

The Office of Patient Protection shall screen all requests for external reviews to determine if they:

- Comply with the requirements of 958 CMR 3.404
- Do not involve a service or Benefit that has been explicitly excluded from coverage by us in the Member Handbook or *Schedule of Benefits*
- Result from our issuance of a final decision of a Grievance, provided, however, that no Final Adverse Determination is necessary where we have failed to comply with timelines for the internal Grievance process, we have waived the internal Grievance process in writing, or if the Member or his or her Authorized Representative is requesting an expedited external review at the same time that the Member is requesting an expedited internal review.

If the external review agency overturns our 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 from the OPP.

Such notice shall:

- Acknowledge the decision of the OPP
- 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 Mass General Brigham Health Plan who will assist the Member with final resolution of the Grievance

For more information about your Grievance rights as a resident of the Commonwealth of Massachusetts, contact:

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

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. You have the right to apply for independent expedited external review at the same time a request for an internal expedited review is requested.

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 our expense regardless of the final external review determination.

For more information about your Grievance rights as a resident of the Commonwealth of Massachusetts, contact:

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

As a resident of Massachusetts, you can also seek consumer assistance with the Grievance process by contacting:
Massachusetts Consumer Assistance Program
Health Care for All
30 Winter St., 10th Floor
Boston, MA 02108

800-272-4232
hcfama.org/helpline

Section 15.

Utilization Review and Quality Assurance

Utilization Review

The mission of the Utilization Review (UR) program is to ensure the provision of the highest quality of health care to our Members. This is accomplished through a multidisciplinary team approach to advocate for optimum standards of patient health, education, and safety. Our commitment to providing quality care is consistent with our goal to promote appropriate resource utilization.

The Utilization Review program promotes the continuity of patient care through the facilitation and coordination of patient services to ensure a smooth transition for Members as they obtain the appropriate level and intensity of services, across the continuum of health care. The Utilization Review program continually evaluates the needs of our Members and promotes enhancements and improvements to the program as well as to the care delivery system.

The plan recognizes that under-use of medically appropriate services can harm our Member's health and wellness. For this reason, we promote appropriate use of services. UR decisions are based only on appropriateness of care and service and existence of 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.

Adverse Determinations

Decisions made by us or a designated Utilization Review Organization such as Optum 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, 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 must be 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 discuss reconsideration of an Adverse Determination from a clinical peer reviewer in any case involving a prospective or concurrent 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 clinical peer reviewer. If the reconsideration process does not reverse the Adverse 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, implementation, 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 have a concern about the quality of care you have received by an In-Network Provider or the Service provided by us, please contact the Quality Services Department at 1-800-433-5556.

Development of Clinical Guidelines and Utilization Review Criteria

Mass General Brigham Health Plan utilizes a nationally recognized criterion et 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 1-866-414-5533 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 under the Clinical Resources tab. 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.

Decisions to approve the use of a new technology are based on the highest Benefit and lowest risk to the Member.

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 our 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. You may call 866-414-5533 (TTY 711) or fax 617-772-5512. 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; Pharmacy to our Pharmacy Vendor; and Harvard Vanguard Medical Associates for all HVMA Members.

Section 16.

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.

Allowed Amount

The Allowed Amount is the maximum amount that we will pay for Covered Benefits minus any applicable Member Cost-sharing. The Allowed Amount for In-network Benefits is the contracted rate accepted by In-Network Providers. The Allowed Amount for Out-of-Network Benefits is based on the lower of the Provider's charge or the Usual and Customary charge used by Providers in a particular geographic area. The Allowed Amount for Out-of-Network Providers may sometimes be less than your In-Network's Provider's actual charge. If this is the case, you will be responsible for the amount of the Provider's actual charge that is in excess of the Allowed Amount.

Applied Behavior Analysis (ABA)

The design, implementation, and evaluation of environmental 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/Network

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 laws 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 provide or arrange for the provision of behavioral, substance use disorder, and mental health services to voluntarily enrolled Members of the carrier.

Optum is the plan's delegated Behavioral Health Manager.

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 an Evidence of Coverage, determining covered services provided by insurers to Members.

Benefit Period

If you have non-group coverage with us, your benefit period resets on January 1. If you are enrolled through employer sponsored group coverage with us, your benefit period resets on your employer's anniversary date.

Board Certified Behavior Analyst

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

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 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 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.

Complete PPO Plus Network

The national network of licensed health care Providers with contractual agreements to provide Health Care Services to this plan's Members.

Connector

"Connector", the commonwealth health insurance connector, established by chapter 176Q

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 premiums, 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 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 refer to 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 an individual becomes a Member of the plan and is eligible for Covered Services.

Eligible Individuals

Eligible Individuals are individuals who have permanent residence in the Service Area or are employees of a sole proprietorship, 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 mental, 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 Individuals and 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.

Essential Health Benefits (EHBs)

A set of health care service categories that must be covered by certain plans. Please see “Section 6: Your Covered Health Care Services” for a list of EHBs.

Evidence of Coverage

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

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 Management 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, 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.

Health Care Services

Services for the diagnosis, prevention, treatment, 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 High Deductible Health Plan or invest for your future health needs. We do not administer these accounts, so please contact your employer for more information.

Hearing Aid

A wearble 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. The Deductibles are generally higher, and the Premiums are generally lower compared to a standard health insurance plan.

HMO

A health maintenance organization licensed pursuant to M.G.L. c. 176G.

In-Network

The level of Cost-sharing a Member pays when Covered Services are obtained through a Network Provider.

Inpatient

Care in a hospital that requires admission and requires at least one overnight stay. An overnight 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.

Licensed Mental Health Professional

Includes a licensed physician who specializes in the practice of psychiatry, a licensed alcohol and drug counselor I, a licensed psychologist, a licensed independent clinical social worker, a licensed marriage and family therapist, a licensed mental health counselor or a licensed nurse mental health clinical specialist.

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 or Medical Necessity

Medically Necessary or Medical Necessity describes Health Care Services that are 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 Individual, subscriber or dependent enrolled in a health insurance plan, either by choice of the Eligible Individual or through an employer group.

Member Financial Responsibility

The Member's financial responsibility, if any, for any Premiums, 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.

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.

Non-preferred (Out-of-Network) Provider

A Provider that does not have a contractual agreement with the plan to provide services to Members.

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.

Office of Patient Protection

The office within the Health Policy Commission established by M.G.L. c. 6D, § 16, responsible for the administration and enforcement of M.G.L. c.176O, §§ 13, 14, 15 and 16.

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

The level of Cost-sharing a Member pays (generally higher) when Covered Services are obtained through a Non-Preferred (Out-of-Network) Provider.

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 premium or a service your plan does not cover.

Penalty

The amount that a Member may be responsible to pay for certain Out-of-Network services when Prior Authorization was not granted by us and you already received the Health Care Services.

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.

Preferred (In-Network) Provider

A Provider that has a contractual agreement with the plan to provide Health Care Services to this plans Members for which In-Network cost-sharing will apply.

Premium

The amount of money paid to us by the Member (or on the subscriber's behalf by an employer) to cover the cost of health insurance.

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 provide general medical care for common health care problems who: supervises, coordinates, prescribes, or otherwise provides or proposes Health Care Services; initiates referrals for Specialist care; and maintains continuity of care within the scope of practice. Doctors (including pediatricians), Physician Assistants and Nurse Practitioners may all serve as PCPs.

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. Before a Member receives services from an Out-of-Network Provider, the Member is responsible for obtaining Prior Authorization from us. Otherwise, the Member may have to pay higher Cost-sharing amounts and a Penalty.

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 In-Network medical facilities and professionals, including PCPs, Specialists, hospitals, and Urgent Care centers. The Provider Directory can be accessed online by visiting Member.MassGeneralBrighamHealthPlan.org.

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 (Copay), 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).

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

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 “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.

Usual and Customary Charge

The fees identified by a carrier as the usual fees charged by similar health care Providers in the same geographic area. To determine the Usual and Customary Charge, the plan relies on a commercially available solution which applies statistical principles to a large national database, representing more than half of all claims submitted in the United States, to estimate the 80th percentile cost of a given procedure and region.

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.

Utilization Review Organization

An entity that conducts Utilization Review under contract with or on behalf of a carrier, but does not include a carrier performing Utilization Review for its own health Benefit plans. A Behavioral Health manager is considered a Utilization Review organization.

Workers Compensation

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

Mass General Brigham Health Plan 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 **866-414-5533** (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.

Underwritten by Mass General Brigham Health Plan, Inc.

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