Mass General Brigham
Health Plan

Complete PPO Plus *for Individuals and Small Group Employers*

Member Handbook

Effective July 1, 2026

Mass General Brigham
Health Plan

Your Complete PPO Plus Member Handbook

Welcome to Mass General Brigham Health Plan.

We are 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 collaborating with you to keep you healthy.

When need help understanding your benefits or membership, you can view all of your Benefit information on Member.MGBHP.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 has information that is important about your plan Benefits. It also has technical terms you may be unfamiliar with. If you need help understanding this handbook, Customer Service Representatives are available to help you. We also have free translation services for Members.

Mass General Brigham
Health Plan

Multi-language Interpreter Services

English

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العربية (Arabic)
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ខែ#ɜ (Khmer/Cambodian)
សម្គាល់៖ មានផ្តល់ជូនដល់អ្នកនូវសេវាជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃ។ ជំនួយបន្ថែម និងសេវាបន្ថែមដែលមានលក្ខណៈសមស្រប ដើម្បីផ្តល់ព័ត៌មាននៅក្នុងទម្រង់ដែលអាចប្រើប្រាស់បាន ដូចជា ការព្រីនអក្សរធំ អក្សរស្ទាប ឬសំឡេង ក៏មានផ្តល់ជូនដោយឥតគិតថ្លៃដែរ។ ទូរសព្ទទៅលេខ **1-800-462-5449 (TTY: 711)** ឬ និយាយទៅកាន់អ្នកផ្តល់សេវាកម្មរបស់អ្នក។

Deutsch (German)
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Soomaali (Somali)
FIIRO GAAR AH: Waxaad heli kartaa adeeg bilaash ah oo la xiriira taageerada luuqadda. Sidoo kale waxaa bilaash lagu heli karaa taageerada iyo adeegyo habboon oo bilaash ah kuwaasoo la xiriira helitaanka qaababka xogta macluumaadka, tusaale ahaan sida daabacaadda waaweyn, nooca daabacaadda ee loogu talo-galey indhoolayaasha, ama maqalka. Fadlan soo wac lanbarkal **1-800-462-5449 (TTY: 711)** ama la hadal bixiyaha qaabbilsan adeegga daryeelkaaga.

ગુજરાતી (Gujarati)
ધ્યાન આપો: તમારા માટે નિઃશુલ્ક ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. મોટી પ્રિન્ટ, બ્રેઇલ અથવા ઑડિઓ જેવા સુલભ ફોર્મેટમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સહાય અને સેવાઓ પણ નિઃશુલ્ક ઉપલબ્ધ છે. **1-800-462-5449 (TTY: 711)** પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

Tagalog (Tagalog)
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ພາສາລາວ (Laotian)
ກະລຸນາຮັບຊາບ: ມີບໍລິການພາສາແບບບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ເຄື່ອງຊ່ວຍເຫຼືອ ແລະ ບໍລິການເສີມທີ່ເໝາະສົມໃນການໃຫ້ຂໍ້ມູນໃນຮູບແບບເຂົ້າເຖິງໄດ້ ຊຶ່ນ: ຕົວອັກສອນຂະໜາດໃຫຍ່, ຕົວໜັງສືນູນ ຫຼື ສຽງ ກໍ່ມີໃຫ້ແບບບໍ່ເສຍຄ່າຊຶ່ນກັນ. ໂທຫາເບີ **1-800-462-5449 (TTY: 711)** ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

日本語 (Japanese)
注意：無料の言語サポートサービスをご利用いただけます。大きい活字、点字、音声など、アクセスしやすい形で情報を提供するための適切な補助器具やサービスも無料でご利用いただけます。**1-800-462-5449 (TTY: 711)** までお電話いただくか、ご利用のプロバイダーにお問い合わせください。

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Section 1.

Your Evidence of Coverage (EOC)

Your Member Handbook and Schedule of Benefits are your EOC.

We are 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. If you do not meet these requirements, it could jeopardize your coverage.

We have certain obligations to you as part of our agreement with you as explained in your (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 at Member.MGBHP.org.

We will send you, at least 60 days in advanced, of 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 do this by sending you an amendment to your EOC 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 is also your guide to the most important things you need know, including:

- Exclusions
- Covered services from (In-Network) and 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.MGBHP.org. For help, 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 set up 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

Certain words in this Member Handbook have special meaning. We have capitalized these words throughout the handbook, and defined them 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" and our delegated vendors.

Two Levels of Coverage

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 an In-Network Provider, in most cases you will pay less out-of-pocket costs. When using Out-of-Network Providers, the plan pays a percentage of the cost of your care up to the Allowed Amount* for the service. If an Out-of-Network Provider charges over the Allowed Amount for that service, you must pay the rest. Please see "Section 12: Financial Obligations" for more information about Out-of-Network charges over the Allowed Amount.

*The Allowed Amount is the most that we will pay for Covered Benefits minus your Member Cost-sharing.

Provider Directory

To find if a provider is in the Network, please visit Member.MGBHP.org and go to Find doctors & care. You can search for Providers by name, location, specialty, gender, languages spoken, and hospital affiliation.

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

National Coverage

The plan gives you coverage wherever you go in the U.S. You may access the Provider Directory at Member.MGBHP.org to find In-Network Providers by state or contact Customer Service for help in finding In-Network Providers nationwide.

Information about Providers

Details about physicians licensed to practice in Massachusetts is available from The Board of Registration in Medicine. Visit the Board of Registration in Medicine at mass.gov to find your physician's education, hospital affiliations, board certification status, and more. You can find information about nurse practitioners at the MA Division of Health Professionals Licensure website at mass.gov/nursing-licenses and Physician Assistants can be found at mass.gov/physician-assistant-licenses.

The websites below include information for 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)—** jointcommission.org/en-us/accreditation (for information that allows you to compare quality of care at hospitals, home care agencies, laboratories, nursing homes, and behavioral health programs)

For information about us, 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:

- Information rating insurance plan Members' satisfaction about the quality of covered health care services offered by the health plan;
- Data on physicians whose contracts ended with a health plan during the last calendar year;
- The percentage of Premium revenue used for health care services. The data is for the most recent year for which information is available;
- A report, for the previous calendar year, of Grievances and Appeals by the health plan.

Member Portal

Visit Member.MGBHP.org (Member Portal) to register and log into your 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 pre-existing condition limitation or waiting periods when you enroll with us. See your employer group's Benefit Administrator for questions about a waiting period before you enroll with the plan. The plan does not use the results of genetic testing in making any decisions about enrollment, renewal, payment or coverage of health care services and we do not consider any history of domestic abuse or actual or suspected exposure to diethylstilbestrol (DES) in making such decisions.

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

We will mail you a Member ID Card upon receipt of a completed enrollment transaction. Use the Member ID card to access covered services. The plan will not cover 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 you are enrolling through your employer's group plan.

The Service Area consists of the state of MA.

Subscriber Eligibility

Eligible Subscribers must:

- Be an Individual who lives and has a permanent residence in the Service Area
- Be an employee of a sole proprietorship, firm, corporation, partnership, or association actively engaged in a business that is based within the Service Area, and:
    - Enrolled through an employer group that is up-to-date in the payment of premiums for coverage
    - Meet all eligibility guidelines approved by the employer and the plan
    - Reside in the United States except Puerto Rico.

Dependent Eligibility

The plan will cover Dependents, Dependents that must meet one of the following:

- The Subscriber's legal spouse. A legal spouse is a same sex or opposite sex spouse of the Subscriber who has a legally valid marriage or civil union in a district where such marriage or civil union is legal. We recognize same sex spouses and partners in a civil union per the plan sponsors eligibility policies.
- The former spouse of a Subscriber, until the Subscriber or the former spouse remarries or until such time as stated 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 where legal

adoption proceedings have started), under custody due to a court order, or under legal guardianship. We cover until the age of twenty-six (26) in accordance with the Patient Protection and Affordable Care Act.

- A foster child who has been living in the home 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. Coverage ends when the parent of such child is no longer an eligible Dependent of the Subscriber or Subscribers' spouse.
- Children with the right to enroll under a qualified medical child support order are eligible for coverage up to the Dependent's 26th birthday.
- An enrolled mentally or physically disabled child incapable of earning his or her own living under the Subscriber's plan even after he or she would otherwise lose dependent eligibility. Dependents at age 26 mentally or physically incapable of earning their own living may be eligible for handicapped dependent coverage.

Contact us for the Handicapped Dependent Application to apply . We will review the 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 group's records, including payroll records, to verify eligibility and premium payments.

Status Changes

Your are responsible to notify your plan sponsor about any changes that may affect eligibility for coverage. This includes:

- An addition to the family
- The marriage of a Dependent
- Address change

- Death of a Member
- Change in marital status

Call your employer group's Benefits Administrator or Plan Sponsor to make changes or correct your address and telephone number. We must have your current address and telephone number on file so that we can contact you when necessary and to correctly process Claims.

Effective Date

Eligible individuals of a qualified MA 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 ends.

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 enrolled through an employer group may end 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 not to renew a Member's coverage if they do not meet the eligibility requirements. We will notify the Subscriber in writing if coverage ends for loss of eligibility. They may be eligible for continued coverage under federal or state law, if membership terminates. See "Continuation of Employer Group Coverage" for more information.

Membership Termination for Cause

The plan may end or not renew a Member's coverage 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 members covered through a qualified MA 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 MA Small Group Continuation Coverage Law, you also have the right to continue your policy in the following circumstances and eligible members who were covered through a qualified Massachusetts employer group of twenty (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 active on the plan on the day before coverage ends due to one of the events noted below, coverage may 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 or until the employee does not have to by law supply 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 spouse may be bound 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 extend beyond the applicable time allowed under federal law. The size of your employer group will decide whether you select your continuation of coverage rights under state or federal law. Please also note that we may not have current information concerning Membership status. Employer groups may let us know of Enrollment changes retroactively. Only your employer group can confirm Membership status.

Individual Coverage

If your coverage ends, you may be eligible to enroll in an individual plan we offer. The Benefits and premium amounts for these plans may not be the same as what you have under the coverage provided under your employer. For more information 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 information about you and your Benefits. It informs Providers and pharmacists that you are a Member and how much your Cost-sharing for certain services should be. Other 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 our Member Portal. 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 Provider (PCP)

You do not have to choose a PCP to manage your care. However, the plan encourages you to choose a PCP from the online Provider Directory on our Member Portal to help coordinate your care. You may choose any Provider to provide your care. However, your choice of Provider is important because it impacts your out-of-pocket costs. Your out-of-pocket costs will be less when you see an In-Network Provider. If you choose an Out-of-Network Provider for your care, you will pay more out-of-pocket.

In-Network Care

To get care from an In-Network Provider, use the online Provider Directory on our member portal to search for In-Network Providers. You can search for Providers by name, gender, specialty, hospital affiliation, languages spoken, and locations.

In-Network Providers are under contract to provide care to Members of this plan. Members should contact the Provider to verify their status. Members are responsible for telling Providers that they are members of the plan and show them their ID card before getting services.

Out-of-Network Care

Out-of-Network Benefits are when you get care from Out-of-Network Providers. Your out-of-pocket costs are higher for Out-of-Network services. However, you have more options in getting care and may go to the Provider of your choice.

Some Out-of-Network Benefits require prior approval by the plan. Please see "Section 4: Prior Authorizations (Prior Auth)" for these requirements. To request Prior Auth for medical and surgical services, please call Customer Service at 866-414-5533 (TTY 711). To request Prior Auth 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 with certain Out-of-Network Providers, there is no limit on what certain Out-of-Network Providers can charge. You have to pay 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: Financial Obligations."

You have the right to get help from the plan or Optum if your PCP or Treating Provider has a hard time finding an In-Network Provider for covered services. Please call Customer Service for assistance. Upon your request, the plan or Optum will confirm the availability of these services and, if needed, will arrange and pay for covered Out-of-Network services at In-Network cost sharing 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*. We will cover care in an Emergency.

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

An Emergency is a medical condition, whether physical, behavioral, related to substance use disorder, or a mental disorder, with symptoms of sufficient severity, including severe pain, that if you don't receive 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. For a pregnant woman who is having contractions, an emergency also

includes having inadequate time to safely transfer to another hospital before delivery or a threat to the safety of the member or her unborn child in case of transfer to another hospital before delivery.

You or your representative (such as another member of your family) must call your PCP for emergency medical conditions within 48 hours of any Emergency care. Notification by the attending Emergency physician to us or your PCP within 48 hours of receiving Emergency services will satisfy this requirement as well. Your Treating Provider will arrange for any follow-up care you may need. We will cover you for medical and transportation expenses incurred as a result of any such Emergency.

If you are admitted from an emergency visit, your Treating Provider or the Hospital Emergency department must tell the plan within 24 hours of admission.

We may require a Hospital Emergency department to contact a physician on-call chosen by us, Optum, or its designee for Authorization of post-stabilization services. The Hospital Emergency department shall take all reasonable steps to contact us, Optum, or its designee within 30 minutes of stabilization. We will approve the Authorization if we, Optum, or its designee did not respond 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, if that treatment is consistent with general accepted principles of professional medical practice and is a Covered Health Care Service under this 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. You can find an In-Network Urgent Care Provider, by using the online Provider Directory on our Member Portal 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 is not limited to fever, sore throat, and earache.

Behavioral Health Hospital Care

If you need immediate Inpatient hospital, call 911, go to the nearest emergency room, or contact the Community Behavioral Health Center in your area. A clinician at the Community Behavioral Health Center or the Emergency room will screen and evaluate you for potential admission. See your Provider Directory for a listing of Community Behavioral Health Centers and Emergency Rooms. Or you can call your PCP, Treating Provider, or Optum's Clinical Department at 1-844-451-3518 (TTY 711).

Intermediate or Diversionary Services

"Section 7: Behavioral Health Services" has detailed information on Behavioral Health services that we cover and how to access these services.

In addition to traditional outpatient services (including individual, couples, family, group counseling and medication management), diversionary services are available to our Members. Diversionary 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 help 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 Optum at 1-844-451-3518 (TTY 711).

Structured Outpatient Addiction Programs (SOAPs) give short-term, clinically intensive structured day and/or evening addiction treatment services, usually given in half- or full-day units, up to six (6) or seven (7) days per week. This

program is to enhance continuity for Members when 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 Provider or a covering Provider will be available to direct your care. Talk to your Provider to find available 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 (7) 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 the Community Behavioral Health Center in your area at once, or go to the nearest Emergency room.

Family Planning Services

Family Planning Services include birth control methods, exams, counseling, pregnancy testing, and certain 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 services to help you have a healthy pregnancy and a healthy baby. If you think you might be pregnant, call your family doctor or PCP. Your provider will schedule an appointment for a pregnancy test. If you are pregnant, your PCP will arrange your maternity care with an obstetrician or nurse midwife.

You will have regularly scheduled 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 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 started by calling Customer Service at 866-414-5533. More details about Prior Approval is in "Section 4: Prior Authorizations."

Transplants

These services are covered at the In-Network Benefit level when you get them from an In-Network Provider. In order to receive In-Network Benefits f, you must get the care at an In-Network facility. If you choose to get treatment at a facility that is not In-Network, then your coverage will be at the Out-of-Network Benefit level. For more details, contact Customer Service.

Concierge Services

Certain physicians charge an annual fee to patients as a condition to be part of their panel of patients and to receive special customer service from the provider (e.g., access to the provider's cellular telephone, more personalized service). For Members who use physicians who provide additional customer service for a fee (also known as concierge service) 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 and we have separate contracts with them. Providers may not change the EOC or create or imply any obligation for us. We are not liable for statements made by Network Providers, their employees, or agents. We do not 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 you accessed the directory. For the most up-to-date information on Network Providers, refer to our online Provider Directory on our Member Portal.

Continuity of Medical Care and Behavioral Health Care

We will cover Health Services from a Provider (including Nurse Practitioners and Physician Assistants) who is not participating in our Network in the following instances:

- We will cover up to ninety (90) calendar days from the Effective Date of coverage if you are 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. For a Member in her second or third trimester of pregnancy, this applies to services received through the first postpartum visit by the Provider caring for her pregnancy. For a Member with a terminal illness, this applies to services received until death.
- We will cover up to ninety (90) calendar days if your Provider has been disenrolled from the network, for reasons unrelated to quality of care or fraud, if they are providing you with active treatment for a chronic or acute medical condition or until you complete that active treatment, whichever comes first. This coverage will continue for a pregnant Member who is in her second or third trimester through the first postpartum visit. This coverage will continue through the Member's death for a Member who is terminally ill.

To continue care in the above situations, the Provider must adhere to our quality assurance standards and give us the necessary medical information related to the care you get. The Provider must adhere to our policies and procedures, including procedures about Prior Authorizations and providing services per a treatment plan, if any, approved by us. If the Provider is disenrolled, they must also agree to accept reimbursement from us at the rates applicable prior to notice of disenrollment as payment in full and shall not to impose cost-sharing with respect to the Insured in an amount that would exceed the cost-sharing applied 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 service. If you have any questions, please call Customer Service.

Section 4.

Prior Authorizations

A Prior Authorization (Prior Auth) is an approval by Mass General Brigham Health Plan or our delegated vendors (collectively referred to as 'we' or 'us') for coverage of certain services. Not all services require Prior Auth. For services that require a Prior Auth, you must get the approval before you receive the service. Your In-Network Provider will request a Prior Auth from us if it is necessary. If you get care from an Out-of-Network Provider, you must get the necessary Prior Auth. Examples of services that may require Prior Auth are surgical procedures and elective admissions, Inpatient psychiatric care, and so forth. We give Authorizations as soon as possible.

We make decisions within two (2) **business** days after all necessary information and no longer than fourteen (14) calendar days for initial or Prior Auth for a planned elective admission, procedure or service. We will inform Providers of the decision verbally within 24 hours of the decision. The plan will send the Provider and the Member written notice of the decision within one (1) business day of the verbal notice for denied or reduced Benefits (an "Adverse Determination"), and within two (2) business days for approvals.

We make urgent initial Authorization decisions within 72 hours/three (3) **calendar** days of receipt of the request. We will inform Providers of the decision within 24 hours. We will send the Provider and the Member written notice 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 during non-business hours (e.g., home skilled nursing) require notification by the next business day.

We will make Concurrent Authorization decisions categorized as urgent within 24 hours. We will make Concurrent Authorization decisions categorized as non-urgent within one (1) business day of obtaining all necessary information and no longer than fourteen calendar days. We will inform Providers verbally of an urgent decision within twenty-four (24) hours and one (1) business day for non-urgent requests. We will send written or electronic confirmation of approval 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, we will send written notification to the Provider and Member within one (1) business day thereafter.

Once we review 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 say the service(s) the plan has approved for coverage. Before you receive any service(s) requiring Authorization, you must have this Authorization letter. If your Provider feels that you need a service(s) beyond those authorized, he or she will ask for Authorization directly from us. 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 a portion of the services, or do not authorize the full amount, duration or scope of services requested, we will send you and your Provider a denial letter. We will not pay for any services not authorized. We 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 Auth Requirements

This section explains when you need a Prior Auth and the process to meet the requirements to get 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, you will not be covered and you may have to pay for the entire cost of the services.

When Prior Auth is Required

Prior Auth is required before receiving specific medically necessary covered services. Providers and facilities in the Network are required to get Prior Auth for you. If you visit an Out-of-Network Provider, it is your responsibility to get the Prior Auth. The Out-of-Network Provider may seek Prior Auth on your behalf. Whether you visit an In-Network or Out-of-Network Provider, it is 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 Auth, please contact Optum at 1-844-451-3518 (TTY 711).
2) For a list of medical and surgical services that require a Prior Auth, go to the Member Portal or call Customer Service. Please visit this site often as services can be added and updated to the list at any time.

How to Obtain Prior Auth

To seek Prior Auth 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 Auth for Behavioral Health services. The below information must be given at least ten (10) business days prior when seeking Prior Auth for 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

For Inpatient admission to an Out-of-Network Provider, the below 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 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 Auth on Coverage

If you obtain Prior Auth and get approval from us, the plan will pay for services authorized per this Member Handbook and your *Schedule of Benefits*. However, if you do not obtain Prior Auth or receive approval from us when required, you will not be covered you may have to pay for the entire cost of these services.

Non-medically Necessary Services

If we determine at any point that a service was not Medically Necessary, you will not be covered for these services, and you will have to pay the entire cost of these services.

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

If we deny a coverage request, we will send you written notice that explains the decision, your Provider's right to get reconsideration of the decision, and your appeal rights. "Section 15: Utilization Review and Quality Assurance" has more information on the time limits for Prior Auth decisions and the process for Providers if coverage is denied. "Section 14: Complaint and Grievance Process" has details of your appeal rights if coverage is denied by us.

Major Disasters

We will try to provide or arrange for services in the case of major disasters such as 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 work hard to provide a high quality and cost-effective pharmacy benefit for our members. Your plan includes a variety of prescription drug programs to help make paying for your medications and premiums more affordable. The pharmacy benefit puts all covered drugs into tiers. Depending on your plan, you may have three, four or six tiers. Drugs are in the three, four, or six tier structures as described below. Cost-sharing (e.g., Copays, Deductibles and/or Coinsurance) applies to each tier and is in your *Schedule of Benefits*. More information about your financial obligations is in "Section 12: Financial Obligations."

4 Tier Placement

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

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6 Tier Placement

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

Each tier has a level of cost sharing. The amount you have to pay may be a Copay, Deductible, Coinsurance, or a combination of these. Your *Schedule of Benefits* tells you the amounts you have to pay. Sometimes, your cost sharing responsibility is just a part of the total cost for a prescription.

The plan covers the list of medicines in the Drug List. Doctors and pharmacists have reviewed the drugs for safety, quality, effectiveness, and cost. You can find the tier of your drug in the searchable Drug Lookup Tool on our Member Portal.

Copayments
Copayments are fixed dollar amounts you must pay for covered drugs. You will pay Copayments to the pharmacy at the time of purchase. Your copayment amounts are on your Schedule of Benefits.

Coinsurance
Coinsurance refers to a percentage of the cost of the drug that you must pay. The coinsurance percentage is listed in your Schedule of Benefits.

Deductibles
Your plan may have a Deductible. A Deductible is the amount you must pay for certain covered services before we begin to pay. If a Deductible applies to your plan, 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 it applies to. The applicable Copay or Coinsurance amount applies after you meet the Deductible.

Out of Pocket Maximum
This is the most you will have to pay each Benefit Period and includes the Deductible, Copay and Coinsurance amounts you paid. Some plans may have separate amount of drugs. Your *Schedule of Benefits* tells you if you have a combined medical and pharmacy maximum or a separate pharmacy maximum amount.

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 our plan.

Certain drugs need an Authorization (Auth). Your Provider can ask for an Auth so you can have the prescriptions you need. For a listing of pharmacies or if you have any questions about which drugs need an Auth, visit our Member Portal, or call Pharmacy Customer Service at 866-414-5533 (TTY 711).

Self-Injectable/Administered Drugs

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

Mail Order Pharmacy

For members who prefer the convenience of receiving drugs through the mail, certain maintenance drugs (like for asthma, blood pressure, high cholesterol, and arthritis) are available through our pharmacy vendor. This gives members a 90-day supply of prescription drugs at a reduced cost. To find out your cost sharing, see your *Schedule of Benefits*.

To order your prescriptions through the mail, please visit our Member Portal to download the registration form. Members only need to complete the form once. You may refill orders by calling Pharmacy Customer Service at 866-414-5533 (TTY 711).

Access90

Access90 gives members a 90-day supply of certain maintenance medications when bought through participating pharmacies. For a list of pharmacies, log into our Member Portal. Members get a 90-day supply of most prescription medicines at a reduced cost.

Over-the-Counter Drug Benefit

We cover certain over-the-counter (OTC) medications (including cough, cold, and allergy) through the pharmacy benefit with a valid prescription from your doctor. You may receive some of these drugs for up to a 90-day supply. Your cost may vary depending on drug prescribed.

Go to our Member Portal for a complete list of the OTC drugs, cost amounts and quantity limitations.

Quantity Limit

The plan may limit the number of units for a specific drug you may receive in a given time period to ensure safe and proper 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 you buy the prescriptions bought.

Mandatory Generic Policy

The plan has a mandatory generic policy and requires a generic version of a drug before we will cover the brand name

drug is. A generic drug is the same drug and works in the same way as the brand name drug. Generic drugs are approved by the US Food and Drug Administration (FDA) as safe and are the equivalent of the original brand name drug. In addition, there are usually multiple manufacturers of a generic drug that may result in a lower cost compared to the branded alternative. You need a Prior Auth for an exception to our mandatory generic drug policy.

If you have already tried a generic equivalent, and wish to appeal the mandatory generic policy, you may call Pharmacy Customer Service. Some exceptions may apply.

Prior Authorization (Prior Auth)

You will need a Prior Auth for some drugs. A Prior Auth is where we do a clinical review. The review applies criteria approved by the plan's Pharmacy and Therapeutics Committee of physicians and pharmacists and helps to assure the safe, effective, and correct use of a drug. The criteria are based on clinical studies and standards of care. The Prior Auth process may delay you being able to fill the prescription until the clinical review with all required information from your Network Provider happens. The clinical review decision is made within two (2) **business** days of obtaining all necessary information and no longer than fourteen (14) calendar days.

Exception Requests for Non-Formulary Drugs

Members, their authorized representative on file, or Network Provider may ask that we do a review, within 72 hours, in order to make a coverage decision for a non-formulary drug. The plan will give the Member, their authorized representative, and Provider notice of the decision for the non-formulary drug within 72 hours. We will decide to cover or not the non-formulary drug within 24 hours if you request an expedited review process due to an exigent (emergent) circumstance.

To start the review process, a Member, their authorized representative, or Provider must call Pharmacy Customer Service at 866-414-5533 (TTY 711) and give us the following information:

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

We have online tools to help you understand your drug benefits. Visit our Member Portal for detailed information about your coverage, including a list of covered drugs, and whether any tier, restrictions or limits apply.

Grievance Review for Coverage of Non-Formulary Drugs

If we deny your first request for coverage of a non-formulary drug, you have the right to submit a Grievance to us. You may request in your Grievance for a coverage determination by us 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 us or an IRO decide on your Grievance.

The plan will send notification of the coverage determination for the non-formulary drug within 72 hours of your request. If you request an expedited review process due to an exigent (emergent) circumstance, we will send notification of the coverage determination for the 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 Auth criteria for certain drugs. Members who qualify for this program get immediate coverage without the need for a clinical review based on the drugs already filled through the plan. For more information, call Pharmacy Customer Service.

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

Specialty Pharmacy Program

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

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

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

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

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

Limitations

There are certain drugs that are either not covered or have limited coverage. 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. We will not cover the following drugs or services:

- 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 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**
- We will not cover the brand name equivalent, if an FDA approved generic drug is available, 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 applies 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 given by any other Drug or Medical service for which no charge applies to the Member
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one (1) 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 our Member Portal. Please refer to your *Schedule of Benefits* as there may be more exclusions applicable to your specific plan design.

*Covered in certain circumstances under the Durable Medical Equipment (DME) Benefit.

**Covered in certain circumstances under medical Benefit.

***Some exceptions may apply.

Section 6.

Your Covered Health Care Services

The Affordable Care Act ensures Americans have access to quality, affordable health insurance. As a result, the plan must follow certain requirements if your employer covers benefits if any of these ten categories. See your *Schedule of Benefits* to find your exact benefits under these 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

For the plan to cover these services, all services and supplies must be:

- Given by a licensed health care Provider
- Authorized by the plan when required. For more information on Prior Auth requirements, check with your Treating Provider or call Customer Service. You should always check with your Treating Provider to make sure that any required Notifications or Prior Authorizations are in place before receiving the services or supplies. If you do not obtain necessary Notifications or Prior Auth for Out-of-Network care, you may have to pay for those services.
- Medically Necessary, as defined in this handbook and clarified in our medical policies.
- Listed as a Covered Health Care Service in this handbook.
- From a licensed health care Provider.
- For an eligible Member enrolled in the plan.

We are not responsible for paying any services before a Member's eligibility date or after the disenrollment date. If you have questions about your Benefits, please call Customer Service.

Abortion and Abortion Related Care

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

Acupuncture

The plan may cover Acupuncture depending on your specific plan. See your *Schedule of Benefits* or call Customer Service.

Just a reminder: Your *Schedule of Benefits* tells you how much you must pay for covered services, in and out of network. It also tells you if there are any benefit limits that may apply to services. If you reach the limit for a covered service, we will not cover those services or supplies after you reach the limit.

Acute Hospital Care

The plan covers acute care Hospital services. Your Treating Provider must arrange for this.

Ambulance Transportation

The plan covers ambulance transportation, including air ambulance in an emergency. This includes transportation to the nearest Hospital that can give you the care you need. The plan does not cover this when you refuse to be transported. The plan covers non-emergency transportation when arranged by a Network Provider. We also cover transfer from one health care facility to another.

Ambulatory/Day Surgery

The plan covers outpatient surgery related diagnostic and medical services. Your Treating Provider must arrange for this.

Assisted Reproductive Services, Infertility, and Treatment for Infertility

Infertility is the condition of an individual who is unable to conceive or produce conception during a period of one (1) year if the female is age 35 or younger or during a period of 6 months if the female is over the age of thirty-five.

To meet the criteria for Infertility, the calculation of the 1 year or 6 month period, includes if a person conceives but is unable to carry that pregnancy to live birth and the period of time, she tried to conceive prior to achieving that pregnancy.

The plan will cover expenses for Assisted Reproductive Services including the diagnosis and nonexperimental treatment of infertility in the same way we provide for other services and prescription medications.

The plan covers the following procedures, but 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, when not covered by the donor's insurer, if any (not limited to sperm from the spouse)
- Assisted Hatching
- Cryopreservation of embryos, eggs, and sperm when the Member is undergoing authorized infertility services
- The plan covers cryopreservation of eggs and sperm when authorized for a Member undergoing a medical treatment that may result in infertility.

Just a reminder: Your *Schedule of Benefits* tells you how much you must pay for covered services, in and out of network. It also tells you if there are any benefit limits that may apply to services. If you reach the limit for a covered service, we will not cover those services or supplies after you reach the limit.

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 Spectrum Disorders and Applied Behavior Analysis

The plan covers the diagnosis and treatment of Autism Spectrum Disorders (ASD) when Medically Necessary. Diagnosis includes assessments, evaluations including neuropsychological evaluations, genetic testing, or other tests to diagnose whether an individual has ASD. ASD is 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.

The plan covers habilitative or rehabilitative care, pharmacy care, psychiatric care, psychological care, and therapeutic care. The plan covers services from 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 (ABA) supervised by a Board-Certified Behavior Analyst, which 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. ABA services are covered for members who have a diagnosis within the Autism Spectrum Disorders or other applicable diagnosis per Massachusetts State mandates, such as Down syndrome.

Pharmacy care are drugs prescribed by a licensed physician and health-related services to determine the need or effectiveness of the drugs. The plan covers this in the same way as pharmacy care for other medical conditions.

Therapeutic care are services from licensed or certified speech therapists, occupational therapists, physical therapists, or social workers. The plan covers the treatment of Autism Spectrum Disorder and does not affect an obligation to give services to an individual under an individualized family service plan, an individualized education program, or an individualized service plan. The plan does not cover services from 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.

Just a reminder: Your *Schedule of Benefits* tells you how much you must pay for covered services, in and out of network. It also tells you if there are any benefit limits that may apply to services. If you reach the limit for a covered service, we will not cover those services or supplies after you reach the limit.

Cardiac Rehabilitation

The plan covers multidisciplinary treatment of persons with documented cardiovascular disease, in either a Hospital or other setting that meets the standards set by the Commissioner of the Department of Public Health. Your PCP or Treating Provider must arrange for this.

Chiropractic Care

The plan covers Chiropractic care. See your *Schedule of Benefits* or contact Customer Service for visit limitations that may apply. Please see the medical policy at MGBHP.org for additional coverage details.

Cleft Lip and Cleft Palate Treatment for Children

The plan covers cleft lip and cleft palate treatment for children under the age of eighteen, including oral and maxillofacial surgery, plastic surgery, speech therapy, audiology, and nutrition services. The plan covers preventive and restorative dentistry and orthodontic treatment related to the treatment of cleft lip or palate. When dental and orthodontic services are available through us and a Member's dental plan, we may elect to coordinate Benefits. (See "Section 9: When You Have Other Coverage" for more information on coordination of Benefits.)

Clinical Trials

The plan covers Covered Health Services in this section if you take part in an approved clinical trial during the period of the clinical trial that you are active with our plan as long as you meet certain requirements.

Members must qualify to be part of an approved clinical trial for the treatment of cancer or other life-threatening medical condition. A network Provider must refer a member to the clinical trial or have medical and scientific information sent to us that the Member meets the conditions for participation in the clinical trial.

An approved clinical trial is one that is: (a) 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 does not cover 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 Auth is required.

Cytological Screening (Pap smears)

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

Dental Services (Emergency)

The plan covers emergency dental service for a traumatic injury to sound/natural and permanent teeth caused by a source external to the mouth. The services are available by a doctor in a hospital emergency room or operating room within 72 hours after the injury.

Just a reminder: Your *Schedule of Benefits* tells you how much you must pay for covered services, in and out of network. It also tells you if there are any benefit limits that may apply to services. If you reach the limit for a covered service, we will not cover those services or supplies after you reach the limit.

Dental Services (Other)

The plan covers the extraction of impacted wisdom teeth when we decide that the Member has a serious medical condition and makes it necessary for the Member to be in an acute care hospital or surgical day care setting to do the extraction safely. You will need a Prior Auth.

Diabetic Services and Supplies

The plan covers services and supplies used in the treatment of insulin-dependent, insulin-using, gestational and non-insulin dependent diabetes. The plan covers this when prescribed by an authorized health care professional. The plan covers the following services and supplies:

- 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.

Your *Schedule of Benefits* tells you how much you have to pay and any limits for services. Durable medical equipment noted above will take Diabetic Supplies cost-sharing. Prosthetics will take Durable Medical Equipment cost-sharing. When diabetic medications, continuous glucose monitors/supplies, and insulin pumps/supplies are available through the pharmacy benefit, applicable cost sharing and/or restrictions may apply.

Dialysis

The plan covers kidney dialysis Inpatient, Outpatient, or at home. You must apply for Medicare when federal law allows Medicare to be the primary payor for dialysis. When Medicare is primary or had the Member been promptly enrolled, would be primary the plan will pay for services only to the extent payments would exceed what would be payable by Medicare. Your Treating Provider must arrange for these services.

Disposable Medical Supplies

The plan covers supplies that meet a medical or surgical purpose and are non-reusable and disposable. This includes hypodermic syringes or needles. Your Treating Provider must order these.

Durable Medical Equipment (DME)

The plan covers equipment for a medical purpose and is not useful in the absence of illness or injury. It also must withstand repeated use over an extended period of time; and is appropriate for home use.

The plan covers the purchase, replacement parts, and repairs. Your Treating Provider must order these. Examples of equipment not covered is an assisted listening devices, power wheelchair and/or accessories and components when used for community mobility only, exercise equipment that is for a professional setting and not needed for home use and includes Functional Electrical Stimulation, physiotherapy equipment and foot orthotics except for children fifteen and under with symptomatic flat feet and pronation.

Just a reminder: Your *Schedule of Benefits* tells you how much you must pay for covered services, in and out of network. It also tells you if there are any benefit limits that may apply to services. If you reach the limit for a covered service, we will not cover those services or supplies after you reach the limit.

Early Intervention Services

The plan covers services for Members under the age of three (3) when criteria is met. These may be available by early intervention Specialists who are working in early intervention programs approved by the Massachusetts Department of Public Health.

The plan covers Early Intervention Applied Behavioral Analysis (EI-ABA) as part of an Early Intervention (EI) plan for children, up to age three years, who have a diagnosis within the Autism Spectrum Disorders or other applicable diagnosis per Massachusetts State mandates, such as Down syndrome, and are currently receiving services through an Early Intervention provider. EI-ABA services are rendered by a qualified Massachusetts Department of Public Health (MDPH) Specialty Services Program (SSP).

Please visit Optum's public.providerexpress.com/content/ope-provexpr/us/en/our-network/welcomeNtwk/wMA.html and click on Provider Manual Addendum for Prior Auth requirements and click on Clinical Criteria for medical necessary criteria.

For the most current medical necessary criteria for Early Intervention Services, please visit MGBHP.org/providers/medical-policies.

Emergency Services

The plan covers Emergency services including ambulance services for transportation to the nearest hospital that can give you the care you need. The plan will cover these 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. You can find a list of In-Network Ophthalmologists or Optometrists in the Provider Directory which you can access on your Member Portal. The plan does not cover eyeglasses or contact lenses (except 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 consults, exams, procedures, and other medical services on an outpatient basis and related to the use of FDA-approved contraceptive methods. This includes to lab tests, birth control counseling, pregnancy testing, voluntary sterilization, IUDs, diaphragms, and Norplant. You can get these from your PCP, OB/GYN, Planned Parenthood, or any other Provider who have them.

Fitness Programs

The plan may cover Fitness programs depending on your specific plan. See your *Schedule of Benefits* or call Customer Service.

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Gender Affirming

The plan covers these services and includes facial feminization/masculinization, breast reconstruction surgery/mastectomy, and cryopreservation of eggs/embryos, and sperm. For a more complete list of Covered services, please see the Gender Affirming medical policy at MGBHP.org.

Gynecologic/Obstetric Care

The plan covers these services. Prior Auth is not required for routine care but may be needed for other services. We do not change higher Copays, Coinsurance, Deductibles, or other cost-sharing for these services.

Habilitation Services

The plan covers these for members with certain conditions. See your *Schedule of Benefits* for benefit limits.

Hearing Aids for Children

The plan covers hearing aids for children 21 years old or younger, including the first 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 limit. The plan does not cover batteries and assistive listening devices.

Hearing Examinations

The plan covers exams and evaluations performed by a hearing Specialist. Before discharge from the hospital, the plan covers the cost of a newborn hearing-screening test.

HIV-Associated Lipodystrophy Treatment

The plan covers medical or drug treatments to correct or repair disturbances of body composition related to HIV-associated lipodystrophy syndrome when approved by us. The plan covers reconstructive surgery, such as suction assisted lipectomy, approved 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. The plan covers Home health care services in a patient's residence by a public or private home health agency. This includes nursing, Physical, Occupational, and Speech Therapy, medical social work, and nutritional consultation, home health aide services and the use of DME and supplies.

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 these services.

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Hormone Replacement Therapy

The plan covers therapy services including outpatient prescription drugs for peri- and post-menopausal women in the same way as for other outpatient services and prescription drugs. See "Section 5: Pharmacy Benefit" for more information.

Hospice

The plan covers terminally ill Members with a life expectancy of six months or less, when services are appropriate and approved by the Treating Provider. These are the same as services from a licensed hospice program regulated by the Department of Public Health.

House Calls

The plan covers house calls. Providers include Physicians, Nurse Practitioners and Physician Assistants. Your Treating Provider must arrange for these.

Immunizations and Vaccinations

The plan covers these, including travel vaccines with no cost or dollar limits with a Network Provider.

Laboratory Services

The plan covers the diagnosis, treatment, and prevention of disease and for the maintenance of the health of the Member. The plan covers these when ordered by your Treating Provider from a licensed laboratory.

Long-Term Antibiotic Therapy for the Treatment of Lyme Disease

The plan covers long-term antibiotic therapy for a member with Lyme disease. Your Treating provider must arrange for this.

Mammographic Examination (Mammogram)

The plan covers preventive breast cancer screening by mammogram is covered, including 3D mammograms. Women must be age Forty or older. The plan also covers follow-up breast ultrasounds as preventive breast cancer screenings (instead of or in addition to a screening mammogram). The plan covers breast MRIs as preventive breast cancer screenings based on meeting criteria.

Maternity Services (General Coverage)

The plan covers prenatal care, childbirth, and postpartum care in the same way as medical conditions not related to pregnancy. The plan covers services from an obstetrician, pediatrician, or certified nurse midwife for the mother and child.

Maternity Services (Inpatient)

The plan covers services from an attending obstetrician, pediatrician, or certified nurse midwife for a mother and newborn child. The plan covers for at least 48 hours after a vaginal delivery or for cesarean delivery it is 96 hours. If the

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mother and doctor agree to an early discharge, the plan covers one home visit by a registered nurse, physician, or certified midwife. The plan may cover more home visits. Your Treating Provider, obstetrician, or certified nurse midwife must arrange for services. Coverage also includes the supply of pasteurized donor human milk and donor human-derived products.

Maternity Services (Outpatient)

The plan covers prenatal and postpartum care for Members. The plan covers prenatal exams, diagnostic tests, prenatal nutrition, health care counseling, risk assessment, and postpartum exams, including post-partum depression screenings. Routine prenatal care includes your visits to the provider managing your pregnancy and a postpartum visit. Your Schedule of Benefits tells you how much you pay for these services. All other services may be subject to cost sharing including labs, obstetrical ultrasounds, and other diagnostic tests.

Mental Health Wellness Exam

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

Newborn Care

The plan covers newborn care.

Non-durable Medical Equipment and Supplies

The plan covers equipment and supplies used in the course of diagnosis or treatment in a medical facility or authorized home care.

Nutritional Formulas

The plan covers nutritional formula as follows:

- 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 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.

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- 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, and so forth).
- Formulas for the treatment of pediatric Members diagnosed with failure to thrive
- 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 covers the use of off-label drugs in the treatment of cancer as it would for any covered prescription drug. The drug must be for treatment of cancer in one of the standard reference compendia, or in the medical literature, or by the Commissioner of Insurance. The plan also covers 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.

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

The plan covers the use of off-label drugs in the treatment of HIV/AIDS as it would for any covered prescription drug. The drug must be 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.

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

The plan covers the off-label use of drugs approved by the FDA in the treatment of Lyme disease. Your Treating Provider must arrange for this.

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 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. The plan covers Orthotics/Support Devices for feet including support devices for the feet and corrective shoes 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 us.

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Outpatient Surgery

The plan covers surgical procedures in an outpatient surgical setting. These services are subject to outpatient surgery cost sharing. The plan covers outpatient surgery in an office setting. These services would apply cost sharing based on the office setting, PCP or Specialty.

Oxygen Supplies and Therapy

The plan covers the rental and supplies required to deliver the oxygen. Your Treating Provider must arrange for this.

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

The plan covers the treatment and includes the use of intravenous immunoglobulin therapy.

Pediatric Specialty Care

The plan covers specialty care for children, including mental health care by providers with recognized expertise in specialty care for children.

Pharmacy

See “Section 5: Pharmacy Benefit”.

Physician Services

The plan covers the diagnosis, treatment, consultation, nutrition counseling, health education, and minor surgery when given by the Member’s Treating Provider.

Podiatry Services

The plan covers services with a doctor or licensed podiatrist.

Preventive Care Services and Tests

The plan covers preventive care services and tests for adults, women (including pregnant women) and children The plan covers as annual physical exam that is appropriate for the Member’s age and gender including, immunizations, well child visits and annual gynecological exams. The plan covers routine cytological screening (Pap smears) and mammographic examinations.

For a complete list of Preventive Care services, please visit our Member Portal or contact Customer Service.

Preventive services are from 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. Descriptions are from content on the healthcare.gov website.

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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: certain prosthetics may require a Prior Authorization. This includes prosthetic devices which replace in whole or in part, an arm or leg, and includes repairs. Your Treating Provider must arrange for this.

Psychiatric Collaborative Care

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

Radiation and Chemotherapy

The plan covers radiation and chemotherapy. The plan covers orally administered anticancer medication used to eliminate or slow the growth of cancerous cells in the same way as intravenously administered or injected cancer medications as medical Benefits.

Radiology

The plan covers radiological services including x-rays, MRIs, and CAT scans. Your Treating Provider must arrange for this.

Reconstructive/Restorative Surgery

The plan covers the procedure to repair, improve, restore, or correct bodily function caused by accidental injury, congenital anomaly or a prior surgical procedure or disease. The plan covers surgery for post-mastectomy of the impacted breast including:

- Reconstruction of the breast.
- 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 this.

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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 in a hospital. The plan covers when you need this care in an Inpatient setting. This care includes physical, speech, and occupational therapies. Your Treating Provider must arrange these services. See to your *Schedule of Benefits* for limits.

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

The plan covers the evaluation and restorative, short term treatment to improve the ability to perform activities of daily living when there will be significant improvement in the Member's level of function after illness or injury. This includes coverage for the treatment of members with Down syndrome. See your *Schedule of Benefits* for limits.

Second Opinions

The plan covers second opinions with another licensed physician on proposed treatment or diagnosis.

Skilled Nursing Facility Care

The plan covers admissions to a skilled nursing facility. The plan covers only when you need daily skilled nursing care or rehabilitative services in an inpatient setting. Your Treating Provider must arranged for these services. Please see your *Schedule of Benefits* for limitations on Skilled Nursing Facility Care.

Specialty Care

You may get specialty care from any licensed Provider and includes adult and pediatric specialty care. Specialty care for children includes mental health care and is available from Providers with expertise in providing specialty care for children.

Speech, Hearing and Language Disorders

The plan covers the diagnosis and treatment of speech, hearing, and language disorders by licensed speech-language pathologists or audiologists. The plan covers the services when given within the lawful scope of practice for speech-language pathologists or audiologists, regardless of whether they are available in a hospital, clinic, or a private office. The plan does not cover the diagnosis or treatment of speech, hearing and language disorders in a school-based setting. The plan covers these in the same way as any other Health Care Service from the plan.

Surgery

The plan covers surgery including related anesthesia. Surgery, including oral maxillofacial and reconstructive may require Prior Auth.

Just a reminder: Your *Schedule of Benefits* tells you how much you must pay for covered services, in and out of network. It also tells you if there are any benefit limits that may apply to services. If you reach the limit for a covered service, we will not cover those services or supplies after you reach the limit.

Telemedicine

The plan covers audiovisual visits through a national network of U.S. board-certified doctors 24/7 for non-emergency physical or mental health conditions accessed by smartphone, mobile device, or online via computer. Your provider may also offer this service. Doctors can diagnose and treat common illnesses. Member cost will depend on the type of services given as noted in your *Schedule of Benefits*. Telephone (voice only), facsimile or email communications with your provider are not telemedicine. To find a Telemedicine provider, visit our Member Portal or speak with your doctor.

Temporomandibular Joint Syndrome (TMJ) Services:

The plan covers the diagnosis and treatment TMJ caused by a specific medical condition. The plan covers the following medical services only:

- 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.
- 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

To get In-Network Benefits for Transplants, you must get care at an In-Network Provider. If you choose to get care at an Out-of-Network facility, you will get 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 us. This includes not limited to Members with breast cancer that has progressed to metastatic disease, if the Member meets criteria established by the Department of Public Health.
- Human organ transplants. Transplants must be non-experimental surgical procedures. This 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 us.
- The plan covers human leukocyte antigen testing for certain individuals and patients. The plan will cover 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. This 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.

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Urgent Care

The plan covers Urgent Care. Urgent Care does not include care in an emergency room or care that is elective, Emergency, preventive, or health maintenance. Examples of Urgent Care conditions include but not limited to fever, sore throat, earache, and acute pain.

Vision Care

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

Weight Loss Programs

The plan may cover Weight Loss programs depending on your specific plan. See your *Schedule of Benefits* or call Customer Service.

Wigs (Scalp Hair Prosthesis for Cancer Patients)

The plan covers 1 Wig per benefit period 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 may be required.

Section 7.

Behavioral Health Services

Behavioral Health Services (General)

The plan's Behavioral Health services help with help with mental health and substance use problems and includes inpatient (staying in the hospital), outpatient (office visit), and others. These services are based on what your doctor thinks is best for you. We will not apply any Copays, Deductibles, Coinsurance, or maximum lifetime benefits to Behavioral Health services when not equally applied to other Covered Health Care Services. You can find more details about your Behavioral Health benefits in your *Schedule of Benefits* or by calling Customer Service.

Optum is the group that manages Behavioral Health services for the plans. Only by the licensed mental health professionals can decide if you get these services or not. Optum has agreements with a network of providers, groups, and clinics, that offer Behavioral Health treatment.

You can use the Provider Directory on our Member Portal to find an In-Network Behavioral Health Provider, or you can call Customer Service to help find the services you need.

You will not need special permission from the plan for visits to a therapist or doctor for Behavioral Health Issues. This also includes treatment for Substance Use Disorder like outpatient treatment and program. The plan covers Acute Treatment Services and Clinical Stabilization Services for up to a total of 14 days without needing permission. When admitted, facilities should tell Optum within 48 hours and a review of your medical needs may start on the seventh day.

For the most up to date list of services that require a Prior Authorization, please visit Optum's public.providerexpress.com/content/ope-provexpr/us/en/our-network/welcomeNtwk/wMA.html and click on Mass General Brigham Health Plan's Provider Manual Addendum.

The plan covers the diagnosing and treating of Behavioral Health problems listed in the most recent *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and American Society of Addiction Medicine (ASAM) criteria. The type and amount of treatment you get will depend on what your doctor thinks you need, and you may need a Prior Auth. See "Section 4: Prior Auth" for details. You can find information about how much you will have to pay and any limits in your *Schedule of Benefits*.

The plan covers 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 when 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; as long as the 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 cover such Benefits to any adolescent who is engaged in an ongoing course of treatment beyond the adolescent's nineteenth birthday until completion of said course of treatment 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.

The plan cover Psychopharmacological and neuropsychological assessments when Medically Necessary.

If your Behavioral Health Provider is not part of the Network, you must contact Optum at 844-451-3518 (TTY 711) to get a Prior Auth for all services that require Prior Auth. See "Section 4: Prior Auth" for information. All Prior Auth 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, Applied Behavior Analysis providers, and recovery coaches. Members may directly contact In-network providers for these services for treatment. Please use the online Provider Directory at MGBHP.org on our Member Portal, to find a Behavioral Health Provider nearby. See your *Schedule of Benefits* for detailed 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, is in your *Schedule of Benefits*. Biologically-based mental health services are available 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 apply to covered medical services within the plan.

Services may be available 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, when with a licensed mental health professional acting within the scope of his or her license.

Behavioral Health Services (Intermediate)

The plan covers Medically Necessary Intermediate Behavioral Health services including:

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

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

Behavioral Health Help Line

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

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

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

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

Community Based Acute Treatment (CBAT)
Mental health services 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)
Gives 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. ICBAT may be an alternative to inpatient hospitalization for children and adolescents but is not 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 services given 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 give 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 limited to, teaching the child to understand, direct, interpret, manage, and control feelings and emotional responses to situations and assisting the family in supporting the child and addressing the child's emotional and mental health needs.

Intensive Care Coordination (ICC)
A collaborative service gives 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. The plan covers 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. This is based on a system of care philosophy and the individualized care plan is tailored to meet the needs of the individual. The plan covers both face-to face and telephonic meetings, as indicated and as clinically appropriate. ICC 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. The plan covers based on 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 for 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. The plan covers based, 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. The plan may also cover services in the community, to allow the youth to practice desired skills in appropriate settings.

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

To obtain services, call Optum at 1-844-451-3518 (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). You may also contact your PCP or Community Behavioral Health Center for assistance. Prior Authorization is not required for inpatient mental health or substance use services. You or your Behavioral Health Provider must, however, notify Optum of your admission within 72 hours. Biologically-based inpatient services are provided without annual, lifetime or day limitations.

Federal and State Mental Health Parity Laws

Federal and state laws require that all Managed Care Organizations, including us, cover mental health and substance use services to Members in the same way they cover medical/surgical Health Services. This is “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 cover 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 Auth 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 give you or your Provider a copy of the Medical Necessity criteria used by us for Prior Auth.
- Within a reasonable period, the plan must give you a written notice regarding any denial of Authorization for mental or substance use services. See "Section 15: 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 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 Us
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 Division of Insurance
You may submit complaints alleging a Carrier's non-compliance with the mental health parity laws verbally or in writing to the Division's Consumer Services Section for review. A written submission includes using the Division's Insurance Complaint Form. You can request a copy of the form by telephone or by mail, and the form can is on the Division's webpage at: mass.gov/how-to/filing-an-insurance-complaint.

You may submit consumer complaints regarding alleged non-compliance with the mental health parity laws by telephone to the Division's Consumer Services section by calling 877-563-4467 or 617-521-7794. You must follow up with a written submission for complaints made initially verbally by telephone 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 applied in a manner that considers the individual's Behavioral Health needs, and are otherwise compliant with applicable state and federal law.

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

Section 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

The plan does not cover ambulance costs to take you to a facility of your choice. The plan does not cover returning you to the United States from another Country, also known as repatriation or medical evacuation.

Benefits from Other Sources

The plan does not cover Health Care Services and supplies to treat an illness or injury for which you have the right to Benefits under government programs. This includes the Veterans Administration for an illness or injury related to military service. This also includes programs set up by other local, state, federal or foreign laws or regulations that give or pay for Health Care Services and supplies or that require care or treatment to be furnished in a public facility. The plan does not cover services if you could have received government Benefits by applying for them on time. This also includes services paid by a Workers' Compensation plan or an employer under state or federal law.

Biofeedback

The plan does not cover Biofeedback.

Blood and Related Fees

Blood or blood products except as specified under "Section 6: Your Covered Health Care Services."

Charges for Missed Appointments

The plan does not cover charges for missed appointments.

Concierge Services

The plan does not cover Concierge Services. Certain providers charge a fee to patients to be part of the physician's panel of patients and to receive special customer service from the Provider like access to the Provider's cellular telephone or more personalized service. The plan does not cover these fees.

Cosmetic Services and Procedures

The plan does not cover Cosmetic Services performed for the purpose of making you look better. Even if these services are meant to make you feel better about yourself or treat a mental condition. Examples are surgery to treat acne lesions or remove tattoos, and medications for cosmetic purposes to treat hair loss or wrinkles.

Custodial Care or Rest Care

The plan does not cover for Custodial or Rest Care. This is care furnished 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 cover 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 cover Dentures.

Diet Foods

The plan does not cover the purchase of special foods to support any type of diet.

Educational Testing and Evaluations

The plan does not cover these services except for services as part of Early Intervention, Mental Health, and Substance use care. This plan does not cover services intended to enhance educational achievement or to fix school performance problems.

Exams Required by a Third Party

The plan does not cover for physical, psychiatric, and psychological exams or testing by a third party. This includes employment, insurance, licensing and court-ordered or school-ordered exams, drug testing when not Medically Necessary evaluations for work-related performance.

Experimental Services and Procedures

The plan does not cover medical and behavioral health care services procedures, devices biological products, and drugs (collectively "treatment") when there is insufficient scientific evidence to support their use, except when the treatment is required by regulation. The plan does not cover even if it is a treatment available as a last resort.

Please refer to the following policies for more information:

For behavioral health services, visit: public.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/bh_Clinnical_Policies.html

For medical health services, visit: MGBHP.org/providers/medical-policies

As required by law, the plan does cover:

- One or more stem cell (bone marrow) transplants for a member 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.
- Patient care services furnished pursuant to qualified clinical trials intended to treat cancer or another life-threatening disease or condition.
- 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 cover eyeglasses or contact lenses. The plan does not cover eye surgery to treat conditions when available by means other than surgery. For example: the plan does not cover laser surgery for a conditions like nearsighted vision.

There is an exception to this exclusion. The plan does cover 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 cover routine Foot Care services like trimming of corns, trimming of nails and other hygienic care.

Hearing Aids for Adults Aged 22 and Older

The plan does not cover Hearing Aids for Adults Aged 22 and Older.

Long-term Care

The plan does not cover medical or behavioral health Long-Term Care.

Massage Therapy

The plan does not cover Massage Therapy.

Other Non-covered Services

The plan does not cover any service or supply not described as a Covered Health Care Services in this Member Handbook. Including, but not limited to:

- A service or supply that is not Medically Necessary.
- Facility 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 not be deemed 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 cover personal comfort or convenience items. The plan does not cover services for your personal care or for the convenience of your family. Examples of non-covered items or services include telephones, radios, televisions, and personal care services. The list includes but not limited to:

- 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 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 cover planned home births.

Private-duty Nursing

The plan does not cover private-duty nursing.

Reversal of Voluntary Sterilization

The plan does not cover the reversal of voluntary sterilization.

Self-monitoring Devices

The plan does not cover 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 cover a wilderness program when the program involves adventure, challenge experience or like activities in an outdoor setting.

Section 9.

When You Have Other Coverage

We coordinate benefits with other insurance coverage available that can pay for Health Care Services that a Member has received. The plan coordinates Benefits among Carriers to prevent duplicate payments for the same service.

This section does not cover any service or supply not expressly covered under this handbook or to increase the level of coverage.

Coordination of Benefits

We will coordinate Benefits under this Handbook to the extent allowed by law with other plans covering health Benefits including but not limited to homeowner's insurance, motor vehicle insurance, group and/or non-group health insurance, and governmental Benefits (including Medicare).

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 then reduced because of the primary plan's Benefits.

In the case of health Benefit plans that have provisions for the Coordination of Benefits, the following rules 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 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 Separated or Divorced

Unless a court order, of which hawse have 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 Our Coverage is Secondary

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

Worker's Compensation/ Government Programs

If federal, state, or other government agencies that cover these services, we may suspend payment for the services until it is determined whether the other program has to make payment or not. If we paid for services by these programs, we would recover our expenses from the Provider of services or the party or parties legally obligated to pay for such services.

Subrogation

The plan will subrogate our coverage when injured by an act or omission of another person. 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 payment for other than health care expenses. We will not reduce the amount you must reimburse us 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 services which we cover. You must not do anything that might limit our right to full reimbursement. The subrogation and recovery provisions in this EOC apply whether or not the Member recovering money is a minor. To enforce its subrogation rights under this policy, we 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 given 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 us in exercising its rights of subrogation and coordination of Benefits under the EOC. Such cooperation will include, but not 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 given or paid for by the plan
- The prompt notification to the plan of any instances that may give rise to our rights

The Member further agrees to do nothing to prejudice or interfere with the plan's rights to subrogation or coordination of Benefits. Failure of the Member to perform the obligations stated in this section shall render the Member liable to the plan for any expenses we may incur, including reasonable attorneys' fees, in enforcing its rights under this plan and without limiting Mass General Brigham Health Plan's 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

You must submit claims to Medicare before payment by the plan when you receive Covered Benefits that are eligible for coverage by Medicare as the primary payer. The plan will be liable for any amount eligible for coverage that not paid by Medicare. You shall take such action as 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 covers benefits to a Member for which the Member is eligible under Medicare, we request reimbursement from Medicare for such services. The Member shall take such action as 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, and so forth) professionals who have expertise helping individuals with a range of health care needs. We can give telephonic care management 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 covers care for Members who may have mental health and substance use concerns. We have delegated the plan's Behavioral Health Care Management program to 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

For members with complex care needs, we have care managers who will collaborate to develop a health and wellness action plan, give coaching and education, and collaborate with your Providers to coordinate your health care needs.

Coordinated Whole Health Care Management Program

The program offers child, adolescent, and adult members with complex behavioral or health related needs a collaborative, interdisciplinary team to reach their goals and increase their health and well-being. The team has independently licensed behavioral health clinicians, licensed nurses, and peer support specialists including community health workers and recovery coaches. The program features are:

- Working 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

Our Health & Wellness Coaches give telephonic health coaching to help members gain the knowledge, skills, tools, and self-efficacy to achieve their health goals. We use strategies such as motivational interviewing and goal planning. Health coaches help members achieve behavior change in a variety of health and wellness needs including healthy eating, weight management, physical activity, stress management, and prevention of chronic conditions including diabetes and heart disease. We use 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.

Our Disease and Condition Management Programs

Our programs give comprehensive support, education, and outcomes measurement for conditions and diseases that affect our Members. We identify Members with these conditions and offer the opportunity to participate in the program to meet the needs of individuals living with these conditions. Our Clinicians with expertise in these programs 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 collaborate with you and your health care Provider to develop a treatment plan that works for you. A respiratory therapist can 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 forms of lung conditions 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 gives. 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

This program is for members with diabetes and gives them extra care and education. Diabetes care managers will reach out to Members considered to be at-risk for diabetes-related complications and provide education and support.

Maternal & Child Health Clinical Nurse Specialist

This program is for members who are pregnant and gives them 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 certain 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

Members with CVD may be eligible for this program and helps 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 covers support to try to quit tobacco. Research shows that a combination of counseling and use of tobacco cessation drugs increases 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, you have the right to:

- Receive information about us, 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.
- 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 understood by you.
- 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 a straight forward 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 a change or correction, as explained in the Notice of Privacy Practices. The form is available at MGBHP.org under Member resources & forms. For your convenience, you may mail, fax or email your request as follows:

  Mail: Mass General Brigham Health Plan Customer Service Department
  399 Revolution Drive – Suite 820
  Somerville, MA 02145
  Email: MGBHPCS@mgb.org
  Fax: 617-526-1985

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

Your Responsibilities as a Member

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

- Tell health care Providers who are treating you that you are a our Member.
- Give complete and accurate health information that we or your Provider needs in order to give 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 care plans agreed to by you and your Provider.
- Understand your covered and excluded benefits.
- Call your PCP within forty-eight (48) hours of any Emergency visit or treatment by an Out-of-Network Provider. If you experienced a mental health or 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, and so forth.
- Understand that you may be responsible for payment of services you receive when 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
- Asked to give 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. The plan will reimburse your out-of-pocket cost minus any Member Cost-Sharing according to the plan enrolled in at the time of service. If you do pay for Emergency or Urgent Care while traveling 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:

- Member's full name
- Member's date of birth
- Member's identification number
- Date you received the health care service
- 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 will not 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 obtained in accordance with our policies.

Section 12.

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—** Copays are fixed dollar amounts due at the time of the service or when billed by the provider. Certain plans include Coinsurance is 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—**The amount you pay in a Benefit Period for a certain covered service before your health insurance plan starts to pay. After you have met your Deductible, you may have to pay a Copayment and/or Coinsurance. Plans may include a separate Deductible for prescription drugs.
- **Out-of-Pocket Maximum**—This is the most you will pay each Benefit Period and, includes Deductible, Copay and Coinsurance amounts you paid. 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

An Out-of-Network Provider may charge amounts in excess of the Allowed Amount. When this happens, you must pay the difference between what the Provider charges and the Allowed Amount. This means that you must pay the full amount above the Allowed Amount. Amounts charged by an Out-of-Network Provider above 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 need to pay for certain Out-of-Network services when a Prior Auth has not been received before getting services. The Penalty charge is in addition to any Member Cost-Sharing amounts. These charges do not count toward any Deductible or Out-of-Pocket Maximum. Please see “Section 4. Prior Authorizations” for information on the Prior Auth process.

Coverage Levels and Location of Service

If you are a new patient, it is your responsibility to know if a Provider you wish to see is an In-Network Provider and is accepting new patients. In-Network Providers meet our Provider quality standards and will work with us and Optum to help you get the care you need. If you have a Medically Necessary service at an In-Network Provider’s location but with an Out-of-Network Provider, you will not have to pay more than the cost-share amount for In-Network services. However, the plan may not cover the service if you had an opportunity to have the service 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 our Member Portal 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. We can give you a real time estimate 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 is an estimate based on what you gave us at the time of the request. It is our best effort to assist Members in what your Cost-Sharing may be prior to getting services and helping you talk with your Providers about your payment and treatment options. This estimate does not guarantee coverage or approval of services. The estimated amount may change due to certain factors, like, changes to your plan design; more Claims received for processing after providing the estimate; other services you received with these procedures; or changes to a Provider's contract with us.

Section 13.

Your Confidentiality and Privacy of Information

Confidentiality

We take protecting your personal and health information seriously. To help in keeping your privacy, we have the following practices:

- Our employees and contractors do not discuss your personal information in public areas.
- Electronic information is secure by using passwords, automatic screen savers and giving limited access to those employees with a "need to know."
- Written information is secure by storing it in locked file cabinets, enforcing "clean-desk" practices and using secured shredding bins for its destruction.
- All employees and contractors, during initial orientation, receive training on our confidentiality and privacy practices. Employees sign a statement that they have reviewed and agree to abide by our confidentiality policy during the employee's annual performance appraisal.
- All Providers and other entities with whom we need to share information must sign agreements that they agree to maintain confidentiality.
- We only collect information about you that we need to have in order to give you with the services you have agreed to receive by enrolling in the plan or as otherwise required by law.

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

Notice of Privacy Practices

This describes how we may use and disclose your health information, and how you can get access to this information. We provide 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 we may use and share your health information
- What your rights are regarding your health information

We may use or share your health information:

- When the U.S. Department of Health and Human Services needs it to protect your privacy
- 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
- If we contact you to raise funds for our organization, you have the right to opt out of receiving such fundraising communications.
- With entities that give services or perform functions on behalf of us (Business Associates), as long as they have agreed to safeguard your information

Please also note:

- When a federal or state privacy law gives stricter safeguards of your PHI, we 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.
- Certain uses and disclosures require your written authorization, including most marketing communications and any sale of your protected health information. Other uses and disclosures not described in this notice will be made only with your written authorization. You may revoke an authorization in writing; we will honor your revocation as provided by applicable law, but cannot undo uses or disclosures already made under your authorization.
- For purposes of underwriting, we cannot use or disclose 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 in a "designated record set." You must ask for this in writing. To the extent your information is in an electronic health record, you may be able to receive the information in electronic form. In certain cases, we may deny your request to see and get a copy of your health information. We may charge you to cover certain costs, such as copying and postage.
- Ask us 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. You may file a statement of disagreement with us that will be in any future disclosures of the disputed information if we deny your request.
- Ask us 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 us to contact you in another way, if you believe harm could come to you by us contacting you at the address or telephone number we have on file.
- Get a list of when and with whom hawse have shared your health information. You must ask for this in writing.
- 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 effective February, 16 2026 will remain in effect until we change it. By law, we must give you notice explaining that we protect your health information, and that we must follow the terms of this notice. We can change how we use and share your health information. If we do make significant 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 we have 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 hawse have 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

We 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.

If Mass General Brigham Health Plan receives or maintains any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, Mass General Brigham Health Plan may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us. To contact Customer Service, please call the number on the back of your member ID Card.

Section 14.

Complaint and Grievance Process

We try 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 give you 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 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
Attn: Member Appeals and Grievance Department
399 Revolution Drive, Suite 810
Somerville, MA 02145
Fax: 617-526-1980
email: healthplanappealsgrievance@mgb.org

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

We will ask for information about the Complaint, and work to solve the problem over the phone at the time of your call. If the Representative is not able to resolve the situation to your satisfaction at the time of your call, we make every effort to resolve your Complaint within three business days (called the "internal Inquiry period"). If we are unable to satisfactorily resolve your Complaint within three business days, we will, at your request, we will continue to investigate and resolve the matter through our internal Grievance process.

Grievances

If you are not satisfied with the way we 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. This is a request that we reconsider a decision or investigate a Complaint about the quality of care or services that you received or any part of the plan's administrative operations.

If your Grievance is about a decision, we have made to deny coverage of health care or services, you must file your Grievance within 180 calendar days of 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. Mutual written agreement between you or an Authorized Representative and us may waive or extend time limits. 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 choose an authorized representative such as a friend, relative, or health care Provider to be your representative during the Grievance process. This representative has the same rights and responsibilities as the Member.

Frequently Asked Questions about the Grievance Process

How do I file a Grievance?

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

The plan will send you a written acknowledgement of receipt of your Grievance within one business day. We will transcribe your Grievance if you telephone us or stop by in person, and a copy forwarded to you or your authorized representative within 24 hours (unless we agree to waive the time limit or extend it by mutual written agreement between you or your authorized representative and us). 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, by phone or electronically to initiate the Grievance process. (See address, telephone, email, and fax number above in "Complaints.")

How do I designate an Authorized Representative?

An Authorized Representative is anyone you choose to act on your behalf in filing a Grievance with us. An Authorized Representative can be a family Member, a friend, a Provider, or anyone else you choose. Your Authorized Representative will have the same rights as you do in filing your Grievance. If you wish to choose an Authorized Representative, you must sign and return an Authorized Personal Representative Designation Request Form to the plan. To get this form, please visit the forms section of our Member Portal.

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

You or your authorized representative may need to sign and return a release of medical information to us if your Grievance pertains to a decision the plan has made about your health care or services. We can send the form to you by email and is also available at MGBHP.org under Member resources & forms. You can return the form to us by mail, by fax or email to the addresses on the form.

We will request your medical information after receipt of all necessary releases. You or your authorized representative can access any medical information and records we have about the Grievance. We may ask you to give us a signed authorization to release your medical record to us. If you or your authorized representative do not give us this release within thirty calendar days from the date we received the Grievance, then we may resolve the issue of the Grievance without reviewing 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?

We may need to review your medical records to resolve your Grievance. The process would then start on the day after the Internal Inquiry period or sooner if you tell us that you are not satisfied with our response during the internal inquiry period.

Who will review my Grievance?

Someone who knows about the details of the Grievance will review it. Someone other than those not of the prior decisions will review your issue for an Adverse Determination. These individuals are practicing health care professionals in the same or similar specialty who typically treat the medical condition, perform the procedure, or give the same treatment that your Grievance is about.

How will the plan explain the decision on my Grievance?

When we send you a decision in writing, we include the details of the specific information considered and explain the basis for the decision. For an Adverse Determination, the decision will include the clinical justification consistent with accepted principles of professional medical practice, and will include:

- The date of service, Treating Provider, diagnosis and treatment codes and their meanings.
- The specific information upon which the adverse determination was based.
- The specific reasons the medical evidence fails to meet the relevant medical review criteria.
- Alternative treatment options covered by the plan, if any, and a list of Providers accepting new patients that offer the other treatment.
- Applicable clinical practice guidelines and review criteria.
- A summary of the reviewer's qualifications and a signed statement that they did not participate in previous reviews about the Grievance. We will note that they are also not under the supervision of the reviewer who made the Adverse Determination and had no conflict of interest in making the decision.
- The process for reconsidering the decision made by the plan and what you can do request an external review, an expedited review and to request continuation of services.

When will I hear 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 Grievance is about the termination of ongoing services, the disputed coverage or treatment will remain in effect, without liability to you, until we tell you or your authorized representative what our decision is as long as you filed your Grievance on a timely basis. For the services we approved at the time of their initiation, and as long as they did not end because your reached your coverage limit, then the continuation of coverage or treatment applies.

Reconsideration

The plan may offer you or your Authorized Representative a chance to reconsider a Final Adverse Determination when the medical information was:

- Received too late for us to review within the thirty calendar days' time limit
- Not received, but was going to be available within a reasonable time after the written resolution, or
- Offered by the Member or your Authorized Representative.

If you ask us to reconsider, we must agree in writing to a new time period for review that is no greater than thirty calendar days from when we agree 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

You can request an expedited Grievance review if you or your Provider believe your health, life, or ability to regain function may be at risk by waiting thirty calendar days.

We will review and expedited Grievance as soon as possible, based on the medical requirements involved but no later than seventy-two 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 automatically reverse the denial for services or durable medical equipment, until the outcome of the expedited internal appeal, within forty-eight hours of receiving written certification from the Member's provider. The clarification must state that the service or durable medical equipment:

- Is Medically Necessary,
- If denied would create substantial risk of serious harm and
- That the risk is so immediate that services or durable medical equipment should not await for the outcome of the normal appeal process. For durable medical equipment, the Treating Provider must also certify what the specific, immediate, and severe harm that will result if the equipment is not available within forty-eight hours.

Expedited Grievance Review for Persons Hospitalized

We will resolve a Grievance as quickly as possible. We will consider the medical and safety needs of the Member when hospitalized. We will give a written resolution before the Member leaves the hospital. During a Member's hospital stay, and only during hospitalization, a health care professional or a representative of the hospital may be the Member's Authorized Representative without written Authorization by the Member.

Expedited Grievance Review for Persons with Terminal Illness

We will give a resolution to the Member or Authorized Representative within five (5) business days from the receipt date of the Grievance for a Member with terminal illness. We resolve Grievances for urgently needed services, within seventy-two hours. If the Expedited Review process affirms the denial of coverage or treatment to a Member with a terminal illness, we will give the Member or their Authorized Representative, within five (5) business days of the decision:

- A statement, that includes the specific medical and scientific reasons for denying coverage or treatment, and
- A description of alternative treatment, services or supplies covered 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 let the Member, or their Authorized Representative request a conference. We will schedule the conference within ten days of receiving a request from a Member. We will have the conference within five (5) business days of the request if the Treating Provider determines, after consultation with our medical director or designee, and based on

standard medical practice, that the effectiveness of either the proposed treatment, services or supplies or any alternative covered by the plan would be materially reduced if not given at the earliest possible date.

At the conference, we allow attendance of the Member or Authorized Representatives, or both, as well as the Treating Provider or other Providers. A representative of the plan with authority to determine the disposition of the Grievance, will conduct the review.

Our Obligation to Timely Resolution of Grievances

If we do not act upon your Grievance within the prescribed period or the agreed upon extended period, the Grievance will be in your favor. Upon mutual written agreement between you or your Authorized Representative and us, we may grant an extension, if necessary, to complete the review of your Grievance.

Independent External Review

You have the right to apply for an independent external review with the Massachusetts Health Policy Commission's Office of Patient Protection (OPP) if you are not satisfied with the final outcome of review you received. The OPP gives an independent review of Grievances not resolved at the plan level to your satisfaction. They will review the Grievance to determine if the service or treatment in question is Medically Necessary and a Covered Service. 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 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 excluded in the Member Handbook or *Schedule of Benefits*
- Result from our issuance of a final decision of a Grievance, as long as 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 of payment or the Authorization for services will be issued by the plan
- Advise the Member of the name and phone number of the person at who will assist 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
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 and request for an internal expedited review at the same time.

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 request for an expedited external review must be 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 other good reason, 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. Through a multidisciplinary team approach to advocate for optimum standards of patient health, education, and safety. We are committed to providing quality care 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 give 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 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)

Certain services require a Prior Auth to ensure the efficient and appropriate use of covered Health Care Services. The provider obtains the Prior Auth before you receive the service. The plan or a designated Utilization Review organization makes decisions within two (2) working days of obtaining all necessary information, including any necessary evaluations and/or second opinions. We notify Providers and Members of the decision within twenty-four (24) hours. We send Providers and Members 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 medically necessary. We make concurrent review decisions within one (1) working day after receiving all required information. We inform Providers of the decision within twenty-four (24) hours of the concurrent review decision. We send Providers and Members 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.

We will continue services subject to concurrent review without liability to the member until we notify the member.

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. We will inform the Treating Provider of this opportunity within the written denial letter. The reconsideration process will occur within one (1) working day of the request from the provider and we will conduct the review between the Provider our 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 from us, please contact the Quality Services Department at 1-800-433-5556.

Development of Clinical Guidelines and Utilization Review Criteria

We utilize a nationally recognized criterion set from InterQual® to assess medical necessity for inpatient and outpatient services. For medical therapies not addressed by the InterQual® policy, we may develop evidence based medical polices to address these therapies. The plan creates Medical policy criteria developed 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 applied in a way that considers the member's health care needs and are compliant with applicable state and federal law.

We review our Medical policies once a year, or more often, as new treatments, and technologies become accepted medical practice.

We makes our Utilization Review criteria available on our Member Portal 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 give you applicable criteria and protocols within thirty (30) days of your request.

Optum makes their clinical policies available online at public.providerexpress.com/content/ope-provexpr/us/en/our-network/welcomeNtwk/wMA.html. 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 this technology on a case-by-case basis as well as on a Benefit level.

Decisions to approve the use of this 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 selected for review is based on actual or potential demand.

The Chief Medical Officer or Medical Director is responsible for making Medical Necessity decisions on urgent requests for the technologies not yet 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.

We incorporate these technologies 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. We will retrieve 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.

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, giving evaluation and withdrawal management, and may include biopsychosocial assessment, individual and group counseling, psychoeducational groups, and discharge planning.

Adverse Determination

A determination, based upon a review of information from 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 most 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 certain geographic area. The Allowed Amount for Out-of-Network Providers may be less than your In-Network's Provider's actual charge. If this is the case, you must pay the amount of the Provider's actual charge that is over 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 and 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 treats 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 give 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 Services

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

Behavioral Health Treatment

Mental health and substance use treatment.

Benefit

A specific area of plan coverage, such as outpatient visits or hospitalization, which make up the range of medical services available to Members. Also, a contractual agreement, specified in an EOC, determining covered services from 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.

Chronic Disease Management

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

Claim

An invoice from a Provider that describes the services for a Member or a request that qualifies as a claim under applicable law. All claim determinations (including claim appeal decisions) by the plan and/or Optum shall be final and binding in the absence of clear and convincing evidence that the determination was arbitrary and capricious.

Clinical Stabilization Services

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

Coinsurance

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

Community-based Acute Treatment

Defined as 24-hour clinically managed mental health diversionary or step-down services for children and adolescents available as an alternative to mental health acute treatment.

Community Behavioral Health Centers

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

- Routine and urgent outpatient services, including same-day evaluation and referral to treatment, evening and weekend hours, timely follow-up appointments, and evidence-based behavioral health treatment. Services may be 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 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 of your visit. A Covered Service may require other member cost-sharing (such as a Deductible and/or Coinsurance) before or after a Copayment.

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").

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 not 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 specified as a business day).

Deductible

The amount you 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 (EOC)

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

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 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 a family planning service but apply appropriate cost sharing based on where you obtain the service.

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, 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 is not 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 contracted with or a delegated entity and has agreed to give health care services to members of with an expectation of receiving payment, other than Coinsurance, Copays or Deductibles, directly or indirectly from us.

Health Care Services

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

Health Savings Account (HSA)

A Health Savings Account is a fund you can establish to pay for medical expenses associated with a 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 wearable aid or device, typically worn in the ear, which improves a Member's ability to hear sound. A hearing aid may include parts, attachments, accessories, and supplies. Hearing aid batteries are not part of the hearing aid Benefit.

High Deductible Health Plan

A High Deductible Health Plan is a health insurance plan that meets certain government requirements with respect to Deductibles and Out-of-Pocket Maximums. The Deductibles may be higher, and the Premiums 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 (1) overnight stay. An overnight stay in an observation bed is outpatient.

Inquiry

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

Intensive Community-based Acute Treatment

Defined as intensive 24-hour clinically managed mental health diversionary or step-down services for children and adolescents available as an alternative to mental health acute treatment.

Licensed Mental Health Professional

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

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 give accessible health care delivery systems, which are Member-focused, quality-driven, and culturally responsive to our Members' needs.

Medically Necessary Services

Medically Necessary or Medical Necessity describes Health Care Services that 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 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. Show your Member ID Card to Providers prior to receipt of services.

Mental Health Acute Treatment

Defined as 24-hour medically supervised mental health services provided in an inpatient facility, licensed by the department of mental health, giving psychiatric evaluation, management, treatment and discharge planning in a

structured treatment setting. See "Section 7: Behavioral Health Services", Behavioral Health Services (Inpatient) for additional details.

Member Portal

Member portal has what you need to manage your plan 24 hours a day, 7 days a week. Visit Member.MGBHP.org to register and log in.

Network Provider

A Provider who, under contract with us or a delegated entity, has agreed to give 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 from 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 us 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 (usually higher) when Covered Services are with a Non-Preferred (Out-of-Network) Provider.

Out-of-Pocket Maximum

The amount a Member pays 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 we did not get a Prior Auth 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 give 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 give Health Care Services to this plans Members 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 with 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. Primary Care Provider may include but not limited to medical doctors and Nurse Practitioners and Physicians Assistants who concentrate in primary care, and/or gynecological and reproductive health.

Prior Authorization (Prior Auth)

A process that the plan requires in order to (1) verify that certain Covered Services are and continue to be Medically Necessary and given in an appropriate and cost-effective manner, and (2) to arrange for the payment of Benefits. In-Network Providers are responsible for obtaining Prior Auth on behalf of the Member. Before a Member receives services from an Out-of-Network Provider, the Member is responsible for obtaining Prior Auth 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 our Member Portal.

Rehabilitation Services

Health care services that help a person keep, get back, or improve skills and functioning for daily living 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 Member ID Card (see Member ID Card).

Specialist

A Provider trained and certified by his/ her state to give 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 paid 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 our Member Portal 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, given, 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 uses a commercially available solution that applies statistical principles to a large national database, and represents more than half of all claims submitted in the United States. This allows us 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 not limited to, ambulatory review, prospective review/Prior Auth, 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 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.

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