

Blue Cross and Blue Shield of Massachusetts, Inc.

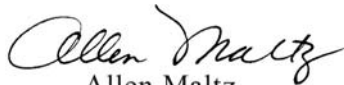
Blue Care[®] Elect Preferred Provider Plan

Subscriber Certificate

Welcome to Blue Cross and Blue Shield!

We are very pleased that you've selected Blue Cross and Blue Shield of Massachusetts, Inc. This Subscriber Certificate is a comprehensive description of your benefits, so it includes some technical language. It also explains your responsibilities — and our responsibilities — in order for you to receive the full extent of your coverage. If you need any help understanding the terms and conditions of your health plan, please contact us. We're here to help!

Blue Cross and Blue Shield of Massachusetts, Inc.



Allen Maltz
Executive Vice President





Fredi Shonkoff
Senior Vice President
Corporate Secretary

Incorporated under the laws of the
Commonwealth of Massachusetts as a Non-Profit Organization

Translation and Interpretation Services

A language translator service is available when you call the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your health plan identification card. This service provides you with access to interpreters who are able to translate over 140 different languages. If you need these translation services, just tell the customer service representative when you call. Then during your call, *Blue Cross and Blue Shield* will use a language line service to access an interpreter who will assist in answering your questions or helping you to understand *Blue Cross and Blue Shield* procedures. (This interpreter is not an employee or designee of *Blue Cross and Blue Shield*.)

Traduction et interprétation en ligne

Un service de traduction et d'interprétation est disponible lorsque vous appelez le service clientèle de *Blue Cross and Blue Shield* au numéro gratuit figurant sur la carte d'identification de votre plan de santé. Ce service vous donne accès à des interprètes qui peuvent traduire dans plus de 140 langues. Si vous avez besoin de ces services, mentionnez-le à l'agent du service clientèle lorsque vous nous appelez. Ensuite, au cours de votre appel, *Blue Cross and Blue Shield* utilisera un service de traduction et d'interprétation en ligne pour joindre un interprète qui assurera la traduction des questions que vous poserez ou qui vous aidera à comprendre les procédures de *Blue Cross and Blue Shield*. (Cet interprète n'est pas un employé de *Blue Cross and Blue Shield* ni une personne mandatée par *Blue Cross and Blue Shield*.)

Sèvis Tradiksyon ak Entèpretasyon

Genyen yon sèvis tradiksyon ki disponib lè w rele biwo sèvis kliyan *Blue Cross and Blue Shield* nan nimewo telefòn gratis ki sou kat didantifikasyon plan asirans ou an Sèvis sa a ba w aksè a entèprèt ki ka tradwi plis ke 140 lang diferan. Si w ta bezwen itilize sèvis tradiksyon sa yo, senpleman di reprezantan sèvis kliyan an sa lè w rele. Epi lè w rele a, *Blue Cross and Blue Shield* pral itilize yon liy sèvis pou lang pou gen aksè a yon entèprèt ki pral ede w jwenn repons a keksyon ou genyen oswa ede w konprann pwosedi *Blue Cross and Blue Shield* yo. (Entèprèt sa a pa yon anplwaye *Blue Cross and Blue Shield* ni tou li pa mandate pa *Blue Cross and Blue Shield*.)

Servizio di traduzione e di interpretariato

Quando chiamate l'ufficio di assistenza clienti *Blue Cross and Blue Shield* al numero verde indicato sulla vostra tessera sanitaria avrete a disposizione un servizio di traduzione nella vostra lingua. Tramite tale servizio potrete accedere ad interpreti in grado di tradurre in oltre 140 lingue diverse. Qualora aveste bisogno di un servizio di traduzione, fatelo presente al rappresentante del servizio clienti durante la vostra chiamata; in questo caso *Blue Cross and Blue Shield* utilizzerà un servizio in linea di lingue straniere per chiamare un interprete che vi aiuterà a rispondere alle domande ed a comprendere le procedure *Blue Cross and Blue Shield*. (L'interprete non è un dipendente e non è selezionato da *Blue Cross and Blue Shield*.)

សេវាផ្នែកបកប្រែភាសាសរសេរ និងបកប្រែផ្ទាល់មាត់

សេវាផ្នែកបកប្រែភាសាសរសេរអាចមានផ្តល់ជូនកាលណាអ្នកទូរស័ព្ទមកការិយាល័យផ្នែកសេវាចំរើអតិថិជនរបស់ *Blue Cross and Blue Shield* តាមលេខទូរស័ព្ទឥតបង់ថ្លៃដែលមាននៅក្នុងអត្តសញ្ញាណប័ណ្ណផែនការសុខភាពរបស់អ្នក ។ សេវានេះផ្តល់ឱ្យអ្នកទូរសុខភាពទាក់ទងដល់ក្រុម អ្នកបកប្រែភាសាជាច្រើនដែលមានលទ្ធភាពបកប្រែភាសាលើសពី ១៤០ ភាសាទៅទៀត ។ បើអ្នកត្រូវការសេវាផ្នែកបកប្រែភាសាទាំងនេះ គ្រាន់តែប្រាប់អ្នកតំណាងផ្នែកសេវាអតិថិជនកាលណាអ្នកទូរស័ព្ទមក ។ នៅពេលដែល អ្នកទូរស័ព្ទមក *Blue Cross and Blue Shield* និងប្រើ បណ្តាញសេវាភាសា ដើម្បីរកអ្នកបកប្រែណា ម្នាក់ដែលគេនឹងជួយឆ្លើយសំណួររបស់អ្នក ឬជួយអ្នកឱ្យយល់អំពីទម្រង់ការរបស់ក្រុមហ៊ុន *Blue Cross and Blue Shield* ។ (អ្នកបកប្រែនេះមិនមែនជានិយោជក ឬអ្នកចាត់តាំងរបស់ *Blue Cross and Blue Shield* ទេ ។)

翻譯服務

當您以健康計劃識別卡上的免付費電話號碼致電 *Blue Cross and Blue Shield* 客戶服務辦公室之時，您就能獲得語言翻譯服務。這項服務能提供您 140 多種不同語言的翻譯服務。若您需要翻譯服務，在致電時告訴客戶服務代表即可。隨後 *Blue Cross and Blue Shield* 會利用一電話公司的語言服務專線找一個翻譯，為您釋疑或幫助您了解 *Blue Cross and Blue Shield* 程序。(此翻譯並非 *Blue Cross and Blue Shield* 的雇員或所指派的人。)

Υπηρεσίες Μετάφρασης και Διερμηνείας

Υπάρχει ξενόγλωσση υπηρεσία όταν τηλεφωνείτε στην εξυπηρέτηση πελατών της Blue Cross and Blue Shield στον ατελή αριθμό που αναγράφεται στην κάρτα του ασφαλιστικού σας προγράμματος. Η υπηρεσία αυτή σας παρέχει πρόσβαση σε διερμηνείς που μπορούν να μεταφράσουν 140 διαφορετικές γλώσσες. Αν χρειάζεστε μεταφραστικές υπηρεσίες, να το λέτε στον αντιπρόσωπο εξυπηρέτησης πελατών όταν τηλεφωνείτε. Στη συνέχεια, η Blue Cross and Blue Shield θα επικοινωνήσει με μια ξενόγλωσση τηλεφωνική υπηρεσία για να φέρει στο τηλέφωνο διερμηνέα που θα σας βοηθήσει για να πάρετε απάντηση στις ερωτήσεις σας ή για να καταλάβετε τις διαδικασίες του Blue Cross and Blue Shield. (Ο διερμηνέας δεν είναι υπάλληλος ούτε αντιπρόσωπος της Blue Cross and Blue Shield.)

Услуги по письменным и устным переводам

Позвонив в отдел обслуживания клиентов медицинского плана Blue Cross and Blue Shield по бесплатному телефону, указанному в вашем удостоверении клиента плана, вы можете воспользоваться услугами переводчика. В распоряжении наших клиентов имеются переводчики, работающие с более чем 140 языками. Если вы нуждаетесь в переводе, сообщите об этом ответившему на ваш звонок сотруднику отдела обслуживания клиентов плана. В этом случае план Blue Cross and Blue Shield свяжется с переводчиком службы переводов, который переведет для вас ответы на ваши вопросы и поможет вам понять правила, действующие в плане Blue Cross and Blue Shield. (Такой переводчик не является сотрудником или назначенным лицом плана Blue Cross and Blue Shield.)

خدمات الترجمة التحريرية و الشفوية

عندما تتصل بقسم خدمة العميل لدى Blue Cross and Blue Shield على الرقم المجاني الذي تجده مطبوعاً على بطاقة تأمينك الصحي، تستطيع الاستفادة من خدمة الترجمة. توفر لك هذه الخدمة إمكانية الاتصال بمتترجمين لأكثر من 140 لغة. إذا كنت في حاجة إلى الترجمة، عليك فقط بإخبار موظف خدمة العميل عندما تتصل. و أثناء اتصالك، ستستخدم Blue Cross and Blue Shield خدمات ترجمة على الهاتف للاتصال بالمتترجم الذي سيساعد في الإجابة على أسئلتك أو يساعدك على فهم إجراءات Blue Cross and Blue Shield. (هذا المترجم ليس موظفاً أو معيناً من قبل Blue Cross and Blue Shield).

ຫ້ອງການຊ່ອຍ ບໍລິການດ້ານແປພາສາ

ນິນາຍພາສາຈະຊ່ອຍທ່ານໄດ້ ເມື່ອໂທລະສັບໄປຫາ ຫ້ອງການຊ່ອຍລູກຄ້າ ຂອງ Blue Cross and Blue Shield ທີ່ນິໂທລະສັບໂທລີ ຢູ່ໃນບັດສູນາຂະພາບຂອງທ່ານ. ໃນ ຫ້ອງການບໍລິການນີ້ນິນາຍພາສາ ທີ່ສາມາດແປທາລາຍກວ່າ 140 ພາສາໄດ້ທ່ານ. ຫາກທ່ານຕ້ອງການ ບໍລິການນີ້, ບອກໃຫ້ຜູ້ຕາງໜ້າຊ່ອຍລູກຄ້າ ເມື່ອທ່ານໂທໄປ. ໃນຍາມທ່ານໂທໄປຫາ , Blue Cross and Blue Shield ຈະ ໃຊ້ ສາຍໂທລະສັບສາຍນຶ່ງ ຫານາຍພາສາ ທີ່ຈະຊ່ອຍທ່ານຕອບຄໍາຖາມຫລື ຊ່ອຍ ທ່ານ ໃຫ້ເຂົ້າໃຈການແມ່ນໍາຂອງ Blue Cross and Blue Shield. (ນາຍພາສາ ຜູ້ນີ້ບໍ່ແມ່ນ ຜະນິກງານ ຫລືຜູ້ແມ່ນໍາຂອງ Blue Cross and Blue Shield.)

Servicio de Traducción e Interpretación

Disponemos de un servicio de traductores para cuando usted llame a la oficina de atención al cliente de Blue Cross and Blue Shield al número de teléfono de la línea gratuita que figura en su tarjeta de identificación del plan de salud. A través de este servicio, usted tiene acceso a intérpretes que pueden traducir a más de 140 idiomas diferentes. Si usted necesita este servicio de traducción, simplemente solicítelo al representante de atención al cliente al hacer su llamada. Durante su llamada telefónica, Blue Cross and Blue Shield utilizará un servicio de línea de idiomas para ponerlo en contacto con un intérprete que lo ayudará a responder sus preguntas o a entender los procedimientos de Blue Cross and Blue Shield. (Este intérprete no es un empleado de Blue Cross and Blue Shield, ni ha sido designado por Blue Cross and Blue Shield.)

Serviço de Tradução e Interpretação

O serviço de apoio aos clientes da Blue Cross and Blue Shield tem disponível um serviço de tradução, quando telefona para o número grátis indicado no seu cartão de identificação do plano de saúde. Este serviço dá acesso a intérpretes em mais de 140 idiomas diferentes. Se necessitar destes serviços de tradução, comunique-o ao representante do serviço de clientes que o atender via telefone. Então, durante a sua chamada, a Blue Cross and Blue Shield utilizará um intérprete de um serviço de interpretação por telefone, que o ajudará a obter respostas às suas questões ou a entender os procedimentos da Blue Cross and Blue Shield. (Este intérprete não é um funcionário da Blue Cross and Blue Shield.)

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Introduction

This Subscriber Certificate explains your health care coverage and the terms of your enrollment in this *Blue Cross and Blue Shield* Blue Care Elect health plan. It describes your responsibilities to receive health care coverage and *Blue Cross and Blue Shield's* responsibilities to you. This Subscriber Certificate also has a *Schedule of Benefits* for your specific plan option. This schedule describes the cost share amounts that you must pay for *covered services* (such as a *deductible* or a *copayment*). You should read all parts of this Subscriber Certificate and your *Schedule of Benefits* to become familiar with the key points. You should keep them handy so that you can refer to them. The words that are shown in italics have special meanings. These words are explained in Part 2 of this Subscriber Certificate.

When you enroll for coverage in this Blue Care Elect health plan, you may enroll as a *group member* under a *group contract*. Or, you may enroll directly under an *individual contract*. The contract for coverage in this health plan is a prepaid (“insured”) preferred provider plan. *Blue Cross and Blue Shield* certifies that you have the right to this health care coverage as long as: you are enrolled in this health plan when you receive *covered services*; the *premium* that is owed for your health plan has been paid to *Blue Cross and Blue Shield*; and you follow all of the requirements to receive this health care coverage. *Blue Cross and Blue Shield* is located at: Landmark Center, 401 Park Drive, Boston, Massachusetts 02215-3326.

Blue Cross and Blue Shield and/or your *group* (when you are enrolled in this health plan as a *group member*) may change the health care coverage described in this Subscriber Certificate and your *Schedule of Benefits*. If this is the case, the change is described in a *rider*. Please keep any *riders* with your Subscriber Certificate and *Schedule of Benefits* so that you can refer to them.

This health plan is a preferred provider health plan. This means that you determine the costs that you will pay each time you choose a health care provider to furnish *covered services*. You will receive the highest level of benefits when you use health care providers who participate in your PPO health care network. These are called your “in-network benefits.” If you choose to use covered health care providers who do not participate in your PPO health care network, you will usually receive a lower level of benefits. In this case, your out-of-pocket costs will be more. These are called your “out-of-network benefits.”

Before using your health care coverage, you should make note of the limits and exclusions. These limits and exclusions are described in this Subscriber Certificate in Parts 3, 4, 5, 6, 7, and 8.

Important Note:

The term “you” refers to any *member* who has the right to the coverage provided by this health plan—the *subscriber* or the enrolled spouse or any other enrolled dependent.

Part 1

Member Services

Your Primary Care Provider

As a *member* of this health plan, you are not required to choose a *primary care provider* to coordinate the health care benefits described in this Subscriber Certificate. You may choose any *covered provider* to furnish your health care services and supplies. **But, your choice is important because it will impact the costs that you pay for your health care services and supplies.** Your costs will be less when you use health care providers who participate in your PPO health care network to furnish your *covered services*. These are called your “in-network benefits.” If you choose to use covered health care providers who do not participate in your PPO health care network, you will usually receive a lower level of benefits. In this case, your out-of-pocket costs will be more. These are called your “out-of-network benefits.”

Your Health Care Network

This health plan consists of two benefit levels: one for in-network benefits; and one for out-of-network benefits. The costs that you pay for *covered services* will differ based on the benefit level. To receive the highest benefit level (your in-network benefits), you must obtain your health care services and supplies from providers who participate in your PPO health care network. These health care providers are referred to as “*preferred providers*.” (See “*covered providers*” in Part 2.) If you choose to obtain your health care services and supplies from a *covered provider* who does not participate in this PPO health care network, you will usually receive the lowest benefit level (your out-of-network benefits). See Part 8 in this Subscriber Certificate for the times when in-network benefits will be provided if you receive *covered services* from a *covered provider* who is not a *preferred provider*.

When You Need Help to Find a Health Care Provider. There are a few ways for you to find a health care provider who participates in your health care network. At the time you enroll in this health plan, a directory of health care providers for your specific plan option will be made available to you at no additional cost. To find out if a health care provider participates in your health care network, you can look in this provider directory. Or, you can also use any one of the following ways to find a provider who participates in your health care network. You can:

- Call the *Blue Cross and Blue Shield* customer service office. The toll free phone number to call is shown on your ID card. They will tell you if a provider is in your health care network. Or, they can help you find a *covered provider* who is in your local area.
- Call the *Blue Cross and Blue Shield* Physician Selection Service at **1-800-821-1388**.
- Use the *Blue Cross and Blue Shield* online physician directory (Find a Doctor). To do this, log on to **www.bluecrossma.com**. This online provider directory will provide you with the most current list of health care providers who participate in your health care network.

If you or your physician cannot find a provider in your health care network who can furnish a *medically necessary covered service* for you, you can ask *Blue Cross and Blue Shield* for help. To ask for this help, you can call the *Blue Cross and Blue Shield* customer service office. They will help you find providers in your health care network who can furnish the *covered service*. They will tell you who those providers are.

If there is not a provider in your health care network who can furnish the *covered service*, *Blue Cross and Blue Shield* will arrange for the *covered service* to be furnished by another health care provider.

When You Are Traveling Outside of Massachusetts. If you are traveling outside of Massachusetts, you can get help to find a health care provider. Just call **1-800-810-BLUE**. You can call this phone number 24 hours a day for help to find a health care provider. When you call, you should have your ID card ready. You must be sure to let the representative know that you are looking for health care providers that participate with the BlueCard PPO program. Or, you can also use the internet. To use the online “Blue National Doctor & Hospital Finder,” log on to **www.bcbs.com**. (For some types of *covered providers*, a local Blue Cross and/or Blue Shield Plan may not have, in the opinion of *Blue Cross and Blue Shield*, established an adequate PPO health care network. If this is the case and you obtain *covered services* from this type of *covered provider*, the in-network benefit level will be provided for these *covered services*. See Part 8 in this Subscriber Certificate.)

**Massachusetts
Board of
Registration:**

If you are looking for more specific information about your physician, the Massachusetts Board of Registration in Medicine may have a profile. To see this profile, you can log on to **www.massmedboard.org**.

Your Identification Card

After you enroll in this health plan, you will receive an identification (ID) card. The ID card will identify you as a person who has the right to coverage in this health plan. The ID card is for identification purposes only. While you are a *member*, you must show your ID card to your health care provider before you receive *covered services*. If you lose your ID card or it is stolen, you should contact the *Blue Cross and Blue Shield* customer service office. They will send you a new card. Or, you can use the *Blue Cross and Blue Shield* Web site to ask for a new ID card. To use the *Blue Cross and Blue Shield* online member self service option, you must log on to **www.bluecrossma.com**. Just follow the steps to ask for a new ID card.

Your Inquiries and/or Claim Problems or Concerns

Blue Cross and Blue Shield can help you to understand the terms of your coverage in this health plan. They can also help you to resolve a problem or concern that you may have about your health care benefits. You can call or write to the *Blue Cross and Blue Shield* customer service office. A *Blue Cross and Blue Shield* customer service representative will work with you to resolve your problem or concern as quickly as possible. *Blue Cross and Blue Shield* will keep a record of each inquiry you, or someone on your behalf, makes to *Blue Cross and Blue Shield*. *Blue Cross and Blue Shield* will keep these records, including the answers to each inquiry, for two years. These records may be reviewed by the Commissioner of Insurance and the Massachusetts Department of Public Health.

If You Are Enrolled as a Group Member. If you are enrolled in this health plan as a *group member* under a *group contract*, you can call Monday through Friday from 8:00 a.m. to 8:00 p.m. (Eastern Time). The toll free phone number to call is shown on your ID card. To use the Telecommunications Device for the Deaf, call 1-800-522-1254. Or, you can write to: Blue Cross Blue Shield of Massachusetts, Member Service, P.O. Box 9134, North Quincy, MA 02171-9134.

If You Are Enrolled as an Individual Member. If you enrolled in this health plan under an *individual contract*, you can call Monday through Friday from 8:00 a.m. to 6:00 p.m. (Eastern Time). The toll free phone number to call is shown on your ID card. To use the Telecommunications Device for the Deaf, call 1-800-522-1254. Or, you can write to: Blue Cross Blue Shield of Massachusetts, Member Service, P.O. Box 9140, North Quincy, MA 02171-9140.

The Office of Patient Protection

You can obtain information about Massachusetts health plans from the Office of Patient Protection of the Massachusetts Department of Public Health. Some of the information that you can obtain from them is:

- A health plan report card. This report card contains data that can help you evaluate and compare health plans.
- Data about physicians who are disenrolled by a health plan. This data is from the prior calendar year.
- A chart that compares the premium revenue that has been used for health care. This chart has data for the most recent year for which the data is available.
- A report with data for health plan grievances and appeals for the prior calendar year.

The Office of Patient Protection is also available to assist Massachusetts consumers. To ask for this information or to seek their assistance, you must contact the Office of Patient Protection. You can call them toll free at **1-800-436-7757**. Or, you can send a fax to **1-617-624-5046**. Or, you can go online and log on to the Web site at **www.state.ma.us/dph/opp**.

Part 2

Explanation of Terms

The following words are shown in italics in this Subscriber Certificate, your *Schedule of Benefits*, and any *riders* that apply to your coverage in this health plan. The meaning of these words will help you understand your benefits.

Allowed Charge

Blue Cross and Blue Shield calculates payment of your benefits based on the *allowed charge*. The *allowed charge* that *Blue Cross and Blue Shield* uses depends on the type of health care provider that furnishes the *covered service* to you.

- **For Preferred Providers in Massachusetts.** For health care providers who have a preferred provider arrangement (a “PPO payment agreement”) with *Blue Cross and Blue Shield*, the *allowed charge* is based on the provisions of that health care provider’s PPO payment agreement. In general, when you share in the cost for your *covered services* (such as a *deductible*, and/or a *copayment* and/or a *coinsurance*), the calculation for the amount that you pay is based on the initial full *allowed charge* for that health care provider. This amount that you pay for a *covered service* is generally not subject to future adjustments—up or down—even though the health care provider’s payment may be subject to future adjustments for such things as provider contractual settlements, risk-sharing settlements, and fraud or other operations.
- **For Health Care Providers Outside of Massachusetts With a Local Payment Agreement.** For health care providers outside of Massachusetts who have a payment agreement with the local Blue Cross and/or Blue Shield Plan, the *allowed charge* is the “negotiated price” that the local Blue Cross and/or Blue Shield Plan passes on to *Blue Cross and Blue Shield*. (Blue Cross and/or Blue Shield Plan means an independent corporation or affiliate operating under a license from the Blue Cross and Blue Shield Association.) In many cases, the negotiated price paid by *Blue Cross and Blue Shield* to the local Blue Cross and/or Blue Shield Plan is a discount from the provider’s billed charges. However, a number of local Blue Cross and/or Blue Shield Plans can determine only an estimated price at the time your claim is paid. Any such estimated price is based on expected settlements, withholds, any other contingent payment arrangements and non-claims transactions, such as provider advances, with the provider (or with a specific group of providers) of the local Blue Cross and/or Blue Shield Plan in the area where services are received. In addition, some local Blue Cross and/or Blue Shield Plans’ payment agreements with providers do not give a comparable discount for all claims. These local Blue Cross and/or Blue Shield Plans elect to smooth out the effect of their payment agreements with providers by applying an average discount to claims. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. Local Blue Cross and/or Blue Shield Plans that use these estimated or averaging methods to calculate the negotiated price may prospectively adjust their estimated or average prices to correct for overestimating or underestimating past prices. However, the amount you pay is considered a final price. **In most cases for *covered services* furnished by these health care providers, you pay only your *deductible* and/or your *copayment* and/or your *coinsurance*, whichever applies.**

- **For Other Health Care Providers.** For physicians and other covered professional providers in Massachusetts who do not have a PPO payment agreement with *Blue Cross and Blue Shield*, *Blue Cross and Blue Shield* uses the provider’s charge up to the usual and customary charge (also referred to as the “*allowed charge*”) to calculate your claim payment for most *covered services*. This “usual and customary” charge, as defined by *Blue Cross and Blue Shield*, is based on the standard fee schedule that *Blue Cross and Blue Shield* has established for its indemnity product participating physicians and other participating professional providers. This usual and customary charge may sometimes be less than the health care provider’s actual charge. **If this is the case, you will be responsible for the amount of the covered provider’s actual charge that is in excess of the usual and customary charge. (This is in addition to your deductible and/or your copayment and/or your coinsurance, whichever applies.)** For this reason, you may wish to discuss charges with your health care provider before you receive *covered services*. This does not apply to *covered services* furnished by hospital-based emergency medicine physicians or to *covered services* furnished by hospital-based anesthesiologists, pathologists, or radiologists. For these *covered services*, the full amount of the health care provider’s actual charge is used to calculate your claim payment.

For all other *covered providers* in Massachusetts who do not have a PPO payment agreement with *Blue Cross and Blue Shield* and for all covered health care providers outside of Massachusetts who do not have a payment agreement with the local Blue Cross and/or Blue Shield Plan, *Blue Cross and Blue Shield* uses the health care provider’s actual charge to calculate your claim payment. **For covered services furnished by these covered providers, you pay only your deductible and/or your copayment and/or your coinsurance, whichever applies.**

Pharmacy Providers. *Blue Cross and Blue Shield* may have payment arrangements with pharmacy providers that may result in rebates on covered drugs and supplies. The cost that you pay for a covered drug or supply is determined at the time you buy the drug or supply. The cost that you pay will not be adjusted for any later rebates, settlements, or other monies paid to *Blue Cross and Blue Shield* from pharmacy providers or vendors.

Benefit Limit

For certain health care services or supplies, there are day, visit, or dollar benefit maximums that apply to your coverage in this health plan. The *Schedule of Benefits* for your plan option and Part 5 of this Subscriber Certificate describe the *benefit limits* that apply to your coverage. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.) Once the amount of the benefits that you have received reaches the *benefit limit* for a specific *covered service*, no more benefits will be provided by this health plan for those health care services or supplies. When this happens, you must pay the full amount of the provider’s charges that you incur for those health care services or supplies that are more than the *benefit limit*.

Blue Cross and Blue Shield

The term “*Blue Cross and Blue Shield*” refers to Blue Cross and Blue Shield of Massachusetts, Inc. It also refers to an employee or designee of Blue Cross and Blue Shield of Massachusetts, Inc. (including another Blue Cross and/or Blue Shield Plan) who is authorized to make decisions or take action called for by this health plan.

Coinsurance

For some *covered services*, you may have to pay a *coinsurance*. This means the cost that you pay for these *covered services* (your “cost share amount”) will be calculated as a percentage. When a *coinsurance* does apply to a specific *covered service*, *Blue Cross and Blue Shield* will calculate your cost share amount based on the health care provider’s actual charge or the *Blue Cross and Blue Shield allowed charge*, whichever is less (unless otherwise required by law). The *Schedule of Benefits* for your plan option shows the *covered services* for which you must pay a *coinsurance* (if there are any). If a *coinsurance* does apply, your *Schedule of Benefits* also shows the percentage that *Blue Cross and Blue Shield* will use to calculate your cost share amount. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.)

Copayment

For some *covered services*, you will have to pay a *copayment*. This means the cost that you pay for these *covered services* (your “cost share amount”) is a fixed dollar amount. In most cases, a *covered provider* will collect the *copayment* from you at the time he or she furnishes the *covered service*. However, when the health care provider’s actual charge at the time of providing the *covered service* is less than your *copayment*, you pay only that health care provider’s actual charge or the *Blue Cross and Blue Shield allowed charge*, whichever is less. Any later charge adjustment—up or down—will not affect your *copayment* (or the cost you were charged at the time of the service if it was less than the *copayment*). The *Schedule of Benefits* for your plan option shows the amount of your *copayment*. It also shows those *covered services* for which you must pay a *copayment*. (Also refer to *riders*—if there are any—that apply to coverage in this health plan.)

Covered Providers

To receive the highest benefit level under this health plan (your in-network benefits), you must obtain your health care services and supplies from *covered providers* who participate in your PPO health care network. These health care providers are referred to as “*preferred providers*.” A *preferred provider* is a health care provider who has a written preferred provider arrangement (a “PPO payment agreement”) with, or that has been designated by, *Blue Cross and Blue Shield* or with a local Blue Cross and/or Blue Shield Plan to provide access to *covered services* to *members*. You also have the option to seek *covered services* from a *covered provider* who is not a *preferred provider*. (These health care providers are often called “*non-preferred providers*.”) In this case, you will receive the lowest benefit level under this health plan (your out-of-network benefits). To find out if a health care provider participates in your PPO health care network, you can look in the provider directory that is provided for your specific plan option.

The kinds of health care providers that are *covered providers* are those that are listed below in this section.

- **Hospital and Other Covered Facilities.** These kinds of health care providers are: alcohol and drug treatment facilities; ambulatory surgical facilities; chronic disease hospitals (sometimes referred to as a chronic care or long term care hospital for *medically necessary covered services*); community health centers; day care centers; detoxification facilities; free-standing diagnostic imaging facilities; free-standing dialysis facilities; free-standing radiation therapy and chemotherapy facilities; general hospitals; independent labs; limited services clinics; mental health centers; mental hospitals; rehabilitation hospitals; and skilled nursing facilities.

- **Physician and Other Covered Professional Providers.** These kinds of health care providers are: certified registered nurse anesthetists; chiropractors; clinical specialists in psychiatric and mental health nursing; dentists; licensed audiologists; licensed dietitian nutritionists (or a dietitian or a nutritionist who is licensed or certified by the state in which the provider practices); licensed independent clinical social workers; licensed marriage and family therapists; licensed mental health counselors; licensed speech-language pathologists; nurse midwives; nurse practitioners; occupational therapists; optometrists; physical therapists; physicians; podiatrists; psychiatric nurse practitioners; and psychologists.
- **Other Covered Health Care Providers.** These kinds of health care providers are: ambulance services; appliance companies; cardiac rehabilitation centers; early intervention providers; home health agencies; home infusion therapy providers; hospice providers; mail service pharmacy; oxygen suppliers; retail pharmacies; and visiting nurse associations.

(These may include other health care providers that are designated for you by *Blue Cross and Blue Shield*.)

Covered Services

This Subscriber Certificate and your *Schedule of Benefits* describe the health care services and supplies for which *Blue Cross and Blue Shield* will provide coverage for you while you are enrolled in this health plan. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.) These health care services and supplies are referred to as “*covered services*.” Except as described otherwise in this Subscriber Certificate, all *covered services* must be *medically necessary* for you, furnished by *covered providers* and, when it is required, approved by *Blue Cross and Blue Shield*.

Custodial Care

Custodial care is a type of care that is not covered by *Blue Cross and Blue Shield*. *Custodial care* means **any of the following**:

- Care that is given primarily by medically-trained personnel for a *member* who shows no significant improvement response despite extended or repeated treatment; or
- Care that is given for a condition that is not likely to improve, even if the *member* receives attention of medically-trained personnel; or
- Care that is given for the maintenance and monitoring of an established treatment program, when no other aspects of treatment require an acute level of care; or
- Care that is given for the purpose of meeting personal needs which could be provided by persons without medical training, such as assistance with mobility, dressing, bathing, eating and preparation of special diets, and taking medications; or
- Care that is given to maintain the *member's* or anyone else's safety. (*Custodial care* does not mean care that is given to maintain the *member's* or anyone else's safety when that *member* is an *inpatient* in a psychiatric unit.)

Deductible

For some *covered services*, you may have to pay a *deductible* before you will receive benefits from this health plan. When your plan option includes a *deductible*, the amount that is put toward your *deductible* is calculated based on the health care provider's actual charge or the *Blue Cross and Blue Shield allowed charge*, whichever is less (unless otherwise required by law). The *Schedule of Benefits* for your plan option shows the amount of your *deductible* (if there is one). Your *Schedule of Benefits* also shows those *covered services* for which you must pay the *deductible* before you receive benefits. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.) When a *deductible* does apply, there are some costs that you pay that do not count toward the *deductible*. These costs that do **not** count toward the *deductible* are:

- Any *copayments* and/or *coinsurance* that you pay.
- The costs that you pay when your coverage is reduced or denied because you did not follow the requirements of the *Blue Cross and Blue Shield utilization review* program. (See Part 4.)
- The costs that you pay that are more than the *Blue Cross and Blue Shield allowed charge*.
- The costs that you pay because your health plan has provided all of the benefits it allows for that *covered service*.

(There may be certain times when amounts that you have paid toward a deductible under a prior health plan or contract may be counted toward satisfying your *deductible* under this health plan. To see if this applies to you, you can call the *Blue Cross and Blue Shield* customer service office.)

Under a High Deductible Health Plan, an annual cost of living adjustment may be applied to your *deductible*. (This applies to you if you are enrolled in a Blue Care Elect Saver plan option.) This adjustment will ensure that *deductibles* are not less than the minimum *deductible* amounts established by the Internal Revenue Service for High Deductible Health Plans for the applicable calendar year. This means that your *deductible* amount may increase from time to time, as determined by *Blue Cross and Blue Shield*. *Blue Cross and Blue Shield* will notify you if this happens.

Diagnostic Lab Tests

This health plan provides coverage for *diagnostic lab tests*. These *covered services* include the examination or analysis of tissues, liquids, or wastes from the body. These covered tests also include (but are not limited to): the taking and interpretation of 12-lead electrocardiograms; all standard electroencephalograms; and glycosylated hemoglobin (HgbA1C) tests, urinary protein/microalbumin tests, and lipid profiles to diagnose and treat diabetes.

Diagnostic X-Ray and Other Imaging Tests

This health plan provides coverage for *diagnostic x-rays and other imaging tests*. These *covered services* include: fluoroscopic tests and their interpretation; and the taking and interpretation of roentgenograms and other imaging studies that are recorded as a permanent picture, such as film. Some examples of imaging tests are: magnetic resonance imaging (MRI); and computerized axial tomography (CT scans). These types of tests also include diagnostic tests that require the use of radioactive drugs.

Effective Date

This term is used to mean the date, as shown on *Blue Cross and Blue Shield's* records, on which your coverage in this health plan starts. Or, it means the date on which a change to your coverage in this health plan takes effect.

Emergency Medical Care

As a *member* of this health plan, you have worldwide coverage for *emergency medical care*. This is medical, surgical, or psychiatric care that you need immediately due to the sudden onset of a condition that manifests itself by symptoms of sufficient severity, including severe pain, which are severe enough that the lack 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 your life or health or the health of another (including an unborn child) in serious jeopardy or serious impairment of bodily functions or serious dysfunction of any bodily organ or part or, as determined by a provider with knowledge of your condition, to result in severe pain that cannot be managed without such care. Some examples of conditions that require *emergency medical care* are: suspected heart attacks; strokes; poisoning; loss of consciousness; convulsions; and suicide attempts. This also includes treatment of *mental conditions* when: you are admitted as an *inpatient* as required under Massachusetts General Laws, Chapter 123, Section 12; you seem very likely to endanger yourself as shown by a serious suicide attempt, a plan to commit suicide, or behavior that shows that you are not able to care for yourself; or you seem very likely to endanger others as shown by an action against another person that could cause serious physical injury or death or by a plan to harm another person.

Important Note:

For purposes of filing a claim or the formal grievance review (see Parts 9 and 10 of this Subscriber Certificate), *Blue Cross and Blue Shield* considers “*emergency medical care*” to constitute “urgent care” as defined under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Group

When you are enrolled in this health plan as a *group member*, the *group* is your agent and is not the agent of *Blue Cross and Blue Shield*. The term “*group*” refers to the corporation, partnership, individual proprietorship, or other organization that has an agreement for *Blue Cross and Blue Shield* to provide its enrolled *group members* with access to health care services and benefits.

Group Contract

When you enroll in this health plan as a *group member*, you are enrolled under a *group contract*. If this applies to your coverage in this health plan, your *group* eligibility, termination, and continuation of coverage provisions are described in Part 11 of this Subscriber Certificate. Under a *group contract*, the *subscriber's group* has an agreement with *Blue Cross and Blue Shield* to provide the *subscriber* and his or her enrolled dependents with access to health care services and benefits. The *group* will make payments to *Blue Cross and Blue Shield* for coverage in this health plan for its enrolled *group members*. The *group* should also deliver to its *group members* all notices from *Blue Cross and Blue Shield*. The *group* is the *subscriber's* agent and is not the agent of *Blue Cross and Blue Shield*. A *group contract* includes: this Subscriber Certificate; the *Schedule of Benefits* for your plan option; any *riders* or other changes to the *group contract*; the *subscriber's* enrollment form; and the agreement that *Blue Cross and Blue Shield* has with the *subscriber's group* to provide coverage for the *subscriber* and his or her enrolled dependents.

Part 2 – Explanation of Terms (continued)

This Subscriber Certificate is not a contract between you and *Blue Cross and Blue Shield*. The *group contract* will be governed by and construed according to the laws of the Commonwealth of Massachusetts, except as preempted by federal law.

You hereby expressly acknowledge your understanding that the *group contract* constitutes a contract solely between your *group* on your behalf and Blue Cross and Blue Shield of Massachusetts, Inc. (*Blue Cross and Blue Shield*), which is a corporation independent of and operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the “Association”), permitting *Blue Cross and Blue Shield* to use the Blue Cross and Blue Shield Service Marks in the Commonwealth of Massachusetts, and that *Blue Cross and Blue Shield* is not contracting as the agent of the Association. You further acknowledge and agree that your *group* on your behalf has not entered into the *group contract* based upon representations by any person other than *Blue Cross and Blue Shield* and that no person, entity, or organization other than *Blue Cross and Blue Shield* will be held accountable or liable to you or your *group* on your behalf for any of *Blue Cross and Blue Shield’s* obligations to you created under the *group contract*. This paragraph will not create any additional obligations whatsoever on the part of *Blue Cross and Blue Shield* other than those obligations created under other provisions of the *group contract*.

Individual Contract

When you enroll in this health plan directly as an individual, you are enrolled for coverage under an *individual contract*. (This means that you did not enroll for coverage in this health plan as a *group member*.) If this applies to your coverage in this health plan, your eligibility and termination provisions are described in Part 12 of this Subscriber Certificate. Under an *individual contract*, the *subscriber* has an agreement directly with *Blue Cross and Blue Shield* to provide the *subscriber* and his or her enrolled dependents with access to health care services and benefits. The *subscriber* will make payments to *Blue Cross and Blue Shield* for coverage in this health plan. *Blue Cross and Blue Shield* will send notices to the *subscriber*. An *individual contract* includes: this Subscriber Certificate; the *Schedule of Benefits* for your plan option; any *riders* or other changes to the *individual contract*; and the *subscriber’s* enrollment form. The *individual contract* will be governed by and construed according to the laws of the Commonwealth of Massachusetts, except as preempted by federal law.

You hereby expressly acknowledge your understanding that an *individual contract* constitutes a contract solely between you and Blue Cross and Blue Shield of Massachusetts, Inc. (*Blue Cross and Blue Shield*), which is a corporation independent of and operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the “Association”), permitting *Blue Cross and Blue Shield* to use the Blue Cross and Blue Shield Service Marks in the Commonwealth of Massachusetts, and that *Blue Cross and Blue Shield* is not contracting as the agent of the Association. You further acknowledge and agree that you have not entered into an *individual contract* based upon representations by any person other than *Blue Cross and Blue Shield* and that no person, entity, or organization other than *Blue Cross and Blue Shield* will be held accountable or liable to you for any of *Blue Cross and Blue Shield’s* obligations to you created under an *individual contract*. This paragraph will not create any additional obligations whatsoever on the part of *Blue Cross and Blue Shield* other than those obligations created under other provisions of the *individual contract*.

Inpatient

The term “inpatient” refers to a patient who is a registered bed patient in a hospital or other covered health care facility and *Blue Cross and Blue Shield* has determined that *inpatient* care is *medically necessary*. This also includes a patient who is receiving *Blue Cross and Blue Shield* approved intensive services such as: partial hospital programs; or covered residential care. A patient who is kept overnight in a hospital solely for observation is **not** considered an *inpatient* even though the patient uses a bed. In this case, the patient is considered an *outpatient*. This is important for you to know since your cost share amount and *benefit limits* may differ for *inpatient* and *outpatient* coverage.

Medical Policy

To receive your health plan coverage, your health care services and supplies must meet the criteria for coverage that are defined in each *Blue Cross and Blue Shield* medical policy that applies. Each health care service or supply must also meet the *Blue Cross and Blue Shield* medical technology assessment criteria. (See below.) The policies and criteria that will apply are those that are in effect at the time you receive the health care service or supply. These policies are based upon *Blue Cross and Blue Shield’s* assessment of the quality of the scientific and clinical evidence that is published in peer reviewed journals. *Blue Cross and Blue Shield* may also consider other clinical sources that are generally accepted and credible. (These sources may include specialty society guidelines, textbooks, and expert opinion.) These *medical policies* explain *Blue Cross and Blue Shield’s* criteria for when a health care service or supply is *medically necessary*, or is not *medically necessary*, or is investigational. These policies form the basis of coverage decisions. A policy may not exist for each health care service or supply. If this is the case for a certain health care service or supply, *Blue Cross and Blue Shield* may apply its *medical technology assessment criteria* and its *medical necessity* criteria to determine if the health care service or supply is *medically necessary* or if it is not *medically necessary* or if it is investigational. If you have access to a fax machine, you can ask for a fax of a *Blue Cross and Blue Shield* medical policy. To do this, you can call the Medical Policy on Demand toll free service. The phone number is **1-888-MED-POLI**. (Your health care provider can also access a policy by using the *Blue Cross and Blue Shield* provider Web site.) Or, you can call the *Blue Cross and Blue Shield* customer service office. You can ask them to mail a copy to you.

Medical Technology Assessment Criteria

To receive your health plan coverage, all of your health care services and supplies must conform to *Blue Cross and Blue Shield* medical technology assessment criteria. These criteria assess whether a technology improves health outcomes such as length of life or ability to function when performing everyday tasks. The *medical technology assessment criteria* that apply are those that are in effect at the time you receive a health care service or supply. These criteria are:

- The technology must have final approval from the appropriate government regulatory bodies. This criterion applies to drugs, biological products, devices (such as durable medical equipment), and diagnostic services. A drug, biological product, or device must have final approval from the U.S. Food and Drug Administration (FDA). Any approval granted as an interim step in the FDA regulatory process is not sufficient. (The FDA Humanitarian Device Exemption is one example of an interim step.) Except as required by law, *Blue Cross and Blue Shield* may limit coverage for drugs, biological products, and devices to those specific indications, conditions, and methods of use approved by the FDA.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed English-language journals. The qualities of the body of studies and the consistency

of the results are considered in evaluating the evidence. The evidence should demonstrate that the technology can measurably alter the physiological changes related to a disease, injury, illness, or condition. In addition, there should be evidence or a convincing argument based on established medical facts that the measured alterations affect health outcomes. Opinions and evaluations by national medical associations, consensus panels, and other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence upon which they are based.

- The technology must improve the net health outcome. The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
- The technology must be as beneficial as any established alternatives. The technology should improve the net outcome as much as or more than established alternatives. The technology must be as cost effective as any established alternative that achieves a similar health outcome.
- The improvement must be attainable outside the investigational setting. When used under the usual conditions of medical practice, the technology should be reasonably expected to improve health outcomes to a degree comparable to that published in the medical literature.

Medically Necessary (Medical Necessity)

To receive your health plan coverage, all of your health care services and supplies must be *medically necessary* and appropriate for your health care needs. (The only exceptions are for routine and preventive health care services that are covered by this health plan.) *Blue Cross and Blue Shield* decides which health care services and supplies that you receive (or you are planning to receive) are *medically necessary* and appropriate for coverage. It will do this by using all of the guidelines described below.

All health care services must be required services that a health care provider, using prudent clinical judgment, would provide to a patient in order to prevent or to evaluate or to diagnose or to treat an illness, injury, disease, or its symptoms. And, these health care services must also be:

- Furnished in accordance with generally accepted standards of professional medical practice (as recognized by the relevant medical community);
- Clinically appropriate, in terms of type, frequency, extent, site, and duration; and they must be considered effective for your illness, injury, or disease;
- Consistent with the diagnosis and treatment of your condition and in accordance with *Blue Cross and Blue Shield medical policies* and *medical technology assessment criteria*;
- Essential to improve your net health outcome and as beneficial as any established alternatives that are covered by *Blue Cross and Blue Shield*;
- Consistent with the level of skilled services that are furnished and furnished in the least intensive type of medical care setting that is required by your medical condition; and
- Not more costly than an alternative service or sequence of services at least as likely to produce the same therapeutic or diagnostic results to diagnose or treat your illness, injury, or disease.

This does **not** include a service that: is primarily for your convenience or for the convenience of your family or the health care provider; is furnished solely for your religious preference; promotes athletic achievements or a desired lifestyle; improves your appearance or how you feel about your appearance; or increases or enhances your environmental or personal comfort.

Member

The term “you” refers to any *member* who has the right to the coverage provided by this health plan. A *member* may be the *subscriber* or his or her enrolled eligible spouse (or former spouse, if applicable) or any other enrolled eligible dependent.

Mental Conditions

This health plan provides coverage for treatment of psychiatric illnesses or diseases. These include drug addiction and alcoholism. The illnesses or diseases that qualify as *mental conditions* are listed in the latest edition, at the time you receive treatment, of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders.

Mental Health Providers

This health plan provides coverage for treatment of a *mental condition* when these *covered services* are furnished by a mental health provider who participates in your health care network. These covered providers include any one or more of the following kinds of health care providers: alcohol and drug treatment facilities; clinical specialists in psychiatric and mental health nursing; community health centers (that are a part of a general hospital); day care centers; detoxification facilities; general hospitals; licensed independent clinical social workers; licensed marriage and family therapists; licensed mental health counselors; mental health centers; mental hospitals; physicians; psychiatric nurse practitioners; psychologists; and other mental health providers that are designated for you by *Blue Cross and Blue Shield*.

Out-of-Pocket Maximum

Under this health plan, you may have a maximum cost share amount that you will have to pay (such as the total of your *deductible* and/or *copayments* and/or *coinsurance*) for certain *covered services*. This is referred to as an “*out-of-pocket maximum*.” The *Schedule of Benefits* for your plan option will show whether or not your coverage has an *out-of-pocket maximum* and, if it does, for which *covered services*. If it does, your *Schedule of Benefits* will also show the amount of your *out-of-pocket maximum* and the time frame for which it applies—such as each calendar year or each *plan year*. It will also describe the cost share amounts you pay that will count toward the *out-of-pocket maximum*. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.) If the cost share amounts you have paid that count toward the *out-of-pocket maximum* add up to the *out-of-pocket maximum* amount, your health plan will provide full benefits based on the *Blue Cross and Blue Shield allowed charge* if you receive more of these *covered services* during the rest of the time frame in which the *out-of-pocket maximum* provision applies. When an *out-of-pocket maximum* does apply, there are some costs that you pay that do not count toward the *out-of-pocket maximum*. These costs that do **not** count toward the *out-of-pocket maximum* are:

- The *premium* that you pay for your health plan.
- The costs that you pay when your coverage is reduced or denied because you did not follow the requirements of the *Blue Cross and Blue Shield utilization review* program. (See Part 4.)
- The costs that you pay that are more than the *Blue Cross and Blue Shield allowed charge*.
- The costs that you pay because your health plan has provided all of the benefits it allows for that *covered service*.

Important Note:

See the *Schedule of Benefits* for your plan option for other costs that you may have to pay that do not count toward your *out-of-pocket maximum*.

Part 2 – Explanation of Terms (continued)

Under a High Deductible Health Plan, an annual cost of living adjustment may be applied to your *out-of-pocket maximum* amount. (This applies to you if you are enrolled in a Blue Care Elect Saver plan option.) This adjustment will be based on changes in the Consumer Price Index or other index used by the Federal Government. This means that your *out-of-pocket maximum* amount may increase from time to time, as determined by *Blue Cross and Blue Shield*. *Blue Cross and Blue Shield* will notify you if this happens.

Outpatient

The term “outpatient” refers to a patient who is not a registered bed patient in a hospital or other health care facility. For example, a patient who is at a health center, at a health care provider’s office, at a surgical day care unit, or at an ambulatory surgical facility is considered an *outpatient*. A patient who is kept overnight in a hospital solely for observation is also considered an *outpatient* even though the patient uses a bed. (This does not include a patient who is receiving *Blue Cross and Blue Shield* approved intensive services. This means services such as: a partial hospital program; or covered residential care. See the explanation for “Inpatient” in this Part 2 in this Subscriber Certificate.)

Plan Sponsor

When you are enrolled in this health plan as a *group member*, the *plan sponsor* is usually your employer and is the same as the plan sponsor designated under the Employee Retirement Income Security Act of 1974, as amended (ERISA). If you are a *group member* and you are not sure who your *plan sponsor* is, you should ask the *subscriber’s* employer.

Plan Year

When your plan option includes a *deductible* and/or an *out-of-pocket maximum*, these amounts will be calculated based on a calendar year or a *plan year* basis. The *Schedule of Benefits* for your plan option will show whether a calendar year or a *plan year* calculation applies to your coverage. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.) If a *plan year* calculation applies, it means the 12-month period of time that starts on the original *effective date* of your coverage in this health plan (or if you are enrolled in this health plan as a *group member*, your *group’s* coverage under the *group contract*) and continues for 12 consecutive months or until your annual renewal date. A new *plan year* begins each 12-month period thereafter. If you do not know when your *plan year* begins, you can ask *Blue Cross and Blue Shield*. Or, if you are enrolled in this health plan as a *group member*, you can ask your *plan sponsor*.

Premium

For coverage in this health plan, the *subscriber* (or the *subscriber’s group* on your behalf when you are enrolled in this health plan as a *group member*) will pay a monthly *premium* to *Blue Cross and Blue Shield*. The total amount of your monthly *premium* is provided to you in the yearly evidence of coverage packet that is issued by *Blue Cross and Blue Shield*. *Blue Cross and Blue Shield* will provide you with access to health care services and benefits as long as the total *premium* that is owed for your coverage in this health plan is paid to *Blue Cross and Blue Shield*. *Blue Cross and Blue Shield* may change your *premium*. Each time *Blue Cross and Blue Shield* changes the *premium* for coverage in this health plan, *Blue Cross and Blue Shield* will notify you (or the *subscriber’s group* when you are enrolled in this health plan as a *group member*) before the change takes place.

Primary Care Provider

Your PPO health care network includes physicians and nurse practitioners that you may choose to furnish your primary medical care. These health care providers are generally called *primary care providers*. As a *member* of this health plan, you are not required to choose a *primary care provider* in order for you to receive your health plan coverage. **You may choose any covered provider to furnish your health care services and supplies. But, your choice is important because it will impact the costs that you pay for your health care services and supplies.** Your costs will be less when you use health care providers who participate in your PPO health care network to furnish your *covered services*.

Rider

Blue Cross and Blue Shield and/or your *group* (when you are enrolled in this health plan as a *group member*) may change the terms of your coverage in this health plan. If a material change is made to your coverage in this health plan, it is described in a *rider*. For example, a *rider* may change the amount that you must pay for certain services such as the amount of your *copayment*. Or, it may add to or limit the benefits provided by this health plan. *Blue Cross and Blue Shield* will supply you with *riders* (if there are any) that apply to your coverage in this health. You should keep these *riders* with this Subscriber Certificate and your *Schedule of Benefits* so that you can refer to them.

Room and Board

For an approved *inpatient* admission, *covered services* include *room and board*. This means your room, meals, and general nursing services while you are an *inpatient*. This includes hospital services that are furnished in an intensive care or similar unit.

Schedule of Benefits

This Subscriber Certificate includes a *Schedule of Benefits* for your specific plan option. It describes the cost share amount that you must pay for each *covered service* (such as a *deductible*, a *copayment*, or a *coinsurance*). And, it includes important information about your *deductible* and *out-of-pocket maximum*. It also describes *benefit limits* that apply for certain *covered services*. Be sure to read all parts of this Subscriber Certificate and your *Schedule of Benefits* to understand your health care benefits. You should read the *Schedule of Benefits* along with the descriptions of *covered services* and the limits and exclusions that are described in this Subscriber Certificate.

Important Note:

A *rider* may change the information that is shown in your *Schedule of Benefits*. Be sure to read each *rider* (if there is any).

Service Area

The *service area* is the geographic area in which you may receive all of your health care services and supplies. Your *service area* includes all counties in the Commonwealth of Massachusetts. In addition, for those *members* who are living or traveling outside of Massachusetts (but within the United States) this health plan provides access to the local *Blue Cross and/or Blue Shield Plan's* PPO health care networks.

Special Services (Hospital and Facility Ancillary Services)

When you receive health care services from a hospital or other covered health care facility, *covered services* include certain services and supplies that the health care facility normally furnishes to its patients for diagnosis or treatment while the patient is in the facility. These *special services* include (but are not limited to) such things as:

- The use of special rooms. These include: operating rooms; and treatment rooms.
- Tests and exams.
- The use of special equipment in the facility. Also, the services of the people hired by the facility to run the equipment.
- Drugs, medications, solutions, biological preparations, and medical and surgical supplies that are used while you are in the facility.
- Administration of infusions and transfusions and blood processing fees. These do not include the cost of: whole blood; packed red blood cells; blood donor fees; or blood storage fees.
- Internal prostheses (artificial replacements of parts of the body) that are part of an operation. These include things such as: hip joints; skull plates; intraocular lenses that are implanted after corneal transplant, cataract surgery, or other covered eye surgery, when the natural eye lens is replaced; and pacemakers. They do not include things such as: ostomy bags; artificial limbs or eyes; hearing aids; or airplane splints.

Subscriber

The *subscriber* is the eligible person who signs the enrollment form at the time of enrollment in this health plan.

Urgent Care

This health plan provides coverage for *urgent care*. This is medical, surgical, or psychiatric care, other than *emergency medical care*, that you need right away. This is care that you need to prevent serious deterioration of your health when an unforeseen illness or injury occurs. In most cases, *urgent care* will be brief diagnostic care and treatment to stabilize your condition. (For purposes of filing a claim or a formal grievance review, *Blue Cross and Blue Shield* considers “*emergency medical care*” to constitute “urgent care” as defined under the Employee Retirement Income Security Act of 1974, as amended (ERISA). As used in this Subscriber Certificate, this *urgent care* term is not the same as the “urgent care” term defined under ERISA.)

Utilization Review

This term refers to the programs that *Blue Cross and Blue Shield* uses to evaluate the necessity and appropriateness of your health care services and supplies. *Blue Cross and Blue Shield* uses a set of formal techniques that are designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings, and drugs. These programs are designed to encourage appropriate care and services (not less care). *Blue Cross and Blue Shield* understands the need for concern about underutilization. *Blue Cross and Blue Shield* shares this concern with its *members* and health care providers. *Blue Cross and Blue Shield* does not compensate individuals who conduct *utilization review* activities based on denials. *Blue Cross and Blue Shield* also does not offer incentives to health care providers to encourage inappropriate denials of care and services. These programs may include any or all of the following.

- Pre-admission review, concurrent review, and discharge planning.
- Pre-approval of some *outpatient* services, including drugs (whether the drugs are furnished to you by a health care provider along with a *covered service* or by a pharmacy).
- Drug formulary management (compliance with the *Blue Cross and Blue Shield* Drug Formulary). This also includes quality care dosing which helps to monitor the quantity and dose of the drug that you receive, based on Food and Drug Administration (FDA) recommendations and clinical information.
- Step therapy to help your health care provider furnish you with the appropriate drug treatment. (With step therapy, before coverage is approved for certain “second step” drugs, it is required that you first try an effective “first step” drug.)
- Post-payment review.
- Individual case management.

Part 3

Emergency Services

You do not need a referral from your health care provider or an approval from *Blue Cross and Blue Shield* before you obtain *emergency medical care*. As a *member* of this health plan, you will receive worldwide emergency coverage. These emergency medical services may include *inpatient* or *outpatient* services by health care providers who are qualified to furnish *emergency medical care*. This includes care that is needed to evaluate or stabilize your emergency medical condition. **At the onset of an emergency medical condition that in your judgment requires *emergency medical care*, you should go to the nearest emergency room. If you need help, dial 911. Or, call your local emergency medical service system phone number.** You will not be denied coverage for medical and transportation services that you incur as a result of your emergency medical condition. You usually need emergency medical services because of the sudden onset of a condition that manifests itself by symptoms of sufficient severity, including severe pain, which are severe enough that the lack 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 your life or health or the health of another (including an unborn child) in serious jeopardy or serious impairment of bodily functions or serious dysfunction of any bodily organ or part or, as determined by a provider with knowledge of your condition, to result in severe pain that cannot be managed without such care. Some examples of conditions that require *emergency medical care* are: suspected heart attacks; strokes; poisoning; loss of consciousness; convulsions; and suicide attempts.

Inpatient Emergency Admissions

Your condition may require that you be admitted into a hospital for *inpatient emergency medical care*. If this happens, you or the admitting facility (or someone on your behalf) must call *Blue Cross and Blue Shield* within 48 hours of your admission. (A health care facility that participates in your health care network should call *Blue Cross and Blue Shield* for you.) This call must include: your name; your ID number; the name of the health care facility; the date of admission; and the condition for which you are receiving treatment. This information is required so that *Blue Cross and Blue Shield* can evaluate and monitor the appropriateness of your *inpatient* health care services.

Outpatient Emergency Services

When you have an emergency medical condition, you should receive care at the nearest emergency room. If you receive *emergency medical care* at an emergency room of a hospital that does not participate in your health care network, your health plan will provide the same coverage that you would otherwise receive if you had gone to a hospital that does participate in your health care network.

Post-Stabilization Care

After your emergency medical condition has been evaluated and stabilized in the hospital emergency room, you may be ready to go home. Or, you may require further care. *Blue Cross and Blue Shield* will consider post-stabilization *covered services* to be approved if an approval is not given within 30 minutes of the emergency room provider's call. If the emergency room provider and your health care provider do not agree as to the right medical treatment for you, your health plan will cover the health care services and supplies that are recommended by the emergency room provider. But, benefits will be provided only for the health care services and supplies that are covered by your health plan.

- **Admissions From the Emergency Room.** Your condition may require that you be admitted directly from the emergency room into that hospital for *inpatient emergency medical care*. If this happens, you or the admitting facility (or someone on your behalf) must call *Blue Cross and Blue Shield*. (A health care facility that participates in your health care network should call *Blue Cross and Blue Shield* for you.) This call must be made within 48 hours of your admission. This call must include: your name; your ID number; the name of the health care facility; the date of admission; and the condition for which you are receiving treatment. This is required so that *Blue Cross and Blue Shield* can evaluate and monitor the appropriateness of your *inpatient* health care services.
- **Transfers to Other Inpatient Facilities.** Your emergency room provider may recommend your transfer to another facility for *inpatient* care. If this happens, you or the admitting facility (or someone on your behalf) must call *Blue Cross and Blue Shield*. (A health care facility that participates in your health care network should call *Blue Cross and Blue Shield* for you.) This call must be made within 48 hours of your admission. This is required so that *Blue Cross and Blue Shield* can evaluate the appropriateness of the *inpatient* health care services.
- **Outpatient Follow Up Care.** Your emergency room provider may recommend that you have *outpatient* follow up care. If this happens, the emergency room provider must call *Blue Cross and Blue Shield* to obtain an approval when the type of care that you need requires an approval from *Blue Cross and Blue Shield*. (See Part 4.) If you need to have more follow up care and an approval is required, you or your health care provider must obtain the approval from *Blue Cross and Blue Shield*.

Part 4

Utilization Review Requirements

To receive all of the coverage provided by your health plan, you must follow all of the requirements described in this section. **Your coverage may be denied if you do not follow these requirements.**

Pre-Service Approval Requirements

There are certain health care services or supplies that must be approved for you by *Blue Cross and Blue Shield*. A health care provider who participates in your health care network should request a pre-service approval on your behalf. (You must request this review if the health care provider does not start the process for you.) For the pre-service review, *Blue Cross and Blue Shield* will consider your health care provider to be your authorized representative. ***Blue Cross and Blue Shield* will tell you and your health care provider if coverage for a proposed service has been approved or if coverage has been denied.** To check on the status of a request or to check for the outcome of a *utilization review* decision, you can call your health care provider or the *Blue Cross and Blue Shield* customer service office. The toll free phone number to call is shown on your ID card. Remember, you should check with your health care provider before you receive services or supplies to make sure that your health care provider has received approval from *Blue Cross and Blue Shield* when a pre-service approval is required. Otherwise, you will have to pay all charges for those health care services and/or supplies.

(The requirements described below in this part do not apply to your *covered services* when Medicare is the primary coverage.)

Referrals for Specialty Care

You do not need a referral from your *primary care provider* or your attending physician in order for you to receive your health plan coverage. But, there are certain health care services and supplies that must be approved by *Blue Cross and Blue Shield* before you receive them. (See below.)

Pre-Service Review for Outpatient Services

To receive all of your coverage for certain *outpatient* health services and supplies, you must obtain a pre-service approval from *Blue Cross and Blue Shield*. A health care provider who participates in your health care network will request this approval on your behalf. During the pre-service review, *Blue Cross and Blue Shield* will determine if your proposed health care services or supplies should be covered as *medically necessary* for your condition. *Blue Cross and Blue Shield* will make this decision within two working days of the date that it receives all of the needed information from your health care provider. You must receive a pre-service approval from *Blue Cross and Blue Shield* for:

- Certain specialty care, surgical procedures, and/or other *outpatient* health care services and supplies. These services and supplies may include those that are furnished for you by a *covered provider* such as a hospital, a professional health care provider (for example, chiropractors and physical and occupational therapists), or a non-emergency ambulance. **For your specific plan option, to find out if your proposed service or supply needs a pre-service review, you can check with your health care provider.** You can also call the *Blue Cross and Blue Shield* customer service office or use the online *Blue Cross and Blue Shield* member self service option. To do this, log on to the *Blue Cross and Blue Shield* Web site at www.bluecrossma.com. Just follow the steps to check your benefits.

WORDS IN ITALICS ARE EXPLAINED IN PART 2.

- Infertility treatment.
- Home health care. (If you have been receiving *inpatient* care, *Blue Cross and Blue Shield* may approve these services through Discharge Planning.)
- Certain prescription drugs that you buy from a pharmacy or that are administered to you by a non-pharmacy health care provider during a covered visit. For example, you receive an injection or an infusion of a drug in a physician's office or in a hospital outpatient setting. A key part of this pre-service approval process is the step therapy program. It helps your health care provider provide you with the appropriate drug treatment. To find out if your prescription drug requires a prior approval from *Blue Cross and Blue Shield*, you can call the *Blue Cross and Blue Shield* customer service office.

Pre-Approval Requirements Can Change:

From time to time, *Blue Cross and Blue Shield* may change the list of health care services and supplies that require a prior approval. When a material change is made to these requirements, *Blue Cross and Blue Shield* will let the *subscriber* (or the *subscriber's group* on your behalf when you are enrolled in this health plan as a *group member*) know about the change at least 60 days before the change becomes effective.

Missing Information. In some cases, *Blue Cross and Blue Shield* will need more information or records to determine if your proposed health care services or supplies should be covered as *medically necessary* to treat your condition. For example, *Blue Cross and Blue Shield* may ask for the results of a face-to-face clinical evaluation or of a second opinion. If *Blue Cross and Blue Shield* does need more information, *Blue Cross and Blue Shield* will ask for this missing information or records within 15 calendar days of the date that it received your health care provider's request for pre-service approval. The information or records that *Blue Cross and Blue Shield* asks for must be provided to *Blue Cross and Blue Shield* within 45 calendar days of the request. If this information or these records are not provided to *Blue Cross and Blue Shield* within these 45 calendar days, your proposed coverage will be denied. If *Blue Cross and Blue Shield* receives this information or these records within this time frame, *Blue Cross and Blue Shield* will make a decision within two working days of the date it is received.

Coverage Approval. If through the pre-service review *Blue Cross and Blue Shield* determines that your proposed health care service, supply, or course of treatment should be covered as *medically necessary* for your condition, *Blue Cross and Blue Shield* will call the health care provider. *Blue Cross and Blue Shield* will make this phone call within 24 hours of the time the decision is made to let the health care provider know of the coverage approval status of the review. Then, within two working days of that phone call, *Blue Cross and Blue Shield* will send a written (or electronic) notice to you and to the health care provider. This notice will let you know (and confirm) that your coverage was approved.

Coverage Denial. If through the pre-service review *Blue Cross and Blue Shield* determines that your proposed health care service, supply, or course of treatment should **not** be covered as *medically necessary* for your condition, *Blue Cross and Blue Shield* will call the health care provider. *Blue Cross and Blue Shield* will make this phone call within 24 hours of the time the decision is made to let the health care provider know that the coverage was denied and to discuss alternative treatment. Then, within one working day of that phone call, *Blue Cross and Blue Shield* will send a written (or electronic) notice to you and to the health care provider. This notice will explain *Blue Cross and Blue Shield's* coverage decision. This notice that is sent to you will: describe the reasons that *Blue Cross and Blue Shield* has denied the request and the applicable terms of your coverage in this health plan; give the specific medical and scientific reasons for which *Blue Cross and Blue Shield* has denied the request; specify any

alternative treatment or health care services and supplies that would be covered; refer to and include *Blue Cross and Blue Shield* clinical guidelines that apply and were used and any review criteria; and describe the review process and your right to pursue legal action.

Reconsideration of Adverse Determination. Your health care provider may ask that *Blue Cross and Blue Shield* reconsider its decision when *Blue Cross and Blue Shield* has determined that your proposed health care service, supply, or course of treatment is not *medically necessary* for your condition. In this case, *Blue Cross and Blue Shield* will arrange for the decision to be reviewed by a clinical peer reviewer. This review will be held between your health care provider and the clinical peer reviewer. And, it will be held within one working day of the date that your health care provider asks for *Blue Cross and Blue Shield's* decision to be reconsidered. If the initial decision is not reversed, you (or the health care provider on your behalf) may ask for a formal review. The process to ask for a formal review is described in Part 10 of this Subscriber Certificate. You may request a formal review even if your health care provider has not asked that the *Blue Cross and Blue Shield* decision be reconsidered.

Pre-Admission Review

Before you go into a hospital or other covered health care facility for *inpatient* care, your health care provider must obtain an approval from *Blue Cross and Blue Shield* in order for your care to be covered by this health plan. (This does not apply to your admission if it is for *emergency medical care* or for maternity care.) *Blue Cross and Blue Shield* will determine if the health care setting is suitable to treat your condition. *Blue Cross and Blue Shield* will make this decision within two working days of the date that it receives all of the needed information from your health care provider.

Missing Information. In some cases, *Blue Cross and Blue Shield* will need more information or records to determine if the health care setting is suitable to treat your condition. For example, *Blue Cross and Blue Shield* may ask for the results of a face-to-face clinical evaluation or of a second opinion. If *Blue Cross and Blue Shield* does need more information, *Blue Cross and Blue Shield* will ask for this missing information or records within 15 calendar days of the date that it received your health care provider's request for approval. The information or records that *Blue Cross and Blue Shield* asks for must be provided to *Blue Cross and Blue Shield* within 45 calendar days of the request. If this information or these records are not provided to *Blue Cross and Blue Shield* within these 45 calendar days, your proposed coverage will be denied. If *Blue Cross and Blue Shield* receives this information or records within this time frame, *Blue Cross and Blue Shield* will make a decision within two working days of the date it is received.

Coverage Approval. If *Blue Cross and Blue Shield* determines that the proposed setting for your health care is suitable, *Blue Cross and Blue Shield* will call the health care facility. *Blue Cross and Blue Shield* will make this phone call within 24 hours of the time the decision is made to let the facility know of the coverage approval status of the pre-admission review. Then, within two working days of that phone call, *Blue Cross and Blue Shield* will send a written (or electronic) notice to you and to the facility. This notice will let you know (and confirm) that your coverage was approved.

Coverage Denial. If *Blue Cross and Blue Shield* determines that the proposed setting is not *medically necessary* for your condition, *Blue Cross and Blue Shield* will call the health care facility. *Blue Cross and Blue Shield* will make this phone call within 24 hours of the time the decision is made to let the facility know that the coverage was denied and to discuss alternative treatment. Then, within one working day of that phone call, *Blue Cross and Blue Shield* will send a written (or electronic) notice to you and to the facility. This notice will explain *Blue Cross and Blue Shield's* coverage decision. This notice that is sent to you will: describe the reasons that *Blue Cross and Blue Shield* has denied the request and the applicable

Part 4 – Utilization Review Requirements (continued)

terms of your coverage in this health plan; give the specific medical and scientific reasons for which *Blue Cross and Blue Shield* has denied the request; specify any alternative treatment or health care services and supplies that would be covered; refer to and include *Blue Cross and Blue Shield* clinical guidelines that apply and were used and any review criteria; and describe the review process and your right to pursue legal action.

Reconsideration of Adverse Determination. Your health care provider may ask that *Blue Cross and Blue Shield* reconsider its decision when *Blue Cross and Blue Shield* has determined that *inpatient* coverage is not *medically necessary* for your condition. In this case, *Blue Cross and Blue Shield* will arrange for the decision to be reviewed by a clinical peer reviewer. This review will be held between your health care provider and the clinical peer reviewer. And, it will be held within one working day of the date that your health care provider asks for the *Blue Cross and Blue Shield* decision to be reconsidered. If the initial decision is not reversed, you (or the health care provider on your behalf) may ask for a formal review. The process to ask for a formal review is described in Part 10 of this Subscriber Certificate. You may request a formal review even if your health care provider has not asked that the *Blue Cross and Blue Shield* decision be reconsidered.

Concurrent Review and Discharge Planning

Concurrent Review means that while you are an *inpatient*, *Blue Cross and Blue Shield* will monitor and review the health care services you receive to make sure you still need *inpatient* coverage in that facility.

In some cases, *Blue Cross and Blue Shield* may determine upon review that you will need to continue *inpatient* coverage in that health care facility beyond the number of days first thought to be required for your condition. When *Blue Cross and Blue Shield* makes this decision (within one working day of receiving all necessary information), *Blue Cross and Blue Shield* will let the health care facility know of the coverage approval status of the review. *Blue Cross and Blue Shield* will do this within one working day of making this decision. *Blue Cross and Blue Shield* will also send a written (or electronic) notice to you and to the facility to explain the decision. This notice will be sent within one working day of that first notice. This notice will include: the number of additional days that are being approved for coverage (or the next review date); the new total number of approved days or services; and the date the approved services will begin.

In other cases, based on a *medical necessity* determination, *Blue Cross and Blue Shield* may determine that you no longer need *inpatient* coverage in that health care facility. Or, you may no longer need *inpatient* coverage at all. *Blue Cross and Blue Shield* will make this decision within one working day of receiving all necessary information. *Blue Cross and Blue Shield* will call the health care facility to let them know of this decision. *Blue Cross and Blue Shield* will discuss plans for continued coverage in a health care setting that better meets your needs. This phone call will be made within 24 hours of the *Blue Cross and Blue Shield* coverage decision. For example, your condition may no longer require *inpatient* coverage in a hospital, but it still may require skilled nursing coverage. If this is the case, your physician may decide to transfer you to a skilled nursing facility. Any proposed plans will be discussed with you by your physician. All arrangements for discharge planning will be confirmed in writing with you. *Blue Cross and Blue Shield* will send this written (or electronic) notice to you and to the facility within one working day of that phone call to the facility.

You may choose to stay in the health care facility after you have been told by your health care provider or *Blue Cross and Blue Shield* that *inpatient* coverage is no longer *medically necessary*. But, if you do, *Blue Cross and Blue Shield* will not provide any more coverage (except as otherwise may be required during

the formal grievance process). You must pay all costs for the rest of that *inpatient* stay. This starts from the date the written notice is sent to you from *Blue Cross and Blue Shield*.

Reconsideration of Adverse Determination. Your health care provider may ask that *Blue Cross and Blue Shield* reconsider its decision when *Blue Cross and Blue Shield* has determined that continued *inpatient* coverage is not *medically necessary* for your condition. In this case, *Blue Cross and Blue Shield* will arrange for the decision to be reviewed by a clinical peer reviewer. This review will be held between your health care provider and the clinical peer reviewer. And, it will be held within one working day of the date that your health care provider asks for the *Blue Cross and Blue Shield* decision to be reconsidered. If the initial decision is not reversed, you (or the health care provider on your behalf) may ask for a formal review. The process to ask for a formal review is described in Part 10 of this Subscriber Certificate. You may request a formal review even if your health care provider has not asked that the *Blue Cross and Blue Shield* decision be reconsidered.

Individual Case Management

Individual Case Management is a flexible program for managing your benefits in some situations. Through this program, *Blue Cross and Blue Shield* works with your health care providers to make sure that you get *medically necessary* services in the least intensive setting that meets your needs. Under this program, coverage may be approved for services that are in addition to those that are already covered by this health plan. For example, *Blue Cross and Blue Shield* may approve these services to:

- Shorten an *inpatient* stay. This may occur by sending a *member* home or to a less intensive setting to continue treatment.
- Direct a *member* to a less costly setting when an *inpatient* stay has been proposed.
- Prevent future *inpatient* stays. This may occur by providing coverage for *outpatient* care instead.

Blue Cross and Blue Shield may, in some situations, present a specific alternative treatment plan to you and your attending physician. This treatment plan will be one that is *medically necessary* for you. *Blue Cross and Blue Shield* will need the full cooperation of everyone involved. This includes: the patient (or the guardian); the hospital; the attending physician; and the proposed health care provider. *Blue Cross and Blue Shield* may require that there be a written agreement between the patient (or the patient's family or guardian) and *Blue Cross and Blue Shield*. *Blue Cross and Blue Shield* may also require that there be an agreement between the health care provider and *Blue Cross and Blue Shield* to furnish the services that are approved through this alternative treatment plan.

Part 5

Covered Services

You have the right to the coverage described in this part, except as limited or excluded in other parts of this Subscriber Certificate. Also, be sure to read the *Schedule of Benefits* for your plan option. It describes the cost share amounts that you must pay for *covered services*. And, it shows the *benefit limits* that apply to specific *covered services*. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.) **Your coverage in this health plan consists of two benefit levels: one for in-network benefits; and one for out-of-network benefits.** This means that your cost share amount differs based on the benefit level of the *covered services* that you receive. The highest benefit level is provided when you receive *covered services* from a *covered provider* who participates in your PPO health care network. This is your in-network benefit level. The lowest benefit level is usually provided when you receive *covered services* from a *covered provider* who does not participate in your PPO health care network. This is your out-of-network benefit level. Your out-of-network benefit level will be at least 80% of the in-network benefit level. This means that the *coinsurance* percentage for out-of-network benefits for non-emergency *covered services* will be no more than 20 percentage points greater than the *coinsurance* percentage for in-network benefits for the same *covered services* (excluding any reasonable *deductible* or *copayment*). The *Schedule of Benefits* for your plan option shows the cost share amounts that will you pay for in-network benefits and for out-of-network benefits.

Admissions for Inpatient Medical and Surgical Care

General and Chronic Disease Hospital Admissions

Except for an admission for *emergency medical care* or for maternity care, you and your health care provider must receive approval from *Blue Cross and Blue Shield* as outlined in this Subscriber Certificate before you enter a general or chronic disease hospital for *inpatient* care. *Blue Cross and Blue Shield* will let you and your health care provider know when your coverage is approved. (See Part 4.) When *inpatient* care is approved by *Blue Cross and Blue Shield* or it is for *inpatient emergency medical care*, this health plan provides coverage for as many days as are *medically necessary* for you. (For maternity care, see page 35.) This coverage includes:

- Semiprivate *room and board*; and *special services* that are furnished for you by the hospital.
- Surgery that is performed for you by a physician; or a podiatrist; or a nurse practitioner; or a dentist. This may also include the services of an assistant surgeon (physician) when *Blue Cross and Blue Shield* decides that an assistant is needed. These *covered services* include (but are not limited to):
 - **Reconstructive surgery.** This means non-dental surgery that is meant to improve or give you back bodily function or to correct a functional physical impairment that was caused by: a birth defect; a prior surgical procedure or disease; or an accidental injury. It also includes surgery that is done to correct a deformity or disfigurement that was caused by an accidental injury.

Women’s Health and Cancer Rights: As required by federal law, this coverage includes breast reconstruction in connection with a mastectomy. This health plan provides coverage for: all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas. These

IMPORTANT: Refer to the *Schedule of Benefits* for your plan option for the cost share amounts that you must pay for covered services and for the benefit limits that may apply to specific covered services. Once you reach your benefit limit for a specific covered service, no more benefits are provided by Blue Cross and Blue Shield for those services or supplies.

services will be furnished in a manner determined in consultation with the attending physician and the patient.

- **Transplants.** This means human organ (or tissue) and stem cell (“bone marrow”) transplants that are furnished according to *Blue Cross and Blue Shield medical policy* and *medical technology assessment criteria*. It also includes one or more stem cell transplants for a *member* who has been diagnosed with breast cancer that has spread and the *member* meets the standards that have been set by the Massachusetts Department of Public Health. For covered transplants, coverage also includes: the harvesting of the donor’s organ (or tissue) or stem cells when the recipient is a *member*; and drug therapy that is furnished during the transplant procedure to prevent the transplanted organ (or tissue) or stem cells from being rejected. “Harvesting” includes: the surgical removal of the donor’s organ (or tissue) or stem cells; and the related *medically necessary* services and/or tests that are required to perform the transplant itself. No benefits are provided for the harvesting of the donor’s organ (or tissue) or stem cells when the recipient is not a *member*. (See “Lab Tests, X-Rays, and Other Tests” for your coverage for donor testing.)
- **Oral surgery.** This means: reduction of a dislocation or fracture of the jaw or facial bone; excision of a benign or malignant tumor of the jaw; and orthognathic surgery that you need to correct a significant functional impairment that cannot be adequately corrected with orthodontic services. You must have a serious medical condition that requires that you be admitted to a hospital as an *inpatient* in order for the surgery to be safely performed. (Orthognathic surgery is not covered when it is performed mainly for cosmetic reasons. This surgery must be performed along with orthodontic services. If it is not, the oral surgeon must send a letter to *Blue Cross and Blue Shield* asking for approval for the surgery. No benefits are provided for the orthodontic services.)

This health plan may also cover the removal of impacted teeth when the teeth are fully or partially imbedded in the bone. The *Schedule of Benefits* for your plan option will tell you whether or not you have coverage for these services. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.)

- Voluntary termination of pregnancy; and voluntary sterilization procedures.
- Anesthesia services that are related to covered surgery. This includes those services that are furnished for you by a physician other than the attending physician; or by a certified registered nurse anesthetist.
- Radiation and x-ray therapy that is furnished for you by a physician. This includes: radiation therapy using isotopes, radium, radon, or other ionizing radiation; and x-ray therapy for cancer or when used in place of surgery.
- Chemotherapy (drug therapy for cancer) that is furnished for you by a physician.

IMPORTANT: Refer to the *Schedule of Benefits* for your plan option for the cost share amounts that you must pay for *covered services* and for the *benefit limits* that may apply to specific *covered services*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by *Blue Cross and Blue Shield* for those services or supplies.

- Interpretation of *diagnostic x-ray and other imaging tests, diagnostic lab tests*, and diagnostic machine tests, when these tests are furnished by a physician or by a podiatrist instead of by a hospital-based radiologist or pathologist who is an employee of the hospital. (When these services are furnished by a radiologist or pathologist who is an employee of the hospital, coverage is provided as a *special service* of the hospital.)
- Medical care that is furnished for you by a physician; or by a nurse practitioner; or by a podiatrist. This includes medical care furnished for you by a physician other than the attending physician to treat an uncommon aspect or complication of your illness or injury. This health plan will cover medical care furnished for you by two or more physicians at the same time. But, this is the case only when *Blue Cross and Blue Shield* decides that the care is needed to treat a critically ill patient. The second physician must be an expert in a different medical sub-specialty than the attending physician. This health plan will cover only the attending physician if the second physician is an expert in the same medical sub-specialty as the attending physician.
- Monitoring services that are related to dialysis, when they are furnished for you by a *covered provider*.
- Consultations. These services must be furnished for you by a physician other than the attending physician. The consultation must be needed to diagnose or treat the condition for which you were admitted. Or, it must be for a complication that develops after you are an *inpatient*. The attending physician must order the consultation. The physician who furnishes it must send a written report to *Blue Cross and Blue Shield* if they ask for one. The physician who furnishes this consultation for you must be an expert in a different medical sub-specialty than the attending physician. This health plan will cover only the attending physician if the consultant is an expert in the same medical sub-specialty as the attending physician.
- Intensive care services. These services must be furnished for you by a physician other than the attending physician; or by a nurse practitioner. This means services that you need for only a limited number of hours to treat an uncommon aspect or complication of your illness or injury.
- Emergency admission services. These services must be furnished for you by a physician; or by a nurse practitioner. This means that a complete history and physical exam is performed before you are admitted as an *inpatient* for *emergency medical care* and your treatment is taken over immediately by another physician.
- Pediatric specialty care. This is care that is furnished for you by a *covered provider* who has a recognized expertise in specialty pediatrics.
- Second surgical opinions. These services must be furnished for you by a physician. This includes a third opinion when the second opinion differs from the first.

IMPORTANT: Refer to the *Schedule of Benefits* for your plan option for the cost share amounts that you must pay for *covered services* and for the *benefit limits* that may apply to specific *covered services*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by *Blue Cross and Blue Shield* for those services or supplies.

Rehabilitation Hospital Admissions

You and your health care provider must receive approval from *Blue Cross and Blue Shield* as outlined in this Subscriber Certificate before you enter a rehabilitation hospital for *inpatient* care. *Blue Cross and Blue Shield* will let you and your health care provider know when your coverage is approved. (See Part 4.) When *inpatient* care is approved by *Blue Cross and Blue Shield*, this health plan provides coverage only until you reach your *benefit limit*. The *Schedule of Benefits* for your plan option describes the *benefit limit* that applies for these *covered services*. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.) Once you reach this *benefit limit*, no more benefits will be provided for these services. This is the case whether or not the care is *medically necessary*. (Whether or not your plan option has a *benefit limit* for these services, coverage is provided only for those services that are determined by *Blue Cross and Blue Shield* to be *medically necessary* for you.) This coverage includes: semiprivate *room and board* and *special services* furnished for you by the hospital; and medical care furnished for you by a physician or by a nurse practitioner.

Skilled Nursing Facility Admissions

You and your health care provider must receive approval from *Blue Cross and Blue Shield* as outlined in this Subscriber Certificate before you enter a skilled nursing facility for *inpatient* care. *Blue Cross and Blue Shield* will let you and your health care provider know when your coverage is approved. (See Part 4.) When *inpatient* care is approved by *Blue Cross and Blue Shield*, this health plan provides coverage only until you reach your *benefit limit*. The *Schedule of Benefits* for your plan option describes the *benefit limit* that applies for these *covered services*. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.) Once you reach this *benefit limit*, no more benefits will be provided for these services. This is the case whether or not the care is *medically necessary*. (Whether or not your plan option has a *benefit limit* for these services, coverage is provided only for those services that are determined by *Blue Cross and Blue Shield* to be *medically necessary* for you.) This coverage includes: semiprivate *room and board* and *special services* furnished for you by the facility; and medical care furnished for you by a physician or by a nurse practitioner.

Ambulance Services

This health plan covers ambulance transport. This coverage includes:

- **Emergency Ambulance.** This includes an ambulance that takes you to an emergency medical facility for *emergency medical care*. For example, this may be an ambulance that takes you from an accident scene to the hospital. Or, it may take you from your home to a hospital due to a heart attack. This also means an air ambulance that takes you to a hospital when your emergency medical condition requires that you use an air ambulance rather than a ground ambulance. If you need help, call 911. Or, call your local emergency phone number.
- **Other Ambulance.** This includes *medically necessary* transport by an ambulance. For example, this may be an ambulance that is required to take you to or from the nearest hospital (or other covered health care facility) to receive care. It also includes an ambulance that is needed for a *mental condition*.

IMPORTANT: Refer to the *Schedule of Benefits* for your plan option for the cost share amounts that you must pay for *covered services* and for the *benefit limits* that may apply to specific *covered services*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by *Blue Cross and Blue Shield* for those services or supplies.

No benefits are provided: for taxi or chair car service; or to transport you to or from your medical appointments.

Cardiac Rehabilitation

This health plan covers *outpatient* cardiac rehabilitation when it is furnished for you by a cardiac rehabilitation provider. You will be covered for as many visits as are *medically necessary* for your condition. This coverage is provided according to the regulations of the Massachusetts Department of Public Health. This means that your first visit must be within 26 weeks of the date that you were first diagnosed with cardiovascular disease. Or, you must start within 26 weeks after you have had a cardiac event. *Blue Cross and Blue Shield* must determine through medical documentation that you meet one of these conditions: you have cardiovascular disease or angina pectoris; or you have had a myocardial infarction, angioplasty, or cardiovascular surgery. (This type of surgery includes: a heart transplant; or coronary bypass graft surgery; or valve repair or replacement.) For angina pectoris, this health plan covers only one course of cardiac rehabilitation for each *member*.

No benefits are provided for: club membership fees (except when they are covered by this health plan as a fitness benefit); counseling services that are not part of your cardiac rehabilitation program (for example, these *non-covered services* may be educational, vocational, or psychosocial counseling); medical or exercise equipment that you use in your home; services that are provided to your family; and additional services that you receive after you complete a cardiac rehabilitation program.

Chiropractor Services

This health plan covers *outpatient* chiropractic services when they are furnished for you by a chiropractor who is licensed to furnish the specific *covered service*. This coverage includes: *diagnostic lab tests* (such as blood tests); diagnostic x-rays other than magnetic resonance imaging (MRI), computerized axial tomography (CT scans), and other imaging tests; and *outpatient* medical care services, including spinal manipulation.

Dialysis Services

This health plan covers *outpatient* dialysis when it is furnished for you by a hospital; or by a community health center; or by a free-standing dialysis facility; or by a physician. This coverage also includes home dialysis when it is furnished under the direction of a *covered provider*. Your home dialysis coverage includes: non-durable medical supplies (such as dialysis membrane and solution, tubing, and drugs that are needed during dialysis); the cost to install the dialysis equipment in your home up to \$300; and the cost to maintain or to fix the dialysis equipment. *Blue Cross and Blue Shield* will decide whether to rent or to buy the dialysis equipment. If the dialysis equipment is bought, *Blue Cross and Blue Shield* keeps ownership rights to it. It does not become your property. No home dialysis benefits are provided for: costs to get or supply power, water, or waste disposal systems; costs of a person to help with the dialysis procedure; and costs that are not needed to run the dialysis equipment.

IMPORTANT: Refer to the *Schedule of Benefits* for your plan option for the cost share amounts that you must pay for *covered services* and for the *benefit limits* that may apply to specific *covered services*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by *Blue Cross and Blue Shield* for those services or supplies.

Durable Medical Equipment

This health plan covers durable medical equipment that you buy or rent from a *covered provider* that is an appliance company or from another provider who is designated by *Blue Cross and Blue Shield* to furnish the specific covered appliance. This health plan provides coverage only until you reach your *benefit limit*. The *Schedule of Benefits* for your plan option describes the *benefit limit* that applies for these *covered services*. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.) Once you reach the *benefit limit*, no more benefits will be provided for these services. (A *benefit limit* does not apply when durable medical equipment is furnished as part of covered home dialysis, home health care, or hospice services.) This coverage is provided for equipment that: can stand repeated use; serves a medical purpose; is *medically necessary* for you; is not useful if you are not ill or injured; and can be used in the home. Some examples of covered durable medical equipment include (but are not limited to):

- Knee braces; and back braces.
- Orthopedic and corrective shoes that are part of a leg brace.
- Hospital beds; wheelchairs; crutches; and walkers.
- Glucometers. These are covered when the device is *medically necessary* for you due to your type of diabetic condition.
- Visual magnifying aids; and voice-synthesizers. These are covered only for a legally blind *member* who has insulin dependent, insulin using, gestational, or non-insulin dependent diabetes.
- Insulin injection pens. (Your benefits for these items are provided as a prescription drug benefit when you buy them from a pharmacy. See “Prescription Drugs and Supplies.”)

From time to time, the equipment that is covered by this health plan may change. This change will be based on *Blue Cross and Blue Shield’s* periodic review of its *medical policies* and *medical technology assessment criteria* to reflect new applications and technologies. You can call the *Blue Cross and Blue Shield* customer service office for help to find out what is covered. (See Part 1.)

Blue Cross and Blue Shield will decide whether to rent or buy the durable medical equipment. If *Blue Cross and Blue Shield* decides to rent the equipment, your benefits will not be more than the amount that would have been covered if the equipment were bought. This health plan covers the least expensive equipment of its type that meets your needs. If *Blue Cross and Blue Shield* determines that you chose durable medical equipment that costs more than what you need for your medical condition, benefits will be provided only for those costs that would have been paid for the least expensive equipment that meets your needs. In this case, you must pay all of the health care provider’s charges that are more than the *Blue Cross and Blue Shield* claim payment.

IMPORTANT: Refer to the *Schedule of Benefits* for your plan option for the cost share amounts that you must pay for *covered services* and for the *benefit limits* that may apply to specific *covered services*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by *Blue Cross and Blue Shield* for those services or supplies.

Early Intervention Services

This health plan covers early intervention services when they are furnished by an early intervention provider for an enrolled child from birth through age two. (This means until the child turns three years old.) This coverage includes *medically necessary*: physical, speech/language, and occupational therapy; nursing care; and psychological counseling.

Emergency Medical Outpatient Services

This health plan covers *emergency medical care* that you receive at an emergency room of a general hospital. (See Part 3.) At the onset of an emergency medical condition that (in your judgment) requires *emergency medical care*, you should go to the nearest emergency room. If you need help, call 911. Or, call your local emergency phone number. This health plan also covers *emergency medical care* when the care is furnished for you by a *covered provider* such as by a hospital outpatient department; or by a community health center; or by a physician; or by a dentist; or by a nurse practitioner.

For emergency room visits, you may have to pay a *copayment* for *covered services*. If a *copayment* does apply to your emergency room visit, it is waived if the visit results in your being held for an overnight observation stay or being admitted for *inpatient* care within 24 hours. (Your *Schedule of Benefits* describes your cost share amount. Also refer to *riders*—if there are any—that apply to your coverage in this health plan.)

Home Health Care

You and your health care provider must receive approval from *Blue Cross and Blue Shield* as outlined in this Subscriber Certificate before you receive home health care. *Blue Cross and Blue Shield* will let you and your health care provider know when your coverage is approved. (See Part 4.) This health plan covers home health care when it is furnished (or arranged and billed) for you by a home health care provider. This coverage is provided only when: you are expected to reach a defined medical goal that is set by your attending physician; the “home” health care is furnished at a place where you live (unless it is a hospital or other health care facility that furnishes skilled nursing or rehabilitation services); and, for medical reasons, you are not reasonably able to travel to another treatment site where medically appropriate care can be furnished for your condition. This coverage includes:

- Part-time skilled nursing visits; physical, speech/language, and occupational therapy; medical social work; nutrition counseling; home health aide services; medical supplies; durable medical equipment; enteral infusion therapy; and basic hydration therapy.
- Home infusion therapy that is furnished for you by a home infusion therapy provider. This includes: the infusion solution; the preparation of the solution; the equipment for its administration; and necessary part-time nursing.

(When physical, speech/language, and/or occupational therapy is furnished as part of your covered home health care program, a *benefit limit* will not apply to these services.)

IMPORTANT: Refer to the *Schedule of Benefits* for your plan option for the cost share amounts that you must pay for *covered services* and for the *benefit limits* that may apply to specific *covered services*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by *Blue Cross and Blue Shield* for those services or supplies.

No **benefits** are provided for: meals, personal comfort items, and housekeeping services; *custodial care*; treatment of *mental conditions*; and home infusion therapy, including the infusion solution, when it is furnished by a pharmacy or other health care provider that is not a home infusion therapy provider. (The only exception is for enteral infusion therapy and basic hydration therapy that is furnished by a home health care provider.)

Hospice Services

This health plan covers hospice services when they are furnished (or arranged and billed) for you by a hospice provider. “Hospice services” means pain control and symptom relief and supportive and other care for a *member* who is terminally ill (the patient is expected to live six months or less). These services are furnished to meet the needs of the *member* and of his or her family during the illness and death of the *member*. These services may be furnished at home, in the community, and in facilities. This coverage includes:

- Services furnished and/or arranged by the hospice provider. These may include services such as: physician, nursing, social, volunteer, and counseling services; *inpatient* care; home health aide visits; drugs; and durable medical equipment.
- Respite care. This care is furnished to the hospice patient in order to relieve the family or primary care person from care giving functions.
- Bereavement services. These services are provided to the family or primary care person after the death of the hospice patient. They can include contacts, counseling, communication, and correspondence.

Infertility Services

This health plan covers services to diagnose and treat infertility for a *member* who is healthy and who has not been able to conceive or produce conception during a period of one year. *Blue Cross and Blue Shield* may approve coverage for infertility services in two other situations: when the *member* has been diagnosed with cancer and, after treatment, the *member* is expected to become infertile; or when a healthy *member* is age 35 or older and has not been able to conceive or produce conception during a period of six months. To receive coverage for infertility services, they must be *medically necessary* for you, furnished by a *covered provider*, and approved by *Blue Cross and Blue Shield* as outlined in this Subscriber Certificate and in the *Blue Cross and Blue Shield medical policy*. You and your health care provider must receive approval from *Blue Cross and Blue Shield* before you obtain infertility services. *Blue Cross and Blue Shield* will let you and your health care provider know when your coverage is approved. (See Part 4.) **In all cases, covered services must conform with *Blue Cross and Blue Shield medical policy* and meet *Blue Cross and Blue Shield medical technology assessment criteria*.** (See page 12 for help for how to access or obtain a copy of the *medical policy*.) This coverage may include:

- Artificial insemination.
- Sperm and egg and/or inseminated egg procurement and processing.

IMPORTANT: Refer to the *Schedule of Benefits* for your plan option for the cost share amounts that you must pay for *covered services* and for the *benefit limits* that may apply to specific *covered services*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by *Blue Cross and Blue Shield* for those services or supplies.

- Banking of sperm or inseminated eggs. (This health plan covers these charges only when they are not covered by the donor’s health plan.)
- Infertility technologies. These include: in vitro fertilization and embryo placement; gamete intrafallopian transfer; zygote intrafallopian transfer; natural oocyte retrieval intravaginal fertilization; and intracytoplasmic sperm injection.

If *covered services* are furnished outside of Massachusetts and the health care provider does not have a payment agreement with the local Blue Cross and/or Blue Shield Plan, this health plan will provide these benefits only when the provider is board certified and meets the appropriate American Society of Reproductive Medicine standards for an infertility provider. Otherwise, no benefits will be provided for the services furnished by those providers.

Coverage for Prescription Drugs. The drugs that are used for infertility treatment are covered by this health plan as a prescription drug benefit. This means that coverage will be provided for these covered drugs only when the drugs are furnished by a covered pharmacy, even if a non-pharmacy health care provider administers the drug for you during a covered visit. For your coverage for these covered drugs, see “Prescription Drugs and Supplies.” (There are no exclusions, limitations, or other restrictions for drugs prescribed to treat infertility that are different from those applied to drugs that are prescribed for other medical conditions.)

No benefits are provided for: long term sperm or egg preservation or long term cryopreservation not associated with active infertility treatment; costs that are associated with achieving pregnancy through surrogacy (gestational carrier); infertility treatment that is needed as a result of a prior sterilization or unsuccessful sterilization reversal procedure (except for *medically necessary* infertility treatment that is needed after a sterilization reversal procedure that is successful as determined by appropriate diagnostic tests); and in vitro fertilization furnished for a fertile woman to select the genetic traits of the embryo (coverage may be available for the genetic testing alone when the testing conforms with *Blue Cross and Blue Shield medical policy*).

Lab Tests, X-Rays, and Other Tests

This health plan covers *outpatient* diagnostic tests when they are furnished for you by a *covered provider*. This coverage includes:

- *Diagnostic lab tests.*
- Diagnostic machine tests such as pulmonary function tests and holter monitoring.
- *Diagnostic x-ray and other imaging tests.*
- Preoperative tests. These tests must be performed before a scheduled *inpatient* or surgical day care unit admission for surgery. And, they must not be repeated during the admission. These tests include: *diagnostic lab tests; diagnostic x-ray and other imaging tests;* and diagnostic machine tests (such as pulmonary function tests).
- Human leukocyte antigen testing or histocompatibility locus antigen testing. These tests are necessary to establish stem cell (“bone marrow”) transplant donor suitability. They include testing for A, B, or

WORDS IN ITALICS ARE EXPLAINED IN PART 2.

IMPORTANT: Refer to the *Schedule of Benefits* for your plan option for the cost share amounts that you must pay for *covered services* and for the *benefit limits* that may apply to specific *covered services*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by *Blue Cross and Blue Shield* for those services or supplies.

DR antigens or any combination according to the guidelines of the Massachusetts Department of Public Health.

You may have to pay a *copayment* for some of these *covered services*. The *Schedule of Benefits* for your plan option describes your cost share amount. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.) If a *copayment* does apply, it will be waived when these *covered services* are furnished during an emergency room visit or during a day surgery admission. Or, when a *copayment* applies for *diagnostic lab tests* at a hospital, the *copayment* will be waived if the results of the lab test(s) are required right away so that the hospital can furnish treatment to you. There may be other times when a *copayment* for lab tests, x-rays, and other covered tests at a hospital may be waived or be the same *copayment* amount that you would pay for the same services at a free-standing facility. You can call the *Blue Cross and Blue Shield* customer service office for information about the times when your *copayment* may be waived. The toll free phone number to call is shown on your ID card.

Maternity Services and Well Newborn Inpatient Care

Maternity Services

This health plan covers all medical care that is related to pregnancy and childbirth (or miscarriage) when it is furnished for you by a *covered provider*. This coverage is provided for any female *member*. This coverage includes:

- Semiprivate *room and board* and *special services* when the enrolled mother is an *inpatient* in a general hospital. This includes nursery charges for a well newborn. These charges are included with the benefits for the mother's maternity admission. The mother's (and newborn child's) *inpatient* stay will be no less than 48 hours following a vaginal delivery or 96 hours following a Caesarian section unless the mother and her attending physician decide otherwise as provided by law. If the mother chooses to be discharged earlier, this health plan covers one home visit within 48 hours of discharge, when it is furnished by a physician; or by a registered nurse; or by a nurse midwife; or by a nurse practitioner. This visit may include: parent education; assistance and training in breast or bottle feeding; and appropriate tests. This health plan will cover more visits that are furnished by a *covered provider* only if *Blue Cross and Blue Shield* determines the visits are clinically necessary.
- Delivery of one or more than one baby. This includes prenatal and postnatal medical care that is furnished for you by a physician; or by a nurse midwife. Your benefits for prenatal and postnatal medical care that is furnished by a physician or by a nurse midwife are included in *Blue Cross and Blue Shield's* payment for the delivery. The benefits that are provided for these services will be those that are in effect on the date of delivery. When a physician or a nurse midwife furnishes only prenatal and/or postnatal care, benefits for those services are based on the date the care is received. This health plan also covers prenatal and postnatal medical care exams and lab tests when they are furnished for you by a general hospital; or by a community health center. Your benefits for these services are based on the date the care is received.

IMPORTANT: Refer to the *Schedule of Benefits* for your plan option for the cost share amounts that you must pay for *covered services* and for the *benefit limits* that may apply to specific *covered services*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by *Blue Cross and Blue Shield* for those services or supplies.

- Standby attendance that is furnished for you by a physician (who is a pediatrician), when a known or suspected complication threatening the health of the mother or the child requires that a pediatrician be present during the delivery.
- Childbirth classes for up to \$90 for one childbirth course for each covered expectant mother and up to \$45 for each refresher childbirth course. The expectant mother is encouraged to attend the childbirth course that is recommended by her physician or by her health care facility or by her nurse midwife. You must pay the full cost of the childbirth course. After you complete the course, call the *Blue Cross and Blue Shield* customer service office for a claim form to file your claim. You will not be reimbursed for this amount unless you complete the course, except when your delivery occurs before the course ends.

All expectant mothers enrolled under this health plan may take part in a program that provides support and education for expectant mothers. Through this program, *members* receive outreach and education that add to the care the *member* gets from her obstetrician or nurse midwife. You can call the *Blue Cross and Blue Shield* customer service office for more information.

No benefits are provided for home births, except for an emergency or unplanned delivery that occurs at home prior to being admitted to a hospital or for maternity services furnished outside of Massachusetts.

Well Newborn Inpatient Care

This health plan covers well newborn care when it is furnished during the enrolled mother's *inpatient* maternity stay. This coverage includes:

- Pediatric care that is furnished for a well newborn by a physician (who is a pediatrician); or by a nurse practitioner.
- Routine circumcision that is furnished by a physician.
- Newborn hearing screening tests that are performed by a *covered provider* before the newborn child (an infant under three months of age) is discharged from the hospital to the care of the parent or guardian, or as provided by regulations of the Massachusetts Department of Public Health.

(See “Admissions for Inpatient Medical and Surgical Care” for your coverage when an enrolled newborn child requires *medically necessary inpatient* care.)

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Medical Care Outpatient Visits

This health plan covers *outpatient* care to diagnose or treat your medical condition when the services or supplies are furnished for you by a *covered provider*. This may include (but is not limited to): a physician; or a nurse practitioner; or an optometrist; or a licensed dietitian nutritionist. These services may be furnished in the provider’s office or at a covered facility or, as determined appropriate by *Blue Cross and Blue Shield*, at home. This coverage includes:

- Medical care services to diagnose or treat your illness, condition, or injury. These medical services also include (but are not limited to) nutrition counseling.

Women’s Health and Cancer Rights. As required by federal law, this coverage includes medical care services to treat physical complications at all stages of mastectomy, including lymphedemas and breast reconstruction in connection with a mastectomy. These services will be furnished in a manner determined in consultation with the attending physician and the patient.

- Certain medical services that are furnished for you by a limited services clinic. This coverage for a limited services clinic is restricted to those health care services that are approved by *Blue Cross and Blue Shield* for this type of *covered provider*. To find out if a specific service is covered for this provider type, you can call the *Blue Cross and Blue Shield* customer service office. The cost share amount that you must pay for these *covered services* is the same cost share amount that you would pay for similar services furnished by a physician.
- Medical exams and contact lenses that are needed to treat keratoconus. This includes the cost of the fitting of these contact lenses.
- Hormone replacement therapy for peri- and post-menopausal women.
- *Urgent care* services.
- Follow up care that is related to an accidental injury or an emergency medical condition.
- Allergy testing. (This includes tests that you need such as PRIST, RAST, and scratch tests.)
- Injections. This includes the administration of injections that you need such as allergy shots or other *medically necessary* injections. And except for certain self injectable drugs as described below in this section, this coverage also includes the vaccines, serum, or other covered drug that is furnished during your covered visit. (This section does not include injections that are covered as a surgical service such as a nerve block injection or an injection of anesthetic agents. See “Surgery as an Outpatient.”)

Coverage for Self Injectable and Certain Other Drugs. There are self injectable and certain other prescription drugs used for treating your medical condition that are covered by this health plan only when these drugs are furnished by a covered pharmacy, even when a non-pharmacy health care provider administers the drug for you during a covered visit. For your coverage for these covered drugs, see “Prescription Drugs and Supplies.” **No benefits are provided for the cost of these drugs when the drug is furnished by a non-pharmacy health care provider.** For a list of these drugs, you can call the *Blue Cross and Blue Shield* customer service office. Or, you can log on to the *Blue Cross and Blue Shield* Web site at www.bluecrossma.com.

IMPORTANT: Refer to the *Schedule of Benefits* for your plan option for the cost share amounts that you must pay for *covered services* and for the *benefit limits* that may apply to specific *covered services*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by *Blue Cross and Blue Shield* for those services or supplies.

- Syringes and needles when they are *medically necessary* for you. If a *copayment* would normally apply to your visit, it is waived if the visit is only to obtain these items. (Your coverage for these items is provided as a prescription drug benefit when you buy them from a pharmacy.)
- Diabetes self-management training and education, including medical nutrition therapy, when it is furnished for you by a certified diabetes health care professional who is a *covered provider* or who is affiliated with a *covered provider*.
- Pediatric specialty care that is furnished for you by a *covered provider* who has a recognized expertise in specialty pediatrics.
- Non-dental services that are furnished for you by a dentist who is licensed to furnish the specific *covered service*. This coverage is provided only if the services are covered when they are furnished for you by a physician.
- Monitoring and medication management for *members* taking psychiatric drugs; and/or neuropsychological assessment services. These services may also be furnished by a *mental health provider*.

Medical Formulas

This health plan covers medical formulas and low protein foods to treat certain conditions. This coverage includes:

- Special medical formulas that are approved by the Massachusetts Department of Public Health and are *medically necessary* for you to treat one of the listed conditions: homocystinuria; maple syrup urine disease; phenylketonuria; propionic acidemia; methylmalonic acidemia; or tyrosinemia.
- Enteral formulas that you need to use at home and are *medically necessary* for you to treat malabsorption caused by one of the listed conditions: Crohn’s disease; chronic intestinal pseudo-obstruction; gastroesophageal reflux; gastrointestinal motility; ulcerative colitis; or inherited diseases of amino acids and organic acids.
- Food products that are modified to be low protein and are *medically necessary* for you to treat inherited diseases of amino acids and organic acids. (You may buy these food products directly from a distributor.) This coverage is provided only until you reach your *benefit limit*. The *Schedule of Benefits* for your plan option describes the *benefit limit* that applies for these *covered services*. Once you reach the *benefit limit*, no more benefits will be provided for these food products.

Your benefits for these *covered services* are provided as a prescription drug benefit. See “Prescription Drugs and Supplies.”

IMPORTANT: Refer to the *Schedule of Benefits* for your plan option for the cost share amounts that you must pay for *covered services* and for the *benefit limits* that may apply to specific *covered services*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by *Blue Cross and Blue Shield* for those services or supplies.

Mental Health and Substance Abuse Treatment

This health plan covers *medically necessary* services to diagnose and/or treat *mental conditions*. This coverage includes:

- Biologically-based *mental conditions*. “Biologically-based mental conditions” means: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder; delirium and dementia; affective disorders; eating disorders; post-traumatic stress disorders; autism; substance abuse disorders (drug addiction and alcoholism); and any biologically-based *mental conditions* that appear in the most recent edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders that are scientifically recognized and approved by the Commissioner of the Department of Mental Health.
- Rape-related mental or emotional disorders for victims of a rape or victims of an assault with intent to rape.
- Non-biologically-based mental, behavior, or emotional disorders of enrolled dependent children who are under age 19. This coverage includes pediatric specialty mental health care that is furnished by a *mental health provider* who has a recognized expertise in specialty pediatrics. (This coverage is not limited to those disorders that substantially interfere with or limit the way the child functions or how he or she interacts with others.) If a child who is under age 19 is receiving an ongoing course of treatment, this coverage will continue to be provided after the child’s 19th birthday until that ongoing course of treatment is completed, provided that the child or someone acting on behalf of the child continues to pay for coverage in this health plan in accordance with federal (COBRA) or state law, or the child enrolls with no lapse in coverage under another *Blue Cross and Blue Shield* or a *Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.* health plan.
- All other non-biologically-based *mental conditions* not described above.

No benefits are provided for: psychiatric services for a condition that is not a *mental condition*; residential or other care that is *custodial care*; and services and/or programs that are not *medically necessary* to treat your *mental condition*. Some examples of services and programs that are not covered by this health plan are: services that are performed in educational, vocational, or recreational settings; and “outward bound-type,” “wilderness,” “camp,” or “ranch” programs. These types of non-covered programs may be in residential or nonresidential settings. They may include therapeutic elements and/or clinical staff services as well as vocational, educational, problem solving, and/or recreational activities. These programs may have educational accreditation. The staff may include some licensed mental health providers who may provide some therapy. No benefits are provided for any services furnished along with one of these non-covered programs. For example, no benefits are provided for therapy and/or psychotherapy furnished along with one of these non-covered programs.

Inpatient Services

To receive coverage for *inpatient* services for a *mental condition*, you and your *mental health provider* must receive approval from *Blue Cross and Blue Shield* as outlined in this Subscriber Certificate before you enter a general or mental hospital or substance abuse treatment facility for *inpatient* care. *Blue Cross*

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and *Blue Shield* will let you and your *mental health provider* know when your coverage is approved. (See Part 4.) When *inpatient* care is approved by *Blue Cross and Blue Shield*, this health plan provides coverage for as many days as are *medically necessary* for you (except as may be limited for certain non-biologically-based *mental conditions* when you are an *inpatient* in a mental hospital—see note below). This coverage includes: semiprivate *room and board* and *special services*; and psychiatric care that is furnished for you by a physician (who is a specialist in psychiatry), or by a psychologist, or by a clinical specialist in psychiatric and mental health nursing, or by another *mental health provider*.

Your Benefit Limit for Non-Biologically-Based Mental Conditions. Your *inpatient* coverage in a mental hospital may be limited for non-biologically-based *mental conditions* other than treatment of rape-related conditions and treatment of children who are under age 19. The *Schedule of Benefits* for your plan option describes the day *benefit limit* (if there is one) that applies for *covered services* in a mental hospital. Once you reach the *benefit limit*, no more benefits will be provided for these services. But in all cases, coverage is provided only for those services that are determined by *Blue Cross and Blue Shield* to be *medically necessary* for you.

Intermediate Treatments

During the pre-service approval process (see Part 4), *Blue Cross and Blue Shield* will assess your specific mental health needs. The least intensive type of setting that is required for your condition will be approved by *Blue Cross and Blue Shield*. There are times when you will require *covered services* that are more intensive than the typical *outpatient* services. But, these services may not require that you be admitted for 24-hour hospital care. These “intermediate” mental health care services that may be approved by *Blue Cross and Blue Shield* include (but are not limited to): acute residential treatment; partial hospital programs; or intensive outpatient programs. *Blue Cross and Blue Shield* will arrange for treatment with the appropriate *mental health provider*.

Blue Cross and Blue Shield considers coverage for these intermediate mental health care services to be an *inpatient* benefit. If an *inpatient copayment* applies to your coverage, it will be waived when you receive *Blue Cross and Blue Shield* approved intermediate mental health care services in lieu of an *inpatient* admission. (You must still pay any *deductible* and/or *coinsurance* amounts, if there is any that applies for *inpatient* care.) If a day *inpatient benefit limit* applies, these treatments will be counted as follows:

- One acute residential treatment day will count as one day of your *inpatient day benefit limit*.
- Two partial hospital treatment days will count as one day of your *inpatient day benefit limit*.
- Two intensive outpatient treatment days will count as one day of your *inpatient day benefit limit*.

Outpatient Services

This health plan covers *outpatient covered services* to diagnose and/or treat *mental conditions* when the services are furnished for you by a *mental health provider*. This coverage is provided for as many visits as are *medically necessary* for your *mental condition* (except as may be limited for certain non-biologically-based *mental conditions*—see note below).

IMPORTANT: Refer to the *Schedule of Benefits* for your plan option for the cost share amounts that you must pay for *covered services* and for the *benefit limits* that may apply to specific *covered services*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by *Blue Cross and Blue Shield* for those services or supplies.

Your Benefit Limit for Non-Biologically-Based Mental Conditions. Your *outpatient* coverage may be limited for non-biologically-based *mental conditions* other than treatment of rape-related conditions and treatment of children who are under age 19. The *Schedule of Benefits* for your plan option describes the visit *benefit limit* (if there is one) that applies for these *covered services*. Once you reach the *benefit limit*, no more benefits will be provided for these services. But in all cases, coverage is provided only for those services that are determined by *Blue Cross and Blue Shield* to be *medically necessary* for you.

Oxygen and Respiratory Therapy

This health plan covers:

- Oxygen and the equipment to administer it for use in the home. These items must be obtained from an oxygen supplier. This includes oxygen concentrators.
- Respiratory therapy services. These services must be furnished for you by a *covered provider*. Some examples are: postural drainage; and chest percussion.

Podiatry Care

This health plan covers non-routine podiatry (foot) care when it is furnished for you by a *covered provider*. This may include (but is not limited to): a physician; or a podiatrist. This coverage includes: *diagnostic lab tests*; diagnostic x-rays; surgery and necessary postoperative care; and other *medically necessary* foot care such as treatment for hammertoe and osteoarthritis.

No benefits are provided for: routine foot care services such as trimming of corns, trimming of nails, and other hygienic care, except when the care is *medically necessary* because you have systemic circulatory disease (such as diabetes); and certain non-routine foot care services and supplies such as foot orthotics, arch supports, shoe (foot) inserts, orthopedic and corrective shoes that are not part of a leg brace (except as described in this Subscriber Certificate for “Prosthetic Devices”), and fittings, castings, and other services related to devices for the feet.

Prescription Drugs and Supplies

Your plan option may or may not include pharmacy coverage. The *Schedule of Benefits* for your plan option will tell you whether or not you have pharmacy coverage under this PPO health plan and if this section applies to you. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.)

When your pharmacy coverage is provided under this health plan, coverage is provided for certain drugs and supplies that are furnished by a covered pharmacy. This coverage is provided **only** when all of the following criteria are met.

- The drug or supply is listed on the *Blue Cross and Blue Shield* Drug Formulary as a covered drug or supply. For certain covered drugs, you must have prior approval from *Blue Cross and Blue Shield* in

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order for you to receive this drug coverage. A covered pharmacy will tell you if your drug needs prior approval from *Blue Cross and Blue Shield*. They will also tell you how to request this approval.

- The drug or supply is prescribed for your use while you are an *outpatient*.
- The drug or supply is purchased from a pharmacy that is approved by *Blue Cross and Blue Shield* for payment for the specific covered drug and/or supply. This means that for most covered drugs and supplies, you may buy your drug or supply from any covered retail pharmacy. However, for a select number of covered drugs and supplies, you may need to buy your drug or supply from certain covered pharmacies that specialize in treating specific diseases and that have been approved by *Blue Cross and Blue Shield* for payment for that specific covered drug or supply.

The Drug Formulary. The *Blue Cross and Blue Shield* Drug Formulary is a list of *Blue Cross and Blue Shield* approved drugs and supplies. *Blue Cross and Blue Shield* may update its Drug Formulary from time to time. In this case, your coverage for certain drugs and supplies may change. For example, a drug may be added to or excluded from the Drug Formulary; or a drug may change from one *member* cost share level to another *member* cost share level. **For the list of drugs that are excluded from the *Blue Cross and Blue Shield* Drug Formulary, you can refer to your Pharmacy Program booklet.** This booklet was sent to you as a part of your evidence of coverage packet. Please check for updates. If the exclusion list has been changed, you should use the revised booklet that is in effect at the time you buy your drug or supply. You can check for updates or obtain more information about the *Blue Cross and Blue Shield* Drug Formulary, including which drugs are not included on the formulary, by calling the *Blue Cross and Blue Shield* customer service office. The toll free phone number to call is shown on your ID card. You can also go online and log on to the *Blue Cross and Blue Shield* Web site at www.bluecrossma.com.

The Drug Formulary Exception Process. Your drug coverage includes a Drug Formulary Exception Process. This process allows your prescribing health care provider to ask for an exception from *Blue Cross and Blue Shield*. This exception is to ask for coverage for a drug that is not on the *Blue Cross and Blue Shield* Drug Formulary. *Blue Cross and Blue Shield* will consider a Drug Formulary exception request if there is a medical basis for your not being able to take, for your condition, any of the covered drugs or an over-the-counter drug. If the Drug Formulary exception request is approved by *Blue Cross and Blue Shield*, you will receive coverage for the drug that is not on the *Blue Cross and Blue Shield* Drug Formulary. For this drug, you will pay the highest *member* cost share amount.

Buying Covered Drugs and Supplies. For help to obtain your drug coverage, you can call the *Blue Cross and Blue Shield* customer service office. The toll free phone number to call is shown on your ID card. A *Blue Cross and Blue Shield* customer service representative can help you find a pharmacy where you may buy a specific drug or supply. They can also help you find out which *member* cost share level you will pay for a specific covered drug or supply. Or, you can also go online and log on to the *Blue Cross and Blue Shield* Web site at www.bluecrossma.com.

IMPORTANT: Refer to the *Schedule of Benefits* for your plan option for the cost share amounts that you must pay for *covered services* and for the *benefit limits* that may apply to specific *covered services*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by *Blue Cross and Blue Shield* for those services or supplies.

Mail Service Pharmacy Benefits:

There are certain covered drugs and supplies that you may not be able to buy from the *Blue Cross and Blue Shield* designated mail service pharmacy. To find out if your covered drug or supply qualifies for the mail service pharmacy benefit, you can check with the mail service pharmacy. Or, you can call the *Blue Cross and Blue Shield* customer service office.

Covered Drugs and Supplies. This drug coverage is provided for:

- Drugs that require a prescription by law and are furnished in accordance with *Blue Cross and Blue Shield medical technology assessment criteria*. These covered drugs include: birth control drugs; oral diabetes medication that influences blood sugar levels; hormone replacement therapy drugs for peri- and post-menopausal women; and certain drugs used on an off-label basis (such as: drugs used to treat cancer; and drugs used to treat HIV/AIDS).
- Injectable insulin and disposable syringes and needles needed for its administration, whether or not a prescription is required. (When a *copayment* applies to your pharmacy coverage, if insulin, syringes, and needles are bought at the same time, you pay two *copayments*: one for the insulin; and one for the syringes and needles.)
- Materials to test for the presence of sugar when they are ordered for you by a physician for home use. These include (but are not limited to): blood glucose monitoring strips; ketone strips; lancets; urine glucose testing strips; normal, low, and high calibrator solution/chips; and dextrostik or glucose test strips. (See “Durable Medical Equipment” for your coverage for glucometers.)
- Insulin injection pens.
- Insulin infusion pumps and related pump supplies. (You will obtain the insulin infusion pump from an appliance company instead of a pharmacy.)
- Syringes and needles when they are *medically necessary* for you.
- Drugs that do not require a prescription by law (“over-the-counter” drugs), if any, that are listed on the *Blue Cross and Blue Shield* Drug Formulary as a covered drug. Your Pharmacy Program booklet will list the over-the-counter drugs that are covered, if there are any. Or, you may go online and log on to the *Blue Cross and Blue Shield* Web site at www.bluecrossma.com.
- Diaphragms and other prescription birth control devices that have been approved by the U.S. Food and Drug Administration (FDA). For these, you pay the cost of the lowest *member* cost share level.
- Prescription prenatal vitamins and pediatric vitamins with fluoride.
- Nicotine gum or nicotine patches (or other smoking cessation aids that require a prescription by law) when they are prescribed for you by a physician. The coverage for these supplies is limited to one 90-day supply for each *member* in each calendar year.

IMPORTANT: Refer to the *Schedule of Benefits* for your plan option for the cost share amounts that you must pay for *covered services* and for the *benefit limits* that may apply to specific *covered services*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by *Blue Cross and Blue Shield* for those services or supplies.

Non-Covered Drugs and Supplies. No benefits are provided for:

- Anorexiant.
- Non-sedating antihistamines.
- Pharmaceuticals that you can buy without a prescription, except as described in this Subscriber Certificate or in your Pharmacy Program booklet.
- Medical supplies such as dressings and antiseptics.
- The cost of delivering drugs to you.
- Combination vitamins that require a prescription, except for: prescription prenatal vitamins; and pediatric vitamins with fluoride.
- Dental topical fluoride, rinses, and gels that require a prescription.
- Immunizing agents; toxoids; blood; and blood products.
- Drugs and supplies that you buy from a non-designated mail service pharmacy.
- Drugs and supplies that you buy from any pharmacy that is not approved by *Blue Cross and Blue Shield* for payment for the specific covered drug and/or supply.

Preventive Health Services

Routine Pediatric Care

This health plan covers routine pediatric care for a *member* from birth through age 18 when the care is furnished by a *covered provider*. This coverage is limited to an age-based schedule and a maximum number of visits. The *Schedule of Benefits* for your plan option describes the age-based schedule and the visit limits that apply for these *covered services*. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.) As required by state law, this coverage is provided for at least: six visits during the first year of life (birth to age one, including *inpatient* visits for a well newborn); three visits during the second year of life (age one to age two); and one visit in each calendar year from age two through age five (until age 6). This coverage includes:

- Routine medical exams; history; measurements; sensory (vision and auditory) screening; and neuropsychiatric evaluation and development screening; and assessment.
- Hereditary and metabolic screening at birth.
- Appropriate immunizations. (This includes: flu shots; and travel immunizations.)
- Tuberculin tests; hematocrit, hemoglobin, and other appropriate blood tests; urinalysis; and blood tests to screen for lead poisoning (as required by state law).
- Other related routine services that are furnished in line with *Blue Cross and Blue Shield medical policies*.

For an enrolled child who gets benefits for hepatitis B vaccine from a state agency, this health plan provides coverage only to administer the vaccine. Otherwise, this health plan also provides coverage for the hepatitis B vaccine when the child is at high risk for getting the disease.

IMPORTANT: Refer to the *Schedule of Benefits* for your plan option for the cost share amounts that you must pay for *covered services* and for the *benefit limits* that may apply to specific *covered services*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by *Blue Cross and Blue Shield* for those services or supplies.

No **benefits** are provided for exams that are needed: to take part in school, camp, and sports activities; or by third parties. The only exception to this is when these exams are furnished as a covered routine exam.

Routine Adult Physical Exams and Tests

This health plan covers routine physical exams (including related lab tests and x-rays) for a *member* who is age 19 or older when the services are furnished by a *covered provider*. This coverage includes:

- Routine medical exams and related routine lab tests and x-rays that are furnished in line with *Blue Cross and Blue Shield medical policies*. This coverage is limited to an age-based schedule and a maximum number of visits. The *Schedule of Benefits* for your plan option describes the age-based schedule and visit limits that may apply for these *covered services*. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.)
- A routine baseline mammogram during the five-year period a *member* is age 35 through 39; and a routine mammogram once in each calendar year for a *member* who is age 40 or older.
- Blood tests to screen for lead poisoning (as required by state law).
- Immunizations. (This includes: flu shots; and travel immunizations.)
- A routine prostate-specific antigen (PSA) blood test once in each calendar year for a *member* who is age 40 or older.
- A routine sigmoidoscopy or barium enema once every three calendar years for a *member* who is age 50 or older.
- A routine colonoscopy once every ten calendar years for a *member* who is age 50 or older.

No **benefits** are provided for exams that are needed: to take part in school, camp, and sports activities; or by employers or third parties. The only exception to this is when these exams are furnished as a covered routine exam.

Routine Gynecological (GYN) Exams

This health plan covers routine GYN exams as described in the *Schedule of Benefits* for your plan option when they are furnished by a *covered provider*. This may include (but is not limited to): a physician; or a nurse practitioner; or a nurse midwife. This coverage also includes one routine Pap smear test for each *member* in each calendar year.

Family Planning

This health plan covers family planning services when they are furnished for you by a *covered provider*. This may include (but is not limited to): a physician; or a nurse practitioner; or a nurse midwife. This coverage includes:

- Consultations, exams, procedures, and medical services related to the use of all contraceptive methods to prevent pregnancy that have been approved by the U.S. Food and Drug Administration (FDA).
- Injection of birth control drugs. This includes the prescription drug when it is supplied during the visit.

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- Insertion of a levonorgestrel implant system. This includes the implant system itself.
- IUDs, diaphragms, and other prescription contraceptive methods that have been approved by the U.S. Food and Drug Administration (FDA), when the items are supplied during the visit.
- Genetic counseling.

No **benefits** are provided for: services related to achieving pregnancy through a surrogate (gestational carrier); and non-prescription birth control preparations (for example: condoms; birth control foams; jellies; and sponges).

Routine Hearing Exams and Tests

This health plan covers:

- Routine hearing exams when they are furnished for you by a *covered provider*. This includes hearing tests that are part of the covered hearing exam.
- Newborn hearing screening tests for a newborn child (an infant under three months of age) when they are furnished by a *covered provider*, or as provided by regulations of the Massachusetts Department of Public Health. (See “Maternity Services and Well Newborn Inpatient Care” for your *inpatient* coverage.)

Routine Vision Exams

This health plan may cover a periodic routine vision exam when it is furnished for you by an ophthalmologist or by an optometrist. The *Schedule of Benefits* for your plan option will tell you whether or not you have coverage for these services. If you do have this coverage, it will also describe the *benefit limit* that applies for routine vision exams—this is the time period during which a routine vision exam will be covered by your health plan. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.) Once you have received this coverage, no more benefits will be provided for another exam during the same time period.

No **benefits** are provided for eyeglasses or contact lenses (except as described otherwise in this Subscriber Certificate).

Wellness Benefits

While you are enrolled in this health plan, you may be reimbursed for some fees that you pay to participate in fitness programs and/or weight loss programs. (Any *deductible*, *copayment*, *coinsurance*, and *out-of-pocket maximum* provisions do not apply to these wellness benefits.)

- **Fitness Benefit.** For each membership, *Blue Cross and Blue Shield* will provide up to a total of \$150 in each calendar year to reimburse you for fees paid for a health club membership or for fitness classes at a health club. You can claim this maximum fitness benefit of \$150 for any combination of fees incurred by the *subscriber*, the enrolled spouse (or former spouse, if it applies), and enrolled dependents. However, this \$150 benefit is the total fitness benefit that is reimbursed during a calendar year. (For a health club membership, each *member* claiming all or part of the fitness benefit must

IMPORTANT: Refer to the *Schedule of Benefits* for your plan option for the cost share amounts that you must pay for *covered services* and for the *benefit limits* that may apply to specific *covered services*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by *Blue Cross and Blue Shield* for those services or supplies.

have paid at least four months' health club fees for that calendar year.) You are eligible for the fitness benefit for fees paid to: privately-owned or privately-sponsored health clubs or fitness facilities, including individual health clubs and fitness centers; YMCAs; YWCAs; Jewish Community Centers; and municipal fitness centers. No fitness benefit is provided for any fees or costs that you pay for: country clubs; social clubs (such as ski or hiking clubs); sports teams or leagues; spas; instructional dance studios; and martial arts schools.

- **Weight Loss Program Benefit.** For each membership, *Blue Cross and Blue Shield* will provide up to a total of \$150 in each calendar year to reimburse you for fees paid for hospital-based weight loss programs or for non-hospital-based weight loss programs designated by *Blue Cross and Blue Shield*. You can claim this maximum weight loss program benefit of \$150 for any combination of fees incurred by the *subscriber*, the enrolled spouse (or former spouse, if it applies), and enrolled dependents. However, this \$150 benefit is the total weight loss program benefit that is reimbursed during a calendar year. To find out which weight loss program(s) are designated by *Blue Cross and Blue Shield*, you can log on to the *Blue Cross and Blue Shield* Web site at www.bluecrossma.com. Or, you can call the *Blue Cross and Blue Shield* customer service office. The toll free phone number to call is shown on your ID card. No weight loss program benefit is provided for any fees or costs that you pay for: online weight loss programs; any non-hospital-based weight loss program not designated by *Blue Cross and Blue Shield*; individual nutrition counseling sessions (see "Medical Care Outpatient Visits" for your coverage for nutritional counseling); pre-packaged meals, books, videos, scales, or other items or supplies bought by the *member*; and any other items not included as part of a weight loss class or weight loss course.

To receive your fitness benefit or your weight loss program benefit, you must file a claim no later than March 31st after the year for which you are claiming your benefit. The date on which you file a claim will be considered the "incurred date," unless your claim is for eligible expenses for the prior calendar year. In that case, the incurred date will be shown as December 31st of that prior year. This means that the incurred date reflects the calendar year for which you are claiming your benefit. To file a claim, you must: fill out a claim form; attach your original itemized paid receipt(s); and mail the claim to *Blue Cross and Blue Shield*. For a claim form or help to file a claim, you can call the *Blue Cross and Blue Shield* customer service office. Or, you can log on to the *Blue Cross and Blue Shield* Web site at www.bluecrossma.com for help or to print a claim form.

IMPORTANT: Refer to the *Schedule of Benefits* for your plan option for the cost share amounts that you must pay for *covered services* and for the *benefit limits* that may apply to specific *covered services*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by *Blue Cross and Blue Shield* for those services or supplies.

Prosthetic Devices

This health plan covers prosthetic devices that you get from an appliance company, or from another provider who is designated by *Blue Cross and Blue Shield* to furnish the covered prosthetic device. This coverage is provided for devices that are: used to replace the function of a missing body part; made to be fitted to your body as an external substitute; and not useful when you are not ill or injured. Some examples of covered prosthetic devices include (but are not limited to):

- Artificial limb devices to replace (in whole or in part) an arm or a leg. This includes any repairs that are needed for the artificial leg or arm.
- Artificial eyes.
- Ostomy supplies; and urinary catheters.
- Breast prostheses. This includes mastectomy bras.
- Therapeutic/molded shoes and shoe inserts that are furnished for a *member* with severe diabetic foot disease.
- Scalp hair prostheses (wigs). This coverage is provided only when hair loss is due to: chemotherapy; radiation therapy; infections; burns; traumatic injury; congenital baldness; and medical conditions resulting in alopecia areata or alopecia totalis (capitus). This coverage is limited to \$500 for each *member* in each calendar year. Once you reach the *benefit limit*, no more benefits will be provided for these services. No benefits are provided for wigs when hair loss is due to: male pattern baldness; female pattern baldness; or natural or premature aging.
- Augmentative communication devices. An “augmentative communication device” is one that assists in restoring speech. It is needed when a *member* is unable to communicate due to an accident, illness, or disease such as amyotrophic lateral sclerosis (ALS).

If you are enrolled in this PPO health plan and it does not include pharmacy coverage and you are not enrolled in a *Blue Cross and Blue Shield* prescription drug plan, this coverage for prosthetic devices is also provided for: insulin infusion pumps and related pump supplies; and materials to test for the presence of sugar when they are ordered for you by a physician for home use. These testing materials are: blood glucose monitoring strips; ketone strips; lancets; urine glucose testing strips; normal, low, and high calibrator solution/chips; and dextrostik or glucose test strips.

This health plan covers the most appropriate *medically necessary* model that meets your medical needs. This means that if *Blue Cross and Blue Shield* determines that you chose a model that costs more than what you need for your medical condition, benefits will be provided only for those charges that would have been paid for the most appropriate *medically necessary* model that meets your medical needs. In this case, you must pay all of the provider’s charges that are more than the *Blue Cross and Blue Shield* claim payment.

IMPORTANT: Refer to the *Schedule of Benefits* for your plan option for the cost share amounts that you must pay for *covered services* and for the *benefit limits* that may apply to specific *covered services*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by *Blue Cross and Blue Shield* for those services or supplies.

Qualified Clinical Trials for Treatment of Cancer

This health plan covers health care services and supplies that are received by a *member* as part of a qualified clinical trial (for treatment of cancer) when the *member* is enrolled in that trial. This coverage is provided for health care services and supplies that are consistent with the study protocol and with the standard of care for someone with the patient’s diagnosis, and that would be covered if the patient did not participate in the trial. This coverage may also be provided for investigational drugs and devices that have been approved for use as part of the trial. This health plan coverage for health care services and supplies that you receive as part of a qualified clinical trial is provided to the same extent as it would have been provided if you did not participate in a trial.

No benefits are provided for:

- Investigational drugs and devices that have not been approved for use in the trial.
- Investigational drugs and devices that are paid for by the manufacturer, distributor, or provider of the drug or device, whether or not the drug or device has been approved for use in the trial.
- *Non-covered services* under your health plan.
- Costs associated with managing the research for the trial.
- Items, services, or costs that are reimbursed or otherwise furnished by the sponsor of the trial.
- Costs that are inconsistent with widely accepted and established national and regional standards of care.
- Costs for clinical trials that are not “qualified trials” as defined by law.

Radiation Therapy and Chemotherapy

This health plan covers *outpatient* radiation and x-ray therapy and chemotherapy when it is furnished for you by a *covered provider*. This may include (but is not limited to): a physician; or a nurse practitioner; or a free-standing radiation therapy and chemotherapy facility; or a hospital; or a *covered provider* who has a recognized expertise in specialty pediatrics.) This coverage includes:

- Radiation therapy using isotopes, radium, radon, or other ionizing radiation.
- X-ray therapy for cancer or when it is used in place of surgery.
- Drug therapy for cancer (chemotherapy).

Coverage for Self Injectable and Certain Other Drugs. There are self injectable and certain other prescription drugs used for cancer treatment or treatment of cancer symptoms due to cancer treatment that are covered by this health plan only when these covered drugs are furnished by a covered pharmacy, even when a non-pharmacy health care provider administers the drug for you during a covered visit. For your coverage for these covered drugs, see “Prescription Drugs and Supplies.” **No benefits are provided for the cost of these drugs when the drug is furnished by a non-pharmacy health care provider.** For a list of these drugs, you can call the *Blue Cross and Blue Shield* customer service office. Or, you can log on to the *Blue Cross and Blue Shield* Web site at www.bluecrossma.com.

IMPORTANT: Refer to the *Schedule of Benefits* for your plan option for the cost share amounts that you must pay for *covered services* and for the *benefit limits* that may apply to specific *covered services*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by *Blue Cross and Blue Shield* for those services or supplies.

Second Opinions

This health plan covers an *outpatient* second surgical opinion when it is furnished for you by a physician. This coverage includes a third opinion when the second opinion differs from the first. (See “Lab Tests, X-Rays, and Other Tests” for your coverage for related diagnostic tests.)

Short-Term Rehabilitation Therapy

This health plan covers *medically necessary outpatient* short-term rehabilitation therapy when it is furnished for you by a *covered provider*. This may include (but is not limited to): a physical therapist; or an occupational therapist; or a licensed speech-language pathologist; or a *covered provider* who has a recognized expertise in specialty pediatrics. This coverage includes: physical therapy; speech/language therapy; occupational therapy; or an organized program of these combined services. This health plan provides coverage only until you reach your *benefit limit*. The *Schedule of Benefits* for your plan option describes the *benefit limit* that applies for these *covered services*. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.) Once you reach the *benefit limit*, no more benefits will be provided for these services. The *benefit limit* does not apply when these services are furnished as part of a covered home health care program; or to diagnose and treat speech, hearing, and language disorders. (Whether or not your plan option has a *benefit limit* for these services, coverage is provided only for those services that are determined by *Blue Cross and Blue Shield* to be *medically necessary* for you.)

Speech, Hearing, and Language Disorder Treatment

This health plan covers *medically necessary* services to diagnose and treat speech, hearing, and language disorders when the services are furnished for you by a *covered provider*. This may include (but is not limited to): a licensed audiologist; or a licensed speech-language pathologist; or a *covered provider* who has a recognized expertise in specialty pediatrics. This coverage includes: diagnostic tests, including hearing exams and tests; speech/language therapy; and medical care to diagnose or treat speech, hearing, and language disorders.

No benefits are provided when these services are furnished in a school-based setting.

IMPORTANT: Refer to the *Schedule of Benefits* for your plan option for the cost share amounts that you must pay for *covered services* and for the *benefit limits* that may apply to specific *covered services*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by *Blue Cross and Blue Shield* for those services or supplies.

Surgery as an Outpatient

This health plan covers *outpatient* surgical services when they are furnished for you by a *covered provider*. This may include (but is not limited to): a surgical day care unit of a hospital; or an ambulatory surgical facility; or a physician; or a nurse practitioner; or a *covered provider* who has a recognized expertise in specialty pediatrics. This coverage includes:

- Routine circumcision; voluntary termination of pregnancy; and voluntary sterilization procedures.
- Endoscopic procedures.
- Surgical procedures. This includes emergency and scheduled surgery. This coverage includes (but is not limited to):
 - **Reconstructive surgery.** This means non-dental surgery that is meant to improve or give back bodily function or correct a functional physical impairment that was caused by a birth defect, a prior surgical procedure or disease, or an accidental injury. It also includes surgery to correct a deformity or disfigurement that was caused by an accidental injury.

Women’s Health and Cancer Rights: As required by federal law, this coverage includes breast reconstruction in connection with a mastectomy. This health plan provides coverage for: all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas. These services will be furnished in a manner determined in consultation with the attending physician and the patient.

- **Transplants.** This means human organ (or tissue) and stem cell (“bone marrow”) transplants that are furnished according to *Blue Cross and Blue Shield medical policy* and *medical technology assessment criteria*. This includes one or more stem cell transplants for a *member* who has been diagnosed with breast cancer that has spread and the *member* meets the standards that have been set by the Massachusetts Department of Public Health. For covered transplants, this coverage also includes: the harvesting of the donor’s organ (or tissue) or stem cells when the recipient is a *member*; and drug therapy during the transplant procedure to prevent the transplanted organ (or tissue) or stem cells from being rejected. “Harvesting” includes: the surgical removal of the donor’s organ (or tissue) or stem cells; and the related *medically necessary* services and/or tests that are required to perform the transplant itself. No benefits are provided for the harvesting of the donor’s organ (or tissue) or stem cells when the recipient is not a *member*. (See “Lab Tests, X-Rays, and Other Tests” for your coverage for donor testing.)
- **Oral surgery.** This means: reduction of a dislocation or fracture of the jaw or facial bone; excision of a benign or malignant tumor of the jaw; and orthognathic surgery that you need to correct a significant functional impairment that cannot be adequately corrected with orthodontic services. This coverage is provided when the surgery is furnished at a facility, provided that you have a serious medical condition that requires that you be admitted to a surgical day care unit of a

IMPORTANT: Refer to the *Schedule of Benefits* for your plan option for the cost share amounts that you must pay for *covered services* and for the *benefit limits* that may apply to specific *covered services*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by *Blue Cross and Blue Shield* for those services or supplies.

hospital or to an ambulatory surgical facility in order for the surgery to be safely performed. This coverage is also provided when the surgery is furnished at an oral surgeon's office. (Orthognathic surgery is not covered when it is performed mainly for cosmetic reasons. This surgery must be performed along with orthodontic services. If it is not, the oral surgeon must send a letter to *Blue Cross and Blue Shield* asking for approval for the surgery. No benefits are provided for the orthodontic services.)

This health plan may also cover the removal of impacted teeth when the teeth are fully or partially imbedded in the bone. The *Schedule of Benefits* for your plan option will tell you whether or not you have coverage for these services. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.)

- Internal prostheses (artificial replacements of parts of the body) that are furnished by the health care facility as part of a covered surgery such as intraocular lenses that are implanted after corneal transplant, cataract surgery, or other covered eye surgery, when the natural eye lens is replaced.
- Non-dental surgery and necessary postoperative care that is furnished for you by a dentist who is licensed to furnish the specific *covered service*. (See Part 6, “Dental Care.”)
- Necessary postoperative care that you receive after covered *inpatient* or *outpatient* surgery.
- Anesthesia services that are related to covered surgery. This includes anesthesia that is administered by a physician other than the attending physician; or by a certified registered nurse anesthetist.

Coverage for Self Injectable and Certain Other Drugs Furnished in an Office or Health Center Setting. There are self injectable and certain other prescription drugs used for treating your medical condition that are covered by this health plan only when these covered drugs are furnished by a covered pharmacy, even when a non-pharmacy health care provider administers the covered drug for you during a covered office or health center visit. For your coverage for these drugs, see “Prescription Drugs and Supplies.” **No benefits are provided for the cost of these drugs when the drug is furnished by a non-pharmacy health care provider.** For a list of these drugs, you can call the *Blue Cross and Blue Shield* customer service office. Or, you can log on to the *Blue Cross and Blue Shield* Web site at www.bluecrossma.com. (This exclusion does not apply when these covered drugs are furnished to you during a covered day surgical admission at a surgical day care unit of a hospital, ambulatory surgical facility, or hospital outpatient department.)

IMPORTANT: Refer to the *Schedule of Benefits* for your plan option for the cost share amounts that you must pay for *covered services* and for the *benefit limits* that may apply to specific *covered services*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by *Blue Cross and Blue Shield* for those services or supplies.

TMJ Disorder Treatment

This health plan covers *outpatient* services that are furnished for you by a *covered provider* to diagnose and/or treat temporomandibular joint (TMJ) disorders that are caused by or result in a specific medical condition (such as degenerative arthritis and jaw fractures or dislocations). The medical condition must be proven to exist by means of diagnostic x-ray tests or other generally accepted diagnostic procedures. This coverage includes:

- Diagnostic x-rays.
- Surgical repair or intervention.
- Non-dental medical care services to diagnose and treat a TMJ disorder.
- Splint therapy. (This also includes measuring, fabricating, and adjusting the splint.)
- Physical therapy. (See “Short-Term Rehabilitation Therapy.”)

No benefits are provided for: TMJ disorders that are not proven to be caused by or to result in a specific medical condition; appliances, other than a mandibular orthopedic repositioning appliance (MORA); and services, supplies, or procedures to change the height of teeth or otherwise restore occlusion (such as bridges, crowns, or braces).

Part 6

Limitations and Exclusions

Your coverage in this health plan is limited or excluded as described in this part. Other limits or restrictions and exclusions on your coverage may be found in Parts 3, 4, 5, 7, and 8 of this Subscriber Certificate. You should be sure to read all of the provisions that are described in this Subscriber Certificate, your *Schedule of Benefits*, and any *riders* that apply to your coverage in this health plan.

Admissions That Start Before Effective Date

This health plan provides coverage only for those *covered services* that are furnished on or after your *effective date*. If you are already an *inpatient* in a hospital (or in another covered health care facility) on your *effective date*, you or your health care provider must call *Blue Cross and Blue Shield*. (See Part 4.) This health plan will provide coverage starting on your *effective date* but only if *Blue Cross and Blue Shield* is able to coordinate your care. This coverage is subject to all of the provisions that are described in this Subscriber Certificate, your *Schedule of Benefits*, and any *riders* that apply to your coverage in this health plan.

Benefits From Other Sources

No benefits are provided for health care services and supplies to treat an illness or injury for which you have the right to benefits under government programs. These include the Veterans Administration for an illness or injury connected to military service. They also include programs set up by other local, state, federal, or foreign laws or regulations that provide or pay for health care services and supplies or that require care or treatment to be furnished in a public facility. No benefits are provided by this health plan if you could have received governmental benefits by applying for them on time. This exclusion does not include Medicaid or Medicare.

Cosmetic Services and Procedures

No benefits are provided for cosmetic services that are performed solely for the purpose of making you look better. This is the case whether or not these services are meant to make you feel better about yourself or to treat your *mental condition*. For example, no benefits are provided for: acne related services such as the removal of acne cysts, injections to raise acne scars, cosmetic surgery, and dermabrasion or other procedures to plane the skin; electrolysis; hair removal or restoration (except as described in Part 5 for scalp hair prostheses); and liposuction. (See Part 5 for your coverage for reconstructive surgery.)

Custodial Care

No benefits are provided for *custodial care*. This type of care may be furnished with or without routine nursing or other medical care and the supervision or care of a physician.

Dental Care

Except as described otherwise in this Subscriber Certificate or your *Schedule of Benefits*, no benefits are provided for treatment that *Blue Cross and Blue Shield* determines to be for dental care. This is the case even when the dental condition is related to or caused by a medical condition or medical treatment. There is one exception. This health plan will cover facility charges when you have a serious medical condition that requires that you be admitted to a hospital as an *inpatient* or to a surgical day care unit of a hospital or to an ambulatory surgical facility in order for your dental care to be safely performed. Some examples of serious medical conditions are: hemophilia; and heart disease.

Educational Testing and Evaluations

No benefits are provided for exams, evaluations, or services that are performed solely for educational or developmental purposes. The only exceptions are for: covered early intervention services; treatment of *mental conditions* for enrolled dependents who are under age 19; and *covered services* to diagnose and/or treat speech, hearing, and language disorders. (See Part 5.)

Exams or Treatment Required by a Third Party

No benefits are provided for physical, psychiatric, and psychological exams or treatments and related services that are required by third parties. Some examples of *non-covered services* are: exams and tests that are required for recreational activities, employment, insurance, and school; and court-ordered exams and services, except when they are *medically necessary* services. (But, certain exams may be covered when they are furnished as part of a covered routine physical exam. See Part 5.)

Experimental Services and Procedures

This health plan provides coverage only for *covered services* that are furnished according to *Blue Cross and Blue Shield medical technology assessment criteria*. No benefits are provided for health care charges that are received for or related to care that *Blue Cross and Blue Shield* considers experimental services or procedures. The fact that a treatment is offered as a last resort does not mean that this health plan will cover it. There are two exceptions. As required by law, this health plan will cover:

- One or more stem cell (“bone marrow”) transplants for a *member* who has been diagnosed with breast cancer that has spread. The *member* must meet the eligibility standards that have been set by the Massachusetts Department of Public Health.
- Certain drugs that are used on an off-label basis. Some examples of these drugs are: drugs used to treat cancer; and drugs used to treat HIV/AIDS.

Eyewear

Except as described otherwise in this Subscriber Certificate, no benefits are provided for eyeglasses and contact lenses.

Medical Devices, Appliances, Materials, and Supplies

No benefits are provided for medical devices, appliances, materials, and supplies, except as described otherwise in Part 5. Some examples of non-covered items are:

- Devices such as: air conditioners; air purifiers; arch supports; bath seats; bed pans; bath tub grip bars; chair lifts; computerized communication devices (except for those that are described in Part 5); computers; computer software; dehumidifiers; dentures; elevators; foot orthotics; hearing aids; heating pads; hot water bottles; humidifiers; orthopedic and corrective shoes that are not part of a leg brace; raised toilet seats; and shoe (foot) inserts.
- Special clothing, except for: gradient pressure support aids for lymphedema or venous disease; clothing needed to wear a covered device (for example, mastectomy bras and stump socks); and therapeutic/molded shoes and shoe inserts for a *member* with severe diabetic foot disease.
- Self-monitoring devices, except for certain devices that *Blue Cross and Blue Shield* decides would give a *member* having particular symptoms the ability to detect or stop the onset of a sudden life-threatening condition.

Missed Appointments

No benefits are provided for charges for appointments that you do not keep. Physicians and other health care providers may charge you if you do not keep your scheduled appointments. They may do so if you do not give them reasonable notice. You must pay for these costs. Appointments that you do not keep are not counted against any *benefit limits* that apply to your coverage in this health plan.

Non-Covered Providers

No benefits are provided for any services and supplies that are furnished by the kinds of health care providers that are not covered by this health plan. This Subscriber Certificate describes the kinds of health care providers that are covered by the health plan. (See “*covered providers*” in Part 2 of this Subscriber Certificate.)

Non-Covered Services

No benefits are provided for:

- A service or supply that is not described as a *covered service*. Some examples of *non-covered services* are: acupuncture; private duty nursing; and reversal of sterilization.
- A service or supply that is furnished along with a *non-covered service*.
- A service or supply that does not conform to *Blue Cross and Blue Shield medical policies*.
- A service or supply that does not conform to *Blue Cross and Blue Shield medical technology assessment criteria*.
- A service or supply that is not considered by *Blue Cross and Blue Shield* to be *medically necessary* for you. The only exceptions are for: covered routine or other covered voluntary health care services or supplies; preventive health care services and supplies; and donor suitability for bone marrow transplant.
- A service or supply that is furnished by a health care provider who has not been approved by *Blue Cross and Blue Shield* for payment for the specific service or supply.
- A service or supply that is furnished to someone other than the patient, except as described in this Subscriber Certificate for: hospice services; and the harvesting of a donor’s organ (or tissue) or stem cells when the recipient is a *member*. This coverage includes the surgical removal of the donor’s

organ (or tissue) or stem cells and the related *medically necessary* services and tests that are required to perform the transplant itself.

- A service or supply that you received when you were not enrolled in this health plan. (The only exception is for routine nursery charges that are furnished during an enrolled mother's maternity admission and certain other newborn services.)
- A service or supply that is furnished to all patients due to a facility's routine admission requirements.
- A service or supply that is related to achieving pregnancy through a surrogate (gestational carrier).
- A service or supply that is related to sex change surgery or to the reversal of a sex change.
- Refractive eye surgery for conditions that can be corrected by means other than surgery. This type of surgery includes radial keratotomy.
- Whole blood; packed red blood cells; blood donor fees; and blood storage fees.
- A health care provider's charge for shipping and handling or taxes.
- A health care provider's charge to file a claim for you. Also, a health care provider's charge to transcribe or copy your medical records.
- A separate fee for services furnished by: interns; residents; fellows; or other physicians who are salaried employees of the hospital or other facility.
- Expenses that you have when you choose to stay in a hospital or another health care facility beyond the discharge time that is determined by *Blue Cross and Blue Shield*.

Personal Comfort Items

No benefits are provided for items or services that are furnished for your personal care or for your convenience or for the convenience of your family. Some examples of non-covered items or services are: telephones; radios; televisions; and personal care services.

Private Room Charges

While you are an *inpatient*, this health plan covers *room and board* based on the semiprivate room rate. If a private room is used, you must pay all costs that are more than the semiprivate room rate.

Services and Supplies Furnished After Termination Date

No benefits are provided for services and supplies that are furnished after your termination date in this health plan. There is one exception. This health plan will continue to provide coverage for *inpatient covered services*, but only if you are receiving covered *inpatient* care on your termination date. In this case, coverage will continue to be provided until all the benefits allowed by your health plan have been used up or the date of discharge, whichever comes first. But, this does not apply if your coverage in this health plan is canceled for misrepresentation or fraud.

Services Furnished to Immediate Family

No benefits are provided for a *covered service* that is furnished by a health care provider to himself or herself or to a member of his or her immediate family. The only exception is for drugs that this health plan covers when they are used by a physician, dentist, or podiatrist while furnishing a *covered service*. “Immediate family” means any of the following members of a health care provider’s family:

- Spouse or spousal equivalent.
- Parent, child, brother, or sister (by birth or adoption).
- Stepparent, stepchild, stepbrother, or stepsister.
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law. (For purposes of providing *covered services*, an in-law relationship does not exist between the provider and the spouse of his or her wife’s (or husband’s) brother or sister.)
- Grandparent or grandchild.

(For the purposes of this exclusion, the immediate family members listed above will still be considered immediate family after the marriage which had created the relationship is ended by divorce or death.)

Part 7

Other Party Liability

Coordination of Benefits (COB)

Blue Cross and Blue Shield will coordinate payment of *covered services* with hospital, medical, dental, health, or other plans under which you are covered. *Blue Cross and Blue Shield* will do this to make sure that the cost of your health care services is not paid more than once. Other plans include: personal injury insurance; automobile insurance, including medical payments coverage; homeowner's insurance; and other plans that cover hospital or medical expenses.

You must include information on your enrollment forms about all other health plans under which you are covered. Once you are enrolled in this health plan, you must notify *Blue Cross and Blue Shield* if you add or change health plan coverage. Upon *Blue Cross and Blue Shield's* request, you must also supply *Blue Cross and Blue Shield* with information about other plans that may provide you with coverage for health care services.

Under COB, the plan that provides benefits first is known as the primary payor. And the plan(s) that provide benefits next are known as the secondary payor(s). When coverage in this health plan is secondary, no coverage will be provided until after the primary payor determines its share, if any, of the liability. *Blue Cross and Blue Shield* decides which is the primary and secondary payor. To do this, *Blue Cross and Blue Shield* relies on Massachusetts law, including the COB regulations issued by the Massachusetts Division of Insurance. A copy of these rules is available from *Blue Cross and Blue Shield* upon request. Unless otherwise required by law, coverage in this health plan will be secondary when another plan provides you with coverage for health care services.

Blue Cross and Blue Shield will not provide any more coverage than what is described in this Subscriber Certificate. *Blue Cross and Blue Shield* will not provide duplicate benefits for *covered services*. If *Blue Cross and Blue Shield* pays more than the amount that it should have under COB, then you must give that amount back to *Blue Cross and Blue Shield*. *Blue Cross and Blue Shield* has the right to get that amount back from you or any appropriate person, insurance company, or other organization.

Important Notice: If you fail to comply with the provisions of this COB section, payment of your claim may be denied.

Blue Cross and Blue Shield's Rights to Recover Benefit Payments

Subrogation and Reimbursement of Benefit Payments

If you are injured by any act or omission of another person, the benefits under this health plan will be subrogated. This means that *Blue Cross and Blue Shield* may use your right to recover money from the person(s) who caused the injury or from any insurance company or other party. If you recover money, *Blue Cross and Blue Shield* is entitled to recover up to the amount of the benefit payments that it has made. This is true no matter where or by whom the recovered money is held or how it is designated and even if you do not recover the total amount of your claim against the other person(s). This is also true if

the payment you receive is described as payment for other than health care expenses. The amount that you must reimburse to *Blue Cross and Blue Shield* will not be reduced by any attorney's fees or expenses that you incur.

Member Cooperation

You must give *Blue Cross and Blue Shield* information and help. This means you must complete and sign all necessary documents to help *Blue Cross and Blue Shield* get this money back. This also means that you must give *Blue Cross and Blue Shield* timely notice of all significant steps during negotiation, litigation, or settlement with any third party (such as filing a claim or lawsuit, initiation of settlement discussions, agreement to a settlement in principle, etc.) and before settling any claim arising out of injuries you sustained by an act or omission of another person(s) for which *Blue Cross and Blue Shield* paid benefits. You must not do anything that might limit *Blue Cross and Blue Shield's* right to full reimbursement.

Workers' Compensation

No benefits are provided for health care services that are furnished to treat an illness or injury that *Blue Cross and Blue Shield* determines was work related. This is the case even if you have an agreement with the workers' compensation carrier that releases them from paying for the claims. All employers provide their employees with workers' compensation or similar insurance. This is done to protect employees in case of a work-related illness or injury. All health care claims for a work-related illness or injury must be billed to the employer's workers' compensation carrier. It is up to you to use the workers' compensation insurance. If *Blue Cross and Blue Shield* pays for any work-related health care services, *Blue Cross and Blue Shield* has the right to get paid back from the party that legally must pay for the health care claims. *Blue Cross and Blue Shield* also has the right, where possible, to reverse payments made to providers.

If you have recovered any benefits from a workers' compensation insurer (or from an employer liability plan), *Blue Cross and Blue Shield* has the right to recover from you the amount of benefits it has paid for your health care services. This is the case even if:

- the workers' compensation benefits are in dispute or are made by means of a settlement or compromise;
- no final determination is made that an injury or illness was sustained in the course of or resulted from your employment;
- the amount of workers' compensation due to medical or health care is not agreed upon or defined by you or the workers' compensation carrier; or
- the medical or health care benefits are specifically excluded from the workers' compensation settlement or compromise.

If *Blue Cross and Blue Shield* is billed in error for these services, you must promptly call or write to the *Blue Cross and Blue Shield* customer service office.

Part 8

Other Health Plan Provisions

Access to and Confidentiality of Medical Records

Blue Cross and Blue Shield and health care providers may, in accordance with applicable law, have access to all of your medical records and related information that is needed by *Blue Cross and Blue Shield* or health care providers. *Blue Cross and Blue Shield* may collect information from health care providers or from other insurance companies or *the plan sponsor* (for *group members*). *Blue Cross and Blue Shield* will use this information to help them administer the coverage provided by this health plan and to get facts on the quality of care that is provided under this and other health care contracts. In accordance with law, *Blue Cross and Blue Shield* and health care providers may use this information and may disclose it to necessary persons and entities as permitted and required by law. For example, *Blue Cross and Blue Shield* may use and disclose it as follows:

- For administering coverage (including coordination of benefits with other insurance plans); managing care; quality assurance; utilization management; the prescription drug history program; grievance and claims review activities; or other specific business, professional, or insurance functions for *Blue Cross and Blue Shield*.
- For bona fide medical research according to the regulations of the U.S. Department of Health and Human Services and the U.S. Food and Drug Administration for the protection of human subjects.
- As required by law or valid court order.
- As required by government or regulatory agencies.
- As necessary for the operations of *Blue Cross and Blue Shield*.
- As required by the *subscriber's group* or by its auditors to make sure that *Blue Cross and Blue Shield* is administering your coverage in this health plan properly. (This applies only when you are enrolled in this health plan as a *group member*.)

Commitment to Confidentiality:

To get a copy of *Blue Cross and Blue Shield's* Commitment to Confidentiality statement, call the *Blue Cross and Blue Shield* customer service office. (See Part 1.)

Blue Cross and Blue Shield will not share information about you with the Medical Information Bureau (MIB). *Blue Cross and Blue Shield* respects your right to privacy. *Blue Cross and Blue Shield* will not use or disclose personally identifiable information about you without your permission, unless the use or disclosure is permitted or required by law and is done in accordance with the law. You have the right to get the information *Blue Cross and Blue Shield* collects about you. You may also ask *Blue Cross and Blue Shield* to correct any of this information that you believe is not correct. *Blue Cross and Blue Shield* may charge you a reasonable fee for copying your records, unless your request is because *Blue Cross and Blue Shield* is declining or terminating your coverage in this health plan.

Acts of Providers

Blue Cross and Blue Shield is not liable for the acts or omissions by any individuals or institutions that furnish care or services to you. In addition, a health care provider who participates in your health care network and has a payment agreement with *Blue Cross and Blue Shield* or any other health care provider does not act as an agent on behalf of or for *Blue Cross and Blue Shield*. And, *Blue Cross and Blue Shield* does not act as an agent for health care providers who participate in your health care network and have payment agreements with *Blue Cross and Blue Shield* or for any other health care providers.

Blue Cross and Blue Shield will not interfere with the relationship between health care providers and their patients. You are free to select or discharge any health care provider. *Blue Cross and Blue Shield* is not responsible if a provider refuses to furnish services to you. *Blue Cross and Blue Shield* does not guarantee that you will be admitted to any facility or that you will get a special type of room or service. If you are admitted to a facility, you will be subject to all of its requirements. This includes its requirements on admission, discharge, and the availability of services.

Assignment of Benefits

You cannot assign any benefit or monies due from this health plan to any person, corporation, or other organization without *Blue Cross and Blue Shield's* written consent. Any assignment by you will be void. Assignment means the transfer of your rights to the benefits provided by this health plan to another person or organization. There is one exception. If Medicaid has already paid the health care provider, you can assign your benefits to Medicaid.

Authorized Representative

You may choose to have another person act on your behalf concerning your health care coverage in this health plan. You must designate this person in writing to *Blue Cross and Blue Shield*. Or, if you are not able to do this, a person such as a conservator, a person with power of attorney, or a family member may be your authorized representative. In some cases, *Blue Cross and Blue Shield* may consider your health care facility or your physician or other health care provider to be your authorized representative. For example, *Blue Cross and Blue Shield* may tell your hospital that a proposed *inpatient* admission has been approved. Or, *Blue Cross and Blue Shield* may ask your physician for more information if more is needed for *Blue Cross and Blue Shield* to make a decision. *Blue Cross and Blue Shield* will consider the health care provider to be your authorized representative for *emergency medical care*. *Blue Cross and Blue Shield* will continue to send benefit payments and written communications regarding your health care coverage according to *Blue Cross and Blue Shield's* standard practices, unless you specifically ask *Blue Cross and Blue Shield* to do otherwise. You can get a form to designate an authorized representative from the *Blue Cross and Blue Shield* customer service office. (See Part 1.)

Changes to Health Plan Coverage

Blue Cross and Blue Shield may change the provisions of your coverage in this health plan. (When you are enrolled in this health plan as a *group member*, the *plan sponsor* may also change a part of the *group contract*.) For example, a change may be made to the cost share amount that you must pay for certain *covered services* such as your *copayment* or your *deductible* or your *coinsurance*. When *Blue Cross and Blue Shield* makes a material change to your coverage in this health plan, *Blue Cross and Blue Shield* will send a notice about the change at least 60 days before the *effective date* of the change. The notice will be sent to the *subscriber* or, when you are enrolled in this health plan as a *group member*, to the *plan sponsor*. The notice from *Blue Cross and Blue Shield* will describe the change being made. It will also

WORDS IN ITALICS ARE EXPLAINED IN PART 2.

give the *effective date* of the change. (If you are enrolled as a *group member*, the *plan sponsor* should deliver to its *group members* all notices from *Blue Cross and Blue Shield*.)

Charges for Non-Medically Necessary Services

You may receive health care services that would otherwise be covered by this health plan, except that these services are not determined to be *medically necessary* for you by *Blue Cross and Blue Shield*. This health plan does not cover health care services or supplies that are not *medically necessary* for you. If you receive care that is not *medically necessary* for you, you might be charged for the care by the health care provider. In some cases, *Blue Cross and Blue Shield* will defend you from a claim for payment for this care. *Blue Cross and Blue Shield* will defend you when this care is furnished by a health care provider who has a payment agreement with *Blue Cross and Blue Shield* not to charge for services that are not *medically necessary*. This does not apply if you were told, knew, or reasonably should have known before you received this treatment that it was not *medically necessary*. To obtain *Blue Cross and Blue Shield's* defense in this situation, you must notify *Blue Cross and Blue Shield*. You must do this within 10 days of the date the lawsuit to collect for the service has been started. And, you must cooperate in the defense. If it is determined in the action that the *covered services* were *medically necessary*, this health plan will cover them.

Clinical Guidelines and Utilization Review Criteria

Blue Cross and Blue Shield applies *medical technology assessment criteria* and *medical necessity* guidelines when it develops its clinical guidelines, *utilization review* criteria, and *medical policies*. *Blue Cross and Blue Shield* reviews its clinical guidelines, *utilization review* criteria, and *medical policies* from time to time. *Blue Cross and Blue Shield* does this to reflect new treatments, applications, and technologies. For example, when a new drug is approved by the U.S. Food and Drug Administration (FDA), *Blue Cross and Blue Shield* reviews its safety, effectiveness, and overall value on an ongoing basis. While a new treatment, technology, or drug is being reviewed, it will not be covered by this health plan. Another example is when services and supplies are approved by the U.S. Food and Drug Administration (FDA) for the diagnosis and treatment of insulin dependent, insulin using, gestational, or non-insulin dependent diabetes. In this case, coverage will be provided for those services or supplies as long as they can be classified under a category of *covered services*.

Disagreement With Recommended Treatment

When you enroll for coverage in this health plan, you agree that it is up to your health care provider to decide the right treatment for your care. You may (for personal or religious reasons) refuse to accept the procedures or treatments that are advised by your health care provider. Or, you may ask for treatment that a health care provider judges does not meet generally accepted standards of professional medical care. You have the right to refuse the treatment advice of the health care provider. Or, you have the right to seek other care at your own expense. If you want a second opinion about your care, you have the right to coverage for second and third opinions. (See Part 5.)

Mandates for Residents or Services Outside of Massachusetts

When you live or receive health care services or supplies in a state other than Massachusetts, your coverage and other requirements for health care services you receive in that state may be different from those described in this Subscriber Certificate. In this case, you may be entitled to receive additional coverage under this health plan as required by that state's law. You should call the *Blue Cross and Blue Shield* customer service office for more help if this applies to you.

Member Cooperation

You agree to provide *Blue Cross and Blue Shield* with information it needs to comply with federal and/or state law and regulation. If you do not do so in a timely manner, your claims may be denied and/or your coverage in this health plan may be affected.

Pre-Existing Conditions

Both federal law and Massachusetts state law may affect your health care coverage if you enroll (or become eligible to enroll) in a health plan that excludes benefits for pre-existing conditions. These laws limit the times when benefits may be excluded for medical conditions that are present before you enroll in a health plan. A pre-existing condition exclusion may not be imposed for more than six months (under federal law, 12 months–18 months for a late enrollee) from the effective date of your coverage in the health plan. In addition, pregnancy may not be considered a pre-existing condition. A pre-existing condition exclusion period is reduced by the time you were enrolled in a prior health plan as long as that prior plan was terminated within 63 days of your effective date in the new health plan. You are entitled to a certificate that will show evidence of your prior health care coverage. A certificate of prior coverage may help you obtain coverage without a pre-existing condition exclusion even if you buy health insurance other than through an employer group health plan.

Your coverage in this health plan is not limited based on medical conditions that are present on or before your *effective date*. This means that your health care services will be covered from the *effective date* of your coverage in this health plan without a pre-existing condition restriction or a waiting period. But, benefits for these health care services are subject to all the provisions of this health plan.

Quality Assurance Programs

Blue Cross and Blue Shield uses quality assurance programs. These programs are designed to improve the quality of health care and the services that are provided to *Blue Cross and Blue Shield members*. These programs affect different aspects of health care. This may include, for example, health promotion. From time to time, *Blue Cross and Blue Shield* may add or change the programs that it uses. *Blue Cross and Blue Shield* will do this to ensure that it continues to provide you and your family with access to high-quality health care and services. For more information, you can call the *Blue Cross and Blue Shield* customer service office. The toll free phone number to call is shown on your ID card. Some of the clinical programs that *Blue Cross and Blue Shield* uses are:

- A breast cancer screening program. It encourages female *members* who are over 50 to have mammograms.
- A cervical cancer screening program. It helps to get more female *members* who are age 18 and older to have a Pap smear test.
- A program that furnishes outreach and education to an expectant mother. It adds to the care that the *member* gets from her obstetrician or nurse midwife.

- A program that promotes timely postnatal checkups for new mothers.
- Diabetes management and education. This helps diabetic *members* to self-manage their diabetes. It also helps to identify high-risk *members* and helps to assess their ongoing needs.
- Congestive heart failure disease management, education, and monitoring.

Services Furnished by Non-Preferred Providers

As a *member* of this health plan, you will usually receive the highest benefit level (your in-network benefits) only when you obtain *covered services* from a *covered provider* who participates in your PPO health care network. There are few times when this health plan will provide in-network benefits for *covered services* you receive from a *covered provider* who does not participate in your PPO network. These few situations are described below in this section. If you receive *covered services* from a *covered provider* who does not participate in your PPO health care network, you will receive in-network benefits **only when:**

- You receive *emergency medical care*.
- You receive *covered services* that are not reasonably available from a *preferred provider* (see “*covered provider*” in Part 2 of this Subscriber Certificate) and you had prior approval from *Blue Cross and Blue Shield* to obtain these *covered services*. Or, you receive *covered services* from a *covered provider* before a preferred network is established for that type of provider.
- You are traveling outside of Massachusetts and you receive *covered services* from a type of *covered provider* for which the local Blue Cross and/or Blue Shield Plan has not, in the opinion of *Blue Cross and Blue Shield*, established an adequate PPO health care network.
- You receive *covered services* from a non-preferred hospital-based anesthetist, pathologist, or radiologist while you are at a preferred hospital.
- You are a *member* who is in her second or third trimester of pregnancy and your health care provider is involuntarily disenrolled from your health care network for a reason other than a quality-related reason or fraud. In this case, coverage will be continued by this health plan for *covered services* you receive in connection with the pregnancy up through the first postnatal visit.
- You are a *member* with a terminal illness and your health care provider is involuntarily disenrolled from your health care network for a reason other than a quality-related reason or fraud. In this case, coverage will be continued by this health plan for *covered services* you receive in connection with the terminal illness. (This coverage is continued only when the terminally ill *member* is expected to live six months or less as determined by a physician.)
- You are a newly enrolled *group member* who is receiving an ongoing course of treatment from a physician (or a primary care provider who is a nurse practitioner) who does not participate in your health care network, and your *group* only offers its employees a choice of health insurance plans in which your physician (or your primary care provider who is a nurse practitioner) does not participate as a *covered provider*. In this case, coverage will be provided by this health plan for up to 30 days from your *effective date* or, for a *member* who is in her second or third trimester of pregnancy, up through the first postnatal visit or, for a *member* with a terminal illness, until the *member’s* death. (For a *member* with a terminal illness, this coverage is provided only when the *member* is expected to live six months or less as determined by a physician.)

Services in a Disaster

Blue Cross and Blue Shield is not liable if events beyond its control—such as war, riot, public health emergency, or natural disaster—cause delay or failure of *Blue Cross and Blue Shield* to arrange for or coordinate access to health care services and coverage for its *members*. *Blue Cross and Blue Shield* will make a good faith effort to arrange for or to coordinate health care services to be furnished in these situations.

Time Limit for Legal Action

Before you pursue a legal action against *Blue Cross and Blue Shield* for any claim under this health plan, you must complete the *Blue Cross and Blue Shield* internal formal grievance review. (See Part 10.) You may, but you do not need to, complete an external review before you pursue a legal action. If, after you complete the grievance review, you choose to bring a legal action against *Blue Cross and Blue Shield*, you must bring this action within two years after the cause of the action arises. For example, if you are filing a legal action because you were denied a service or you were denied a claim for coverage from this health plan, you will lose your right to bring a legal action against *Blue Cross and Blue Shield* unless you file your action within two years after the date of the decision of the final internal appeal of the service or claim denial.

Part 9

Filing a Claim

When the Provider Files a Claim

The health care provider will file a claim for you when you receive a *covered service* from a *covered provider* who has a payment agreement with *Blue Cross and Blue Shield*. Or, for *covered services* you receive outside of Massachusetts, a health care provider will file a claim for you when he or she has a payment agreement with the local Blue Cross and/or Blue Shield Plan. Just tell the health care provider that you are a *member* and show the health care provider your ID card. Also, be sure to give the health care provider any other information that is needed to file your claim. You must properly inform your health care provider within 30 days after you receive the *covered service*. If you do not, coverage will not have to be provided. *Blue Cross and Blue Shield* will pay the health care provider directly for *covered services* when the provider has a payment agreement with *Blue Cross and Blue Shield* (or with the local Blue Cross and/or Blue Shield Plan).

When the Member Files a Claim

You may have to file your claim when you receive a *covered service* from a *covered provider* who does not have a payment agreement with *Blue Cross and Blue Shield* or a *covered provider* outside of Massachusetts who does not have a payment agreement with the local Blue Cross and/or Blue Shield Plan. The health care provider may ask you to pay the entire charge at the time of the visit or at a later time. It is up to you to pay your health care provider. To file a claim to *Blue Cross and Blue Shield* for repayment, you must:

- Fill out a claim form;
- Attach your original itemized bills; and
- Mail the claim to the *Blue Cross and Blue Shield* customer service office.

You can get claim forms from the *Blue Cross and Blue Shield* customer service office. (See Part 1.) *Blue Cross and Blue Shield* will mail to you all forms that you will need within 15 days after receiving notice that you obtained some service or supply for which you may be paid. (In the event *Blue Cross and Blue Shield* fails to comply with this provision or, within 45 days of receiving your claim, fails to send you a check or a notice in writing of why your claim is not being paid or a notice that asks you for more information about your claim, you may be paid interest on your claim when the claim is for a *covered service* that is furnished by a non-participating hospital, other covered health care facility, or other covered non-professional provider. This interest will be accrued beginning 45 days after *Blue Cross and Blue Shield* receives your claim at the rate of 1½% for each month, but no more than 18% in a year. This interest payment provision does not apply to a claim which *Blue Cross and Blue Shield* is investigating because of suspected fraud.)

When you receive *covered services* outside the United States, you must file your claim to the BlueCard Worldwide Service Center. (The BlueCard Worldwide International Claim Form you receive from *Blue Cross and Blue Shield* will include the address to mail your claim.) The service center will prepare your claim. This includes: converting your bill to U.S. currency; and sending it to *Blue Cross and Blue Shield* for repayment to you.

You must file a claim within two years of the date you received the *covered service*. *Blue Cross and Blue Shield* will not have to provide coverage for services and/or supplies for which a claim is submitted after this two-year period.

Timeliness of Claim Payments

Within 30 calendar days after *Blue Cross and Blue Shield* receives a completed request for coverage or payment, *Blue Cross and Blue Shield* will make a decision. When appropriate, *Blue Cross and Blue Shield* will make a payment to the health care provider (or to you in certain situations) for your claim to the extent of your coverage in this health plan. Or, *Blue Cross and Blue Shield* will send you and/or the health care provider a notice in writing of why your claim is not being paid in full or in part.

Missing Information

If the request for coverage or payment is not complete or if *Blue Cross and Blue Shield* needs more information to make a final determination for your claim, *Blue Cross and Blue Shield* will ask for the information or records it needs. *Blue Cross and Blue Shield* will make this request within 30 calendar days of the date that *Blue Cross and Blue Shield* received the request for coverage or payment. This additional information must be provided to *Blue Cross and Blue Shield* within 45 calendar days of this request.

- **Missing Information Received Within 45 Days.** If the additional information is provided to *Blue Cross and Blue Shield* within 45 calendar days of *Blue Cross and Blue Shield's* request, *Blue Cross and Blue Shield* will make a decision within the time remaining in the original 30-day claim determination period. Or, *Blue Cross and Blue Shield* will make the decision within 15 calendar days of the date that the additional information is received by *Blue Cross and Blue Shield*, whichever is later.
- **Missing Information Not Received Within 45 Days.** If the additional information is not provided to *Blue Cross and Blue Shield* within 45 calendar days of *Blue Cross and Blue Shield's* request, the claim for coverage or payment will be denied by *Blue Cross and Blue Shield*. If the additional information is submitted to *Blue Cross and Blue Shield* after these 45 days, then it may be viewed by *Blue Cross and Blue Shield* as a new claim for coverage or payment. In this case, *Blue Cross and Blue Shield* will make a decision within 30 days as described previously in this section.

Part 10

Grievance Program

You have the right to a review when you disagree with a decision that is made by *Blue Cross and Blue Shield* to deny payment for services; or if you have a complaint about the care or service you received from *Blue Cross and Blue Shield* or from a health care provider who participates in your health care network.

Inquiries and/or Claim Problems or Concerns

Most problems or concerns can be handled with just one phone call. (See page 3.) For help to resolve a problem or concern, you should first call the *Blue Cross and Blue Shield* customer service office. The toll free phone number to call is shown on your ID card. A customer service representative will work with you to help you understand your coverage or to resolve your problem or concern as quickly as possible.

When resolving a problem or concern, *Blue Cross and Blue Shield* will consider all aspects of the particular case. This includes looking at: all of the provisions of this health plan; the policies and procedures that support this health plan; the health care provider's input; and your understanding and expectation of coverage by this health plan. *Blue Cross and Blue Shield* will use every opportunity to be reasonable in finding a solution that makes sense for all parties. *Blue Cross and Blue Shield* may use an individual consideration approach when it is judged to be appropriate. *Blue Cross and Blue Shield* will follow its standard guidelines when it resolves your problem or concern.

You may request a review through the *Blue Cross and Blue Shield* internal formal grievance program if you disagree with a decision that is given to you by *Blue Cross and Blue Shield's* customer service representative. You may also request this type of review if *Blue Cross and Blue Shield* has not responded to you within three working days of receiving your inquiry. If this is the case, *Blue Cross and Blue Shield* will notify you and let you know the steps you may follow to request an internal formal grievance review.

You may also request a formal grievance review when *Blue Cross and Blue Shield* has determined that a service or supply is not *medically necessary* for your condition.

Formal Grievance Review

Internal Formal Grievance Review

How to Request a Grievance Review. To request a formal review from the *Blue Cross and Blue Shield* internal Grievance Program, you (or your authorized representative) have three options.

- **Write or Fax.** The preferred option is for you to send your grievance in writing to: Member Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Or, you may fax your grievance to 1-617-246-3616. *Blue Cross and Blue Shield* will let you know that your request was received by sending you a written confirmation within 15 calendar days.
- **E-mail.** Or, you may send your grievance to the *Blue Cross and Blue Shield* Member Grievance Program internet address grievances@bcbsma.com. *Blue Cross and Blue Shield* will let you know that your request was received by sending you a confirmation immediately by e-mail.

WORDS IN ITALICS ARE EXPLAINED IN PART 2.

- **Telephone Call.** Or, you may call the *Blue Cross and Blue Shield* Member Grievance Program at **1-800-472-2689**. When your request is made by phone, *Blue Cross and Blue Shield* will send you a written account of the grievance within 48 hours of your phone call.

Once your request is received, *Blue Cross and Blue Shield* will research the case in detail. They will ask for more information if it is needed. *Blue Cross and Blue Shield* will let you know in writing of the decision or the outcome of the review. If your grievance is about termination of your coverage for concurrent services that were previously approved by *Blue Cross and Blue Shield*, the disputed coverage will continue until this grievance review process is completed. This continuation of your coverage does not apply to: services that are limited by a dollar or visit maximum and that exceed that *benefit limit*; *non-covered services*; or services that were received prior to the time that you requested a formal grievance review; or when a grievance is not received on a timely basis, based on the course of treatment.

All grievances must be received by *Blue Cross and Blue Shield* within one year of the date of treatment, event, or circumstance, such as the date you were told of the service denial or claim denial.

Office of Patient Protection. The Office of Patient Protection of the Massachusetts Department of Public Health is available to help *members* with information and/or reports about grievances. To contact that office, you can call **1-800-436-7757**. Or, you can fax a request to **1-617-624-5046**. Or, you can go online and log on to the Office of Patient Protection’s Web site at **www.state.ma.us/dph/opp**.

What to Include in a Grievance Review Request. Your request for a formal grievance review should include: the name and ID number of the *member* asking for the review; a description of the problem; all relevant dates; names of health care providers or administrative staff involved; and details of the attempt that has been made to resolve the problem. If *Blue Cross and Blue Shield* needs to review the medical records and treatment information that relate to your grievance, *Blue Cross and Blue Shield* will promptly send you an authorization form to sign if needed. You must return this signed form to *Blue Cross and Blue Shield*. It will allow for the release of your medical records. You also have the right to look at and get copies (free of charge) of records and criteria that *Blue Cross and Blue Shield* has and that are relevant to your grievance, including the identity of any experts who were consulted.

Authorized Representative. You may choose to have another person act on your behalf during the grievance review process. You must designate this person in writing to *Blue Cross and Blue Shield*. Or, if you are not able to do this, a person such as a conservator, a person with power of attorney, or a family member may be your authorized representative. Or, he or she may appoint another party to be the authorized representative. (When you are an *inpatient*, a health care provider may act as your authorized representative to ask for an expedited grievance review. In this case, you do not have to designate the health care provider in writing.)

Who Handles the Grievance Review. All grievances are reviewed by professionals who are knowledgeable about *Blue Cross and Blue Shield* and the issues involved in the grievance. The professionals who will review your grievance will be those who did not participate in any of *Blue Cross and Blue Shield*’s prior decisions regarding the subject of your grievance, nor do they work for anyone who did. When a grievance is related to a *medical necessity* denial, at least one grievance reviewer is an individual who is an actively practicing health care professional in the same or similar specialty who usually treats the medical condition or performs the procedure or provides treatment that is the subject of your grievance.

Response Time. The review and response for *Blue Cross and Blue Shield's* internal formal grievance review will be completed within 30 calendar days. Every reasonable effort will be made to speed up the review of grievances that involve health care services that are soon to be obtained by the *member*. With your permission, *Blue Cross and Blue Shield* may extend the 30-calendar-day time frame to complete a grievance review. This will happen in those cases when *Blue Cross and Blue Shield* and the *member* agree that additional time is required to fully investigate and respond to the grievance.

Blue Cross and Blue Shield may also extend the 30-calendar-day time frame when the grievance review requires a review of your medical records and *Blue Cross and Blue Shield* requires your authorization to get these records. The 30-day response time will not include the days from when *Blue Cross and Blue Shield* sends you the authorization form to sign until it receives your signed authorization form (if needed). If *Blue Cross and Blue Shield* does not receive your authorization within 30 working days after your grievance is received, *Blue Cross and Blue Shield* may make a final decision about your grievance without that medical information. In any case, for a grievance review involving services that have not yet been obtained by you, *Blue Cross and Blue Shield* will ask for your permission to extend the 30-day time frame if it cannot complete the review within 30 calendar days of receipt of your grievance.

A grievance that is not acted upon within the specified time frames will be considered resolved in favor of the *member*.

Important Note:

If your grievance review began after an inquiry, the 30-day response time will begin on the day you tell *Blue Cross and Blue Shield* that you disagree with *Blue Cross and Blue Shield's* answer and would like a formal grievance review.

Written Response. Once the grievance review is completed, *Blue Cross and Blue Shield* will let you know in writing of the decision or the outcome of the review. If *Blue Cross and Blue Shield* continues to deny coverage for all or part of a health care service or supply, *Blue Cross and Blue Shield* will send an explanation to you. It will: describe the reasons for the denial and the applicable terms of your coverage in this health plan; give the specific medical and scientific reasons for the denial; specify any alternative treatment or health care services and supplies that would be covered; reference and include applicable *Blue Cross and Blue Shield* clinical guidelines used and review criteria; and explain how to request an external review.

Grievance Records. *Blue Cross and Blue Shield* will maintain a record of all formal grievances, including the response for each grievance review, for up to seven years.

Expedited Review for Immediate or Urgently-Needed Services. In place of the formal grievance review described above, you have the right to request an “expedited” review right away when your situation is for immediate or urgently-needed services. *Blue Cross and Blue Shield* will review and respond to grievances for immediate or urgently-needed services as follows:

- When your grievance review concerns medical care or treatment for which waiting for a response under the grievance review time frames described above would seriously jeopardize your life or health or your ability to regain maximum function as determined by *Blue Cross and Blue Shield* or your physician, or if your physician says that you will have severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance review, *Blue Cross and Blue Shield* will review your grievance and notify you of the decision within 72 hours after your request is received (or earlier as described below).

- When a grievance review is requested while you are an *inpatient*, *Blue Cross and Blue Shield* will complete the review and make a decision regarding the request before you are discharged from that *inpatient* stay. *Blue Cross and Blue Shield's* coverage for those services in dispute will continue for you until this review is completed.
- *Blue Cross and Blue Shield's* decision to deny payment for health care services, including durable medical equipment, may be reversed within 48 hours if your attending physician certifies to *Blue Cross and Blue Shield* that a denial for those health care services would create a substantial risk of serious harm to you if you were to wait for the outcome of the normal grievance process. Your physician can also request the reversal of a denial for durable medical equipment earlier than 48 hours by providing more specific information to *Blue Cross and Blue Shield* about the immediate and severe harm to you.
- A grievance review requested by a *member* with a terminal illness will be completed by *Blue Cross and Blue Shield* within five working days of receiving the request. In this case, if the expedited review results in a denial for health care services or treatment, *Blue Cross and Blue Shield* will send a letter to the *member* within five working days. It will: describe the reasons for the denial and the applicable terms of your coverage in this health plan; give the specific medical and scientific reasons for the denial; specify any alternative treatment or health care services and supplies that would be covered; reference and include applicable *Blue Cross and Blue Shield* clinical guidelines used and review criteria; and explain how to request a hearing. When the *member* requests a hearing, the hearing will be held within ten days. (Or, it will be held within five working days if the attending physician determines after consultation with *Blue Cross and Blue Shield's* Medical Director and based on standard medical practice that the effectiveness of the health care service, supply, or treatment would be materially reduced if it were not furnished at the earliest possible date.) You and/or your authorized representative(s) may attend this hearing.

External Review From the Office of Patient Protection

For all grievances, you must first go through the *Blue Cross and Blue Shield* internal formal grievance process as described above. In some cases, you are then entitled to a voluntary external review. You are not required to pursue an external review. Your decision whether to pursue it will not affect your other coverage. The *Blue Cross and Blue Shield* grievance review may deny coverage for all or part of a health care service or supply. When you are denied a service or supply because *Blue Cross and Blue Shield* has determined that the service or supply is not *medically necessary*, you have the right to an external review. If you receive a denial letter from *Blue Cross and Blue Shield* for this reason, the letter will tell you what steps you should take to file a request for an external grievance review. The review will be conducted by a review agency under contract with the Office of Patient Protection of the Massachusetts Department of Public Health.

To obtain an external review, you must submit your request on the form required by the Office of Patient Protection. On this form, you (or your authorized representative) must sign a consent to release your medical information for external review. Attached to the form, you must send a copy of the letter of denial that you received from *Blue Cross and Blue Shield*. In addition, you must send the required \$25 fee to pay for your portion of the cost of the review. *Blue Cross and Blue Shield* will be charged the rest of the cost by the Commonwealth of Massachusetts. (Your portion of the cost may be waived by the Commonwealth of Massachusetts in the case of extreme financial hardship.) **If you decide to request an external review, you must file your request within the 45 days after you receive the denial letter from *Blue Cross and Blue Shield*.**

You (or your authorized representative) also have the right to request an “expedited” external review. This request must include a written statement from a physician. This statement should explain that a delay in providing or continuing those health care services that have been denied for coverage would pose a serious and immediate threat to your health. Based on this information, the Office of Patient Protection will determine if you are eligible for an expedited external review.

If your grievance is regarding termination of coverage for concurrent services that were previously approved by *Blue Cross and Blue Shield*, you may request approval to have the disputed coverage continue until the external grievance review process is completed. To do this, you must make your request before the end of the second working day after your receipt of the denial letter from *Blue Cross and Blue Shield*. The request may be approved if it is determined that not continuing these services may pose substantial harm to your health. In the event that coverage is approved to continue, you will not be charged for those health care services, regardless of the outcome of your grievance review. This continuation of coverage does not apply to services: that are limited by day, dollar, or visit *benefit limits* and that exceed those *benefit limits*; that are *non-covered services*; or that are services that were received prior to the time that you requested the external grievance review.

To contact the Office of Patient Protection, you can call toll free at **1-800-436-7757**. Or, you can fax a request to **1-617-624-5046**. Or, you can go online and log on to the Office of Patient Protection’s Web site at **www.state.ma.us/dph/opp**.

External Review Process. As required by state regulations, the Office of Patient Protection will determine whether or not your request is eligible for an external review. If it is determined that your request is not eligible, you (or your authorized representative) will be notified within ten working days of the receipt of your request. In the case of an expedited external review, you will be notified within 72 hours of the receipt of your request. The notice sent to you will explain the reasons why your request is not eligible for an external review. The fee that you paid for the review will also be refunded to you with this notice.

When your request is eligible for an external review, an external review agency will be selected and your case will be referred to them. You (or your authorized representative) will be notified of the name of the review agency. This notice will also state whether or not your case is being reviewed on an expedited basis. This notice will also be sent to *Blue Cross and Blue Shield* along with a copy of your signed medical information release form.

In some cases, the review agency may need more information about your grievance. If this is the case, they will request it from *Blue Cross and Blue Shield*, you, or your authorized representative and, in the case of an expedited grievance, require that it be returned within 24 hours. In the case of a regular review, the information will be required within three working days.

External Review Decision. As required by state regulations, the review agency will consider all aspects of the case and send a written response of the outcome. They will send the response to you (or your authorized representative) and to *Blue Cross and Blue Shield* within 60 working days of the request. If the agency determines additional time is needed to fully and fairly evaluate the request, the agency will notify you and *Blue Cross and Blue Shield* of the extended review period.

In the case of an expedited review, you will be notified of their decision within five working days. This five-day period starts when the external review agency is assigned to your case.

If the review agency overturns *Blue Cross and Blue Shield's* decision in whole or in part, *Blue Cross and Blue Shield* will send you (or your authorized representative) a notice within five working days of receiving the review decision made by the agency. This notice will confirm the decision of the review agency. It will also tell you (a) what steps or procedures you must take (if any) to obtain the requested coverage or services; (b) the date by which *Blue Cross and Blue Shield* will pay for or authorize the requested services; and (c) the name and phone number of the person at *Blue Cross and Blue Shield* who will make sure your grievance is resolved.

The decision made by way of the external review process will be accepted as final.

You have the right to look at and get copies of records and criteria that *Blue Cross and Blue Shield* has and that are relevant to your grievance. These copies will be free of charge.

Appeals Process for Rhode Island Residents or Services

You may also have the right to appeal as described in this section when your claim is denied as being not *medically necessary* for you. If so, these rights are in addition to the other rights to appeal that you have as described in other parts of this Subscriber Certificate. The following provisions apply only to:

- A member who lives in Rhode Island and that member is planning to obtain services which *Blue Cross and Blue Shield* has determined are not *medically necessary*.
- A member who lives outside of Rhode Island and that member is planning to obtain services in Rhode Island which *Blue Cross and Blue Shield* has determined are not *medically necessary*.

Blue Cross and Blue Shield decides which *covered services* are *medically necessary* for you by using its *medical necessity* guidelines. Some of the services that are described in this Subscriber Certificate may not be *medically necessary* for you. **If *Blue Cross and Blue Shield* has determined that a service is not *medically necessary* for you, you have the right to the following appeals process:**

Reconsideration. A reconsideration is the first step in this process. If you receive a letter from *Blue Cross and Blue Shield* that denies payment for your health care services, you may ask that *Blue Cross and Blue Shield* reconsider its decision. You must do this by writing to: Member Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. You must send your request within 180 days of *Blue Cross and Blue Shield's* adverse decision. Along with your letter, you should include any information that will support your request. *Blue Cross and Blue Shield* will review your request. *Blue Cross and Blue Shield* will let you know the outcome of your request within 15 calendar days after it has received all information needed for the review.

Appeal. An appeal is the second step in this process. If *Blue Cross and Blue Shield* continues to deny coverage for all or part of the original service, you may request an appeal. You must do this within 60 days of the date that you receive the reconsideration denial letter from *Blue Cross and Blue Shield*. Your appeal request should include any information that supports your appeal. You may also inspect and add information to your *Blue Cross and Blue Shield* case file to prepare your appeal. In accordance with Rhode Island state law, if you wish to review the information in your *Blue Cross and Blue Shield* case file, you must make your request in writing and you must include the name of a physician who may review your case file on your behalf. Your physician may review, interpret, and disclose any or all of that information to you. Once received by *Blue Cross and Blue Shield*, your appeal will be reviewed by a health care provider in the same specialty as your attending provider. *Blue Cross and Blue Shield* will notify you of the outcome of your appeal within 15 calendar days after it has received all information needed for the appeal.

External Appeal. If your appeal is denied, you have the right to present your case to an appeals agency that is designated by Rhode Island and not affiliated with *Blue Cross and Blue Shield*. If you request this voluntary external appeal, Rhode Island requires that you pay for half of the cost of the appeal. *Blue Cross and Blue Shield* will pay for the remaining half. To file an external appeal, you must make your request in writing to: Member Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Along with your request, you must: state your reason(s) for your disagreement with *Blue Cross and Blue Shield's* decision; and enclose a check payable to one of the following external appeals agencies: Masspro (your fee is \$147.50) or the MAXIMUS Center for Health Dispute Resolution (your fee is \$144.20).

If your service denial is for treatment of a *mental condition*, your fee is: \$237.50 for Masspro and \$144.20 for the MAXIMUS Center for Health Dispute Resolution.

Within five working days after *Blue Cross and Blue Shield* receives your written request and payment for the appeal, *Blue Cross and Blue Shield* will forward your request to the external appeals agency. *Blue Cross and Blue Shield* will also send its portion of the fee and your entire *Blue Cross and Blue Shield* case file. The external appeals agency will notify you in writing of the decision within ten working days of receiving all necessary information.

Expedited Appeal. If your situation is an emergency, you have the right to an “expedited” appeal at all three levels of appeal as stated above. An emergency is defined as the sudden onset of a medical or *mental condition* that in the absence of immediate medical attention could reasonably be expected to result in placing your health or your ability to regain maximum function in serious jeopardy or, in your physician’s opinion, would result in severe pain. You may request an expedited reconsideration or appeal by calling *Blue Cross and Blue Shield* at the phone number shown in your letter. *Blue Cross and Blue Shield* will notify you of the result of your expedited appeal within two working days or 72 hours, whichever is sooner, of its receipt. To request an expedited external appeal, you must send your request in writing to: Member Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Your request should state your reason(s) for your disagreement with the decision and include signed documentation from your provider that describes the emergency nature of your treatment. In addition, you must also enclose a check payable to one of the following external appeals agencies: Masspro (your fee is \$172.50) or the MAXIMUS Center for Health Dispute Resolution (your fee is \$144.20).

If your service denial is for treatment of a *mental condition*, your fee is: \$237.50 for Masspro and \$144.20 for the MAXIMUS Center for Health Dispute Resolution.

Within two working days after the receipt of your written request and payment for the appeal, *Blue Cross and Blue Shield* will forward your request to the external appeals agency along with *Blue Cross and Blue Shield's* portion of the fee and your entire *Blue Cross and Blue Shield* case file. The external appeals agency will notify you in writing of the decision within two working days or 72 hours, whichever is sooner, of receiving your request for a review.

External Appeal Final Decision. If the external appeals agency upholds the original decision of *Blue Cross and Blue Shield*, this completes the appeals process for your case. But, if the external appeals agency reverses *Blue Cross and Blue Shield's* decision, the claim in dispute will be reprocessed by *Blue Cross and Blue Shield* upon receipt of the notice of the final appeal decision. In addition, *Blue Cross and Blue Shield* will repay you for your share of the cost for the external appeal within 60 days of the receipt of the notice of the final appeal decision.

Part 11

Group Policy

This part applies to you when you enroll in this health plan as a *group member*. Under a *group contract*, the *subscriber's group* has an agreement with *Blue Cross and Blue Shield* to provide its *group members* with access to health care services and benefits. The *group* will make payments to *Blue Cross and Blue Shield* for its *group members* for coverage in this health plan. The *group* should also deliver to its *group members* all notices from *Blue Cross and Blue Shield*. The *group* is the *subscriber's* agent and is not the agent of *Blue Cross and Blue Shield*. For questions about enrollment and billing, you must contact the *group* (which may also be referred to as your *plan sponsor*). The *plan sponsor* is usually the *subscriber's* employer and is the same as the plan sponsor designated under the Employee Retirement Income Security Act of 1974, as amended (ERISA). If you are not sure who your *plan sponsor* is, contact your employer.

Eligibility and Enrollment for Group Coverage

Eligible Employee

An employee is eligible to enroll in this health plan as a *subscriber* under this *group contract* as long as the employee meets the rules on length of service, active employment, and number of hours worked that the *plan sponsor* has set to determine eligibility for *group* coverage. For details, contact your *plan sponsor*.

Eligible Spouse

The *subscriber* may enroll an eligible spouse for coverage in this health plan under the *group contract*. An “eligible spouse” includes the *subscriber's* legal spouse. (A legal civil union spouse, where applicable, is eligible to enroll for coverage in this health plan under the *group contract* to the extent that a legal civil union spouse is determined eligible by the *plan sponsor*. For more details, contact your *plan sponsor*.)

Former Spouse. In the event of a divorce or a legal separation, the person who was the spouse of the *subscriber* prior to the divorce or legal separation will remain eligible for coverage in this health plan under the *subscriber's group contract*, whether or not the judgment was entered prior to the *effective date* of the *group contract*. This health plan coverage is provided with no additional *premium* other than the normal cost of covering a current spouse. The former spouse will remain eligible for this coverage only until the *subscriber* is no longer required by the judgment to provide health insurance for the former spouse or the *subscriber* or former spouse remarries, whichever comes first. In these situations, *Blue Cross and Blue Shield* must be notified within 30 days of a change to the former spouse's address. Otherwise, *Blue Cross and Blue Shield* will not be liable for any acts or omissions due to having the former spouse's incorrect address on file.

If the *subscriber* remarries, the former spouse may continue coverage in this health plan under a separate membership within the *subscriber's group*, provided the divorce judgment requires that the *subscriber* provide health insurance for the former spouse. This is true even if the *subscriber's* new spouse is not enrolled for coverage in this health plan under the *subscriber's group contract*.

Eligible Dependents

The *subscriber* may enroll eligible dependents for coverage in this health plan under the *group contract*. The *subscriber's* “eligible dependents” include dependents that are age 25 or under, provided that they have status as a dependent under the Internal Revenue Code. When a dependent loses his or her dependent status under the Internal Revenue Code, that dependent will continue to be eligible as a dependent for coverage in this health plan under the *subscriber's group contract* for two years after the end of the calendar year in which he or she last qualified as a dependent under the Internal Revenue Code or until the dependent turns age 26, whichever comes first.

These eligible dependents may include:

- A newborn child. The *effective date* of coverage for a newborn child will be the child's date of birth provided that the *subscriber* formally notifies the *plan sponsor* within 30 days of the date of birth. (A claim for the enrolled mother's maternity admission may be considered by *Blue Cross and Blue Shield* to be this notice when the *subscriber's* coverage is a family plan.) This health plan provides coverage for newborn infants for injury and sickness. This includes the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth. The coverage for these services is subject to all of the provisions of this health plan.
- An adopted child. The *effective date* of coverage for an adopted child will be the date of placement with the *subscriber* for the purpose of adoption. The *effective date* of coverage for an adoptive child who has been living with the *subscriber* and for whom the *subscriber* has been getting foster care payments will be the date the petition to adopt is filed. If the *subscriber* is enrolled under a family plan as of the date he or she assumes custody of a child for the purpose of adoption, the child's health care services for injury or sickness will be covered from the date of custody. (This coverage is provided without a waiting period or pre-existing condition restriction.) This includes the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth. The coverage for these services is subject to all of the provisions of this health plan.
- A child who is recognized under a Qualified Medical Child Support Order as having the right to enroll for health care coverage.
- An unmarried full-time student dependent child age 24 or under who lives with the *subscriber* or the spouse on a regular basis **and who does not otherwise qualify as an eligible dependent as described above in this section**. In this case, the *subscriber* must give written verification to *Blue Cross and Blue Shield* that the child is a full-time student at an accredited educational institution. This coverage ends when the student turns age 25 or marries or on November 1st after the date the student discontinues full-time classes or graduates, whichever comes first. There is one exception. A dependent student who takes a leave of absence from a post-secondary school for a medical reason may be eligible to remain enrolled under the *subscriber's group contract*. This continued coverage is provided only when the student takes a medically necessary leave of absence (or he or she experiences any other change in enrollment status that would impact his or her eligibility for coverage) due to a serious illness or injury. The attending physician must certify this in writing. The *subscriber* must give the physician's written statement to *Blue Cross and Blue Shield*. In this case, the child will continue to be covered until one year from the date the leave of absence begins or until the date on which the coverage would otherwise end, whichever comes first.
- A disabled dependent child **who does not otherwise qualify as an eligible dependent as described above in this section**. A dependent child who is mentally or physically incapable of earning his or her own living and who is enrolled under the *subscriber's group contract* will continue to be covered after he or she would otherwise lose dependent eligibility as described above, so long as the child continues to be mentally or physically incapable of earning his or her own living. In this case, the *subscriber* must make arrangements with *Blue Cross and Blue Shield* through the *plan sponsor* not

more than 30 days after the date the child would normally lose eligibility. Also, *Blue Cross and Blue Shield* must be given any medical or other information that it may need to determine if the child can maintain coverage in this health plan under the *subscriber's group contract*. From time to time, *Blue Cross and Blue Shield* may conduct reviews that will require a statement from the attending physician. This is to confirm that the child is still an eligible disabled dependent child.

- A newborn infant of an enrolled dependent immediately from the moment of birth and continuing after, until the enrolled dependent is no longer eligible as a dependent.

**Important
Reminder:**

The eligibility provisions for dependents that are described in this section may differ from the federal tax laws that define who may qualify as a dependent.

Enrollment Periods for Group Coverage

Initial Enrollment

You may enroll for coverage in this health plan under a *group contract* on your initial *group* eligibility date. This date is determined by your *plan sponsor*. The *plan sponsor* is responsible for providing you with details about how and when you may enroll for coverage in this health plan under a *group contract*. To enroll, you must complete the enrollment form provided by your *plan sponsor* no later than 30 days after your eligibility date. (For more information, contact your *plan sponsor*.) If you choose not to enroll for coverage in this health plan under a *group contract* on your initial eligibility date, you may enroll under a *group contract* only during your *group's* open enrollment period or within 30 days of a special enrollment event as provided by federal or Massachusetts law.

Special Enrollment

If an eligible employee or an eligible dependent (including the employee's spouse) chooses not to enroll for coverage in this health plan under a *group contract* on his or her initial *group* eligibility date, federal or Massachusetts law may allow the eligible employee and/or his or her eligible dependents to enroll under the *group contract* when:

- The employee and/or his or her eligible dependents have a loss of other coverage (see "Loss of Other Qualified Coverage" below for more information); or
- The employee gains a new eligible dependent (see "New Dependents" below for more information).
- The employee and/or his or her eligible dependent become eligible for assistance under a Medicaid plan or a state Children's Health Insurance Program plan.

These rights are known as your "special enrollment rights."

Loss of Other Coverage. An eligible employee may choose not to enroll himself or herself or an eligible dependent (including a spouse) for coverage in this health plan under a *group contract* on the initial *group* eligibility date because he or she or the eligible dependent has other health plan coverage as defined by federal law. (This is referred to as "qualified" coverage.) In this case, the employee and the eligible dependent may enroll under the *group contract* if the employee or the eligible dependent at a later date loses that other qualified health plan coverage due to any one of the following reasons.

- The employee or the eligible dependents (including a spouse) cease to be eligible for the other qualified health plan. For example, this could mean that the loss of the other qualified health plan was due to: the loss of the spouse's coverage; the death of the spouse; divorce; loss of dependent status; or involuntary termination. This includes when an employee or eligible dependent is covered under a

Medicaid plan or a state Children’s Health Insurance Program plan and coverage is terminated as a result of loss of eligibility for that coverage.

- The employer that is sponsoring the other qualified group health plan coverage ceases to make employer contributions for the other group health plan coverage.
- The employee or the eligible dependents (including a spouse) exhaust their continuation of group coverage under the other qualified group health plan.
- The prior qualified health plan was terminated due to the insolvency of the health plan carrier.

Important Note:

You will **not** have this special enrollment right if the loss of other health plan coverage is a result of the eligible employee or the *subscriber* or the eligible dependent’s failure to pay the applicable premiums.

New Dependents. If an eligible employee gains a new spouse or other new eligible dependent(s) due to marriage, adoption, placement for adoption, or birth, the employee and the spouse and/or the new dependent(s) may enroll for coverage in this health plan under a *group contract*. (If the new dependent is gained by birth, adoption, or placement for adoption, enrollment under the *group contract* will be retroactive to the date of birth or the date of adoption or the date of placement for adoption, provided that the enrollment time requirements described below are met.)

Special Enrollment Time Requirement. To exercise your special enrollment rights, you must notify your *plan sponsor* no later than 30 days after the date on which the loss of other coverage occurs or the date which the *subscriber* gains a new dependent, whichever is applicable. For example, if your coverage under another health plan is terminated, you must request enrollment for coverage in this health plan under a *group contract* within 30 days after your other health care coverage ends. Upon request, the *plan sponsor* will send you any special forms you may need. If you do not request enrollment within 30 days, you will have to wait until the *group’s* next open enrollment period to enroll under a *group contract*. You also have special enrollment rights related to termination of coverage under a state Children’s Health Insurance Program plan or a Medicaid plan or eligibility for assistance under a Medicaid plan or a state Children’s Health Insurance Program plan. When this situation applies, you must notify your *plan sponsor* to request coverage no later than 60 days after the coverage terminates or the employee or eligible dependent is determined to be eligible for assistance.

Qualified Medical Child Support Order

If the *subscriber* chooses not to enroll an eligible dependent for coverage in this health plan under a *group contract* on the initial *group* eligibility date, the *subscriber* may be required by law to enroll the dependent if the *subscriber* is subject to a Qualified Medical Child Support Order (QMCSO). This QMCSO order is a state court or administrative agency order that requires an employer’s *group* to provide coverage to the child of an employee who is covered, or eligible to enroll for *group* coverage, in this health plan.

Open Enrollment Period

If you choose not to enroll for coverage in this health plan under a *group contract* within 30 days of your initial *group* eligibility date, you may enroll during your *group’s* open enrollment period. The open enrollment period is the time each year during which eligible persons may enroll for or change coverage for the next year. The open enrollment period is announced by the *group* to all eligible employees. To enroll for coverage in this health plan under a *group contract* during this enrollment period, you must

complete the enrollment form provided in the *group's* enrollment packet and return it to the *group* no later than the date specified in the *group's* enrollment packet.

Other Membership Changes

Generally, the *subscriber* may make membership changes (for example, change from a *subscriber* only plan to a family plan) only if the *subscriber* has a change in family status. This includes a change such as: marriage or divorce; birth, adoption, or change in custody of a child; death of an enrolled spouse or dependent; or the loss of an enrolled dependent's eligibility under the *subscriber's group contract*. **If you want to ask for a membership change or you need to change your name or mailing address, you should call or write to your *plan sponsor*.** The *plan sponsor* will send you any special forms that you may need. You must request the change within the time period required by the *subscriber's group* to make a change. If you do not make the change within the required time period, you will have to wait until the *group's* next open enrollment period to make the change. All changes are allowed only when they comply with the eligibility and enrollment rules set by the *plan sponsor* for your *group* coverage. They must also comply with the conditions outlined in the *group contract* and in the *Blue Cross and Blue Shield Manual of Underwriting Guidelines for Group Business*.

Termination of Group Coverage

Loss of Eligibility for Group Coverage

When your eligibility for a *group contract* ends, your coverage in this health plan under the *group contract* will be terminated as of the date you lose eligibility (subject to the continuation of coverage provisions described on page 83). You will not be eligible for coverage in this health plan under a *group contract* when any one of the following situations occurs.

- **Subscriber's Group Eligibility Ends.** Your coverage in this health plan under a *group contract* will end when the *subscriber* loses eligibility for the *group's* health care coverage. This means: the *subscriber's* hours are reduced; or the *subscriber* leaves the job; or the *subscriber* no longer meets the rules that are set by the *group* for coverage under the *group contract*. (You will also lose eligibility for *group* coverage if you are an enrolled dependent when the *subscriber* dies.)
- **Your Dependent Status Ends.** Your coverage in this health plan under a *group contract* will end when you lose your status as a dependent under the *subscriber's group contract*. In this case, you may wish to enroll as a *subscriber* under an *individual contract*. Or, you may be able to enroll in another *Blue Cross and Blue Shield* health plan or a health plan offered by Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. For help, you can call the *Blue Cross and Blue Shield* customer service office. They will tell you which health plans are available to you.
- **You Turn Age 65 and Become Eligible for Medicare.** Your coverage in this health plan under a *group contract* will end when you reach age 65 and become eligible for Medicare (Part A and Part B). However, as allowed by federal law, the *subscriber* (and the spouse and/or dependents) may have the option of continuing coverage in this health plan under a *group contract* when the *subscriber* remains as an actively working employee after reaching age 65. You should review all options available to you with the *plan sponsor*. (Medicare eligible *subscribers* who retire and/or their spouses are not eligible to continue coverage in this health plan under a *group contract* once they reach age 65.)
- **Your Group Fails to Pay Premiums.** Your coverage in this health plan under a *group contract* will end when the *plan sponsor* fails to pay the *group premium* to *Blue Cross and Blue Shield* within

30 days of the due date. In this case, *Blue Cross and Blue Shield* will notify you in writing of the termination of your *group* coverage in accordance with the Code of Massachusetts Regulations. This notice will give you information about the termination of your *group* coverage and your options for coverage offered by *Blue Cross and Blue Shield* or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

- **Your Group Cancels (or Does Not Renew) the Group Contract.** Your coverage in this health plan under a *group contract* will end when the *group* terminates (or does not renew) the *group contract*.

Termination of Group Coverage by the Subscriber

Your coverage in this health plan under a *group contract* will end when the *subscriber* chooses to cancel his or her *group contract* as permitted by the *plan sponsor*. *Blue Cross and Blue Shield* must receive the termination request not more than 30 days after the *subscriber's* termination date.

Termination of Group Coverage by Blue Cross and Blue Shield

Your coverage in this health plan under a *group contract* will not be canceled because you are using your coverage or because you will need more *covered services* in the future. In the event that *Blue Cross and Blue Shield* cancels your coverage in this health plan under a *group contract*, a notice will be sent to your *group* that will tell your *group* the specific reason(s) that *Blue Cross and Blue Shield* is canceling the *group contract*. *Blue Cross and Blue Shield* will cancel your coverage in this health plan under a *group contract* **only when** one of the following situations occurs.

- **You Commit Misrepresentation or Fraud to Blue Cross and Blue Shield.** Your coverage in this health plan will be canceled if you have committed misrepresentation or fraud to *Blue Cross and Blue Shield*. For example, you gave false or misleading information on the enrollment form. Or, you misused your ID card by letting another person who was not enrolled for coverage in this health plan attempt to get coverage. In this case, the termination of your coverage will go back to your *effective date*. Or, it may go back to the date of the misrepresentation or fraud. The termination date will be determined by *Blue Cross and Blue Shield*. Or, in some cases *Blue Cross and Blue Shield* may limit your benefits.
- **You Commit Acts of Physical or Verbal Abuse.** Your coverage in this health plan will be canceled if you commit acts of physical or verbal abuse that pose a threat to health care providers or to other *members* of *Blue Cross and Blue Shield* or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc., and these acts are not related to your physical condition or *mental condition*. In this case, this termination will follow the procedures that have been approved by the Massachusetts Commissioner of Insurance.
- **You Fail to Comply With Plan Provisions.** Your coverage in this health plan will be canceled if you fail to comply in a material way with any provision of the *group contract*. For example, if you fail to provide information that *Blue Cross and Blue Shield* requests related to your coverage in this health plan, *Blue Cross and Blue Shield* may terminate your coverage.
- **This Health Plan Is Discontinued.** Your coverage in this health plan will be canceled if *Blue Cross and Blue Shield* discontinues this health plan. *Blue Cross and Blue Shield* may discontinue this health plan for any reason as of a date approved by the Massachusetts Commissioner of Insurance.

Continuation of Group Coverage

Family and Medical Leave Act

An employee may continue coverage in this health plan under a *group contract* as provided by the Family and Medical Leave Act. (The Family and Medical Leave Act generally applies to you if your *group* has 50 or more employees.) An employee who has been employed at least one year and worked at least 1,250 hours within the previous 12 months is eligible to choose to continue coverage for up to 12 weeks of unpaid leave for any one of the following reasons.

- The birth of the employee's child.
- The placement of a child with the employee for the purpose of adoption or foster care.
- To care for a seriously ill spouse, child, or parent.
- A serious health condition rendering the employee unable to perform his or her job.

If the employee chooses to continue *group* coverage during the leave, the employee will be given the same health care benefits that would have been provided if the employee were working, with the same *premium* contribution ratio. If the employee's *premium* for continued coverage under the *group contract* is more than 30 days late, the *plan sponsor* will send written notice to the employee. It will tell the employee that his or her coverage will be terminated. It will also give the date of the termination if payment is not received by that date. This notice will be mailed at least 15 days before the termination date.

If coverage in this health plan under the *group contract* is discontinued due to non-payment of *premium*, the employee's coverage will be restored when he or she returns to work to the same level of benefits as those the employee would have had if the leave had not been taken and the *premium* payment(s) had not been missed. This includes coverage for eligible dependents. The employee will not be required to meet any qualification requirements imposed by *Blue Cross and Blue Shield* when he or she returns to work. This includes: new or additional waiting periods; waiting for an open enrollment period; or passing a medical exam to reinstate coverage. You should contact your *plan sponsor* with any questions that you may have about your coverage during a leave of absence.

Limited Extension of Group Coverage Under State Law

When you are no longer eligible for coverage in this health plan under a *group contract*, you may be eligible to continue coverage under the *group contract* as provided by state law. These laws apply to you if you lose eligibility for coverage due to one of the following reasons:

- Lay off or death of the *subscriber*. If you lose eligibility due to one of these reasons, coverage in this health plan may continue for up to 39 weeks from the date of the qualifying event. To continue your *group* coverage, you will pay 100% of the *premium* cost.
- Plant closing or a partial plant closing (as defined by law) in Massachusetts. If this happens to you, you and your *group* will each pay your shares of the *premium* cost for up to 90 days after the plant closing. Then, to continue your *group* coverage for up to 39 more weeks, you will pay 100% of the *premium* cost.

At this same time, you may also be eligible for continued *group* coverage under other state laws or under federal law (see below). If you are, the starting date for continued *group* coverage under all of these laws will be the same date. But, after the 90-day extension period provided by this state law ends, you may have to pay more *premium* to continue your coverage under the *group contract*. If you become eligible for coverage under another employer sponsored health plan at any time before the 39-week extension period ends, continued coverage in this health plan under the *group contract* under these provisions also ends.

Continuation of Group Coverage Under Federal or State Law

When you are no longer eligible for coverage in this health plan under a *group contract*, you may be eligible to continue *group* coverage as provided by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or under Massachusetts state law. (These provisions apply to you if your *group* has two or more employees.) To continue this *group* coverage, you may be required to pay up to 102% of the *premium* cost. These laws apply to you if you lose eligibility for coverage due to one of the following reasons.

- Termination of employment (for reasons other than gross misconduct).
- Reduction of work hours.
- Divorce or legal separation. (In the event of divorce or legal separation, a spouse is eligible to keep coverage in this health plan under the employee's *group contract*. This is the case only until the employee is no longer required by law to provide health insurance for the former spouse or the employee or former spouse remarries, whichever comes first. The former spouse's eligibility for continued *group* coverage will start on the date of divorce, even if he or she continues coverage under the employee's *group contract*. While the former spouse continues coverage under the employee's *group contract*, there is no additional *premium*. After remarriage, under state and federal law, the former spouse may be eligible to continue *group* coverage in this health plan under a separate *group contract* for additional *premium*.)
- Death of the *subscriber*.
- *Subscriber's* entitlement to Medicare benefits.
- Loss of status as an eligible dependent.

The period of this continued *group* coverage begins with the date of your qualifying event. And, the length of this continued *group* coverage will be up to 36 months from that qualifying event. This is true except for termination of employment or reduction of work hours, in which cases continued *group* coverage is available for only 18 months or, if you are qualified for disability under Title II or Title XVI of the Social Security Act, up to 29 months. (See below for more information about continued coverage for disabled employees.) You should contact your *plan sponsor* for more help about continued coverage.

Important Note:

When a *subscriber's* legal same-sex spouse is no longer eligible for coverage under the *group contract*, that spouse (or if it applies, that civil union spouse) and his or her dependents may continue coverage in the *subscriber's group* to the same extent that a legal opposite-sex spouse (and his or her dependents) could continue coverage upon loss of eligibility for coverage under the *group contract*.

Additional Continued Coverage for Disabled Employees. At the time of the employee's termination of employment or reduction in hours (or within 60 days of the qualifying event under federal law), if an employee or his or her eligible dependent is determined to be disabled under Title II or Title XVI of the Social Security Act, continued *group* coverage will be available for up to 29 months from the date of the qualifying event. The *premium* cost for the additional 11 months may be up to 150% of the *premium* rate. If during these 11 months eligibility for disability is lost, *group* coverage may cancel before the 29 months is completed. You should contact your *plan sponsor* for more help about continued coverage.

Special Rules for Retired Employees. A retired employee, the spouse, and/or eligible dependent children of a retired employee or a surviving spouse of a retired deceased employee who loses eligibility for coverage in this health plan under the *group contract* as a result of a bankruptcy proceeding (Title 11 of the United States Code) is also eligible to continue *group* coverage as provided by COBRA or under Massachusetts state law. A retired employee and/or the surviving spouse of a deceased retired employee may enroll for lifetime continued *group* coverage as of the date of the bankruptcy proceeding, provided that the loss of *group* eligibility occurs within one year before the date on which the bankruptcy proceeding begins. Or, if *group* eligibility is lost within one year after the date on which the bankruptcy proceeding begins, they may enroll for lifetime continued *group* coverage as of the date *group* eligibility is lost. Spouses and/or eligible dependents of these retired employees may enroll for continued *group* coverage until the retired employee dies. Once the retired employee dies, his or her surviving spouse and/or eligible dependents may enroll for up to an additional 36 months of continued *group* coverage beyond the date of the retired employee's death.

Lifetime continued coverage in this health plan for retired employees will end if the *group* cancels its agreement with *Blue Cross and Blue Shield* to provide its *group members* with coverage in this health plan under a *group contract* or for any of the other reasons described below. (See "Termination of Continued Group Coverage.")

Enrollment for Continued Group Coverage. In order to enroll for continued *group* coverage in this health plan, you must complete an Election Form. The completed election form must be returned to the office at the address on the form. The form must be returned within 60 days from your date of termination of *group* coverage or your notification of eligibility, whichever is later. If you do not return the completed form, it will be considered a waiver. And, you will not be allowed to continue coverage in this health plan under a *group contract*. (The 60 days will be counted from the date of the eligibility notice to the postmarked date of the mailed election form.)

Termination of Continued Group Coverage. Your continued *group* coverage will end when:

- The length of time allowed for continued *group* coverage is reached (for example, 18 months or 29 months or 36 months from the qualifying event).
- You fail to make timely payment of your premiums.
- You enroll in another employer sponsored health plan and that plan does not include pre-existing condition limitations or waiting periods.
- You become entitled to Medicare benefits.
- You are no longer disabled (if your continued *group* coverage had been extended because of disability.)
- The *group* terminates its agreement with *Blue Cross and Blue Shield* to provide its *group members* with access to health care services and benefits under this health plan. In this case, health care coverage may continue under another health plan. Contact your *plan sponsor* or *Blue Cross and Blue Shield* for more information

Certificates of Group Health Plan Coverage

As provided by federal law, you are entitled to a certificate that will show evidence of your prior health care coverage. A certificate of prior coverage may help you obtain coverage without a pre-existing condition exclusion even if you buy health insurance other than through an employer group health plan. All *members* have the right to receive a certificate of group health plan coverage when:

- The *member* ceases coverage under the group's health plan or coverage would have been lost had the *member* not elected to continue *group* coverage under COBRA or Massachusetts state law.
- The *member's* continued coverage under COBRA or Massachusetts state law ends.
- The *member* requests a certificate of group health plan coverage within 24 months of his or her loss of health care coverage.
- The *member's* claim is denied because he or she has reached a lifetime limit on all benefits (if there is a limit).

While you are enrolled for coverage in this health plan, *Blue Cross and Blue Shield* will provide this certificate to you. When your coverage under this *group contract* ends and you are eligible for a certificate of group health plan coverage, the *plan sponsor* and/or *Blue Cross and Blue Shield* will provide this certificate to you. It is important that you promptly notify your *group* when you are terminating your coverage.

Medicare Program

When you are eligible for Medicare and Medicare is allowed by federal law to be the primary payor, the coverage provided by this health plan will be reduced by the amount of benefits allowed under Medicare for the same *covered services*. This reduction will be made whether or not you actually receive the benefits from Medicare.

Under Age 65 with End Stage Renal Disease (ESRD)

If you are under age 65 and are eligible for Medicare only because of ESRD (permanent kidney failure), the benefits of this health plan will be provided before Medicare benefits. This is the case only during the first 30 months of your ESRD Medicare coverage. After 30 months, the benefits that are provided by this health plan will be reduced by the amount that Medicare allows for the same *covered services*.

Under Age 65 with Other Disability

If your *group* employs 100 or more employees and if you are under age 65 and you are eligible for Medicare only because of a disability other than ESRD, this health plan will provide benefits before Medicare benefits. This is the case **only** if you are the actively employed *subscriber* or the enrolled spouse or dependent of the actively employed *subscriber*. If you are an inactive employee or a retiree or the enrolled spouse or dependent of the inactive employee or retiree, the benefits that are provided by this health plan will be reduced by the amount that Medicare allows for the same *covered services*. (In some cases, this provision also applies to certain smaller groups. Your *plan sponsor* can tell you if it applies to your *group*.)

Age 65 or Older

If your *group* employs 20 or more employees and if you are age 65 or older and are eligible for Medicare only because of age, this health plan will provide benefits before Medicare benefits as long as you have chosen this health plan as your primary payor. This can be the case only if you are an actively employed *subscriber* or the enrolled spouse of the actively employed *subscriber*. (If you are actively employed at

the time you reach age 65 and become eligible for Medicare, you must choose between Medicare and this *contract* as the primary payor of your health care benefits. For more help, contact your *plan sponsor*.)

Dual Medicare Eligibility

If you are eligible for Medicare because of ESRD and a disability or because of ESRD and you are age 65 or older, this health plan will provide benefits before Medicare benefits. This is the case during the first 30 months of your ESRD Medicare coverage only if the coverage under this health plan was primary when you became eligible for ESRD Medicare benefits. Then, for as long as you maintain dual Medicare eligibility, the benefits that are provided by this health plan will be reduced by the amount that Medicare allows for the same *covered services*. (This provision may not apply to you. To find out if it does, contact your *plan sponsor*.)

Part 12

Individual Policy

This part applies to you when you enroll in this health plan as a direct pay *member* (and not as a *group member* under a *group contract*). Under an *individual contract*, the *subscriber* has an agreement with *Blue Cross and Blue Shield* to provide the *subscriber* and his or her enrolled eligible spouse and other enrolled eligible dependents with access to health care services and benefits. The *subscriber* will make payments to *Blue Cross and Blue Shield* for coverage in this health plan under an *individual contract*. For questions about enrollment and billing, you can call the *Blue Cross and Blue Shield* customer service office.

Eligibility and Enrollment for Individual Coverage

Eligible Individual

An individual is eligible to enroll in this health plan as a *subscriber* under an *individual contract* as long as the individual is a resident of Massachusetts. (A “resident” is a person who lives in the commonwealth. But, the fact that you are in a nursing home, a hospital, or other institution does not by itself mean you are a resident.)

This health plan is not a Medicare supplement plan. If you are eligible for Medicare, this health plan cannot be issued to you. You should look at the Guide to Health Insurance for People with Medicare. You may be able to sign up for a health plan that is designed to supplement Medicare. To ask for a copy of the Guide, you can call the *Blue Cross and Blue Shield* customer service office. (See Part 1.) If you are already enrolled in this health plan when you become eligible for Medicare, you may choose to stay enrolled. If you choose to remain enrolled, Medicare may provide coverage for the same health care services that are covered by this health plan. In this case, Medicare is the primary payor.

Eligible Spouse

The *subscriber* may enroll an eligible spouse for coverage in this health plan under his or her *individual contract*. An “eligible spouse” includes the *subscriber’s* legal spouse or legal civil union spouse. In order to enroll for coverage in this health plan, the eligible spouse must also be a resident of Massachusetts. (A “resident” is a person who lives in the commonwealth. But, the fact that you are in a nursing home, a hospital or other institution does not by itself mean you are a resident.)

(If the spouse is eligible for Medicare, this health plan can not be issued to your spouse. You should use the Guide to Health Insurance for People with Medicare should be used to find a health plan that is designed to supplement Medicare. To ask for a copy of the Guide, you can call the *Blue Cross and Blue Shield* customer service office.)

Former Spouse. In the event of a divorce or a legal separation, the person who was the spouse of the *subscriber* prior to the divorce or legal separation may maintain coverage in this health plan under the *subscriber’s individual contract*. This coverage may continue only until: the *subscriber* is no longer required by the divorce judgment to provide health insurance for the former spouse; or the *subscriber* or former spouse remarries. In either case, the former spouse may wish to enroll as a *subscriber* under his or her own *individual contract*. The *Blue Cross and Blue Shield* customer service office can help you with

WORDS IN ITALICS ARE EXPLAINED IN PART 2.

these options. In these situations, *Blue Cross and Blue Shield* must be notified within 30 days of a change to the former spouse's address. Otherwise, *Blue Cross and Blue Shield* will not be liable for any acts or omissions due to having the former spouse's incorrect address on file.

Eligible Dependents

The *subscriber* may enroll eligible dependents for coverage in this health plan under his or her *individual contract*. In order to enroll for coverage in this health plan, eligible dependents must be residents of Massachusetts. (A "resident" is a person who lives in the commonwealth. But, the fact that you are in a nursing home, a hospital or other institution does not by itself mean you are a resident.) The *subscriber's* "eligible dependents" include dependents that are age 25 or under, provided that they have status as a dependent under the Internal Revenue Code. When a dependent loses his or her dependent status under the Internal Revenue Code, that dependent will continue to be eligible as a dependent for coverage in this health plan under the *subscriber's individual contract* for two years after the end of the year in which he or she last qualified as a dependent under the Internal Revenue Code or until the dependent turns age 26, whichever comes first.

These eligible dependents may include:

- A newborn child. The *effective date* of coverage for a newborn child will be the child's date of birth provided that the *subscriber* formally notifies *Blue Cross and Blue Shield* within 30 days of the date of birth. (A claim for the enrolled mother's maternity admission may be considered by *Blue Cross and Blue Shield* to be this notice when the *subscriber's* coverage is a family plan.) This health plan provides coverage for newborn infants for injury and sickness. This includes the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth. The coverage for these services is subject to all of the provisions of this health plan.
- An adopted child. The *effective date* of coverage for an adopted child will be the date of placement with the *subscriber* for the purpose of adoption. The *effective date* of coverage for an adoptive child who has been living with the *subscriber* and for whom the *subscriber* has been getting foster care payments will be the date the petition to adopt is filed. If the *subscriber* is enrolled under a family plan as of the date he or she assumes custody of a child for the purpose of adoption, the child's health care services for injury or sickness will be covered from the date of custody. (This coverage is provided without a waiting period or pre-existing condition restriction.) This includes the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth. The coverage for these services is subject to all of the provisions of this health plan.
- A child who is recognized under a Qualified Medical Child Support Order as having the right to enroll for health care coverage.
- An unmarried full-time student dependent child age 24 or under who lives with the *subscriber* or the spouse on a regular basis **and who does not otherwise qualify as an eligible dependent as described above in this section**. In this case, the *subscriber* must give written verification to *Blue Cross and Blue Shield* that the child is a full-time student at an accredited educational institution. This coverage ends when the student turns age 25 or marries or on November 1st after the date the student discontinues full-time classes or graduates, whichever comes first. There is one exception. A dependent student who takes a leave of absence from a post-secondary school for a medical reason may be eligible to remain enrolled under the *subscriber's individual contract*. This continued coverage is provided only when the student takes a medically necessary leave of absence (or he or she experiences any other change in enrollment status that would impact his or her eligibility for coverage) due to a serious illness or injury. The attending physician must certify this in writing. The *subscriber* must give the physician's written statement to *Blue Cross and Blue Shield*. In this case, the

child will continue to be covered until one year from the date the leave of absence begins or until the date on which the coverage would otherwise end, whichever comes first.

- A disabled dependent child **who does not otherwise qualify as an eligible dependent as described above in this section**. A dependent child who is mentally or physically incapable of earning his or her own living and who is enrolled under the *subscriber's individual contract* will continue to be covered after he or she would otherwise lose dependent eligibility as described above, so long as the child continues to be mentally or physically incapable of earning his or her own living. In this case, the *subscriber* must make arrangements with *Blue Cross and Blue Shield* not more than 30 days after the date the child would normally lose eligibility. Also, *Blue Cross and Blue Shield* must be given any medical or other information that it may need to determine if the child can maintain coverage in this health plan under the *subscriber's individual contract*. From time to time, *Blue Cross and Blue Shield* may conduct reviews that will require a statement from the attending physician. This is to confirm that the child is still an eligible disabled dependent child.
- A newborn infant of an enrolled dependent immediately from the moment of birth and continuing after, until the enrolled dependent is no longer eligible as a dependent.

**Important
Reminder:**

The eligibility provisions for dependents that are described in this section may differ from the federal tax laws that define who may qualify as a dependent.

Enrollment for Individual Coverage

An eligible individual may enroll for coverage in this health plan under an *individual contract* at any time. When you apply for coverage, *Blue Cross and Blue Shield* may require that you include certain information on the enrollment form about your prior health plan(s). For example, if you are age 65 or older and not eligible for Medicare, you must give *Blue Cross and Blue Shield* proof that you are not eligible for Medicare. *Blue Cross and Blue Shield* may also require that you include a copy of your certificate(s) of health plan coverage. Or, *Blue Cross and Blue Shield* may ask you for other information about your prior health plan(s). During the enrollment process, *Blue Cross and Blue Shield* will check and verify each person's eligibility for coverage in this health plan under an *individual contract*. If you fail to provide information to *Blue Cross and Blue Shield* that it needs to verify your eligibility for an *individual contract*, *Blue Cross and Blue Shield* will deny your enrollment request. The *effective date* for coverage in this health plan under an *individual contract* will be within 30 days after the date *Blue Cross and Blue Shield* receives the completed enrollment application.

This health plan is not a Medicare supplement plan. If you are eligible for Medicare, this health plan can not be issued to you. You should look at the Guide to Health Insurance for People with Medicare. You may be able to sign up for a health plan that is designed to supplement Medicare. To ask for a copy of the Guide, you can call the *Blue Cross and Blue Shield* customer service office. (See Part 1.)

Blue Cross and Blue Shield may deny your enrollment for coverage in this health plan under an *individual contract* for any of the following reasons:

- You fail to provide information to *Blue Cross and Blue Shield* that it needs to verify your eligibility for coverage in this health plan under an *individual contract*.
- You committed misrepresentation or fraud to *Blue Cross and Blue Shield* about your eligibility for coverage in this health plan under an *individual contract*.
- You made at least three or more late payments for your health plan(s) in a 12-month period.

- You voluntarily ended your coverage in this health plan within the past 12 months on a date that is not your renewal date. But, this does not apply if you had creditable coverage (as defined by state law) continuously up to a date not more than 63 days prior to the date of your request for enrollment in this health plan under an *individual contract*.

If your application is denied, *Blue Cross and Blue Shield* will send you a letter that will tell you the specific reason(s) for which they have denied your enrollment for coverage in this health plan under an *individual contract*. This information will be made available, upon request, to the Massachusetts Commissioner of Insurance.

Initial Enrollment for Individual Coverage

To apply for coverage in this health plan as a *subscriber* under an *individual contract*, you must complete an enrollment application. Send your completed application to *Blue Cross and Blue Shield*. You must also send any other documentation or statements that *Blue Cross and Blue Shield* may ask that you send in order for *Blue Cross and Blue Shield* to verify that you are eligible to enroll in this health plan under an *individual contract*. You must make sure that all of the information that you include on these forms is true, correct, and complete. Your right to coverage in this health plan under an *individual contract* is based on the condition that all information that you provide to *Blue Cross and Blue Shield* is true, correct, and complete.

Eligible Individuals Under Age 18. In the event that the eligible individual who is enrolling as a *subscriber* is under the age of 18, the enrollment form must be completed by the parent, guardian, or other person who is acting on behalf of that minor. In this case, the person who is executing the *individual contract* is not eligible for benefits under the *individual contract*. But, he or she will be responsible for acting on behalf of the *subscriber* as necessary and making *premium* payments as described in this *individual contract*. The person who executes the *individual contract* will be considered the *subscriber's* authorized representative.

Available Plans Types. You may enroll in this health plan as a *subscriber* under an *individual contract* in one of the following types of plans:

- A plan that covers only the *subscriber*.
- A plan that covers two adults (the *subscriber* and his or her spouse).
- A plan that covers one adult and one or more children (the *subscriber* and his or her eligible dependents).
- A plan that covers two adults and one or more children (the *subscriber*, his or her spouse, and any eligible dependents).

Newly enrolled *members* will **not** have a waiting period before *Blue Cross and Blue Shield* will provide access to health care services and benefits.

Other Membership Changes

Generally, the *subscriber* may make membership changes (for example, change from a plan that covers only one person to a family plan) only if the *subscriber* has a change in family status. This includes a change such as: marriage or divorce; birth, adoption or change in custody of a child; death of an enrolled spouse or dependent; or the loss of an enrolled dependent's eligibility under the *subscriber's individual contract*. If you want to ask for a membership change or you need to change your name or mailing address, you should call or write to *Blue Cross and Blue Shield*. *Blue Cross and Blue Shield* will send you any special forms that you may need. You must request a membership change within 30 days of the

reason for the change. Or, if the newly eligible person had prior creditable coverage (as defined by state law), the change must be requested within 63 days of the termination date of the prior qualified health care coverage. If you do not request the change within the time required, the change will become effective within 30 days after the date *Blue Cross and Blue Shield* receives your request for the change.

Termination of Individual Coverage

Loss of Eligibility for Individual Coverage

When your eligibility for an *individual contract* ends, your coverage in this health plan under an *individual contract* will be terminated as of the date you lose eligibility. You will lose eligibility for coverage in this health plan under an *individual contract* when any one of the following situations occurs.

- **Your Dependent Status Ends.** Your coverage in this health plan under an *individual contract* will end when you lose your status as an eligible dependent under the *subscriber's individual contract*. In this case, you may wish to enroll as a *subscriber* under an *individual contract*. Or, you may be able to enroll in another *Blue Cross and Blue Shield* health plan or a health plan offered by Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. For help, you can call the *Blue Cross and Blue Shield* customer service office. They will tell you which health plans are available to you.
- **You Move Out of the State.** Your coverage in this health plan under an *individual contract* will end when you move permanently out of Massachusetts. In this case, you may be able to enroll in another Blue Cross and/or Blue Shield Plan's health plan. For help, you can call the *Blue Cross and Blue Shield* customer service office. They will help you with your options.

Termination of Individual Coverage by the Subscriber

Your coverage in this health plan under an *individual contract* will end when any one of the following situations occurs.

- **Subscriber Terminates Coverage.** The *subscriber* may cancel coverage in this health plan under an *individual contract* at any time and for any reason. To do this, the *subscriber* must send a written request to *Blue Cross and Blue Shield*. The termination date will be effective 15 days after the date that *Blue Cross and Blue Shield* receives the termination request. Or, the *subscriber* may ask for a specific termination date. In this case, *Blue Cross and Blue Shield* must receive the request at least 15 days before that requested termination date. *Blue Cross and Blue Shield* will return to the *subscriber* any *premiums* that are paid for a time after the termination date.
- **Subscriber Fails to Pay Premiums.** Your coverage in this health plan under an *individual contract* will be terminated when the *subscriber* fails to pay his or her *premium* to *Blue Cross and Blue Shield* within 35 days after it is due (or 60 days for *premium* due before December 1, 2009). If *Blue Cross and Blue Shield* does not get the full *premium* on or before the due date, *Blue Cross and Blue Shield* will stop claim payments as of the last date through which the *premium* is paid. Then, if *Blue Cross and Blue Shield* does not get the full *premium* within this required time period, *Blue Cross and Blue Shield* will cancel your coverage in this health plan under an *individual contract*. The termination date will be the last date through which the *premium* is paid.

Termination of Individual Coverage by Blue Cross and Blue Shield

Your coverage in this health plan under an *individual contract* will not be canceled because you are using your coverage or because you will need more *covered services* in the future. In the event that *Blue Cross and Blue Shield* cancels your coverage in this health plan under an *individual contract*, a notice will be sent to you that will tell you the specific reason(s) that *Blue Cross and Blue Shield* is canceling your *individual contract*. *Blue Cross and Blue Shield* will cancel your coverage in this health plan under an *individual contract* **only when** one of the following situations occurs.

- **You Commit Misrepresentation or Fraud to Blue Cross and Blue Shield.** Your coverage in this health plan will be canceled if you have committed misrepresentation or fraud to *Blue Cross and Blue Shield*. For example, you gave false or misleading information on the enrollment form. Or, you misused your ID card by letting another person who was not enrolled in this health plan attempt to get coverage. In this case, the termination of your coverage will go back to your *effective date*. Or, it may go back to the date of the misrepresentation or fraud. The termination date will be determined by *Blue Cross and Blue Shield*. Or, in some cases *Blue Cross and Blue Shield* may limit your benefits.
- **You Commit Acts of Physical or Verbal Abuse.** Your coverage in this health plan will be canceled if you commit acts of physical or verbal abuse that pose a threat to health care providers or to other *members* of *Blue Cross and Blue Shield* or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc., and these acts are not related to your physical condition or *mental condition*. In this case, this termination will follow the procedures that have been approved by the Massachusetts Commissioner of Insurance.
- **You Fail to Comply With Plan Provisions.** Your coverage in this health plan will be canceled if you fail to comply in a material way with any provision of the *individual contract*. For example, if you fail to provide information that *Blue Cross and Blue Shield* requests related to your coverage in this health plan, *Blue Cross and Blue Shield* may terminate your coverage.
- **This Health Plan Is Discontinued.** Your coverage in this health plan will be canceled if *Blue Cross and Blue Shield* discontinues this health plan. *Blue Cross and Blue Shield* may discontinue this health plan for any reason as of a date approved by the Massachusetts Commissioner of Insurance.

Medicare Program

When you are eligible for Medicare and Medicare is allowed by federal law to be the primary payor, the coverage provided by this health plan will be reduced by the amount of benefits allowed under Medicare for the same *covered services*. This reduction will be made whether or not you actually receive the benefits from Medicare.

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Schedule of Benefits

Blue Care[®] Elect Student Health Plan Blue Care Elect Preferred Plan Option

This is the *Schedule of Benefits* that is a part of your Subscriber Certificate. This chart describes the cost share amounts that you must pay for *covered services*. It also shows the *benefit limits* that apply for *covered services*. Do not rely on this chart alone. Be sure to read all parts of your Subscriber Certificate to understand the requirements that you must follow to receive all of your coverage. You should also read the descriptions of *covered services* and the limitations and exclusions that apply for this coverage. These provisions are fully described in your Subscriber Certificate. To be sure that you receive in-network benefits, you must obtain all of your health care services and supplies from *covered providers* who participate in your PPO network. If you obtain *covered services* from a *covered provider* who does not participate in your PPO network, you will usually receive out-of-network benefits. Also, when it is required for coverage, you must receive an approval from *Blue Cross and Blue Shield* as outlined in your Subscriber Certificate. (See Part 4 in your Subscriber Certificate.) If an approval is required, you should make sure that you have received the approval from *Blue Cross and Blue Shield* before you receive the *covered services*. Otherwise, you may have to pay all costs.

IMPORTANT NOTE: *Blue Cross and Blue Shield* and/or your *group* may change the provisions described in this *Schedule of Benefits*. If this is the case, the change is described in a *rider*. Be sure to read each *rider* (if there is any) that applies to your coverage in this health plan to see if it changes this *Schedule of Benefits*.

Overall Member Cost Share Provisions	In-Network Benefits	Out-of-Network Benefits
Deductible	None	None
Out-of-Pocket Maximum Your <i>out-of-pocket maximum</i> per Plan Year is: The <i>out-of-pocket maximum</i> is a total of your <i>coinsurance</i> only, excluding costs for prescription drugs and supplies. You will still have to pay any costs not included in this <i>out-of-pocket maximum</i> .	None	\$1,000 per member; \$2,000 per family
	The family <i>out-of-pocket maximum</i> can be met by eligible costs incurred by any combination of <i>members</i> enrolled under the same family plan. But, no one <i>member</i> will have to pay more than the per <i>member out-of-pocket maximum</i> .	
Overall Benefit Maximum	None	None

Note: This coverage also includes benefits for Christian Science services that are furnished by a Christian Science sanatorium, practitioner, or nurse to the same extent that in-network benefits are provided for similar services when they are furnished by a preferred hospital, physician, or nurse practitioner.

WORDS IN ITALICS ARE EXPLAINED IN PART 2 OF YOUR SUBSCRIBER CERTIFICATE.

Blue Care Elect Preferred Plan Option

Covered Services		In-Network Benefits	Out-of-Network Benefits
		Your Cost is:	Your Cost* is:
Admissions for Inpatient Medical and Surgical Care	• In a General Hospital	Nothing	20% <i>coinsurance</i>
	• In a Chronic Disease Hospital	Nothing	20% <i>coinsurance</i>
	• In a Rehabilitation Hospital (60-day <i>benefit limit</i> per member per calendar year)	Nothing up to <i>benefit limit</i> ; then, you pay all costs	20% <i>coinsurance</i> up to <i>benefit limit</i> ; then, you pay all costs
	• In a Skilled Nursing Facility (100-day <i>benefit limit</i> per member per calendar year)	Nothing up to <i>benefit limit</i> ; then, you pay all costs	20% <i>coinsurance</i> up to <i>benefit limit</i> ; then, you pay all costs
Ambulance Services (ground or air ambulance transport)	• Emergency ambulance	Nothing	Nothing
	• Other ambulance	Nothing	20% <i>coinsurance</i>
Cardiac Rehabilitation	<i>Outpatient</i> services	\$20 <i>copayment</i> per visit	20% <i>coinsurance</i>
Chiropractor Services (for members of any age)	• <i>Outpatient</i> lab tests and x-rays	Nothing	20% <i>coinsurance</i>
	• <i>Outpatient</i> medical care services, including spinal manipulation	\$20 <i>copayment</i> per visit	20% <i>coinsurance</i>
Dialysis Services	<i>Outpatient</i> services and home dialysis	Nothing	20% <i>coinsurance</i>
Durable Medical Equipment	Purchased or rented for home use (\$1,500 <i>benefit limit</i> per member per calendar year)	Nothing up to <i>benefit limit</i> ; then, you pay all costs	20% <i>coinsurance</i> up to <i>benefit limit</i> ; then, you pay all costs
		The <i>benefit limit</i> does not apply when furnished as part of covered home dialysis, home health care, or hospice services.	
Early Intervention Services	(for an eligible child through age two)	\$20 <i>copayment</i> per visit	20% <i>coinsurance</i>
Emergency Medical Outpatient Services	• Emergency room services	\$50 <i>copayment</i> per visit	\$50 <i>copayment</i> per visit
		The emergency room <i>copayment</i> is waived if the visit results in your being held for an overnight observation stay or being admitted for <i>inpatient</i> care within 24 hours.	
	• Office, health center, and hospital services	\$20 <i>copayment</i> per visit	20% <i>coinsurance</i>
		In-network benefits are provided for <i>emergency medical care</i> furnished by a covered out-of-network provider when an in-network provider is not reasonably available.	
Home Health Care	Home care program	Nothing	20% <i>coinsurance</i>

*In some cases for out-of-network benefits, you may also have to pay any balance that is in excess of *Blue Cross and Blue Shield's allowed charge*. Refer to the explanation of *allowed charge* in your Subscriber Certificate.

WORDS IN ITALICS ARE EXPLAINED IN PART 2 OF YOUR SUBSCRIBER CERTIFICATE.

Blue Care Elect Preferred Plan Option

Covered Services		In-Network Benefits	Out-of-Network Benefits
		Your Cost is:	Your Cost* is:
Hospice Services	<i>Inpatient</i> or <i>outpatient</i> hospice services for terminally ill	Nothing	20% <i>coinsurance</i>
Infertility Services	• <i>Inpatient</i> services	Nothing	20% <i>coinsurance</i>
	• <i>Outpatient</i> surgical services	\$20 <i>copayment</i> per office or health center visit or nothing for surgical day care unit, ambulatory surgical facility, or hospital day surgery services	20% <i>coinsurance</i>
	• <i>Outpatient</i> lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests	20% <i>coinsurance</i>
	• <i>Outpatient</i> medical care services	\$20 <i>copayment</i> per visit	20% <i>coinsurance</i>
Lab Tests, X-Rays, and Other Tests (diagnostic services)	• <i>Outpatient</i> lab tests	Nothing	20% <i>coinsurance</i>
	• <i>Outpatient</i> CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	\$50 <i>copayment</i> per category of test per service date (<i>copayment</i> does not apply to interpretation costs)	20% <i>coinsurance</i>
	• Other <i>outpatient</i> tests and preoperative tests	Nothing	20% <i>coinsurance</i>
Maternity Services and Well Newborn Inpatient Care (includes \$90/\$45 for childbirth classes)	• Maternity services (includes delivery, prenatal care, and postnatal care)	Nothing	20% <i>coinsurance</i>
	• Well newborn care during enrolled mother's maternity admission	Nothing	20% <i>coinsurance</i>
Medical Care Outpatient Visits (includes syringes and needles dispensed during a visit)	• Office, health center, and hospital services	\$20 <i>copayment</i> per visit	20% <i>coinsurance</i>
Medical Formulas (includes certain medical formulas and low protein foods)	\$5,000 <i>benefit limit</i> per <i>member</i> per calendar year for low protein foods	Nothing for <i>covered services</i> ; otherwise, you pay all costs	Nothing for <i>covered services</i> ; otherwise, you pay all costs

*In some cases for out-of-network benefits, you may also have to pay any balance that is in excess of *Blue Cross and Blue Shield's allowed charge*. Refer to the explanation of *allowed charge* in your Subscriber Certificate.

WORDS IN ITALICS ARE EXPLAINED IN PART 2 OF YOUR SUBSCRIBER CERTIFICATE.

Blue Care Elect Preferred Plan Option

Covered Services		In-Network Benefits	Out-of-Network Benefits
		Your Cost is:	Your Cost* is:
Mental Health and Substance Abuse Treatment Refer to your Subscriber Certificate for more about biologically-based and non-biologically-based <i>mental conditions</i> .	<ul style="list-style-type: none"> <i>Inpatient</i> admissions in a General Hospital or Substance Abuse Facility 	Nothing	20% <i>coinsurance</i>
	<ul style="list-style-type: none"> <i>Inpatient</i> admissions in a Mental Hospital (a day <i>benefit limit</i> may apply) 	Nothing up to <i>benefit limit</i> (if any); then, you pay all costs	20% <i>coinsurance</i> up to <i>benefit limit</i> (if any); then, you pay all costs
	<ul style="list-style-type: none"> <i>Outpatient</i> services (a visit <i>benefit limit</i> may apply) 	\$20 <i>copayment</i> per visit up to <i>benefit limit</i> (if any); then, you pay all costs	20% <i>coinsurance</i> up to <i>benefit limit</i> (if any); then, you pay all costs
	For non-biologically-based <i>mental conditions</i> (other than rape-related mental or emotional conditions and all conditions for enrolled children under age 19), a 60-day <i>inpatient benefit limit</i> and a 24-visit <i>outpatient benefit limit</i> per member per calendar year applies.		
Oxygen and Respiratory Therapy	<ul style="list-style-type: none"> Oxygen and equipment for its administration 	Nothing	20% <i>coinsurance</i>
	<ul style="list-style-type: none"> <i>Outpatient</i> respiratory therapy 	\$20 <i>copayment</i> per visit	20% <i>coinsurance</i>
Podiatry Care	<ul style="list-style-type: none"> <i>Outpatient</i> lab tests and x-rays 	See Lab Tests, X-Rays, and Other Tests	20% <i>coinsurance</i>
	<ul style="list-style-type: none"> <i>Outpatient</i> surgical services 	\$20 <i>copayment</i> per office or health center visit or nothing for surgical day care unit, ambulatory surgical facility, or hospital day surgery services	20% <i>coinsurance</i>
	<ul style="list-style-type: none"> <i>Outpatient</i> medical care services 	\$20 <i>copayment</i> per visit	20% <i>coinsurance</i>
Prescription Drugs and Supplies	Not covered	You pay all costs	You pay all costs
Preventive Health Services \$150 Fitness Benefit \$150 Weight Loss Program Benefit Refer to your Subscriber Certificate for a complete description of <i>covered services</i> .	<ul style="list-style-type: none"> Routine pediatric care (10 visits first year of life, 3 visits second year of life, and once per calendar year from age 2-18) 	\$20 <i>copayment</i> per visit (nothing for routine tests) for <i>covered services</i> ; otherwise, you pay all costs	20% <i>coinsurance</i> for <i>covered services</i> ; otherwise, you pay all costs
		These <i>covered services</i> include (but are not limited to): routine exams for age-based schedule; immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning.	
	<ul style="list-style-type: none"> Routine adult exams and tests (once per calendar year for a member age 19 or older) 	\$20 <i>copayment</i> per visit (nothing for routine tests) for <i>covered services</i> ; otherwise, you pay all costs	20% <i>coinsurance</i> for <i>covered services</i> ; otherwise, you pay all costs
		These <i>covered services</i> include (but are not limited to): routine exams and related routine lab tests and x-rays during a covered visit; immunizations; routine mammograms once between age 35 through 39 and once per calendar year for a member age 40 or older; and blood tests to screen for lead poisoning.	

*In some cases for out-of-network benefits, you may also have to pay any balance that is in excess of *Blue Cross and Blue Shield's allowed charge*. Refer to the explanation of *allowed charge* in your Subscriber Certificate.

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Blue Care Elect Preferred Plan Option

Covered Services		In-Network Benefits	Out-of-Network Benefits
		Your Cost is:	Your Cost* is:
Preventive Health Services (continued)	• Routine GYN exams (once per member per calendar year)	\$20 <i>copayment</i> per covered visit (nothing for routine lab tests); otherwise you pay all costs	20% <i>coinsurance</i> for covered services; otherwise, you pay all costs
	These <i>covered services</i> include a routine Pap smear test once per member per calendar year.		
	• Family planning	\$20 <i>copayment</i> per visit	20% <i>coinsurance</i>
	• Routine hearing exams and tests (includes newborn hearing screening)	\$20 <i>copayment</i> per visit (nothing for routine tests)	20% <i>coinsurance</i>
	• Routine vision exams (one exam per member every 24 months)	\$20 <i>copayment</i> per visit per covered exam; otherwise, you pay all costs	20% <i>coinsurance</i> for covered exams; otherwise, you pay all costs
Prosthetic Devices	• Ostomy supplies	Nothing	20% <i>coinsurance</i>
	• Artificial limb devices (includes repairs)	Nothing	20% <i>coinsurance</i>
	• Other external prosthetic devices	Nothing	20% <i>coinsurance</i>
Radiation Therapy and Chemotherapy	<i>Outpatient</i> services	Nothing	20% <i>coinsurance</i>
Second Opinions	<i>Outpatient</i> second and third surgical opinions	\$20 <i>copayment</i> per visit	20% <i>coinsurance</i>
Short-Term Rehabilitation Therapy	<i>Outpatient</i> physical and occupational therapy (100-visit <i>benefit limit</i> per member per calendar year)	\$20 <i>copayment</i> per visit up to <i>benefit limit</i> ; then, you pay all costs	20% <i>coinsurance</i> up to <i>benefit limit</i> ; then, you pay all costs
Speech, Hearing, and Language Disorder Treatment	• <i>Outpatient</i> diagnostic tests	See Lab Tests, X-Rays, and Other Tests	20% <i>coinsurance</i>
	• <i>Outpatient</i> speech therapy	\$20 <i>copayment</i> per visit	20% <i>coinsurance</i>
	• <i>Outpatient</i> medical care services	\$20 <i>copayment</i> per visit	20% <i>coinsurance</i>
Surgery as an Outpatient (excludes removal of impacted teeth whether or not the teeth are imbedded in the bone)	• Surgical day care unit of hospital, ambulatory surgical facility, and hospital day surgery services	Nothing	20% <i>coinsurance</i>
	• Office and health center services	\$20 <i>copayment</i> per visit	20% <i>coinsurance</i>

*In some cases for out-of-network benefits, you may also have to pay any balance that is in excess of *Blue Cross and Blue Shield's allowed charge*. Refer to the explanation of *allowed charge* in your Subscriber Certificate.

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Blue Care Elect Preferred Plan Option

Covered Services		In-Network Benefits	Out-of-Network Benefits
		Your Cost is:	Your Cost* is:
TMJ Disorder Treatment	• <i>Outpatient</i> x-rays	See Lab Tests, X-Rays, and Other Tests	20% <i>coinsurance</i>
	• <i>Outpatient</i> surgical services	\$20 <i>copayment</i> per office or health center visit or nothing for surgical day care unit, ambulatory surgical facility, or hospital day surgery services	20% <i>coinsurance</i>
	• <i>Outpatient</i> physical therapy (short-term rehabilitation therapy limits apply)	\$20 <i>copayment</i> per visit up to <i>benefit limit</i> ; then, you pay all costs	20% <i>coinsurance</i> up to <i>benefit limit</i> ; then, you pay all costs
	• <i>Outpatient</i> medical care services	\$20 <i>copayment</i> per visit	20% <i>coinsurance</i>

*In some cases for out-of-network benefits, you may also have to pay any balance that is in excess of *Blue Cross and Blue Shield's allowed charge*. Refer to the explanation of *allowed charge* in your Subscriber Certificate.

WORDS IN ITALICS ARE EXPLAINED IN PART 2 OF YOUR SUBSCRIBER CERTIFICATE.

Student Health Plan

You are enrolled in a qualified Student Health Plan. This qualified Student Health Plan is sponsored by the institution of higher education (the *group*) that has entered into an agreement with Blue Cross and Blue Shield of Massachusetts, Inc. to provide health care benefits to eligible students and, when dependents are eligible to enroll in the Student Health Plan, their eligible dependents. (In this case, your *plan sponsor* is the institution of higher education.) Parts 11 and 12 of your *Blue Cross and Blue Shield* Subscriber Certificate are replaced in their entirety by the following sections.

Eligibility and Enrollment for Student Health Plan Coverage

Eligible Student

You are eligible for coverage under this qualified Student Health Plan as long as you are a student enrolled in a certificate, diploma, or degree-granting program through the *group* and you are either:

- A full-time student who meets the minimum academic requirements for full-time students set by the *group*; or
- A part-time student who participates in at least 75% of the academic requirements for full-time students.

An eligible student will be automatically enrolled in this qualified Student Health Plan by the *group*. The *group* may allow an eligible student to waive enrollment in this qualified Student Health Plan if he or she has coverage in another health plan that is comparable to the coverage that is required by law for a qualified Student Health Plan. For enrollment information or details about waiving coverage in this qualified Student Health Plan, you must contact the *group*. (You must also contact the *group* if you require information about partial year student enrollment.)

For coverage in this qualified Student Health Plan, the *group* will include the enrolled student's total *premium* amount in the student's tuition bill. Then each month, the *group* will pay the monthly *premium* amount to Blue Cross and Blue Shield of Massachusetts, Inc. for your coverage in this qualified Student Health Plan. Except for a medical withdrawal due to an illness or injury, if a student withdraws from school during the first 31 days of the period for which coverage was purchased, the student will not be covered in this qualified Student Health Plan, and the *group* will refund the *premium* payment in full. Enrolled students who withdraw from school after that first 31 days will remain enrolled in this qualified Student Health Plan for the full period for which the *premium* was paid, and no refund of *premium* will be made by the *group*. There is one exception. In the event that an enrolled student enters the armed forces of any country, coverage in this qualified Student Health Plan will end as of the date of entry. In this case, the *group* will make a pro rata *premium* refund as long as it receives a written request for the refund within 90 days of the student's withdrawal from school. For more information about your *premium* or if you would like to request the *group's* written policy regarding *premium* refunds, you must contact the *group*.

WORDS IN ITALICS ARE EXPLAINED IN PART 2 OF YOUR SUBSCRIBER CERTIFICATE.

Eligible Spouse

An eligible student who is enrolled in this qualified Student Health Plan may enroll an eligible spouse for coverage under his or her Student Health Plan membership, subject to the *group's* eligibility requirements. If a spouse is eligible to enroll, an “eligible spouse” includes the enrolled student’s legal spouse. (A legal civil union spouse, where applicable, is eligible to enroll under the student’s qualified Student Health Plan membership to the extent that a legal civil union spouse is determined eligible by the *group*.)

Former Spouse. In the event of a divorce or a legal separation, the person who was the spouse of the enrolled student prior to the divorce or legal separation will remain eligible for coverage under the enrolled student’s Student Health Plan membership, whether or not the judgment was entered prior to the *effective date* of this qualified Student Health Plan membership. This coverage is provided with no additional *premium*. The former spouse will remain eligible for this coverage **only** until the enrolled student is no longer required by the judgment to provide health insurance for the former spouse or the enrolled student or former spouse remarries, whichever comes first. (In these situations, Blue Cross and Blue Shield of Massachusetts, Inc. must be notified within 30 days of a change to the enrolled student’s former spouse’s address. Otherwise, Blue Cross and Blue Shield of Massachusetts, Inc. will not be liable for any acts or omissions due to having the enrolled student’s former spouse’s incorrect address on file.) If the enrolled student remarries, the former spouse may continue coverage under a separate qualified Student Health Plan membership with the *group*, provided the divorce judgment requires that the enrolled student provide health insurance for his or her former spouse. This is true even if the enrolled student’s new spouse is not enrolled under his or her qualified Student Health Plan membership.

Eligible Dependents

An eligible student who is enrolled in this qualified Student Health Plan may enroll eligible dependents for coverage under his or her Student Health Plan membership, subject to the *group's* eligibility requirements. If a dependent child is eligible to enroll, “eligible dependents” include the enrolled student’s dependents that are age 25 or under, provided that they have status as a dependent under the Internal Revenue Code. When a dependent loses his or her dependent status under the Internal Revenue Code, that dependent will continue to be eligible as a dependent for coverage under the enrolled student’s qualified Student Health Plan membership for two years following the loss of the dependent status under the Internal Revenue Code or until the dependent turns age 26, whichever comes first.

These eligible dependents may include:

- A newborn child. The *effective date* of coverage for a newborn child will be the child’s date of birth provided that the enrolled student formally notifies the *group* within 30 days of the date of birth. (A claim for the enrolled mother’s maternity admission may be considered to be this notice when the enrolled student’s coverage is a family plan.) This qualified Student Health Plan provides coverage for newborn infants for injury and sickness. This includes the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities and premature birth. The coverage for these services is subject to all of the provisions of this qualified Student Health Plan.
- An adopted child. The *effective date* of coverage for an adopted child will be the date of placement with the enrolled student for the purpose of adoption. The *effective date* of coverage for an adoptive child who has been living with the enrolled student and for whom the enrolled student has been getting foster care payments will be the date the petition to adopt is filed. If the enrolled student is enrolled under a family plan as of the date he or she assumes custody of a child for the purpose of adoption, the child’s health care services for injury or sickness will be covered from the date of custody. (This coverage is provided without a waiting period or pre-existing condition restriction.) This includes the necessary care and treatment of medically diagnosed congenital defects, birth

Student Health Plan (continued)

abnormalities and premature birth. The coverage for these services is subject to all of the provisions of this qualified Student Health Plan.

An “eligible dependent” also includes the following dependent children **who do not otherwise qualify as an eligible dependent as described above:**

- A child who is recognized under a Qualified Medical Child Support Order as having the right to enroll for health care coverage.
- An unmarried full-time student dependent child age 24 or under who lives with the enrolled student or the spouse on a regular basis and who does not otherwise qualify as an eligible dependent as described above in this section. In this case, the enrolled student must give written verification to Blue Cross and Blue Shield of Massachusetts, Inc. that the child is a full-time student at an accredited educational institution. This coverage ends when the student dependent turns age 25 or marries or on November 1st after the date the student dependent discontinues full-time classes or graduates, whichever comes first.
- A disabled dependent child who does not otherwise qualify as an eligible dependent as described above in this section. A dependent child who is mentally or physically incapable of earning his or her own living and who is enrolled under the enrolled student’s qualified Student Health Plan membership will continue to be covered after he or she would otherwise lose dependent eligibility as described above, so long as the child continues to be mentally or physically incapable of earning his or her own living. In this case, the enrolled student must make arrangements through the *group* not more than 30 days after the date the child would normally lose eligibility. Also, Blue Cross and Blue Shield of Massachusetts, Inc. must be given any medical or other information that it may need to determine if the child can maintain coverage under the enrolled student’s qualified Student Health Plan. From time to time, reviews may be conducted that will require a statement from the attending physician. This is to confirm that the child is still an eligible disabled dependent child.
- A newborn infant of an enrolled dependent immediately from the moment of birth and continuing after, until the enrolled dependent is no longer eligible as a dependent.

**Important
Reminder:**

The eligibility provisions for dependents that are described in this section may differ from the federal tax laws that define who may qualify as a dependent.

Membership Changes

Generally, the enrolled student may make membership changes (for example, change from an individual plan to a family plan) only if he or she has a change in family status. This includes a change such as: marriage or divorce; birth, adoption or change in custody of a child; death of an enrolled spouse or dependent; or the loss of an enrolled dependent’s eligibility under the enrolled student’s qualified Student Health Plan membership. If you want to ask for a change or you need to change your name or mailing address, you should call or write to the *group*. The *group* will send you any special forms you may need. You must request the change within the time period required by the enrolled student’s *group* to make a change. If you do not make the change within the required time period, you will have to wait until the *group*’s next open enrollment period to make the change. All changes are allowed only when they comply with the enrollment rules set by the *group*. They must also comply with the conditions outlined in this qualified Student Health Plan.

WORDS IN ITALICS ARE EXPLAINED IN PART 2 OF YOUR SUBSCRIBER CERTIFICATE.

Termination of Student Health Plan Coverage

You will lose eligibility for coverage in this qualified Student Health Plan when you are no longer an “eligible student” as determined by the *group*. In the event that a spouse and/or dependents are enrolled under the student’s Student Health Plan, they will lose coverage when the enrolled student is no longer eligible for coverage in this qualified Student Health Plan. If you are enrolled as a dependent of an enrolled student, your coverage in this qualified Student Health Plan will end when your eligibility as the enrolled student’s dependent ends. If you are enrolled as a spouse or dependent of an enrolled student, your coverage will end in the event that the enrolled student dies.

Whether you are the enrolled student or you are the enrolled student’s spouse or dependent, your coverage in this qualified Student Health Plan will end when:

- The *group* fails to pay your *premium* for your coverage in this qualified Student Health Plan to Blue Cross and Blue Shield of Massachusetts, Inc. within 30 days of the due date.
- The *group* terminates (or does not renew) its agreement for this qualified Student Health Plan with Blue Cross and Blue Shield of Massachusetts, Inc.
- You committed misrepresentation or fraud to Blue Cross and Blue Shield of Massachusetts, Inc. For example, you misused the qualified Student Health Plan identification card by letting another person not enrolled under this Student Health Plan attempt to get coverage. Termination will go back to your *effective date*. Or, it will go back to the date of the misrepresentation or fraud, as determined by Blue Cross and Blue Shield of Massachusetts, Inc.
- You commit acts of physical or verbal abuse that pose a threat to covered health care providers or other members and that are not related to your physical condition or mental condition. This termination will follow procedures approved by the Massachusetts Commissioner of Insurance.

Coordination of Benefits (COB)

The benefits that are available under this qualified Student Health Plan are secondary to or in excess of the benefits provided by any other plan(s). This means that when you are covered under other hospital, medical, dental, health or other plans, the benefits provided by this qualified Student Health Plan will be reduced by the benefits provided by those plan(s). All other COB provisions remain as described in your Subscriber Certificate.

Medicare Program

Generally, the benefits that are available under this qualified Student Health Plan are secondary to or in excess of the benefits provided by Medicare. This means that when you are eligible for Medicare and Medicare is allowed by federal law to be the primary payor, the coverage provided by this qualified Student Health Plan will be reduced by the amount of benefits allowed under Medicare for the same *covered services*. This reduction will be made whether or not you actually receive the benefits from Medicare.