Mass General Brigham Health Plan

Commonwealth of Massachusetts Group Insurance Commission

Complete HMO for Members of the Group Insurance Commission

Member Handbook

Effective July 1, 2023

IMPORTANT NOTICE: This plan includes a Tiered Provider Network. In this plan, members pay different levels of member cost sharing depending on the tier of the provider delivering a covered service or supply. Please consult the provider directory or visit the provider search tool at Member.MassGeneralBrighamHealthPlan.org to determine the tier of providers in the network.

Your Complete HMO Member Handbook

Welcome! Mass General Brigham Health Insurance Company (Mass General Brigham Health Plan) has been designated by the Group Insurance Commission (also referred to as the GIC or Plan Sponsor in this document) to provide administrative services for this self-funded Complete HMO Plan (Plan), including Claims processing, quality assurance, case management, Claim review and other related services.

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

This handbook contains important information about your Benefits which are provided through the Group Insurance Commission (GIC) and administered by Mass General Brigham Health Plan. The GIC is the funding source, Plan Sponsor and Plan Administrator. The GIC is an ERISA-exempt governmental entity meaning that ERISA does not apply to the benefits described in this handbook.

This handbook contains some technical terms you may be unfamiliar with. Please refer to the Glossary in Section 17 for explanations. If you need help understanding this handbook, Customer Service Representatives are available to help you. We also provide Members with free translation services.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see "Section 14. Notices" for more details.

Mass General Brigham
Health Plan

Translation Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Your Complete HMO Schedule of Benefits

The below is your Schedule of Benefits. This is only a general description of your coverage as a member of Mass General Brigham Health Plan. For more information about your benefits, read the complete text found in "Section 7. Your Covered Health Care Services," which describes each Member's Coverage in more detail and provides important information about requirements for, and any limits of, Coverage. These Benefits are covered when Medically Necessary and authorized by the Plan, ordered by your Primary Care Provider (PCP), and provided by a Network Provider. Before Coverage begins for certain services, you may pay a Copayment and/or a Deductible each benefit period.

The Plan includes a Deductible which resets at the start of the benefit period. Once the Deductible is satisfied, you no longer need to pay a Deductible for any service through the remainder of the benefit period.

Effective 7/1/2023 through 6/30/2024, your medical deductible is $500 for Individual coverage and $1,000 for Family coverage. A covered family member will not exceed $500 in deductible expenses.

Your Out-of-Pocket Maximum from 7/1/2023 through 6/30/2024 will be $5,000 for an Individual coverage and $10,000 for a Family coverage. A covered family member will not exceed an Out-of-Pocket Maximum of $5,000.

For some services you are first required to pay a Copayment and then the Deductible before coverage begins. For example: Tier 1 Inpatient Acute Medical Hospital admissions require a Copayment of $275 and then the Deductible applies. All Deductibles, Copayments and Coinsurance apply to the Out-of-Pocket Maximum.

A maximum of one Copayment per quarter* for Inpatient Acute Medical and Inpatient Mental Health and Substance use and a maximum of four Outpatient Surgical Copayments apply per benefit period.

*Quarters are as follows: 7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30

In addition, the Inpatient Hospital Copayment (for inpatient acute medical and mental health and substance use) will be waived for re-admission to a hospital for any reason if the re-admission occurs within 30 days of release from a hospital (waiver is not automatic and depends on your notifying the Plan of the re-admission). Members should keep receipts for all visits and Copayments. Contact Customer Service at 1-866-567-9175 (TTY 711) about reimbursement if Copayments were made after the maximum was reached.

Acute Medical Hospitals and their affialited PCPs and Specialists are assigned to different Copayment "Tiers." For an explanation of your Tiered Provider Network, please see "Section 3. Your Plan Providers" or "Section 17. Glossary."

Coverage/Benefit	Copayments
Medical Deductible per benefit period	$500 Individual, $1,000 Family
Out-of-Pocket Maximum per benefit period	$5,000 Individual/$10,000 Family

The Deductible, Coinsurance, and Copayments for Medical, Behavioral Health Services, and Prescription Drug expenses apply to the annual Out-of-Pocket Maximum.

OUTPATIENT MEDICAL CARE

Preventive Services

Annual Gynecological Exams*	No Member Cost-Sharing
Family Planning*	No Member Cost-Sharing
Annual Physical Exams	No Member Cost-Sharing
Immunizations & Vaccinations	No Member Cost-Sharing
Preventive Laboratory Tests	No Member Cost-Sharing
Screening Colonoscopy	No Member Cost-Sharing
Screening Mammography	No Member Cost-Sharing
Well Child Visits	No Member Cost-Sharing

*Services for specific conditions rendered during an annual exam may be subject to Cost-Sharing when not preventive.

OTHER PRIMARY & SPECIALTY CARE OFFICE VISITS COPAYMENTS
(Primary Care Physicians and Specialists are Tiered by Hospital Affiliation: Tier 1 l Tier 2 l Tier 3)

	Tier 1 l Tier 2 l Tier 3
Office Visits for Other Primary Care	$10 copayment / $20 copayment / $40 copayment
Office Visits for Other Specialty Care	$30 copayment / $60 copayment / $75 copayment
Acupuncture (up to 20 visits per benefit period)	$20 copayment
Allergy Shots	Subject to deductible
Cardiac Rehabilitation Services	$20 copayment
Chiropractic Care (up to 20 visits per benefit period)	$20 copayment
Routine Eye Exam (one visit per member every 24 months)	$30 copayment / $60 copayment / $75 copayment
Hearing Exams	$30 copayment / $60 copayment / $75 copayment
Infertility Services	$30 copayment / $60 copayment / $75 copayment
Physical Therapy/Occupational Therapy (up to 30 visits per condition per benefit period)	$20 copayment
Pulmonary Rehabilitation Services	$20 copayment
Routine Foot Care (covered for diabetes and some circulatory diseases)	$30 copayment / $60 copayment / $75 copayment
Routine Prenatal and Postnatal Care (OB/GYN)	No Member Cost-Sharing
Second Opinion (PCP)	$10 copayment / $20 copayment / $40 copayment
Second Opinion (Specialist)	$30 copayment / $60 copayment / $75 copayment
Speech Therapy	$20 copayment
Telemedicine (Virtual Visits) through On Demand, PCP, or Specialist	$10 copayment

OTHER OUTPATIENT SERVICES

Diagnostic, Laboratory and X-ray	Subject to deductible
High-tech Radiology (MRI, CT, PET Scan, Nuclear Cardiac Imaging)	$100 copayment, then subject to deductible (maximum of one copayment per day)
Outpatient Surgery—Facility Fee	$250 copayment*, then subject to deductible
Outpatient Surgery—Professional Fee	Subject to deductible
Outpatient Surgery for non-preventive colonoscopies, endoscopies, and eye surgeries—Facility Fee	Free-standing/ASC: $150 copayment*, then subject to deductible Hospital-based: $250 copayment*, then subject to deductible

*Per occurrence with a cap of four copayments per benefit period

INPATIENT MEDICAL CARE ***TIER 1 / TIER 2 / TIER 3***

Inpatient Medical Services (includes Maternity)—Facility Fee	$275 copayment, then subject to deductible* / $500 copayment, then subject to deductible* / $1,500 copayment, then subject to deductible*
Inpatient Medical Services—Professional Fee	Subject to deductible
Inpatient Care in a Skilled Nursing Facility (for up to 100 days per benefit period)	Subject to deductible, then 20% coinsurance
Inpatient Care in a Skilled Nursing Facility—Professional Fee	Subject to deductible, then 20% coinsurance
Inpatient Care in a Rehabilitation Facility (for up to 60 days per benefit period)	Subject to deductible
Inpatient Care in a Rehabilitation Facility—Professional Fee	Subject to deductible
Routine Nursery and Newborn Care	No Member Cost-Sharing

*Per admission with a cap of four copayments per benefit period, with a maximum of one inpatient copayment per quarter. Inpatient copayment will be waived for readmission to a hospital for any reason if the readmission occurs within 30 days of release from a hospital; you must contact Mass General Brigham Health Plan to have the copayment waived.

BEHAVIORAL HEALTH SERVICES—OUTPATIENT

Mental Health or Substance Use Care .....$10 copayment
Telemedicine (Virtual Visits) for Mental Health Care or Substance Use Care . . . . $10 copayment (waived for first 3 visits)

BEHAVIORAL HEALTH SERVICES—INPATIENT

Mental Health Care—Facility Fee . . . . . $275 copayment*
Mental Health Care – Professional Fee . . . . . No Member Cost-Sharing
Substance Use Detoxification or Rehabilitation—Facility Fee . . . . . $275 copayment*
Substance Use Detoxification or Rehabilitation—Professional Fee . . . . . No Member Cost-Sharing

*Per admission with a cap of four copayments per benefit period, with a maximum of one inpatient copayment per quarter. Inpatient copayment will be waived for readmission to a hospital for any reason if the readmission occurs within 30 days of release from a hospital; you must contact Mass General Brigham Health Plan to have the copayment waived.

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.

Urgent Care . . . . . $20 copayment

EMERGENCY CARE

In an emergency, go to the nearest emergency room or call 911. When admitted to a hospital for emergency care, you or a family member should notify your PCP within 48 hours.

Care you receive in an emergency room, in or out of
Mass General Brigham Health Plan Service Area . . . . . $100 copayment, then subject to deductible (copayment waived if admitted to hospital for inpatient care)
Ambulance Services (Emergency transport only) . . . . . Subject to deductible
Emergency Dental Care (within 72 hours of accident or injury) . . . . . $100 copayment, then subject to deductible (copayment waived if admitted to hospital for inpatient care)

ADDITIONAL SERVICES

Diabetic Supplies (includes DME items such as: insulin pumps, Continuous Glucose Monitoring Systems (CGMS), and artificial pancreas systems)*	Subject to deductible
Dialysis (inpatient or outpatient)	Subject to deductible
Disposable Medical Supplies	Subject to deductible
Durable Medical Equipment (DME)	Subject to deductible, then 20% coinsurance
Early Intervention (from birth up to age three)	No Member Cost-Sharing
Fitness Program Reimbursement	Up to $150/Individual, $300/Family per calendar year
Hearing Aids (age 21 and under)	Covered up to $2,000 for each affected ear every 2 years
Hearing Aids (age 22 and older)	Covered up to $1700 every 2 years for both ears
Home Health Care	Subject to deductible
Hospice Care	Subject to deductible
Orthotics	Subject to deductible, then 20% coinsurance
Oxygen Supplies and Therapy	Subject to deductible
Prosthetic Devices	Subject to deductible, then 20% coinsurance
Radiation and Chemotherapy	Subject to deductible
Tobacco Cessation (up to 300 minutes of counseling per benefit period, including telephonic counseling)	No Member Cost-Sharing
Wigs (when medically necessary for hair loss due to cancer treatment or other conditions)	Subject to deductible, then 20% coinsurance

*****_Please note some services and/or equipment may be covered under your prescription drug benefit with CVS Caremark. Lancets, syringes, test strips, and certain glucometers must be obtained through your prescription drug benefit._

Prescription Drug Benefits

The GIC's Prescription Drug benefit is administered through CVS Caremark.

PRESCRIPTION DRUGS	
Deductible	$100 Individual/$200 Family
With a valid prescription and purchased at a participating pharmacy for up to a 30-day supply	Generic: Subject to prescription deductible, then $10 copayment Preferred brand-name: Subject to prescription deductible, then $30 copayment Non-preferred brand-name: Subject to prescription deductible, then $65 copayment
Specialty Drugs Must be obtained at a designated specialty pharmacy. Some drugs require prior authorization to be covered. Some drugs are subject to quantity limitations. Some specialty drugs may also be covered under your medical benefit.	Limited to a 30-day supply with appropriate tier copayment (see above) when purchased at a designated specialty pharmacy.
90-day supply: With a valid prescription for a 90-day supply of a maintenance medication and purchased through the mail or at a participating pharmacy	Generic: Subject to prescription deductible, then $25 copayment Preferred brand-name: Subject to prescription deductible, then $75 copayment Non-preferred brand-name: Subject to prescription deductible, then $165 copayment

For more information or how to find a Participating Pharmacy:
CVS Caremark, info.caremark.com/oe/gic 1-877-876-7214

Section 1.

Your Plan Document

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

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

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

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

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

1-866-567-9175 (TTY 711)

Words with Special Meaning

Some words in this *Member Handbook* have special meaning. These words will start with upper case letters, and are defined in the glossary at the end of the *Handbook*. In this *Member Handbook*, the word "you" means "Members of this Complete HMO plan" and "the Plan", "us", "we", or "our" means "Mass General Brigham Health Plan".

GIC Provider Directory

The GIC Provider Directory lists:

- Primary Care Sites
- Primary Care Providers
- Hospitals
- Specialists
- Mental Health and Substance Use Care Providers

Visit our website at Member.MassGeneralBrighamHealthPlan.org for the most up-to-date listing of Providers in your Plan.

Information about Providers

More information about physicians, Nurse Practitioners and Physician Assistants licensed to practice in Massachusetts is available from the Board of Registration in Medicine. Visit massmedboard.org to find information on your Provider's education, hospital affiliations, board certification status and more. You can find information about Nurse Practitioners at

the Massachusetts Division of Health Professions Licensure website located at mass.gov and information about Physician Assistants at mass.gov/eohhs/Provider.

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

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

For information about Mass General Brigham Health Plan you may contact the Office of Patient Protection (OPP) at any time by phone at 1-800-436-7757, by fax at 1-617-624-5046, or online at mass.gov/hpc/opp.

The following information is available to you from the OPP:

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

Member Portal

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

You can:

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

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 866-567-9175 (TTY 711) and a representative will assist you.

Our hours of operation are 8:00 a.m. to 6:00 p.m., Monday through Friday, and Thursday from 8:00 a.m. to 8:00 p.m.

Section 2.

Eligibility and Enrollment

Enrollment

There is no pre-existing condition limitation when enrolling with Mass General Brigham Health 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 nor do we consider any history of domestic abuse or actual or suspected exposure to diethylstilbestrol (DES) in making such decisions. We will accept you into our plan regardless of your income status, source of income, physical or mental condition, age, expected length of life, gender, gender identity, sexual orientation, religion, creed, ethnicity or race, color, physical or mental disability, personal appearance, national origin, English proficiency, ancestry, marital status, veteran's status, occupation, political affiliation, Claims experience, duration of medical coverage, pre-existing conditions, actual or expected health status, need for Health Care Services, ultimate payer for services or your expected health status as a Member.

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

Your Member Identification Card

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

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

The Service Area

As an Eligible Individual, you may enroll in the Plan if you reside within the Service Area. The Service Area includes the state of Massachusetts.

Eligibility

To enroll and get GIC health coverage through the Plan, a person must meet all eligibility requirements that apply. See the next section for the list of requirements.
Individuals must satisfy any eligibility requirements of the Group Insurance Commission (GIC). The GIC requires the Subscriber to give proof, satisfying to the GIC, on any family Member's eligibility, such as a marriage certificate, birth certificate, court order for support, or a divorce decree.

Subscriber Eligibility

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

- Be an employee of the Commonwealth of Massachusetts, certain Municipalities or other entities that participate with the GIC and is entitled on his or her own (and not as a Dependent) to receive Coverage under the Group Insurance Commission's health Benefit plan, or

- Be a retiree of the Commonwealth of Massachusetts, certain Municipalities or other entities that participate with the GIC and is entitled on his or her own (and not as a Dependent) to receive Coverage under the Group Insurance Commission's health Benefit plan and not eligible for Medicare Part A.
- Be an employee or retiree as indicated above, in accordance with eligibility guidelines approved by the GIC and Mass General Brigham Health Plan. This includes GIC's up-to-date payment of applicable Premium for Coverage.
- Live, and have a permanent residence in certain areas of Massachusetts (see the Service Area in the glossary section of this handbook), at least nine months of a year. Adult children age 19 – 26 may reside outside of the service area but will be subject to the plan's coverage rules.

  Coverage will begin for a new employee on the first day of the month following 60 days of employment or two calendar months, whichever is less. Employees who do not choose to join a health plan when first eligible must wait until the next Annual Enrollment period to join. If you declined coverage when you were first eligible, you may be able to enroll outside of the Annual Enrollment period if you apply to the GIC with proof of a qualifying status change event satisfactory to the GIC.

Eligibility Rules for Dependents

To be eligible to enroll as a Dependent, a person must be:

- The employee or retiree's spouse or surviving spouse (until remarriage) or a divorced spouse who is eligible for Dependent Coverage pursuant to Massachusetts General Laws Chapter 32A, as amended; or
- The former spouse of the Subscriber, until the Subscriber or the former spouse remarries or until such time as may be specified in the divorce judgment consistent with state law, whichever occurs first; or
- A child (including grandchildren, if they are eligible dependents of your covered dependents) of the employee or the employee's spouse, by birth, legal adoption, under custody pursuant to a court order, or under legal guardianship, until age twenty-six (26) in accordance with the Patient Protection and Affordable Care Act; or
- A physically or mentally disabled child age twenty-six (26) and older who was incapable of earning his/her own living (self-support) before his/her 19th birthday, as determined by the Group Insurance Commission; or
- Orphan coverage is also available for some surviving dependents.

If you have questions about coverage for someone whose relationship is not listed above, please contact the GIC.

Handicapped Dependents

A dependent child who is mentally or physically incapable of earning his or her own living and who is enrolled under the subscriber's plan will continue to be covered after he or she would otherwise lose dependent eligibility, so long as the child continues to be mentally or physically incapable of earning his or her own living.

Dependents that, at age 26, are mentally or physically incapable of earning their own living may be eligible for handicapped dependent coverage, if the onset of disability occurred before their 19th birthday.

The handicapped dependent application is available at mass.gov/gic.

Residence

To be eligible for Membership in the Plan, all Subscribers and their Dependents must reside at least nine months of each year within the Service Area. The Service Area covers most Massachusetts counties, cities and towns; see " The Service Area" in this section of this handbook. Service Areas and Provider Networks can change, so it is important that you check that Providers in your area are part of the Provider Network.

Effective Date and Enrollment Requirements

Visit Mygiclink for enrollment instructions. Questions? State and municipal employees may contact their GIC Coordinator at GIC coordinators, and retirees can contact the GIC at contact the GIC or by calling 617-727-2310.

Persons who meet the requirements of the section titled "Eligibility and Enrollment" and subsections titled "Subscriber Eligibility," "Eligibility Rules for Dependents," "Handicapped Dependents," and/or "Residence" may enroll in the Plan. To

enroll, active employees should submit an Enrollment application to their GIC Coordinator, and retirees should contact the GIC. The GIC determines the Effective Date of coverage.

At the time of Enrollment, each Member will need to choose a Network PCP to whom he or she must go for primary care. Members of a family may each choose a different PCP for their care. Each Member chooses a PCP who provides or arranges for a Member's Covered Services. If you do not choose a PCP when enrolling in the plan, we may assign one for you. You can change your PCP by calling Customer Service.

Effective Date

Coverage under the plan starts as follows:

For new employees: New employee coverage begins on the first day of the month following 60 calendar days from the first date of employment, or two calendar months, whichever comes first.

For persons applying during an annual enrollment period: Coverage begins each year on July 1.

For spouses and dependents: Coverage begins the later of:

1. The date your own coverage begins, or
2. The date that the GIC has determined your spouse or dependent is eligible

Individuals may be eligible to enroll in the Plan throughout the year with certain qualifying status change events if:

1. The employee's spouse or eligible Dependent involuntarily lost other insurance.
2. The employee marries.
3. The employee has a newborn or adopts a child.

Enrollment deadlines and Effective Date of coverage will be determined by the GIC.

New Dependents

You must enroll dependents when they become eligible. Newborns (including grandchildren, if they are eligible dependents of your covered dependents) must be enrolled within 60 days of birth and adopted children within 60 days of placement in the home. Spouses must be enrolled within 60 days of marriage.

You must complete an enrollment form to enroll or add dependents. Additional documentation may be required as follows:

- **Newborns:** copy of hospital announcement letter or the child's certified birth certificate
- **Adopted children:** photocopy of proof of placement letter, court decree of adoption, or amended birth certificate
- **Foster children ages 19-26:** photocopy of proof of placement letter or court order
- **Spouses:** copy of certified marriage certificate

New Dependents of a Subscriber with Individual Coverage, including newborn children, will be covered as Dependents only if the Subscriber obtains Family Coverage within 60 days of the date dependency is established and applies for and has been approved for Family Coverage. To apply for Family Coverage, active employees should contact their GIC Coordinator, and retirees should contact the GIC directly.

Existing Family Members

Eligible family Members may be added as Dependents when the Subscriber changes from Individual to Family Coverage if application is made to the GIC within 60 days of a qualifying status change event or during annual enrollment.

Adoptive Dependents

A legally adopted child under the age of twenty-six (26) can enroll within 60 days from the date the child is physically placed in the home in the custody of the Subscriber for the purpose of adoption.

Enrollment While Hospitalized

If a covered person is in the hospital on the date that his or her coverage takes effect, coverage shall be provided by the Plan as of that date. The covered person, if physically capable, must notify the Plan within 48 hours of the date his or her Coverage takes effect. Following notification, he or she must comply with the Plan's instructions for further care.

Status Changes

It is your responsibility to immediately notify the Group Insurance Commission about any changes that may affect you or your dependents' eligibility for coverage, such as:

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

To make status changes, please contact your GIC Coordinator at your work site or, if you are retired, please contact the GIC.

Disenrollment

Voluntary Termination by the Subscriber

You may end your Mass General Brigham Health Plan Membership with the GIC's approval subject to applicable law, including but not limited, Section 125 of the Internal Revenue Service code.

Termination for Loss of Eligibility

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

Please note that we may not have current information concerning Membership status. The GIC may notify us of Enrollment changes retroactively. As a result, the information we have may not be current—only the GIC can confirm Membership status.

Membership Termination for Cause

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

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

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 at least 30 days in advance of the retroactive termination taking place.

Your coverage ends on the earliest of:

1. The end of the month covered by your last contribution toward the cost of coverage
2. The end of the month in which you cease to be eligible for coverage
3. The date of death
4. The date the surviving spouse remarries, or
5. The date the plan terminates

A dependent's coverage ends on the earliest of:

1. The date your coverage under the plan ends
2. The end of the month covered by your last contribution toward the cost of coverage
3. The date you become ineligible to have a spouse or dependents covered
4. The end of the month in which the dependent ceases to qualify as a dependent
5. The date the dependent child, who was permanently and totally disabled by age 19, marries
6. The date the covered divorced spouse remarries (or the date the Member marries)
7. The date of the spouse or dependent's death, or
8. The date the plan terminates

Continuation of Employer Group Coverage Required by Law

Contact the GIC for more information if Membership ends due to:

- Loss of dependent coverage due to age
- Loss of employment or reduction of work hours

If you lose Group coverage you may be eligible to continue group Coverage under the federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA). You must complete and submit the GIC COBRA Election Form by no later than 60 days after your group coverage ends. If you do not submit a completed election form by this deadline, you will lose your right to elect COBRA coverage.

Divorce or Legal Separation

Your former spouse will not cease to qualify as a dependent under the plan solely because a judgment of divorce or separate support is granted. (For the purposes of this provision, "judgment" means only a judgment of absolute divorce or of separate support.) Massachusetts law presumes that he or she continues to qualify as a dependent, unless the divorce judgment states otherwise.

If you get divorced, you must notify the GIC within 60 days and send the GIC a copy of the following sections of your divorce decree: Divorce Absolute Date, Signature Page, and Health Insurance Provisions.

If you or your former spouse remarries, you must also notify the GIC. If you fail to report a divorce or remarriage, the Plan and the GIC have the right to seek recovery of health claims paid or premiums owed for your former spouse.

Under M.G.L. Ch. 32A as amended and the GIC's regulations, your former spouse will no longer qualify as a dependent after the earliest of these dates:

1. The end of the period in which the judgment states he or she must remain eligible for coverage
2. The end of the month covered by the last contribution toward the cost of the coverage
3. The date he or she remarries

4. The date you remarry. If your former spouse is covered as a dependent on your remarriage date, and the divorce judgment gives him or her the right to continue coverage, coverage will be available at full premium cost (as determined by the GIC) under a divorced spouse rider. Alternatively, your former spouse may in certain circumstances enroll in COBRA coverage. See Group Health Continuation Coverage Under COBRA- General Notice Section 14.

Section 3.

Your Plan Providers

Group Insurance Commission (GIC) Provider Directory

For the most up to date listing of providers in the Network visit Member.MassGeneralBrighamHealthPlan.org. The *GIC Provider Directory* lists Primary Care Sites, Primary Care Providers, Hospitals, affiliated Specialists, and Mental Health and Substance Use Care Providers in the Network. The *GIC Provider Directory* also identifies the tier designation of Providers within the Tiered Provider Network.

Tiered Provider Network

As a member of this Plan, you will pay different levels of copayments depending on the tier of the provider delivering a covered service or supply. All providers must meet high-quality standards and are measured by a set of quality benchmarks from publicly available resources like Leapfrog and Hospital Compare in consultation with the GIC.

Cost-efficient PCPs and specialists were identified based on their hospital affiliation and placed in the appropriate tier as described in your Schedule of Benefits. For PCPs and Specialists unaffiliated with a hospital, they default to Tier 2 and therefore apply the middle level of member cost sharing.

It is important to check the tier of the provider and the hospital/site that you are being referred to in order to understand what your member cost sharing will be. To find the most up-to-date information on providers in the network and tier information, please refer to the GIC Provider Directory at Member.MassGeneralBrighamHealthPlan.org**.** Services with an out-of-network provider are not covered except for urgent and emergent care.

Your Primary Care Provider (PCP)

All Members must choose a PCP upon Enrollment in the Plan. Your PCP provides or arranges all of your health care. The PCP you select can be a health care professional specializing in Internal Medicine, Family Practice or General Practice, a Physician Assistant or a Nurse Practitioner. You have the right to designate any PCP who participates in our Network and who is available to accept you or your family members. For children you may designate a pediatrician as a PCP.

To select or change a PCP or Primary Care Site, go to our secure member portal Member.MassGeneralBrighamHealthPlan.org or call Customer Service. You should choose a Primary Care Site close to your home or place of work.

The Plan provides coverage on a Nondiscriminatory Basis for Covered Services delivered or arranged for by a Nurse Practitioner or Physician Assistant when acting as a PCP.

GIC Centered Care Program

Efficiency and Quality

Mass General Brigham Health Plan has partnered with the GIC to administer a Centered Care program that makes it even easier for our members to get the care they need, when they need it—all at a price they can afford. With Centered Care, GIC members can get access to high quality providers who provide enhanced services such as:

- Coordination with Specialists to ensure patients get the very best in personalized care
- Easy access to Urgent Care through convenient expanded hours
- Helpful reminders about necessary tests, checkups, and follow ups

Centered Care providers must meet certain standards for quality and efficiency. Qualifying providers are marked with the Centered Care logo in the Find a Doctor online search tool. Visit Member.MassGeneralBrighamHealthPlan.org to see if your providers are part of a Centered Care organization and to learn more about this innovative program.

Concierge Services

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

Changing Your PCP

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

To change your PCP, go to our secure member portal Member.MassGeneralBrighamHealthPlan.org or call Customer Service at 866-567-9175 (TTY 711). A Customer Service representative can assist you with your choice and process the change. If you choose a new PCP/Primary Care site, the change will be effective immediately or a future date you choose.

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

Why It's Best to Call Your Primary Care Site

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

Get to Know Your Primary Care Provider

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

When you go to your appointment, show your Member ID Card. You and your PCP can use this appointment to get to know each other. After this first appointment, call your Primary Care Site whenever you need health care.

Behavioral Health (Mental Health and Substance Use) Providers

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

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

You can make the appointment on your own or call Optum's clinical department at 844-875-5722 (TTY 711) to help you find a Provider. You may also ask your PCP for help. For information about our Behavioral Health Network Providers, refer to the "Behavioral Health" section of your Provider Directory or:

Visit: liveandworkwell.com
Call: Optum's clinical department at 844-875-5722 (TTY 711) or Customer Service at 866-567-9175 (TTY 711)

Specialty Providers and Care

At times, your PCP may suggest that you see a Specialist. Specialists are Doctors who focus on one area of medicine. Examples of Specialists are cardiologists, dermatologists and allergists.

See "Section 7. Your Covered Health Care Services," Specialty Care for services that do not require a referral.

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

It is your responsibility to make sure that the Specialist you wish to see participates with Mass General Brigham Health Plan and is available in the Network. When you use In-network Providers, you know that they have been credentialed by us and that they will work with our medical staff to help ensure you get the care you need. If you have a medically necessary service at an In-network location but it is performed by an out-of-network provider, you will not be responsible to pay more than the amount required for In-network services. However, we may not cover the service if you had a reasonable opportunity to choose to have the service performed by an In-network Provider. For example, if your In-network Provider refers you to a dermatologist, you must ensure that the dermatologist is in the Network. This process helps the Plan ensure that the PCP is coordinating the Member's care. It is the Member's responsibility to ensure they have a Referral prior to seeing a Specialist. It is a good idea after you have received confirmation from your PCP that a Referral was sent by checking with the Specialist office at the time of your appointment. If you don't have a Referral you can ask the Specialist's office to contact your PCP's office to send the Referral while you wait. Failure to obtain a Referral can result in you being financially responsible for your appointment.

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

If, at any time, you or your PCP has trouble finding needed medical services in the Network, you or your PCP can call for Referral help. You may search our Provider Directory or call Customer Service at 866-567-9175 (TTY 711).

Out-of-Network Specialty Care

You may visit an Out-of-Network Specialist only if we approve it in advance. Services given by Out-of-Network Specialists require prior Authorization. If there are In-network Providers who offer the service, we will usually deny the request to cover services provided by Out-of-Network Specialists. Before you make an appointment or seek medical care from an Out-of-Network Specialist, ask your PCP or treating Doctor to send an Authorization request to Mass General Brigham Health Plan. After reviewing the request, we will notify you and your Doctor of our decision in writing. If you do not receive written approval from us for Out-of-Network specialty care, the plan will not cover the services. If you do receive Authorization for Out-of-Network specialty care, Cost-Sharing, if any, will remain the same.

Relationship of Mass General Brigham Health Plan to Providers

Providers are private independent contractors. Mass General Brigham Health Plan's relationships with its Providers are governed by separate contracts. Providers may not change the Plan Document or create or imply any obligation for Mass General Brigham Health Plan. We are not liable for statements about this contract made by Providers, their employees, or agents. We cannot ensure the availability of specific Providers or Provider groups. We may change arrangements with Providers, including the addition or removal of Providers. Please note that all Providers listed in the

Provider Directory are available to Members at the time the directories were accessed. For the most current information on Network Providers, refer to our online *Provider Directory* located at Member.MassGeneralBrighamHealthPlan.org.

Continuity of Medical and Behavioral Health Care

In order to ensure consistent care, there are some instances when we will provide coverage for health services from a physician (includes Nurse Practitioners and Physician Assistants) who is not participating in the Plan's Network.

If you are enrolling in as a new Member and your employer only offered you a choice of Carriers in which your existing PCP or an actively treating physician was not a participating physician, we will provide coverage for up to ninety calendar (90) days from the Effective Date of coverage. With respect to a Member in her second or third trimester of pregnancy, this provision applies to services rendered through the first postpartum visit by the physician caring for her pregnancy. With respect to a Member with a terminal illness, this provision applies to services rendered until death.

If your Provider has been disenrolled from the Network, for reasons unrelated to quality of care or fraud, we will provide coverage for up to ninety (90) calendar days if they are providing you with active treatment care for a chronic or acute medical condition, or until that active treatment is completed, whichever comes first. For any Member who is in her second or third trimester this coverage will continue through the first postpartum visit. For any Member who is terminally ill, this coverage will continue through the Member's death if he or she remains covered under the plan until death.

To continue care in the above examples, the Provider must adhere to the quality assurance standards of Mass General Brigham Health Plan and provide us with required information on the provided medical care. Also, the Provider must adhere to our policies and procedures, including guidelines on prior Authorizations and providing services before starting a treatment plan, if any, approved by us. In the case of disenrolled Providers, they must also agree to accept repayment from us at the rates set prior to notice of Disenrollment as payment in full, and not charge any remaining amount to the Insured that would exceed the total repayment if the Provider had not been disenrolled. Failure of a Provider to agree to these standards may result in a denial of coverage for the provided service. If you have any questions about this matter please call Customer Service at 1-866-567-9175 (TTY 711).

Section 4.

Accessing Medically Necessary Care

Emergency Care

In an Emergency, go to the nearest Emergency facility, call 911, or call your local Community Behavioral Health Center*. Emergency Services will be covered from all Providers at your Emergency Room visit cost share as indicated in your Schedue of Benefits. If you are admitted for inpatient care from an Emergency Room visit, you will be covered at the lowest cost-sharing tier regardless of the tier that we have classified the Provider. All follow-up care must be arranged by your PCP. If you receive follow-up care in a hospital setting, your member cost sharing will depend on the tier of the hospital that provides that care.

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

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

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

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

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

Urgent Care

Urgent Care is care for a health problem that needs medical attention right away but you do not think it is an Emergency. For an Urgent Care visit, call your PCP first as there may be an Urgent Care Center at your Primary Care Site. You can contact your site twenty-four (24) hours a day, seven (7) days a week. Urgent Care does not include care that is elective, Emergency, preventive or health maintenance. Examples of conditions requiring Urgent Care include, but are not limited to: fever, sore throat, and earache.

After-Hours Care

No matter when you are sick—day or night, any day of the year—call your Primary Care Site. All Primary Care Sites have a Doctor, Physician Assistant or nurse on call 24 hours a day, seven days a week. The Doctor, Physician Assistant or

nurse on call is there to help with any urgent health problems. When you call your Primary Care Site after-hours, the site's answering service will answer your call. The service will take your name and phone number and then contact the doctor, physician assistant or nurse on call. That Doctor, Physician Assistant or nurse will call you back to talk about your problem and help you decide what to do next.

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

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

Non-Emergency Hospital Care

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

Behavioral Health Hospital Care

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

Intermediate or Diversionary Behavioral Health Services

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

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

Diversionary services above do not require a Referral, but these services do require a Provider to obtain prior Authorization from Optum. You may learn more about these services by calling Optum directly or speaking to your outpatient therapist, if you have one.

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

Care When Outside the Service Area

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

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

The Plan *will not* cover:

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

A Provider may ask you to pay for care received outside of the Service Area at the time of service. If you pay for Emergency or Urgent Care you received while outside of the Service Area, you may submit a Claim to us for reimbursement.

See "Section 12. If You Receive a Bill in the Mail" for more information and instructions on how to submit a Claim. You may also call Customer Service for help with any bills that you may receive from a health care Provider.

Family Planning Services

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

Maternity Care

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

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

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

Section 5.

Prior Authorizations

An Authorization is a special approval by Mass General Brigham Health Plan or Optum (our designated Behavioral Health Manager) for coverage of certain services. Not all services require Authorization. If a service does require an Authorization, Authorizations must occur before you receive the service in order for the service to be covered. Your PCP or the Specialist treating you will request an Authorization from Mass General Brigham Health Plan or Optum if it is necessary.

Examples of services requiring Prior Authorization are some surgical procedures and elective admissions, Inpatient psychiatric care, etc. Mass General Brigham Health Plan and Optum gives Authorizations as soon as possible.

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

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

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

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

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

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

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

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

Section 6.

GIC's Pharmacy Benefit

GIC's prescription drug benefits are administered through CVS Caremark.

For questions about any of the information in this section, please contact CVS Caremark at 1-877-876-7214 (option 2) CVS Caremark is the pharmacy benefit manager for your prescription drug benefit plan. The CVS Caremark pharmacy network includes major chain pharmacies nationwide, many independent pharmacies, a mail order pharmacy and a specialty drug pharmacy.

If you have any questions about your prescription drug benefits, contact CVS Caremark Member Services toll free at 1-877-876-7214 (option 2).

About Your Plan

Prescription medications are covered by the plan only if they have been approved by the U.S. Food and Drug Administration (FDA). In addition, except for the over-the-counter versions of preventive drugs, medications are covered only if a prescription is needed for their dispensing. Diabetes supplies and insulin are also covered by the plan.

Copayments and Deductible

One of the ways your plan maintains coverage of quality, cost-effective medications is a multi-tier copayment pharmacy benefit: Tier 1 (mostly generic drugs), Tier 2 (preferred drugs), Tier 3 (non-preferred drugs), or drugs which require no copayments. The following shows your deductible and copayment based on the type of prescription you fill and where you get it filled.

Deductible for Prescription Drugs

Deductible (fiscal year July 1, 2023, through June 30, 2024)

- For individual coverage: **$100 for one person**
- For family coverage: **$200 for the entire family**
- No more than $100 per person will be applied to the family deductible. Multiple family members can satisfy the family deductible.

Copayments for Prescription Drugs

Participating Retail pharmacy up to a 30-day supply and Mail Order or CVS Pharmacy up to a 90-day supply:

Tier 1 – Generic Drugs
30-day supply: $10
90-day supply: $25

Tier 2 – Preferred Drugs
30-day supply: $30
90-day supply: $75

Tier 3 – Non-Preferred Drugs
30-day supply: $65
90-day supply: $165

Other:

$0 member cost (deductible does not apply)

- Orally administered anti-cancer drugs
- Generic drugs to treat opioid use disorder (generic buprenorphine-naloxone, naloxone, and naltrexone products)
- ACA Preventive drugs: Refer to the "Preventive Drugs" section below for detailed information.

Specialty Drugs: Specialty drugs must be filled only through CVS Specialty, a specialty pharmacy. Please call CVS Specialty toll free at (800) 237-2767.

Specialty Drugs: Tier 1
$10 per 30-day supply

Specialty Drugs: Tier 2
$30 per 30-day supply

Specialty Drugs: Tier 3
$65 per 30-day supply

Orally Administered Anti-Cancer Specialty Drugs

$0 per 30-day supply

Specialty medications may be dispensed up to a 30-day supply, some exceptions may apply.

Copayments for ADHD Medications

May be filled through mail order or any network pharmacy. Quantities are limited to a 60-day supply per state statute:

Tier 1: 30-day supply: $10
Tier 1: 60-day supply: $20

Tier 2: 30-day supply: $30
Tier 2: 60-day supply: $60

Tier 3: 30-day supply: $65
Tier 3: 60-day supply: $130

Out-of-Pocket Limit

This plan has an out-of-pocket limit that is combined with your medical and behavioral health out-of-pocket limit. Deductibles and copayments you pay for prescription drugs during the year count toward this limit. Once you reach the limit, your prescription drugs are covered at 100%.

Payments for a brand drug when there is an exact generic equivalent and for drugs not covered by the plan do not count toward the out-of-pocket limit.

Individual	$5,000
Family	$10,000

How to Use the Plan

After you first enroll in the plan, CVS Caremark will send you a welcome packet and CVS Caremark Prescription Card(s). Your Prescription Card(s) will be mailed to you with ID cards for you and your dependents (if any).

Show your new Prescription Card to your pharmacy so they can correctly process your prescription drug benefits.

Register at **caremark.com** on your effective date. As a registered user, you can check drug costs, order mail order refills, and review your prescription drug history. You can access this site 24 hours a day. You may also check this information via the CVS Caremark mobile app.

Filling Your Prescription

You may fill your prescriptions for non-specialty drugs at any participating retail pharmacy, or through mail order from CVS Caremark.

Prescriptions for specialty drugs must be filled as described in the CVS Specialty subsection.

To obtain benefits at a retail pharmacy, you must fill your prescription at a participating pharmacy using your CVS Caremark Prescription Card, except for the limited circumstances detailed in the “Claim Forms” subsection.

Filling Your Prescriptions at a Participating Retail Pharmacy

The retail pharmacy is your most convenient option when you are filling a prescription for a short-term prescription that you need immediately (for example, antibiotics for strep throat or painkillers for an injury). Simply present your CVS Caremark Prescription Card to your pharmacist, along with your written prescription, and pay the required copayment.

Prescriptions filled at a non-participating retail pharmacy are not covered.

You can find the nearest participating retail pharmacy anytime online after registering at **caremark.com** or by calling toll free at 1-877-876-7214 (option 2).

If you do not have your Prescription Card, the pharmacist can also verify eligibility by contacting the CVS Caremark Pharmacy Help Desk at (800) 365-6331. Members can also access their pharmacy ID card information via the CVS Caremark mobile app.

Maintenance Medications – Up to 30 Days

After you fill two 30-day supplies of a maintenance medication at a retail pharmacy, you will receive a letter from CVS Caremark explaining how you may convert your prescription to a 90-day supply to be filled either through mail order or at a CVS Pharmacy.

You will receive coverage for additional fills of that medication only if you convert your prescription to a 90-day supply to be filled either through mail order or at a CVS Pharmacy.

CVS Caremark will assist you in transitioning your maintenance prescription to either Mail Order or a CVS Pharmacy location.

Maintenance Medications – Up to 90 Days

Filling 90-day Prescriptions through mail order or at a CVS Pharmacy.

PLEASE NOTE: CVS Caremark will allow two 30-day fills for long-term medications at your regular pharmacy before being asked to switch to 90-day supplies. If you want to keep filling your long-term medication prescriptions at your current pharmacy in 30-day supplies without paying the full cost, **you must opt-out once your new plan starts by calling CVS Caremark at (877) 876-7214 option 2.**

You have the choice and convenience of filling maintenance prescriptions for up to a 90-day supply at the mail order copayment, or at a CVS Pharmacy.

The CVS Mail Service Pharmacy is a convenient option for prescription drugs that you take on a regular basis for conditions such as asthma, diabetes, high blood pressure and high cholesterol. Your prescriptions are filled and conveniently delivered directly to your home or to another location that you prefer.

CVS Pharmacy is another option for getting your 90-day maintenance medications for the same copayment amount as mail order. Prescriptions can be filled at a CVS Pharmacy location across the country.

Convenient for You

You get up to a 90-day supply of your maintenance medications – which means fewer refills and fewer visits to your pharmacy, as well as lower copayments. Once you begin using mail order, you can order refills online or by phone, or you can use your local CVS Pharmacy.

Using the CVS Caremark Mail Order Pharmacy:

We are automatically transferring prescriptions you have delivered by mail to our mail service pharmacy.

If you have been getting prescriptions through your previous plan's mail service pharmacy, we will automatically transfer them – **as long as there are refills remaining** – to CVS Caremark Mail Service Pharmacy. Once your plan starts, you can visit **caremark.com** to place future refill requests.

If there are no refills left on your prescription, you can request a new prescription by visiting **Caremark.com/MailService** when your new plan starts, and we will contact your doctor for you. Or you can ask your doctor to send a new prescription to CVS Caremark Mail Service Pharmacy.

Please note: We cannot transfer prescriptions for controlled medications – we need a new prescription from your doctor. If you have a prescription for a controlled medication, or if you are not sure, contact your doctor.

CVS Specialty

CVS Specialty is a full-service specialty pharmacy that provides personalized care to each patient and serves a wide range of patient populations, including those with hemophilia, hepatitis, cancer, multiple- sclerosis and rheumatoid arthritis.

You will have to fill your specialty medications at CVS Specialty. This means that your prescriptions can be sent to your home, doctor's office or at a CVS Retail Pharmacy.

Specialty medications may be filled only at a maximum of a 30-day supply; some exceptions may apply. Many specialty medications are subject to a clinical review by CVS Specialty to ensure the medications are being prescribed appropriately.

CVS Specialty offers a complete range of services and specialty drugs. Your specialty drugs are quickly delivered to any approved location, at no additional charge. We ship to all fifty states using one of our preferred expedited carriers. We can also ship to a variety of alternate addresses, including physician's offices or to another family member's address. We do not ship to P.O. Boxes.

You have toll-free access to expert clinical staff who are available to answer all your specialty drug questions. CVS Specialty will provide you with ongoing refill reminders before you run out of your medications.

To begin receiving your specialty drugs through CVS Specialty, call toll free at (800) 237-2767. Hours of operation: 7:30am – 9pm EST M-F; 9am – 4pm EST on Saturday; closed on Sunday.

CVS Specialty

- ❑ **Patient Counseling** – Convenient access to pharmacists and nurses who are specialty medication experts
- ❑ **Patient Education** – Educational materials
- ❑ **Convenient Delivery** – Coordinated delivery to your home, your doctor's office, or other approved location
- ❑ **Refill Reminders** – Ongoing refill reminders from CVS Caremark.
- ❑ **Language Assistance** – Language-interpreting services are provided for non-English speaking patients

Claim Forms*

Retail purchases out of the country, or purchases at a participating retail pharmacy without the use of your CVS Caremark Prescription Card, are covered as follows:

Claims Reimbursement

Type of Claim

- Claims for purchases at a participating (in-network) pharmacy without a CVS Caremark Prescription card.

Claims incurred within 30 days of the member's eligibility effective date will be covered at full cost, less the applicable copayment.

-or-

Claims incurred more than 30 days after the member's eligibility effective date will be reimbursed at a discounted cost, less the applicable copayment.

*Claim forms are available to registered users on **caremark.com** or by calling 1-877-876-7214 (option 2).

Other Plan Provisions

ACA Preventive Drugs

Coverage will be provided for the following drugs:

Aspirin

Generic OTC aspirin, 81mg to help prevent illness and death from preeclampsia in females who are between 12 and 59 years old.

Bowel preparation medications

Generic and brand products until generics become available (Rx only) for adults ages 45 to 75 years old.

Contraceptives

Generic and brand versions of contraceptive drugs and devices, and OTC contraceptive products. Brand products are covered at no cost until a generic become available. Per state statute, some oral contraceptives can be dispensed up to a 3-month supply for the first fill and up to a 12-month supply for subsequent fills.

Diabetes Prevention:

Generic (Rx only) metformin 850mg for preventing or delaying diabetes in adults aged 35 to 70

Folic acid supplements

Generic OTC products (0.4mg – 0.8mg strengths only) when prescribed for women under the age of fifty-five.

HIV Pre-Exposure Prophylaxis (PrEP)

Generic (Rx only)

Immunization vaccines

Generic or brand versions prescribed for children or adults.

Oral fluoride supplements

Generic and brand prescription versions, children 5 years of age or younger for the prevention of dental caries.

Breast cancer

Generic prescriptions (anastrozole, exemestane, raloxifene, tamoxifen) for the primary prevention of breast cancer for females who are at increased risk, age 35 years and older.

Tobacco cessation

Generic (Rx and OTC) tobacco cessation products and brand-name Rx products (Nicotrol, Nicotrol NS) until generics become available. Annual limit of two 12-week cycles (168 days).

Statins

Generic-only, single-entity, low-to-moderate dose statin agents for adults 40 to 75 years old.

Call CVS Caremark at 1-877-876-7214 (option 2) for additional coverage information on specific preventative drugs.

Brand-Name Drugs with Exact Generic Equivalents

The plan encourages the use of generic drugs. There are many brand-name drugs, such as Lipitor®, Ambien® and Fosamax®, for which exact generic equivalents are available. If you fill a prescription for a brand-name medication for which there is an exact generic equivalent, the standard brand copayment will not apply. Instead, you will be responsible for the full difference in price between the brand-name drug and the generic drug, plus the generic copayment. This amount does not count towards the out-of-pocket limit. Exceptions to this provision may apply to certain brand-name preventive drugs. Contact CVS Caremark for more information.

Prescription Drugs with Over the Counter (OTC) Equivalents

Some prescription drugs have over the counter (OTC) equivalent products available. These OTC products have strengths, active chemical ingredients, routes of administration and dosage forms identical to the prescription drug products.

Your plan does not provide benefits for prescription drugs with OTC equivalents. This provision is not applicable to preventive drugs.

Some prescription drugs also have OTC product alternatives available. These OTC products, though not identical, are similar to the prescription drugs.

Prior Authorization

Some drugs in your plan require prior authorization. Prior authorization ensures that you are receiving the right drug for the treatment of a specific condition, in quantities approved by the FDA. For select drugs, prior authorization also includes a medical necessity review that ensures the use of less expensive first-line formulary prescription drugs before the plan will pay for more expensive prescription drugs. First-line formulary prescription drugs are safe and effective medications used for the treatment of medical conditions or diseases.

If a drug that you take requires prior authorization, your physician will need to contact CVS Caremark to see if the prescription meets the plan's conditions for coverage. If you are prescribed a drug that requires prior authorization, your physician should call CVS Caremark at 800-294-5979.

Current Examples of Drugs Requiring Prior Authorization for Specific Conditions[2]

Topical Acne products

Aklief, ArazloTazorac® 0.05% and 0.1% cream, gel; Fabior 0.1% foam; (Retin-A®, Retin-A® Micro®; Avita®; Tretin·X™; Atralin™ gel: other generic topical tretinoin products) and Clindamycin Phosphate 1.2% and Tretinoin 0.025% gel (Ziana®; Veltin™), Winlevi

Testosterone – Topical

Androderm, AndroGel, Axiron, Fortesta, Natesto, Striant, Testim, Vogelxo

Testosterone – Injectable

Aveed®, Depo® - Testosterone [testosterone cypionate injection, generics], Delatestryl®, Xyosted® [testosterone enanthate injection, generics], Testopel® [testosterone pellet]

Compounded - Select medications

A compounded medication is one that is made by combining, mixing or altering ingredients, in response to a prescription, to create a customized medication that is not otherwise commercially available.

Diabetes GLP-1 agonists

Adlyxin, Byetta®, Bydureon®/ BCISE, Mounjaro, Ozempic, Rybelsus, Tanzeum Trulicity®, Victoza®,

Nutritional Supplements

Nonprescription enteral formulas for home use for which a physician has issued a written order and which are medically necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.

Pain

Fentanyl Transmucosal Drugs (Abstral®, Actiq®, Fentora®, Lazanda®, Subsys®) Lidoderm®, Ztlido

Weight Management

Adipex (phentermine), Bontril (phendimetrazine), Contrave (bupropion; naltrexone), Didrex [benzphetamine), Sanorex (mazindol), Suprenza [phentermine], Tenuate (diethylpropion), Xenical (orlistat), Qsymia, Saxenda, Wegovy

Dry Eyes

Cequa, Restasis®, Xildra®

Current Examples of Top Drug Classes that May require Prior Authorization for Medical Necessity

Asthma/COPD Agents

Autoimmune Agents

Dermatological Agents

Diabetic Supplies

Erectile Dysfunction Oral Agents

Erythropoiesis - Stimulating Agents Glaucoma

Growth Hormones

Hepatitis C Agents

Insulins

Nasal Steroids

Ophthalmic Agents

Opioid Analgesics

Osteoarthritis - Hyaluronic Acid Derivatives

Proton Pump Inhibitors

Select drugs within these classes require prior authorization for medical necessity to ensure formulary alternative(s) within the class have been tried. If you are a registered user on **caremark.com**, refer to the National Preferred Formulary or call CVS Caremark toll free at 1-877-876-7214 (option 2) for more information.

Quantity Dispensing Limits

To promote member safety and appropriate and cost-effective use of medications, your prescription plan includes a drug quantity management program. This means that for certain prescription drugs, there are limits on the quantity of the drug that you may receive at one time.

Quantity per dispensing limits is based on the following:

- ❑ FDA-approved product labeling
- ❑ Common usage for episodic or intermittent treatment
- ❑ Nationally accepted clinical practice guidelines
- ❑ Peer-reviewed medical literature
- ❑ As otherwise determined by the plan Examples of drugs with quantity limits currently include Cialis®, Imitrex®, and lidocaine ointment.

Drug Utilization Review Program

Each prescription drug purchased through this plan is subject to utilization review. This process evaluates the prescribed drug to determine if any of the following conditions exist:

- ❑ Adverse drug-to-drug interaction with another drug purchased through the plan
- ❑ Duplicate prescriptions
- ❑ Inappropriate dosage and quantity; or
- ❑ Too-early refill of a prescription.

If any of the above conditions exist, medical necessity must be determined before the prescription drug can be filled.

Exclusions

Benefits exclude:

- Dental preparations (e.g., topical fluoride, Arestin®), except for oral fluoride
- Over-the-counter drugs, vitamins, or minerals (except for diabetic supplies and preventive drugs)
- Prescription Homeopathic and Miscellaneous Natural products
- Prescription products for cosmetic purposes such as photo-aged skin products and skin depigmentation products
- Medications in unit dose packaging
- Impotence medications for members under the age of eighteen
- Injectable allergens
- Cosmetic Drugs - including hair loss drugs, anti-wrinkle creams, hair removal creams and others
- Special medical formulas and medical food products, except as required by state law
- Compounded medications-some exclusions apply-examples include bulk powders, bulk chemicals, and proprietary bases used in compounded medications
- Drugs administered intrathecally, or a drug which must be infused into a space other than the blood, by or under the direction of health care professionals and recommended to be administered under sedation or supervision
- Drugs not suitable for coverage under a pharmacy/outpatient prescription drug benefit, as determined by Caremark
- Select Medical Devices and Artificial Saliva products
- Prescription digital therapeutics, unless otherwise specified
- Unapproved products that may be marketed contrary to the Federal Food, Drug and Cosmetic Act
- Therapeutic devices or appliances, including support garments, ostomy supplies, durable medical equipment, and non-medical substances
- Scar products
- Miscellaneous topical analgesics (containing ingredients in strengths typically used in OTC analgesics) and convenience kits (containing two or more products to be used separately
- Prescription Multivitamins (other than pediatric and prenatal multivitamins)

[3] This list is subject to change during the year. Call CVS Caremark toll free at 1-877-876-7214 (option 2) to check if your drugs are included in the program.

Definitions:

Acute Drugs - Drugs prescribed for a short-term illness or condition, expected to clear up in a short amount of time. They are usually not taken for more than thirty days, and additional refills are typically not included.

Biosimilars - Biosimilar is a biological product that is highly similar to a biological product already approved by the FDA (i.e., reference product) and is licensed and approved by the FDA as a biosimilar under Section 351(k) of the Public Health Service Act, notwithstanding minor differences in clinically inactive component but otherwise no clinically meaningful differences between the biologic product and the reference products in terms of safety, purity and potency of the product.

Brand-Name Drug – The brand name is the trade name under which the product is advertised and sold, and during a period of patent protection it can only be produced by one manufacturer. Once a patent expires, other companies may manufacture a generic equivalent, providing they follow stringent FDA regulations for safety.

Compounded Medication – A compounded medication is one that is made by combining, mixing or altering ingredients, in response to a iption, to create a customized medication that is not otherwise commercially available. At least one of the ingredients must be a medication that can only be dispensed with a written prescription.

Controlled Drug - Prescription medications that are designated as a Controlled Drug under the Controlled Substances Act (CSA). These include prescription drugs associated with potential for dependency or abuse.

Copayment – A copayment is the amount that members pay for covered prescriptions. If the plan's contracted cost for a medication is less than the applicable copayment, the member pays only the lesser amount.

Deductible – A deductible is the dollar amount you must pay during a plan year before the copayments for covered prescriptions apply.

Diabetes Supplies – Diabetic supplies include needles, syringes, test strips, lancets and blood glucose monitors.

FDA – The U.S. Food and Drug Administration.

Formulary – A formulary is a list of recommended prescription medications that is created, reviewed and continually updated by a team of physicians and pharmacists. The CVS Caremark National Preferred Formulary contains a wide range of generic and preferred brand-name products that have been approved by the FDA. The formulary applies to medications that are dispensed in either the retail pharmacy or mail-order settings. The formulary is developed and maintained by CVS Caremark. Formulary designations may change as new clinical information becomes available.

Generic Drugs – Generic versions of brand medications contain the same active ingredients as their brand counterparts, thus offering the same clinical value. The FDA requires generic drugs to be just as strong, pure and

stable as brand-name drugs. They must also be of the same quality and manufactured to the same rigorous standards. These requirements assure that generic drugs are as safe and effective as brand-name drugs.

Maintenance Drug – A maintenance drug is a medication taken on a regular basis for conditions such as asthma, diabetes, high blood pressure or high cholesterol. They are often filled in 90-day supplies.

Non-Preferred Drug - A non-preferred drug is a medication that usually has an alternative, therapeutically equivalent drug available on the formulary.

Out-of-Pocket Limit – The out-of-pocket limit is the most you could pay in copayments during the year for prescription drugs that are covered by CVS Caremark. Once you reach this limit, you will have no more copayments for covered drugs. Payments for a brand drug when there is an exact generic equivalent and for drugs not covered by the plan do not count toward the out-of-pocket limit.

Over the Counter (OTC) Drugs – Over-the-counter drugs are medications that do not require a prescription. Your plan does not provide benefits for OTC drugs, except for preventive drugs (all of which are covered only if dispensed with a written prescription).

Participating Pharmacy – A participating pharmacy is a pharmacy in the CVS Caremark Nationwide network. All major pharmacy chains and most independently owned pharmacies participate.

Preferred Drug – A preferred brand- name drug, also known as a formulary drug, is a medication that has been reviewed and approved by a group of physicians and pharmacists and has been selected by CVS Caremark for formulary inclusion based on its proven clinical and cost effectiveness.

Prescription Drug – A prescription drug means any and all drugs which, under federal law, are required, prior to being dispensed or delivered, to be labeled with the statement "Caution: Federal Law prohibits dispensing without prescription," or a drug which is required by any applicable federal or state law or regulation to be dispensed pursuant only to a prescription drug order.

Preventive Drugs – Preventive drugs consist primarily of drugs recommended for coverage by the U.S. Preventive Services Task Force, and as specified by the federal Patient Protection and Affordable Care Act (ACA).

Prior Authorization – Prior authorization means determination that a drug is appropriate for treatment of a specific condition. It may also mean determination of medical necessity. It is required before prescriptions for certain drugs will be paid for by the plan.

Special Medical Formulas or Food Products – Special medical formulas or food products means nonprescription enteral formulas for home use for which a physician has issued a written order, and which are medically necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids. These products require prior authorization to determine medical necessity.

Specialty Drugs

Specialty drugs are usually injectable and non-injectable biotech or biological drugs used to treat rare and/or complex conditions with one or more of several key characteristics, including:

- ❑ Potential for frequent dosing adjustments and intensive clinical monitoring
- ❑ Need for intensive patient training and compliance for effective treatment
- ❑ Limited or exclusive product distribution
- ❑ Specialized product handling and/or administration requirements

Clinical Operations Prior Authorizations, Exceptions and Appeals Programs

All timeframes and processes contained in this document refer to CVS Caremark® standard protocols based on federal laws and regulations. Timeframes and processes may vary based on client requirements or state regulations.

CVS Caremark may be delegated to perform prior authorizations (PA), exceptions or appeals on behalf of our clients. CVS Caremark and the client will enter a mutually agreed upon written contract, which defines the requirements for processing PAs, exceptions and/or appeals on the client's behalf. The client provides CVS Caremark with a copy of its Summary Plan Description, including the Prescription Benefit section that describes the prescription benefits to plan members. Employees of CVS Caremark may not participate in a PA, exceptions or appeals review if there is a personal, professional or financial conflict of interest with the claimant.

CVS Caremark may, depending on the client's plan, conduct two types of reviews: Clinical and Non-Clinical Reviews.

• An **Initial Clinical Review** is an initial review of a request for a drug covered by the terms of the Plan when clinically appropriate, including but not limited to PA, step therapy, formulary exceptions and quantity limit exceptions. CVS Caremark will conduct an Initial Clinical Review utilizing the rules, guidelines, protocols, or criteria for coverage adopted by or provided by the Plan and as set forth in the Plan Design Document (PDD).

• An **Initial Non-Clinical Review** is an initial review of a request for a drug not covered by the terms of the Plan, including the PDD, the preferred drug lists, formulary or other plan benefits selected by the client. An Initial Non-Clinical Review does not involve an assessment of whether the requested drug is medically necessary.

Initial Clinical Reviews

Prior Authorization Program

PA is available as a stand-alone service to clients. It may also be provided in conjunction with quantity limits or step therapy protocols when a member fails to meet the requirements for these programs. Prescription claims are processed at the point of sale by the adjudication system to determine if the claim is subject to a PA. If the claim is subject to a PA, a reject message will display informing the dispensing pharmacy to have the prescribing practitioner contact the CVS Caremark PA Department.

A PA may be initiated by phone call, fax, electronic request or in writing to CVS Caremark by a member's prescribing physician or his/her representative. A member or pharmacist may initiate a PA by calling the PA department, who will reach out to the prescribing physician to obtain the necessary information, or they will be instructed to have the member's physician or designated representative contact CVS Caremark directly. Phone calls received during regular business hours will be routed directly to the CVS Caremark PA team.

If the call is received outside of business hours, the caller will be prompted to call back during regular business hours if it is a non-urgent request. If the request is urgent, the automated system will advise the caller to hold for the answering service. The service will then contact the PA department for the on-call pharmacist to process the request within the allowable timeframe.

Once CVS Caremark has received a request, the PA department will check to determine if a new PA is still required and will review the member's PA history for duplicate or pending requests.

The PA request is evaluated using client-approved criteria. A decision will be made solely on the clinical information available at the time of the review.

Pas are processed within the following timeframes:

• **Urgent requests** from the member's physician are processed within 72 hours from receipt of the request. However, the CVS Caremark standard is to complete the review within 24 hours from receipt of all necessary information.

• **Non-urgent requests** are processed within 15 days from receipt of the request. However, the CVS Caremark standard is to complete the review within 72 hours from receipt of all necessary information.

If the information provided is incomplete, and if time permits based on state or federal regulations, the PA department will request the additional information from the physician's office. Once the physician's office provides CVS Caremark with the required information, the original PA is reviewed to decide. If the required information is not provided, the PA will be denied.

If the PA is approved, the technician enters the documentation and applicable overrides into the CVS Caremark authorization system. A test claim is processed to ensure the claim will pay when the member fills the prescription at the pharmacy. Approval letters are generated and faxed to the physician and mailed to the member.

If the PA does not meet the criteria requirements as required by the plan or state rules, the appropriate clinical reviewer will deny the PA request. Denial letters are generated and faxed to the physician and mailed to the member. Denial letters include directions on how to appeal the denial.

CVS Caremark PA activity reporting is available, if requested by the client.

Exceptions Program

A standard exceptions program is available to support client requests to make exceptions to certain aspects of a client's plan design. Exception requests will only be considered if, and to the extent that, a plan allows exceptions.

Exceptions are available for covered and non-covered medications. For the latest list of available exceptions, refer to the Clinical Plan Management (CPM) form.

Examples of **exceptions for covered drugs** include but are not limited to the following:

• Brand Penalty: Request to allow a member to waive the dispense as written (DAW) penalty for a brand-name medication

• Tiering: Request to allow a member to have a non-preferred medication at the preferred copay (e.g., third-tier medication at the second-tier copay)

• Mandatory Mail: Request to allow a member of a plan that mandates the use of mail service or Maintenance Choice® at CVS Pharmacy® the ability to fill maintenance medications at a retail pharmacy on a long-term basis

• Cost Exceeds: Request for coverage of a medication that exceeds the plan's maximum dollar amount per claim

• Contraceptive Zero Copay (Health Care Reform): Request to allow a member to receive a contraceptive product for a zero-dollar member cost share

• Preventive Services Zero Copay (Health Care Reform): Request to allow a member to receive a preventive service product (excluding contraceptives) for a zero-dollar member cost share

• Preventive Breast Cancer Zero Copay (Health Care Reform): Request to allow a member to receive tamoxifen or raloxifene for a zero-dollar member cost share.

Examples of **exceptions for non-covered drugs** include but are not limited to the following:

• Formulary Exceptions: Request to allow a member to have formulary coverage for a drug currently not covered by the CVS Caremark formulary

• Compound: Request to allow coverage of a compounded drug product that contains ingredients excluded from the pharmacy benefit

• Management of Selected Unapproved Products: Request to allow a member to have coverage for select products excluded from the pharmacy benefit

• Miscellaneous Formulations: Request to allow a member to have coverage of select products excluded from the pharmacy benefit

Exception requests may be initiated by contacting Customer Care or submitting a request in writing to the Exceptions department. If the request is initiated by phone, an exceptions fax form or electronic PA (ePA) request will be sent to the physician's office.

The exception fax form or ePA is completed by the member's physician and returned to the Exceptions department. A letter of medical necessity from the physician is also acceptable for exceptions reviews. The exceptions request is reviewed against the supporting criteria.

If the exception is approved, the technician enters the documentation and applicable overrides into the CVS Caremark authorization system. A test claim is processed to ensure the claim will pay when the member fills the prescription at the pharmacy. Approval letters are generated and faxed to the physician and mailed to the member.

If the exception does not meet the criteria requirements as required by the plan or state rules, the appropriate clinical reviewer will deny the exceptions request. Denial letters are generated and faxed to the physician and mailed to the member. Denial letters include directions on how to appeal the denial.

Exceptions are processed within the following time frames:

• **Urgent requests** from the member's physician are processed within 72 hours from receipt of the request. However, the CVS Caremark standard is to complete the review within 24 hours from receipt of all necessary information.

• **Non-urgent requests** are processed within 15 days from receipt of the request. However, the CVS Caremark standard is to complete the review within 72 hours from receipt of all necessary information.

Initial Non-Clinical Reviews

An Initial Non-Clinical Review is a request for coverage of medications or benefits that are not subject to a PA or an exception but are not covered by the Plan. Examples include, but are not limited to, non-covered medications, diabetes supplies and medical devices. A decision is based solely on the terms of the Plan, including the PDD, the preferred drug lists, formulary or other plan benefits selected by the client. An Initial Non-Clinical Review does not involve a clinical review or an assessment of whether the requested drug is medically necessary.

Appeals Program

Once a member or member's representative is notified that a claim is wholly or partially denied (an adverse determination), he or she has the right to appeal. Appeals may be based on an adverse benefit determination from an initial clinical review or an adverse non-clinical determination from an initial non-clinical review. Appeal requests must be submitted to the Appeals department by Fax, Mail or phone within 180 days after receiving an adverse determination notification. Urgent appeals may be submitted by phone or in writing. Non-urgent appeals may be submitted in writing by fax or mail:

Members can call the PA or CVS Caremark Customer Care line 1-877-876-7214 (option 2) and can be transferred to the appeals team to work an urgent appeal over the phone. Preferred method for receiving an appeal is via fax.

Non-specialty PA:

PA fax: 888-836-0730

PA Phone number: 800-294-5979

Specialty PA:

PA fax: 866-249-6155

PA phone number: 866-814-5506

Non-specialty appeals:

Prescription Claim Appeals MC 109

CVS Caremark

P.O. Box 52084

Phoenix, AZ 85072

Fax 866-443-1172

Specialty Appeals:

CVS Caremark

Specialty Appeals Department

800 Biermann Court

Mount Prospect, IL 60056

Fax 855-230-5548

Appeal Process:

The appeal process can be initiated with a letter of medical necessity via fax or mail written by the doctor stating why the medication should be considered for coverage or additional coverage. The letter of medical necessity should include:

- Patient's date of birth and ID number
- Name of requested drug
- State of why the appeal should be approved or the physician's disagreement with the denial reason
- Reason the medication is medically necessary
- Include any office chart, labs, or other clinical notes

The doctor can call to request an urgent appeal and would be transferred to the appeal department.

If you have questions or need help submitting an appeal, please call Customer Care for assistance at 1-877-876-7214 (option 2).

Once an appeal is received, the appeal and all supporting documenting are reviewed and completed, including a notification to the member and physician, within the following timelines:

- Urgent Pre-Service Appeal: 72 hours
- Non-Urgent Pre-Service Appeal:
    - For plans with one level of appeal: 30 days
    - For plans with two levels of appeal: 15 days
- Post-Service Appeal: 30 days

Review of Adverse Benefit Determinations

First-Level Clinical Appeal

First-level appeals are reviewed against predetermined medical criteria relevant to the drug or benefit being requested. This includes the consideration of relevant and supporting documentation submitted by the member or the member's authorized representative. Supporting documentation may include a letter written by the practitioner in support of the appeal, a copy of the denial letter sent by CVS Caremark, a copy of the member's payment receipt, medical records, etc. The appeal will be reviewed by an appropriately qualified reviewer. If the denial is upheld by the appeal, a denial notification will be sent to the member with instructions on how to request a second-level Medical Necessity review.

If a member's appeal is urgent, CVS Caremark will perform both the first level and second-level review as a combined appeal review within the designated timeframes. If the first-level request is approved, no further review is needed, and a notice of approval will be sent to the member. If the first-level review cannot be approved, a second-level Medical Necessity review will be initiated automatically. The member will receive notice of the determination at the conclusion of the Medical Necessity review. The two levels are combined to meet the designated urgent appeal timeframe.

Second-Level Medical Necessity Appeals

If the first-level appeal denial is upheld, the member or the member's authorized representative may choose to pursue a second-level appeal. The second-level appeal consists of a review to determine if the requested drug or benefit is medically necessary. These requests are reviewed either by an appropriately qualified reviewer or a sub-delegated medical necessity review organization (MNRO). If a member's appeal is urgent, CVS Caremark will perform the second-level review within the designated urgent appeal timeframe.

For appeals reviewed by the MNRO, the following will occur:

• CVS Caremark will forward applicable medical records, PA and appeals documentation, plan language and specific criteria to the MNRO.

• The independent physician reviewer selected by the MNRO to conduct the review will evaluate the provided documentation received with the case. If the physician reviewer determines additional information is necessary or potentially useful in the review, the physician reviewer may contact the member's physician to request such information.

• The independent physician reviewer will review current medical literature and available medical records and any additional information obtained from the prescribing physician. The independent physician reviewer will write an independent rationale in support of his or her final decision.

• The letter containing the rationale will be forwarded to CVS Caremark for communication to the member or the member's representative.

Review of Adverse Non-Clinical Determinations
CVS Caremark provides a single-level appeal for non-clinical appeals. Upon receipt of a non-clinical appeal, CVS Caremark will review the member's request for a particular drug or benefit against the terms of the Plan, including the preferred drug lists, formularies or other defined plan benefits selected by the Plan Sponsor or in the PDD. A non-clinical appeal will not involve an assessment of whether the requested drug or benefit is medically necessary.

Appeal Determination Process
Appeals and associated documentation are stamped with the date and time of receipt. Reviews are conducted within the applicable timeframes previously mentioned in this document. The appeal determination is rendered, and pertinent information is entered into the database. The determination is then communicated in writing to the member or the member's representative.
Communications are written in a manner to be understood by the member or the member's representative. Communications include:
• The specific reason(s) for the determination
• A reference to pertinent Plan provision on which the determination was based
• A notice that the member can submit a written request for the following at no cost: copies of all documents, records and other information relevant to the claim
• A copy of the specific rule, guideline, protocol or other similar criterion that was relied upon in making the determination, if applicable; or a statement that such rule, guideline, protocol or other similar criterion will be provided free of charge upon written request
• An explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the member's medical circumstances, if the Adverse Benefit Determination or Appeal of Adverse Benefit Determination is based on a Medical Necessity; or a statement that such explanation will be provided free of charge upon written request
• A statement of the member's right to bring action under (Employee Retirement Income Security Act) ERISA Section 502(a), if applicable
• A description of the available internal appeals processes and external review process, if available
• Information regarding the applicable office of health insurance consumer assistance or ombudsman established under the Section 2793 of the Public Health Services Act to assist individuals with internal claims and appeals and external review

If you have questions or need help submitting an appeal, please call Customer Care for assistance at 1-877-876-7214 (option 2).

Confidentiality

All member and client appeal documentation are handled in a confidential manner and in accordance with applicable statutes and regulations to protect the member's identity and his or her prescription history. To maintain confidentiality of member information, all appeal information becomes a part of a permanent case file.

Section 7.

Your Covered Health Care Services

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

- Provided by or arranged by the Member's PCP or an In-Network Specialist, unless noted otherwise in this Handbook.
- Medically Necessary, as defined in this Handbook
- Listed as a Covered Health Care Service in this Handbook
- Provided by a Network Provider, unless prior Authorization has been obtained from the Plan to see an Out-of-Network Provider.
- Provided to an eligible Member enrolled in the Plan. The Plan is not responsible for payment of any services provided prior to a Member's Eligibility date or after your Disenrollment Date.
- Authorized by the Plan when Authorization is required. For more information on Authorization requirements, see Section 5, check with your PCP, your Treating Provider, or call Customer Service. You should always check with your PCP or Treating Provider to make sure that any required Referrals or prior Authorizations have been obtained before the services are performed or the supplies are provided. Failure to obtain necessary Referrals or prior Authorizations may result in Member liability for payment. You do not need a Referral for: a Gynecologist or Obstetrician for routine, preventive, or Urgent Care; Family Planning Services; outpatient and Diversionary Behavioral Health Services; Emergency services; physical therapy, occupational therapy, speech therapy; and routine eye exams.

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

Major Disasters

The Plan will try to provide or arrange for services after major disasters. These might include war, riot, epidemic, public Emergency, or natural disaster. Other causes include the partial or complete destruction of Mass General Brigham Health Plan's facility(ies) or the disability of service Providers. If the Plan cannot provide or arrange services due to a major disaster, the Plan is not responsible for the costs or outcome of its inability.

Important Note for Some Covered Heath Care Services Noted Below

Services marked with an asterisk (*) below are subject to the Inpatient Copayment per admission/occurence, which is capped at four (4) copayments per benefit period, with a maximum of one copayment per quarter. Inpatient Copayment will be waived for readmission to a hospital for any reason if the readmission occurs within 30 days of release from a hospital; you must contact the Plan to have the Copayment waived.

Abortion and Abortion Related Care

Member cost: *$0 Copayment*

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.

Acupuncture

Member cost: *$20 Copayment*

Acupuncture is covered for the treatment of pain, detoxification, or as an alternative to anesthesia. Coverage is limited to the application of needles by a licensed acupuncturist. No coverage is provided for adjunct therapies including herbal

remedies, cupping, or other services that may be offered by an acupuncturist. See your Schedule of Benefits for applicable visit limits.

Acute Hospital Care

Member cost for facility fee:
Tier 1: *$275 Copayment,* then subject to Deductible per Inpatient admission /* ***Tier 2****: $500 Copayment,* then subject to Deductible per Inpatient admission /* ***Tier 3:*** *$1,500 Copayment,* then subject to Deductible per Inpatient admission*

Member cost for professional fee: *Subject to Deductible per Inpatient admission*

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

Ambulance Transportation

Member cost: *Subject to Deductible, then no Copayment*

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

Ambulatory/Day Surgery

Member cost for facility fee:

Outpatient Surgery for non-preventive colonoscopies, endoscopies, and eye surgeries:

*Free-standing/Ambulatory Surgical Center (ASC): $150 copayment**, then subject to deductible*

*Hospital-based: $250 copayment**, then subject to deductible*

All other Outpatient Surgery services:
*$250 copayment**, then subject to Deductible*

Member cost for professional fee: *Subject to Deductible*

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

** Per occurrence with a cap of four Copayments per benefit period.

Assisted Reproductive Services, Infertility and Treatment for Infertility

Member cost: Tier 1: *$30/* ***Tier 2:*** *$60/* ***Tier 3:*** *$75 Specialty Copayment*

Member cost for facility fee: *$250 copayment,* then Deductible in an outpatient surgical setting*

Member cost for professional fee: *Subject to Deductible per outpatient surgical setting*

Member cost for facility fee: Tier 1: *$275 Copayment,* then subject to Deductible per admission in a hospital setting /* ***Tier 2****: $500 Copayment,* then subject to Deductible per admission in a hospital setting /* ***Tier 3:*** *$1,500 Copayment,* then subject to Deductible per admission in a hospital setting*

Member cost for professional fee: *Subject to Deductible per Inpatient admission*

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

For purposes of meeting the criteria for Infertility, if a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the one-year or six-month period, as applicable.
The Plan will cover Medically Necessary expenses for Assisted Reproductive Services including the diagnosis and nonexperimental treatment of Infertility to the same extent that Benefits are provided for other Medically Necessary services. The following procedures are covered, but are not limited to:

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

The Plan does not provide coverage for:

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

Important notice: Please see the up to date medical policy at Member.MassGeneralBrighamHealthPlan.org detailing clinical coverage criteria.

Autism

Member cost is based on type of service and treating provider.

The Plan covers the diagnosis and treatment of Autism Spectrum Disorders (ASD) when medically necessary. Diagnosis includes medically necessary assessments, evaluations including neuropsychologic evaluations, genetic testing or other tests to diagnose whether an individual has ASD. Autism spectrum disorders are defined as any of the pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, Asperger's Disorder, and pervasive developmental disorders not otherwise specified. Treatment for autism includes habilitative or rehabilitative care, psychiatric care, psychological care, and therapeutic care. Services for autism are provided by Autism Service Providers available in the Network.

Habilitative or rehabilitative care includes professional, counseling and guidance services and treatment programs, including, but not limited to, applied behavior analysis supervised by a board-certified behavior analyst, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of an individual. Applied behavior analysis includes the design, implementation and evaluation of environmental modifications, using

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

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

Behavioral Health (Mental health and Substance Use Benefits)

See "Section 8. Behavioral Health Services" for details.

Blood and Blood Products

Member cost: *$0 Copayment*

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

Blood Glucose Monitoring Strips

Member cost: *Subject to Deductible, then no Copayment*
Also see "Diabetic Services and Supplies" in this section.

The Plan provides coverage for blood glucose monitoring strips. Your Provider must issue a written order when Medically Necessary for the treatment of insulin-dependent, insulin-using, gestational and non-insulin-dependent diabetes.

Cardiac Rehabilitation Coverage

Member cost: *$20 Copayment*

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

Chiropractic Care

Member cost: *$20 Copayment*

The Plan covers Chiropractic care for up to 20 visits per benefit period. Prior authorization is required for members under the age of 13.

Cleft Lip and Cleft Palate Treatment for Children

Member cost is based on type of service and treating provider.

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

Clinical Trials

Member cost is based on type of service and treating provider.

If you participate in an approved clinical trial while you are a Member, we will cover the medically necessary Covered Health Services listed in this Section 7 during the period of the clinical trial that you are a Member of the Plan as long as you meet certain requirements.

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

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

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

Cytologic Screening (Pap Smears)

Member cost: *$0 Copayment*

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

Dental Services—Emergency

Member cost: *$100 Copayment, then subject to Deductible when in Emergency Room (Copayment waived if admitted to hospital).*

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

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

Dental Services—Other

Member cost: *$250 Copayment*, then subject to Deductible in an outpatient surgical setting*

Member cost facility fee: Tier 1: *$275 Copayment,* then subject to Deductible per Inpatient surgical setting /* ***Tier 2****: $500 Copayment,* then subject to Deductible per inpatient surgical setting /* ***Tier 3:*** *$1,500 Copayment,* then subject to Deductible per Inpatient surgical setting*

Member cost professional fee: *Subject to Deductible per Inpatient surgical setting*

Removal of seven or more permanent teeth, excision of radicular cysts involving the roots of three or more teeth, extraction of impacted teeth, gingivectomies of two or more gum quadrants in an outpatient hospital setting.

Benefits are provided for the dental services listed only when the Member has a serious medical condition that makes it essential that he or she be admitted to a general hospital as an Inpatient or to a surgical day care unit or ambulatory surgical facility as an outpatient in order for the dental care to be performed safely. Serious medical conditions include, but are not limited to, hemophilia and heart disease.

Diabetic Services and Supplies

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

Outpatient services: outpatient diabetes self-management training and education:
Member cost: Tier 1: *$10/* ***Tier 2:*** *$20/* ***Tier 3:*** *$40 PCP Copayment,* ***Tier 1:*** *$30/* ***Tier 2:*** *$60/* ***Tier 3:*** *$75 Specialty Copayment*

- Laboratory/radiological services: all laboratory tests and urinary profiles:
  Member cost:
  Preventive lab: $0 Copayment
  Diagnostic, Laboratory and X-ray: Subject to Deductible, then no Copayment
- Durable medical equipment: blood glucose monitors, voice-synthesizers, visual magnifying aids, and continuous glucose monitors:
  Member cost: *Subject to Deductible, then 20% coinsurance*
- Prosthetics: therapeutic/molded shoes and shoe inserts:
  Member cost: *Subject to Deductible, then 20% coinsurance*

Dialysis

Member cost: *Subject to Deductible, then no Copayment*

The Plan covers kidney dialysis on an Inpatient or Outpatient basis, or at home. You must apply for Medicare when federal law permits Medicare to be the primary payer for dialysis. You must also pay any Medicare Premium. When Medicare is primary (or would be primary if the Member were timely enrolled) the Plan will pay for services only to the extent payments would exceed what would be payable by Medicare. Your PCP must arrange dialysis services. If you are temporarily outside the Service Area, the Plan covers limited dialysis services. You must make prior arrangements with your PCP, who must obtain approval from usfor this coverage except in an Emergency.

Disposable Medical Supplies

Member cost: *Subject to Deductible, then no Copayment*

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

Durable Medical Equipment (DME)

Member cost: *Subject to Deductible, then 20% coinsurance*

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

Coverage includes but is not limited to the purchase of medical equipment, replacement parts, and repairs. Your treating provider must order Durable Medical Equipment. Examples of equipment not covered includes but is not limited to: assisted listening devices, exercise equipment that is appropriate for a professional setting, but is not

medically necessary for home use and includes Functional Electrical Stimulation, physiotherapy equipment and foot orthotics except for children 15 and under with symptomatic flat feet and pronation.

Early Intervention Services

Member cost: *$0 Copayment*

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

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

Emergency Services

Member cost: *$100 Copayment, then subject to Deductible (Copayment waived if admitted to hospital)*

The Plan covers Emergency services including ambulance services needed for transportation to the nearest hospital that can provide the care you need. The Cost-Sharing above includes all services you receive during the Emergency occurrence for the same hospital and date of service. If you need Emergency care, the Plan will cover those services even when they are furnished by a Provider who is not an In-network Provider. You do not need a Referral from your PCP for Emergency Services. Simply go to the nearest Emergency facility or call 911 or the Emergency phone number.

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).

Eye Care—Examinations (Vision Care)

Member cost: Tier 1: *$10/* ***Tier 2:*** *$20/* ***Tier 3:*** *$40 PCP Copayment, Eye Exam:* ***Tier 1:*** *$30/* ***Tier 2:*** *$60/* ***Tier 3:*** *$75 Specialty Copayment*

The Plan covers routine eye exams for Members once every 24 months. You may use any Network ophthalmologist or optometrist for routine eye exams, and you do not need a Referral from your PCP. For all other non-routine eye care services (difficult vision, blurry vision, loss of vision), you must see your PCP who will arrange a Referral to an ophthalmologist (eye care Specialist).

There is no coverage for eyeglasses or contact lenses* (except when Medically Necessary for certain eye conditions such as treatment of keratoconus and following cataract surgery), or low vision aids (except for visual magnifying aids used by legally blind Members with diabetes).

*Limited to first pair within 6 months of eye injury or cataract surgery

Family Planning Services

Member cost: *$0 Copayment*

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

Fitness Program Reimbursement

Reimbursement up to $150 per individual or $300 per family per calendar year and are provided for membership fees related to joining a qualified health club, gym, sports club or related physical fitness facility. To qualify for reimbursement, members must be enrolled in a qualified gym and the Plan for at least four months and submit their reimbursement requests by March 31 of the following calendar year. Reimbursement amounts may not exceed the amount paid for the membership.

Gender Affirming

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

Gynecologic/Obstetric Care

Member cost: *$0 PCP Copayment,* ***Tier 1:*** *$30/* ***Tier 2:*** *$60/* ***Tier 3:*** *$75 Specialty Copayment*

The Plan covers Medically Necessary gynecological and obstetrical services. You are not required to obtain a Referral or Prior Authorization for Gynecological or Obstetric care provided by an obstetrician, gynecologist, certified nurse midwife or family practitioner participating in the Network. However, the health care professional may be required to obtain Prior Authorization for certain services and to follow procedures for making Referrals.

Habilitation Services

Member cost: *$20 Copayment per outpatient visit*

Member cost for facility fee: *Subject to Deductible, then no copayment per Inpatient admission*
Member cost for professional fee: *Subject to Deductible, then no copayment per Inpatient admission*

The Plan covers Medically Necessary Habilitation Services for qualified members with certain conditions. These are Health Care Services that help a person keep, learn, or improve skills and functioning for daily living.

Examples include therapy for a child who isn't walking or talking at the expected age. See your Schedule of Benefits for Benefit limits. Depending on setting, please see Physical Therapy/Occupational Therapy, Speech Therapy, Home Health Care or Inpatient Medical Care.

Hearing Aids

Member cost for Members age 21 and younger: *Covered up to $2,000 for each affected ear every 2 years*

Member cost for Members age 22 and older: *Covered up to $1,700 every 2 years for both ears*

The Plan provides coverage of Hearing Aids, including the initial Hearing Aid evaluation, fitting and adjustments, and supplies, including ear molds, when prescribed by a Network Provider. If you choose a higher-priced Hearing Aid, you

must pay the difference between the cost and the Plan's coverage limits above. Batteries and assistive listening devices are not covered.

Hearing Examinations

Member cost: Tier 1: *$30/* ***Tier 2:*** *$60/* ***Tier 3:*** *$75 Specialty Copayment*

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

HIV-Associated Lipodystrophy Treatment

Member cost is based on type of service and treating provider.

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

Home Health Care

Member cost: *Subject to Deductible, then no Copayment*

The Plan covers home health care according to a physician-approved home health care plan when such care is an essential part of medical treatment and there is a defined goal. Home Health Care Services are provided in a patient's residence by a public or private home health agency. Services include, but are not limited to, nursing and physical therapy, occupational therapy, speech therapy, medical social work, and nutritional consultation, the services of a home health aide and the use of Durable Medical Equipment (DME) and supplies if medical necessary. No limits other than medical necessity and being part of a physician approved home health services plan are placed on home care services. Your PCP or Treating Provider must arrange services.

Home Infusion

Member cost: *$0 Copayment*

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

Hospice

Member cost: *Subject to Deductible, then no Copayment*

The Plan covers hospice care for terminally ill Members with a life expectancy of six (6) months or less. Services must be found to be suitable and authorized by the Member's PCP. Services must also be equal to those services provided by a licensed hospice program regulated by the Department of Public Health.

House Calls

Member cost: Tier 1: *$10/* ***Tier 2:*** *$20/* ***Tier 3:*** *$40 PCP Copayment,* ***Tier 1:*** *$30/* ***Tier 2:*** *$60/* ***Tier 3:*** *$75 Specialty Copayment*

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

Immunizations, Vaccinations

Member cost: *$0 Copayment*

The Plan covers immunizations and vaccinations including travel vaccines when approved and part of an office visit.

Laboratory Services

Member cost:
Preventive Lab: $0 Copayment
Diagnostic Lab: Subject to Deductible, then no Copayment

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

Long-Term Antibiotic Therapy for the Treatment of Lyme Disease

Member cost is based on type of service and treating provider.

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

Mammographic Examination (Mammogram)

Member cost: *$0 Copayment*

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

Maternity Services—General Coverage

Member cost is based on type of service and treating provider.

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

Maternity Services—Inpatient

Member cost facility fee: Tier 1: *$275 Copayment,* then subject to Deductible for Inpatient admission hospital /* ***Tier 2****: $500 Copayment,* then subject to Deductible for Inpatient admission hospital /* ***Tier 3:*** *$1,500 Copayment,* then subject to Deductible for Inpatient admission hospital*

Member cost professional fee: *Subject to Deductible, then no copayment for Inpatient admission hospital*

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

If the newborn child requires additional inpatient hospital care after the mother has been discharged, then the newborn child must be enrolled in the plan for services to be covered. This will result in the child being admitted for an inpatient stay and appropriate inpatient medical cost sharing will apply. Newborn children must be added to your GIC insurance policy as a dependent within 60 days of birth.

Maternity Services—Outpatient

Member cost: *$0 PCP Copayment,* ***Tier 1:*** *$30/* ***Tier 2:*** *$60/* ***Tier 3:*** *$75 Specialty Copayment*

The Plan covers prenatal and postpartum care for members when care is received from a Network Provider. Services include: prenatal exams; diagnostic tests; prenatal nutrition; health care counseling; risk assessment; and post-partum exams. Routine prenatal care includes your visits to the provider managing your pregnancy and a postpartum visit. These routine prenatal care services have Cost-Sharing as outlined on your Schedule of Benefits. All other services provided may be subject to Cost-Sharing including labs, obstetrical ultrasounds, and other diagnostic tests. There is no coverage for obstetrical care outside the Service Area within thirty (30) days of expected delivery date. Your PCP, obstetrician, or certified nurse midwife will order medically necessary tests and must arrange for outpatient maternity services. The Plan reimburses Members up to $130 for childbirth education classes.

Nutritional Formulas

Member cost: *Subject to Deductible, then no Copayment*

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

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

Obstetrical Services

See "Gynecologic/Obstetric Care" above.

Optometric/Ophthalmologic Care

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

Orthotics

Member cost: *Subject to Deductible, then 20% coinsurance*

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

Outpatient Surgery

Member cost for facility fee:

Outpatient Surgery for non-preventive colonoscopies, endoscopies, and eye surgeries:

*Free-standing/ASC: $150 copayment**, then subject to deductible*

*Hospital-based: $250 copayment**, then subject to deductible*

*All other Outpatient Surgery services: $250 copayment**, then subject to Deductible*

Member cost for professional fee: *Subject to Deductible when performed in a surgical setting*

Member cost when performed in an office setting: Tier 1: *$10/* ***Tier 2:*** *$20/* ***Tier 3:*** *$40 PCP Copayment,* ***Tier 1:*** *$30/* ***Tier 2:*** *$60/* ***Tier 3:*** *$75 Specialty Copayment*

The Plan covers Medically Necessary surgical procedures in an outpatient surgical setting. These services are subject to outpatient surgery Cost-Sharing. If you have an emergency room visit resulting in surgery and you expect to be discharged the same day, emergency room Cost-Sharing will not apply, outpatient surgery Cost-Sharing applies. The Plan also covers Medically Necessary outpatient surgery that occurs in an office setting; these services would be subject to Cost-Sharing associated with the office in which it was performed (PCP or Specialty).

** Per occurrence with a cap of four Copayments per benefit period.

Oxygen Supplies and Therapy

Member cost: *Subject to Deductible, then no Copayment*

The Plan covers oxygen therapy for Members, when medically necessary. Coverage includes oxygen and equipment rental and supplies required to deliver the oxygen. Your treating provider must arrange oxygen therapy services.

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

Member cost is based on type of service and treating provider.

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

Pediatric Specialty Care

Member cost: Tier 1: *$30/* ***Tier 2:*** *$60/* ***Tier 3:*** *$75 Specialty Copayment*
$10 Copayment for outpatient Behavioral Health Specialist

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

Pharmacy

Pharmacy Benefits are offered under separate GIC Coverage and administered through CVS Caremark. See "Section 6. GIC's Pharmacy Benefit" for details on your Benefits and Copayments.

Physician Services

Member cost:
$10 copayment for Tier 1 PCP
$20 copayment for Tier 2 PCP
$40 copayment for Tier 3 PCP
$30 Copayment for Tier 1 Specialist
$60 copayment for Tier 2 Specialist
$75 copayment for Tier 3 Specialist
$10 Copayment for Behavioral Health Specialist

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

Podiatry Services

Member cost: Tier 1: *$10/* ***Tier 2:*** *$20/* ***Tier 3:*** *$40 PCP Copayment,* ***Tier 1:*** *$30/* ***Tier 2:*** *$60/* ***Tier 3:*** *$75 Specialty Copayment*

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

Preventive Care Services and Tests

Member cost: *$0 Copayment*

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

For a complete list of eligible Preventive Care services, please visit Member.MassGeneralBrighamHealthPlan.org or contact Customer Service. Covered preventive services reflect the United States Preventive Services Task Force (USPSTF) grade "A" and "B" recommendations, the Advisory Committee on Immunization Practices (ACIP) recommendations, the Women's Preventive Task Force, and the Health Resources and Services Administration for Infants, Children and Adolescents. Preventive service descriptions have been adopted from content on the https://www.healthcare.gov/ website.

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

Prosthetic Devices

Member cost: *Subject to Deductible, then 20% coinsurance*

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

Radiation and Chemotherapy

Member cost: *Subject to Deductible, then no Copayment*

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

Radiology

Member cost: *Subject to Deductible, then no Copayment for Diagnostic, Laboratory and X-ray $100 Copayment, then subject to Deductible with a maximum of 1 Copayment per day for High Technology Radiology (outpatient MRI, CT, PET Scan, and Nuclear Cardiac Imaging)*

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

Reconstructive/Restorative Surgery

Member cost for facility fee: Tier 1: *$275 Copayment,* then subject to Deductible per Inpatient surgical admission / **Tier 2**: $500 Copayment,* then subject to Deductible per Inpatient surgical admission /* ***Tier 3:*** *$1,500 Copayment,* then subject to Deductible per Inpatient surgical admission*

Member cost for professional fee: *Subject to Deductible per Inpatient surgical admission*

Member cost for facility fee: *$250 copayment*, then subject to Deductible per outpatient Surgery occurrence*

Member cost for professional fee: *Subject to Deductible per outpatient Surgery occurrence*

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

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

Your PCP must arrange reconstructive or restorative surgery services.

Registered Nurse or Nurse Practitioner

Member cost: Tier 1: *$10/* ***Tier 2:*** *$20/* ***Tier 3:*** *$40 PCP Copayment,* ***Tier 1:*** *$30/* ***Tier 2:*** *$60/* ***Tier 3:*** *$75 Specialty Copayment*

The Plan covers services given by a registered nurse, Nurse Practitioner, nurse midwife, or nurse anesthetist if such services are in the nurse's scope of practice. Your PCP must arrange these services.

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

Member cost for facility fee: *Subject to Deductible per Inpatient admission*

Member cost for professional fee: *Subject to Deductible per Inpatient admission*

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

Rehabilitation Therapy – Outpatient (Includes Physical, Occupational, and Speech Therapy)

Member cost: *$20 copayment*

The Plan covers evaluation and restorative, short-term treatment when needed to improve the ability to perform activities of daily living and when there is likely to be a significant improvement in the Member's level of function after illness or injury. See your Schedule of Benefits for limitations on Physical or Occupational Therapy. A medical necessity review process is in place for members requiring visits beyond the limitation.

Routine Nursery and Newborn Care

Member cost: *$0 Copayment*

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

Second Opinions

Member cost: Tier 1: *$10/* ***Tier 2:*** *$20/* ***Tier 3:*** *$40 PCP Copayment,* ***Tier 1:*** *$30/* ***Tier 2:*** *$60/* ***Tier 3:*** *$75 Specialty Copayment*

The Plan covers second opinions when provided by another Network Provider. A Referral from your PCP is needed when seeking a Second Opinion for another Network Provider. Second opinions from Out-of-Network Providers are covered only when the specific expertise requested is not available in the Network. Prior Authorization from the Plan is required.

Skilled Nursing Facility Care

Member cost for facility and professional fee: *Subject to Deductible, then 20% coinsurance*

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

Specialty Care

Member cost: *Cost sharing varies depending on type of service. Please see your schedule of Benefits for cost sharing associated with specialty care.*

The Plan covers specialty care when arranged by a Member's PCP.

Referrals for Specialty Care

A Referral is required for Specialty Care; without a Referral, the Plan will not reimburse for the Specialist visit and you could be liable for the cost. You are not required to get a Referral or Prior Authorization for the following care in the Provider Network:

- Gynecologist or Obstetrician for routine, preventive, or Urgent Care
- Family planning services
- Emergency services
- Routine Eye exam
- Physical Therapy

- Occupational Therapy
- Speech Therapy

Speech, Hearing and Language Disorders

Member cost: *$20 copayment*

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

Surgery

Member cost for facility fee: Tier 1: *$275 Copayment,* then subject to Deductible per Inpatient hospital admission /* ***Tier 2****: $500 Copayment,* then subject to Deductible per Inpatient hospital admission /* ***Tier 3:*** *$1,500 Copayment,* then subject to Deductible per Inpatient hospital admission*

Member cost for professional fee: *Subject to Deductible per Inpatient hospital admission*

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

Telemedicine

Member cost:
$10 copayment for On Demand, Primary Care, or Specialty Care
*$10 copayment for behavioral health visit**

**member cost sharing is waived for first 3 behavioral health visits*

Additional Cost-Sharing may apply to services ordered by the physician, such as labs and prescription drugs.

The Plan provides audiovisual urgent care visits through a national network of U.S. board-certified doctors 24/7 to discuss nonemergency physical or mental health conditions accessed by smartphone, mobile device, or online via computer. Your PCP or Specialist provider may also offer this type of service. Behavioral health telemedicine visits are provided by Optum and can be accessed via the "My Coverage: Behavioral Health" page on Member.MassGeneralBrighamHealthPlan.org. Doctors can diagnose and treat many common illnesses via telemedicne. Telephone (voice only), facsimile or email communications with your provider are not considered telemedicine. Regulations concerning future Telemedicine services are currently under review by state regulators. To find updated information on Telemedicine services or a Telemedicine provider visit Member.MassGeneralBrighamHealthPlan.org or talk with your provider directly.

Temporomandibular Joint Syndrome (TMJ) Dysfunction Services

Member cost will be associated with the service and where it occurs. For example, Diagnostic imaging will take Cost-Sharing associated with Diagnostic Laboratory and X-ray as it appears on your Schedule of Benefits.

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

- Medical and Surgical consultation and treatment;
- Surgery;
- Diagnostic imaging;

- Physical therapy, subject to the visit limit for outpatient physical therapy provided by a licensed physical therapist; and
- Splint therapy

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

Transplants

Member cost for Inpatient facility fee: Tier 1: *$275 Copayment,* then subject to Deductible per Inpatient hospital admission /* ***Tier 2****: $500 Copayment,* then subject to Deductible per Inpatient hospital admission /* ***Tier 3:*** *$1,500 Copayment,* then subject to Deductible per Inpatient hospital admission*

Member cost for Inpatient professional fee: *Subject to Deductible per Inpatient hospital admission*

The Plan covers transplants as follows:

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

Transportation

Member cost: *Subject to deductible*

Emergency ambulance transportation, including air ambulance, is covered. The Plan covers such ambulance transport to the nearest Hospital that can provide the care you need. Except in an Emergency, ambulance transportation is covered only when arranged by a Network Provider. Medically Necessary transfers from one health care facility to another are also covered.

Urgent Care

Member cost: *$20 Copayment*

The Plan covers Urgent Care and walk-in Clinics inside and outside the Service Area. Walk-in clinics are sites that offer medical care on a walk-in basis, so no appointment is needed. Although walk-in clinics have a variety of different names, they fall into four general categories. These four categories differ based on the services they offer and how they bill for their services.

- **Medical practices** – Some doctors' offices offer services to walk-in patients. They offer the services you'd expect to get at a primary care practice.
- **Retail health clinics** (such as CVS's MinuteClinic®) are located in retail stores or pharmacies. They offer basic services like treatment for colds or mild sinus infections.
- **Urgent care centers** are independent, stand-alone locations that treat conditions that should be handled quickly but that aren't life-threatening. They often do X-rays, lab tests and stitches.
- **Hospitals** – Some hospitals have walk-in clinics within or associated with their emergency departments.

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

Vision Care

See “Eye Care—Examinations (Vision Care).”

Wigs (Scalp Hair Prosthesis for Cancer Patients)

Member cost: *Subject to Deductible, then 20% coinsurance*

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

* Per admission/occurrence with a cap of four Copayments per benefit period, with a maximum of one Inpatient Copayment per quarter. Inpatient Copayment will be waived for readmission to a hospital for any reason if the readmission occurs within 30 days of release from a hospital; you must contact Mass General Brigham Health Plan to have the Copayment waived.

Section 8.

Behavioral Health Services

Behavioral Health (General)

The Plan's Behavioral Health treatment Benefits include non-custodial, Inpatient, intermediate and outpatient services based on medical necessity criteria for treatment in the least restrictive, clinically appropriate setting. The Plan does not apply any Copayments, Deductibles, Coinsurance or maximum lifetime Benefits to Behavioral Health services that are not equally applied to other covered Health Care Services. Please see your Schedule of Benefits for more information on your Behavioral Health Benefits, or call Customer Service.

Optum is the Plan's delegated managed Behavioral Health Organization (MBHO). All decisions to deny Behavioral Health services are made only by the appropriately Licensed Mental Health Professionals. Optum maintains a Network of clinicians, groups, clinics and practices to provide Behavioral Health treatment services within the Service Area.

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

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

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

The Plan provides coverage for the diagnosis and treatment of:

- Biologically-based mental, behavioral, or emotional disorders, including schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia, panic disorder, obsessive-compulsive disorder, delirium and dementia, affective disorders, eating disorders, post-traumatic stress disorder, substance use disorders, autism, and other psychotic disorders or other biologically- based mental disorders appearing in the Diagnostic and Statistical Manual (DSM) that are scientifically recognized.
- Rape-related mental or emotional disorders to 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 or annual dollar or unit limitation.
- Non-biologically-based mental, behavioral or emotional disorders, in children and adolescents under the age of 19, which substantially interfere with or substantially limit the functioning and social interactions of such a child or adolescent; provided that said interference or limitation is documented by and the Referral for said diagnosis and treatment is made by the PCP, primary pediatrician or a Licensed Mental Health Professional of such a child or adolescent or is evidenced by conduct, including, but not limited to: an inability to attend school as a result of such a disorder; the need to hospitalize the child or adolescent as a result of such a disorder; or a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others. The Plan will continue to provide such Benefits to any adolescent who is engaged in an ongoing course of treatment beyond the adolescent's nineteenth birthday until said course of treatment is completed, provided that the Benefits available remain in effect. Treatment is based on medical need for the service without any annual or lifetime dollar or unit limitation.
- All other non-biologically-based mental health conditions.

Psychopharmacological and neuropsychological assessments are covered when Medically Necessary.

Behavioral Health Services (Outpatient)

Members may directly seek outpatient mental health and substance use counseling or medication services from any licensed clinician in the Network. Please use the online Provider Directory at Provider Directory at MassGeneralBrighamHealthPlan.org, to locate a Behavioral Health clinician nearby.

The Network includes:

- Physicians with a specialty in psychiatry
- Licensed psychologists
- Licensed alcohol and drug counselors
- Licensed independent clinical social workers
- Licensed marriage and family therapists
- Licensed mental health clinical nurse Specialists
- Licensed mental health counselors

Members can contact In-Network Providers of these services for treatment. A Referral from your PCP is not needed.

Your mental health provider is required to contact Optum for any Authorizations needed. All Authorizations are based on the medical necessity and the Member's clinical needs. All cost-sharing for outpatient mental health or substance use services are listed in your Schedule of Benefits. Biologically-based mental health services are provided without annual, lifetime or visit/unit/day limitations. No other limitations, Coinsurance, Copayment, Deductible or other Cost-Sharing may be applied toward these Benefits except as are applied to covered medical services within the Plan. Services may be provided in a licensed hospital; a mental health or substance use clinic licensed by the Department of Mental Health or Public Health; a community mental health center; or a professional office or home-based service, as long as services are rendered by a Licensed Mental Health Professional acting within the scope of his or her license.

Behavioral Health Services (Intermediate)

The Plan covers Medically Necessary Intermediate Behavioral Health services. Services including:

- Partial hospitalization
- Day Treatment
- Acute and other residential treatment programs
- Clinically managed detoxification services
- Crisis stabilization
- Intensive Outpatient Programs (IOP)

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

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

Intensive community-based treatment (ICBAT)
Provides the same services as CBAT for children and adolescents but of higher intensity, including more frequent psychiatric and psychopharmacological evaluation and treatment and more intensive staffing and service delivery.

ICBAT programs have the capability to admit children and adolescents with more acute symptoms than those admitted to CBAT. ICBAT programs are able to treat children and adolescents with clinical presentations similar to those referred to inpatient mental health services but who are able to be cared for safely in an unlocked setting. Children and adolescents may be admitted to an ICBAT as an alternative to inpatient hospitalization; ICBAT is not used as a step-down placement following discharge from a locked, 24-hour setting.

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

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

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

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

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

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

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

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

You or your Behavioral Health Provider must get prior Authorization from Optum or provide notification to Optum for these services except for SOAP, community based detoxification, addiction day treatment program for pregnant women.

To obtain services, call Optum at 844-875-5722 (TTY 711). You may also contact your PCP for help.

Behavioral Health Services (Inpatient)

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

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

Mental Health/Substance Use Summary of Copayments

Member cost: *$10 per Office Visit for outpatient Mental/Substance Use including detoxification rehabilitation*

$0 Copayment Office Visit for Medication Assisted Treatment (MAT)

$0 Copayment for the following generic drugs for Medication Assisted Treatment: generic buprenorphine-naloxone, naloxone, and naltrexone

$275 Copayment for Inpatient Care Mental Health or Substance Use including detoxification*

*Per admission with a cap of four copayments per benefit period, with a maximum of one inpatient copayment per quarter. Inpatient copayment will be waived for readmission to a hospital for any reason if the readmission occurs within 30 days of release from a hospital; you must contact Mass General Brigham Health Plan to have the copayment waived.

Federal and State Mental Health Parity laws

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

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

Your Rights and Obligations According to the Mental Health Parity Laws

- The Plan must provide you with the same level of Benefits for mental health and substance use problems you have as for other medical/surgical problems you may have.
- The Plan must have similar prior Authorization requirements and treatment limitations for mental health and substance use services as we do for medical/surgical services.
- Upon your or your Provider's request, the Plan must provide you or your Provider with a copy of the medical necessity criteria used by us for prior Authorization.
- Within a reasonable time frame, the Plan must provide you with a written notice regarding any denial of Authorization for mental or substance use services. See "Section 17. Utilization Review."
- You have the right to receive a second medical opinion on a mental health or substance use problem when you are given a diagnosis or treatment option. Also remember that you can access outpatient mental health and substance use services from a Optum Behavioral Health Provider without obtaining a Referral from your PCP.

Submitting a Complaint About a Mental Health Parity Issue

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

Submitting a Complaint to Mass General Brigham Health Plan

To submit a Complaint about a mental health parity issue to us, follow the instructions shown in "Section 15. Complaint and Grievance Process."

Submitting a Complaint to the Massachusetts Department of Insurance

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

Consumer Complaints regarding alleged non-compliance with the mental health parity laws may also be submitted by telephone to the Division's Consumer Services Section by calling (877) 563-4467 or (617) 521-7794. All Complaints that are initially made verbally by telephone must be followed up by a written submission to the Consumer Services Section, which must include but is not limited to the following information requested 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 Clinical Guidelines and Utilization Review Criteria

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

Section 9.

Benefit Exclusions and Limitations

The Plan does not cover the following services or supplies whether provided in connection with medical and surgical benefits or with mental health and substance use disorder benefits:

Ambulance

No benefits are provided for ambulance costs to transport you to a facility of your choice or to return you to the United States from another Country, also referred to as repatriation or medical evacuation.

Benefits from Other Sources

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

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

Biofeedback

The Plan does not provide coverage for biofeedback.

Blood and Related Fees

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

Charges for Missed Appointments

No coverage is provided for charges for missed appointments.

Concierge Services

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

Cosmetic Services and Procedures

The Plan does not provide coverage for Cosmetic Services that are performed solely for the purpose of making you look better whether or not these services are meant to make you feel better about yourself or treat a mental condition. For

example, Surgery to treat acne lesions or remove tattoos and medications for cosmetic purposes to treat hair loss or wrinkles. Reconstructive Surgery is covered, please see "Section 7. Your Covered Health Care Services" for details.

Custodial Care

The Plan does not provide coverage for custodial or rest care: this is care given to help a person in the activities of daily living and does not require day-to-day attention by medically-trained persons.

Dental Care

The Plan does not provide coverage for routine, preventive, and restorative dental care.

Dentures

The Plan does not provide coverage for dentures.

Diet Foods

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

Drugs prescribed off-label

The Plan does not provide coverage for the off-label use of a prescription drug (the use of a drug for a purpose not approved by the Food and Drug Administration) unless the use meets the Plan's definition of medical necessity.

Educational Testing and Evaluations

The Plan does not provide coverage for educational services or testing unless they are covered under the Early Intervention Services and Outpatient Mental Health and Substance Use Benefit. No Benefits are provided for educational services whose sole intent is to enhance educational achievement (e.g., subject achievement testing) or to resolve problems regarding school performance.

Exams Required by a Third Party

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

Experimental Services and Procedures

The Benefits described in this Member Handbook are provided only when covered services are furnished in accordance with the Plan's medical technology assessment guidelines. No Benefits are provided for health care charges that are received for or related to care that the Plan considers experimental services or procedures. The fact that a treatment is offered as a last resort does not mean that Benefits will be provided for it.

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

- One or more stem cell (bone marrow) transplants for a member who has been diagnosed with breast cancer that has spread. The Member must meet the eligibility standards that have been set by the Massachusetts Department of Public Health;
- Coverage of patient care services provided during a qualified clinical trial intended to treat cancer.
- Services, procedures, devices, biologic products, drugs (collectively "treatment") and programs when there is sufficient scientific evidence to support their use.

Eyewear/Laser Eyesight Correction

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

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

Foot Care

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

Long-term Care

The Plan does not provide coverage for medical or behavioral long-term care.

Massage Therapy

The Plan does not provide coverage for Massage Therapy.

Other Non-Covered Services

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

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

Out-of-Network Providers

The Plan does not provide coverage for any service that is provided to, arranged by, or approved by a Provider that is not Member's PCP or another Network Provider. Also, no Benefits are provided for Medications or supplies prescribed by Providers not authorized to provide care by the Plan, except as covered outside the Service Area.

Personal Comfort Items

The Plan does not provide coverage for items or services that are furnished for your personal comfort or for the convenience of your family. Examples of these types of items or services are: phones, radios, TVs and personal care services. The following items are generally deemed convenience items:

- Air conditioners

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

Planned Home Births

The Plan does not provide coverage for planned home births.

Prescription Drugs

Prescription drugs and/or over-the-counter drugs are administered through CVS Caremark.

Private-Duty Nursing

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

Reversal of Voluntary Sterilization

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

Self-Monitoring Devices Limitation

The Plan does not provide coverage for self-monitoring devices that are used in the absence of serious medical conditions. For example, a Personal Emergency Response System is not covered. Coverage is provided for:

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

Wilderness Therapy

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

Section 10.

When You Have Other Coverage

This section explains how Benefits under this policy will be coordinated with other health Benefits available to pay for Health Care Services that a Member has received. Benefits are coordinated among payors, such as insurance Carriers, so that only one payment is made for a service. Nothing in this section should be interpreted to provide coverage for any service or supply that is not expressly covered under this Handbook or to increase the level of coverage provided.

Coordination of Benefits

Benefits in the Plan Document will be coordinated to the extent permitted by law with other health Benefits including but not limited to homeowner's insurance, motor vehicle insurance, group and/or non-group health insurance, Hospital indemnity Benefits that exceed $100 per day, and governmental Benefits (including Medicare).

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

Primary vs. Secondary Coverage

When a Member is covered by two or more health Benefit plans, one plan will be "primary" and the other plan (or plans) will be "secondary." The Benefits of the primary plan are determined before those of the secondary plan(s) and without considering the Benefits of the secondary plan(s). The Benefits of the secondary plan(s) are determined after those of the primary plan and may be reduced because of the primary plan's Benefits.

In the case of health Benefit plans that contain provisions for the Coordination of Benefits, the following rules shall decide which health Benefit plans are primary or secondary based upon the Massachusetts Regulation 211 CMR 38.00:

Dependent/Non-dependent

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

A Dependent Child Whose Parents/Guardians are Not Separated or Divorced

The order of Benefits is determined as follows:

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

A Dependent Child Whose Parents are Separated or Divorced

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

- First, the plan of the parent with custody of the child.
- Then, the plan of the spouse of the parent with custody of the child
- Finally, the plan of the parent not having custody of the child

Active/Inactive Employee

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

Longer/Shorter Length of Coverage

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

Provider Payment when Mass General Brigham Health Plan Coverage is Secondary

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

Worker's Compensation/Government Programs

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

Subrogation on Behalf of GIC

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

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

You must give us information and help. This means you must complete and sign all necessary documents to help Mass General Brigham Health Plan get this money back.This also means that you must give us notice before settling any Claim arising out of injuries you sustained by an act or omission of another person(s) for which we provide coverage. You must not do anything that might limit our right to full reimbursement. The subrogation and recovery provisions in this Plan Document apply whether or not the Member recovering money is a minor.

To enforce its Subrogation rights under this policy, Mass General Brigham Health Plan will have the right to take legal action, with or without the Member's consent, against any party to secure recovery of the value of services provided or paid for by the Plan for which such party is, or may be, liable.

Member Cooperation

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

- Providing all information and documents requested by the Plan.

- Executing any instruments deemed necessary by the Plan to protect its rights.
- Promptly assigning the Plan any monies received for services provided or paid for by the Plan.
- Promptly notify the Plan of any instances that may give rise to our rights.

The Member further agrees to do nothing to prejudice or interfere with the Plan's rights to Subrogation or Coordination of Benefits. Failure of the Member to perform the obligations stated in this section shall render the Member liable to the Plan for any expenses we may incur, including reasonable attorneys' fees, in enforcing its rights under this Plan and without limiting Mass General Brigham Health Plan's or the GIC'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. Massachusetts law will apply to subrogation regardless of where the injury occurs.

Members Eligible for Medicare – Medicare Primary Where Permitted by law

When you receive Covered Benefits that are eligible for coverage by Medicare as the primary payer, the Claim must be submitted to Medicare before payment by the Plan. Medicare is primary in all circumstances as permitted by law. The Plan will be liable for any amount eligible for coverage that is not paid by Medicare. You shall take such action as is required to assure payment by Medicare. If you are eligible for Medicare by reason of End Stage Renal Disease, the Plan will be the primary payor for Covered Benefits during the "coordination period" specified by federal regulations at 42 CFR Section 411.62. Thereafter, Medicare will be the primary payor. When Medicare is primary (or would be primary if you were timely enrolled) the Plan will pay for services only to the extent payments would exceed what would be payable by Medicare. To avoid such a gap in coverage, if eligible, you must enroll timely in Medicare. When the plan provides Benefits to a Member for which the Member is eligible under Medicare, the Plan shall be entitled to reimbursement from Medicare for such services to the extent permitted by law. The Member shall take such action as is required to assure this reimbursement.

Please note: Retirees who are eligible for Medicare Part A for free must enroll in Part B, and must enroll in a GIC Medicare plan in order to continue coverage through the GIC.

Section 11.

Care Management and Disease Management Programs

Our Care Management Programs

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

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

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

Behavioral Health Care Management Program

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

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

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

Clinical Care Partners

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

Your Care Circle Program

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

- The team works within the members community
- Conduct comprehensive assessments
- Develop member centered care plans
- Works with natural supports, as well as providers to direct care around the member
- Address Social Determinants of Health (SDoH)
- Ensure communication with providers

Pediatric Care Management

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

Health Coaching

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

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

Our Disease and Condition Management Programs

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

Asthma Management Program

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

Chronic Obstructive Pulmonary Disease (COPD) Program

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

Diabetes Management Program

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

Maternal & Child Health Clinical Nurse Specialist

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

- Help from our care manager
- Rental or purchase of an electric breast pump
- Access to our Tobacco Treatment Specialist

- Access to mental health or substance use services
- Immunization information, schedules, and reminders

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

Cardiovascular Disease (CVD) Program

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

The Quit for Life Tobacco Cessation Program

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

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

For more information about quitting tobacco, contact:

Certified Tobacco Treatment Specialist
857-282-3096

Massachusetts Quitline
800-TRY-TO-STOP

Section 12.

Member Rights and Responsibilities

Your Rights as a Member

As a valued Member, you have the right to:

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

Your Responsibilities as a Member

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

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

Reporting Health Care Fraud

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

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

Member Satisfaction

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

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

Please contact the GIC at 617-727-2310 if you:

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

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

Network Providers should not bill you for any service included in the description of Covered Health Care Services that exceeds Deductibles, Copayments or Coinsurance specified in your Schedule of Benefits. Your Summary of Payments, a monthly statement that we mail you, shows what the Plan has paid a Provider and what your Cost-Sharing obligations to the Provider are for Covered Services. If you believe you have overpaid or received a bill from a Provider in error for any service included on the Covered Health Care Services list, you should contact Customer Service at 866-567-9175.

If you need Emergency or Urgent Care while traveling abroad or out-of-state, the Plan will pay the Provider directly. Ask the Provider to contact us to discuss payment if the Provider asks you for money.

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

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

Be sure to include the following information:

- Member's full name
- Member's date of birth
- Member's identification number
- Date the Health Care Service was provided
- A brief description of the illness or injury

Limits on Claims

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

Section 13.

Financial Obligations

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

Deductibles—This plan requires you to pay a Deductible. Your Schedule of Benefits indicates what your Deductible amount is. A Deductible is a specific annual dollar amount you must pay each Benefit Period for certain services. You have a Deductible for medical expenses. Once you meet your Deductible, you may still be responsible for Copayments and any applicable Coinsurance (see below for more on copayments and Coinsurance). If you have an individual membership, you must pay the individual Deductible each year. A family Deductible is met when the combined Deductible payments for any covered family members adds up to the total family Deductible amount. The most each Member can contribute towards the family Deductible per Benefit year is equal to the individual Deductible amount.

Please note that not all services may apply to a Deductible. Your Schedule of Benefits tells your deductible amounts and which services apply to the deductible. Your plan includes a benefit period Deductible for individuals and family members. The benefit period begins on July 1st and ends on June 30th of the following year and Cost-Sharing changes occurring on July 1st.

Copayments (Copays) and Coinsurance—In some cases, you will be asked to pay a Copayment when receiving a covered health care Benefit, such as a visit to the doctor, or a prescription. Copays are fixed dollar amounts that are due at the time the service is received or when billed by the Provider. Your Schedule of Benefits identifies what your Copayment should be for various health care Benefits. Some plans also provide coverage with Coinsurance. If your coverage requires payment of Coinsurance, the applicable Coinsurance percentages are listed in your Schedule of Benefits. After you have met any applicable Deductible amount, you may be responsible for a specified percentage of the cost of a covered health care Benefit you receive, and the Plan will be responsible for the remainder of the cost.

For example: your plan includes Coinsurance for Durable Medical Equipment (DME). Durable Medical Equipment is subject to the benefit period Deductible and then 20 percent Coinsurance of the purchase price or rental cost of the DME service.

Out-of-Pocket Maximum—Your Schedule of Benefits indicates what your Out-of-Pocket Maximum amount is. The Out-of-Pocket Maximum represents the most you are required to pay out-of-pocket, including Deductible, Copayment and Coinsurance amounts.

In order to ensure that you are not held responsible for amounts in excess of your Copayments, Coinsurance, Deductible amounts or Out-of-Pocket Maximum, your Health Care Services (except as specified in this Member Handbook) must be provided by a Network Provider; arranged by your PCP; authorized by us, if prior Authorization is required; and services received during your active enrollment with the Plan. If you fail to meet these requirements you may have to pay for the total cost of the service provided to you.

When seeing a Network Provider you should never be asked to pay more than your Copayments, Coinsurance, or Deductible amounts stated in your Schedule of Benefits. If you receive a bill from a Network Provider that is more than these allowed amounts please contact Customer Service.

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

Section 14.

Notices

Confidentiality

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

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

To comply with state law, we take special steps to protect any information about mental health or substance use, HIV status, sexually transmitted diseases, pregnancy or termination of pregnancy.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could result in significant costs to you depending on the procedure or service.

You're protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're

in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay the balance of the 'allowed' costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your summary of payment.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket maximum.

If you think you've been wrongly billed, please call the Customer Service number on the back of your member ID card (TTY users call 711). We are open Monday through Friday, 8:00 AM to 6:00 PM and Thursday from 8:00 AM to 8:00 PM.

You can also call the **No Surprises Help Desk** (NSHD): 800-985-3059 on or after January 1, 2022, if you have additional questions about the No Surprises Act.

Visit ***http://www.cms.gov/nosurprises*** for more information about your rights under federal law.

Group Insurance Commission Notices

NOTICE OF GROUP INSURANCE COMMISSION
PRIVACY PRACTICES
Effective July 1, 2022

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law·, the GIC must protect the privacy and security of your personal health information The GIC retains this type of information because you receive health benefits from the Group Insurance Commission. Under federal law, your health information (known as "protected health information or ''PHI includes what health plan you are enrolled in and the type of health plan coverage you have. This notice explains your rights and our legal duties and privacy practices.

The GIC will abide by the terms of this notice. Should our information practices materially change, the GIC reserves the right to change the terms of this notice and must abide by the terms of the notice currently in effect. Any new notice provisions will affect all protected health information we already maintain, as well as protected health information that we may receive in the future. We will mail revised notices to the address you have supplied, and will post the updated notice on our website at www.mass.gov/gic.

Required and Permitted Uses and Disclosures

We typically use or share your health information in the following ways.

Run Our Organization:

- We can use and disclose your information to run our organization and contact you when necessary.
- To operate our programs that include evaluating the quality of health care services you receive and performing analyses to reduce health care costs and improve our health plans performance.
- Arrange for legal and auditing services including fraud and abuse protection.

Pay For Your Health Services: We can use and disclose your health information as we pay for your health services, administrative fees for health care and determining eligibility for health benefits.

Provide You With Information On Health Related Programs Or Products: This might be information regarding alternative medical treatments or programs or about other health related services and products.

How Else Can We Use Or Share Your Health Information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues: We can share health information about you for certain situations such as: Preventing disease; Helping with product recalls; Reporting adverse reactions to medications; Preventing or reducing a serious threat to anyone's health or safety.

Do research • We can use or share your information for health research.

Comply with the law:

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law
- Address workers' compensation, law enforcement, and other government requests
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- Respond to lawsuits and legal actions
- We can share health information about you in response to a court or administrative order, or in response to a subpoena

The GIC May Also Use And Share Your Health Information As Follows:

- to resolve complaints or inquiries made by you or on your behalf (such as an appeal);
- to enable business associates that perform functions on our behalf or provide services if the information is necessary for such functions or service. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract. Our business associates are also directly subject to federal privacy laws,
- for data breach notification purposes. We may use your contact information to provide legally-required notice of unauthorized acquisition, access, or disclosure of your health information;

- to verify agency and plan performance (such as audit);
- to communicate with you about your GIC-sponsored benefits (such as your annual benefits statement)
- to tell you about new or changed benefits and services or health care choices.

Organizations That Assist Us: In connection with payment and health care operations, we may share your PHI with our third party "Business Associates" that perform activities on our behalf, for example, our Indemnity Plan administrator. When these services are contracted, we may disclose your health information to our business associates; so that they can perform the job we have asked of them. These business associates will be contractually bound to safeguard the privacy of your PHI and also have direct responsibility to protect your PHI imposed by federal law.

When It Comes To Your Health Information, You Have Certain Rights. This section explains your rights and some of our responsibilities to help you. You have the right to:

Get a copy of your health and claims records: You can ask to see or get a copy of your health and claims records and other health information we have about you. You must ask for this in writing. Under certain circumstances we may deny your request. If the GIC did not create the information you seek, we will refer you to the source {e.g. your health plan administrator). We will provide a copy or a summary of your health and claims records. We may charge a reasonable, cost-based fee.

Ask us to correct our records: You can ask us to correct your health and claims records if you think they are incorrect or incomplete. You must ask for this in writing along with a reason for your request. • We may say "no" to your request, but we'll tell you why in writing within 60 days. If we deny your request, you may file a written statement of disagreement to be included with your information for future disclosures.

Request confidential communications • You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share: You can ask us not to use or share certain health information for payment or our operations, and disclosures to family members or friends. You must ask for this in writing. We are not required to agree to your request, and in some cases federal law does not permit a restriction.

Get a list of those with whom we've shared information • You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make or was part of a limited data set for research).

Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. (An electronic version of this notice is on our website at www.mass.gov/gic)

Choose someone to act for you: If you have given someone power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

Receive notification of any breach or your unsecured PHI.

File a complaint if you feel your rights are violated: You can complain if you feel we have violated your rights by writing to us at: GIC Privacy Officer, P.O. Box 566, Randolph, MA 02368. Filing a complaint or exercising your rights will not affect your GIC benefits. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a

complaint. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call (617) 727-2310 or TTY for the deaf and hard of hearing at (617)-227-8583.

GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA ELECTION NOTICE AND APPLICATION

This notice explains your COBRA rights and what you need to do to protect your right to receive it. You will receive a COBRA notice and application if the Group Insurance Commission (GIC) is informed that your current GIC coverage is ending due either to (1) end of employment, (2) reduction in hours of employment; (3) death of employee/retiree; (4) divorce or legal separation; or (5) loss of dependent child status. This COBRA notice contains important information about your right to temporarily continue your health care coverage in the Group Insurance Commission's (GIC's) health plan through a federal law known as COBRA. If you elect to continue your coverage, COBRA continuation coverage will begin on the first day of the month immediately after your current GIC coverage ends.

You must complete the GIC COBRA Election Form and return it to the GIC by no later than 60 days after your group coverage ends by sending it by mail to the Public Information Unit at the GIC at P.O. Box 556, Randolph, MA 02368 or by hand delivery to the GIC, 1 Ashburton Place, Suite 1619. If you do not submit a completed election form by this deadline, you will lose your right to elect COBRA coverage.

WHAT IS COBRA CONTINUATION COVERAGE? COBRA is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called 'Qualifying Events.' If you elect COBRA continuation coverage ("COBRA coverage"), you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

This notice explains your COBRA rights and what you need to do to protect your right to receive it. If you have questions about COBRA coverage, contact the GIC's Public Information Unit at 617-727-2310 or write to the Unit at P.O. Box 556, Randolph, MA 02368. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at **www.dol.gov/ebsa** for more general information about COBRA.

WHO IS ELIGIBLE FOR COBRA CONTINUATION COVERAGE? Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an *independent right* to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee of the Commonwealth of Massachusetts or municipality covered by the GIC's health benefits program, you have the right to choose COBRA coverage if:

- You lose your group health coverage because your hours of employment are reduced; or
- Your employment ends for reasons other than gross misconduct.

If you are the spouse of an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage for yourself if you lose GIC health coverage for any of the following reasons (known as "qualifying events"):

- Your spouse dies;
- Your spouse's employment with the Commonwealth or participating municipality ends for any reason other than gross misconduct;
- Your spouse's hours of employment with the Commonwealth or participating municipality are reduced; or
- You and your spouse legally separate or divorce.

If you have dependent children who are covered by the GIC's health benefits program, each child has the right to elect COBRA coverage if he or she loses GIC health coverage for any of the following reasons (known as "qualifying events"):

- The employee-parent dies;
- The employee-parent's employment is terminated (for reasons other than gross misconduct);
- The employee-parent's hours or employment are reduced
- The parents legally separate or divorce; or
- The dependent ceases to be a dependent child under GIC eligibility rules.

HOW LONG DOES COBRA CONTINUATION COVERAGE LAST? By law, COBRA coverage must begin on the day immediatelyafter your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA continuation coverage due to employment termination or reduction in hours, your family members'COBRA continuation coverage may be extended beyond the initial 18-month period up to a *total* of 36 months (as measured from the initial qualifying event) if a second qualifying event – the insured's death or divorce - occurs during the 18 months of COBRA coverage. **You must notify the GIC in writing within 60 days of the second qualifying event andbefore the 18-month COBRA period ends in order to extend the coverage**. Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. **You must provide the GIC with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before yourinitial 18 month COBRA period ends in order to extend the coverage**. For more information about extending the length of COBRA continuation coverage visit https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource- center/publications/an-employees-guide-to-health-benefits-under-cobra.pdf.

COBRA continuation coverage will end before the maximum coverage period ends if any of the following occurs:

- The COBRA cost is not paid ***in full*** when due (see section on paying for COBRA);
- You or another qualified beneficiary become covered under another group health plan that does not impose any pre- existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits;
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability);
- The Commonwealth of Massachusetts or your municipal employer no longer provides group health coverage to any of its employees; or
- Any reason for which the GIC terminates a non-COBRA enrollee's coverage (such as fraud).

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

HOW AND WHEN DO I ELECT COBRA CONTINUATION COVERAGE? Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA coverage within the 60-day election period, you will lose all rights to COBRA coverage**.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan), even if the plan generally does not, accept late enrollees, if you request enrollment within 30 days after your GIC coverage ends. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you. **Your special enrollment period will end 60 days from the loss of GIC insurance coverage and you may be unable to enroll in other plans; therefore you should take action right away.**

HOW MUCH DOES COBRA COTINUATION COVERAGE COST? Under COBRA, you must pay 102% of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150% of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically; current COBRA rates are included with this notice.

HOW AND WHEN DO I PAY FOR COBRA CONTINUATION COVERAGE? If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan. You may choose to submit the first payment with your application. If not, you will be billed.**

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. **Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period**. After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but **you are responsible for paying for the coverage even if you do not receive a monthly statement**. Payments should be sent to the GIC's address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.**

CAN I ELECT OTHER HEALTH COVERAGE BESIDES COBRA? Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance 'conversion' policy with your current health plan without providing proof of insurability. Alternately, you may purchase health insurance through the Commonwealth's Health Connector Authority or through the Health Insurance Marketplace in other states (see www.HealthCare.gov or call 1-800-318-2596). In the Marketplace or Connector, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. The GIC has no involvement in conversion programs, and only very limited involvement in the Health Connector programs. You pay the premium to the plan sponsor for the coverage. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you. If you end COBRA coverage early or choose other coverage instead of COBRA, you cannot later switch to COBRA coverage. The Massachusetts Health Connector's website is: https://www.mahealthconnector.org. Also, you may be able to determine if you or your dependents qualify for MassHealth through the Connector's website.

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.; If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage. You may want to think about the following when considering different options: What will each premium cost? What are the provider networks and is my doctor in network? What is on the drug formulary for each plan and will my medications be covered? What is the service area of each plan? What will my cost-sharing obligations be? You should consider what your copayments, co-insurance, deductibles, and other amounts will be under each plan.

YOUR COBRA CONTINUATION COVERAGE RESPONSIBILITIES

- **You must inform the GIC of any address changes to preserve your COBRA rights;**
- **You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above**. If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- **You must make the first payment for COBRA coverage within 45 days after you elect COBRA.** If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.

- **You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill**. If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.
- **You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:**
- The employee's job terminates or his/her hours are reduced;
- The insured dies;
- The insured becomes legally separated or divorced;
- The insured or insured's former spouse remarries;
- A covered child ceases to be a dependent under GIC eligibility rules;
- The Social Security Administration determines that the employee or a covered family member is disabled; or
- The Social Security Administration determines that the employee or a covered family member is no longer disabled.

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA continuation coverage. ***To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P. O. Box 556, Randolph, MA 02368.***

If you have questions about COBRA continuation coverage, contact the GIC's Public Information Unit at 617-727-2310, or write to the Unit at P.O. Box 556, Randolph, MA 02368. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at **www.dol.gov/ebsa** or call their toll free number at 866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit **www.healthcare.gov** or, in Massachusetts visit, https://www.mahealthconnector.org.

Important Notice from the Group Insurance Commission (GIC) about your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Mass General Brigham Health Plan's Complete HMO for GIC members and your options under Medicare's prescription drug coverage. This information can help you decide whether or not to join a non-GIC Medicare drug plan.

If you are considering joining a non-GIC plan, you should compare your current coverage, particularly which drugs are covered, and at what cost with that of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage can be found at the end of this notice.

For most people, the drug coverage that you currently have through your GIC health plan is a better value than the non-GIC Medicare Part D drug plans.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available to everyone with Medicare in 2006. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly Premium.
- The GIC has determined that the prescription drug coverage offered by your plan is, on average for all participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore

  considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare Part D drug plan.

When Can You Join a Medicare Part D Drug Plan?

You can join a non-GIC Medicare drug plan when you first become eligible for Medicare and each subsequent year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period to join a non-GIC Medicare drug plan.

What Happens To Your Current Coverage If You Decide To Join a Non-GIC Medicare Drug Plan?

If you enroll in another Medicare prescription drug plan or a Medicare Advantage plan with or without prescription drug coverage you will be disenrolled from the GIC-sponsored Mass General Brigham Health Plan. If you are disenrolled from the Plan, you will lose your GIC-sponsored medical, prescription drug, and behavioral health coverage.

If you are the insured and decide to join a non-GIC Medicare drug plan, both you and your covered spouse/dependents will lose your GIC medical, prescription drug, and behavioral health coverage.

If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage. Help is available online at www.socialsecurity.gov, or by phone at 1-**800-772-1213** (TTY: 1-800-325-0778).

When will you Pay a Higher Premium (penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with a GIC plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary Premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information about This Notice or your Current prescription drug Coverage

Contact the GIC at (**617) 727-2310**, ext. 1.

NOTE: You will receive this notice each year, and if this coverage through the Group Insurance Commission changes. You may request a copy of this notice at any time.

For More Information about Your Options under
Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug Coverage

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for the telephone number) for personalized help.
- Call 1-**800-Medicare** (1-800-633-4227).
- TTY users should call 1-877-486-2048

If you have limited income and assets, extra help paying for Medicare prescription drug coverage is available. For information about the Extra Help program, visit Social Security online at www.socialsecurity.gov, or call 1-**800-772-1213** (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The uniformed Services Employment and Reemployment Rights Act (USERRA) protects the rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. The GIC has more generous guidelines for benefit coverage that apply to persons subject to USERRA, as set forth below:

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents while in the military.
- Service members who elect to continue their GIC health coverage are required to pay the employee's share for such coverage.

Even if you don't elect to continue coverage during your military service, you have the right to be reinstated to GIC health coverage when you are reemployed, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its **website at http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. The rights listed here may vary depending on the circumstances.

For more information about your GIC coverage, please contact the Group Insurance Commission at (617) 727-2310.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Website:
Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child- health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: (678) 564-1162, Press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (HAWKI)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website:https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: http://dhhr.wv.gov/bms/ http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement
According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Section 15.

Complaint and Grievance Process

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

Complaints

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

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

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

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

How the Complaint Process Works

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

Grievances

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

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

Frequently Asked Questions About The Grievance Process

How do I file a Grievance?

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

The Plan will send you a written acknowledgement of receipt of your Grievance within one (1) business day. If you telephone us or stop by in person, your Grievance will be transcribed by the Plan and a copy forwarded to you or your Authorized Representative within twenty-four (24) hours (except where this time limit is waived or extended by mutual written agreement between you or your Authorized Representative and Mass General Brigham Health Plan). We request that you read, sign and return to us this written transcription of your oral Complaint. This helps to ensure that we fully understand the nature of your Complaint. You may contact the Plan in writing or by phone to initiate the Grievance process. (See address, telephone, and fax number above in "Complaints.")

How Do I Designate an Authorized Representative?

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

What if My Grievance is About My Health Care or Services?

If your Grievance pertains to a decision the Plan has made about your health care or services, you or your Authorized Representative may be asked to sign and return a release of medical information to us. After receipt of all necessary releases, your medical information will be requested by us. You or your Authorized Representative will have access to any medical information and records relevant to the Grievance which are in the possession of the Plan. If we requested that you provide us with a signed authorization and you (or your Authorized Representative) do not provide the signed authorization within thirty (30) calendar days of the receipt of the Grievance, the Plan, may issue a resolution of the Grievance without review of some or all of the medical records.

What if My Grievance Is About a Behavioral Health Care Service?

The Plan has delegated the management of Grievances involving Behavioral Health or Substance Use services to Optum. To initiate a Grievance with Optum you may contact them in writing or by phone.

Optum
Attn: Grievance/Complaints
425 Market Street
San Francisco, CA 94105
Fax: 877-384-1179
1-844-875-5722 (TTY 711)

If you prefer, you can request that we, instead of Optum, review your Grievance regarding a Behavioral Health or Substance Use service.

What if Resolution of My Grievance Does Not Require Review of My Medical Records?

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

Who Will Review My Grievance?

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

How Will the Decision on My Grievance Be Explained?

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

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

When Will I Hear from Mass General Brigham Health Plan About My Grievance?

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

Reconsideration

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

- Received too late to review within the thirty (30) calendar days time limit; or
- Not received, but is expected to become available within a reasonable time period following the written resolution; or
- For other good cause offered by you or your Authorized Representative

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

Expedited Grievance Review for Special Circumstances

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

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

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

Continuation of Services During the Grievance Process

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

Expedited Grievance Review for Persons Who are Hospitalized

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

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

Expedited Grievance Review for Persons with Terminal Illness

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

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

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

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

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

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

Independent External review

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

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

Such notice shall:

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

Expedited External review and Continuation of Coverage

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

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

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

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

Section 16.

Utilization Review and Quality Assurance

Utilization Reveiw

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

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

The Plan recognizes that the under-utilization of medically appropriate services can harm our 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 in conjunction with the Member's individual coverage. We do not specifically reward practitioners or other individuals conducting Utilization Review for issuing denials of coverage or service, nor does the Plan provide financial rewards to UR decision makers to encourage decisions that cause underutilization.

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

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

Adverse Determinations

Decisions made by us or a designated Utilization Review organization to deny, reduce, modify, or terminate an admission, continued Inpatient stay, or the availability of any other services, for failure to meet the requirements for coverage based on Medical Necessity, appropriateness of health care setting and level of care or effectiveness are considered Adverse Determinations.

Written notice 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 standards.
- Specify other treatment options covered by the Plan, if any.
- Reference and include suitable applicable clinical practice guidelines and review standards.
- Notify you (or your Authorized Representative) of our internal grievance process and the procedures for requesting external review.

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

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

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

Concurrent review

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

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

Reconsideration

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

Care Management

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

Quality Assurance Program

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

The scope of our Quality Assurance Program includes:

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

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

Development of Clinical Guidelines and Utilization Review Criteria

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

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

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

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

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

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

Evaluation of New Technology

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

The Plan reviews and evaluates new and emerging technologies, including diagnostics, surgical procedures, medical therapies, equipment and medicines 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 experts in its evaluation efforts. We may also analyze market trends and legal and ethical issues in its evaluations as appropriate. Technologies are selected for review based on actual or potential demand.

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

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

Access and Utilization

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

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

Section 17.

Glossary

Acute Treatment Services

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

Adverse Determination

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

Applied Behavior analysis (ABA)

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

Authorization

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

Authorized Representative

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

Autism Services Provider/Networks

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

Autism Spectrum Disorders

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

Behavioral Health Manager

A company organized under the law of the Commonwealth, or organized under the laws of another state and qualified to do business in the Commonwealth that has entered into a contractual arrangement with a carrier to provide or arrange for the provision of behavioral, substance use disorder, and mental health services to voluntarily enrolled Member of the carrier.

Optum is the Plan's delegated Behavioral Health Manager.

Behavioral Health Treatment

Mental health and substance use treatment.

Benefit

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

Benefit Period

The annual cycle in which your health insurance plan operates. The Group Insurance Commission cycle is from July 1st to June 30th with potential benefit changes occurring on July 1st.

Board-Certified Behavior Analyst

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

Centered Care Program

The Plan has partnered with the GIC to launch Centered Care, a program for members to get personalized care from providers that meet certain high standards for quality and efficiency. The program offers members enhanced services such as care coordination with Specialists, expanded hours, easy access to Urgent Care, helpful reminders about necessary tests, checkups, and more. Qualified Centered Care providers are marked with the Centered Care logo in the Plan's 'Find a Doctor' online tool.

Claim

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

Clinical Stabilization Services

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

Coinsurance

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

Community Behavioral Health Centers

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

- Routine and urgent outpatient services, including same-day evaluation and referral to treatment, evening and weekend hours, timely follow-up appointments, and evidence-based behavioral health treatment. Services may be provided in-person, at CBHC and community-based locations, and via telehealth;

- Mobile crisis intervention services for adults and youth, including 24/7 site- and community-based mobile crisis assessment, intervention and stabilization, as an alternative to hospital emergency departments; and

- Community crisis stabilization services for adults and youth, offering short-term, 24/7, staff-secure, safe, and structured crisis treatment services in a community-based program that serves as a medically necessary, less-restrictive, and voluntary alternative to inpatient psychiatric hospitalization.

Complaint

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

Copayment (Copay)

A fixed amount paid by a Member for applicable covered services or for prescription medications at the time they are provided. A Covered Service may require other Member Cost-Sharing (such as Deductible and/or Coinsurance) before or after a Copayment is required.

Cost-Sharing

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

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

Coverage Date

The date medical coverage becomes effective for a Plan Member.

Covered Benefits/Covered Services

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

Day

A calendar Day (unless business day specified).

Deductible

The amount you are required to pay to Providers for covered Health Care Services before the Plan begins to pay for these services. Please refer to your Schedule of Benefits to determine your annual Deductible.

Diagnosis of Autism Spectrum Disorders

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

Disenrollment

The process by which a Member's coverage ends.

Effective Date

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

Eligible Individuals

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

Emergency Medical Condition

A medical condition, whether physical, behavioral, related to substance use disorder, or 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 Member or another person in serious jeopardy, serious impairment to bodily 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 amount of time to affect a safe transfer to another hospital before delivery or a threat to the health or safety of the Member or her unborn child. For further information refer to section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).

Enrollment

The process by which the Plan registers Eligible Employees for Membership.

Enrollment Date

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

Essential Community provider

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

Facility

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

Family Planning Services

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

Final Adverse Determination

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

Grievance

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

Group Insurance Commission Contract

The Contract between the Group Insurance Commission and Mass General Brigham Health Plan that sets forth the obligations of the GIC and the terms of the Plan's coverage for GIC insureds.

Habilitation Services

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

Health Care Agent

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

Health Care Provider

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

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

Health Care Services

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

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.

HMO

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

Independent Review Organization (IRO)

A company contracted to conduct independent external reviews of Adverse Determinations specific to members of this Plan, involving appropriateness of care, medical necessity criteria, level of care, and effectiveness of a requested service. The Plan contracts with several IROs: MCMC, ProPeer Resources, Inc and Medical Review Institute of America, LLC, (these are subject to change without prior notification) to perform external reviews.

In-Network Provider

A Provider contracted with the Plan to provide services to members. All Covered Services except Emergency Services must be with In-network Providers.

Inpatient

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

Inquiry

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

Licensed Mental Health Professional

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

Limited Service Clinic

These clinics offer basic services to treat non-life threatening illnesses or injury. They are usually staffed by certified nurse practitioners or physician assistants.

Managed Care

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

Mass General Brigham Health Plan

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

Medically Necessary Services

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

Member

An Eligible subscriber or dependent actively enrolled in the Plan.

Member Financial Responsibility

The Member's financial responsibility, if any, for any contribution for coverage, Coinsurance, Copayments, or Deductibles.

Member ID Card

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

Network

The group of Providers contracted by Mass General Brigham Health Plan to provide Health Care Services to our Members.

Network Provider

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

Nondiscriminatory Basis Coverage

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

Nurse Practitioner

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

Optum

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

Out-of-Network Provider

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

Out-of-Pocket Maximum

Maximum amount of money that a member must pay on his own during a Benefit period before the Plan will pay 100% of the allowed amount. The limit does not include your contribution for coverage or a service your plan does not cover.

Physician Assistant

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

Plan Document

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

Plan Sponsor

The Group Insurance Commission, the state agency with which Mass General Brigham Health Plan enters into an Agreement to provide health care Coverage for the GIC's eligible members and their Dependents.

Premium Contribution

The amount of money you pay monthly to your plan sponsor towards your health insurance coverage.

Preventive Care

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

Primary Care Provider (PCP)

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

Primary Care Site

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

Prior Authorization

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

Provider

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

Provider Directory

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

Referral

A recommendation by a PCP for a Member to receive medical services from another Provider. In most cases, the Plan requires Referrals for Specialist services provided by In-network Providers. Please see "Section 4. Accessing Medically Necessary Care" for more information.

Rehabilitation Services

Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational

therapy, speech-language pathology and psychiatric Rehabilitation Services in a variety of Inpatient and/or outpatient settings.

Schedule of Benefits

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

Service Area

The geographical area where the Plan has developed a Network of Providers to provide adequate access to Covered Services. The Plan's Service Area includes most communities in Massachusetts, see Section 2 for details.

Specialist

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

Summary of Payments (SOP)

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

Telemedicine (Virtual Visit)

A visit through the use of interactive audio, video or other electronic media for a diagnosis, consultation or treatment of a patient's physical or mental health. Telemedicine does not include audio-only telephone, facsimile machine, online questionnaires, texting or text-only e-mail. Regulations concerning future Telemedicine services are currently under review by state regulators.

Tiered Provider Network

A Provider Network in which Providers have been assigned to different benefit tiers and in which members pay the member cost sharing associated with a Provider's aissgned benefit tier. All providers must meet high-quality standards and are measured by a set of quality benchmarks from publicly available resources like Leapfrog and Hospital Compare in consultation with the GIC.

Cost-efficient PCPs and specialists were identified based on their hospital affiliation and placed in the appropriate tier as described in your Schedule of Benefits. For PCPs and Specialists unaffiliated with a hospital, they default to Tier 2 and therefore apply the middle level of member cost sharing.

It is important to check the tier of the provider and/or hospital that you are being referred to in order to understand what your member cost sharing will be. To find the most up-to-date information on providers in the network and tier information, please refer to the GIC Provider Directory at Member.MassGeneralBrighamHealthPlan.org**.** Services with an out-of-network provider are not covered except for urgent and emergent care.

Treating Provider

See "Network Provider" above.

Treatment of Autism Spectrum Disorders

Includes the following care prescribed, provided or ordered for an individual diagnosed with one of the Autism Spectrum Disorders by a licensed physician or a licensed psychologist who determines the care to be medically necessary: habilitative or rehabilitative care; 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. Urgent Care does not include Routine Care.

Utilization Review

A set of formal review techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness or efficiency of Covered Health Care Services, procedures, or settings. Such review techniques may include, but are not limited to, ambulatory review, prospective review/Prior Authorization, second opinion, certification, concurrent review, care management, discharge planning or retrospective review.

Utilization Review Organization

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

Workers Compensation

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

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 or **you can go online to Member.MassGeneralBrighamHealthPlan.org—our secure Member portal.**

You can reach Customer Service at **866-567-9175** (TTY 711) and a representative will assist you.

Our hours of operation are Monday–Friday 8:00 a.m.–6:00 p.m., and Thursday 8:00 a.m. –8:00 p.m.

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