Date: 04/30/2010

To: WHEELOCK COLLEGE STUDENTS

Documents Provided: Subscriber Certificate(s) and Riders as of 04/30/2010

Attached are the Blue Cross Blue Shield of Massachusetts Subscriber Certificate(s) and associated riders for your health plan. While the Subscriber Certificate(s) and riders provide complete and detailed benefit information, they may not include information that you, as the sponsor of a group health plan, may need to comply with your statutory or regulatory notice obligations under ERISA or other applicable law. For example, these documents may not include all the information required under ERISA to be in a "summary plan description". In addition, these documents do not constitute a complete Evidence of Coverage as defined under Massachusetts state law and regulations.

Blue Cross and Blue Shield of Massachusetts, Inc. or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. administers your health plan benefits in accordance with the terms contained in this Subscriber Certificate(s) and associated riders. In the event of a dispute between any description prepared by you and the Subscriber Certificate(s) and associated riders, this Subscriber Certificate(s) and associated riders will govern.

The Subscriber Certificate(s) and associated riders are accurate as of 04/30/2010.

As you use this information, please keep in mind that Blue Cross and Blue Shield of Massachusetts, Inc. has a copyright on these documents. In addition, the use of these documents is for your plan administration purposes only. Please do not pass these documents on to any other person or entity for any other purpose unless authorized by Blue Cross and Blue Shield of Massachusetts, Inc. or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

Blue Care® Elect

PREFERRED

Subscriber Certificate

Welcome to Blue Care Elect

We are very pleased that you've selected a Blue Cross and Blue Shield plan. This document 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 this contract, 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 និងបកប្រែផ្ដាល់មាត់

សេវាផ្នែកបកប្រែភាសាអាចមានផ្ដល់ជូនកាលណាអ្នកទូរស័ព្ទមកការិយាល័យផ្នែកសេវាបំរើអតិថិជនរបស់ Blue Cross and Blue Shield តាមលេខទូរស័ព្ទឥតបង់ថ្លៃដែលមាននៅក្នុងអត្តសញ្ញាណប័ណ្ណផែនការសុខភាពរបស់អ្នក ។ សេវានេះផ្ដល់ឲ្យអ្នកទូរលទ្ធភាពទាក់ទងដល់ក្រុមអ្នកបកប្រែភាសាជាច្រើនដែលមានលទ្ធភាពបកប្រែភាសាលើសពី ១៤០ ភាសាទៅទៀត ។ បើអ្នកត្រូវការសេវាផ្នែកបកប្រែភាសាទាំងនេះ គ្រាន់តែប្រាប់អ្នកតំណាងផ្នែកសេវាអតិថិជនកាលណាអ្នកទូរស័ព្ទមក ។ នៅពេលដែល អ្នកទូរស័ព្ទមក Blue Cross and Blue Shield នឹងប្រើបណ្ដាញសេវាភាសា ដើម្បីរកអ្នកបកប្រែណា ម្នាក់ដែលគេនឹងជួយឆ្លើយសំនួររបស់អ្នក ឬជួយអ្នកឲ្យយល់អំពីទម្រង់ការរបស់ក្រុមហ៊ុន Blue Cross and Blue Shield ។ (អ្នកបកប្រែនេះមនមែនជានយោជក ឬអ្នកចាតតាំងរបស់ 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 σάς 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 بمترجمين 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 بالمترجم 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).

ຫ້ອງການຊ່ວຍ ບໍຣິການດ້ານແປພາສາ

ມີບາຍພາສາຈະຊ່ວຍທ່ານໄດ້ ເມື່ອໂທລະສັບໄປຫາ ຫ້ອງການຊ່ວຍລູກຄ້າ ຂອງ Blue Cross and Blue Shield ທີ່ມີໂທລະສັບໂທຟີ ຢູ່ໃນບັດສຸກຂະພາບຂອງທ່ານ. ໃນ ຫ້ອງການບໍຣິການນີ້ມີນາຍພາສາ ທີ່ສາມາດແປຫລາຍກ່ວ່າ 140 ພາສາໃຫ້ທ່ານ. ຫາກທ່ານຕ້ອງການ ບໍຣິການນີ້, ບອກໃຫ້ຜູ້ຕາງໜ້າຊ່ວຍລູກຄ້າ ເມື່ອທ່ານໂທໄປ. ໃນຍາມທ່ານໂທໄປຫາ , Blue Cross and Blue Shield ຈະໃຊ້ ສາຍໂທລະສັບສາຍນຶ່ງ ຫານາຍພາສາ ທີ່ຈະຊ່ວຍທ່ານຕອບຄຳຖາມຫລື ຊ່ວຍ ທ່ານໃຫ້ເຂົ້າໃຈການແນ່ນຳຂອງ Blue Cross and Blue Shield. (ນາຍພາສາ ຜູ້ນີ້ບໍ່ແມ່ນ ພະນັກງານ ຫລືຜູ້ແນ່ນຳຂອງ Blue Cross and Blue Shield.)

Servicio de Traducción e Interpretatión

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

Blue Cross and Blue Shield certifies that you have the right to benefits according to the terms of this Blue Care Elect PPO *contract*. This Blue Care Elect PPO *contract* is a prepaid ("insured") group preferred provider organization (PPO) plan contract between the *subscriber's group* and Blue Cross and Blue Shield of Massachusetts, Inc. (*Blue Cross and Blue Shield*) to provide health care benefits to participants of the group health plan sponsored by the *subscriber's group*. *Blue Cross and Blue Shield* will provide the benefits that are described in this PPO *contract* as long as you are enrolled under this PPO *contract* when you receive *covered services* and the *premium* that your *group* owes for these benefits has been paid to *Blue Cross and Blue Shield*.

This Blue Care Elect Subscriber Certificate is part of the *contract* between the *subscriber's group* and Blue Cross and Blue Shield of Massachusetts, Inc., located at Landmark Center, 401 Park Drive, Boston, Massachusetts 02215-3326, to provide benefits to you (the *member*). It explains your benefits and the terms of your membership under this PPO *contract*. You should read your PPO *contract* to familiarize yourself with the main provisions and keep it handy for reference. The words in italics have special meanings and are described in Part 2.

Your *group* or *Blue Cross and Blue Shield* may change the benefits described in your PPO *contract*. If this is the case, the change is described in a *rider*. Your *group* or *Blue Cross and Blue Shield* can supply you with any *riders* that apply to your benefits under your PPO *contract*. Please keep any *riders* with your PPO *contract* for easy reference.

Blue Care Elect is a preferred provider health care plan. This means that **you** determine the amount of your benefits each time you obtain a health care service. You will receive the highest level of benefits provided under your PPO *contract* when you use providers in the Blue Care Elect preferred network. These are called your "in-network benefits." When you obtain services from a non-*preferred provider*, you will usually receive a lower level of benefits. If this is the case, your out-of-pocket costs will be more. These are called your "out-of-network benefits." *Blue Cross and Blue Shield* can help you make informed choices about your health care options. Through the *utilization review* program, *Blue Cross and Blue Shield*, working with your health care provider, helps you make certain you receive benefits for the health care setting that best suits your condition. See Part 4 for information about these requirements.

Before using your benefits, you should remember there are limitations or exclusions. Be sure to read the limitations and exclusions on your benefits that are described in Parts 4, 5, 6 and 7.

Important Note:	In this PPO *contract*, the term "you" refers to any *member* who has the right to the coverage provided under this PPO *contract*—the *subscriber* or the enrolled spouse or any other enrolled dependent.

Blue Care Elect Preferred

Schedule of Benefits

This is your PPO Schedule of Benefits. This chart describes the amounts that you must pay for *covered services* and any *benefit limits* that may apply to specific services or supplies. **Do not rely on this chart alone. Be sure to read all of your PPO *contract* for the requirements you must follow to receive coverage, the explanations of *covered services* and the limitations and exclusions for benefits under this PPO *contract*.**

Blue Care Elect is a preferred provider plan. This means that you determine the amount of your benefits. You do this each time you obtain a health care service. You will receive the highest *benefit level* when you use providers in your preferred network. These are called your "in-network benefits." When you obtain *covered services* from a non-*preferred provider*, you will usually receive a lower *benefit level*. If this is the case, your costs will be more. These are called your "out-of-network benefits." **For certain *covered services* such as for a proposed *inpatient* stay, you (or the provider on your behalf) must obtain prior approval from *Blue Cross and Blue Shield*. You must do this to be sure that you receive all your benefits.** (See Part 4 for more information.)

Note: Your *group* or *Blue Cross and Blue Shield* may change these benefits. If this is the case, the change is described in a *rider*. Your *plan sponsor* or *Blue Cross and Blue Shield* can supply you with any *riders* that apply to your coverage under this PPO *contract*. Please keep any *riders* with your PPO *contract* for easy reference.

Overall *Member* Cost-Share Provisions:		**In-Network:**	**Out-of-Network:**
Annual *Deductible*		None	$250 per *member* ($500 per family) per calendar year
Annual *Out of-Pocket Maximum* (includes *coinsurance* only)		None	$1,000 per *member* ($2,000 per family) per calendar year
Overall Lifetime Benefit Maximum		None	None
Your Blue Care Elect PPO Benefits:		**In-Network Your Cost is:**	**Out-of-Network Your Cost is:**
Admissions for *Inpatient* Medical and Surgical Care	• In a General or Chronic Disease Hospital	Nothing	20% *coinsurance* after *deductible*
	• In a Rehabilitation Hospital (60-day *benefit limit* per calendar year)	Nothing up to *benefit limit*; then, all costs	20% *coinsurance* after *deductible* up to *benefit limit*; then, all costs
	• In a Skilled Nursing Facility (100-day *benefit limit* per calendar year)		

Note: 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*).

WORDS IN ITALICS ARE DEFINED IN PART 2.

Your Blue Care Elect PPO Benefits:		In-Network Your Cost is:	Out-of-Network Your Cost is:
Ambulance Services	• Emergency ambulance transport	Nothing	Nothing (*deductible* does not apply)
	• Other *medically necessary* ambulance transport	Nothing	20% *coinsurance* after *deductible*
Cardiac Rehabilitation	*Outpatient* visits	$15 *copayment* per visit	20% *coinsurance* after *deductible*
Chiropractor Services	• *Outpatient* lab tests and x-rays	Nothing	20% *coinsurance* after *deductible*
	• *Outpatient* medical care services	$15 *copayment* per visit	
Dialysis Services	*Outpatient* and home dialysis	Nothing	20% *coinsurance* after *deductible*
Durable Medical Equipment	$1,500 *benefit limit* per *member* per calendar year	Nothing up to *benefit limit*; then, all costs	20% *coinsurance* after *deductible* up to *benefit limit*; then, all costs
	(This *benefit limit* does not apply when medical equipment is furnished as part of covered home dialysis, home health care or hospice services.)		
Early Intervention Services	$5,200 per eligible child per calendar year ($15,600 lifetime) *benefit limit*	$15 *copayment* per visit up to *benefit limit*; then, all costs	20% *coinsurance* after *deductible* up to *benefit limit*; then, all costs
Emergency Medical *Outpatient* Services	• Emergency room visits	$50 *copayment* per visit	$50 *copayment* per visit (*deductible* does not apply)
	• Office, health center and hospital visits	$15 *copayment* per visit	20% *coinsurance* after *deductible**
Home Health Care	*Medically necessary* home care	Nothing	20% *coinsurance* after *deductible*
Hospice Services	*Inpatient* or *outpatient* hospice services for terminally ill	Nothing	20% *coinsurance* after *deductible*
Infertility Services	• *Inpatient* services	Nothing	20% *coinsurance* after *deductible*
	• *Outpatient* surgical services	$15 *copayment* per office or health center visit; or nothing for surgical day care unit, ambulatory surgical facility or hospital services	
	• O*utpatient* lab tests and x-rays	Nothing	
	• *Outpatient* medical care services	$15 *copayment* per visit	
Lab Tests, X-Rays and Other Tests	*Outpatient* diagnostic tests (includes preoperative tests)	Nothing	20% *coinsurance* after *deductible*

*Note: If you obtain accident treatment or *emergency medical care* from a non-*preferred provider* when a *preferred provider* is not reasonably available, in-network benefits will be provided for these services.
**Your benefits for these supplies are provided only when they are furnished on and after July 13, 2006.

WORDS IN ITALICS ARE DEFINED IN PART 2.

Your Blue Care Elect PPO Benefits:		**In-Network** **Your Cost is:**	**Out-of-Network** **Your Cost is:**
Maternity Services and Well Newborn *Inpatient* Care	• *Inpatient* and *outpatient* maternity services • Well newborn care during enrolled mother's maternity admission	Nothing	20% *coinsurance* after *deductible*
Medical Care *Outpatient* Visits (includes syringes and needles** dispensed during a visit)	Office, health center, hospital and home visits	$15 *copayment* per visit	20% *coinsurance* after *deductible*
Medical Formulas	Medical formulas and low protein food products for certain conditions ($2,500 *benefit limit* per *member* per calendar year for low protein foods)	Nothing (when not covered by your *Blue Cross and Blue Shield* Prescription Drug Plan)	Nothing (*deductible* does not apply) when not covered by your *Blue Cross and Blue Shield* Prescription Drug Plan
	(When you are covered under a *Blue Cross and Blue Shield* Prescription Drug Plan, your benefits for these *covered services* are provided under that drug plan.)		
Mental Health and Substance Abuse Treatment	• *Inpatient* admissions in a General Hospital	Nothing	20% *coinsurance* after *deductible*
	• *Inpatient* admissions in a Mental Hospital or Substance Abuse Facility	Nothing up to *benefit limit* (if any); then, all costs	20% *coinsurance* after *deductible* up to *benefit limit* (if any); then, all costs
	• *Outpatient* services	$15 *copayment* per visit up to *benefit limit* (if any); then, all costs	
	For non-biologically-based *mental conditions* other than rape-related mental or emotional conditions and all conditions for enrolled children under age 19, these benefits are limited to: 60 *inpatient* days per calendar year in a mental hospital or substance abuse facility plus 30 more days for alcoholism; and 24 *outpatient* visits per *member* per calendar year plus 8 more visits for alcoholism ($500 minimum value).		
Oxygen and Respiratory Therapy	• Oxygen and equipment for its administration	Nothing	20% *coinsurance* after *deductible*
	• *Outpatient* respiratory therapy	$15 *copayment* per visit	
Pharmacy Services and Supplies	Prescription drugs and supplies from a pharmacy	(Refer to your *Blue Cross and Blue Shield* Prescription Drug Plan)	(Refer to your *Blue Cross and Blue Shield* Prescription Drug Plan)
Podiatry Care	• *Outpatient* surgical services	$15 *copayment* per office or health center visit; or nothing for surgical day care unit, ambulatory surgical facility or hospital services	20% *coinsurance* after *deductible*
	• *Outpatient* lab tests and x-rays	Nothing	

*Note: If you obtain accident treatment or *emergency medical care* from a non-*preferred provider* when a *preferred provider* is not reasonably available, in-network benefits will be provided for these services.
**Your benefits for these supplies are provided only when they are furnished on and after July 13, 2006.
WORDS IN ITALICS ARE DEFINED IN PART 2.

Your Blue Care Elect PPO Benefits:		In-Network Your Cost is:	Out-of-Network Your Cost is:
Podiatry Care (continued)	• *Outpatient* medical care services	$15 *copayment* per visit	
Preventive Health Services (routine services include: immunizations; routine mammograms once between age 35 through 39 and once per calendar year for age 40 and older; and other related routine services and tests)	• Routine pediatric care (10 visits first year of life, 3 visits second year of life, once per calendar year from age 2-11 and once every two calendar years from age 12-18)	$15 *copayment* per visit (nothing for related routine lab tests and x-rays) for *covered services*; otherwise, you pay all costs	20% *coinsurance* after *deductible* for *covered services*; otherwise, you pay all costs
	• Routine adult exams (once every five years from age 19-29, once every three years from age 30-39, once every two years from age 40-54 and once per calendar year for age 55 or older)	$15 *copayment* per visit (nothing for related routine lab tests and x-rays) for *covered services*; otherwise, you pay all costs	20% *coinsurance* after *deductible* for *covered services*; otherwise, you pay all costs
	• Routine GYN exams and routine Pap smear tests (once per calendar year)	$15 *copayment* per visit (nothing for related routine lab tests) for *covered services*; otherwise, you pay all costs	20% *coinsurance* after *deductible* for *covered services*; otherwise, you pay all costs
	• Family planning	$15 *copayment* per visit	20% *coinsurance* after *deductible*
	• Routine hearing exams and tests	$15 *copayment* per visit (nothing for routine tests)	20% *coinsurance* after *deductible*
	• Routine vision exams (once every 24 months)	$15 *copayment* per visit for covered exams; otherwise, you pay all costs	20% *coinsurance* after *deductible* for covered exams; otherwise, you pay all costs
Prosthetic Devices	Prosthetic devices from an appliance company	Nothing	20% *coinsurance* after *deductible*
Radiation Therapy and Chemotherapy	• Office and health center services	Nothing	20% *coinsurance* after *deductible*
	• *Outpatient* hospital and free-standing radiation and chemotherapy facility services		
Second Opinions	*Outpatient* second and third surgical opinions	$15 *copayment* per visit	20% *coinsurance* after *deductible*
Short-Term Rehabilitation Therapy	*Outpatient* physical and/or occupational therapy (100-visit *benefit limit* per *member* per calendar year)	$15 *copayment* per visit up to *benefit limit*; then, all costs	20% *coinsurance* after *deductible* up to *benefit limit*; then, all costs

*Note: If you obtain accident treatment or *emergency medical care* from a non-*preferred provider* when a *preferred provider* is not reasonably available, in-network benefits will be provided for these services.
**Your benefits for these supplies are provided only when they are furnished on and after July 13, 2006.
WORDS IN ITALICS ARE DEFINED IN PART 2.

Your Blue Care Elect PPO Benefits:		In-Network Your Cost is:	Out-of-Network Your Cost is:
Speech, Hearing and Language Disorder Treatment	• *Outpatient* diagnostic tests	Nothing	20% *coinsurance* after *deductible*
	• *Outpatient* speech/language therapy	$15 *copayment* per visit	
	• *Outpatient* medical care services		
Surgery as an *Outpatient*	• Day surgery at a surgical day care unit, ambulatory surgical facility or hospital outpatient department	Nothing	20% *coinsurance* after *deductible*
	• Office and health center services	$15 *copayment* per visit	
TMJ Disorder Treatment	• *Outpatient* diagnostic x-rays	Nothing	20% *coinsurance* after *deductible*
	• *Outpatient* surgical services	$15 *copayment* per office or health center visit; or nothing for surgical day care unit, ambulatory surgical facility or hospital services	
	• *Outpatient* physical therapy (short-term rehabilitation therapy *benefit limit* applies)	$15 *copayment* per visit up to *benefit limit*; then, all costs	20% *coinsurance* after *deductible* up to *benefit limit*; then, all costs
	• *Outpatient* medical care services	$15 *copayment* per visit	20% *coinsurance* after *deductible*

*Note: If you obtain accident treatment or *emergency medical care* from a non-*preferred provider* when a *preferred provider* is not reasonably available, in-network benefits will be provided for these services.
**Your benefits for these supplies are provided only when they are furnished on and after July 13, 2006.

WORDS IN ITALICS ARE DEFINED IN PART 2.

Part 1

Member Services

Identification Cards

After you enroll for coverage under this PPO *contract*, you will receive a PPO identification card. This card will identify you as a person who has the right to the benefits described in this PPO *contract*. This card is for identification purposes only. While you are a *member*, you must show your PPO identification card to the provider before you receive *covered services*.

Lost Your ID Card? If your PPO identification card is lost or stolen, you should contact the *Blue Cross and Blue Shield* customer service office. They will send you a new PPO identification card. Or, you may also use the online member self-service option that is located at **www.bluecrossma.com**.

Network of *Preferred Providers*

Finding a *Preferred Provider*. At the time you enroll for coverage under this PPO *contract*, the *group* will make available to you a directory of preferred providers. This provider directory is available to you at no additional charge. To find out if a health care provider is a *preferred provider*, you may look in your directory of preferred providers. Or, you may also use any of the following options to find out if a provider is a *preferred provider*. You may:

- Call the *Blue Cross and Blue Shield* customer service office. The toll-free telephone number is shown on your PPO identification card; or
- Call the Physician Selection Service at **1-800-821-1388**; or
- Access the online physician directory (Find a Doctor) at **www.bluecrossma.com**. (The list of *preferred providers* is subject to change. The online physician directory will provide you with the most current list of *preferred providers*.)

Massachusetts Board of Registration:	If you are looking for more specific information regarding your physicians, the Massachusetts Board of Registration in Medicine may have a profile available at **www.massmedboard.org**.

***Preferred Providers* Outside of Massachusetts.** If you live or are traveling outside of Massachusetts and need health care services, you can check the status of an out-of-state provider or obtain help in finding a *preferred provider* by calling **1-800-810-BLUE**. You can call this telephone number for help finding a provider 24 hours a day. Or, you may access the BlueCard® Doctor & Hospital Finder on the internet at **www.bcbs.com**. When you call, you should have your PPO identification card ready. Be sure to let the representative know that you are looking for providers that are part of the BlueCard PPO program.

For some types of covered health care 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 *preferred*

provider network. If this is the case and you obtain *covered services* from that type of non-*preferred provider*, *Blue Cross and Blue Shield* will provide "in-network benefits" for these services. (See Part 11 for more information.)

Making an Inquiry and/or Resolving Claim Problems or Concerns

Calling Member Service. For help to understand the terms of your PPO *contract* or to resolve a problem or concern, you may call the *Blue Cross and Blue Shield* customer service office. A customer service representative will work with you to help you understand your benefits or resolve your problem or concern as quickly as possible. You can call the *Blue Cross and Blue Shield* customer service office Monday through Friday from 8:00 a.m. to 8:00 p.m. (Eastern Time). The toll-free telephone number is shown on your PPO identification 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

Blue Cross and Blue Shield will keep a record of each inquiry you (or someone on your behalf) makes. These records, including the responses to each inquiry, will be kept for two years. They may be reviewed by the Commissioner of Insurance and Massachusetts Department of Public Health.

More Information:	For information about *Blue Cross and Blue Shield's* inquiry process and the formal grievance review process, see Part 9.

Requesting Medical Policy Information. To receive all the benefits described in your PPO *contract*, your treatment must conform to *Blue Cross and Blue Shield's* medical policy guidelines that are in effect at the time the services or supplies are furnished. If you have access to a FAX machine, you may request medical policy information by calling the Medical Policy on Demand toll-free service at **1-888-MED-POLI**. Or, you may call the *Blue Cross and Blue Shield* customer service office to request a copy of the information.

Office of Patient Protection

The Office of Patient Protection of the Massachusetts Department of Public Health can provide information about health care plans in Massachusetts. Some of the information that this office can provide includes:

- A health plan report card that contains information and data providing a basis by which health insurance plans may be evaluated and compared by consumers. Also available are health plan employer data collected for the National Committee on Quality Assurance and a list of sources that can provide information about member satisfaction and the quality of health care services offered by health care plans.
- Information about physicians who are voluntarily and/or involuntarily disenrolled by a health plan during the prior calendar year.

- A chart comparing the premium revenue that has been used for health care services for the most recent year for which the information is available.
- A report that provides information for health care plan grievances and external appeals for the previous calendar year.

To request any of this information, you may contact the Office of Patient Protection by calling **1-800-436-7757** or faxing a request to **1-617-624-5046**. This information is also available on the Office of Patient Protection's internet website **www.state.ma.us/dph/opp**.

Part 2

Definitions

The following terms are shown in italics in your PPO *contract*. These terms will give you a better understanding of your PPO benefits.

Allowed Charge

The charge that is used to calculate payment of your benefits. The *allowed charge* depends on the type of health care provider that furnishes a *covered service* to you.

- ***Preferred Providers* in Massachusetts.** For providers that have a preferred payment agreement with *Blue Cross and Blue Shield*, the *allowed charge* is based on the provisions of that provider's preferred payment agreement. In general, when you share in the cost for *covered services* (such as a *deductible*, *copayment* and/or *coinsurance*), the calculation for the amount that you pay is based on the initial full *allowed charge* for the *preferred provider*. This amount that you pay is generally not subject to future adjustments—up or down—even though the *preferred provider's* payment may be subject to future adjustments for such things as provider contractual settlements, risk-sharing settlements and fraud or other operations.

- **Providers Outside of Massachusetts.** For providers outside of Massachusetts that 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.

For *covered services* furnished by these providers, you pay only your *copayment, deductible* and/or *coinsurance*, whichever applies.

- **Non-*Preferred Providers*.** For non-*preferred providers* in Massachusetts and non-*preferred providers* outside of Massachusetts that do not have a payment agreement with the local Blue Cross and/or Blue Shield Plan, the provider's actual charges are used to calculate your benefits.

Pharmacy Providers. *Blue Cross and Blue Shield* may have payment arrangements with pharmacy providers that may result in rebates on covered drugs and supplies. When your PPO *contract* includes pharmacy benefits, the amount that you pay for a covered drug or supply is determined at the time you buy the drug or supply. The amount 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 Level

The in-network and out-of-network levels of benefits provided under this PPO *contract* for *covered services*. The *benefit level* for *covered services* furnished by non-*preferred providers* (out-of-network benefit level) will be at least 80% of the *benefit level* for the same *covered services* when furnished by *preferred providers* (in-network *benefit leve*l). 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*).

Benefit Limit

The day, visit or dollar benefit maximum that applies to benefits under this PPO *contract* for certain health care services or supplies. **Refer to your PPO Schedule of Benefits (or *riders*, if any) for any *benefit limits* that apply for your benefits under this PPO *contract*.** Once the amount of the benefits you have received reaches the *benefit limit* for a specific *covered service*, no further benefits are provided by *Blue Cross and Blue Shield* for those health care services or supplies. When this is the case, you must pay all charges that you may incur that are in excess of the *benefit limit* for those health care services or supplies.

Blue Cross and Blue Shield

Blue Cross and Blue Shield of Massachusetts, Inc. This includes an employee or designee of *Blue Cross and Blue Shield* who is authorized to make decisions or take action called for under this PPO *contract*.

Coinsurance

The amount that you pay for a certain *covered service* that is calculated as a percentage. **Your PPO Schedule of Benefits shows those *covered services* (if any) that are subject to *coinsurance* and your *coinsurance* percentage that will be used to calculate your cost of the *covered service*.** Your *coinsurance* is a percentage of:

- The provider's actual charge or the *allowed charge*, whichever is less (unless otherwise required by law) when you receive *covered services* from a *preferred provider* or a non-*preferred provider* outside of Massachusetts who has a payment agreement with a local Blue Cross and/or Blue Shield Plan.
- The provider's actual charge when you receive *covered services* from a non-*preferred provider* in Massachusetts or a non-*preferred provider* outside of Massachusetts who does not have a payment agreement with the local Blue Cross and/or Blue Shield Plan.

Contract

This PPO *contract*, including your PPO Schedule of Benefits, any *riders* or other changes to this PPO *contract*, the *subscriber's* enrollment form and the agreement that *Blue Cross and Blue Shield* has with the *subscriber's group* to provide benefits to the *subscriber* and his or her covered dependents. This PPO *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 this *contract* constitutes a contract solely between the account (your *group*) on your behalf and Blue Cross and Blue Shield of Massachusetts, Inc. (*Blue Cross and Blue Shield*), which is an independent corporation 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* has not entered into this *contract* on your behalf 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* for any of *Blue Cross and Blue Shield's* obligations to you created under this *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 this *contract*.

Copayment

The amount that you must pay for a certain *covered service* which is a fixed dollar amount. In most cases, a *preferred provider* will collect the *copayment* from you at the time he or she furnishes the *covered service*. However, when the provider's actual charge at the time of providing the *covered service* is less than your *copayment*, you pay only that provider's actual charge or the *allowed charge*, whichever is less. Any later charge adjustment—up or down—will not affect your *copayment* (or the amount you were charged at the time of the service if it was less than the *copayment*). **Your PPO Schedule of Benefits shows the amount of your**

***copayment* (if any) and which *covered services* are subject to a *copayment*.** At certain times when a *copayment* would normally apply, your *copayment* may be waived. Your *copayment* will be waived when:

- Your hospital emergency room visit results in your being held for an overnight observation stay or being admitted for *inpatient* care within 24 hours. In this case, any emergency room *copayment* will be waived.
- Your *outpatient* visit is only for lab tests and/or x-rays. In this case, any *outpatient* visit *copayment* will be waived.
- You receive certain approved "intermediate" mental health care services such as day treatment program services in lieu of an *inpatient* admission (see page 43 for more information).

Covered Services

Health care services or supplies for which *Blue Cross and Blue Shield* provides benefits as described in this PPO *contract*, including your PPO Schedule of Benefits and any *riders* to this PPO *contract*. Most *covered services* must be furnished by providers in your preferred health care network in order for you to receive the highest level of benefits provided under this PPO *contract*. These are called your "in-network benefits." For most of your health care needs, a *preferred provider* will be available to you. To find out if a health care provider is a *preferred provider*, you may look in the directory of *preferred providers*. (See page 7 for more information about finding a *preferred provider*.) You also have the option to seek health care from a provider that is not in this preferred network. Your out-of-pocket costs are higher when you receive care from a non-*preferred provider*. These are called your "out-of-network benefits."

Custodial Care

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

The amount that you must pay before benefits are provided for certain *covered services*. **Your PPO Schedule of Benefits shows the amount of your *deductible* (if any) and which *covered services* are subject to the *deductible*.** The amount that is put toward your *deductible* is calculated based on:

- The provider's actual charge or the *allowed charge*, whichever is less (unless otherwise required by law) when you receive *covered services* from a *preferred provider* or a non-*preferred provider* outside of Massachusetts who has a payment agreement with a local Blue Cross and/or Blue Shield Plan.
- The provider's actual charge when you receive *covered services* from a non-*preferred provider* in Massachusetts or a non-*preferred provider* outside of Massachusetts who does not have a payment agreement with the local Blue Cross and/or Blue Shield Plan.

When a *deductible* applies to your benefits, there are amounts you pay that **do not** count toward your *deductible*. These include: any *copayments*; amounts you pay when your benefits are reduced or denied because you did not follow the requirements of the *utilization review* program (see Part 4); and any charges that you pay because *Blue Cross and Blue Shield* has provided all the benefits it allows for that *covered service* (for example, early intervention services).

Satisfying a family *deductible.* When you are enrolled under a membership that includes the *subscriber* and an eligible spouse and/or other eligible dependents, a "family *deductible*" means that the *deductible* amounts paid by *members* covered under the same membership will not total more than the family *deductible* amount. The family *deductible* can be met by eligible costs incurred by any combination of family *members*. But, no one *member* will have to pay more than the *deductible* amount for a *member*.

Diagnostic Lab Tests

The examination or analysis of tissues, liquids or wastes from the body. This also includes: 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

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 include 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

The date, as shown on *Blue Cross and Blue Shield's* records, on which your membership under this PPO *contract* starts. Or, the date on which a change to your PPO *contract* takes effect.

Emergency Medical Care

Medical, surgical or psychiatric care that you need immediately due to the sudden onset of a condition manifesting 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, 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 8 and 9), *Blue Cross and Blue Shield* considers "*emergency medical care*" to constitute "urgent care" as defined under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Group

Any corporation, partnership, individual proprietorship or other organization that has an agreement with *Blue Cross and Blue Shield* to provide health care benefits for a group of *members*. The *group* will make payment to *Blue Cross and Blue Shield* for covered *members* and will also deliver to the *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*.

Inpatient

A patient who is a registered bed patient in a facility. This also includes a patient who is receiving approved intensive services such as day treatment or partial hospital programs or covered residential care. (A patient who is kept overnight in a hospital solely for observation is not considered a registered *inpatient*. This is true even though the patient uses a bed. In this case, the patient is considered an *outpatient*. This is important for you to know since *member* cost sharing and *benefit limits* may differ for *inpatient* and *outpatient* benefits.)

Medical Technology Assessment Guidelines

The guidelines that *Blue Cross and Blue Shield* uses to assess whether a technology improves health outcomes such as length of life or ability to function. These guidelines include the following five criteria:

- 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 Food and Drug Administration (FDA). Any approval granted as an interim step in the FDA regulatory process is not sufficient. Except as required by law, *Blue Cross and Blue Shield* may limit benefits 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

All *covered services*, except routine circumcision, voluntary termination of pregnancy, voluntary sterilization, stem cell ("bone marrow") transplant donor suitability testing and preventive health services, must be *medically necessary* and appropriate for your specific health care needs. This means that all *covered services* must be consistent with generally accepted principals of professional medical practice. *Blue Cross and Blue Shield* decides which *covered services* are *medically necessary* and appropriate for you by using the following guidelines. All health care services must be required to diagnose or treat your illness, injury, symptom, complaint or condition and they must also be:

- Consistent with the diagnosis and treatment of your condition and in accordance with *Blue Cross and Blue Shield* medical policy and *medical technology assessment guidelines*.
- Essential to improve your net health outcome and as beneficial as any established alternatives covered by this PPO *contract*. This means that if *Blue Cross and Blue Shield* determines that your treatment is more costly than an alternative treatment, benefits are provided for the amount that would have been provided for the least expensive alternative treatment that meets your needs. In this case, you pay the difference between the claim payment and the actual charge.
- As cost effective as any established alternatives and consistent with the level of skilled services that are furnished.
- Furnished in the least intensive type of medical care setting required by your medical condition.

It is not a service that: is furnished solely for your convenience or religious preference or the convenience of your family or health care provider; 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

You, the person who has the right to the benefits described in this PPO *contract*. A *member* may be the *subscriber* or his or her enrolled spouse (or former spouse, if applicable) or any other enrolled dependent.

Mental Conditions

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 Provider

A provider that may furnish *covered services* for the treatment of *mental conditions*. These providers include:

- 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 mental health counselors.
- Mental health centers.
- Mental hospitals.
- Physicians.
- Psychologists.
- Other mental health providers designated by *Blue Cross and Blue Shield.*

Out-of-Pocket Maximum

The total amount that you pay for certain *covered services*. **If this provision applies to your benefits, your PPO Schedule of Benefits will show the amount of the *out-of-pocket maximum* and which amounts you pay that will count to the *out-of-pocket maximum*.** Under this provision, when the amounts you have paid for *covered services* that count toward your *out-of-pocket maximum* add up to the *out-of-pocket maximum* amount, *Blue Cross and Blue Shield* will provide full benefits based on the *allowed charge* for these *covered services* until the end of the time frame in which the *out-of-pocket maximum* provision applies. There are amounts you pay that **do not** count toward your *out-of-pocket maximum*. These include:

- Any charges that you pay because *Blue Cross and Blue Shield* has provided all the benefits it allows for that *covered service* (for example, early intervention services).
- Any charges you pay when your benefits are reduced or denied because you did not follow the requirements of the *utilization review* program. (See Part 4.)

Satisfying a family *out-of-pocket maximum.* When you are enrolled under a membership that includes the *subscriber* and an eligible spouse and/or other eligible dependents, a "family *out-of-pocket maximum*" means that the amounts that count toward the *out-of-pocket maximum* and paid by *members* covered under the same membership will not total more than the family *out-of-pocket maximum* amount. The family *out-of-pocket maximum* can be met by eligible costs paid by any combination of family *members*. But, no one *member* will have to pay more than the *out-of-pocket maximum* amount for a *member*.

Outpatient

A patient who is not a registered bed patient in a facility. For example, a patient at a health center, provider's office, surgical day care unit or ambulatory surgical facility is considered an *outpatient*. A patient who is kept overnight in a hospital solely for observation is also considered an *outpatient*. This is true even though the patient uses a bed. (This does not include a patient who is receiving approved intensive services such as day treatment or partial hospital programs or covered residential care—see the definition of "Inpatient.")

Plan Sponsor

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 (ERISA), as amended. If you are not sure who your *plan sponsor* is, contact your employer.

Plan Year

The 12-month period of time that starts on the original effective date of your *group's* coverage under this PPO *contract* and continues for 12 consecutive months. A new plan year begins each 12-month period thereafter. If you are not sure when your plan year begins, contact your *plan sponsor*.

Preferred Provider

A health care provider that has a written Blue Care Elect preferred provider payment agreement with *Blue Cross and Blue Shield* or a health care provider outside of Massachusetts that has a written preferred provider payment agreement with a local Blue Cross and/or Blue Shield Plan. For each *covered service*, this PPO *contract* specifies the kinds of providers that are covered under this PPO *contract*. (A covered health care provider that does not have a written preferred provider payment agreement with *Blue Cross and Blue Shield* or a local Blue Cross and/or Blue Shield Plan is referred to as a "non-*preferred provider*" in this PPO *contract*.) The kinds of health care providers that are covered under this PPO *contract* include:

- **Hospital and Other Covered Facilities.** Alcohol and drug treatment facilities; ambulatory surgical facilities; chronic disease hospitals; community health centers; detoxification facilities; free-standing diagnostic imaging facilities; free-standing dialysis facilities; free-standing radiation therapy and chemotherapy facilities; general hospitals; independent labs; mental health centers; mental hospitals; rehabilitation hospitals; and skilled nursing facilities.

- **Physician and Other Covered Professional Providers.** Certified registered nurse anesthetists; chiropractors; clinical specialists in psychiatric and mental health nursing; dentists; licensed audiologists; licensed dietitian nutritionists; licensed independent clinical social workers; licensed mental health counselors; licensed speech-language pathologists; nurse midwives; nurse practitioners; occupational therapists; optometrists; physical therapists; physicians; podiatrists; and psychologists.

- **Other Covered Health Care Providers.** Ambulance services; appliance companies; cardiac rehabilitation centers; early intervention providers; home health agencies; home infusion therapy providers; hospice providers; oxygen suppliers; and visiting nurse associations.

(See page 7 for more information about finding a *preferred provider*.)

Premium

The total monthly cost of your benefits under this PPO *contract*. The *premium* amount is part of the agreement between *Blue Cross and Blue Shield* and the *group*. *Blue Cross and Blue Shield* may change your *premium* amount. Each time *Blue Cross and Blue Shield* changes the *premium*, *Blue Cross and Blue Shield* will notify your *group* before the change is effective. It is up to the *group* to notify a *subscriber* of any *premium* changes. The *group* may require that you pay all or a portion of this *premium* amount. In all cases, the *group* must pay the total *premium* charges owed for your benefits under this *contract* to *Blue Cross and Blue Shield*. *Blue Cross and Blue Shield* is not responsible for providing benefits for a *group's member* if the *group* fails to make *premium* payments. In this case, *Blue Cross and Blue Shield* must provide notification to the *group's member*.

Rider

An amendment that changes the terms described in this PPO *contract* (which includes this Subscriber Certificate). *Blue Cross and Blue Shield* or your *group* may change the terms of your PPO *contract*. For example, a *rider* may change the amount you must pay for certain services such as the amount of your *copayment* or it may add or limit the benefits provided by *Blue Cross and Blue Shield* under this PPO *contract*. A *rider* describes the material change that is made to your PPO *contract*. *Blue Cross and Blue Shield* will supply you with any *riders* that apply to your benefits under this PPO *contract*. You should keep any *riders* with your PPO *contract*.

Room and Board

Your room, meals and general nursing services while you are an *inpatient*. This includes hospital services furnished in an intensive care or similar unit.

Special Services

The services and supplies that a facility ordinarily furnishes to its patients for diagnosis or treatment while the patient is in the facility. *Special services* include 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 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; and pacemakers. They do not include things such as: ostomy bags; artificial limbs or eyes; hearing aids; or airplane splints.

Subscriber

The eligible person who signs the enrollment form at the time of enrollment under this PPO *contract*. This is the person on whose behalf *Blue Cross and Blue Shield* and the *plan sponsor* have entered into this PPO *contract*.

Utilization Review

The approach that *Blue Cross and Blue Shield* uses to evaluate the necessity and appropriateness of many different services. This approach employs a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. These techniques include pre-admission review, concurrent review, discharge planning, pre-authorization of selected *outpatient* services, post-payment review and individual case management. *Blue Cross and Blue Shield's* utilization management policies are designed to encourage appropriate care and services (not less care). *Blue Cross and Blue Shield* understands the need for special concern about underutilization, and shares this concern with its *members* and providers. *Blue Cross and Blue Shield* does not compensate individuals who conduct *utilization review* activities based on denials. It also does not offer incentives to providers to encourage inappropriate denials of care and services. (See Part 11, "Process to Develop Clinical Guidelines and *Utilization Review* Criteria" for more information.)

Part 3

Emergency Medical Services

Obtaining Emergency Medical Services

Blue Cross and Blue Shield provides benefits for emergency medical services whether you are in or outside of Massachusetts. These emergency medical services may include *inpatient* or *outpatient* services by providers qualified to furnish *emergency medical care* and that are needed to evaluate or stabilize your emergency medical condition.

Call 911. At the onset of an emergency medical condition that in your judgment requires *emergency medical care*, you should go to the nearest emergency room. For assistance, call your local emergency medical service system by dialing the emergency telephone access number 911, or the local emergency telephone number. You will not be denied benefits for medical and transportation services described in this PPO *contract* 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 manifesting 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, 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.

Note: When you receive *emergency medical care* at a non-preferred hospital emergency room, *Blue Cross and Blue Shield* will provide the same benefits that you would normally receive if a preferred hospital emergency room had furnished the services.

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 as described in this section. But, *Blue Cross and Blue Shield* provides benefits only for treatment that is covered by this PPO *contract*.

- **Admission from the Emergency Room.** Your condition may require that you be admitted directly from the emergency room for *inpatient emergency medical care* in that hospital. If this is the case, you, the facility or someone on your behalf must notify *Blue Cross and Blue Shield* within 48 hours of the admission. (In Massachusetts, the preferred hospital will call *Blue Cross and Blue Shield* for you.)

This notification to *Blue Cross and Blue Shield* must include the patient's name, the patient's identification number, the name of the facility, the date of admission and the condition for which the patient is receiving treatment. *Blue Cross and Blue Shield* will monitor and evaluate the clinical necessity and appropriateness of the health care services you are receiving in order to make sure you continue to need *inpatient* coverage in that facility. (For more information about Concurrent Review, see Part 4, "*Utilization Review* Requirements.")

- **Transfer to Another *Inpatient* Facility.** Your emergency room provider may recommend transfer for *inpatient* care to another facility. If this is the case, you or the admitting facility must call *Blue Cross and Blue Shield* within 48 hours of the admission so that *Blue Cross and Blue Shield* can evaluate the appropriateness of the health care services you are receiving in order to make sure you need *inpatient* coverage in that facility. (In Massachusetts, the preferred facility will call *Blue Cross and Blue Shield* for you.)

- ***Outpatient* Follow-up Care.** Your emergency room provider may recommend *outpatient* follow-up care. If this is the case, *Blue Cross and Blue Shield* will provide benefits for *covered services*.

Filing a Claim for Emergency Medical Services

You do not have to file a claim when you receive *emergency medical care* from a *preferred provider* or a non-*preferred provider* outside of Massachusetts who has a payment agreement with the local Blue Cross and/or Blue Shield Plan. The provider will file the claim for you. Just tell the provider that you are a *member* and show the provider your PPO identification card. *Blue Cross and Blue Shield* will pay the provider directly for *covered services*. But, you may have to file your claim when you receive *emergency medical care* from a non-*preferred provider* who **does not** have a payment agreement with *Blue Cross and Blue Shield* or the local Blue Cross and/or Blue Shield Plan. The 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 provider. *Blue Cross and Blue Shield* will repay you, less any applicable *deductible*, *copayment* and/or *coinsurance*, whichever applies.

More Information:	See Part 8 for more information about filing a claim for repayment.

Part 4

Utilization Review Requirements

You must follow the requirements of this *utilization review* program. This program applies anywhere in the United States. **Your benefits may be reduced or denied if you do not follow the requirements of this program.** (The requirements of this program do not apply to *covered services* when Medicare is the primary coverage.)

Your Authorized Representative. Your provider will be considered your authorized representative for the prior approval process. *Blue Cross and Blue Shield* will tell your provider if a proposed service has been approved or may ask your provider for more information if it is needed to make a decision. (See Part 11 for more information about authorized representatives.)

Checking Status of Pre-Approval Request. To check on the status or outcome of a *utilization review* decision, you may call your health care provider or the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your PPO identification card.

Pre-Admission Review

Before you enter a facility for *inpatient* non-*emergency medical care* and non-maternity care, approval must be obtained from *Blue Cross and Blue Shield* in order for the care to be covered under this PPO *contract*. **Within two working days of receiving all necessary information, *Blue Cross and Blue Shield* will determine if the health care setting is suitable to treat your condition.**

Starting Pre-Admission Review. For proposed admissions in a preferred facility, the facility may start this pre-admission review process for you. A *preferred provider* can tell you if you must start this process. **You must start the pre-admission review process if the preferred facility does not start this process or if your proposed admission is to a non-preferred facility. To start the pre-admission review process, you must call the *Blue Cross and Blue Shield utilization review* unit at the toll-free telephone number shown on your PPO identification card.**

Missing Information. *Blue Cross and Blue Shield* will get in touch with your physician about the proposed admission if more information is needed. In some situations, *Blue Cross and Blue Shield* may arrange an evaluation (usually face to face) with an assessment provider who will assess your specific need and determine if the health care setting is suitable to treat your condition. If necessary information is missing or more information is needed, *Blue Cross and Blue Shield* will request the necessary information or records within 15 calendar days of receiving the pre-approval request. The requested information or records must be provided within 45 calendar days of *Blue Cross and Blue Shield's* request. If the requested information or records are not provided to *Blue Cross and Blue Shield* within 45 calendar days of the request, the proposed coverage will be denied. Within two working days of receiving all necessary

information, *Blue Cross and Blue Shield* will determine if the health care setting is suitable to treat your condition.

Coverage Approval. If *Blue Cross and Blue Shield* determines that the proposed setting for your care is suitable, *Blue Cross and Blue Shield* will call the health care facility within 24 hours of the determination to let the facility know the coverage approval status of the pre-admission review. *Blue Cross and Blue Shield* will also send a written (or electronic) confirmation of the coverage approval to you and the facility within two working days of the phone call to the facility.

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 within 24 hours of the determination to let the facility know of the denial of coverage and to recommend alternative treatment. *Blue Cross and Blue Shield* will also send a written (or electronic) explanation of the coverage decision to you and the facility within one working day of the phone call to the facility. (This explanation will: describe the reasons for the denial and the applicable terms of your coverage as described in this PPO *contract*; give the specific medical and scientific reasons for the denial; specify any alternative treatment, 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 describe the review process and your right to pursue legal action.)

Reconsideration of Adverse Determination. When *Blue Cross and Blue Shield* determines that *inpatient* coverage is not *medically necessary* for your condition, your health care provider may ask *Blue Cross and Blue Shield* to arrange a reconsideration of that decision from a clinical peer reviewer. This reconsideration will be conducted between your provider and the clinical peer reviewer within one working day of the request for a reconsideration. If the initial determination is not reversed, you (or the health care provider on your behalf) may request a formal review as described in Part 9 of this PPO *contract*. (You may request a formal review even though your health care provider has not followed this reconsideration process.)

Non-Compliance with Pre-Admission Review Requirements. If you do not call for pre-admission review prior to being admitted as an *inpatient*, you must pay the first $1,000 of otherwise covered facility charges for each admission that *Blue Cross and Blue Shield* determines is *medically necessary*. You must pay this amount as well as any costs that you would normally be required to pay for *covered services*.

If you do not call for pre-admission review and *Blue Cross and Blue Shield* determines your admission is not *medically necessary* (or if you choose to be admitted after the pre-admission review determined that *inpatient* coverage was not *medically necessary*), you must pay the entire amount for facility and physician (or other professional provider) services for the admission.

Concurrent Review and Discharge Planning

Concurrent Review means that while you are an *inpatient*, *Blue Cross and Blue Shield* will monitor and evaluate the clinical necessity and appropriateness of the health care services you are receiving and to make sure you still need *inpatient* coverage in that facility.

In some cases, *Blue Cross and Blue Shield* may determine that you will need to continue *inpatient* coverage in that facility beyond the number of days initially thought to be required for your condition. *Blue Cross and Blue Shield* will make this determination within one working day of receiving all necessary information. When this is the case, *Blue Cross and Blue Shield* will call the health care facility within one working day of the coverage determination to let the facility know the approval status of the review. *Blue Cross and Blue Shield* will also send a written (or electronic) explanation of the decision to you and the facility within one working day of the phone call to the facility. This written (or electronic) explanation 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 *medical necessity* determination, *Blue Cross and Blue Shield* may determine that you no longer need *inpatient* coverage in that facility. Or, you may no longer need *inpatient* coverage at all. *Blue Cross and Blue Shield* will make this coverage determination within one working day of receiving all necessary information. When this is the case, *Blue Cross and Blue Shield* will call the health care facility within 24 hours of the coverage determination to let the facility know of the decision and to discuss plans for continued coverage in a health care setting that better meets your needs. For example, your condition may no longer require *inpatient* coverage in a hospital, but 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) explanation to you and the facility within one working day of the phone call to the facility.

If you choose to stay in the facility after you have been notified by your provider or *Blue Cross and Blue Shield* that *inpatient* coverage is no longer *medically necessary*, no further benefits are provided (except as otherwise required during the formal grievance process). You must pay all charges for the rest of that *inpatient* stay, starting from the date the written notification is sent to you.

Reconsideration of Adverse Determination. When *Blue Cross and Blue Shield* determines that continued *inpatient* coverage is not *medically necessary* for your condition, your health care provider may ask *Blue Cross and Blue Shield* to arrange a reconsideration of that decision from a clinical peer reviewer. This reconsideration will be conducted between your health care provider and the clinical peer reviewer within one working day of the request for a reconsideration. If the initial determination is not reversed, you (or the health care provider on your behalf) may request a formal review as described in Part 9 of this PPO *contract*. (You may request a formal review even though your health care provider has not followed this reconsideration process.)

Prior Approval for Home Health Care

Before you receive home health care, approval must be obtained from *Blue Cross and Blue Shield* in order for the care to be covered under your PPO *contract*. **Within two working days of receiving all necessary information, *Blue Cross and Blue Shield* will determine if the proposed services should be covered as *medically necessary* for your condition.** (If you have been receiving *inpatient* care, *Blue Cross and Blue Shield* may approve these services through Discharge Planning.)

Starting the Pre-Approval Process. If you are planning to obtain home health care from a *preferred provider*, the provider may start the approval process for you. A *preferred provider* can tell you if you must start this process. **You must start the pre-approval process if the *preferred provider* does not start this process or if you are planning to obtain these services from a non-*preferred provider*. To start this pre-approval process, you must call the *Blue Cross and Blue Shield utilization review* unit at the toll-free telephone number shown on your PPO identification card.**

Missing Information. If necessary information is missing or more information is needed, *Blue Cross and Blue Shield* will request the necessary information or records within 15 calendar days of receiving the pre-approval request. The requested information or records must be provided within 45 calendar days of *Blue Cross and Blue Shield's* request. If the requested information or records are not provided to *Blue Cross and Blue Shield* within 45 calendar days of the request, the proposed coverage will be denied. Within two working days of receiving all necessary information, *Blue Cross and Blue Shield* will determine if the proposed services should be covered as *medically necessary* for your condition.

Coverage Approval. If *Blue Cross and Blue Shield* determines that the proposed course of treatment should be covered as *medically necessary* for your condition, *Blue Cross and Blue Shield* will call the health care provider within 24 hours of the determination to let the provider know the approval status of the review. *Blue Cross and Blue Shield* will also send a written (or electronic) confirmation of the approval to you and the provider within two working days of the phone call to the provider.

Coverage Denial. If *Blue Cross and Blue Shield* determines that the proposed course of treatment should **not** be covered as not *medically necessary* for your condition, *Blue Cross and Blue Shield* will call the health care provider within 24 hours of the determination to let the provider know of the denial of coverage and to recommend alternative treatment. *Blue Cross and Blue Shield* will also send a written (or electronic) explanation of the decision to you and the provider within one working day of the phone call to the provider. (This explanation will: describe the reasons for the denial and the applicable terms of your coverage as described in this PPO *contract*; give the specific medical and scientific reasons for the denial; specify any alternative treatment, health care services and supplies that would be covered; reference and include applicable *Plan* clinical guidelines used and review criteria; and describe the review process and your right to pursue legal action.)

Reconsideration of Adverse Determination. When *Blue Cross and Blue Shield* determines that the proposed course of treatment will not be covered as *medically necessary* for your condition, your health care provider may ask *Blue Cross and Blue Shield* to arrange a reconsideration of that decision from a clinical peer reviewer. This reconsideration will be conducted between your provider and the clinical peer reviewer within one working day of the request for a reconsideration. If the initial review determination is not reversed, you (or the health care provider on your behalf) may request a formal review as described in Part 9 of this PPO *contract*. (You may request a formal review even though your health care provider has not followed this reconsideration process.)

Non-Compliance with Pre-Approval Requirements. If you receive *medically necessary* services without calling for prior approval from *Blue Cross and Blue Shield*, you must pay the first $1,000 of otherwise covered charges for each course of treatment. You must pay this amount in addition to any costs that you would normally be required to pay for *covered services*.

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 providers to make sure that you get *medically necessary* services in the least intensive setting that meets your needs. Individual Case Management is for a *member* whose condition may otherwise require *inpatient* hospital care. Under Individual Case Management, coverage for services in addition to those described in this PPO *contract* may be approved to:

- Shorten an *inpatient* stay 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* admission has been proposed; or
- Prevent future *inpatient* stays by providing *outpatient* benefits 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: the patient (or guardian); the hospital; the attending physician; and the proposed setting or health care provider. Also, there must be a written agreement between the patient (or family or guardian) and *Blue Cross and Blue Shield*, and between the provider and *Blue Cross and Blue Shield* to furnish the services approved through this alternative treatment plan.

Part 5

Covered Services

You have the right to the benefits described in this section, except as limited or excluded in other sections of this PPO *contract*. Also, be sure to read your PPO Schedule of Benefits for a description of the amounts that you must pay for *covered services* and for any *benefit limit* that may apply to a specific service or supply. Under this PPO *contract*, you determine the amount of your benefits. You do this each time you obtain a health care service. You will receive the highest level of benefits when you use providers in your preferred network. These are called your "in-network benefits." When you obtain *covered services* from a non-*preferred provider*, you will usually receive a lower level of benefits. If this is the case, your costs will be more. These are called your "out-of-network benefits." For certain *covered services* such as for a proposed *inpatient* stay, you (or the provider on your behalf) must obtain prior approval from *Blue Cross and Blue Shield*. You must do this to be sure that you receive all your benefits. (See Part 4 for more information.)

Admissions for *Inpatient* Medical and Surgical Care

General and Chronic Disease Hospital Admissions

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for as many days as are *medically necessary* for *inpatient* admissions in a general or chronic disease hospital. These benefits include:

- Semiprivate *room and board* and *special services*.
- Surgery furnished by a physician, podiatrist, nurse practitioner or dentist and services of an assistant surgeon (physician) when *Blue Cross and Blue Shield* decides an assistant is needed. These surgical services also include:

  – Reconstructive surgery. This non-dental surgery 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. This 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, these benefits include breast reconstruction in connection with a mastectomy. *Blue Cross and Blue Shield* provides benefits 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.

IMPORTANT: Refer to your PPO Schedule of Benefits for the amount that you must pay for *covered services* and for any *benefit limit* that may apply to a specific service or supply. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for those services or supplies.

  - Human organ and stem cell ("bone marrow") transplants furnished in accordance with *Blue Cross and Blue Shield* medical policy and *medical technology assessment guidelines*. This includes one or more stem cell transplants for a *member* who has been diagnosed with breast cancer that has spread and who meets the eligibility standards that have been set by the Massachusetts Department of Public Health. For covered transplants, benefits also include the harvesting of the donor's organ or stem cells when the recipient is a *member* ("harvesting" includes the surgical removal of the donor's organ or stem cells and related *medically necessary* services and/or tests that are required to perform the transplant itself) and drug therapy during the transplant procedure to prevent rejection of the transplanted organ/tissue or stem cells. (See "Lab Tests, X-Rays and Other Tests" for benefits for transplant donor suitability testing.) No benefits are provided for the harvesting of the donor's organ or stem cells when the recipient is not a *member*.

  - Oral surgery. This includes: 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 but **only** if you 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 primarily 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.)

  - Voluntary termination of pregnancy and voluntary sterilization procedures.

- Anesthesia services furnished by a physician other than the attending physician or by a certified registered nurse anesthetist, when the anesthesia is related to covered surgery.
- Radiation and x-ray therapy furnished 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) furnished by a physician.
- Interpretation of *diagnostic x-ray and other imaging tests*, *diagnostic lab tests* and diagnostic machine tests furnished by a physician or podiatrist, when these tests are not furnished by a hospital-based radiologist or pathologist.

IMPORTANT: Refer to your PPO Schedule of Benefits for the amount that you must pay for *covered services* and for any *benefit limit* that may apply to a specific service or supply. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for those services or supplies.

- Medical care furnished by a physician, nurse practitioner or podiatrist and medical care furnished by a physician other than the attending physician to treat an uncommon aspect or complication of your illness or injury. *Blue Cross and Blue Shield* provides benefits for medical care by two or more physicians at the same time **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. If the second physician is an expert in the same medical sub-specialty as the attending physician, *Blue Cross and Blue Shield* provides benefits only for the services of the attending physician.
- Monitoring services related to dialysis when furnished by a covered health care provider.
- Consultations furnished 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 it asks for one. The physician who furnishes this consultation for you must be an expert in a different medical sub-specialty than the attending physician. If the consultant is an expert in the same medical sub-specialty as the attending physician, *Blue Cross and Blue Shield* provides benefits **only** for the services of the attending physician.
- Intensive care services furnished by a physician other than the attending physician or by a nurse practitioner. This means services that are needed for only a limited number of hours to treat an uncommon aspect or complication of your illness or injury.
- Emergency admission services furnished by a physician or nurse practitioner. This means a complete history and physical exam of a *member* who is admitted as an *inpatient* for *emergency medical care*, when the treatment is taken over immediately by another physician.
- Pediatric specialty care furnished by covered health care providers with recognized expertise in specialty pediatrics.
- Second surgical opinions furnished by a physician. This includes a third surgical opinion when the second opinion differs from the first.

Rehabilitation Hospital Admissions

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for *medically necessary inpatient* admissions in a rehabilitation hospital. These benefits include: semiprivate *room and board* and hospital *special services*; and medical care furnished by a physician or nurse practitioner. **Refer to your PPO Schedule of Benefits or any *riders* that apply to your PPO *contract* for a description of any *inpatient benefit limit.***

IMPORTANT: Refer to your PPO Schedule of Benefits for the amount that you must pay for *covered services* and for any *benefit limit* that may apply to a specific service or supply. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for those services or supplies.

Skilled Nursing Facility Admissions

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for *medically necessary inpatient* admissions in a skilled nursing facility. These benefits include: semiprivate *room and board* and facility *special services*; and medical care furnished by a physician or nurse practitioner. **Refer to your PPO Schedule of Benefits or any *riders* that apply to your PPO *contract* for a description of any *inpatient benefit limit*.**

Ambulance Services

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for:

- **Emergency Ambulance Transport.** This includes ambulance transport to an emergency medical facility for *emergency medical care*. For example, covered ambulance services include transport from an accident scene or to a hospital due to symptoms of a heart attack. These benefits include air ambulance transport to take you to a hospital when your emergency medical condition requires the use of an air ambulance rather than a ground ambulance. **If you need assistance at the onset of an emergency medical condition that in your judgment requires *emergency medical care*, call your local emergency medical service system by dialing the emergency telephone access number 911, or the local emergency telephone number.**

- **Other *Medically Necessary* Ambulance Transport**. This includes *medically necessary* ambulance transport by an ambulance service to take you to or from the nearest hospital (or another covered facility). This includes ambulance transport that is needed for a *mental condition*.

No benefits are provided for taxi or chair car service or to transport the *member* to or from medical appointments.

Cardiac Rehabilitation

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for *outpatient* cardiac rehabilitation furnished by a general or chronic disease hospital or cardiac rehabilitation center for as many visits as are *medically necessary* for your condition. *Blue Cross and Blue Shield* provides these benefits according to the regulations of the Massachusetts Department of Public Health. Your first visit must be within 26 weeks of the date you were first diagnosed with cardiovascular disease or after a cardiac event. *Blue Cross and Blue Shield* must determine through medical documentation that you have cardiovascular disease, angina pectoris or have had a myocardial infarction, angioplasty or cardiovascular surgery. This type of surgery includes

IMPORTANT: Refer to your PPO Schedule of Benefits for the amount that you must pay for *covered services* and for any *benefit limit* that may apply to a specific service or supply. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for those services or supplies.

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a heart transplant, coronary bypass graft surgery or valve repair or replacement. For angina pectoris, only one course of cardiac rehabilitation is covered for each *member*.

No benefits are provided for: club membership fees (except as reimbursed as a fitness benefit); counseling services that are not part of the cardiac rehabilitation program (for example, educational, vocational and psychosocial counseling); medical or exercise equipment used in your home; services provided to your family; and additional services after you complete a cardiac rehabilitation program.

Chiropractor Services

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for chiropractic services furnished by a chiropractor when the chiropractor is licensed to furnish the specific *covered service*. These benefits include:

- Accident treatment.
- *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.
- *Outpatient* medical care services, including spinal manipulation.

Dialysis Services

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for:

- *Outpatient* dialysis furnished by a general or chronic disease hospital, community health center, free-standing dialysis facility or physician.
- Home dialysis that is under the direction of a general or chronic disease hospital or free-standing dialysis facility. These benefits include: non-durable medical supplies such as dialysis membrane and solution; tubing and drugs needed during dialysis; the cost to install dialysis equipment for up to $300; and the cost to maintain or fix 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 this equipment. It does not become your property. No 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 not needed to run the dialysis equipment.

IMPORTANT: Refer to your PPO Schedule of Benefits for the amount that you must pay for *covered services* and for any *benefit limit* that may apply to a specific service or supply. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for those services or supplies.

Durable Medical Equipment

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for durable medical equipment you buy or rent from an appliance company (or another provider who is designated by *Blue Cross and Blue Shield* to furnish the specific covered appliance). These benefits include 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 and back braces and orthopedic and corrective shoes that are part of a leg brace.
- Hospital beds; wheelchairs; crutches and walkers.
- Glucometers *medically necessary* due to the patient's type of diabetic condition.
- Visual magnifying aids and voice-synthesizers for a legally blind *member* who has insulin dependent, insulin using, gestational or non-insulin dependent diabetes.
- Insulin injection pens. (If you are enrolled in a *Blue Cross and Blue Shield* Prescription Drug Plan along with this PPO *contract*, benefits for insulin injection pens that you buy from a pharmacy are provided as described for pharmacy benefits.)

From time to time, covered equipment may change based on *Blue Cross and Blue Shield's* periodic review of its medical policy and *medical technology assessment guidelines* to reflect new applications and technologies. For more information about covered equipment, you may call the *Blue Cross and Blue Shield* customer service office.

If *Blue Cross and Blue Shield* provides benefits to rent durable medical equipment, those benefits will not be more than the amount that would have been paid if the equipment were bought. If the equipment is bought, *Blue Cross and Blue Shield* keeps ownership rights to the equipment. It does not become your property.

Blue Cross and Blue Shield provides these benefits for 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, *Blue Cross and Blue Shield* will provide benefits **only** for those charges that would have been paid for the least expensive equipment that meets your needs. In this case, you pay the provider's charges that are more than the claim payment.

Refer to your PPO Schedule of Benefits or any *riders* that apply to your PPO *contract* for a description of any *benefit limit* that applies to durable medical equipment. When a *benefit limit* applies to durable medical equipment, the *benefit limit* **does not** apply when durable medical equipment is furnished as part of covered home dialysis, home health care or hospice services.

IMPORTANT: Refer to your PPO Schedule of Benefits for the amount that you must pay for *covered services* and for any *benefit limit* that may apply to a specific service or supply. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for those services or supplies.

Early Intervention Services

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for early intervention services furnished by an early intervention provider. These benefits include physical, speech/language and occupational therapy, nursing care and psychological counseling for enrolled dependent children from birth through age two (until the child turns three years old). **These benefits are limited to $5,200 for each eligible child in each calendar year. But, no more than $15,600 will be paid during the whole time the child is eligible for these benefits.**

Emergency Medical *Outpatient* Services

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for *outpatient* accident treatment and emergency medical services you receive at an emergency room of a general hospital. (See Part 3 for more information.) **At the onset of an emergency medical condition that in your judgment requires *emergency medical care*, you should go to the nearest emergency room. For assistance, call your local emergency medical service system by dialing the emergency telephone access number 911, or the local emergency telephone number.**

Blue Cross and Blue Shield also provides benefits based on the *allowed charge* for accident treatment and *emergency medical care* furnished by a hospital outpatient department, community health center, physician, dentist or nurse practitioner. These *covered services* include:

- Non-dental accident treatment.
- Treatment of fractures, dislocations and burns.
- *Emergency medical care*.

Home Health Care

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for home health care. These benefits include:

- Part-time skilled nursing visits and physical therapy furnished by a visiting nurse association.
- Part-time skilled nursing visits, physical therapy, speech/language therapy, occupational therapy, medical social work, nutrition counseling, home health aide services, medical supplies, durable medical equipment, enteral infusion therapy and basic hydration therapy furnished by a coordinated home health agency.
- Home infusion therapy, including the infusion solution, preparation of the solution and equipment for its administration and necessary part-time nursing furnished by a home infusion therapy provider.

IMPORTANT: Refer to your PPO Schedule of Benefits for the amount that you must pay for *covered services* and for any *benefit limit* that may apply to a specific service or supply. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for those services or supplies.

Blue Cross and Blue Shield provides these benefits only when you are expected to reach a defined medical goal set by your attending physician 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.

(When physical, speech/language and/or occupational therapy services are furnished as part of a covered home health care program, any *benefit limit* that would normally apply to short-term rehabilitation therapy **does not** apply.)

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 furnished by a pharmacy or other provider that is not a home infusion therapy provider (except for enteral infusion therapy and basic hydration therapy by a coordinated home health agency).

Hospice Services

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for hospice services furnished by (or arranged and billed 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. These hospice benefits include:

- 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

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for services to diagnose and treat infertility for a healthy *member* who is unable to conceive or produce conception during a period of one year. These benefits include: artificial insemination; sperm, egg and/or inseminated egg procurement and processing; banking of sperm or inseminated eggs (provided these charges are not covered by the donor's health plan); and infertility technologies

IMPORTANT: Refer to your PPO Schedule of Benefits for the amount that you must pay for *covered services* and for any *benefit limit* that may apply to a specific service or supply. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for those services or supplies.

(such as in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer, natural oocyte retrieval intravaginal fertilization, intracytoplasmic sperm injection and assisted embryo hatching). **All services must be furnished in accordance with *Blue Cross and Blue Shield* medical policy and *medical technology assessment guidelines*.**

All *covered services* must be *medically necessary* for you and furnished by an infertility provider approved by *Blue Cross and Blue Shield*. If *Blue Cross and Blue Shield* determines that infertility services are not *medically necessary* for you or you receive services from an infertility provider not approved by *Blue Cross and Blue Shield*, no benefits will be provided for these services.

Important Note:	There are no exclusions, limitations or other restrictions for drugs that are prescribed to treat infertility different from those applied to drugs that are prescribed for other medical conditions. This includes drugs that are dispensed by an infertility provider or a pharmacy.

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); and infertility treatment that is needed as a result of a prior sterilization or unsuccessful sterilization reversal procedure. (*Blue Cross and Blue Shield* will provide benefits for *medically necessary* infertility treatment that is needed after a sterilization reversal procedure that is successful as determined by appropriate diagnostic tests.)

Lab Tests, X-Rays and Other Tests

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for:

- *Diagnostic lab tests* furnished by a general, chronic disease, rehabilitation or mental hospital, surgical day care unit, ambulatory surgical facility, community health center, independent lab, physician or nurse practitioner. These tests also include diagnostic machine tests such as pulmonary function tests and holter monitoring.
- *Diagnostic x-ray and other imaging tests* furnished by a general, chronic disease, rehabilitation or mental hospital, surgical day care unit, ambulatory surgical facility, community health center or physician. These tests also include diagnostic imaging tests by a free-standing diagnostic imaging facility.
- Preoperative tests furnished by a general hospital or community health center (that is part of a hospital). 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).

IMPORTANT: Refer to your PPO Schedule of Benefits for the amount that you must pay for *covered services* and for any *benefit limit* that may apply to a specific service or supply. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for those services or supplies.

- Human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to establish stem cell ("bone marrow") transplant donor suitability when the tests are furnished to a *member* by a covered health care provider. This includes testing for A, B or DR antigens or any combination in accordance with the guidelines of the Massachusetts Department of Public Health.

Maternity Services and Well Newborn *Inpatient* Care

Maternity Services

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for all medical care related to pregnancy and childbirth (or miscarriage) for any female *member*. These benefits include:

- Semiprivate *room and board* and *special services* when the enrolled mother is an *inpatient* in a general hospital. Nursery charges for a well newborn 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, *Blue Cross and Blue Shield* provides benefits for one home visit by a physician, registered nurse, nurse midwife or nurse practitioner within 48 hours of discharge. This visit may include: parent education; assistance and training in breast or bottle feeding; and appropriate tests. *Blue Cross and Blue Shield* will provide benefits for more visits by a covered health care provider **only** if *Blue Cross and Blue Shield* determines they are clinically necessary.
- Delivery of one or more than one baby, including prenatal and postnatal medical care furnished by a physician or nurse midwife. Your benefits for prenatal and postnatal medical care by a physician or nurse midwife are included in the payment for the delivery. The benefits that are available for these obstetrical services will be those that are in effect on the date of delivery. But, when a physician or nurse midwife furnishes only prenatal and/or postnatal care, benefits are those which are available on the date the care is received.

  These benefits also include prenatal and postnatal medical care exams and lab tests by a general hospital or community health center. The benefits that are available for these services are those which are available on the date the care is received.

IMPORTANT: Refer to your PPO Schedule of Benefits for the amount that you must pay for *covered services* and for any *benefit limit* that may apply to a specific service or supply. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for those services or supplies.

- Standby attendance furnished by the pediatrician, when a known or suspected complication threatening the health of the mother or child requires the presence of a pediatrician 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. 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 unless you complete the course. There is one exception. You will be reimbursed if your delivery occurs before the course ends.

All expectant mothers enrolled under this PPO *contract* 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 may call the *Blue Cross and Blue Shield* customer service office for more information.

Well Newborn *Inpatient* Care

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for well newborn care furnished during the enrolled mother's *inpatient* maternity stay. These benefits include:

- Pediatric care by a physician (who is a pediatrician) or nurse practitioner for a well newborn for up to ten visits. (These visits include any subsequent visits for *outpatient* routine pediatric care received during the first year of life.)
- Routine circumcision by a physician.
- Newborn hearing screening tests performed by a covered health care 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.

Note: See "Admissions for *Inpatient* Medical and Surgical Care" for benefits when an enrolled newborn child requires *medically necessary inpatient* care.

IMPORTANT: Refer to your PPO Schedule of Benefits for the amount that you must pay for *covered services* and for any *benefit limit* that may apply to a specific service or supply. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for those services or supplies.

Medical Care *Outpatient* Visits

When you need *outpatient* care to treat a medical condition, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for services furnished by a general, chronic disease or rehabilitation hospital, community health center, physician, nurse practitioner, nurse midwife, optometrist or licensed dietitian nutritionist. These benefits include:

- Medical care to diagnose or treat your illness or injury. This includes nutrition counseling.

  Women's Health and Cancer Rights: As required by federal law, these benefits include medical care services to treat physical complications for 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.

- Medical exams and contact lenses (plus the fitting of these contact lenses) that are needed to treat keratoconus.
- Hormone replacement therapy for peri- and post-menopausal women.
- Follow-up care related to an accidental injury or emergency medical condition.
- Allergy testing (such as PRIST, RAST and scratch tests).
- Injections (such as allergy shots).
- Diabetes self-management training and education, including medical nutrition therapy when provided by a certified diabetes health care professional who is a covered provider or who is affiliated with a covered provider.
- Pediatric specialty care by covered health care providers with recognized expertise in specialty pediatrics.
- Non-dental services by a dentist only if the services would normally be covered when furnished by a physician (see Part 6, "Dental Care").
- Monitoring and medication management for *members* taking psychiatric drugs. This also includes neuropsychological assessment services. (These services may also be furnished by a mental hospital or mental health center.)

These benefits also include syringes and needles that are furnished on and after July 13, 2006, provided that they are *medically necessary* for you and they are supplied by a covered health care provider during your visit or when you buy them from a licensed pharmacy. For these covered supplies, any *copayment* that you would normally pay for your visit will be waived when the visit is only to obtain the syringes and needles. (If you are enrolled in a *Blue Cross and Blue*

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Shield Prescription Drug Plan along with this PPO *contract*, benefits for syringes and needles that you buy from a pharmacy are provided as described for pharmacy benefits.)

Medical Formulas

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for:

- Special medical formulas that are approved by the Massachusetts Department of Public Health and *medically necessary* to treat: homocystinuria; maple syrup urine disease; phenylketonuria; propionic acidemia; methylmalonic acidemia; and tyrosinemia.
- Enteral formulas for home use that are *medically necessary* to treat malabsorption caused by: Crohn's disease; chronic intestinal pseudo-obstruction; gastroesophageal reflux; gastrointestinal motility; ulcerative colitis; and inherited diseases of amino acids and organic acids.
- Food products modified to be low protein that are *medically necessary* to treat inherited diseases of amino acids and organic acids. (You may buy these food products directly from a distributor.) **These benefits are limited to $2,500 for each *member* in each calendar year.**

If you are enrolled in a *Blue Cross and Blue Shield* Prescription Drug Plan along with this PPO *contract*, your benefits for these covered medical formulas are provided as described for pharmacy benefits.

Mental Health and Substance Abuse Treatment

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for *medically necessary* services to diagnose and/or treat *mental conditions.* This includes drug addiction and alcoholism. These benefits are provided for:

- 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; and

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  - 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 and are scientifically recognized and approved by the Commissioner of the Department of Mental Health in consultation with the Commissioner of the Division of Insurance.
- 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. These benefits include pediatric specialty mental health care furnished by *mental health providers* with a recognized expertise in specialty pediatrics. (These benefits are 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, these benefits 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 under this *contract* in accordance with federal (COBRA) or state law, or the child enrolls with no lapse in coverage under this or a subsequent Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. or *Blue Cross and Blue Shield* plan.
- All other non-biologically-based *mental conditions* (including drug addiction and alcoholism) not described above.

No benefits are provided for: psychiatric services for a condition that is not a *mental condition*; for residential or other care that is *custodial care*, or for services and/or programs that are not *medically necessary* to treat the *member's mental condition*. Some examples of services and programs that are not covered include (but are not limited to): "outward bound-type," "wilderness" or "ranch" programs; and services that are performed in educational, vocational or recreational settings.

***Inpatient* Services**

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for admissions in a general or mental hospital or substance abuse treatment facility. These benefits are provided for as many days as are *medically necessary* for the *member's mental condition*, except as may be limited for certain non-biologically-based *mental conditions*. For *mental conditions* other than biologically-based *mental conditions*, treatment of rape-related conditions and treatment of children who are under age 19, these benefits are limited to 60 days for each *member* in each calendar year when the admission is in a mental hospital or substance abuse treatment facility. (An additional 30 days each calendar year is available for alcohol treatment.) For *covered*

IMPORTANT: Refer to your PPO Schedule of Benefits for the amount that you must pay for *covered services* and for any *benefit limit* that may apply to a specific service or supply. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for those services or supplies.

services, these benefits include: semiprivate *room and board*; *special services*; and psychiatric care furnished by a physician (who is a specialist in psychiatry), psychologist or clinical specialist in psychiatric and mental health nursing.

All services must be approved in advance by *Blue Cross and Blue Shield*. During the pre-admission review process (see Part 4), *Blue Cross and Blue Shield* will assess the *member's* specific mental health needs. The least intensive type of setting that is required for the *member's* condition will be approved by *Blue Cross and Blue Shield*. There are times when a *member* will require *covered services* that are more intensive than the typical *outpatient* services. But, these services may not require that the *member* 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*.

If an *inpatient* day *benefit limit* applies for the *mental condition* (see above), these treatments will be counted as part of the day limit as follows:

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

(Since *Blue Cross and Blue Shield* considers benefits for these intermediate mental health care services to be an *inpatient* benefit, any *benefit limits* or *member* cost sharing for *outpatient* mental health services will **not** apply.)

Note: The *inpatient* day limit that would normally apply to alcohol or drug addiction treatment **will not** apply when this treatment is furnished in conjunction with covered treatment of another *mental condition*. This provision applies to the mental health benefits described in this entire section.

***Outpatient* Services**

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for *outpatient* services furnished by a *mental health provider*. These benefits are provided for as many visits as are *medically necessary* for the *member's mental condition*, except as may be limited for certain non-biologically-based *mental conditions*. For *mental conditions* other than biologically-based *mental conditions*, treatment of rape-related conditions and treatment of children who are under age 19, these benefits are limited to 24 visits for each *member* in each calendar year. (An

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additional 8 visits each calendar year are available for alcohol treatment. As required by state law, the value of these 8 visits for alcohol treatment will be at least $500 in each calendar year.) These *benefit limits* do not apply to electric shock therapy.

Note: The *outpatient* visit limits that would normally apply to alcohol or drug addiction treatment **will not** apply when this treatment is furnished in conjunction with covered treatment of another *mental condition*. This provision applies to the mental health benefits described in this entire section.

Oxygen and Respiratory Therapy

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for:

- Oxygen and the equipment to administer it for use in the home when obtained from an oxygen supplier. This includes oxygen concentrators.
- Respiratory therapy services by a general, chronic disease or rehabilitation hospital or community health center. Some examples include postural drainage and chest percussion.

Podiatry Care

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for non-routine podiatry (foot) care furnished by a general hospital, surgical day care unit, ambulatory surgical facility, community health center, physician or podiatrist. These benefits include:

- Accident treatment and treatment of fractures and dislocations.
- *Diagnostic lab tests*.
- Diagnostic x-rays.
- Surgery and necessary postoperative care.
- 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 PPO *contract* for "Prosthetic Devices") and fittings, castings and other services related to devices for the feet.

IMPORTANT: Refer to your PPO Schedule of Benefits for the amount that you must pay for *covered services* and for any *benefit limit* that may apply to a specific service or supply. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for those services or supplies.

Preventive Health Services

Routine Pediatric Care

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for routine pediatric care furnished by a general hospital, community health center, physician, nurse practitioner or independent lab for a *member* from birth through age 18. **These benefits are limited to an age-based schedule and a maximum number of visits. Refer to your PPO Schedule of Benefits or any *riders* that apply to your PPO *contract* for the age-based schedule and visit limit that apply to your benefits for these services.** As required by state law, these benefits are provided for at least six visits during the first year of life (birth to age one), including *inpatient* visits for pediatric care 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 5 (until age 6). These *covered services* include:

- Routine medical exams, history, measurements, sensory screening, neuropsychiatric evaluation and development screening and assessment.
- Other related routine services that are furnished in accordance with *Blue Cross and Blue Shield's* medical policy guidelines.
- Hereditary and metabolic screening at birth.
- Appropriate immunizations (including flu shots and travel immunizations).
- Tuberculin tests.
- Hematocrit, hemoglobin and other appropriate blood tests.
- Urinalysis.
- Blood tests to screen for lead poisoning (as required by state law).

For an enrolled dependent child who gets benefits for hepatitis B vaccine from a state agency, *Blue Cross and Blue Shield* provides benefits only to administer the vaccine. Otherwise, *Blue Cross and Blue Shield* also provides benefits for the hepatitis B vaccine when the child is at high risk for getting the disease.

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

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for routine physical exams, including related x-ray and lab tests furnished by a general hospital, community health center, physician, nurse practitioner, nurse midwife or independent lab for a *member* age 19 or older. **These benefits are limited to an age-based schedule. Refer to your PPO Schedule of**

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Benefits or any *riders* that apply to your PPO *contract* for the age-based schedule that applies to your benefits for these services. These *covered services* include: routine medical exams; and related routine services that are furnished in accordance with *Blue Cross and Blue* S*hield* medical policy guidelines.

These preventive health services also include:

- Immunizations (including flu shots and travel immunizations).
- Blood tests to screen for lead poisoning (as required by state law).
- One baseline mammogram during the five-year period a *member* is age 35 through 39 and one routine mammogram in each calendar year for a *member* age 40 or older.
- One routine prostate-specific antigen (PSA) blood test in each calendar year for a *member* age 40 or older.
- One routine sigmoidoscopy or barium enema every three calendar years for a *member* age 50 or older.
- One routine colonoscopy every ten calendar years for a *member* 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

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for one routine GYN exam, including a routine Pap smear test and other related lab tests, for each *member* in each calendar year when furnished by a general hospital, community health center, physician, nurse practitioner, nurse midwife or independent lab.

Family Planning

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for family planning services furnished by a community health center, general hospital, physician, nurse practitioner or nurse midwife. These benefits include:

- 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, including the prescription drug when supplied by the health care provider during the visit.
- Insertion of a levonorgestrel implant system, including the implant system itself.

IMPORTANT: Refer to your PPO Schedule of Benefits for the amount that you must pay for *covered services* and for any *benefit limit* that may apply to a specific service or supply. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for those services or supplies.

- 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 by the health care provider 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

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for:

- Routine hearing exams (including hearing tests that are part of a covered hearing exam) when the services are furnished by a general hospital, community health center or physician.
- Newborn hearing screening tests for a newborn child (an infant under three months of age) when furnished by a covered health care provider or as provided by regulations of the Massachusetts Department of Public Health. (See "Maternity Services and Well Newborn *Inpatient* Care" for your *inpatient* benefits.)

Routine Vision Exams

Blue Cross and Blue Shield provides benefits for a routine vision exam furnished by an ophthalmologist or optometrist. **Refer to your PPO Schedule of Benefits or any *riders* that apply to your PPO *contract* for a description of any *benefit limit* that applies to routine vision exams.**

Wellness Benefits

While you are enrolled in this PPO *contract*, you may be reimbursed for some fees that you pay to participate in fitness programs and/or weight loss programs.

Fitness Benefit. For each membership in this PPO *contract*, *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 *subscriber's* enrolled spouse (or former spouse, if applicable) and enrolled dependent children. However, this $150 benefit is the total fitness benefit that is reimbursed during a calendar year for a membership in this PPO *contract*. (For a health club membership, each *member* claiming all or part of the fitness benefit must have paid at least four months' health club fees for that calendar year.)

IMPORTANT: Refer to your PPO Schedule of Benefits for the amount that you must pay for *covered services* and for any *benefit limit* that may apply to a specific service or supply. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for those services or supplies.

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.
- Martial arts schools.

Weight Loss Program Benefit. For each membership in this PPO *contract*, *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 *subscriber's* enrolled spouse (or former spouse, if applicable) and enrolled dependent children. However, this $150 benefit is the total weight loss program benefit that is reimbursed during a calendar year for a membership in his PPO *contract.*

Note: To find out which weight loss program(s) are designated by *Blue Cross and Blue Shield*, you may use the internet website at **www.bluecrossma.com**. Or, you may call the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your PPO identification card.

No weight loss program benefit is provided for any fees or costs that you pay for:

- On-line weight loss programs.
- Any non-hospital-based weight loss program not designated by *Blue Cross and Blue Shield*.
- Individual nutrition counseling sessions. (For your benefits for nutritional counseling services, see "Medical Care *Outpatient* Visits.")
- Pre-packaged meals; books; videos; scales; or other items or supplies bought by the *member*.
- Any other items not included as part of a weight loss class or weight loss course.

IMPORTANT: Refer to your PPO Schedule of Benefits for the amount that you must pay for *covered services* and for any *benefit limit* that may apply to a specific service or supply. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for those services or supplies.

Filing a Claim for the Fitness Benefit or Weight Loss Program Benefit. 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 may call the *Blue Cross and Blue Shield* customer service office. Or, you may use the internet website at **www.bluecrossma.com** for help or to print a claim form.

Prosthetic Devices

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for prosthetic devices you get from an appliance company (or another provider who is designated by *Blue Cross and Blue Shield* to furnish the covered prosthetic device). These benefits include 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 prosthetic devices include (but are not limited to):

- Artificial arms, legs and eyes.
- Ostomy supplies and urinary catheters.
- Breast prostheses, including mastectomy bras.
- Therapeutic/molded shoes and shoe inserts for a *member* with severe diabetic foot disease.
- Insulin infusion pumps and related pump supplies that are *medically necessary* for *members* with insulin dependent diabetes.
- Scalp hair prostheses (wigs). These benefits are limited to $500 for each *member* in each calendar year 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). No benefits are provided for wigs when hair loss is due to: male pattern baldness; female pattern baldness; or natural or premature aging.

In addition, these benefits are provided for materials to test for the presence of sugar, including blood glucose monitoring strips, ketone strips, lancets, urine glucose testing strips, normal, low and high calibrator solution/chips and dextrostik or glucose test strips when ordered by a physician for home use. (*Blue Cross and Blue Shield* will provide "in-network benefits" for these testing materials.)

IMPORTANT: Refer to your PPO Schedule of Benefits for the amount that you must pay for *covered services* and for any *benefit limit* that may apply to a specific service or supply. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for those services or supplies.

If you are enrolled in a *Blue Cross and Blue Shield* Prescription Drug Plan along with this PPO *contract*, your benefits for insulin infusion pumps and related pump supplies and diabetic testing materials are provided as described for pharmacy benefits.

Blue Cross and Blue Shield provides these benefits for the least expensive prosthesis of its type that meets your needs. If *Blue Cross and Blue Shield* determines that you chose a prosthesis that costs more than what you need for your medical condition, *Blue Cross and Blue Shield* will provide benefits **only** for those charges that would have been paid for the least expensive prosthesis that meets your needs. In this case, you pay the provider's charges that are more than the claim payment.

Qualified Clinical Trials for Treatment of Cancer

Blue Cross and Blue Shield provides benefits for health care services and supplies received by a *member* as part of a qualified clinical trial (for treatment of cancer) when the *member* is enrolled in that trial. These benefits are 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. These benefits may also be provided for investigational drugs and devices that have been approved for use as part of the trial. The benefits for health care services and supplies that are received as part of a qualified clinical trial are provided to the same extent as it would have been provided if the patient 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 PPO *contract*.
- 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.

IMPORTANT: Refer to your PPO Schedule of Benefits for the amount that you must pay for *covered services* and for any *benefit limit* that may apply to a specific service or supply. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for those services or supplies.

Radiation Therapy and Chemotherapy

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for radiation and x-ray therapy and chemotherapy by a general, chronic disease or rehabilitation hospital, community health center, free-standing radiation therapy and chemotherapy facility, physician, nurse practitioner or other covered health care provider with a recognized expertise in specialty pediatrics. These benefits include:

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

Second Opinions

When your physician recommends that you have non-emergency surgery, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for an *outpatient* second surgical opinion furnished by a consulting physician. This includes a third opinion when the second opinion differs from the first. (See "Lab Tests, X-Rays and Other Tests" for your benefits for related diagnostic tests.)

Short-Term Rehabilitation Therapy

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for short-term rehabilitation therapy furnished by a general, chronic disease or rehabilitation hospital, skilled nursing facility, community health center, physical therapist, licensed speech-language pathologist, occupational therapist or other covered health care provider with a recognized expertise in specialty pediatrics. These benefits include:

- Physical therapy.
- Speech/language therapy.
- Occupational therapy.
- An organized program of these combined services.

Refer to your PPO Schedule of Benefits or any *riders* that apply to your PPO *contract* for a description of any *benefit limit* that applies to short-term rehabilitation therapy. (When a *benefit limit* applies to short-term rehabilitation therapy, the *benefit limit* **does not** apply when physical, speech/language and/or occupational therapy is furnished as part of a covered home health care program or to diagnose and treat speech, hearing and language disorders.)

IMPORTANT: Refer to your PPO Schedule of Benefits for the amount that you must pay for *covered services* and for any *benefit limit* that may apply to a specific service or supply. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for those services or supplies.

Speech, Hearing and Language Disorder Treatment

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for *medically necessary* services to diagnose and treat speech, hearing and language disorders when the services are furnished by a general, chronic disease or rehabilitation hospital, skilled nursing facility, community health center, licensed audiologist, licensed speech-language pathologist or other covered health care provider with a recognized expertise in specialty pediatrics. These benefits include:

- Diagnostic tests, including hearing exams and tests.
- Speech/language therapy.
- 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.

Surgery as an *Outpatient*

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for *outpatient* surgical services by a surgical day care unit, ambulatory surgical facility, general, chronic disease or rehabilitation hospital, community health center, physician, nurse practitioner or other covered health care provider with a recognized expertise in specialty pediatrics. These benefits include:

- Routine circumcision, voluntary termination of pregnancy and voluntary sterilization.
- Endoscopic procedures.
- Surgical procedures, including emergency and scheduled surgery. These surgical services include (but are not limited to):

  – Reconstructive surgery. This non-dental surgery 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. This 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, these benefits include breast reconstruction in connection with a mastectomy. *Blue Cross and Blue Shield* provides benefits 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.

IMPORTANT: Refer to your PPO Schedule of Benefits for the amount that you must pay for *covered services* and for any *benefit limit* that may apply to a specific service or supply. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for those services or supplies.

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

- Human organ and stem cell ("bone marrow") transplants furnished in accordance with *Blue Cross and Blue Shield* medical policy and *medical technology assessment* guidelines. This includes one or more stem cell transplants for a *member* who has been diagnosed with breast cancer that has spread and who meets the eligibility standards that have been set by the Massachusetts Department of Public Health. For covered transplants, benefits also include the harvesting of the donor's organ or stem cells when the recipient is a *member* ("harvesting" includes the surgical removal of the donor's organ or stem cells and related *medically necessary* services and/or tests that are required to perform the transplant itself) and drug therapy during the transplant procedure to prevent rejection of the transplanted organ/tissue or stem cells. (See "Lab Tests, X-Rays and Other Tests" for benefits for transplant donor suitability testing.) No benefits are provided for the harvesting of the donor's organ or stem cells when the recipient is not a *member*.

- Oral surgery. This includes: 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 when the surgery is furnished at a hospital provided that you have a serious medical condition that requires that you be admitted to a surgical day care unit of a hospital or to an ambulatory surgical facility in order for the surgery to be safely performed. These benefits are also provided when the surgery is furnished at an oral surgeon's office. (Orthognathic surgery is not covered when it is performed primarily 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.)

- Non-dental surgery and necessary postoperative care by a dentist (see Part 6, "Dental Care").

- Necessary postoperative care after covered *inpatient* or *outpatient* surgery.
- Anesthesia services related to covered surgery, including anesthesia administered by a physician other than the attending physician or by a certified registered nurse anesthetist.

IMPORTANT: Refer to your PPO Schedule of Benefits for the amount that you must pay for *covered services* and for any *benefit limit* that may apply to a specific service or supply. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided for those services or supplies.

TMJ Disorder Treatment

Blue Cross and Blue Shield provides benefits based on the *allowed charge* for temporomandibular joint (TMJ) disorder treatment furnished by a general, chronic disease or rehabilitation hospital, community health center, surgical day care unit, ambulatory surgical facility, physician, dentist or physical therapist. These benefits include:

- Non-dental medical care services to diagnose and treat a TMJ disorder.
- Diagnostic x-rays.
- Splint therapy (measuring, fabricating and adjusting the splint).
- Physical therapy. (These benefits are subject to the short-term rehabilitation therapy *benefit limit*. See "Short-Term Rehabilitation Therapy.")
- Surgical repair or intervention.

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

The benefits described in this PPO *contract* are limited or excluded as follows:

Admissions Before a *Member's Effective Date*

The benefits described in this PPO *contract* are provided only for *covered services* furnished on or after your *effective date*. If you are already an *inpatient* in a hospital (or another covered health care facility) on your *effective date*, *Blue Cross and Blue Shield* will provide benefits starting on your *effective date*. But, these benefits are subject to all the provisions described in this PPO *contract*.

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 if you could have received governmental benefits by applying for them on time. (This exclusion does not include Medicaid or Medicare. (See Part 7 for more information if you are eligible for Medicare benefits.)

Blood and Related Fees

No benefits are provided for whole blood, packed red blood cells, blood donor fees and blood storage fees.

Cosmetic Services and Procedures

No benefits are provided for cosmetic services that are performed solely for the purpose of making you look better, whether or not these services are meant to make you feel better about yourself or treat 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 benefits 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

No benefits are provided for services that *Blue Cross and Blue Shield* determines to be for dental care, even when the dental condition is related to or caused by a medical condition or medical treatment. There is one exception to this exclusion. *Blue Cross and Blue Shield* does provide benefits for facility charges **only** 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 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 children with serious behavioral or emotional disorders; and *covered services* to diagnose and/or treat speech, hearing and language disorders. (See Part 5.)

Exams/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 required for recreational activities, employment, insurance and school; and court-ordered exams and services except for *medically necessary* services. (But, certain exams may be covered when they are furnished as part of a covered routine physical exam.)

Experimental Services and Procedures

The benefits described in this PPO *contract* are provided only when *covered services* are furnished in accordance with *Blue Cross and Blue Shield medical technology assessment guidelines*. No benefits are provided for health care charges that are received for or related to care that *Blue Cross and Blue Shield* considers to be experimental services or procedures. The fact that a treatment is offered as a last resort does not mean that benefits will be provided for it. There are two exceptions to this exclusion. As required by law, *Blue Cross and Blue Shield* does provide benefits for:

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

Eyewear

No benefits are provided for eyeglasses and contact lenses. There are two exceptions to this exclusion. *Blue Cross and Blue Shield* does provide benefits for: contact lenses when they are needed to treat keratoconus (including the fitting of these contact lenses); and intraocular lenses that are implanted after corneal transplant, cataract surgery or other covered eye surgery when the natural eye lens is replaced.

Foot Care

No benefits are provided for:

- Routine foot care services such as trimming of corns, trimming of nails and other hygienic care, except when your care is *medically necessary* due to systemic circulatory diseases (such as diabetes).
- Certain non-routine foot care services and supplies such as: foot orthotics, arch supports, shoe (foot) inserts and orthopedic and corrective shoes that are not part of a leg brace (except as described in Part 5 for "Prosthetic Devices"); and fittings, castings and other services related to devices for the feet.

Medical Devices, Appliances, Materials and Supplies

No benefits are provided for medical devices, appliances, materials and supplies, except as otherwise described 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, computers, computerized communication devices, 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 providers may charge you if you do not keep your scheduled appointments. They may do so if you do not give reasonable notice to the office. You must pay for these charges. Appointments that you do not keep are not counted against any visit or dollar limits for benefits described in your PPO *contract*.

Non-Covered Providers

No benefits are provided for any services and supplies furnished by the kinds of providers that **are not** covered under your PPO *contract*. For each *covered service*, this PPO *contract* specifies the kinds of providers that are covered.

Non-*Covered Services*

No benefits are provided for:

- A service or supply that is not described as a *covered service* in your PPO *contract*. Some examples of non-*covered services* are: acupuncture; private duty nursing; and prescription drugs (except when administered to a *member* while an *inpatient* or *outpatient* in a health care facility covered under this PPO *contract*).

  Note: There is one exception to this exclusion. As other services and supplies are approved by the United States Food and Drug Administration (FDA) for the diagnosis and treatment of insulin dependent, insulin using, gestational or non-insulin dependent diabetes, your benefits will be changed to include those services and supplies as long as they can be classified under categories of services or supplies that are already described in this PPO *contract* and they are in accordance with *Blue Cross and Blue Shield medical technology assessment guidelines*.

- Services that do not conform with *Blue Cross and Blue Shield* medical policy guidelines.
- Services or supplies that you received when you were not enrolled under this PPO *contract*. There are two exceptions to this exclusion. *Blue Cross and Blue Shield* does provide benefits for routine nursery charges and routine newborn exams furnished during the enrolled mother's maternity admission. But, to ensure benefits for all other *covered services* for the newborn child, you must remember to enroll the newborn under the *subscriber's* membership within the time period required to make membership changes.
- Any service or supply furnished along with a non-*covered service*.
- Any service or supply furnished by a provider who has not been approved by *Blue Cross and Blue Shield* for payment for the specific service or supply.
- Services and supplies that are not considered *medically necessary* by *Blue Cross and Blue Shield*. The only exceptions are for: routine circumcision; voluntary termination of pregnancy; voluntary sterilization; stem cell ("bone marrow") transplant donor suitability testing; and preventive health services as described in Part 5.
- Services that are furnished to someone other than the patient, except as described in this PPO *contract* for: hospice services; and the harvesting of a donor's organ or stem cells when the recipient is a *member*.
- Services that are furnished to all patients due to a facility's routine admission requirements.
- Services and supplies that are related to sex change surgery or to the reversal of a sex change.
- A provider's charge for shipping and handling or taxes.
- A provider's charge to file a claim. Also, a provider's charge to transcribe or copy your medical records.
- A separate fee for services 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 other health care facility beyond the discharge time 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 convenience or for the convenience of your family. Some examples of non-covered items or services include: telephones; radios; televisions; and personal care services.

Private Room Charges

For covered *room and board*, the benefits described in this PPO *contract* are provided based on the semiprivate room rate. If a private room is used, you must pay for any charges that are more than the semiprivate room rate.

Refractive Eye Surgery

No benefits are provided for refractive eye surgery for conditions that can be corrected by means other than surgery. This type of surgery includes radial keratotomy.

Reversal of Voluntary Sterilization

No benefits are provided for the reversal of sterilization.

Services and Supplies after a *Member's* Termination Date

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

Services Furnished to Immediate Family

No benefits are provided for a *covered service* furnished by a provider to himself or herself or to a member of his or her immediate family. The only exception is for drugs for which benefits are provided when used by a physician, dentist or podiatrist while furnishing a *covered service*. (Benefits for such drugs are based on the *allowed charge* or the provider's actual costs, whichever is less.) "Immediate family" means any of the following members of a 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.

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

Surrogate Pregnancy

No benefits are provided for services related to achieving pregnancy through a surrogate (gestational carrier).

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 other health plans under which you are covered. Once you are enrolled under this PPO *contract*, you must notify *Blue Cross and Blue Shield* if you add or change health plan coverage. Upon 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 under this PPO *contract* is secondary, no benefits 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 under this PPO *contract* will be secondary when another plan provides you with coverage for health care services.

Blue Cross and Blue Shield will not provide any more benefits than those already described in this PPO *contract*. *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.**

Medicare Program

When you are eligible for the Medicare program and Medicare is allowed by federal law to be the primary payor, the benefits provided by *Blue Cross and Blue Shield* 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 eligible for Medicare only because of ESRD (permanent kidney failure), the benefits described in this PPO *contract* will be provided before Medicare benefits. This is the case **only** during the first 30 months of your ESRD Medicare coverage. Then, the benefits described in this PPO *contract* 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 eligible for Medicare only because of a disability other than ESRD, the benefits described in this PPO *contract* will be provided before Medicare benefits. This is the case **only** if you are the actively employed *subscriber* or the enrolled spouse or child of the actively employed *subscriber*. If you are an inactive employee or a retiree or the enrolled spouse or child of the inactive employee or retiree, the benefits described in this PPO *contract* 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 eligible for Medicare only because of age, the benefits described in this PPO *contract* will be provided before Medicare benefits as long as you have chosen this PPO *contract* 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*.

Note: If you are actively employed at the time you reach age 65 and become eligible for Medicare, you must choose between Medicare and this PPO *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, the benefits described in this PPO *contract* will be provided before Medicare benefits. This is the case during the first 30 months of your ESRD Medicare coverage **only** if the benefits described in this PPO *contract* were primary when you became eligible for ESRD Medicare benefits. Then, for as long as you maintain dual Medicare eligibility, the benefits described in this PPO *contract* will be reduced by the amount that Medicare allows for the same *covered services*.

Note: This provision may not apply to you. To find out if it does, contact your *plan sponsor*.

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

Subrogation and Reimbursement of Benefit Payments

If you are injured by any act or omission of another person, the benefits under this PPO *contract* 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 you must reimburse *Blue Cross and Blue Shield* will not be reduced by any attorney's fees or expenses 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 *Blue Cross and Blue Shield's* customer service office.

Part 8

Filing a Claim

When the Provider Files a Claim

Your provider will file a claim for you when you receive a *covered service* from a *preferred provider* or a non-*preferred provider* outside of Massachusetts who has a payment agreement with the local Blue Cross and/or Blue Shield Plan. Just tell the provider that you are a *member* and show him or her your PPO identification card. Also, be sure to give the provider any other information that is needed to file your claim. You must properly inform your provider within 30 days after you receive the *covered service*. If you do not, benefits will not have to be provided. *Blue Cross and Blue Shield* will pay the provider directly for *covered services*.

When the *Member* Files a Claim

You may have to file your claim when you receive a *covered service* from a non-*preferred provider* in Massachusetts or a non-*preferred provider* outside of Massachusetts who **does not** have a payment agreement with the local Blue Cross and/or Blue Shield Plan. The provider may ask you to pay the entire charge at the time of the visit or at a later date. It is up to you to pay your provider. To file a claim 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. *Blue Cross and Blue Shield* will mail to you all applicable forms within 15 days after receiving notice that you obtained some service or supply for which you may be paid.

Note: When you receive *covered services* outside the United States, you must file your claim to the Blue Card® Worldwide Service Center. (The Blue Card 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, including the conversion to U.S. currency and forward 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 benefits 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 benefits or payment, a decision will be made and, where appropriate, payment will be made to the provider (or to you if you sent in the claim) for your claim to the extent of your benefits described in this PPO *contract*. Or, you and/or the provider will be sent a notice in writing of why your claim is not being paid in full or in part.

Missing Information. If the request for benefits or payment is not complete or if more information is needed to make a final determination for the claim, *Blue Cross and Blue Shield* will ask for the information or records it needs within 30 calendar days of receiving the request for benefits 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 the request, a decision will be made within the time remaining in the original 30-day claim determination period or within 15 calendar days of the date the additional information is received, 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 the request, the claim for benefits or payment will be denied. If the additional information is submitted after these 45 days, then it may be viewed as a new claim for benefits or payment. In this case, a decision will be made within 30 days as described previously in this section.

Part 9

Grievance Program

You have the right to a review when you disagree with a decision 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 a *preferred provider*.

Making an Inquiry and/or Resolving Claim Problems or Concerns

Most problems or concerns can be handled with just one phone call. (See page 8 for more information about *Member* Services.) For help resolving a problem or concern, you should first call the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your PPO identification card. A customer service representative will work with you to help you understand your benefits or 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, including the terms of your PPO *contract*, the policies and procedures that support the PPO *contract*, the provider's input, as well as your understanding and expectation of benefits. *Blue Cross and Blue Shield* will use every opportunity to be reasonable in finding a solution that makes sense for all parties and may use an individual case management approach when it is judged to be appropriate. *Blue Cross and Blue Shield* will follow its standard business practices guidelines when resolving your problem or concern.

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

The formal grievance review process described below will be followed when your request for a review is because *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 *Blue Cross and Blue Shield's* 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:

  Grievance Program
  Blue Cross Blue Shield of Massachusetts
  Landmark Center
  401 Park Drive
  Boston, Massachusetts 02215-3326
  Fax: 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 *Blue Cross and Blue Shield's* 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.

- **Telephone Call.** Or, you may call *Blue Cross and Blue Shield's* Grievance Program at **1-800-472-2689**. When your request is made by telephone, *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, ask for more information as needed and let you know in writing of the decision or the outcome of the review. If your grievance is regarding termination of 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 coverage does not apply to services that are limited by dollar or visit maximums and that exceed those maximums, 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 also available to provide *members* with information and/or reports about grievances. To contact the Office of Patient Protection, you may call **1-800-436-7757** or fax a request to **1-617-624-5046**. Or, you can visit the Office of Patient Protection's internet website **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 identification 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. You do not have to designate the health care provider in writing.)

Who Handles the Grievance Review. All grievances are reviewed by individuals who are knowledgeable about *Blue Cross and Blue Shield* and the issues involved in the grievance. The individuals 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 that usually treats the medical condition, 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* formal internal 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*. The 30 calendar day time frame to complete a grievance review may be extended, with your permission, in cases when *Blue Cross and Blue Shield* and the *member* agree that additional time is required to fully investigate and respond to the grievance.

The 30 calendar day time frame may also be extended when the grievance review requires a review of your medical records and 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*.

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 benefits as described in this PPO *contract*; give the specific medical and scientific reasons for the denial; specify any alternative treatment, 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 timeframes 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 the *member* is an *inpatient*, *Blue Cross and Blue Shield* will complete the review and make a decision regarding the request before the patient is discharged from that *inpatient* stay. Coverage for those services in dispute will continue until this review is completed.
- A decision to deny payment for health care services, including durable medical equipment, may be reversed within 48 hours if the *member's* attending physician certifies that a denial for those health care services would create a substantial risk of serious harm to the *member* if the *member* were to wait for the outcome of the normal grievance process. The *member's* physician can also request reversal of a denial for durable medical equipment earlier than 48 hours by providing more specific information about the immediate and severe harm to the *member*.
- A grievance review requested by a *member* with a terminal illness will be completed 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 benefits as described in this PPO *contract*; give the specific medical and scientific reasons for the denial; specify any alternative treatment, 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 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 *Blue Cross and Blue Shield's* formal internal 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. *Blue Cross and Blue Shield's* 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 your receipt of 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 maximums and that exceed those maximums; 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 may call **1-800-436-7757**. Or, you may fax a request to **1-617-624-5046**. Or, you can visit the Office of Patient Protection's website **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 telephone 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 a claim is denied as being not *medically necessary*. If so, these rights are in addition to the other rights to appeal that you have as described in other parts of this PPO *contract.*

The following provisions apply only to:

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

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

Reconsideration. Reconsideration is the first step in this appeals process. If you receive a letter denying payment for your health care services, you may request that *Blue Cross and Blue Shield* reconsider its decision by writing to: Grievance Program, Blue Cross and Blue Shield of Massachusetts, Inc., Landmark Center, 401 Park Drive, Boston, Massachusetts 02215-3326. You must submit your reconsideration request within 180 days of the adverse decision. Along with your letter, you should include any information that supports your request. *Blue Cross and Blue Shield* will review your request and let you know the outcome of your reconsideration request within 15 calendar days after receipt of all necessary information.

Appeal. An appeal is the second step in this process. If *Blue Cross and Blue Shield* continues to deny benefits for all or part of the original service, you may request an appeal within 60 days of receiving the reconsideration denial letter. 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 include the name of a physician who may review your 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 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 of receiving all necessary information.

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 you be responsible for half of the cost of the appeal and *Blue Cross and Blue Shield* will be responsible for the remaining half. To file an external appeal, you must make your request in writing to: Grievance Program, Blue Cross and Blue Shield of Massachusetts, Inc., Landmark Center, 401 Park Drive, Boston, Massachusetts 02215-3326. 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).

Note: If your service denial is for treatment of *mental conditions*, your fee is: $237.50 for MassPRO and $144.20 for the MAXIMUS Center for Health Dispute Resolution.

Within five 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 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 contacting *Blue Cross and Blue Shield* at the telephone 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: Grievance Program, Blue Cross and Blue Shield of Massachusetts, Inc., Landmark Center, 401 Park Drive, Boston, Massachusetts 02215-3326. 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).

Note: If your service denial is for treatment of *mental conditions*, 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 10

Quality Assurance Programs

Blue Cross and Blue Shield uses quality assurance programs that are designed to improve the quality of health care and services provided to *members*. These quality assurance programs affect different aspects of health care such as disease treatment, health promotion and service. From time to time, *Blue Cross and Blue Shield* may add or change the quality assurance programs that it uses to ensure that you and your family continue to receive high-quality health care and services. **For more information about these programs, you may call the *Blue Cross and Blue Shield* customer service office. The toll-free telephone number is shown on your PPO identification card.**

Clinical Programs

Blue Cross and Blue Shield uses clinical programs that are designed to improve the health care you receive. Some of these programs include:

- A program that furnishes additional outreach and education to an expectant mother that adds to the care the *member* gets from her obstetrician or nurse midwife.
- Diabetes case management and general education to assist diabetic *members* with the self-management of diabetes and to identify high-risk *members* and to assess their ongoing care management needs.
- Congestive heart failure disease management, education and ongoing monitoring to assist the patient and his or her physician, cardiologist and family to develop, coordinate and monitor a comprehensive treatment plan in an effort to lead to the best health outcome for the *member*.

Service Program

Management and technology solutions have been implemented to assist *Blue Cross and Blue Shield* anticipate the health care needs of *members* and to resolve issues quickly and accurately. While the *member* is still on the telephone with a *Blue Cross and Blue Shield* customer service representative, a call can be made directly to a health care provider to try to resolve claim problems. The *Blue Cross and Blue Shield* customer service representative will also call pharmacies to help clear up eligibility questions so that *members* can get their prescriptions.

Part 11

Other *Contract* Provisions

Access to and Confidentiality of a *Member's* Medical Records

Blue Cross and Blue Shield and health care providers may, in accordance with applicable law, have access to all medical records and related information needed by *Blue Cross and Blue Shield* or health care providers. *Blue Cross and Blue Shield* may collect information from health care providers, other insurance companies or the *plan sponsor* to help them administer the benefits described in this PPO *contract* and to get facts on the quality of care 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 follows:

- For administering benefits (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 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 required by the *subscriber's group* or its auditors to ensure that *Blue Cross and Blue Shield* is administering your benefits properly.

Note: To obtain a copy of *Blue Cross and Blue Shield's* Commitment to Confidentiality statement, call the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your PPO identification card.

Blue Cross and Blue Shield will not share information about you with the Medical Information Bureau (MIB). Except as described above, *Blue Cross and Blue Shield* will keep all information confidential and not disclose it without your consent.

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 information that you believe is not correct. *Blue Cross and Blue Shield* may charge a reasonable fee for copying records, unless your request is because *Blue Cross and Blue Shield* is declining or terminating your benefits under the PPO *contract*.

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 *preferred provider* or 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 *preferred providers* or other health care providers.

Blue Cross and Blue Shield will not interfere with the relationship between providers and their patients. You are free to select or discharge any provider. It is not up to *Blue Cross and Blue Shield* to find a provider for you. *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 under this PPO *contract* 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 under this PPO *contract* to another person or organization. There is one exception to this rule. If Medicaid has already paid the provider, you can assign your benefits to Medicaid.

Authorized Representative

You may choose to have another person act on your behalf concerning your benefits under this PPO *contract*. 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 certain situations, *Blue Cross and Blue Shield* may consider your health care facility or your physician 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 may ask your physician for more information if more is needed to make a decision. Or, *Blue Cross and Blue Shield* will consider the provider to be your authorized representative for *emergency medical care* services. *Blue Cross and Blue Shield* will continue to send benefit payments and written communications regarding health care coverage in accordance with *Blue Cross and Blue Shield's* standard practices, unless specifically requested to do otherwise.

Note: You can get a form to designate an authorized representative from the *Blue Cross and Blue Shield* customer service office.

Changes to This *Contract*

The *plan sponsor* or *Blue Cross and Blue Shield* may change a part of this PPO *contract*. For example, a change may be made: to the amount you must pay for certain services (your *copayment* or *deductible* and/or *coinsurance*). When *Blue Cross and Blue Shield* makes a change to this PPO *contract*, the *plan sponsor* will be notified at least 60 days before the *effective date* of the change. The notice will describe the change being made. It will also give the *effective date* of the change. When a material change is made to this PPO *contract*, *Blue Cross and Blue Shield* will send you a *rider* that describes the change.

Charges for Services That Are Not *Medically Necessary*

You may receive treatment that is otherwise covered as a benefit as described in this PPO *contract*; but, this treatment may not be *medically necessary* for you. In this case, you might be charged for the treatment by the provider. *Blue Cross and Blue Shield* will defend you from a claim for payment for this treatment. *Blue Cross and Blue Shield* will do this if it is furnished by a provider that has a payment agreement with *Blue Cross and Blue Shield* and that agreement keeps the provider from charging for services that are not *medically necessary*. This does not apply if you were told, knew or reasonably should have known before you received the treatment that it was not *medically necessary*. If you want *Blue Cross and Blue Shield* to defend you in this case, you must let *Blue Cross and Blue Shield* know. You must do this within ten days of the date the lawsuit to collect for the services is started. Also, you must work with *Blue Cross and Blue Shield* in the defense. If it is judged in the action that the services were *medically necessary*, *Blue Cross and Blue Shield* will provide benefits for them.

Mandated Benefits for Services Outside Massachusetts

In addition to the *covered services* described in this PPO *contract,* when you live in a state other than Massachusetts, you may be entitled to receive benefits for other services and supplies as required by that state's law. You should call the *Blue Cross and Blue Shield* customer service office for more information.

Process to Develop Clinical Guidelines and *Utilization Review* Criteria

Blue Cross and Blue Shield applies *medical technology assessment guidelines* to develop its clinical guidelines and *utilization review* criteria. In developing these, *Blue Cross and Blue Shield* carefully assesses a treatment to determine that it is:

- Consistent with generally accepted principals of professional medical practice; and
- Required to diagnose or treat your illness, injury, symptom, complaint or condition; and
- Essential to improve your net health outcome and as beneficial as any established alternatives covered by your PPO *contract*; and
- As cost effective as any established alternatives and consistent with the level of skilled services that are furnished; and
- Furnished in the least intensive type of medical care setting required by your medical condition.

Blue Cross and Blue Shield reviews clinical guidelines and *utilization review* criteria periodically to reflect new treatments, applications and technologies. As new drugs are approved by the Food and Drug Administration (FDA), *Blue Cross and Blue Shield* reviews their safety, effectiveness and overall value on an ongoing basis. While a new drug is being reviewed, it will not be covered under this PPO *contract*.

Services Furnished by Non-*Preferred Providers*

Under this PPO *contract*, you will usually receive the highest *benefit level* ("in-network benefits") **only** when you obtain *covered services* from a *preferred provider*. But, *Blue Cross and Blue Shield* will provide "in-network benefits" for *covered services* furnished by non-*preferred providers* in the following situations:

- You receive accident treatment or *emergency medical care* in the emergency room of a hospital as described in Part 5 or you receive accident treatment or emergency medical services from any other type of non-*preferred provider* as described in Part 5 when a *preferred provider* is not reasonably available.
- You receive *covered services* that are not reasonably available from a *preferred provider* and you had prior approval from *Blue Cross and Blue Shield* to obtain those *covered services*. Or, you receive *covered services* from a covered health care provider before a preferred network is established (for example, from a licensed speech-language pathologist or licensed audiologist).
- You are traveling (or you live) outside of Massachusetts and you receive *covered services* from a type of 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 *preferred provider* network.
- You are a newly enrolled *member* who is receiving an ongoing course of treatment by a non-preferred physician and your *group* only offers its employees a choice of health insurance plans in which your physician does not participate as a covered provider. In this case, *Blue Cross and Blue Shield* will provide "In-Network Benefits" for up to 30 days from your *effective date* or, for a *member* who is in her second or third trimester of pregnancy, until the first postnatal visit or, for a *member* with a terminal illness, until the *member's* death. (For a *member* with a terminal illness, these benefits are provided when the *member* is expected to live six months or less as determined by a physician.)
- The *preferred provider* of a *member* who is in her second or third trimester of pregnancy is involuntarily disenrolled (for other than quality-related reasons or fraud). In this case, *Blue Cross and Blue Shield* will continue to provide "In-Network Benefits" for *covered services* in connection with the pregnancy until the first postnatal visit.
- The *preferred provider* of a *member* with a terminal illness is involuntarily disenrolled (for other than quality-related reasons or fraud). In this case, *Blue Cross and Blue Shield* will continue to provide "In-Network Benefits" for *covered services* in connection with the terminal illness until the *member's* death. (These benefits are provided when the terminally ill *member* is expected to live six months or less as determined by a physician.)

Time Limit for Legal Action

Before pursuing a legal action against *Blue Cross and Blue Shield* for any claim under this PPO *contract,* you must complete *Blue Cross and Blue Shield's* formal internal grievance review (see Part 9). You may, but do not need to, pursue an external review prior to pursuing a legal action.

If, after completing the grievance review, you choose to bring legal action against *Blue Cross and Blue Shield,* this action must be brought within two years after the cause of action arises. For example, if you are filing a legal action because you were denied a service or a claim for benefits under this PPO *contract*, 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 you were first sent a notice of the service or claim denial. Going through the internal formal grievance process does not extend the two-year limit for filing a lawsuit. However, if you choose to pursue a voluntary external review, the days from the date your request is received by the external reviewer until the date you receive the response are not counted toward the two-year limit.

Part 12

Eligibility for Coverage

Who Is Eligible to Enroll

Eligible Employees

An employee is eligible to enroll as a *subscriber* under this PPO *contract* as long as he or she 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* health care benefits. For details, contact your *plan sponsor*.

Eligible Dependents

A *subscriber* may enroll eligible dependents under his or her membership under this PPO *contract*. "Eligible dependents" include the *subscriber's*:

- Legal spouse.

  (A legal civil union spouse, where applicable, is eligible to enroll under this PPO *contract* to the extent that a legal civil union spouse is determined eligible by the *plan sponsor*. For more details, contact your *plan sponsor*.)

- Unmarried dependent children under age 19. These include the *subscriber's* or legal spouse's dependent children who: live with the *subscriber* or the spouse on a regular basis; or qualify as dependents for federal tax purposes; or are the subjects of a court order that requires the *subscriber* to provide health insurance for the children.

  (Eligibility for membership under this PPO *contract* also includes the *subscriber's* children who are recognized under a Qualified Medical Child Support Order as having the right to enroll for *group* coverage.)

- Newborn dependent children. The *effective date* of coverage for a newborn child will be the 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 this notice when the *subscriber's* membership under this PPO *contract* is a family plan.)

  Blue Cross and Blue Shield provides benefits for newly born infants for injury and sickness. This includes the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities and premature birth. Benefits for these services are subject to all of the provisions described in this PPO *contract*.

- Unmarried adoptive dependent children under age 19. The *effective date* of coverage for an adoptive 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 adoptive parent is enrolled under a family membership 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 (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. But, benefits for these services are subject to all the provisions described in this PPO *contract*.

- Unmarried full-time student dependent children under age 25. In this case, the *subscriber* must give *Blue Cross and Blue Shield* verification 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 following the date the student discontinues full-time classes or graduates, whichever comes first.
- Unmarried disabled dependent children age 19 or older. An unmarried disabled dependent child may maintain coverage under the *subscriber's* membership. But, the child must be either mentally or physically handicapped so as not to be able to earn his or her own living on the date he or she would normally lose eligibility under the *subscriber's* membership. 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 under the *subscriber's* membership. 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.
- Unmarried children of enrolled dependent children.

Important Reminder:	The eligibility provisions described in this section may differ from the federal tax laws that define who may qualify as a dependent.

Former Spouse

In the event of divorce or legal separation, the person who was the spouse of the *subscriber* prior to the divorce or legal separation will remain eligible for coverage under the *subscriber's* membership, whether or not the judgment was entered prior to the *effective date* of this PPO *contract*. This coverage is provided with no additional *premium*. 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.)

Note: In the event the *subscriber* remarries, the former spouse may continue coverage under a separate membership with 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 under the *subscriber's* membership.

Enrollment Periods

Initial Enrollment

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

Special Enrollment

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

- The employee and/or his or her eligible dependents have a loss of other coverage (see "Loss of Other Coverage" below for more information); or
- The employee gains a new eligible dependent (see "New Dependents" below for more information).

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 under this PPO *contract* on the initial eligibility date because he or she or the eligible dependent has other group health plan coverage. In this case, the employee and the eligible dependent may enroll under this PPO *contract* if the employee or the eligible dependent at a later date loses that other group health plan coverage because:

- The employee or the eligible dependents cease to be eligible for the other group health plan or the employer that is sponsoring the other group health plan ceases to make employer contributions for the other group health plan coverage; or
- The employee or the eligible dependents exhaust COBRA coverage under the other group health plan.

Note: You will not have this special enrollment right if the loss of other coverage is a result of the eligible employee 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 under this PPO *contract*. (If the new dependent is gained by birth, adoption or placement for adoption, enrollment under this PPO *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 group health plan is terminated, you must request enrollment under this PPO *contract* within 30 days after your other group health care coverage ends. 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.

Qualified Medical Child Support Order

If the *subscriber* chooses not to enroll an eligible dependent for coverage under this PPO *contract* on the initial 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 health plan to provide coverage to the child of an employee who is covered, or eligible to enroll for coverage, under the group health plan.

Open Enrollment Period

If you choose not to enroll for coverage under this PPO *contract* within 30 days of your initial eligibility date, you may enroll during an 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 to all eligible employees. To enroll for coverage under this PPO *contract* during this enrollment period, you must complete the enrollment form provided in your enrollment packet and return it no later than the date specified in the enrollment packet.

Making Other Membership Changes

Generally, the *subscriber* may make membership changes (for example, change from an individual membership to a family membership) only if the *subscriber* has a change in family status such as:

- Marriage or divorce.
- Birth, adoption or change in custody of a child.
- Death of an enrolled spouse or dependent child.
- The loss of an enrolled dependent's eligibility under the *subscriber's* membership. For example, when an unmarried dependent child turns age 19 or when a full-time student dependent turns age 25, his or her coverage ends under the *subscriber's* membership.

If you want to ask for a membership change or you need to change your name or mailing address, you should call or write your *plan sponsor*. The *plan sponsor* will send you any special forms you may need. You must request the change within the time period required by the *subscriber's group* to make a membership 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 membership changes or any additions are allowed only when they comply with the eligibility and enrollment rules set by the *plan sponsor* for your *group* health care benefits and they comply with the conditions outlined in your PPO *contract* and in *Blue Cross and Blue Shield's* Manual of Underwriting Guidelines for Group Business.

Part 13

Termination of Coverage

Loss of Eligibility for Coverage under This *Contract*

You are no longer eligible for membership under this PPO *contract* when:

- The *subscriber* loses eligibility for health care coverage with the *group*. This means: the *subscriber's* hours are reduced; or the *subscriber* leaves the job; or the *subscriber* no longer meets the rules set by the *group* for eligibility under this PPO *contract*.
- 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 dependent children) may have the option of continuing coverage under this PPO *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*.

  Note: Medicare eligible *subscribers* who retire and/or their spouses are not eligible to continue coverage under this PPO *contract* once they reach age 65.

- You lose eligibility as a dependent under the *subscriber's* membership. When a dependent child loses eligibility for coverage, the termination date of membership under this PPO *contract* will be the date on which eligibility is lost.
- The *subscriber* dies.
- The *plan sponsor* fails to pay your *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 membership in accordance with the Code of Massachusetts Regulations. This notice will give you information about the termination of your membership and your options, if any, to continue coverage offered by the *Blue Cross and Blue Shield* or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
- The *subscriber's group* terminates (or does not renew) this PPO *contract*.

In any of these situations, your membership under this PPO *contract* will be terminated as of the date you lose eligibility.

Termination by the *Subscriber*

Your membership under this *contract* ends when the *subscriber* chooses to cancel his or her *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 by *Blue Cross and Blue Shield*

You do not have to worry that *Blue Cross and Blue Shield* will cancel you because you are using your benefits or because you will need more *covered services* in the future. *Blue Cross and Blue Shield* will cancel your membership under this PPO *contract* **only when**:

- You committed misrepresentation or fraud to *Blue Cross and Blue Shield*. For example, you gave false or misleading information on the enrollment application form. Or, you misused the PPO identification card by letting another person not enrolled under this PPO *contract* attempt to get benefits. 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*.
- You commit acts of physical or verbal abuse that pose a threat to participating 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.
- *Blue Cross and Blue Shield* cancels this PPO *contract* for any reason as of a date approved by the Massachusetts Commissioner of Insurance (without prior notice) or cancels all contracts of this type as of any date.

Part 14

Continuation of Coverage

Family and Medical Leave Act

An employee may continue membership under this PPO *contract* as provided by the Family and Medical Leave Act. (The Family and Medical Leave Act 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 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 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 membership under this PPO *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 membership will be terminated and what the date of the termination will be if payment is not received by that date. This notice will be mailed at least 15 days before the termination date.

If membership under this PPO *contract* is discontinued for 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.

Limited Extension of *Group* Coverage under State Law

When you lose eligibility for membership under this PPO *contract*, you may be eligible to continue this coverage as provided by state law. These state laws may apply to you if you lose eligibility for coverage due to one of the following reasons:

- Lay off or death of the *subscriber*. If this situation applies to you, coverage may continue for up to 39 weeks from the date of the qualifying event. To continue this coverage, you will pay 100% of the *premium* cost.
- Plant closing or a partial plant closing in Massachusetts. If this situation applies to you, you and your *group* will each pay your share of the *premium* cost for up to 90

days after the plant closing. Then, to continue this coverage for up to an additional 39 weeks, you will pay 100% of the *premium* cost.

If you become eligible for coverage under another employer sponsored health care plan at any time before the extension period ends, continued coverage under this PPO *contract* under these provisions also ends.

Note: If one of these situations applies to you, you may also be eligible for continued coverage under other state laws or under federal law. (See below for more information.) If you are, the starting date for continued coverage under these laws will be the same. But, after the extension period as provided under these provisions ends, you may have to pay additional *premium* to continue your coverage under this PPO *contract*.

Continuation of *Group* Coverage under Federal or State Law

When you are no longer eligible for membership under this PPO *contract*, you may be eligible to continue this 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 coverage, you will 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.

  Note: In the event of divorce or legal separation, a spouse is eligible to keep coverage under the employee's membership. This is the case **only** until the employee is no longer required by law to provide health insurance for the former spouse or the employee or former spouse remarries, whichever comes first. The former spouse's eligibility for continued coverage will start on the date of divorce, even if he or she continues coverage under the employee's membership. While the former spouse continues coverage under the employee's membership, there is no additional *premium*. After remarriage, under state and federal law, the former spouse may be eligible to continue coverage under an individual membership 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 coverage begins with the date of your qualifying event. And, the length of this continued 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.)

Continuation of Coverage for Same-Sex Spouses. When a *subscriber's* legal same-sex spouse is no longer eligible for coverage under this PPO *contract*, that spouse (or if applicable, civil union spouse) and his or her dependent children may continue coverage in the *subscriber's group* to the same extent that a legal opposite-sex spouse (and his or her dependent children) could continue coverage upon loss of eligibility for coverage under this PPO *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 coverage will remain in effect 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 the 11 additional months, eligibility for disability is lost, coverage may terminate before the 29 months is completed. You should contact your *plan sponsor* for more information 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 membership under this PPO *contract* as a result of a bankruptcy proceeding (Title 11 of the United States Code) is also eligible to continue this coverage as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA) or under Massachusetts state law. A retired employee and/or the surviving spouse of a deceased retired employee may enroll for lifetime continued 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 coverage as of the date *group* eligibility is lost. Spouses and/or eligible dependent children of these retired employees may enroll for continued coverage until the retired employee dies. Once the retired employee dies, his or her surviving spouse and/or eligible dependent children may enroll for up to an additional 36 months of continued coverage beyond the date of the retired employee's death.

Note: Lifetime continued coverage for retired employees will end if the *group* terminates its agreement with *Blue Cross and Blue Shield* to provide the coverage described in this PPO *contract* or for any of the other reasons described below. (See "Termination of Continued Coverage.")

Enrollment for Continued Coverage

In order to enroll for continued coverage under this PPO *contract*, 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 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 under this PPO

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 Coverage

Your continued coverage will end when:

- The length of time allowed for continued 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 care plan **and** that plan does not include pre-existing condition limitations or waiting periods.
- You become entitled to Medicare benefits.

In addition, your continued coverage under this PPO *contract* will end when the *group* terminates its agreement with *Blue Cross and Blue Shield* to provide the coverage described in this PPO *contract*. In this case, coverage may continue under another health care plan. Contact your *plan sponsor* for more information.

Note: The longer time allowed for continued coverage for disabled *members* will end when the *member* is no longer disabled.

Enrollment in a Nongroup Plan

When your membership under this PPO *contract* is terminated, you may be eligible to enroll in a nongroup plan offered by *Blue Cross and Blue Shield* or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. The benefits and premium charges for these nongroup plans may differ from your coverage provided under this PPO *contract*. At the time you lose eligibility for membership under this PPO *contract*, *Blue Cross and Blue Shield* will send you a letter explaining your health care options. This letter will include a toll-free telephone number that you may call to find out about if you are eligible for a nongroup plan offered by *Blue Cross and Blue Shield* or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. and how you may apply for enrollment in one of these nongroup plans.

Part 15

Health Insurance Portability

Benefits for Pre-Existing Conditions

Both federal law and Massachusetts state law may affect your health care coverage if you are enrolled or become eligible to enroll in a health benefit plan that excludes coverage for pre-existing conditions. These laws limit the circumstances under which benefits may be excluded for medical conditions that are present before you enroll in a health benefit 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 a health benefit 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 benefit plan as long as that prior plan was terminated within 63 days of your effective date in the new health benefit 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 benefits under this PPO *contract* are 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 membership under this PPO *contract* without a pre-existing condition restriction. But, benefits for these services are subject to all the provisions described in this PPO *contract*.

HIPAA Certificates of Group Health Plan Coverage

All *members* have the right to receive a certificate of group health plan coverage when:

- The *member* ceases coverage under the *group's* health benefit plan or coverage would have been lost had the *member* not elected to continue 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 any).

When a *member's* coverage under this PPO *contract* ends and that *member* is eligible for a certificate of group health plan coverage, the *plan sponsor* and/or *Blue Cross and Blue Shield* will provide this certificate to the *member*.

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QSHP
Qualified Student Health Plan

This *rider* is part of your *contract*. Please keep this *rider* with your *contract* for easy reference.

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 their eligible dependents. (In this case, your *plan sponsor* is the institution of higher education.) This *contract* describes your coverage in this qualified student health plan.

Notwithstanding any provisions in the *contract* to the contrary, the following changes apply to your coverage in this qualified student health plan.

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1. The "Eligibility for Coverage" section of your Subscriber Certificate is replaced in its entirety by the following new section:

Eligibility for Coverage in this Qualified Student Health Plan

An 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.

Automatic Enrollment. An eligible student will be automatically enrolled in this qualified student health plan by the *group*. The *group* will include the enrolled student's total *premium* for this coverage in the student's tuition bill. 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, or if you would like to request the *group's* written policy regarding *premium* refunds.)

An 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 *contract*. 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 *contract* to the extent that a legal civil union spouse is determined eligible by the *group*.)

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 *contract*, whether or not the judgment was entered prior to the *effective date* of this qualified student health plan *contract*. 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 *contract* 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 *contract*.

Eligible Dependents. An eligible student who is enrolled in this qualified student health plan may enroll eligible dependents for coverage under his or her *contract*. "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 in this health plan under the enrolled student's qualified student health plan *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 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 that are described in this qualified student health plan *contract*.
- 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 abnormalities and premature birth. The coverage for these services is subject to all of the provisions that are described in this qualified student health plan *contract*.

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 *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 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 *contract*. 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.

(The eligibility provisions 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 *contract*. 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 *contract*.

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2. The overall *deductible* and *out-of-pocket maximum* provisions that are described in your Subscriber Certificate are changed as follows:

Overall Deductible. When your coverage under this qualified student health plan includes an annual *deductible*, the amount of your *deductible* is $250 for each *member*. The *deductible* will be calculated based on the *group's plan year* (instead of a calendar year). If you are not sure when your *plan year* begins, contact the *group*. **Your Schedule of Benefits shows if an overall annual *deductible* applies to your coverage. If an overall annual *deductible* does apply, your Schedule of Benefits will also show those *covered services* for which you must pay the *deductible*.** (Also refer to *riders*—if there are any—that apply to your qualified student health plan *contract*.)

Out-of-Pocket Maximum. When your coverage under this qualified student health plan includes an annual *out-of-pocket maximum* provision, the *out-of-pocket maximum* will be calculated based on the *group's plan year* (instead of a calendar year). If you are not sure when your *plan year* begins, contact the *group*. **Your Schedule of Benefits shows if an *out-of-pocket maximum* applies to your coverage. If an annual *out-of-pocket maximum* does apply, your Schedule of Benefits will also show the amount of your *out-of-pocket maximum* and the costs that will count toward your**

out-of-pocket maximum. (Also refer to *riders*—if there are any—that apply to your qualified student health plan *contract*.)

3. The "Covered Services" section of your Subscriber Certificate has been changed to include the following new provision:

Your coverage under this qualified student health plan includes benefits for **Christian Science services**. This coverage includes services that are furnished by a Christian Science sanatorium; by a Christian Science practitioner; or by a Christian Science nurse. These benefits are provided 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. (Refer to your Schedule of Benefits for the cost that you must pay for these *covered services*.)

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4. The "Coordination of Benefits (COB)" section of your Subscriber Certificate has been changed as follows:

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.

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5. The "Medicare Program" section of your Subscriber Certificate is replaced in its entirety by the following new section:

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.

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6. The provisions regarding *premium* payments that are described in your Subscriber Certificate are changed as follows:

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 the *group's premium* refund policy, you must contact the *group*.

All other provisions about your *premium* remain as described in your Subscriber Certificate.

7. The following provisions as described in your Subscriber Certificate have been changed as follows:

The "Continuation of Coverage" section is deleted in its entirety.
All references to the Employee Retirement Income Security Act, as amended (ERISA) are deleted.
Certificates of group health plan coverage as described in the "HIPAA Certificates of Group Health Plan Coverage" section will be provided to the extent required by law.

8. The "Termination of Coverage" section of your Subscriber Certificate is replaced in its entirety by the following new section:

Termination of Coverage in this Qualified Student Health Plan

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 *contract*, 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 *contract* to Blue Cross and Blue Shield of Massachusetts, Inc. within 30 days of the due date.
- The *group* terminates (or does not renew) this qualified student health plan *contract* 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 *contract* 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.

Rider 02-810
Early Intervention Services

This *rider* modifies the terms of your Subscriber Certificate. Please keep this *rider* with your Subscriber Certificate for easy reference.

Effective on and after July 1, 2009, the dollar benefit maximum that applies to your *outpatient* coverage for early intervention services has been eliminated. This health plan provides coverage for as many visits as are *medically necessary* for the whole time an enrolled dependent child is eligible for early intervention services.

Note: This *rider* does not change the age limit for early intervention services. An enrolled dependent child is eligible for early intervention services from birth through age two (until the child turns three years old).

All other provisions remain as described in your Subscriber Certificate.

Blue Cross and Blue Shield of Massachusetts, Inc.

Allen Maltz
Executive Vice President

Fredi Shonkoff
Senior Vice President
Corporate Secretary

R02-810 (7-30-09) to be attached to: Blue Care® Elect; PPO Basic Blue Direct; PPO Blue® Direct.

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Rider 04-802

CT Scans, MRIs and PET Scans

This *rider* modifies the terms of your Subscriber Certificate. Please keep this *rider* with your Subscriber Certificate for easy reference.

The amount that you pay for certain lab tests, x-rays and other covered tests as described in your Subscriber Certificate has been changed.

You must pay a $25 *copayment* for each of the following categories of in-network *outpatient* diagnostic tests: computerized axial tomography (CT scan); magnetic resonance imaging (MRI); and positron emission tomography (PET scan). A *copayment* will apply for each category of test (regardless of the number of tests) performed on each date of service. (Any *deductible* and/or *coinsurance* will not apply.)

The *copayment* does not apply to the *preferred provider's* interpretation costs that are billed in conjunction with any one of these tests.

Note: When these *covered services* are furnished by a non-*preferred provider*, the out-of-network *coinsurance* percentage that you will pay for non-emergency *covered services* will be 20% (excluding any *deductible*).

All other provisions remain as described in your Subscriber Certificate.

Blue Cross and Blue Shield of Massachusetts, Inc.

Allen Maltz
Executive Vice President

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Senior Vice President
Corporate Secretary

R04-802 (8-24-07) to be attached to: Blue Care® Elect.

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Rider 08-830
Overall Plan Changes

This *rider* modifies the terms of your Subscriber Certificate. You should read this *rider* since it provides important information about changes to your health plan. It explains the requirements that you must follow to be sure that you receive all of your health plan benefits. Please keep this *rider* with your Subscriber Certificate for easy reference.

Except as described in this *rider*, all other provisions remain as described in your Subscriber Certificate.

Covered Health Care Providers

The health care providers that are covered by your health plan have been changed to include some new types of health care providers.

Licensed Marriage and Family Therapists

Effective on and after May 1, 2008, your *outpatient* coverage for services to diagnose and treat *mental conditions* includes *covered services* that are furnished by a licensed marriage and family therapist. This coverage is provided only when the services are within the scope of practice for a licensed marriage and family therapist. The cost share that you must pay for these *covered services* is the same cost share that you would pay for similar services furnished by a licensed mental health counselor.

Licensed Limited Services Clinics

Effective on and after September 1, 2008, your *outpatient* coverage includes *covered services* that are furnished by a licensed limited services clinic. This coverage is limited to those health care services that have been approved by *Blue Cross and Blue Shield* for this type of health care provider and that are covered by your *contract*. (To find out if a specific service is covered, you can call the *Blue Cross and Blue Shield* customer service office.) The cost share that you must pay for these *covered services* is the same cost share that you would pay for similar services furnished by a physician.

Chronic Disease Hospitals

Effective on August 1, 2008, all of the references to the term "chronic disease hospital" that may appear in your *contract* (and *riders*—if there are any—that apply to your health plan) are changed by adding the phrase "(sometimes referred to as a chronic care or long term care hospital for *medically necessary covered services*)." This is done only to define the type of covered health care provider. It does not change your health plan benefits.

Utilization Review Requirements

Effective on July 1, 2009, *Blue Cross and Blue Shield* Utilization Review Requirements will change. The following Pre-Service Approval Requirements have been added to Part 4 of your Subscriber Certificate. **To receive health plan coverage for the *outpatient* services or supplies that are described below in this section, you must have an approval for the coverage from *Blue Cross and Blue Shield*. This is true for both in- and out-of-network benefits. You should read this section to find out how the pre-service review process works and what you must do to start this process.**

Pre-Service Approval Requirements for Selected Outpatient Services and Supplies

To receive all of your health plan coverage, you must have an approval from *Blue Cross and Blue Shield* for the *outpatient* health care services or supplies that are described below. To get this approval, you (or your provider on your behalf) must request a "pre-service review." 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 necessary information from you or from your health care provider. **If you do not have prior approval from *Blue Cross and Blue Shield,* your claim for in-network or out-of-network benefits may be denied and you may have to pay all charges for these health care services or supplies.**

■ ■ ■ Services and Supplies That Require Pre-Service Review and Approval

To receive all of your health plan coverage, the *outpatient* health care services or supplies listed below must be approved by *Blue Cross and Blue Shield*:

(1) Certain *outpatient* specialty care, surgical procedures and/or other health care services and supplies. These services and supplies may include those that are furnished to you by a provider such as a hospital, a professional health care provider or an ambulance. To find out if your proposed service or supply needs a pre-service review, you can call the *Blue Cross and Blue Shield* customer service office. The toll-free phone number shows on your ID card. Or, you may use the online member self-service option.

(2) Chiropractic services starting with your 13th visit in a calendar year. This means that you do not need to have a prior approval for the first 12 visits for medical care, including spinal manipulation, when it is furnished by a chiropractor. But, before your 13th visit in a calendar year for these services, you must receive a prior approval from *Blue Cross and Blue Shield*. Or, your coverage may be denied for more visits in that calendar year.

(For the calendar year of 2009, the 13 visits will be counted from July 1. For 12 visits starting on or after July 1, you will not need a prior approval from *Blue Cross and Blue Shield*.)

(3) *Outpatient* advanced technology radiology services. These services include: computerized axial tomography (CT scan); magnetic resonance imaging (MRI); nuclear cardiac studies; and positron emission tomography (PET scan). A prior approval is not required when the test is performed as an emergency medical service.

(4) Home health care. (If you have been receiving *inpatient* care, *Blue Cross and Blue Shield* may approve these services through Discharge Planning.)

(5) Short-term rehabilitation therapy—physical therapy and/or occupational therapy—starting with your 9th visit in a calendar year. This means you do not need to have a prior approval for the first 8 visits in a calendar year. But, before your 9th visit in a calendar year for any of these services, you must receive a prior approval from *Blue Cross and Blue Shield*. Or, your coverage may be denied for more visits in that calendar year.

(For the calendar year of 2009, the 9 visits will be counted from July 1. For 8 visits starting on or after July 1, you will not need a prior approval from *Blue Cross and Blue Shield*.)

(6) Infertility treatment.

(7) Certain prescription drugs that are administered to you by a non-pharmacy health care provider during a covered visit. For example, before you receive an injection or an infusion of a drug in a

physician's office or in a hospital outpatient setting, you must receive a prior approval from *Blue Cross and Blue Shield*. Or, your coverage may be denied for the prescription drug and/or related services. 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. The toll-free phone number shows on your ID card.

(This does not change the pre-admission review process that you must follow for your *inpatient* coverage. See your Subscriber Certificate for this information.)

From time to time, *Blue Cross and Blue Shield* may change this list of health care services and supplies that require a prior approval from *Blue Cross and Blue Shield*. When a material change is made to your *contract*, *Blue Cross and Blue Shield* will send a *rider* to you that will describe the change.

■ ■ ■ Starting the Pre-Service Review Process

You or the health care provider on your behalf must start the pre-service review process. If your proposed health care services or supplies are to be furnished by a *preferred provider*, the health care provider will usually start this pre-service review process for you. The *preferred provider* will tell you if they will start this review on your behalf, or if you must start this review. **You must start the pre-service review if the *preferred provider* does not start the review for you, or when you have chosen a non-preferred health care provider to furnish your proposed health care service or supply.** To start the review, you must call the *Blue Cross and Blue Shield utilization review* unit. The toll-free phone number shows on your ID card. **Important reminder: If you obtain a health care service or supply from a non-*preferred provider* that *Blue Cross and Blue Shield* determines is not *medically necessary* for you, you must pay all charges for those health care services or supplies.**

Your health care provider will be considered your authorized representative for the pre-service review process. *Blue Cross and Blue Shield* will tell your health care provider if a proposed service or supply has been approved. Or, *Blue Cross and Blue Shield* may ask your health care provider for more information if it is needed to make a decision. **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 shows on your ID card.**

■ ■ ■ 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. 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 (or 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 *Blue Cross and Blue Shield's* 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 through the pre-service review *Blue Cross and Blue Shield* determines that the 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. This phone call will 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. This phone call will 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 as described in this *contract*; give the specific medical and scientific reasons for which *Blue Cross and Blue Shield* has denied the request; specify any alternative treatment, health care services and supplies that would be covered; refer to and include *Blue Cross and Blue Shield's* 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 will not be *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 9 of your *contract*. (You may request a formal review even if your health care provider has not asked that *Blue Cross and Blue Shield's* decision be reconsidered.)

Definitions

The term "Utilization Review," as described in your Subscriber Certificate, has been clarified by adding the following provisions:

***Blue Cross and Blue Shield* may use the following to determine coverage under your health plan for prescription drugs.**

For prescription drugs that are furnished to you by a covered health care provider along with a *covered service* or by a covered pharmacy, *Blue Cross and Blue Shield* uses a set of *utilization review* techniques and medical policy to decide if the drugs are *medically necessary* and appropriate. These techniques are designed to monitor the use of and evaluate the clinical necessity, appropriateness, efficacy or efficiency of your prescription drugs. *Blue Cross and Blue Shield* uses health management and *utilization review* services such as:

- Drug Formulary Management.
- Quality Care Dosing. This helps to monitor the quantity and dose of the drug that you receive based on Food and Drug Administration (FDA) recommendations and clinical information. To find an up-to-date list of drugs that are subject to Quality Care Dosing, you can call the *Blue Cross and Blue Shield* customer service office. The toll-free phone number shows on your ID card.
- Step Therapy. This helps 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. To find an up-to-date list of drugs that are subject to Step Therapy, you can call the *Blue Cross and Blue Shield* customer service office. The toll-free phone number shows on your ID card.
- Pre-Service Review for selected drugs.

Under your health plan, no coverage is provided for prescription drugs that do not conform to *Blue Cross and Blue Shield's* clinical guidelines and *utilization review* criteria. This includes prescription drugs that are furnished to you by a covered health care provider at the time you receive covered medical treatment, or when you buy them from a covered pharmacy. For help to understand your benefits, you can call the *Blue Cross and Blue Shield* customer service office. The toll-free phone number shows on your ID card.

Covered Services

Your coverage for prosthetic devices has been changed to include augmentative communication devices.

Effective on July 1, 2009, this health plan will cover 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 ALS. This type of device will be covered to the same extent as other covered prosthetic devices. (Refer to your *contract* for more details about your coverage for prosthetic devices.) ***Blue Cross and Blue Shield* will cover only the most appropriate *medically necessary* model that meets your medical needs.** If you choose a model that costs more than what you need for your medical needs, you must pay all of the provider's charges that are more than the cost of the model that does meet your medical needs.

For help to understand your benefits, you can call the *Blue Cross and Blue Shield* customer service office. The toll-free phone number shows on your ID card.

(The exclusion for this type of device no longer applies to your *contract*.)

Blue Cross and Blue Shield of Massachusetts, Inc.

Allen Maltz
Executive Vice President

Fredi Shonkoff
Senior Vice President
Corporate Secretary

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Rider 08-831
Overall Plan Changes

This *rider* modifies the terms of your Subscriber Certificate. Please keep this *rider* with your Subscriber Certificate for easy reference.

The definition of "medically necessary" as described in Part 2 of your Subscriber Certificate has been replaced with the following section:

Medically Necessary (Medical Necessity)

To receive coverage under this *contract*, all of your health care services must be *medically necessary* and appropriate for your health care needs. (The only exceptions to this are for: routine circumcision; voluntary termination of pregnancy; voluntary sterilization procedures; stem cell transplant donor suitability testing; and preventive and routine health care services.) *Blue Cross and Blue Shield* decides which health care services 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 policy and *medical technology assessment guidelines*;
- 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.

All other provisions remain as described in your Subscriber Certificate.

Blue Cross and Blue Shield of Massachusetts, Inc.

Allen Maltz
Executive Vice President

Fredi Shonkoff
Senior Vice President
Corporate Secretary

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Rider 10-519

Hospital-Based Anesthetists, Pathologists and Radiologists

This *rider* modifies the terms of your Subscriber Certificate. Please keep this *rider* with your Subscriber Certificate for easy reference.

The provisions described in Part 11 of your Subscriber Certificate for services furnished by non-*preferred providers* have been changed.

There is another time when your PPO plan will provide in-network benefits. You will receive in-network benefits when *covered services* are furnished by a non-preferred hospital-based anesthetist, pathologist or radiologist while you are at a preferred hospital. *Blue Cross and Blue Shield* will use the health care provider's actual charge to calculate your benefits. You may have to pay the entire charge at the time of the service or at a later time. It is up to you to pay your health care provider. *Blue Cross and Blue Shield* will repay you for *covered services*. *Blue Cross and Blue Shield* will deduct your cost share amount for these *covered services* at the time your claim is paid.

This change goes into effect on January 1, 2009.

All other provisions remain as described in your Subscriber Certificate.

Blue Cross and Blue Shield of Massachusetts, Inc.

Allen Maltz
Executive Vice President

Fredi Shonkoff
Senior Vice President
Corporate Secretary

R10-519 (6-30-08) to be attached to: Blue Care® Elect.

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Rider 12-813
Dependent Eligibility

This *rider* modifies the terms of your Subscriber Certificate. Please keep this *rider* with your Subscriber Certificate for easy reference.

The eligibility provisions for coverage of dependents under this *contract* have been changed.

The *subscriber's* eligible dependents include dependents who are age 25 or under, provided that the individual has status as a dependent under the Internal Revenue Code. When the dependent loses his or her dependent status under the Internal Revenue Code, the dependent will continue to be eligible for coverage under the *subscriber's 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 include newborn children and adoptive children, subject to the provisions described in your Subscriber Certificate.

In addition, the *subscriber's* eligible dependents include the following dependent children **who do not otherwise qualify as an eligible dependent as described above**.

1. Children who are recognized under a Qualified Medical Child Support Order as having the right to enroll for coverage under this *contract*.
2. Unmarried full-time student dependent children age 24 or under who live with the *subscriber* or the spouse on a regular basis. In this case, the employee must give *Blue Cross and Blue Shield* verification 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 following the date the student discontinues full-time classes or graduates, whichever comes first.
3. Disabled dependent children. A dependent child who is mentally or physically incapable of earning his or her own living and who is enrolled under the *subscriber's 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 under the *subscriber's 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.
4. Newborn infants of an enrolled dependent immediately from the moment of birth and continuing after, until the enrolled dependent is no longer eligible as a dependent.

All other provisions remain as described in your Subscriber Certificate.

Blue Cross and Blue Shield of Massachusetts, Inc.

Allen Maltz
Executive Vice President

BLUE CROSS AND BLUE SHIELD OF MASSACHUSETTS, INC. 1937

Fredi Shonkoff
Senior Vice President
Corporate Secretary

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Rider 13-828
Low Protein Foods

This *rider* modifies the terms of your Subscriber Certificate. Please keep this *rider* with your Subscriber Certificate for easy reference.

The *benefit limit* for low protein foods that are covered by this health plan has been changed from the amount described in your Subscriber Certificate to $5,000 for each *member* in each calendar year. Once you reach the *benefit limit*, no more benefits will be provided for these services.

This change goes into effect on October 28, 2008.

All other provisions remain as described in your Subscriber Certificate.

Blue Cross and Blue Shield of Massachusetts, Inc.

Allen Maltz
Executive Vice President

Fredi Shonkoff
Senior Vice President
Corporate Secretary

R13-828 (10-9-08) to be attached to: Blue Care® Elect; PPO Basic Blue Direct; PPO Blue® Direct.

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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 និងបកប្រែផ្តាល់មាត់

សេវាផ្នែកបកប្រែភាសាអាចមានផ្តល់ជូនកាលណាអ្នកទូរស័ព្ទមកការិយាល័យផ្នែកសេវាបំរើអតិថិជនរបស់ Blue Cross and Blue Shield តាមលេខទូរស័ព្ទឥតបង់ថ្លៃដែលមាននៅក្នុងអត្តសញ្ញាណប័ណ្ណផែនការសុខភាពរបស់អ្នក ។ សេវានេះផ្តល់ឲ្យអ្នកនូវលទ្ធភាពទាក់ទងដល់ក្រុមអ្នកបកប្រែភាសាជាច្រើនដែលមានលទ្ធភាពបកប្រែភាសាលើសពី ១៤០ ភាសាទៅឡើត ។ បើអ្នកត្រូវការសេវាផ្នែកបកប្រែភាសាទាំងនេះគ្រាន់តែប្រាប់អ្នកតំណាងផ្នែកសេវាអតិថិជនកាលណាអ្នកទូរស័ព្ទមក ។ នៅពេលដែល អ្នកទូរស័ព្ទមក Blue Cross and Blue Shield នឹងប្រើបណ្តាញសេវាភាសា ដើម្បីរកអ្នកបកប្រែណា ម្នាក់ដែលគេនឹងជួយឆ្លើយសំនួររបស់អ្នក ឬជួយអ្នកឲ្យយល់អំពីទម្រង់ការរបស់ក្រុមហ៊ុន Blue Cross and Blue Shield ។ (អ្នកបកប្រែនេះមនមែនជានយោជក ឬអ្នកចាតតាងរបស 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 σάς 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 بمترجمين 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 بالمترجم 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).

ຫ້ອງການຊ່ວຍ ບໍຣິການດ້ານແປພາສາ

ມີບາຍພາສາຈະຊ່ວຍທ່ານໄດ້ ເມື່ອໂທລະສັບໄປຫາ ຫ້ອງການຊ່ວຍລູກຄ້າ ຂອງ Blue Cross and Blue Shield ທີ່ມີໂທລະສັບໂທຟີ ຢູ່ໃນບັດສຸກຂະພາບຂອງທ່ານ. ໃນ ຫ້ອງການບໍຣິການນີ້ມີນາຍພາສາ ທີ່ສາມາດແປພາສາຍກວ່າ 140 ພາສາໃຫ້ທ່ານ. ຫາກທ່ານຕ້ອງການ ບໍຣິການນີ້, ບອກໃຫ້ຜູ້ຕາງໜ້າຊ່ວຍລູກຄ້າ ເມື່ອທ່ານໂທໄປ. ໃນຍາມທ່ານໂທໄປຫາ , Blue Cross and Blue Shield ຈະໃຊ້ ສາຍໂທລະສັບສາຍນຶ່ງ ຫານາຍພາສາ ທີ່ຈະຊ່ວຍທ່ານຕອບຄຳຖາມຫລື ຊ່ວຍ ທ່ານໃຫ້ເຂົ້າໃຈການແນ່ນຳຂອງ Blue Cross and Blue Shield. (ນາຍພາສາ ຜູ້ນີ້ບໍ່ແມ່ນ ພະນັກງານ ຫລືຜູ້ແນ່ນຳຂອງ Blue Cross and Blue Shield.)

Servicio de Traducción e Interpretatión

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.)

Prescription Drug Plan

You are covered under this Prescription Drug Plan. This group health plan is an insured health plan offered by Blue Cross and Blue Shield of Massachusetts, Inc. *Blue Cross and Blue Shield* will provide the benefits that are described in this Prescription Drug Plan as long as you are enrolled under this Prescription Drug Plan when you obtain covered drugs and supplies and the *premium* that your *group* owes for these benefits has been paid to *Blue Cross and Blue Shield*.

This Prescription Drug Plan is part of the contract between the *subscriber's group* and Blue Cross and Blue Shield of Massachusetts, Inc., located at Landmark Center, 401 Park Drive, Boston, Massachusetts 02215-3326, to provide benefits to you (the member). The contract, including this Prescription Drug Plan and any applicable riders, will be governed by and construed according to the laws of the Commonwealth of Massachusetts, except as preempted by federal law.

Part 1
Benefits

Member Costs for Covered Drugs and Supplies

This chart highlights the benefits that are provided by this Prescription Drug Plan, and the share of the cost that each member must pay for covered drugs and supplies. **Do not rely on this chart alone. It merely highlights your benefits. For a complete description of your benefits, be sure to read all provisions described in this Prescription Drug Plan.**

Schedule of Benefits	
Retail Pharmacy Benefit (up to a 30-day formulary supply)	
	You pay:
• Tier 1	$10 *copayment*
• Tier 2	$25 *copayment*
• Tier 3	$45 *copayment*
Mail Service Pharmacy Benefit (up to a 90-day formulary supply)	
	You pay:
• Tier 1	$20 *copayment*
• Tier 2	$50 *copayment*
• Tier 3	$90 *copayment*

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Under this Prescription Drug Plan, *Blue Cross and Blue Shield* provides benefits for covered drugs and supplies you obtain from a pharmacy **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, prior approval is required from *Blue Cross and Blue Shield* in order for you to receive these benefits. (The pharmacy will tell you if your drug needs prior approval and how to request this approval.)
- The drug or supply is prescribed for use out of the hospital or another health care facility.
- 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 retail pharmacy. However, for a select number of covered drugs and supplies, you may need to buy your drug or supply from certain 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.

Note: *Blue Cross and Blue Shield* may have payment arrangements with pharmacy providers that may result in rebates on covered drugs and supplies. The amount that you pay for a covered drug or supply is determined at the time you buy the drug or supply. The amount 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.

Drug Formulary

Blue Cross and Blue Shield's 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 benefits 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 not included on the Drug Formulary, you may refer to the *Blue Cross and Blue Shield* Pharmacy Program booklet that was sent to you as a part of your Prescription Drug Plan or, if the exclusion list has been changed, the revised booklet that is in effect at the time you buy your drug or supply. Please check for updates. You may check for updates or obtain more information about the Drug Formulary, including which drugs are not included on the formulary, by calling the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your *Blue Cross and Blue Shield* identification card. Or, you may look on the internet website at **www.bluecrossma.com**.

Drug Formulary Exception Process. These drug benefits include a Drug Formulary exception process. This process allows your prescribing provider to request an exception from *Blue Cross and Blue Shield* to obtain benefits for a drug (or supply) that is not included 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, benefits for the drug (or supply) that is not included on the Drug Formulary will be provided at the highest member cost-share level.

Buying Covered Drugs and Supplies

For help to obtain your pharmacy benefits, you may call the *Blue Cross and Blue Shield* customer service office. The toll-free telephone number is shown on your *Blue Cross and Blue Shield* identification card. A customer service representative can help you find a covered 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 may also look on the internet website at **www.bluecrossma.com**.

Certain covered drugs and supplies may not be available 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.

(Remember: When you buy your drugs or supplies, the pharmacist will give you a generic equivalent of the prescribed drug whenever allowed.)

Covered Drugs and Supplies

These benefits are provided for:

- Drugs that require a prescription by law and are furnished in accordance with the *Blue Cross and Blue Shield medical technology assessment guidelines*. These 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 benefits, 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, including blood glucose monitoring strips, ketone strips, lancets, urine glucose testing strips, normal, low and high calibrator solution/chips and dextrostik or glucose test strips when ordered by a network physician for home use.
- 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. For the insulin infusion pump itself, any amount you would normally pay for covered drugs and supplies will be waived.)
- *Medically necessary* syringes and needles.
- Special medical formulas that are approved by the Massachusetts Department of Public Health and *medically necessary* to treat: homocystinuria; maple syrup urine disease; phenylketonuria; propionic acidemia; methylmalonic acidemia; and tyrosinemia.
- Enteral formulas for home use that are *medically necessary* to treat malabsorption caused by: Crohn's disease; chronic intestinal pseudo-obstruction; gastroesophageal reflux; gastrointestinal motility; ulcerative colitis; and inherited diseases of amino acids and organic acids.
- Food products modified to be low protein that are *medically necessary* to treat inherited diseases of amino acids and organic acids. (You may buy these food products directly

from a distributor.) **These benefits are limited to $2,500 for each member in each calendar year.**

- 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. The *Blue Cross and Blue Shield* Pharmacy Program booklet will list the over-the-counter drugs that are covered by this pharmacy coverage, if there are any. Or, you may look on the internet website at **www.bluecrossma.com**.
- Diaphragms. (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 prescribed by a physician. **These benefits are limited to one 90-day supply for each member in each calendar year.**
- Any other drugs and supplies that are approved in the future by the FDA for the diagnosis and treatment of insulin dependent, insulin using, gestational or non-insulin dependent diabetes as long as they are in accordance with *Blue Cross and Blue Shield medical technology assessment guidelines.*

Important Note: There are no exclusions, limitations or other restrictions for drugs that are prescribed to treat infertility different from those applied to drugs that are prescribed for other medical conditions.

Non-Covered Drugs and Supplies

No benefits are provided for:

- Anorexiants.
- Pharmaceuticals, including birth control preparations, that you can buy without a prescription, except as described above.
- 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-participating retail or mail service pharmacy or a drug or supply that you buy from a participating pharmacy other than a participating pharmacy that has been approved by *Blue Cross and Blue Shield* for payment for that specific covered drug or supply. (However, you can get covered drugs from a pharmaceutical company when the drugs are not reasonably available from a participating retail pharmacy.) If you are outside Massachusetts, you may fill your prescription at any retail pharmacy. But, at a non-participating retail pharmacy, you must pay all charges at the time of purchase or at a later time. Then, you may call the *Blue Cross and Blue Shield* customer service office for a claim form to file your claim. *Blue Cross and Blue Shield* will repay you, less the amount you would normally pay for covered drugs and supplies.
- Drugs and supplies dispensed or administered by providers such as physician assistants, home health care providers and visiting nurses when these drugs are supplied by the provider during the visit.

- Drugs and supplies that are not *medically necessary* for you (except for birth control drugs and devices such as diaphragms).
- Drugs and supplies that are not furnished in accordance with *Blue Cross and Blue Shield* medical policy and *medical technology assessment guidelines*, except for certain drugs used on an off-label basis as required by law (such as drugs used to treat cancer and drugs used to treat HIV/AIDS).

Part 2
Member Services

Making an Inquiry and/or Resolving Claim Problems or Concerns

For help to understand the terms of this Prescription Drug Plan, or if you have any questions about the *Blue Cross and Blue Shield* drug formulary, you may call the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your *Blue Cross and Blue Shield* identification card. (Or, to use the Telecommunications Device for the Deaf, call 1-800-522-1254.) A customer service representative will work with you to help you understand your benefits or resolve your problem or concern as quickly as possible. See Part 3 for more information about *Blue Cross and Blue Shield's* inquiry process and the formal grievance review process. You can call the *Blue Cross and Blue Shield* customer service office Monday through Friday from 8:00 a.m. to 8:00 p.m. (Eastern Time). Or, you can write to: Blue Cross Blue Shield of Massachusetts, Inc., Member Services, P.O. Box 9134, North Quincy, MA 02171-9134. *Blue Cross and Blue Shield* will keep a record of each inquiry you (or someone on your behalf) makes. These records, including the responses to each inquiry, will be kept for two years. They may be reviewed by the Commissioner of Insurance and Massachusetts Department of Public Health.

At the onset of an emergency medical condition that in your judgment requires emergency medical care, you should go to the nearest emergency room. For assistance, call your local emergency medical service system by dialing the emergency telephone access number 911, or the local emergency telephone number. You will not be denied coverage for medical and transportation expenses incurred as a result of the emergency medical condition to the extent that such services are covered by this Prescription Drug Plan.

Office of Patient Protection

The Office of Patient Protection of the Massachusetts Department of Public Health can provide information about health care plans in Massachusetts and answer questions you may have concerning new legislation or regulations. The health care information that this office can provide includes: (a) a health plan report card that contains information and data providing a basis by which health insurance plans may be evaluated and compared by consumers as well as health plan employer data collected for the National Committee on Quality Assurance and a list of sources that can provide information about member satisfaction and the quality of health care services offered by health care plans; (b) information about physicians who are voluntarily and/or involuntarily disenrolled by a health plan during the prior calendar year; (c) a chart comparing the premium revenue that has been used for health care services for the most recent year for which the information is available; and (d) a report that provides information for health care plan grievances and external appeals for the previous calendar year. To request any of this information, you may contact the Office of Patient Protection by calling **1-800-436-7757** or

faxing a request to **1-617-624-5046**. This information is also available on the Office of Patient Protection's internet website **www.state.ma.us/dph/opp**.

Filing a Claim

You do not have to file a claim when you buy covered drugs and supplies from a participating retail pharmacy. Just tell the pharmacy that you are a member and show your *Blue Cross and Blue Shield* identification card. But, when you buy covered drugs or supplies from a non-participating retail pharmacy outside Massachusetts, you must file a claim. When this is the case, *Blue Cross and Blue Shield* will reimburse you directly. It is up to you to pay the pharmacy. You can get claim forms from the *Blue Cross and Blue Shield* customer service office. *Blue Cross and Blue Shield* will mail to you all applicable forms within 15 days after receiving notice that you obtained a drug 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. *Blue Cross and Blue Shield* will pay you interest on the claim payment (if any), in addition to the claim payment itself. 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.) You must file your claim within two years of the date you bought the covered drugs or supplies. *Blue Cross and Blue Shield* does not have to honor claims 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 benefits or payment, a decision will be made and, where appropriate, payment will be made to the pharmacy (or to you if you sent in the claim) for your claim to the extent of your benefits described in this Prescription Drug Plan. Or, you and/or the pharmacy will be sent a notice in writing of why your claim is not being paid in full or in part. If the request for benefits or payment is not complete or if more information is needed to make a final determination for the claim, *Blue Cross and Blue Shield* will ask for the information or records it needs within 30 calendar days of receiving the request for benefits or payment. This additional information must be provided to *Blue Cross and Blue Shield* within 45 calendar days of this request. If the additional information is provided to *Blue Cross and Blue Shield* within 45 calendar days of the request, a decision will be made within the time remaining in the original 30-day claim determination period or within 15 calendar days of the date the additional information is received, whichever is later. If the additional information is not provided to *Blue Cross and Blue Shield* within 45 calendar days of the request, the claim for benefits or payment will be denied. If the additional information is submitted after this 45 days, then it may be viewed as a new claim for benefits or payment. In this case, a decision will be made within 30 days as described previously in this section.

Part 3
Grievance Program

You have the right to a review when you disagree with a decision by *Blue Cross and Blue Shield* to deny payment for a drug or supply, or if you have a complaint about the service you received from *Blue Cross and Blue Shield* or a participating pharmacy.

Making an Inquiry and/or Resolving Claim Problems or Concerns

Most problems or concerns can be handled with just one phone call. (See page 5 for more information about Member Services.) For help resolving a problem or concern, you should first call the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your *Blue Cross and Blue Shield* identification card. A customer service representative will work with you to help you understand your benefits or 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, including the terms of this Prescription Drug Plan, the policies and procedures that support these benefits, the provider's input, as well as your understanding and expectation of benefits. *Blue Cross and Blue Shield* will use every opportunity to be reasonable in finding a solution that makes sense for all parties and may use an individual case management approach when it is judged to be appropriate. *Blue Cross and Blue Shield* will follow its standard business practices guidelines when resolving your problem or concern. If you disagree with the decision given to you by the customer service representative or *Blue Cross and Blue Shield* has not responded within three working days of receiving your inquiry, you may request a review through *Blue Cross and Blue Shield's* formal internal grievance program. If this is the case, *Blue Cross and Blue Shield* will notify you of the steps you may follow to request a formal internal grievance review. The formal grievance review process described below will be followed when your request for a review is because *Blue Cross and Blue Shield* has determined that a service or supply is not *medically necessary* for your condition.

Internal Formal Grievance Review

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

- The preferred option is for you to send your grievance in writing to: Grievance Program, Blue Cross and Blue Shield of Massachusetts, Inc., Landmark Center, 401 Park Drive, Boston, Massachusetts 02215-3326. 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.
- Or, you may send your grievance to *Blue Cross and Blue Shield's* 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.
- Or, you may call *Blue Cross and Blue Shield's* Grievance Program at **1-800-472-2689**. When your request is made by telephone, *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, ask for more information as needed and let you know in writing of the decision or the outcome of the investigation.

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 also available to provide members with information and/or reports about grievances. To contact the Office of Patient Protection, you may call **1-800-436-7757** or fax a request to **1-617-624-5046**. Or, you can visit the Office of Patient Protection's internet website **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 identification 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. You do not have to designate the health care provider in writing.)

Who Handles the Grievance Review–All grievances are reviewed by individuals who are knowledgeable about *Blue Cross and Blue Shield* and the issues involved in the grievance. The individuals 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 that usually treats the medical condition, 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* formal internal grievance review will be completed within 30 calendar days. Every reasonable effort will be made to speed up the review of grievances that involve drugs and supplies that are soon to be obtained by the member. The 30 calendar day time frame to complete a grievance review may be extended, with your permission, in cases when *Blue Cross and Blue Shield* and the member agree that additional time is required to fully investigate and respond to the grievance. The 30 calendar day time frame may also be extended when the grievance review requires a review of

your medical records and 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.

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 drug 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 benefits as described in this Prescription Drug Plan; give the specific medical and scientific reasons for the denial; specify any alternative drugs and supplies that would be covered; reference and include applicable 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 timeframes 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).
- A decision to deny payment for drugs and/or supplies may be reversed within 48 hours if the member's attending physician certifies that a denial for those drugs and/or supplies would create a substantial risk of serious harm to the member if the member were to wait for the outcome of the normal grievance process.
- A grievance review requested by a member with a terminal illness will be completed within five working days of receiving the request. In this case, if the expedited review results in a denial for drugs and/or supplies, *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 benefits as described in this Prescription Drug Plan; give the specific medical and scientific reasons for the denial; specify any alternative drugs and supplies that would be covered; reference and include applicable 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 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 drug or supply 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 *Blue Cross and Blue Shield's* formal internal 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. *Blue Cross and Blue Shield's* 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 your receipt of 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.

To contact the Office of Patient Protection, you may call **1-800-436-7757**. Or, you may fax a request to **1-617-624-5046**. Or, you can visit the Office of Patient Protection's website **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 telephone 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.

Part 4
Other Plan Provisions

Access to and Confidentiality of a Member's Medical Records

Blue Cross and Blue Shield and health care providers may, in accordance with applicable law, have access to all medical records and related information needed by *Blue Cross and Blue Shield* or health care providers. *Blue Cross and Blue Shield* may collect information from health care providers, other insurance companies or the *plan sponsor* to help *Blue Cross and Blue Shield* administer the benefits described in this Prescription Drug Plan and to get facts on the quality of care 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 follows:

- For administering benefits (including coordination of benefits with other insurance plans); disease management programs; 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 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 required by the *subscriber's group* or its auditors.

To obtain a copy of *Blue Cross and Blue Shield's* Commitment to Confidentiality statement, call the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your *Blue Cross and Blue Shield* identification card. *Blue Cross and Blue Shield* will not share information about you with the Medical Information Bureau (MIB). Except as described above, *Blue Cross and Blue Shield* will keep all information confidential and not disclose it without your consent. 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 information that you believe is not correct. *Blue Cross and Blue Shield* may charge a reasonable fee for copying records, unless your request is because *Blue Cross and Blue Shield* is declining or terminating your benefits under this Prescription Drug 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 participating pharmacy or 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 participating pharmacy or other health care provider.

Blue Cross and Blue Shield will not interfere with the relationship between providers and their patients. You are free to select or discharge any provider. It is not up to *Blue Cross and Blue Shield* to find a provider for you. *Blue Cross and Blue Shield* is not responsible if a provider refuses to furnish services to you.

Assignment of Benefits

You cannot assign any benefit or monies due under this Prescription Drug 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 under this Prescription Drug Plan to another person or organization. There is one exception to this rule. If Medicaid has already paid the pharmacy, you can assign your benefits to Medicaid.

Authorized Representative

You may choose to have another person act on your behalf concerning your benefits under this Prescription Drug 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. (Or, he or she may appoint another party to be the authorized representative.) *Blue Cross and Blue Shield* will continue to send benefit payments and written communications regarding coverage in accordance with *Blue Cross and Blue Shield's* standard practices, unless specifically requested to do otherwise. (You can get

a form to designate an authorized representative from the *Blue Cross and Blue Shield* customer service office.)

Blue Cross and Blue Shield Rights to Recover Benefit Payment

Subrogation and Reimbursement of Benefit Payments–If you are injured by any act or omission of another person, the benefits under this Presciption Drug 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 you must reimburse *Blue Cross and Blue Shield* will not be reduced by any attorney's fees or expenses 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.

Changes to This Prescription Drug Plan

The *plan sponsor* or *Blue Cross and Blue Shield* may change a part of this Prescription Drug Plan. For example, a change may be made to the amount you must pay for covered drugs and supplies. When *Blue Cross and Blue Shield* makes a change to this Prescription Drug Plan, the *plan sponsor* will be notified at least 60 days before the effective date of the change. The notice will describe the change being made. It will also give the effective date of the change. When a material change is made to this contract, *Blue Cross and Blue Shield* will send you a rider that describes the change.

Coordination of Benefits (COB)

Blue Cross and Blue Shield will coordinate payment of covered drugs and supplies 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 other health plans under which you are covered. Once you are enrolled under this contract, you must notify *Blue Cross and Blue Shield* if you add or change health plan coverage. Upon 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 under this contract is secondary, no benefits 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 under this contract will be secondary when another plan provides you with coverage for health care services. *Blue Cross and Blue Shield* will not provide any more benefits than those already described in this Prescription Drug Plan. *Blue Cross and Blue Shield* will not provide duplicate benefits for covered drugs and supplies. 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.

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

Pre-Existing Conditions

Your benefits under this Prescription Drug Plan are not limited based on medical conditions that are present on or before your effective date. This means that your drugs and supplies will be covered from the effective date of your membership under this Prescription Drug Plan without a pre-existing condition restriction. But, benefits for these services are subject to all the provisions described in this Prescription Drug Plan.

Quality Assurance Programs

Blue Cross and Blue Shield uses quality assurance programs that affect different aspects of health care such as disease treatment and health promotion. Under its prescription drug program, *Blue Cross and Blue Shield* provides general asthma education to assist members with the self-management of asthma and to identify high-risk members and to assess their ongoing care management needs. Ongoing interventions are targeted to members and physicians based on risk levels. The goal is to help the member stay as healthy and active as possible.

Time Limit for Legal Action

Before pursuing a legal action against *Blue Cross and Blue Shield* for any claim under this Presciption Drug Plan, you must complete *Blue Cross and Blue Shield's* formal internal grievance review (see Part 3). You may, but do not need to, pursue an external review prior to pursuing a legal action. If, after completing the grievance review, you choose to bring legal action against *Blue Cross and Blue Shield*, this action must be brought within two years after the cause of action arises. For example, if you are filing a legal action because you were denied a service or a claim for benefits under this Presciption Drug 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 you were first sent a notice of the service or claim denial. Going through the internal formal grievance process does not extend the two-year limit for filing a lawsuit. However, if you choose to pursue a voluntary external review, the days from the date your request is received by the external reviewer until the date you receive the response are not counted toward the two-year limit.

Utilization Review Program

Under this Prescription Drug Plan, *Blue Cross and Blue Shield* uses various utilization review criteria to monitor the use of, or evaluate the clinical necessity, appropriateness and efficacy of prescription drugs. These programs include retrospective and concurrent drug utilization review. Some examples include: duplicate therapy; drug interactions; polypharmacy; and the use of addictive substances. *Blue Cross and Blue Shield* applies *medical technology assessment guidelines* as described in Part 8 to develop its clinical guidelines and utilization review criteria.

Part 5
Eligibility for Coverage

Eligible Employee

An employee is eligible to enroll as a *subscriber* under this Prescription Drug Plan as long as he or she 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* health care benefits.

Eligible Spouse

The *subscriber* may enroll an eligible spouse for coverage under his or her Prescription Drug Plan. An "eligible spouse" includes the *subscriber's* legal spouse. (A legal civil union spouse, where applicable, is eligible to enroll under this Prescription Drug Plan to the extent that a legal civil union spouse is determined eligible by the *plan sponsor*. For more details, contact your *plan sponsor*.)

In the event of divorce or legal separation, the person who was the spouse of the *subscriber* prior to the divorce or legal separation will remain eligible for coverage under the *subscriber's* membership, whether or not the judgment was entered prior to the *effective date* of this Prescription Drug Plan. This coverage is provided with no additional *premium*. 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.)

In the event the *subscriber* remarries, the former spouse may continue coverage under a separate under a separate membership with 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 under the *subscriber's* membership.

Eligible Dependents

The *subscriber* may enroll eligible dependents for coverage under his or her Prescription Drug Plan. All 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 under the *subscriber's* Prescription Drug Plan 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 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 that are described in this Prescription Drug 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 that are described in this Prescription Drug 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 to *Blue Cross and Blue Shield* written verification 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.
- 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* Prescription Drug Plan 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 under the *subscriber's* Prescription Drug Plan. 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.

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

If you want to ask for a membership change or you need to change your name or mailing address, you should call or write your *plan sponsor*. The *plan sponsor* will send you any special forms you may need. You must request the membership change within 30 days of the reason for the change. If you do not make the change within 30 days, you will have to wait until the *group's* next open enrollment period to make the change. All membership changes or any additions are allowed only when they comply with the conditions outlined in this Prescription Drug Plan and in *Blue Cross and Blue Shield's* Manual of Underwriting Guidelines for Group Business.

Part 6
Termination of Coverage

Loss of Eligibility for Coverage Under This Prescription Drug Plan

You are no longer eligible for coverage under this Prescription Drug Plan when:

- The *subscriber* loses eligibility for coverage with the *group*. This means: the *subscriber's* hours are reduced; or the *subscriber* leaves the job; or the *subscriber* no longer meets the rules set by the *group* for eligibility in this Prescription Drug Plan.
- 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 dependent children) may have the option of continuing coverage under this Prescription Drug Plan when the *subscriber* remains as an actively working employee after reaching age 65.
- You lose eligibility as a dependent under the *subscriber's* membership. When a dependent child loses eligibility for coverage, the termination date of membership will be the date on which eligibility is lost.
- The *subscriber* dies.
- The *plan sponsor* fails to pay your *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 membership in accordance with the Code of Massachusetts Regulations. This notice will give you information about the termination of your membership and your options, if any, to continue *Blue Cross and Blue Shield* coverage.
- The *subscriber's group* terminates (or does not renew) this Prescription Drug Plan.

In any of these situations, your membership under this Prescription Drug Plan will be terminated as of the date you lose eligibility.

Termination by the *Subscriber*

Your coverage under this Prescription Drug Plan ends when the *subscriber* chooses to cancel his or her Prescription Drug Plan 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 by *Blue Cross and Blue Shield*

You do not have to worry that *Blue Cross and Blue Shield* will cancel you because you are using your benefits or because you will need more covered drugs and supplies in the future. *Blue Cross and Blue Shield* will cancel your coverage under this Prescription Drug Plan only when:

- You committed misrepresentation or fraud to *Blue Cross and Blue Shield*. For example, you gave false or misleading information on the enrollment application form. Or, you misused the *Blue Cross and Blue Shield* identification card by letting another person not enrolled under this Prescription Drug Plan attempt to get benefits. This 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*.
- You commit acts of physical or verbal abuse that pose a threat to participating 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.
- *Blue Cross and Blue Shield* cancels this Prescription Drug Plan for any reason as of a date approved by the Massachusetts Commissioner of Insurance (without prior notice) or cancels all plans of this type as of any date.

Part 7
Continuation of Coverage Options

Limited Extension of Coverage Under State Law

When you are no longer eligible for membership in this Prescription Drug Plan, you may be eligible to continue this coverage as provided by state law. If you lose eligibility for coverage due to lay off or death of the *subscriber*, coverage may continue for up to 39 weeks from the date of the qualifying event. To continue this coverage, you will pay 100% of the *premium* cost. If you lose eligibility for coverage due to a plant closing or partial plant closing in Massachusetts, you and your *group* will each pay your share of the *premium* cost for up to 90 days after the closing. Then, to continue this coverage for up to an additional 39 weeks, you will pay 100% of the *premium* cost. If you become eligible for coverage under an employer sponsored health care plan at any time before the extension period ends, continued coverage in this Prescription Drug Plan under these provisions also ends. If one of these situations applies to you, you may also be eligible for continued coverage under other state laws or under federal law. (See below for more information.) If you are, the starting date for continued coverage under these laws will be the same. But, after the extension period as provided under these provisions ends, you may have to pay additional *premium* to continue your coverage under this Prescription Drug Plan.

Continuation of *Group* Coverage Under Federal or State Law

When you are no longer eligible for membership in this Prescription Drug Plan, you may be eligible to continue this 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 coverage, you will pay up to 102% of the *premium* cost to your *plan sponsor*. 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 under the employee's membership. This is the case **only** until the employee is no longer required by law to provide health insurance for the former spouse or the employee or former spouse remarries, whichever comes first. The former spouse's eligibility for continued coverage will start on the date of divorce, even if he or she continues coverage under the employee's membership. While the former spouse continues coverage under the employee's membership, there is no additional *premium*. After remarriage, under state and federal law, the former spouse may be eligible to continue coverage under an individual membership 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 coverage begins with the date of your qualifying event. And, the length of this continued 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.)

Note: When a *subscriber's* legal same-sex spouse is no longer eligible for membership in this Prescription Drug Plan, that spouse or if applicable, civil union spouse (and his or her dependent children) may continue coverage in the *subscriber's group* to the same extent that a legal opposite-sex spouse (and his or her dependent children) could continue coverage upon loss of eligibility for membership in this Prescription Drug Plan.

Additional Continued Coverage for Disabled Employees–Within 60 days of the employee's termination of employment or reduction in hours, 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 coverage will remain in effect 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 the 11 additional months, eligibility for disability is lost, coverage may terminate before the 29 months is completed. You should contact your *plan sponsor* for more information 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 membership under this Prescription Drug Plan as a result of a bankruptcy proceeding (Title 11 of the United States Code) is also eligible to continue this coverage as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA) or under Massachusetts state law. A retired employee and/or the surviving spouse of a deceased retired employee may enroll for lifetime continued 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 coverage as of the date *group* eligibility is lost. Spouses and/or eligible dependent children of these retired employees may enroll for continued coverage until the retired employee dies. Once the retired employee dies, his or her surviving spouse and/or eligible dependent children may enroll for up

to an additional 36 months of continued coverage beyond the date of the retired employee's death. Lifetime continued coverage for retired employees will end if the *group* terminates its agreement with *Blue Cross and Blue Shield* to provide the coverage described in this Prescription Drug Plan or for any of the other reasons described below. (See "Termination of Continued Coverage.")

Enrollment for Continued Coverage–In order to enroll for continued coverage under this Prescription Drug 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 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 under this Prescription Drug Plan. (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 Coverage–Your continued coverage will end when: the length of time allowed for continued 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 care plan and that plan does not include pre-existing condition limitations or waiting periods; you become entitled to Medicare benefits; or the *group* terminates its agreement with *Blue Cross and Blue Shield* to provide the coverage described in this Prescription Drug Plan (in this case, coverage may continue under another health care plan–call your *plan sponsor* for more information). The longer time allowed for continued coverage for disabled members will end when the member is no longer disabled.

Part 8
Definitions

Blue Cross and Blue Shield
Blue Cross and Blue Shield of Massachusetts, Inc. This includes an employee or designee of *Blue Cross and Blue Shield* who is authorized to make decisions or take action called for under this Prescription Drug Plan.

Coinsurance
The amount that you pay for a covered drug or supply that is calculated as a percentage. **If a *coinsurance* applies to your pharmacy benefits, Part 1 shows those covered drugs and/or supplies that are subject to *coinsurance* and your *coinsurance* percentage that will be used to calculate your cost of the covered drug or supply.** Your *coinsurance* is a percentage of the provider's actual charge or the *Blue Cross and Blue Shield* allowed charge, whichever is less (unless otherwise required by law).

Copayment
The amount that you must pay for a covered drug or supply which is a fixed dollar amount. In most cases, a participating pharmacy will collect the *copayment* from you at the time the covered drug or supply is furnished. However, when the provider's actual charge at the time of providing the covered drug or supply is less than your *copayment*, you pay only that 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 amount you were charged at the time of the service if it was less than the *copayment*). **If a *copayment* applies to your**

pharmacy benefits, Part 1 shows the amount of your *copayment* and which covered drugs and/or supplies are subject to a *copayment*.

Deductible

The amount that you must pay before benefits are provided for certain covered drugs and/or supplies. **If a *deductible* applies to your pharmacy benefits, Part 1 shows the amount of your *deductible* and which covered drugs and/or supplies are subject to the *deductible*.** The amount that is put toward your *deductible* is calculated based on provider's actual charge or the *Blue Cross and Blue Shield* allowed charge, whichever is less (unless otherwise required by law). (When a *deductible* applies to your benefits, there are amounts you pay that **do not** count toward your *deductible*. These include: any *copayments*; and any amount you pay that is more than the *Blue Cross and Blue Shield* allowed charge.) When you are enrolled under a membership that includes the *subscriber* and an eligible spouse and/or other eligible dependents, a "family *deductible*" means that the *deductible* amounts paid by members covered under the same membership will not total more than the family *deductible* amount. The family *deductible* can be met by eligible costs incurred by any combination of family members. But, no one member will have to pay more than the *deductible* amount for a member.

Group

Any corporation, partnership, individual proprietorship or other organization that has an agreement with *Blue Cross and Blue Shield* to provide health care benefits for a group of members. The *group* will make payment to *Blue Cross and Blue Shield* for covered members and will also deliver to the 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*.

Medical Technology Assessment Guidelines

The guidelines that *Blue Cross and Blue Shield* uses to assess whether a drug or supply improves health outcomes such as length of life or ability to function. These guidelines include the following five criteria:

- The drug or supply must have final approval from the appropriate government regulatory bodies. A drug or supply must have final approval from the Food and Drug Administration (FDA). Any approval granted as an interim step in the FDA regulatory process is not sufficient. Except as required by law, *Blue Cross and Blue Shield* may limit benefits for a drug or supply to those specific indications, conditions and methods of use approved by the FDA.
- The scientific evidence must permit conclusions concerning the effect of the drug or supply 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 drug or supply 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 drug or supply must improve the net health outcome and its beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
- The drug or supply must be as beneficial as any established alternatives. The drug or supply should improve the net outcome as much as or more than established alternatives. The drug or supply must be as cost-effective as any established alternatives that achieve a similar health outcome.
- The improvement must be attainable outside the investigational setting. When used under the usual conditions of medical practice, the drug or supply should be reasonably expected to improve health outcomes to a degree comparable to that published in the medical literature.

As new drugs are approved by the FDA, *Blue Cross and Blue Shield* reviews their safety, effectiveness and overall value on an ongoing basis. While a new drug is being reviewed, it will not be covered by this Prescription Drug Plan.

Medically Necessary

Drugs and supplies must be *medically necessary* and appropriate for your specific health care needs. This means that all drugs and supplies must be consistent with generally accepted principals of professional medical practice. *Blue Cross and Blue Shield* decides which drugs and supplies are *medically necessary* and appropriate for you by using the following guidelines. All drugs and supplies must be: consistent with the diagnosis and treatment of your condition and in accordance with *Blue Cross and Blue Shield* medical policy and *medical technology assessment guidelines*; essential to improve your net health outcome and as beneficial as any established alternatives covered by this Prescription Drug Plan; and as cost effective as any established alternatives.

Out-of-Pocket Maximum

The total amount that you pay for certain covered drugs and/or supplies under this Prescription Drug Plan. **If this provision applies to your pharmacy benefits, Part 1 will show the amount of the *out-of-pocket maximum* and which amounts you pay that will count to the *out-of-pocket maximum*.** Under this provision, when the amounts you have paid for covered drugs and/or supplies that count toward your *out-of-pocket maximum* add up to the *out-of-pocket maximum* amount, *Blue Cross and Blue Shield* will provide full benefits based on the *Blue Cross and Blue Shield* allowed charge for these covered services until the end of the time frame in which the *out-of-pocket maximum* provision applies. There are amounts you pay that **do not** count toward your *out-of-pocket maximum*. These include any amounts you pay when your benefits under this Prescription Drug Plan have been exhausted for a specific service or supply. When you are enrolled under a membership that includes the *subscriber* and an eligible spouse and/or other eligible dependents, a "family *out-of-pocket maximum*" means that the amounts that count toward the *out-of-pocket maximum* and paid by members covered under the same membership will not total more than the family *out-of-pocket maximum* amount. The family *out-of-pocket maximum* can be met by eligible costs paid by any combination of family members. But, no one member will have to pay more than the *out-of-pocket maximum* amount for a member.

Plan Sponsor

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 (ERISA), as amended. If you are not sure who your *plan sponsor* is, contact your employer.

Plan Year

The 12-month period of time beginning on the original effective date of your *group's* coverage under this Prescription Drug Plan and continuing for 12 consecutive months. A new *plan year* begins each 12-month period thereafter. Your *group's plan year* may be used to calculate your *deductible* and *out-of-pocket maximum* amounts. **Part 1 will show whether a calendar year or your *group's plan year* is used to calculate your *deductible* and *out-of-pocket maximum* amounts.** If you are not sure when your *plan year* begins, contact your *plan sponsor*.

Premium

The total monthly cost of your benefits under this Prescription Drug Plan. The *premium* amount is part of the agreement between *Blue Cross and Blue Shield* and the *group*. *Blue Cross and Blue Shield* may change your *premium* amount. Each time *Blue Cross and Blue Shield* changes the *premium, Blue Cross and Blue Shield* will notify your *group* before the change is effective. It is up to the *group* to notify a *subscriber* of any *premium* changes. The *group* may require that you pay all or a portion of this *premium* amount. In all cases, the *group* must pay the total *premium* charges owed for your benefits under this Prescription Drug Plan to *Blue Cross and Blue Shield*. *Blue Cross and Blue Shield* is not responsible for providing benefits for a *group's* member if the *group* fails to make *premium* payments. In this case, *Blue Cross and Blue Shield* must provide notification to the *group's* member.

Subscriber

The eligible person who signs the enrollment form at the time of enrollment under this Prescription Drug Plan. This is the person on whose behalf *Blue Cross and Blue Shield* and the *plan sponsor* have entered into this contract.

You hereby expressly acknowledge your understanding that this contract constitutes a contract solely between the account (your *group*) on your behalf and Blue Cross and Blue Shield of Massachusetts, Inc. (*Blue Cross and Blue Shield*), which is an independent corporation 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* has not entered into this contract on your behalf 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* for any of *Blue Cross and Blue Shield's* obligations to you created under this 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 this contract.

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

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Rider 08-831
Overall Plan Changes

This rider modifies the terms of your Prescription Drug Plan. Please keep this rider with your Prescription Drug Plan for easy reference.

The definition of "medically necessary" as described in your Prescription Drug Plan has been replaced with the following section:

Medically Necessary (Medical Necessity)

To receive coverage under this Prescription Drug Plan, all of your drugs and supplies must be *medically necessary* and appropriate for your health care needs. *Blue Cross and Blue Shield* decides which drugs 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 drugs and supplies must be required drugs and supplies 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 drugs and supplies 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 policy and *medical technology assessment guidelines*;
- essential to improve your net health outcome and as beneficial as any established alternatives that are covered by *Blue Cross and Blue Shield*;
- 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.

All other provisions remain as described in your Prescription Drug Plan.

Blue Cross and Blue Shield of Massachusetts, Inc.

Allen Maltz
Executive Vice President

BLUE CROSS AND BLUE SHIELD OF MASSACHUSETTS, INC. 1937

Fredi Shonkoff
Senior Vice President
Corporate Secretary

R08-831 (10-9-08) to be attached to: Prescription Drug Plans.

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Rider 13-827
Prescription Drugs

This *rider* modifies the terms of your Subscriber Certificate. Please keep this *rider* with your Subscriber Certificate for easy reference.

The *outpatient* benefits described in your Subscriber Certificate have been changed for certain prescription drugs you obtain from a pharmacy on or after January 1, 2009.

As of January 1, 2009, in addition to the exclusions described in your Subscriber Certificate for drugs and supplies, no benefits are provided for non-sedating antihistamines. For these drugs, you must pay all charges.

(The Drug Formulary exception process does not apply to these drugs.)

All other provisions remain as described in your Subscriber Certificate.

Blue Cross and Blue Shield of Massachusetts, Inc.

Allen Maltz
Executive Vice President

Fredi Shonkoff
Senior Vice President
Corporate Secretary

R13-827 (11-5-07) to be attached to Comprehensive Major Medical Plans; Major Medical Plan; Master Health®´; Master Health Plus®´; Master Medical®´; Prescription Drug Plans; Vital Insurance Protection™ Plans.

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Rider 13-828
Low Protein Foods

This *rider* modifies the terms of your Subscriber Certificate. Please keep this *rider* with your Subscriber Certificate for easy reference.

The *benefit limit* for low protein foods that are covered by this health plan has been changed from the amount described in your Subscriber Certificate to $5,000 for each *member* in each calendar year. Once you reach the *benefit limit*, no more benefits will be provided for these services.

This change goes into effect on October 28, 2008.

All other provisions remain as described in your Subscriber Certificate.

Blue Cross and Blue Shield of Massachusetts, Inc.

Allen Maltz
Executive Vice President

Fredi Shonkoff
Senior Vice President
Corporate Secretary

R13-828 (10-9-08) to be attached to: Comprehensive Major Medical Plans; Major Medical Plan; Master Health®´; Master Health Plus®´; Master Medical®´; Prescription Drug Plans; Vital Insurance Protection™ Plans.

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