Date: 07/16/2025

To: WPI STUDENTS

Documents Provided: Subscriber Certificate(s) and Riders as of 08/12/2025

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 08/12/2025.

Blue Cross and Blue Shield of Massachusetts, Inc.

Blue Care® Elect Preferred Provider Plan

Subscriber Certificate

MASSACHUSETTS

Welcome to Blue Cross and Blue Shield!

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

Blue Cross and Blue Shield of Massachusetts, Inc.

Sarah Iselin
President

Donald Savery
Clerk/Secretary

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

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call Member Services at the number on your ID Card (TTY: **711**).

Spanish/Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).

Portuguese/Português: ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

Chinese/简体中文: 注意：如果您讲中文，我们可向您免费提供语言协助服务。请拨打您 ID 卡上的号码联系会员服务部（TTY 号码：**711**）。

Haitian Creole/Kreyòl Ayisyen: ATANSYON: Si ou pale kreyòl ayisyen, sèvis asistans nan lang disponib pou ou gratis. Rele nimewo Sèvis Manm nan ki sou kat Idantitifkasyon w lan (Sèvis pou Malantandan TTY: **711**).

Vietnamese/Tiếng Việt: LƯU Ý: Nếu quý vị nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cung cấp cho quý vị miễn phí. Gọi cho Dịch vụ Hội viên theo số trên thẻ ID của quý vị (TTY: **711**).

Russian/Русский: ВНИМАНИЕ: если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Позвоните в отдел обслуживания клиентов по номеру, указанному в Вашей идентификационной карте (телетайп: **711**).

Arabic/ةيبر:

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هُويتك (جهاز الهاتف النصي للصم والبكم "TTY": **711**).

Mon-Khmer, Cambodian/ខ្មែរ: ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិក តាមលេខនៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (TTY: **711**)។

French/Français: ATTENTION : si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le Service adhérents au numéro indiqué sur votre carte d'assuré (TTY : **711**).

Italian/Italiano: ATTENZIONE: se parlate italiano, sono disponibili per voi servizi gratuiti di assistenza linguistica. Chiamate il Servizio per i membri al numero riportato sulla vostra scheda identificativa (TTY: **711**).

Korean/한국어: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드에 있는 전화번호(TTY: **711**)를 사용하여 회원 서비스에 전화하십시오.

Greek/Ελληνικά: ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε την Υπηρεσία Εξυπηρέτησης Μελών στον αριθμό της κάρτας μέλους σας (ID Card) (TTY: **711**).

Polish/Polski: UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej. Należy zadzwonić do Działu obsługi ubezpieczonych pod numer podany na identyfikatorze (TTY: **711**).

Hindi/हिंदी: ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए नि:शुल्क उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वाई.: **711**).

Gujarati/ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમને ભાષાકીય સહાયતા સેવાઓ વિના મૂલ્યે ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર આપેલા નંબર પર Member Service ને કૉલ કરો (TTY: **711**).

Tagalog/Tagalog: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tawagan ang Mga Serbisyo sa Miyembro sa numerong nasa iyong ID Card (TTY: **711**).

Japanese/日本語: お知らせ：日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。IDカードに記載の電話番号を使用してメンバーサービスまでお電話ください（TTY: **711**）。

German/Deutsch: ACHTUNG: Wenn Sie Deutsche sprechen, steht Ihnen kostenlos fremdsprachliche Unterstützung zur Verfügung. Rufen Sie den Mitgliederdienst unter der Nummer auf Ihrer ID-Karte an (TTY: **711**).

Persian/پارسیان:

توج: اگر زبان شما فارسی است، خدمات کمک زبانی ب صورت رایگان در اختیار شما قرار می گیرد. با شمار تلفن مندرج بر روی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: **711**).

Lao/ພາສາລາວ: ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: **711**).

Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'déé' nóomba biká'ígíiji' béésh bee hodíílnih (TTY: **711**).

Table of Contents

Table of Contents (continued)

Table of Contents (continued)

Introduction

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

When you enroll for coverage in this Blue Care Elect health plan, you may enroll as a *group member* under a *group contract*. Or, you may enroll directly under an *individual contract*. The contract for coverage in this health plan is a prepaid ("insured") preferred provider plan. *Blue Cross and Blue Shield* certifies that you have the right to this health care coverage as long as: you are enrolled in this health plan when you receive *covered services*; the *premium* that is owed for your health plan has been paid to *Blue Cross and Blue Shield*; and you follow all of the requirements to receive this health care coverage. *Blue Cross and Blue Shield* is located at: 101 Huntington Avenue, Suite 1300, Boston, Massachusetts 02199-7611.

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

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

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

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

Part 1
Member Services

Your Primary Care Provider

As a *member* of this health plan, you are not required to choose a *primary care provider* to coordinate the health care benefits described in this Subscriber Certificate. However, your PPO health care network includes physicians who are family or general practitioners, internists, pediatricians, geriatric specialists, nurse practitioners, and physician assistants that you may choose to furnish your primary medical care. **You may choose any *covered provider* to furnish your health care services and supplies. But, your choice is important because it may impact the costs that you pay for some health care services.**

How to Determine a Preferred Physician's Specialty

To determine a preferred physician's specialty, you can look in your PPO provider directory or use the online "Find a Doctor" physician directory. Some preferred physicians may have more than one specialty. When your health plan has a cost share that differs based on the preferred physician's specialty type, *Blue Cross and Blue Shield* will use the primary specialty type as shown in the PPO provider directory to determine your cost share amount. For example, a preferred physician may be primarily a dermatologist but may also be a family practitioner. In this case, your cost share amount is determined based on the "dermatologist" specialty type since it is the preferred physician's primary specialty as shown in the *Blue Cross and Blue Shield* PPO provider directory. A preferred physician may change their specialty at any time. However, *Blue Cross and Blue Shield* will change a preferred physician's specialty only once every two years.

Some preferred physicians and other professional provider types are part of a multi-specialty provider group. When your health plan has a cost share that differs based on the preferred physician's specialty type, *Blue Cross and Blue Shield* will apply the lower cost share amount for primary care provider specialty types to the multi-specialty provider groups.

In other states, the local Blue Cross and/or Blue Shield Plan may have established provider specialty types that are not recognized by *Blue Cross and Blue Shield*. In those cases when a preferred physician's specialty type or professional provider type is not recognized, *Blue Cross and Blue Shield* will apply the higher cost share amount for specialists and other non-primary care provider specialty types.

Refer to the *Schedule of Benefits* for your plan option to see if your cost share amount is based on a preferred physician's specialty type or other provider type.

Your Health Care Network

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

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

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

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

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

When You Are Traveling Outside of Massachusetts
If you are traveling outside of Massachusetts, you can get help to find a health care provider. Just call **1-800-810-BLUE**. You can call this phone number 24 hours a day for help to find a health care provider. When you call, you should have your ID card ready. You must be sure to let the representative know that you are looking for health care providers that participate with the BlueCard PPO program. Or, you can also use the internet. To use the online "Blue National Doctor & Hospital Finder," log on to **www.bcbs.com.** (For some types of *covered providers*, a local Blue Cross and/or Blue Shield Plan may not have, in the opinion of *Blue Cross and Blue Shield*, established an adequate PPO health care network. If this is the case and you obtain *covered services* from this type of *covered provider*, the in-network benefit level will be provided for these *covered services*. See Part 8 in this Subscriber Certificate.) If you are outside the United States, Puerto Rico, and the U.S. Virgin Islands, there are no local Blue Cross and/or Blue Shield Plans. But, you can still call 1-800-810-BLUE. (Or, you can call collect at 1-804-673-1177.) In this case, the Blue Cross Blue Shield Global Core Service Center can help you to access a health care provider. Then, if you are admitted as an *inpatient*, you should call the service center and the hospital should submit the claim for you. (See Part 9.)

Your Identification Card

After you enroll in this health plan, you will receive an identification (ID) card. The ID card will identify you as a person who has the right to coverage in this health plan. The ID card is for identification purposes only. Under federal law, your ID card is required to include information about applicable *deductible* and *out-of-pocket maximum* amounts. It will also include contact information for the *Blue Cross and Blue Shield* customer service office.

While you are a *member*, you must show your ID card to your health care provider before you receive *covered services*. If you lose your ID card or it is stolen, you should contact the *Blue Cross and Blue Shield* customer service office. They will send you a new card. Or, you can use the *Blue Cross and Blue Shield* Web site to ask for a new ID card. To use the *Blue Cross and Blue Shield* online member self service option, you must log on to **www.bluecrossma.org**. Just follow the steps to ask for a new ID card.

How to Get Help for Questions

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

If You Are Enrolled as a Group Member

If you are enrolled in this health plan as a *group member* under a *group contract*, you can call Monday through Friday from 8:00 a.m. to 8:00 p.m. (Eastern Time). The toll free phone number to call is shown on your ID card. (For TTY, call 711.) Or, you can write to: Blue Cross Blue Shield of Massachusetts, Member Service, P.O. Box 9134, North Quincy, MA 02171-9134.

If You Are Enrolled as an Individual Member

If you enrolled in this health plan under an *individual contract*, you can call Monday through Friday from 8:00 a.m. to 6:00 p.m. (Eastern Time). The toll free phone number to call is shown on your ID card. (For TTY, call 711.) Or, you can write to: Blue Cross Blue Shield of Massachusetts, Member Service, P.O. Box 9140, North Quincy, MA 02171-9140.

Discrimination Is Against the Law

Blue Cross and Blue Shield complies with applicable federal civil rights laws and does not discriminate on the basis of race; color; national origin; age; disability; sex; sexual orientation; or gender identity. *Blue Cross and Blue Shield* does not exclude people or treat them differently because of race; color; national origin; age; disability; sex; sexual orientation; or gender identity.

Blue Cross and Blue Shield provides:

- Free aids and services to people with disabilities to communicate effectively with *Blue Cross and Blue Shield*. These aids and services may include qualified sign language interpreters and written information in other formats (such as in large print).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call the *Blue Cross and Blue Shield* customer service office. The toll free phone number to call is shown on your ID card.

If you believe that *Blue Cross and Blue Shield* has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with the *Blue Cross and Blue Shield* Civil Rights Coordinator: by mail at Civil Rights Coordinator, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126; or by phone at 1-800-472-2689 (TTY: 711); or by fax at 1-617-246-3616; or by email at civilrightscoordinator@bcbsma.com. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights online at ocrportal.hhs.gov; or by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F HHH Building, Washington, DC 20201; or by phone at 1-800-368-1019 or 1-800-537-7697 (TDD). Complaint forms are available at www.hhs.gov.

Your Rights under Mental Health Parity Laws

This health plan provides coverage for *medically necessary* mental health and substance use treatment according to federal and state mental health parity laws. The financial requirements and treatment limits for your mental health or substance use coverage can be no more restrictive than those for your medical and surgical coverage. This means that the cost share amounts (a *copayment*, *coinsurance*, or *deductible*) for services to treat mental health and substance use will be the same or less than those for comparable medical and surgical services. Also, the review and authorization of services to treat mental health or substance use will be handled in a way that is comparable to the review and authorization of medical and surgical services. If *Blue Cross and Blue Shield* makes a decision to deny or reduce authorization of a service, you will receive a letter that explains the reason for the denial or reduction. *Blue Cross and Blue Shield* will send you or your health care provider a copy of the criteria used to make this decision, at your request.

You should be sure to read all parts of your Subscriber Certificate to understand your health plan coverage. If you believe that *Blue Cross and Blue Shield* is not compliant with these mental health parity laws, you can make a complaint to the Massachusetts Division of Insurance (the Division) Consumer Services Section. A complaint can be made by phone or in writing. To send a written complaint, you must use the Division's "Insurance Complaint Form." You can request a copy of this form from the Division by phone or by mail. You can also find this form on the Division's Web site at **http://www.mass.gov/ocabr/consumer/insurance/file-a-complaint/filing-a-complaint.html**. To make a complaint by phone, call **1-877-563-4467** or **1-617-521-7794**. If you do make your complaint by phone, you must follow up your phone call by sending your complaint in writing to the Consumer Services Section. When you make a complaint, you must include: your name and address; the nature of your complaint; and your signature authorizing the release of any information about the complaint to help the Division with its review.

In addition to filing a written complaint with the Division, you must file an *appeal* with *Blue Cross and Blue Shield* to have your denial or reduction in coverage reviewed. This may be necessary to protect your right to continued coverage while you wait for an *appeal* decision. To file an *appeal* with *Blue Cross and Blue Shield*, you must follow the formal review procedures outlined in Part 10.

How You Can Request an Estimate for Proposed Covered Services

As required by state law, you or your authorized representative may request an estimate of the costs you will have to pay when your health care provider proposes an *inpatient* admission, procedure, or other *covered service*. You can request this cost estimate in writing using an online form or by phone. To send an online written request, log on to the *Blue Cross and Blue Shield* Web site at **www.bluecrossma.org**. Just follow the steps to request a cost estimate for health care services you are planning to receive. To request an estimate by phone, call the *Blue Cross and Blue Shield* customer service office. The toll free phone number to call is shown on your ID card. *Blue Cross and Blue Shield* will give you a cost estimate within two working days of the date your request is received. *Blue Cross and Blue Shield's* response will include an estimate of the maximum *allowed charge* and your cost share amount, if there is any, for the proposed *covered service*, and your health care provider's network status.

For Services Furnished on or After January 1, 2023. In addition to the above cost estimate, as required by federal law, you or your authorized representative may request a real-time estimate of personalized cost sharing information through *Blue Cross and Blue Shield's* internet-based self-service tool before you receive *covered services*, including prescription drugs when pharmacy coverage is administered by *Blue Cross and Blue Shield*. This self-service tool will help you to understand how costs for *covered services* are determined by this health plan. To begin your cost estimate, you can log on to the *Blue Cross and Blue Shield* Web site at **www.bluecrossma.org**. Just follow the steps to request this cost estimate.

You can also call the *Blue Cross and Blue Shield* customer service office to request the same real-time cost estimate information over the telephone. The toll free phone number to call is shown on your ID card. If you need a paper copy of a cost estimate, you can call the *Blue Cross and Blue Shield* customer service office. This information will be made available to you within two business days.

For items or services covered under this health plan, *Blue Cross and Blue Shield's* internet-based self service tool will include the following information:
- Cost-sharing liability at the time of the cost estimate (such as *deductible*, *copayment*, and/or *coinsurance*).
- Accumulated amounts such as any accrued *deductible* and/or *out-of-pocket maximum* amounts.
- Negotiated rates based on network provider payments.
- Out-of-network allowed amounts, including the maximum this health plan will pay for an out-of-network provider.
- List of items and services covered under this health plan that are subject to bundled payment arrangements, including costs for these bundled *covered services*.
- Notice of plan requirements that apply such as pre-service approval, referrals, pre-admission review or other plan provisions.

For each cost estimate, *Blue Cross and Blue Shield* is required to provide a disclosure notice to you that includes the following:
- Information disclosing that out-of-network providers may *balance bill members* for the difference between what the provider bills and the *member's* cost share amount (*copayment*, *deductible* or *coinsurance*) and if and when *balance billing* is permitted under state or federal law.
- A statement that your health care provider's actual charge for your specific *covered service* may be different from the cost estimate.
- A statement that the cost estimate is not a guarantee of coverage.
- Information on whether copayment amounts, if any, apply toward your *deductible* and/or the *out-of-pocket maximum* amounts.

As required by federal law, real-time cost estimates will be available for all *covered services.* The provisions described above do not apply to you if your health plan is a grandfathered health plan under the Affordable Care Act.

Delivery of Summary of Payments Forms

You will receive a Summary of Health Plan Payments explanation form when you have a cost share (such as a *deductible*, a *copayment*, or a *coinsurance*) that applies for *covered services* or when *Blue Cross and Blue Shield* denies coverage for all or part of a health care service or supply. This Summary of Health Plan Payments explanation form will usually be mailed to the *member* at the address that is on file for the *subscriber*. However, there are a few additional ways you may choose to receive your Summary of Health Plan Payments explanation forms. Upon submitting your request in writing to *Blue Cross and Blue Shield*, you may:

- Have the Summary of Health Plan Payments explanation form mailed to the *member's* address that is on file with *Blue Cross and Blue Shield*. (*Blue Cross and Blue Shield* is not required to maintain more than one alternate address for a *member*.)
- Access the Summary of Health Plan Payments explanations by using the online *Blue Cross and Blue Shield* member self service option. To check online, log on to the *Blue Cross and Blue Shield* Web site at **www.bluecrossma.org**. Just follow the steps to sign-up for paperless statements.

When a *member* selects an alternate method of receipt as described above, this selection will remain in effect until the *member* submits a request in writing for a different method. Your request for a different method will be completed by *Blue Cross and Blue Shield* within three working days of receiving the request. If you enroll in another *Blue Cross and Blue Shield* health plan or a health plan offered by Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc., you should call the *Blue Cross and Blue Shield* customer service office as this may affect the delivery of your Summary of Health Plan Payments explanation forms.

There may be certain times when you may request not to receive a Summary of Health Plan Payments explanation form for a certain health care service or supply. This request must be made by phone or in writing to *Blue Cross and Blue Shield*.

The Office of Patient Protection

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

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

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

Part 2

Explanation of Terms

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

Allowed Charge (Allowed Amount)

Blue Cross and Blue Shield calculates payment of your benefits based on the *allowed charge* (sometimes referred to as the *allowed amount*). This is the maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance,” or “negotiated rate.” The *allowed charge* that *Blue Cross and Blue Shield* uses depends on the type of health care provider that furnishes the *covered service* to you. If your health care provider charges you more than the *allowed amount*, you may have to pay the difference (see below).

- **For Preferred Providers in Massachusetts.** For health care providers who have a preferred provider arrangement (a “PPO payment agreement”) with *Blue Cross and Blue Shield*, the *allowed charge* is based on the provisions of that health care provider’s PPO payment agreement. **For *covered services* furnished by these health care providers, you pay only your *deductible* and/or your *copayment* and/or your *coinsurance*, whichever applies.** In general, when you share in the cost for your *covered services* (such as a *deductible*, and/or a *copayment* and/or a *coinsurance*), the calculation for the amount that you pay is based on the initial full *allowed charge* for that health care provider (or the actual charge if it is less). This amount that you pay for a *covered service* is generally not subject to future adjustments—up or down—even though the health care provider’s payment may be subject to future adjustments for such things as provider contractual settlements, risk-sharing settlements, and fraud or other operations.

  A *preferred provider’s* payment agreement may provide for an *allowed charge* that is more than the provider’s actual charge. For example, a hospital’s *allowed charge* for an *inpatient* admission may be based on a “Diagnosis Related Grouping” (DRG). In this case, the *allowed charge* may be more than the hospital’s actual charge. If this is the case, *Blue Cross and Blue Shield* will calculate your cost share amount based on the lesser amount—this means the *preferred provider’s* actual charge instead of the *allowed charge* will be used to calculate your cost share. The claim payment made to the *preferred provider* will be the full amount of the *allowed charge* less your cost share amount.

- **For Health Care Providers Outside of Massachusetts with a Local Payment Agreement.** For health care providers outside of Massachusetts who have a payment agreement with the local Blue Cross and/or Blue Shield Plan, the *allowed charge* is the “negotiated price” that the local Blue Cross and/or Blue Shield Plan passes on to *Blue Cross and Blue Shield*. (Blue Cross and/or Blue Shield Plan means an independent corporation or affiliate operating under a license from the Blue Cross and Blue Shield Association.) In many cases, the negotiated price paid by *Blue Cross and Blue Shield* to the local Blue Cross and/or Blue Shield Plan is a discount from the provider’s billed charges. However, a number of local Blue Cross and/or Blue Shield Plans can determine only an estimated price at the time your claim is paid. Any such estimated price is based on expected settlements, withholds, any other contingent payment arrangements and non-claims transactions, such as interest on provider advances, with the provider (or with a specific group of providers) of the local Blue Cross and/or

Blue Shield Plan in the area where services are received. In addition, some local Blue Cross and/or Blue Shield Plans' payment agreements with providers do not give a comparable discount for all claims. These local Blue Cross and/or Blue Shield Plans elect to smooth out the effect of their payment agreements with providers by applying an average discount to claims. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. Local Blue Cross and/or Blue Shield Plans that use these estimated or averaging methods to calculate the negotiated price may prospectively adjust their estimated or average prices to correct for overestimating or underestimating past prices. However, the amount you pay is considered a final price. **In most cases for *covered services* furnished by these health care providers, you pay only your *deductible* and/or your *copayment* and/or your *coinsurance*, whichever applies.**

Value-Based Provider Arrangements: A provider's payment agreement with a local Blue Cross and/or Blue Shield Plan may include: a payment arrangement based on health outcomes; and/or coordination of care features. Under these payment agreements, the providers will be assessed against cost and quality standards. Payments to these providers may include provider incentives, risk sharing, and/or care coordination fees. If you receive *covered services* from such a provider, you will not have to pay any cost share for these fees, except when a local Blue Cross and/or Blue Shield Plan passes these fees to *Blue Cross and Blue Shield* through average pricing or fee schedule adjustments for claims for *covered services*. When this happens, you pay only your *deductible* and/or your *copayment* and/or your *coinsurance*, whichever applies.

- **For Other Health Care Providers.** For health care providers who do not have a PPO payment agreement with *Blue Cross and Blue Shield* or for health care providers outside of Massachusetts who do not have a payment agreement with the local Blue Cross and/or Blue Shield Plan, *Blue Cross and Blue Shield* will use the methods outlined below to calculate your claim payment.

Patient Protections Against Surprise Billing
Under federal law, beginning on January 1, 2022, you are protected from "balance billing" or "surprise billing" (an unexpected balance bill) in certain situations. Under the law, you cannot be balance billed for certain *covered services* that you may receive. But, for these *covered services*, you will continue to be responsible for any *copayment*, *deductible* and/or *coinsurance*, whichever applies.

You cannot be *balance billed* when you receive:

– **Emergency services.** This includes: emergency services you receive at an emergency room of a hospital or an independent free-standing emergency facility; and certain *covered services* that may be required to stabilize you (post-stabilization services) until such time that your attending physician determines you meet certain criteria as outlined under federal law. When you become stabilized and any notice and consent requirements as specified in the statute are met, surprise billing protection no longer applies. See "All Other Covered Services" below for how your claim payment will be calculated when this happens.

– **Non-emergency services furnished by a non-*preferred provider* at certain preferred facilities.** This includes services you receive at: a hospital; a hospital outpatient department; a critical access hospital; an ambulatory surgical center; or any other facility designated by the statute that provides items or services for which coverage is provided under this health plan unless the notice and consent requirements as specified in the statute have been met. A provider or facility cannot provide notice and receive consent for certain ancillary services, as defined by the No Surprises Act, including items or services related to emergency medicine, anesthesiology, pathology, radiology and neonatology. This also includes services provided by assistant surgeons and diagnostic services.

– **Air ambulance services by a non-preferred air ambulance provider.**

For the *covered services* described above, the “recognized amount” will be used to calculate your cost share amount (*deductible* and/or *copaymen*t and/or *coinsurance*). The recognized amount is defined by federal law as: an amount determined by an applicable All-Payer Model Agreement under Section 1115A of the Social Security Act; or, if there is no applicable All-Payer Model Agreement, an amount determined by a specified state law where the services were furnished; or, if there is no applicable All-Payer Model Agreement or specified state law, the lesser of the amount billed by the provider or facility or the Qualified Payment Amount (QPA), which under the final rules generally is the median of the contracted rates of the plan or issuer for the item or service in the geographic region.

For *covered services* furnished in Massachusetts, *Blue Cross and Blue Shield* uses the QPA as the recognized amount to calculate your claim payment. For *covered services* furnished in a state other than Massachusetts, *Blue Cross and Blue Shield* uses the applicable recognized amount that is provided by the local Blue Cross and/or Blue Shield Plan for that state to calculate your claim payment. Any cost share amounts that you pay for these *covered services* will count toward your in-network *deductible* (if applicable) and your *out-of-pocket maximum*. (If a non-*preferred provider* is dissatisfied with a payment made by the health plan, the provider can initiate a structured process to resolve the dispute. Federal law protects you from any payment disputes that may arise between plans and providers.) Note: The QPA will be used as the recognized amount to calculate your claim payment for covered air ambulance transport that is furnished by a non-*preferred provider* in or outside of Massachusetts.

All Other Covered Services
For all other *covered services* not described above that are not protected from surprise billing by the No Surprises Act, the *allowed charge* is based on 150% of the Medicare reimbursement rate. If there is no established Medicare reimbursement rate, the *allowed charge* is based on the amount determined by using current publicly-available data reflecting fees typically reimbursed for the *covered service*, adjusted for geographic differences. (There may be times when the Medicare reimbursement rate is not available for part of a claim for *covered services*. When this happens, the *allowed charge* will be based on the lesser of: the total of the Medicare reimbursement rate for the part for which there is a Medicare reimbursement rate plus the provider’s actual charge for the part for which there is no Medicare reimbursement rate; or the amount determined by using the current publicly-available data described above for all parts of the claim for the *covered services*.) *Blue Cross and Blue Shield* has the discretion to determine what current publicly-available data it deems applicable, by using the data maintained by a third party of its choice. In no event will the *allowed charge* be more than the health care provider’s actual charge. However, the *allowed charge* may sometimes be less than the health care provider’s actual charge. If this is the case, you will be responsible for the amount of the *covered provider’s* actual charge that is in excess of the *allowed charge*. This is called “*balance billing*.” This is in addition to your *deductible* and/or your *copayment* and/or your *coinsurance*, whichever applies. For this reason, you may wish to discuss charges with your health care provider before you receive *covered services*. There are a few exceptions. This provision does not apply to: ground ambulance transport for *emergency medical care* or *covered services* for which there is no established *allowed charge* (such as services received outside the United States). For these *covered services*, the full amount of the health care provider’s actual charge is used to calculate your claim payment.

Exception: For health care providers who do not have a payment agreement with *Blue Cross and Blue Shield* or, for health care providers outside of Massachusetts, with the local Blue Cross and/or Blue Shield Plan, there may be times when *Blue Cross and Blue Shield* is able to negotiate a fee with the provider that is less than the *allowed charge* that would have been used to calculate your claim payment (as described in the above paragraph). When this happens, the "negotiated fee" will be used as the *allowed charge* to calculate your claim payment and you will not have to pay the amount of the provider's charge that is in excess of the negotiated fee. You will only have to pay your *deductible* and/or your *copayment* and/or your *coinsurance*, whichever applies. *Blue Cross and Blue Shield* will send you a written notice about your claim that will tell you how your claim was calculated, including the *allowed charge*, the amount paid to the provider, and the amount you must pay to the provider.

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

Appeal

An *appeal* is something you do if you disagree with a *Blue Cross and Blue Shield* decision to deny a request for coverage of health care services or drugs, or payment, in part or in full, for services or drugs you already received. You may also make an *appeal* if you disagree with a *Blue Cross and Blue Shield* decision to stop coverage for services that you are receiving. For example, you may ask for an *appeal* if *Blue Cross and Blue Shield* doesn't pay for a service, item, or drug that you think you should be able to receive. Part 10 explains what you have to do to make an *appeal*. It also explains the review process.

Balance Billing

There may be certain times when a health care provider will bill you for the difference between the provider's charge and the *allowed charge*. This is called *balance billing*. A *preferred provider* cannot *balance bill* you for *covered services*. See "*allowed charge*" above for information about the *allowed charge* and the times when a health care provider may *balance bill* you.

Benefit Limit

For certain health care services or supplies, there may be day, visit, or dollar benefit maximums that apply to your coverage in this health plan. The *Schedule of Benefits* for your plan option and Part 5 of this Subscriber Certificate describe the *benefit limits* that apply to your coverage. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.) Once the amount of the benefits that you have received reaches the *benefit limit* for a specific *covered service*, no more benefits will be provided by this health plan for those health care services or supplies. When this happens, you must pay the full amount of the provider's charges that you incur for those health care services or supplies that are more than the *benefit limit*. An overall lifetime *benefit limit* will not apply for coverage in this health plan.

Blue Cross and Blue Shield

The term "*Blue Cross and Blue Shield*" refers to Blue Cross and Blue Shield of Massachusetts, Inc. It also refers to an employee or designee of Blue Cross and Blue Shield of Massachusetts, Inc. (including another Blue Cross and/or Blue Shield Plan) who is authorized to make decisions or take action called for by this health plan. *Blue Cross and Blue Shield* has full discretionary authority to interpret this Subscriber Certificate. This includes determining the amount, form, and timing of benefits, conducting *medical* *necessity* reviews, and resolving any other matters regarding your right to benefits for *covered services* as described in this Subscriber Certificate. All determinations by *Blue Cross and Blue Shield* with respect to benefits under this health plan will be conclusive and binding unless it can be shown that the interpretation or determination was arbitrary and capricious.

Coinsurance

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

Copayment

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

Covered Providers

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

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

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

- **Physician and Other Covered Professional Providers.** These kinds of health care providers are: certified registered nurse anesthetists; chiropractors; clinical specialists in psychiatric and mental health nursing; dentists; licensed acupuncturists; licensed alcohol and drug counselor I providers; licensed applied behavioral analysts; licensed audiologists; licensed dietitian nutritionists (or a dietitian or a nutritionist or a dietitian nutritionist who is licensed or certified by the state in which the provider practices); licensed hearing instrument specialists; licensed independent clinical social workers; licensed marriage and family therapists; licensed mental health counselors; licensed speech-language pathologists; nurse midwives; nurse practitioners; occupational therapists; optometrists; physical therapists; physicians; physician assistants; podiatrists; psychiatric nurse practitioners; psychologists; and urgent care centers.

- **Other Covered Health Care Providers.** These kinds of health care providers are: ambulance services; appliance companies; cardiac rehabilitation centers; early intervention providers; home health agencies; home infusion therapy providers; hospice providers; mail order pharmacy; oxygen suppliers; retail pharmacies; and visiting nurse associations.

A *covered provider* may include other health care providers that are designated for you by *Blue Cross and Blue Shield*.

Covered Services

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

Custodial Care

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

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

Custodial care does not include the habilitation services that are described as a *covered service* in Part 5.

Deductible

For some *covered services*, you may have to pay a *deductible* before you will receive benefits from this health plan. When your plan option includes a *deductible*, the amount that is put toward your *deductible* is generally calculated based on the health care provider's actual charge or the *Blue Cross and Blue Shield allowed charge*, whichever is less (unless otherwise required by law). As required by federal law for "surprise billing," any *deductible* that applies for certain *covered services* that are furnished by non-*preferred providers* will be calculated based on the recognized amount and will contribute toward satisfying your in-network *deductible* (see Part 2, "Allowed Charge" for an explanation of these services). Your ID card and the *Schedule of Benefits* for your plan option show the amount of your *deductible* (if there is one). Your *Schedule of Benefits* also shows those *covered services* for which you must pay the *deductible* before you receive benefits. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.) When a *deductible* does apply, there are some costs that you pay that do not count toward the *deductible*. These costs that do **not** count toward the *deductible* are:

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

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

The *deductible* is indexed to the average national premium growth and the amount may be increased annually. This means that your *deductible* amount may increase from time to time, as determined by *Blue Cross and Blue Shield*. *Blue Cross and Blue Shield* will notify you if this happens. However, the amount of your *deductible* will never be more than the maximum *deductible* amount allowed under applicable law.

Diagnostic Lab Tests

This health plan provides coverage for *diagnostic lab tests*. These *covered services* include tests which analyze samples from the body such as blood, waste, or tissue. These tests include (but are not limited to): 12-lead electrocardiograms; standard electroencephalograms; and glycosylated hemoglobin (HgbA1C) tests, urinary protein/microalbumin tests, and lipid profiles to diagnose and treat diabetes.

Diagnostic X-Ray and Other Imaging Tests

This health plan provides coverage for *diagnostic x-ray and other imaging tests*. These tests provide an internal image of the body and are recorded as permanent pictures, such as film. These tests can be low-tech radiology services, such as ultrasounds, x-rays, and fluoroscopic tests. Or, they can be high-tech radiology services, such as computerized axial tomography (CT scans), magnetic resonance imaging (MRI), positron emission tomography (PET scans), and nuclear cardiac imaging. Imaging tests may pair pictures of the body with functional measurements, such as a barium swallow test.

Effective Date

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

Emergency Medical Care

As a *member* of this health plan, you have worldwide coverage for *emergency medical care*. This is the type of care you need immediately due to the sudden onset of an emergency medical condition. An "emergency medical condition" is a medical condition, whether physical, behavioral, related to substance use, or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that, in the absence of prompt care, could reasonably be expected by a prudent layperson who has 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, 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.

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

Grievance

A *grievance* is a type of oral or written complaint you make about care or service you received from *Blue Cross and Blue Shield* or from a provider who participates in your health care network. This type of complaint concerns the service you receive or the quality of your care. It does not involve a dispute with a coverage or payment decision. Part 10 explains what you have to do to file a *grievance*. It also explains the review process.

Group

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

Group Contract

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

You hereby expressly acknowledge your understanding that the *group contract* constitutes a contract solely between your *group* on your behalf and Blue Cross and Blue Shield of Massachusetts, Inc. (*Blue Cross and Blue Shield*), which is 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* on your behalf has not entered into the *group contract* based upon representations by any person other than *Blue Cross and Blue Shield* and that no person, entity, or organization other than *Blue Cross and Blue Shield* will be held accountable or liable to you or your *group* on your behalf for any of *Blue Cross and Blue Shield's* obligations to you created under the *group contract*. This paragraph will not create any additional obligations whatsoever on the part of *Blue Cross and Blue Shield* other than those obligations created under other provisions of the *group contract*.

Individual Contract

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

You hereby expressly acknowledge your understanding that an *individual contract* constitutes a contract solely between you and Blue Cross and Blue Shield of Massachusetts, Inc. (*Blue Cross and Blue Shield*), which is 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 you have not entered into an *individual contract* based upon representations by any person other than *Blue Cross and Blue Shield* and that no person, entity, or organization other than *Blue Cross and Blue Shield* will be held accountable or liable to you for any of *Blue Cross and Blue Shield's* obligations to you created under an *individual contract*. This paragraph will not create any additional obligations whatsoever on the part of *Blue Cross and Blue Shield* other than those obligations created under other provisions of the *individual contract*.

Inpatient

The term "inpatient" refers to your status as a hospital patient, or as a patient in a health care facility, when you are admitted as a registered bed patient. Even if you stay in the hospital or health care facility overnight, you might still be considered an "outpatient." Your status is important because it affects how much you will pay for *covered services*, like x-rays, drugs, lab tests, and physician services. You are an *inpatient* starting the day you are formally admitted with a doctor's order as a registered bed patient in a hospital or other health care facility. Note: You are an *outpatient* when you are kept in a hospital or health care facility solely for observation, even though you use a bed or spend the night. Observation services are to help the doctor decide if a patient needs to be admitted for care or can be discharged. These services may be given in the emergency room or another area of the hospital. If you would normally pay a *copayment* for *outpatient emergency medical care* or *outpatient* medical care services, the *copayment* will be waived when you are held for observation. But, you must still pay your *deductible* and/or *coinsurance*, whichever applies.

Medical Policy

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

Medical Technology Assessment Criteria

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

- The technology must have final approval from the appropriate government regulatory bodies. This criterion applies to drugs, biological products, devices (such as durable medical equipment), and diagnostic services. A drug, biological product, or device must have final approval from the U.S. Food and Drug Administration (FDA). Any approval granted as an interim step in the FDA regulatory process is not sufficient. (The FDA Humanitarian Device Exemption is one example of an interim step.) Except as required by law, *Blue Cross and Blue Shield* may limit coverage for drugs, biological products, and devices to those specific indications, conditions, and methods of use approved by the FDA.

- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed English-language journals. The qualities of the body of studies and the consistency of the results are considered in evaluating the evidence. The evidence should demonstrate that the technology can measurably alter the physiological changes related to a disease, injury, illness, or condition. In addition, there should be evidence or a convincing argument based on established medical facts that the measured alterations affect health outcomes. Opinions and evaluations by national medical associations, consensus panels, and other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence upon which they are based.
- The technology must improve the net health outcome. The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
- The technology must be as beneficial as any established alternatives. The technology should improve the net outcome as much as or more than established alternatives. The technology must be as cost effective as any established alternative that achieves a similar health outcome.
- The improvement must be attainable outside the investigational setting. When used under the usual conditions of medical practice, the technology should be reasonably expected to improve health outcomes to a degree comparable to that published in the medical literature.

Blue Cross and Blue Shield may also, as part of a "pilot" program, cover new technologies that are not otherwise described as a *covered service*. In these cases, the technologies that are covered under the pilot program must: be approved by the FDA; have published clinical literature showing safety and efficacy; and be reasonably expected to improve health outcomes.

Medically Necessary (Medical Necessity)

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

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

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

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

Member

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

Mental Conditions

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

Mental Health Providers

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

Out-of-Pocket Maximum (Out-of-Pocket Limit)

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

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

Note: As required by federal law for "surprise billing," any cost share amounts paid for certain *covered services* furnished by non-*preferred providers* will contribute toward satisfying your in-network *out-of-pocket maximum* amount. (See Part 2, "Allowed Charge" for an explanation of these services.)

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

The *out-of-pocket maximum* is indexed to the average national premium growth and the amount may be increased annually. This means that your *out-of-pocket maximum* amount may increase from time to time, as determined by *Blue Cross and Blue Shield*. *Blue Cross and Blue Shield* will notify you if this happens. However, the amount of your *out-of-pocket maximum* will never be more than the maximum *out-of-pocket maximum* amount allowed under applicable law.

Outpatient

The term "outpatient" refers to your status as a patient. Your status is important because it affects how much you will pay for *covered services*. You are an *outpatient* if you are getting emergency room services, observation services, outpatient day surgery, or other hospital services such as lab tests or x-rays and the doctor has not written an order to admit you to the hospital or health care facility as an *inpatient*. In these cases, you are an *outpatient* even if you spend the night at the hospital or health care facility. You are also an *outpatient* if you are getting *covered services* at a health center, at a provider's office (this can be either in-person or via telehealth), or in other covered outpatient settings, or at home. You are also an *outpatient* if you are getting *covered services* from a *Blue Cross and Blue Shield* designated telehealth vendor. Note: You are an *outpatient* when you are kept in a hospital or health care facility solely for observation, even though you use a bed or spend the night. Observation services are to help the doctor decide if a patient needs to be admitted for care or can be discharged. These services may be given in the emergency room or another area of the hospital. If you would normally pay a *copayment* for *outpatient emergency medical care* or *outpatient* medical care services, the *copayment* will be waived when you are held for observation. But, you must still pay your *deductible* and/or *coinsurance*, whichever applies.

Plan Sponsor

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

Plan Year

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

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

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

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

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

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

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

Service Area

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

Special Services (Hospital and Facility Ancillary Services)

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

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

Subscriber

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

Urgent Care

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

Utilization Review

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

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

Part 3

Emergency Services

You do not need a referral from your health care provider or an approval from *Blue Cross and Blue Shield* before you obtain *emergency medical care*. As a *member* of this health plan, you will receive worldwide emergency coverage. These emergency medical services may include *inpatient* or *outpatient* services by health care providers who are qualified to furnish *emergency medical care*. This includes care that is needed to evaluate or stabilize your emergency medical condition. **At the onset of an emergency medical condition that in your judgment requires *emergency medical care*, you should go to the nearest emergency room. If you need help, dial 911. Or, call your local emergency medical service system phone number.** You will not be denied coverage for medical and transportation services that you incur as a result of your emergency medical condition. You usually need emergency medical services because of the sudden onset of an emergency medical condition. An "emergency medical condition" is a medical condition, whether physical, behavioral, related to substance use, or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that, in the absence of prompt care, could reasonably be expected by a prudent layperson who has 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, severe pain that cannot be managed without such care. Some examples of conditions that require *emergency medical care* are: suspected heart attacks; strokes; poisoning; loss of consciousness; convulsions; and suicide attempts.

Inpatient Emergency Admissions

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

Outpatient Emergency Services

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

Post-Stabilization Care

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

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

- **Transfers to Other Inpatient Facilities.** Your emergency room provider may recommend your transfer to another facility for *inpatient* care. If this happens, you or the admitting facility (or someone on your behalf) must call *Blue Cross and Blue Shield*. (A health care facility that participates in your health care network should call *Blue Cross and Blue Shield* for you.) This call must be made within 48 hours of your admission. This is required so that *Blue Cross and Blue Shield* can evaluate the appropriateness of the *inpatient* health care services.

- **Outpatient Follow Up Care.** Your emergency room provider may recommend that you have *outpatient* follow up care. If this happens, the emergency room provider must call *Blue Cross and Blue Shield* to obtain an approval when the type of care that you need requires an approval from *Blue Cross and Blue Shield*. (See Part 4.) If you need to have more follow up care and an approval is required, you or your health care provider must obtain the approval from *Blue Cross and Blue Shield*.

Part 4

Utilization Review Requirements

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

Pre-Service Approval Requirements

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

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

Referrals for Specialty Care

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

Pre-Service Review for Outpatient Services

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

You must receive a pre-service approval from *Blue Cross and Blue Shield* for:

- Certain *outpatient* specialty care, procedures, services, and supplies. Some examples of services that may require prior approval include: some types of surgery; non-emergency ground ambulance; and certain *outpatient* treatment plans that require a review due to factors such as (but not limited to) the variability in length of treatment, the difficulty in predicting a standard length of treatment, the risk factors and provider discretion in determining treatment intensity compared to symptoms, the difficulty in measuring outcomes, or the variability in cost and quality. **To find out if a treatment, service, or supply needs a pre-service review, you can check with your health care provider. You can also find out by calling the *Blue Cross and Blue Shield* customer service office or using the online *Blue Cross and Blue Shield* member self service option. To check online, log on to the**

Blue Cross and Blue Shield **Web site at www.bluecrossma.org. Just follow the steps to check your benefits.**

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

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

Missing Information

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

Coverage Approval

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

Coverage Denial

If through the pre-service review *Blue Cross and Blue Shield* determines that your proposed health care service, supply, or course of treatment should **not** be covered as *medically necessary* for your condition, *Blue Cross and Blue Shield* will call the health care provider. *Blue Cross and Blue Shield* will make this phone call within 24 hours of the time the decision is made to let the health care provider know that the coverage was denied and to discuss alternative treatment. Then, within one working day of that phone call, *Blue Cross and Blue Shield* will send a written (or electronic) notice to you and to the health care provider. This notice will explain *Blue Cross and Blue Shield's* coverage decision. This notice will include: information related to the details about your coverage denial; the reasons that *Blue Cross and Blue Shield* has denied the request and the applicable terms of your coverage in this health plan; the specific medical and scientific reasons for which *Blue Cross and Blue Shield* has denied the request; any alternative treatment or health care services and supplies that would be covered; *Blue Cross and Blue Shield* clinical guidelines that apply and were used and any review criteria; and the review process and your right to pursue legal action.

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

Pre-Admission Review

Before you go into a hospital or other covered health care facility for *inpatient* care, your health care provider must obtain an approval from *Blue Cross and Blue Shield* in order for your care to be covered by this health plan. (This does not apply to your admission if it is for *emergency medical care* or for maternity care.) *Blue Cross and Blue Shield* will determine if the health care setting is suitable to treat your condition. *Blue Cross and Blue Shield* will make this decision within two working days of the date that it receives all of the needed information from your health care provider. Any pre-admission review approval from *Blue Cross and Blue Shield* applies to your *inpatient* admission only. There may be certain health care services or supplies that are furnished during your admission that also require pre-service approval from *Blue Cross and Blue Shield.* See "Pre-Service Approval Requirements" above in this section.

Exception: If your admission is for substance use treatment in a hospital or other covered health care facility that is certified or licensed by the Massachusetts Department of Public Health, prior approval from *Blue Cross and Blue Shield* will **not** be required. For an admission in one of these health care facilities, coverage will be provided for *medically necessary* acute treatment services and clinical stabilization services for up to a total of 14 days without prior approval, as long as the health care facility notifies *Blue Cross and Blue Shield* and provides the initial treatment plan within 48 hours of your admission. Concurrent Review (see page 29) will start on or after day seven of your admission. For all other admissions (except as described in the paragraph above), you must have prior approval from *Blue Cross and Blue Shield* in order for your *inpatient* care to be covered by this health plan.

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

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

Coverage Denial
If *Blue Cross and Blue Shield* determines that the proposed setting is not *medically necessary* for your condition, *Blue Cross and Blue Shield* will call the health care facility. *Blue Cross and Blue Shield* will make this phone call within 24 hours of the time the decision is made to let the facility know that the coverage was denied and to discuss alternative treatment. Then, within one working day of that phone call, *Blue Cross and Blue Shield* will send a written (or electronic) notice to you and to the facility. This notice will explain *Blue Cross and Blue Shield's* coverage decision. This notice will include: information related to the details about your coverage denial; the reasons that *Blue Cross and Blue Shield* has denied the request and the applicable terms of your coverage in this health plan; the specific medical and scientific reasons for which *Blue Cross and Blue Shield* has denied the request; any alternative treatment or health care services and supplies that would be covered; *Blue Cross and Blue Shield* clinical guidelines that apply and were used and any review criteria; and the review process and your right to pursue legal action.

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

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

In other cases, based on a *medical necessity* determination, *Blue Cross and Blue Shield* may determine that you no longer need *inpatient* coverage in that health care facility. Or, you may no longer need *inpatient* coverage at all. *Blue Cross and Blue Shield* will make this decision within one working day of receiving all necessary information. *Blue Cross and Blue Shield* will call the health care facility to let them know of this decision. *Blue Cross and Blue Shield* will discuss plans for continued coverage in a health care setting that better meets your needs. This phone call will be made within 24 hours of the *Blue Cross and Blue Shield* coverage decision. For example, your condition may no longer require *inpatient* coverage in a hospital, but it still may require skilled nursing coverage. If this is the case, your physician may decide to transfer you to a skilled nursing facility. Any proposed plans will be discussed with you by your physician. All arrangements for discharge planning will be confirmed in writing with you. *Blue Cross and Blue Shield* will send this written (or electronic) notice to you and to the facility within one working day of that phone call to the facility. You may choose to stay in the health care facility after you have been told by your health care provider or *Blue Cross and Blue Shield* that *inpatient* coverage is no longer *medically necessary*. But, if you do, *Blue Cross and Blue Shield* will not provide any more coverage (except as otherwise may be required during the formal review process). You must pay all costs for the rest of that *inpatient* stay. This starts from the date the written notice is sent to you from *Blue Cross and Blue Shield*.

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

Individual Case Management

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

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

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

Part 5

Covered Services

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

Admissions for Inpatient Medical and Surgical Care

General and Chronic Disease Hospital Admissions

Except for an admission for *emergency medical care* or for maternity care, you and your health care provider must receive approval from *Blue Cross and Blue Shield* as outlined in this Subscriber Certificate before you enter a general or chronic disease hospital for *inpatient* care. *Blue Cross and Blue Shield* will let you and your health care provider know when your coverage is approved. (See Part 4.) When *inpatient* care is approved by *Blue Cross and Blue Shield* or it is for *inpatient emergency medical care*, this health plan provides coverage for as many days as are *medically necessary* for you. (For maternity care, see page 43.) This coverage includes:

- Semiprivate *room and board*; and *special services* that are furnished for you by the hospital.
- Surgery that is performed for you by a physician; or a podiatrist; or a nurse practitioner; or a dentist. This may also include the services of an assistant surgeon (physician) when *Blue Cross and Blue Shield* decides that an assistant is needed. These *covered services* include (but are not limited to):

  – **Reconstructive surgery.** This means non-dental surgery that is meant to improve or give you back bodily function or to correct a functional physical impairment that was caused by: a birth defect; a prior surgical procedure or disease; or an accidental injury. It also includes surgery that is done to correct a deformity or disfigurement that was caused by an accidental injury. This coverage includes surgery to correct or repair disturbances of body composition caused by HIV associated lipodystrophy syndrome, when the *covered provider* has determined that this treatment is necessary to correct, repair, or lessen the effects of HIV associated lipodystrophy syndrome. These services include, but are not limited to: reconstructive surgery, such as suction-assisted lipectomy; other restorative procedures; and dermal injections or fillers for reversal of facial lipoatrophy syndrome.

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

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

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

– **Oral surgery.** This means: reduction of a dislocation or fracture of the jaw or facial bone; excision of a benign or malignant tumor of the jaw; and orthognathic surgery that you need to correct a significant functional impairment that cannot be adequately corrected with orthodontic services. You must have a serious medical condition that requires that you be admitted to a hospital as an *inpatient* in order for the surgery to be safely performed. (Orthognathic surgery is not covered when it is performed mainly for cosmetic reasons. This surgery must be performed along with orthodontic services. If it is not, the oral surgeon must send a letter to *Blue Cross and Blue Shield* asking for approval for the surgery. No benefits are provided for the orthodontic services, except as described in this Subscriber Certificate on page 36 for the treatment of conditions of cleft lip and cleft palate.)

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

– **Voluntary termination of pregnancy (abortion).**

– **Voluntary sterilization procedures.** To provide coverage for the women's preventive health services as recommended by the U.S. Department of Health and Human Services and, as required by state law, any in-network *deductible*, *copayment*, and/or *coinsurance*, whichever applies to you, will be waived for a sterilization procedure furnished for a female *member* when it is

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

---

performed as the primary procedure for family planning reasons. Or, if you choose to have this service performed by a non-*preferred provider*, you must pay your *deductible*, when it applies, and 20% *coinsurance*. This is the case even if your health plan is a grandfathered health plan under the Affordable Care Act. This provision does not apply for hospital services. For all situations except as described in this paragraph, the cost share amount for elective surgery will still apply.

- Anesthesia services that are related to covered surgery. This includes those services that are furnished for you by a physician other than the attending physician; or by a certified registered nurse anesthetist.
- Radiation and x-ray therapy that is furnished for you by a physician. This includes: radiation therapy using isotopes, radium, radon, or other ionizing radiation; and x-ray therapy for cancer or when used in place of surgery.
- Chemotherapy (drug therapy for cancer) that is furnished for you by a physician.
- Interpretation of *diagnostic x-ray and other imaging tests*, *diagnostic lab tests*, and diagnostic machine tests, when these tests are furnished by a physician or by a podiatrist instead of by a hospital-based radiologist or pathologist who is an employee of the hospital. (When these services are furnished by a radiologist or pathologist who is an employee of the hospital, coverage is provided as a *special service* of the hospital.)
- Medical care that is furnished for you by a physician; or by a nurse practitioner; or by a podiatrist. This includes medical care furnished for you by a physician other than the attending physician to treat an uncommon aspect or complication of your illness or injury. This health plan will cover medical care furnished for you by two or more physicians at the same time. But, this is the case only when *Blue Cross and Blue Shield* decides that the care is needed to treat a critically ill patient. The second physician must be an expert in a different medical sub-specialty than the attending physician. This health plan will cover only the attending physician if the second physician is an expert in the same medical sub-specialty as the attending physician.
- Monitoring services that are related to dialysis, when they are furnished for you by a *covered provider*.
- Consultations. These services must be furnished for you by a physician other than the attending physician. The consultation must be needed to diagnose or treat the condition for which you were admitted. Or, it must be for a complication that develops after you are an *inpatient*. The attending physician must order the consultation. The physician who furnishes it must send a written report to *Blue Cross and Blue Shield* if they ask for one. The physician who furnishes this consultation for you must be an expert in a different medical sub-specialty than the attending physician. This health plan will cover only the attending physician if the consultant is an expert in the same medical sub-specialty as the attending physician.
- Intensive care services. These services must be furnished for you by a physician other than the attending physician; or by a nurse practitioner. This means services that you need for only a limited number of hours to treat an uncommon aspect or complication of your illness or injury.
- Emergency admission services. These services must be furnished for you by a physician; or by a nurse practitioner. This means that a complete history and physical exam is performed before you are

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

---

admitted as an *inpatient* for *emergency medical care* and your treatment is taken over immediately by another physician.
- Pediatric specialty care. This is care that is furnished for you by a *covered provider* who has a recognized expertise in specialty pediatrics.
- Second surgical opinions. These services must be furnished for you by a physician. This includes a third opinion when the second opinion differs from the first.

Rehabilitation Hospital Admissions

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

Skilled Nursing Facility Admissions

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

Ambulance Services

This health plan covers ambulance transport. This coverage includes:
- **Emergency Ambulance.** This includes an ambulance that takes you to an emergency medical facility for *emergency medical care*. For example, this may be an ambulance that takes you from an accident scene to the hospital. Or, it may take you from your home to a hospital due to a heart attack. This also means an air ambulance that takes you to a hospital when your emergency medical condition requires

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

that you use an air ambulance rather than a ground ambulance. If you need help, call 911. Or, call your local emergency phone number.

- **Other Ambulance.** This includes *medically necessary* transport by an ambulance. For example, this may be an ambulance that is required to take you to or from the nearest hospital (or other covered health care facility) to receive care. It also includes an ambulance that is needed for a *mental condition*.

No benefits are provided: for air ambulance transport for non-emergency medical conditions; for taxi or chair car service; to transport you to or from your medical appointments; to transport you to a non-*covered provider*; or for transport that is furnished solely for your convenience or for the convenience of your family or the health care provider (for example, this includes transport for the purposes of being closer to home or to have access to a health care provider for non-emergency care).

Autism Spectrum Disorders Services

This health plan covers *medically necessary* services to diagnose and treat autism spectrum disorders when the *covered services* are furnished by a *covered provider*. This may include (but is not limited to): a physician; a psychologist; or a licensed applied behavioral analyst. This coverage includes:

- Assessments, evaluations (including neuropsychological evaluations), genetic testing, and/or other tests to determine if a *member* has an autism spectrum disorder.
- Habilitative and rehabilitative care. This is care to develop, maintain, and restore, to the maximum extent practicable, the functioning of the *member*. This care includes, but is not limited to, applied behavior analysis that is furnished by or supervised by: a psychologist; a licensed applied behavioral analyst; or an early intervention provider.
- Psychiatric and psychological care that is furnished by a *covered provider* such as: a physician who is a psychiatrist; or a psychologist.
- Therapeutic care that is furnished by a *covered provider*. This may include (but is not limited to): a speech, occupational, or physical therapist; or a licensed independent clinical social worker.

These *covered services* also include covered drugs and supplies that are furnished by a covered pharmacy when your prescription drug coverage is provided under this PPO health plan or under a *Blue Cross and Blue Shield* prescription drug plan.

Your coverage for these *covered services* is provided to the same extent as coverage is provided for similar *covered services* to diagnose and treat a physical condition.

When physical, speech/language, and/or occupational therapy is furnished as part of the treatment of an autism spectrum disorder, a *benefit limit* will not apply to these services.

This coverage for autism spectrum disorders does not affect an obligation to provide services to an individual under an individualized family service plan, an individualized education program, or an individualized service plan. This means that, for services related to autism spectrum disorders, no benefits are provided for: services that are furnished by school personnel under an individualized education

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

---

program; or services that are furnished, or that are required by law to be furnished, by a school or in a school-based setting.

Cardiac Rehabilitation

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

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

Chiropractor Services

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

Cleft Lip and Cleft Palate Treatment

This health plan covers services to treat conditions of cleft lip and cleft palate for a *member* who is under age 18 (from birth through age 17). To receive coverage, these services must be furnished by a *covered provider* such as: a physician; a dentist; a nurse practitioner; a physician assistant; a licensed speech-language pathologist; a licensed audiologist; a licensed dietitian nutritionist; or a *covered provider* who has a recognized expertise in specialty pediatrics. These services may be furnished in the provider's office or at a hospital or other covered facility. This coverage includes:

- Medical, dental, oral, and facial surgery.
- Surgical management and follow-up care by oral and plastic surgeons.
- Speech therapy, audiology services, and nutrition services.
- Orthodontic treatment.

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

- Preventive and restorative dental care to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy.

Your coverage for these *covered services* is provided to the same extent as coverage is provided for similar *covered services* to treat other physical conditions.

COVID-19 Testing and Treatment

This health plan covers services to diagnose or treat the 2019 novel coronavirus disease (COVID-19) when the services are furnished by a *preferred provider* or a non-*preferred provider.* This coverage includes *inpatient* or *outpatient* services such as:

- *Emergency medical care,* including emergency ambulance transport.
- Hospital or other covered health care facility services.
- Cognitive rehabilitation services.
- Professional, diagnostic, and laboratory services.
- *Medically necessary* COVID-19 testing, including testing for asymptomatic *members* according to guidelines set by the Commonwealth of Massachusetts Secretary of the Executive Office of Health and Human Services.

As required by state law, any *deductible*, *copayment*, and/or *coinsurance*, whichever applies to you, will be waived for diagnosis and treatment related to COVID-19 when the services are performed by a *preferred provider* or a non-*preferred provider*. There is one exception. When you are enrolled in a high deductible health plan with a health savings account, your *deductible* will apply to these *covered services.* Otherwise, any cost share amounts will not apply for these *covered services*.

These *covered services* also include covered drugs and supplies that are furnished by a covered pharmacy when your prescription drug coverage is provided under this PPO health plan or under a *Blue Cross and Blue Shield* prescription drug plan.

If a *benefit limit* would normally apply to any of the *covered services* listed above, a *benefit limit* will not apply for *covered services* to diagnose or treat COVID-19.

Dialysis Services

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

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

Durable Medical Equipment

This health plan covers durable medical equipment or covered supplies that you buy or rent from a *covered provider* that is an appliance company or from another provider who is designated by *Blue Cross and Blue Shield* to furnish the specific covered equipment or supply. This coverage is provided for equipment or supplies that in most cases: can stand repeated use; serves a medical purpose; is *medically necessary* for you; is not useful if you are not ill or injured; and can be used in the home.

Some examples of covered durable medical equipment include (but are not limited to):

- Knee braces; back braces; and foot-worn medical devices that help to relieve pain associated with osteoarthritis and other musculoskeletal conditions by restoring alignment and improving walking patterns.
- Orthopedic and corrective shoes that are part of a leg brace.
- Hospital beds; wheelchairs; crutches; and walkers.
- Glucometers. These are covered when the device is *medically necessary* for you due to your type of diabetic condition. (See "Prescription Drugs and Supplies" for your coverage for diabetic testing materials.)
- Visual magnifying aids; and voice-synthesizers. These are covered only for a legally blind *member* who has insulin dependent, insulin using, gestational, or non-insulin dependent diabetes.
- Insulin injection pens. (Your benefits for these items are provided as a prescription drug benefit when you buy them from a pharmacy. See "Prescription Drugs and Supplies.")

These *covered services* include one breast pump for each birth (other than a hospital grade breast pump) that you buy or rent from an appliance company or from a provider who is designated by *Blue Cross and Blue Shield* to furnish breast pumps. However, your coverage will not be more than the full *allowed charge* for the purchase price of a breast pump. Coverage is also provided for breastfeeding equipment (including pump parts and maintenance) and breast milk storage supplies. If an in-network *deductible* and/or *coinsurance* would normally apply to any of these *covered services*, both the *deductible* and *coinsurance* will be waived for your in-network benefits. Or, if you choose to obtain any of these *covered services* from a non-*preferred provider*, you must pay your *deductible*, when it applies, and 20% *coinsurance*. (If your health plan is a grandfathered health plan under the Affordable Care Act, a *deductible* and/or *coinsurance* that would normally apply to you for durable medical equipment will still apply for a covered breast pump.) No benefits are provided for a hospital grade breast pump.

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

Blue Cross and Blue Shield will decide whether to rent or buy durable medical equipment. If *Blue Cross and Blue Shield* decides to rent the equipment, your benefits will not be more than the amount that would have been covered if the equipment were bought. This health plan covers the least expensive equipment of its type that meets your needs. If *Blue Cross and Blue Shield* determines that you chose durable

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

---

medical equipment that costs more than what you need for your medical condition, benefits will be provided only for those costs that would have been paid for the least expensive equipment that meets your needs. In this case, you must pay all of the health care provider's charges that are more than the *Blue Cross and Blue Shield* claim payment.

Early Intervention Services

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

Emergency Medical Outpatient Services

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

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

If a *covered provider's* office is located at, or professional services are billed by, a hospital, your cost share is the same amount as for an office visit.

Gender Affirming Services (Transgender-Related Services)

This health plan covers *medically necessary* gender affirming services for transgender and gender diverse *members* when gender identity differs from assigned sex at birth. These *covered services* include (but are not limited to): surgical services (see "Admissions for Inpatient Medical and Surgical Care" and "Surgery as an Outpatient"); behavioral health services (see "Mental Health and Substance Use Treatment"); certain infertility services (see "Infertility Services"); and medical care services (see "Medical Care Outpatient Visits"). Your coverage for these *covered services* is provided to the same extent as coverage is provided for similar *covered services* to diagnose and treat a physical condition. To receive coverage for these services, they must be furnished by a *covered provider* and, in some cases, approved by *Blue Cross and Blue Shield* as outlined in this Subscriber Certificate and in the *Blue Cross and Blue Shield medical policies* for gender affirming services and other related *covered services*. When a pre-service approval is required, you and your health care provider must receive approval from *Blue Cross and Blue Shield* before you obtain services. *Blue Cross and Blue Shield* will let you and your health care

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

provider know when your coverage is approved. (See Part 4.) **In all cases, *covered services* must conform with *Blue Cross and Blue Shield medical policy* and meet *Blue Cross and Blue Shield medical technology assessment criteria*.**

To access or obtain a copy of the *medical policies* for gender affirming services and other related *covered services*, you can:

- Go online and log on to the *Blue Cross and Blue Shield* Web site at **www.bluecrossma.org**. (Your health care provider can also access the policy by using the *Blue Cross and Blue Shield* provider Web site.)
- Call the *Blue Cross and Blue Shield* customer service office. The toll free phone number to call is shown on your ID card. You can ask them to mail a copy of this *medical policy* to you.

Home Health Care

This health plan covers home health care when it is furnished (or arranged and billed) for you by a home health care provider. This coverage is provided only when: you are expected to reach a defined medical goal that is set by your attending physician; the "home" health care is furnished at a place where you live (unless it is a hospital or other health care facility that furnishes skilled nursing or rehabilitation services); and, for medical reasons, you are not reasonably able to travel to another treatment site where medically appropriate care can be furnished for your condition. This coverage includes:

- Part-time skilled nursing visits; physical, speech/language, and occupational therapy; medical social work; nutrition counseling; home health aide services; medical supplies; durable medical equipment; enteral infusion therapy; and basic hydration therapy.
- Home infusion therapy that is furnished for you by a home infusion therapy provider. This includes: the infusion solution; the preparation of the solution; the equipment for its administration; and necessary part-time nursing. This coverage includes long-term antibiotic therapy treatment for a *member* who has been diagnosed with Lyme disease when the treatment is determined by a licensed physician to be *medically necessary* and is ordered after a complete evaluation of the *member's*: symptoms; results of *diagnostic lab tests*; or response to treatment.

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

No benefits are provided for: meals, personal comfort items, and housekeeping services; *custodial care*; services to treat *mental conditions* as described in this Subscriber Certificate for "Mental Health and Substance Use Treatment"; and home infusion therapy, including the infusion solution, when it is furnished by a pharmacy or other health care provider that is not a home infusion therapy provider. (The only exception is for enteral infusion therapy and basic hydration therapy that is furnished by a home health care provider.)

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

Hospice Services

This health plan covers hospice services when they are furnished (or arranged and billed) for you by a hospice provider. "Hospice services" means pain control and symptom relief and supportive and other care for a *member* who is terminally ill and expected to live 12 months or less. These services are furnished to meet the needs of the *member* and of their family during the illness and death of the *member*. They may be furnished at home, in the community, and in facilities. This coverage includes:

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

Infertility Services

This health plan covers services to diagnose and treat infertility for a *member* who has not been able to conceive or produce conception during a period of one year. *Blue Cross and Blue Shield* may approve coverage for infertility services in two other situations: when the *member* has been diagnosed with cancer and, after treatment, the *member* is expected to become infertile; or when a *member* is age 35 or older and has not been able to conceive or produce conception during a period of six months. If a *member* conceives but cannot carry that pregnancy to live birth, the time period that the *member* tried to conceive prior to achieving that pregnancy will be included in the calculation of the one-year or six-month time period as described above. To receive coverage for infertility services, they must be *medically necessary* for you, furnished by a *covered provider*, and approved by *Blue Cross and Blue Shield* as outlined in this Subscriber Certificate and in the *Blue Cross and Blue Shield medical policy*. You and your health care provider must receive approval from *Blue Cross and Blue Shield* before you obtain infertility services. *Blue Cross and Blue Shield* will let you and your health care provider know when your coverage is approved. (See Part 4.) **In all cases, *covered services* must conform with *Blue Cross and Blue Shield medical policy* and meet *Blue Cross and Blue Shield medical technology assessment criteria*.** (See page 17 for help for how to access or obtain a copy of the *medical policy*.) This coverage may include (but is not limited to):

- Artificial insemination.
- Sperm and egg and/or inseminated egg procurement and processing.
- Banking of sperm or inseminated eggs (only when they are not covered by the donor's health plan); and other services as outlined in *Blue Cross and Blue Shield medical policy*.
- Infertility technologies. These include: in vitro fertilization and embryo placement; gamete intrafallopian transfer; zygote intrafallopian transfer; natural oocyte retrieval intravaginal fertilization; and intracytoplasmic sperm injection.

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

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

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

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

Lab Tests, X-Rays, and Other Tests

This health plan covers *outpatient* diagnostic tests, including prognostic or monitoring tests, when they are furnished by a *covered provider*. The results of these tests may lead to improvements in health outcomes. This health plan also covers *medically necessary* anesthesia services that may be required to perform covered *outpatient* diagnostic tests. This coverage includes:

- *Diagnostic lab tests*. These tests normally use samples from the body such as blood, waste, or tissue. These tests allow providers to obtain information about a *member's* health to help to diagnose or to treat or to prevent disease.
- *Diagnostic x-ray and other imaging tests*, when they are not performed as part of a covered surgical admission. These tests provide a radiological image of the internal body. These types of tests can be low-tech radiology services, such as ultrasounds or x-rays. Or, they can be high-tech radiology services, such as computerized axial tomography (CT scans), magnetic resonance imaging (MRI), positron emission tomography (PET scans), and nuclear cardiac imaging. Imaging tests may pair pictures of the body with functional measurements, such as a barium swallow test.
- Other diagnostic tests not described above. These tests are used: to confirm or diagnose health problems; to monitor a condition; and/or to determine a course of treatment. Some examples of diagnostic tests are: capsule endoscopy; transcranial doppler study; and diagnostic machine tests, such as pulmonary function tests and Holter monitoring.

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

- Preoperative tests. These tests must be performed before a scheduled *inpatient* or surgical day care unit admission for surgery. And, they must not be repeated during the admission. Some examples of these tests are: *diagnostic lab tests; diagnostic x-ray and other imaging tests*; and diagnostic machine tests.
- Human leukocyte antigen testing or histocompatibility locus antigen testing. These tests are necessary to establish stem cell ("bone marrow") transplant donor suitability. They include testing for A, B, or DR antigens or any combination according to the guidelines of the Massachusetts Department of Public Health.

If a *copayment* normally applies to these *covered services*, the *copayment* will **not** apply to the interpretation costs that are billed in conjunction with any one of the tests; and it will be waived when the tests are furnished during an emergency room visit or during a day surgery admission, or at a hospital and the results of the lab test(s) are required right away so the hospital can furnish treatment to you. You can call the *Blue Cross and Blue Shield* customer service office for information about the times when your *copayment* may be waived. The toll free phone number to call is shown on your ID card. Your *Schedule of Benefits* describes your cost share amount. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.)

Maternity Services and Well Newborn Care

Maternity Services

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

- Semiprivate *room and board* and *special services* when you are an *inpatient* in a general hospital. This includes nursery charges for a well newborn. These charges are included with the benefits for the maternity admission. Your (and your newborn child's) *inpatient* stay will be no less than 48 hours following a vaginal delivery or 96 hours following a Caesarian section unless you and your attending physician decide otherwise as provided by law. If you choose to be discharged earlier, this health plan covers one home visit within 48 hours of discharge, when it is furnished by a physician; or by a registered nurse; or by a nurse midwife; or by a nurse practitioner. This visit may include: parent education; assistance and training in breast or bottle feeding; and appropriate tests. This health plan will cover more visits that are furnished by a *covered provider* only if *Blue Cross and Blue Shield* determines the visits are clinically necessary.
- *Outpatient* maternity admissions in a licensed outpatient birthing center for a vaginal delivery. This includes nursery charges for a well newborn. These charges are included with the benefits for the maternity admission. Upon discharge, this health plan covers one home visit within 48 hours, when it is furnished by a physician; or by a registered nurse; or by a nurse midwife; or by a nurse practitioner. This visit may include: parent education; assistance and training in breast or bottle feeding; and appropriate tests. This health plan will cover more visits that are furnished by a *covered provider* only if *Blue Cross and Blue Shield* determines the visits are clinically necessary. For these covered admissions, you will pay the cost share amount that is described in your *Schedule of Benefits* for *outpatient* maternity services furnished at a facility. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.) There may be times when your condition requires you to be

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

---

transferred from the birthing center to a general hospital for *inpatient* care. If this occurs, the cost share amount that is described in your *Schedule of Benefits* for *inpatient* maternity admissions will also apply. (This is in addition to your cost share for any charges that are billed by the birthing center.)

- Delivery of one or more than one baby. This includes prenatal and postnatal medical care and lab tests, x-rays, and other covered tests that are furnished for you by a physician; or by a nurse midwife. Your benefits for prenatal and postnatal medical care and lab tests, x-rays, and other covered tests that are furnished by a physician or by a nurse midwife are included in *Blue Cross and Blue Shield's* payment for the delivery. The benefits that are provided for these services will be those that are in effect on the date of delivery. When a physician or a nurse midwife furnishes only prenatal and/or postnatal care, benefits for those services are based on the date the care is received. This health plan also covers prenatal and postnatal medical care exams and lab tests, x-rays, and other covered tests when they are furnished for you by a general hospital; or by a community health center. Your benefits for these services are based on the date the care is received.
- Standby attendance that is furnished for you by a physician (who is a pediatrician), when a known or suspected complication threatening your health or the health of your child requires that a pediatrician be present during the delivery.
- Childbirth classes for up to $90 for one childbirth course for each covered pregnant *member* and up to $45 for each refresher childbirth course. Pregnant *members* are encouraged to attend the childbirth course that is recommended by their physician or by their health care facility or by their nurse midwife. You must pay the full cost of the childbirth course. After you complete the course, call the *Blue Cross and Blue Shield* customer service office for a claim form to file your claim. You will not be reimbursed for this amount unless you complete the course, except when your delivery occurs before the course ends.

All pregnant *members* may take part in a program that provides support and education for them. Through this program, *members* receive outreach and education that add to the care they get from their obstetrician or nurse midwife. You can call the *Blue Cross and Blue Shield* customer service office for more information.

No benefits are provided for a home birth, unless: the home birth is due to an emergency or unplanned delivery that occurs at home prior to being admitted to a hospital; or the home birth occurs outside of Massachusetts.

Well Newborn Care

This health plan covers well newborn care when it is furnished during a covered *inpatient* maternity stay or during a covered *outpatient* maternity admission in a licensed outpatient birthing center. This coverage includes:

- Pediatric care that is furnished for a well newborn by a physician (who is a pediatrician); or by a nurse practitioner.
- Routine circumcision that is furnished by a physician.

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

- Newborn hearing screening tests that are performed by a *covered provider* before the newborn child (an infant under three months of age) is discharged to the care of the parent or guardian, or as provided by regulations of the Massachusetts Department of Public Health.

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

Medical Care Outpatient Visits

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

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

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

- Certain medical care services you receive from a limited services clinic. A limited services clinic can provide on-the-spot, non-emergency care for symptoms such as a sore throat, cough, earache, fatigue, poison ivy, flu, body aches, or infection. You do not need an appointment to receive this care. If you want to find out if a specific service is covered at a limited services clinic, you can call the limited services clinic or you can call the *Blue Cross and Blue Shield* customer service office. Generally, the cost share amount you pay for these *covered services* is the same cost share amount that you would pay for similar services furnished by a physician. Refer to the *Schedule of Benefits* for your plan option for your cost share amount when you receive *covered services* at a limited services clinic.
- Medical exams and contact lenses that are needed to treat keratoconus. And, for *members* with certain conditions as outlined in the *Blue Cross and Blue Shield medical policy*, coverage is also provided for medical exams and rigid gas permeable scleral contact lenses. This includes the cost of the fitting of these contact lenses for these conditions.
- Hormone replacement therapy for peri- and post-menopausal *members*.
- *Urgent care* services.
- Follow up care that is related to an accidental injury or an emergency medical condition.
- Acupuncture services by a *covered provider* who is licensed to furnish the *covered service*, whether or not these services are *medically necessary*. This health plan provides coverage only until you reach your *benefit limit*. The *Schedule of Benefits* for your plan option describes the cost share amount and *benefit limit* that applies for these *covered services*. Once you reach the *benefit limit*, no more benefits will be provided for these services. For covered acupuncture services, your cost share (such as

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

---

deductible, *copayment*, and/or *coinsurance*) is usually the same cost share that you would pay for other health care services furnished by specialty care providers. A *rider* may change the information that is shown in your *Schedule of Benefits*. Be sure to read each *rider* (if there is any).

- Allergy testing. (This includes tests that you need such as PRIST, RAST, and scratch tests.)
- Certain intravenous infusions (therapeutic, prophylactic, and diagnostic injections) that are furnished in a physician's office or in a hospital outpatient setting to administer fluids, substances, or drugs.
- Injections. This includes the administration of injections that you need such as allergy shots or other *medically necessary* injections (except as described above for intravenous infusions). And, except for certain self injectable drugs as described below in this section, this coverage also includes the vaccine, serum, or other covered drug that is furnished during your covered visit. (This section does not include injections that are covered as a surgical service such as a nerve block injection or an injection of anesthetic agents. See "Surgery as an Outpatient.")

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

- Syringes and needles when they are *medically necessary* for you. If a *copayment* would normally apply to your visit, it is waived if the visit is only to obtain these items. (Your coverage for these items is provided as a prescription drug benefit when you buy them from a pharmacy.)
- Diabetes self-management training and education, including medical nutrition therapy, when it is furnished for you by a certified diabetes health care professional who is a *covered provider* or who is affiliated with a *covered provider*.
- Pediatric specialty care that is furnished for you by a *covered provider* who has a recognized expertise in specialty pediatrics.
- Non-dental services that are furnished for you by a dentist who is licensed to furnish the specific *covered service*. This coverage is provided only if the services are covered when they are furnished for you by a physician.
- Monitoring and medication management for *members* taking psychiatric drugs; and/or neuropsychological assessment services. These services may also be furnished by a *mental health provider*.
- Methadone maintenance treatment that is furnished for opioid dependence. For these *covered services*, this health plan will provide full in-network coverage. The only exception is when you are enrolled in a high deductible health plan with a health savings account. In this case, your *deductible* will apply to these *covered services*. Otherwise, any cost share amounts will not apply for these *covered services*. If you choose to obtain these *covered services* from a non-*preferred provider*, you must pay your *deductible*, when it applies, and 20% *coinsurance*.

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

If a *covered provider's* office is located at, or professional services are billed by, a hospital, your cost share is the same amount as for an office visit.

Medical Formulas

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

- Special medical formulas that are approved by the Massachusetts Department of Public Health and are *medically necessary* for you to treat one of the listed conditions: homocystinuria; maple syrup urine disease; phenylketonuria; propionic acidemia; methylmalonic acidemia; or tyrosinemia.
- Enteral formulas that you need to use at home and are *medically necessary* for you to treat malabsorption caused by one of the listed conditions: Crohn's disease; chronic intestinal pseudo-obstruction; gastroesophageal reflux; gastrointestinal motility; ulcerative colitis; or inherited diseases of amino acids and organic acids.
- Food products that are modified to be low protein and are *medically necessary* for you to treat inherited diseases of amino acids and organic acids. (You may buy these food products directly from a distributor.)

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

Mental Health and Substance Use Treatment

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

- Biologically-based *mental conditions*. "Biologically-based mental conditions" means: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder; delirium and dementia; affective disorders; eating disorders; post-traumatic stress disorders; autism; substance use disorders (such as drug and alcohol addiction); and any biologically-based *mental conditions* that appear in the most recent edition of the American Psychiatric Association's <u>Diagnostic and Statistical Manual of Mental Disorders</u> that are scientifically recognized and approved by the Commissioner of the Department of Mental Health.
- Rape-related mental or emotional disorders for victims of a rape or victims of an assault with intent to rape.
- Non-biologically-based mental, behavior, or emotional disorders of enrolled dependent children who are under age 19. This coverage includes pediatric specialty mental health care that is furnished by a *mental health provider* who has a recognized expertise in specialty pediatrics. (This coverage is not limited to those disorders that substantially interfere with or limit the way the child functions or how they interact with others.) If a child who is under age 19 is receiving an ongoing course of treatment, this coverage will continue to be provided after the child's 19th birthday until that ongoing course of treatment is completed, provided that the child or someone acting on behalf of the child continues to pay for coverage in this health plan in accordance with federal (COBRA) or state law, or the child

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

enrolls with no lapse in coverage under another Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. or Blue Cross and Blue Shield of Massachusetts, Inc. health plan.
- All other non-biologically-based *mental conditions* not described above.

No benefits are provided for:
- Psychiatric services for a condition that is not a *mental condition*.
- Residential or other care that is *custodial care*.
- Services and/or programs that are not *medically necessary* to treat your *mental condition*.
- Services and/or programs that are performed in educational or vocational settings; or, services and/or programs that are not considered to be *inpatient* services, intermediate treatments, or *outpatient* services as described below in this section. These types of non-covered programs may be in residential or nonresidential settings and may include: therapeutic elements and therapy services; clinical staff (such as licensed mental health counselors) and clinical staff services; and vocational, educational, problem solving, and/or recreational activities. These non-covered programs may have state licensure and/or educational accreditation. But, they do not provide the clinically appropriate level of care required for coverage under this health plan. No benefits are provided for any services furnished along with one of these non-covered programs. The only exception is for *outpatient covered services* to diagnose and/or treat *mental conditions* when these services are performed by a *covered provider*. Your coverage for these *covered services* is provided to the same extent as coverage is provided for similar *covered services* to diagnose and treat a *mental condition*.

Inpatient Services

Usually, to receive coverage for *inpatient* services, you and your *mental health provider* must receive approval from *Blue Cross and Blue Shield* as outlined in this Subscriber Certificate before you enter a hospital or other covered facility. (See Part 4 for these requirements.) *Blue Cross and Blue Shield* will let you and your *mental health provider* know when your coverage is approved. When *inpatient* care is approved by *Blue Cross and Blue Shield*, this health plan provides coverage for as many days as are *medically necessary* for you. This coverage includes: semiprivate *room and board* and *special services*; and psychiatric care that is furnished for you by a physician (who is a specialist in psychiatry), or by a psychologist, or by a clinical specialist in psychiatric and mental health nursing, or by another *mental health provider*.

Intermediate Treatments

There may be times when you will need *medically necessary* care that is more intensive than typical *outpatient* care. But, you do not need 24-hour *inpatient* hospital care. This intermediate care may include (but is not limited to):
- Acute residential treatment (this is substantially similar to Community-Based Acute Treatment (CBAT) programs described below in this section), clinically managed detoxification services, or crisis stabilization services. These services may sometimes be referred to as sub-acute care services. These services offer 24 hours a day, 7 days a week access to medical services and on-site or on-call nursing staff. Your coverage for these services is considered to be an *inpatient* benefit. During the *inpatient* pre-service review process (see Part 4), *Blue Cross and Blue Shield* will assess your specific

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

---

health care needs. The least intensive type of setting that is required for your *mental condition* will be approved by *Blue Cross and Blue Shield*.

- Partial hospital programs, intensive outpatient programs, day treatment programs, in-home therapy services, or mobile crisis intervention services. Your coverage for these services is considered to be an *outpatient* benefit, even if you use a bed or spend the night.

In addition to the services listed above, this health plan also covers certain intermediate care for *members* who are under age 19, such as:

- Community-Based Acute Treatment (CBAT) programs that provide mental health care in a staff-secure setting on a 24-hour basis, with sufficient clinical staffing to ensure the *member's* safety, while providing intensive therapeutic services including (but not limited to): daily medication monitoring; psychiatric assessment; nursing availability; specialing (as needed); individual, group, and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing, as needed. Or, you may require services of higher intensity than those provided by a CBAT program, including more frequent psychiatric and psychopharmacological evaluation and treatment and more intensive staffing and service delivery. This may be delivered through an Intensive Community-Based Acute Treatment (ICBAT) program. ICBAT programs may admit *members* with more acute symptoms than those admitted to CBAT. ICBAT programs are able to treat *members* with clinical symptoms that are similar to those which would be treated under *inpatient* mental health care but who are able to be cared for safely in an unlocked setting. Your coverage for these CBAT and ICBAT programs is considered to be an *inpatient* benefit. During the *inpatient* pre-service review process (see Part 4), *Blue Cross and Blue Shield* will assess your specific health care needs. The least intensive type of setting that is required for your *mental condition* will be approved by *Blue Cross and Blue Shield*. (These CBAT and ICBAT programs are substantially similar to acute residential treatment programs described above in this section.)
- In-home behavioral services that provide a combination of *medically necessary* behavior management therapy and behavior management monitoring. These services may be furnished where the *member* resides, including in the *member's* home, a foster home, a therapeutic foster home, or another community setting. Behavior management monitoring is the monitoring of behavior, the implementation of a behavior plan, and reinforcing the implementation of a behavior plan by the *member's* parent or other caregiver. Behavior management therapy addresses challenging behaviors that interfere with a *member's* successful functioning. Behavior management therapy includes: a functional behavioral assessment and observation of the *member* in the home and/or community setting; development of a behavior plan; and supervision and coordination of interventions to address specific behavioral goals or performance, including the development of a crisis-response strategy. Behavior management therapy may also include short-term counseling and assistance. Your coverage for these services is considered to be an *outpatient* benefit.
- In-Home Therapy services that provide *medically necessary* therapeutic clinical intervention or ongoing therapeutic training and support. These services are furnished where the *member* resides, including in the *member's* home, a foster home, a therapeutic foster home, or another community setting. Therapeutic clinical intervention includes: a structured and consistent therapeutic relationship between a licensed clinician and a *member* and their family to treat the *member's* mental health needs, including improvement of the family's ability to provide effective support for the *member* and

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

---

promotion of health functioning of the *member* within the family; the development of a treatment plan; and the use of established psychotherapeutic techniques, working with the family or a subset of the family to enhance problem solving, limit setting, communication, emotional support or other family or individual functions. Ongoing therapeutic training and support services support the implementation of a treatment plan following therapeutic clinical intervention. These services include (but are not limited to): teaching the *member* to understand, direct, interpret, manage, and control feelings and emotional responses to situations; and assisting the family in supporting the *member* and addressing the *member's* emotional and mental health needs. Your coverage for these services is considered to be an *outpatient* benefit. (These In-Home Therapy services are in addition to the "in-home therapy" services described above.)

- Family support and training services that provide *medically necessary* assistance to the *member's* parent or caregiver to increase their ability to reduce or resolve the *member's* emotional or mental health needs. These services are furnished where the *member* resides, including in the *member's* home, a foster home, a therapeutic foster home, or another community setting. Family support and training services support one or more goals on the *member's* treatment plan. These services include (but are not limited to): educating the *member's* parent or caregiver about the *member's* mental health needs and resiliency factors; teaching the *member's* parent or caregiver how to access and use available services on behalf of the *member;* and how to identify formal and informal services and support in their communities, including parent support and self-help groups. Your coverage for these services is considered to be an *outpatient* benefit.
- Therapeutic mentoring services that provide *medically necessary* support to assist a *member* with age-appropriate social functioning or to reduce or resolve deficits in the *member's* age-appropriate social functioning as a result of a diagnosis listed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. These services are furnished where the *member* resides, including in the *member's* home, a foster home, a therapeutic foster home, or another community setting. Therapeutic mentoring is a skill building service that supports one or more goals on the *member's* treatment plan. These services include (but are not limited to): supporting, coaching, and training the *member* in age-appropriate behaviors; interpersonal communication; problem solving; conflict resolution; and relating appropriately to other children, adolescents, and adults. Your coverage for these services is considered to be an *outpatient* benefit.
- Intensive care coordination services that provide targeted case management services to eligible *members* with serious emotional disturbance(s) in order to meet the comprehensive medical, mental health, and psychosocial needs *of* a *member* and the *member's* family. These services include: an assessment; the development of an individualized care plan; referrals to appropriate levels of care; monitoring of goals; and coordinating with other services and social supports and with state agencies, as indicated. These services include both face-to-face and telephone meetings. These services may be furnished in the provider's office or in the *member's* home or in other settings, as clinically appropriate. Your coverage for these services is considered to be an *outpatient* benefit.
- Mobile crisis intervention services that are available 24 hours a day, seven days a week to provide short-term, mobile, on-site, face-to-face therapeutic responses to a *member* experiencing a behavioral health crisis. Mobile crisis intervention is used: to identify, assess, treat, and stabilize a situation; to reduce the immediate risk of danger to the *member* or others; and to make referrals and linkages to all *medically necessary* behavioral health services and supports and the appropriate level of care. Mobile

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

crisis intervention includes a crisis assessment and crisis planning, which may result in the development or update of a crisis safety plan. Your coverage for these services is considered to be an *outpatient* benefit.

These intermediate treatments may be considered an *inpatient* benefit or an *outpatient* benefit. If you would normally pay a *copayment* for *inpatient* or *outpatient* benefits, the *copayment* will be waived when you get covered intermediate care. But, you must still pay your *deductible* and/or *coinsurance*, whichever applies.

No benefits are provided for: a program for which *Blue Cross and Blue Shield* is not able to conduct concurrent review of continued *medical necessity* (see Part 4), including a program that has a pre-defined length of care or stay; a program that provides only meetings or activities that are not based on an individualized treatment plan; and a program that focuses solely on the improvement of interpersonal or other skills, rather than on treatment that is focused on symptom reduction and functional recovery for specific *mental conditions*.

Outpatient Services
This health plan covers *outpatient covered services* to diagnose and/or treat *mental conditions* when the services are furnished for you by a *mental health provider*. This coverage is provided for as many visits as are *medically necessary* for your *mental condition*. (See "Preventive Health Services" for your coverage for *outpatient* mental health wellness exams.)

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

Pain Management Alternatives to Opiates
There are certain health care services or supplies that are covered by this health plan that are considered to be alternative treatments to opiates for pain management, when these *covered services* are furnished by a *covered provider*. Some examples of *covered services* include (but are not limited to):
- Acupuncture services (see "Medical Care Outpatient Visits").
- Chiropractic services (see "Chiropractor Services").
- Devices such as transcutaneous electrical nerve stimulation (TENS) units and their related supplies (see "Durable Medical Equipment" for your coverage for durable medical equipment or covered supplies).
- Pain management services furnished for you by a *covered provider*. These *covered providers* can furnish services such as: nerve block injections or epidural steroid injections (these injections are covered as a surgical service, see "Surgery as an Outpatient"); and electro-muscular stimulation and

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

---

spinal cord and dorsal root stimulation (see "Medical Care Outpatient Visits" for your coverage for *outpatient* care to diagnose or treat your medical condition).
- Occupational therapy and/or physical therapy (see "Short-Term Rehabilitation Therapy").

Alternative treatments to opiates for pain management also include non-opiate covered drugs and supplies that are furnished by a covered pharmacy when your prescription drug coverage is provided under this PPO health plan or under a *Blue Cross and Blue Shield* prescription drug plan.

Your coverage for these *covered services* is provided to the same extent as coverage is provided for similar *covered services* to diagnose and treat a physical condition. (A *benefit limit* may apply for a specific *covered service* listed above. If this is the case, the *benefit limit* will be described in the *Schedule of Benefits* for your plan option and/or any *riders* that apply to your coverage in this health plan.)

PANS/PANDAS Treatment

This health plan covers services to treat pediatric autoimmune neuropsychiatric disorders (PANS) associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome (PANDAS) including, but not limited to the use of intravenous immunoglobulin therapy when they are furnished by a *covered provider*. Your coverage for these *covered services* is provided to the same extent as coverage is provided for similar *covered services* to treat other physical conditions.

Podiatry Care

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

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

Prescription Drugs and Supplies

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

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

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

- The drug or supply is listed on the *Blue Cross and Blue Shield* Drug Formulary as a covered drug or supply. For certain covered drugs, you must have prior approval from *Blue Cross and Blue Shield* in order for you to receive this drug coverage. A covered pharmacy will tell you if your drug needs prior approval from *Blue Cross and Blue Shield*. They will also tell you how to request this approval.
- The drug or supply is prescribed for your use while you are an *outpatient*.
- The drug or supply is purchased from a pharmacy that is approved by *Blue Cross and Blue Shield* for payment for the specific covered drug and/or supply. This means that for most covered drugs and supplies, you may buy your drug or supply from any covered retail pharmacy. However, for some specialty drugs and supplies, you may need to buy your drug or supply from covered pharmacies that specialize in treating specific diseases and that have been approved by *Blue Cross and Blue Shield* for payment for that specific specialty drug or supply. For a list of these specialty drugs and supplies and where to buy them, you can call the *Blue Cross and Blue Shield* customer service office. Or, you can look on the internet Web site at **www.bluecrossma.org**.

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

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

Buying Covered Drugs and Supplies
For help to obtain your drug coverage, you can call the *Blue Cross and Blue Shield* customer service office. The toll free phone number to call is shown on your ID card. A *Blue Cross and Blue Shield*

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

---

customer service representative can help you find a pharmacy where you may buy a specific drug or supply. They can also help you find out which *member* cost share level you will pay for a specific covered drug or supply. Or, you can also go online and log on to the *Blue Cross and Blue Shield* Web site at **www.bluecrossma.org**.

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

Covered Drugs and Supplies
This drug coverage is provided for:

- Drugs that require a prescription by law and are furnished in accordance with *Blue Cross and Blue Shield medical technology assessment criteria*. These covered drugs include, but are not limited to: birth control drugs; oral diabetes medication that influences blood sugar levels; hormone replacement therapy drugs for peri- and post-menopausal *members*; certain drugs used on an off-label basis (such as: drugs used to treat cancer; and drugs used to treat HIV/AIDS); abuse-deterrent opioid drug products on a basis not less favorable than non-abuse deterrent opioid drug products; oral antibiotics for the treatment of Lyme disease; and drugs for HIV associated lipodystrophy syndrome.
- Injectable insulin and disposable syringes and needles needed for its administration, whether or not a prescription is required. (When a *copayment* applies to your pharmacy coverage, if insulin, syringes, and needles are bought at the same time, you pay two *copayments*: one for the insulin; and one for the syringes and needles.)
- Materials to test for the presence of sugar when they are ordered for you by a physician for home use. These include (but are not limited to): blood glucose monitoring strips; ketone strips; lancets; urine glucose testing strips; normal, low, and high calibrator solution/chips; and dextrostik or glucose test strips. (You may obtain these testing supplies from a covered pharmacy or appliance company.) See "Durable Medical Equipment" for your coverage for glucometers.
- Insulin injection pens.
- Insulin infusion pumps and related pump supplies. (You will obtain the insulin infusion pump from an appliance company instead of a pharmacy.)
- Syringes and needles when they are *medically necessary* for you.
- Drugs that do not require a prescription by law ("over-the-counter" drugs), if any, that are listed on the *Blue Cross and Blue Shield* Drug Formulary as a covered drug. Your Pharmacy Program booklet will list the over-the-counter drugs that are covered, if there are any. Or, you can go online and log on to the *Blue Cross and Blue Shield* Web site at **www.bluecrossma.org**.
- Prescription birth control drugs and contraceptive methods (such as diaphragms) that have been approved by the U.S. Food and Drug Administration (FDA). As required by state law, this coverage is provided for up to a 3-month supply for the first fill of the covered drug or other method and up to a 12-month supply for additional fills of the same prescription. (The 12-month supply may be issued all at once or over the course of the 12-month period.) Your cost share will be waived for generic birth control drugs and methods (or for a brand-name drug or method when a generic is not available

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

---

or not medically appropriate for you). This is the case even if your health plan is a grandfathered health plan under the Affordable Care Act. If you choose to use a brand-name birth control drug or method when a generic is available or appropriate for you, you will have to pay your cost share. See "Family Planning" for your coverage for contraceptive implant systems and IUDs.
- Prescription prenatal vitamins and pediatric vitamins with fluoride.
- Prescription dental topical fluoride, rinses, and gels.
- Smoking and tobacco cessation products (this includes drugs and aids such as nicotine gum, patches, lozenges, inhaler systems, nasal sprays, and oral medications) for up to a 168-day supply for each type of product for each *member* in each calendar year, when they are prescribed for you by a health care provider. (These products are typically dispensed in lesser day supply quantities over the course of the calendar year.) Your cost share will be waived for generic products (or for a preferred brand-name product when a generic is not available), unless your health plan is a grandfathered health plan under the Affordable Care Act. If you choose to use a brand-name product when a generic is available, you will have to pay your cost share. Your coverage for "Preventive Health Services" includes smoking and tobacco cessation counseling as recommended by the U.S. Preventive Services Task Force, unless your health plan is a grandfathered health plan under the Affordable Care Act.
- Prescription opioid antagonist drugs that block and reverse the effects of opioids that are used for the emergency treatment of a known or suspected overdose (such as morphine or heroin). Except for auto injection devices, this health plan will provide full in-network coverage for all forms of these covered drugs. (If out-of-network *coinsurance* applies for drugs and supplies, your out-of-network *coinsurance* for these covered drugs will not be more than 20%.) For auto injection devices for these covered drugs, you will have to pay your cost share.

Important Note: Any in-network *deductible*, *copayment*, and/or *coinsurance* (whichever applies to you) will be waived for certain preventive drugs as recommended and supported by the Health Resources and Services Administration and the U.S. Preventive Services Task Force. (If out-of-network *coinsurance* applies for drugs and supplies, your out-of-network *coinsurance* for these covered drugs will not be more than 20%.) The provisions described in this paragraph do not apply to you if your health plan is a grandfathered health plan under the Affordable Care Act.

Non-Covered Drugs and Supplies
No benefits are provided for:
- Anorexiants; non-sedating antihistamines; ophthalmic drug solutions to treat allergies; inhaled topical nasal steroids; or proton pump inhibitors, except for prescription proton pump inhibitors that are prescribed for *members* under age 18 or that are prescribed as part of a combination drug used to treat helicobacter pylori. From time to time, *Blue Cross and Blue Shield* may change this list of non-covered drugs and supplies. When a material change is made to this list of non-covered drugs and supplies, *Blue Cross and Blue Shield* will let the *subscriber* (or the *subscriber's group* on your behalf when you are enrolled in this health plan as a *group member*) know about the change at least 60 days before the change becomes effective. For more information, you can call the *Blue Cross and Blue Shield* customer service office. The toll free phone number to call is shown on your ID card. Or, you can also go online and log on to the *Blue Cross and Blue Shield* Web site at **www.bluecrossma.org**.

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

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

Preventive Health Services

In this Subscriber Certificate, the term "preventive health services" refers to *covered services* that are performed to prevent diseases (or injuries) rather than to diagnose or treat a symptom or complaint, or to treat or cure a disease after it is present. This health plan provides coverage for preventive health services in accordance with applicable federal and state laws and regulations.

Routine Pediatric Care

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

- Routine medical exams; history; measurements; sensory (vision and auditory) screening; and neuropsychiatric evaluation and development screening; and assessment.
- Hereditary and metabolic screening at birth.
- Appropriate immunizations as recommended by the Advisory Committee on Immunization Practices. This includes, but is not limited to: flu shots; and travel immunizations.
- Tuberculin tests; hematocrit, hemoglobin, and other appropriate blood tests; urinalysis; and blood tests to screen for lead poisoning (as required by state law).
- Preventive health services and screenings as recommended by the U.S. Preventive Services Task Force and the U.S. Department of Health and Human Services.
- Other routine services furnished in line with *Blue Cross and Blue Shield medical policies*.

For an enrolled child who receives coverage for vaccines from a federal or state agency, this health plan provides coverage only to administer the vaccine. Otherwise, this health plan also provides coverage for a covered vaccine along with the services to administer the vaccine.

Important Note: You have the right to full in-network coverage (provided the services are furnished by a *preferred provider*) for preventive health services as required by the Affordable Care Act and related

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

---

regulations. For a complete description of these preventive health services, you can call the *Blue Cross and Blue Shield* customer service office. The toll free phone number to call is shown on your ID card. Or, you can also go online and log on to the *Blue Cross and Blue Shield* Web site at **www.bluecrossma.org**. The provisions described in this paragraph do not apply to you if your health plan is a grandfathered health plan under the Affordable Care Act.

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.

Annual Mental Health Wellness Exams
This health plan covers mental health wellness exams for at least one exam for each *member* in each calendar year. This coverage may be furnished by a *covered provider*, including *mental health providers*. As required by state law, this health plan provides full coverage for these *covered services*. You pay nothing for in-network and out-of-network benefits. (Any *deductible*, *copayment*, and/or *coinsurance* that you would normally pay will not apply.)

A mental health wellness exam is a screening or assessment that seeks to identify any behavioral or mental health needs and appropriate resources for treatment. The exam may include: observation, a behavioral health screening, education and consultation on healthy lifestyle changes, referrals to ongoing treatment, mental health services and other necessary supports, and discussion of potential options for medication; and age-appropriate screenings or observations to understand a covered *member's* mental health history, personal history, and mental or cognitive state and, when appropriate, relevant adult input through screenings, interviews, and questions.

Preventive Dental Care
This health plan covers preventive dental care for a *member* who is under age 18 and who is being treated for conditions of cleft lip and cleft palate (see page 36). This coverage includes (but is not limited to) periodic oral exams, cleanings, and fluoride treatments furnished by a dentist or other *covered provider*.

No benefits are provided for preventive dental care, except as described in this section.

Routine Adult Physical Exams and Tests

This health plan covers routine physical exams, routine tests, and other preventive health services when they are furnished for you by a *covered provider* in line with any applicable *Blue Cross and Blue Shield medical policies*. This coverage includes:

- Routine medical exams and related routine lab tests and x-rays. Your coverage for a routine physical exam is limited to one visit for each *member* in a calendar year.
- Appropriate immunizations as recommended by the Advisory Committee on Immunization Practices. This coverage includes, but is not limited to: flu shots; and travel immunizations.
- Blood tests to screen for lead poisoning as required by state law.
- Routine mammograms as recommended and determined suitable by your health care provider. As required by state law, this coverage includes at least one baseline mammogram during the five-year period a *member* is age 35 through 39; and one routine mammogram each calendar year for a *member*

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

---

who is age 40 or older. If you are determined to be at "high risk" for breast cancer, your health care provider may recommend a screening mammogram outside of these time periods.
- Routine prostate-specific antigen (PSA) blood tests. This coverage is limited to one test each calendar year for a *member* who is age 40 or older.
- Routine sigmoidoscopies and barium enemas.
- Routine colonoscopies.
- Preventive health services and screenings as recommended by the U.S. Preventive Services Task Force and the U.S. Department of Health and Human Services.
- Diabetes prevention programs for *members* who have been diagnosed with pre-diabetes. The goal of these programs is to improve health and decrease the rate of progression to non-insulin dependent diabetes through structured health behavior changes, such as: dietary education; increased physical activity; and weight loss strategies. This coverage for diabetes prevention programs is limited to a lifetime *benefit limit* of one program for each eligible *member*.
- Other routine services furnished in line with *Blue Cross and Blue Shield medical policies*.

Important Note: You have the right to full in-network coverage (provided the services are furnished by a *preferred provider*) for preventive health services as required by the Affordable Care Act and related regulations. For a complete description of these preventive health services, you can call the *Blue Cross and Blue Shield* customer service office. The toll free phone number to call is shown on your ID card. Or, you can also go online and log on to the *Blue Cross and Blue Shield* Web site at **www.bluecrossma.org**. The provisions described in this paragraph do not apply to you if your health plan is a grandfathered health plan under the Affordable Care Act.

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.

Annual Mental Health Wellness Exams

This health plan covers mental health wellness exams for at least one exam for each *member* in each calendar year. This coverage may be furnished by a *covered provider*, including *mental health providers*. As required by state law, this health plan provides full coverage for these *covered services*. You pay nothing for in-network and out-of-network benefits. (Any *deductible*, *copayment*, and/or *coinsurance* that you would normally pay will not apply.)

A mental health wellness exam is a screening or assessment that seeks to identify any behavioral or mental health needs and appropriate resources for treatment. The exam may include: observation, a behavioral health screening, education and consultation on healthy lifestyle changes, referrals to ongoing treatment, mental health services and other necessary supports, and discussion of potential options for medication; and age-appropriate screenings or observations to understand a covered *member's* mental health history, personal history, and mental or cognitive state and, when appropriate, relevant adult input through screenings, interviews, and questions.

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

Women's Preventive Health Services
All female *members* have coverage for women's preventive health services as recommended by the U.S. Department of Health and Human Services. These types of preventive health services include: yearly well-woman visits; domestic violence screening; human papillomavirus (HPV) DNA testing; screening for human immunodeficiency virus (HIV) infection; birth control methods and counseling (see "Family Planning"); screening for gestational diabetes; and breastfeeding support and breast pumps (see "Durable Medical Equipment"). For a complete description of these covered preventive health services, you can call the *Blue Cross and Blue Shield* customer service office at the toll free phone number shown on your ID card. Or, you can also go online and log on to the *Blue Cross and Blue Shield* Web site at **www.bluecrossma.org**. **Your coverage for these preventive health services is subject to all of the provisions and requirements of this health plan. See other sections of your Subscriber Certificate to understand the provisions related to your coverage for prenatal care, routine GYN exams, family planning, and pharmacy benefits for birth control drugs and devices when you have prescription drug coverage under this PPO health plan or under a *Blue Cross and Blue Shield* prescription drug plan.**

Routine Gynecological (GYN) Exams
This health plan covers one routine GYN exam for each *member* in each calendar year when it is furnished by a *covered provider*. This may include (but is not limited to): a physician; or a nurse practitioner; or a nurse midwife. This coverage also includes one routine Pap smear test for each *member* in each calendar year.

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

- Consultations, exams, procedures, and medical services related to the use of all contraceptive methods to prevent pregnancy that have been approved by the U.S. Food and Drug Administration (FDA).
- Injection of birth control drugs. This includes a prescription drug when it is supplied during the visit.
- Insertion of a contraceptive implant system (such as levonorgestrel or etonogestrel). This includes the implant system itself.
- IUDs, diaphragms, and other prescription contraceptive methods that have been approved by the U.S. Food and Drug Administration (FDA), when the items are supplied during the visit.
- Emergency contraception medications (over-the-counter; and prescription, when your prescription drug coverage is administered by *Blue Cross and Blue Shield*). For these services, you may need to submit a claim as described in Part 9.
- Genetic counseling.

Important Note: You have the right to full in-network coverage for family planning services as required by state law. Or, if you choose to have these services performed by a non-*preferred provider*, you must pay your *deductible*, when it applies, and 20% *coinsurance*.

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

No benefits are provided for: 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 Care Services

This health plan covers:

- **Routine Hearing Exams and Tests.** This includes routine hearing exams and tests furnished for you by a *covered provider* and newborn hearing screening tests for a newborn child (an infant under three months of age) as provided by regulations of the Massachusetts Department of Public Health. (See "Well Newborn Care" for your *inpatient* coverage for newborn hearing screening tests.)

- **Hearing Aids and Related Services.** This includes hearing aids and *covered services* related to a covered hearing aid when the *covered services* are furnished by a *covered provider*, such as a licensed audiologist or licensed hearing instrument specialist. These *covered services* include: the initial hearing aid evaluation; one hearing aid for each hearing-impaired ear; fitting and adjustments of the hearing aid; and supplies such as (but not limited to) ear molds. No benefits are provided for replacement hearing aid batteries. The *Schedule of Benefits* for your plan option describes the *benefit limit* that applies for hearing aids—this means any age restriction, dollar benefit maximum for the hearing aid device itself, and/or eligible time period during which hearing aids and related services will be covered by your health plan. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.) If you choose a hearing aid device that costs more than your *benefit limit*, you will have to pay the balance of the cost of the device that is in excess of the *benefit limit*. (Any dollar benefit maximum does not apply for *covered services* related to the hearing aid.) As required by state law, this coverage is provided for at least $2,000 (for the hearing aid device itself) for one hearing aid for each hearing-impaired ear every 36 months for a *member* age 21 or younger (from birth through age 21).

Routine Vision Care

This health plan covers a periodic routine vision exam when it is furnished for you by an ophthalmologist or by an optometrist. The *Schedule of Benefits* for your plan option describes the *benefit limit* that applies for routine vision exams—this is the time period during which a routine vision exam will be covered by your health plan. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.) Once you have received this coverage, no more benefits will be provided for another exam during the same time period.

Vision Supplies

Your health plan may also cover certain vision supplies and *covered services* related to covered vision supplies when they are furnished by a *covered provider*, such as an ophthalmologist or an optometrist. Your *Schedule of Benefits* will tell you whether or not you have coverage for vision supplies and related services.

Your health plan may also include a *rider* to add or change coverage for vision supplies and related services. If this is the case, refer to your *rider* for information about your vision supply benefits.

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

Prosthetic Devices

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

- Artificial limb devices to replace (in whole or in part) an arm or a leg. This includes any repairs that are needed for the artificial leg or arm.
- Artificial eyes.
- Ostomy supplies; and urinary catheters.
- Breast prostheses. This includes mastectomy bras.
- Therapeutic/molded shoes and shoe inserts that are furnished for a *member* with severe diabetic foot disease.
- One wig (scalp hair prosthesis) in each calendar year (but no less than $350 in coverage each calendar year, as required by state law) for a *member* whose 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.
- Augmentative communication devices. An "augmentative communication device" is one that assists in restoring speech. It is needed when a *member* is unable to communicate due to an accident, illness, or disease such as amyotrophic lateral sclerosis (ALS).

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

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

Qualified Clinical Trials for Treatment of Cancer

This health plan covers health care services and supplies that are received by a *member* as part of a qualified clinical trial (for treatment of cancer) when the *member* is enrolled in that trial. This coverage is provided for health care services and supplies that are consistent with the study protocol and with the standard of care for someone with the patient's diagnosis, and that would be covered if the patient did not

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

---

participate in the trial. This coverage may also be provided for investigational drugs and devices that have been approved for use as part of the trial. This health plan coverage for health care services and supplies that you receive as part of a qualified clinical trial is provided to the same extent as it would have been provided if you did not participate in a trial.

No benefits are provided for:
- Investigational drugs and devices that have not been approved for use in the trial.
- Investigational drugs and devices that are paid for by the manufacturer, distributor, or provider of the drug or device, whether or not the drug or device has been approved for use in the trial.
- Non-*covered services* under your health plan.
- Costs associated with managing the research for the trial.
- Items, services, or costs that are reimbursed or otherwise furnished by the sponsor of the trial.
- Costs that are inconsistent with widely accepted and established national and regional standards of care.
- Costs for clinical trials that are not "qualified trials" as defined by law.

Other Approved Clinical Trials
In addition to clinical trials for cancer, this health plan covers a *member* who participates in an approved clinical trial for a life-threatening disease or condition, as required by federal law. This means a disease or condition from which death is likely unless the course of the disease is interrupted. This coverage is provided for *covered services* that are consistent with the study protocol and with the standard of care for a person with the *member's* condition; and, as long as the services would be covered if the *member* did not participate in the trial. But, no benefits are provided for an investigational drug or device, whether or not it has been approved for use in the trial. (This coverage does not apply if your health plan is a grandfathered health plan under the Affordable Care Act.)

Radiation Therapy and Chemotherapy
This health plan covers *outpatient* radiation and x-ray therapy and chemotherapy when it is furnished for you by a *covered provider*. This may include (but is not limited to): a physician; or a nurse practitioner; or a free-standing radiation therapy and chemotherapy facility; or a hospital; or a *covered provider* who has a recognized expertise in specialty pediatrics. This coverage includes:
- Radiation therapy using isotopes, radium, radon, or other ionizing radiation.
- X-ray therapy for cancer or when it is used in place of surgery.
- Drug therapy for cancer (chemotherapy).

Coverage for Orally-Administered Chemotherapy Drugs
In most cases, this health plan will provide full coverage based on the *allowed charge* for in-network or out-of-network anticancer prescription drugs that are orally administered to kill or slow the growth of cancerous cells. The only exception is when you are enrolled in a high deductible health plan with a health savings account. In this case, your *deductible* will apply to these *covered services*. Otherwise, any cost share amounts will not apply for these *covered services*. (This provision also applies when these prescription drugs are covered under your *Blue Cross and Blue Shield* prescription drug plan.)

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

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

Second Opinions

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

Short-Term Rehabilitation Therapy

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

This coverage is also provided when the short-term therapy is *medically necessary* habilitation therapy. Coverage for short-term habilitation therapy is most often included in the *benefit limit* for short-term rehabilitation therapy. But, the *benefit limit* for short-term habilitation therapy may be separate from the *benefit limit* for short-term rehabilitation therapy. If this is the case, the *Schedule of Benefits* for your plan option describes the separate *benefit limits* that apply for these *covered services*. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.)

What Are Rehabilitation and Habilitation Services
Rehabilitation services are those health care services that help a person keep, get back, or improve skills and functioning that have been lost or impaired because a person was sick, hurt, or disabled. Habilitation

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

services are those health care services that help a person keep, learn, or improve skills and functioning for daily living.

Speech, Hearing, and Language Disorder Treatment

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

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

Surgery as an Outpatient

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

- Routine circumcision.
- Voluntary termination of pregnancy (abortion).
- Voluntary sterilization procedures. To provide coverage for the women's preventive health services as recommended by the U.S. Department of Health and Human Services and, as required by state law, any in-network *deductible*, *copayment*, and/or *coinsurance*, whichever applies to you, will be waived for a sterilization procedure furnished for a female *member* when it is performed as the primary procedure for family planning reasons. Or, if you choose to have this service performed by a non-*preferred provider*, you must pay your *deductible*, when it applies, and 20% *coinsurance*. This is the case even if your health plan is a grandfathered health plan under the Affordable Care Act. This provision does not apply for hospital services. For all situations except as described in this paragraph, the cost share amount for elective surgery will still apply.
- Endoscopic procedures.
- Surgical procedures. This includes emergency and scheduled surgery. This coverage includes (but is not limited to):

  - **Reconstructive surgery.** This means non-dental surgery that is meant to improve or give you back bodily function or to correct a functional physical impairment that was caused by: a birth defect; a prior surgical procedure or disease; or an accidental injury. It also includes surgery to correct a deformity or disfigurement that was caused by an accidental injury. This coverage includes surgery to correct or repair disturbances of body composition caused by HIV associated lipodystrophy syndrome, when the *covered provider* has determined that this treatment is necessary to correct, repair, or lessen the effects of HIV associated lipodystrophy syndrome.

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

These services include, but are not limited to: reconstructive surgery, such as suction-assisted lipectomy; other restorative procedures; and dermal injections or fillers for reversal of facial lipoatrophy syndrome.

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

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

– **Oral surgery.** This means: reduction of a dislocation or fracture of the jaw or facial bone; excision of a benign or malignant tumor of the jaw; and orthognathic surgery that you need to correct a significant functional impairment that cannot be adequately corrected with orthodontic services. This coverage is provided when the surgery is furnished at a facility, provided that you have a serious medical condition that requires that you be admitted to a surgical day care unit of a hospital or to an ambulatory surgical facility in order for the surgery to be safely performed. This coverage is also provided when the surgery is furnished at an oral surgeon's office. (Orthognathic surgery is not covered when it is performed mainly for cosmetic reasons. This surgery must be performed along with orthodontic services. If it is not, the oral surgeon must send a letter to *Blue Cross and Blue Shield* asking for approval for the surgery. No benefits are provided for the orthodontic services, except as described in this Subscriber Certificate on page 36 for the treatment of conditions of cleft lip and cleft palate.)

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

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

- – Internal prostheses (artificial replacements of parts of the body) that are furnished by the health care facility as part of a covered surgery such as intraocular lenses that are implanted after corneal transplant, cataract surgery, or other covered eye surgery, when the natural eye lens is replaced.

- – Non-dental surgery and necessary postoperative care that is furnished for you by a dentist who is licensed to furnish the specific *covered service*. (See Part 6, "Dental Care.")

- Necessary postoperative care that you receive after covered *inpatient* or *outpatient* surgery.
- Anesthesia services that are related to covered surgery. This includes anesthesia that is administered by a physician other than the attending physician; or by a certified registered nurse anesthetist.
- Restorative dental services and orthodontic treatment or prosthetic management therapy for a *member* who is under age 18 to treat conditions of cleft lip and cleft palate. (See page 36 for more information.) If a *copayment* normally applies for office surgery, the office visit *copayment* will be waived for these *covered services*. Any *deductible* and *coinsurance* will still apply.

If a *covered provider's* office is located at, or professional services are billed by, a hospital, your cost share is the same amount as for an office visit.

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

Telehealth Services

This health plan covers telehealth services that are furnished by a *Blue Cross and Blue Shield covered provider* or by a *Blue Cross and Blue Shield* designated telehealth vendor. Telehealth services are synchronous or asynchronous communications (audio, video, or other approved electronic media or telecommunications technology including, but not limited to: interactive audio-video technology; remote patient monitoring devices; audio-only telephone; and online adaptive interviews) between you and the health care provider. Your health care provider will work with you to determine if a telehealth visit is medically appropriate for your health care needs or if an in-person visit is required. These services are available for medically appropriate *covered services*, including services to diagnose and/or treat *mental conditions*. The cost share amount that you will pay depends on the health care provider that furnishes the *covered service* to you. (See below.) For covered telehealth services, you will not have to pay any more than you would normally pay for the same in-person *covered service* with your health care provider. In

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

---

some cases, the cost share amount that you will pay for covered telehealth services may be less than you would pay for an in-person visit.

Note: Any *benefit limits* that may apply for a specific *covered service* will still apply when the *covered service* is furnished as a telehealth service. The *Schedule of Benefits* for your plan option and/or any *riders* that apply to your coverage in this health plan describe any *benefit limits* that apply to your coverage.

Telehealth Services with a Covered Provider

When medically appropriate telehealth services are furnished by a *Blue Cross and Blue Shield covered provider*, your cost share (such as *deductible*, *copayment*, and/or *coinsurance*) is the same amount as an in-person visit with that provider. Your *Schedule of Benefits* describes your cost share amount. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.) Your cost share for covered telehealth services may be lower than your in-person cost share. If this is the case, this will be described in a *rider*.

Telehealth Services with a Designated Telehealth Vendor

You may use a *Blue Cross and Blue Shield* designated telehealth vendor when you need care for a minor illness or injury such as a cough, a sore throat, or a fever; or you need care for a chronic condition; or you need mental health and substance use care for conditions or symptoms such as anxiety and depression; or you have a general health and wellness concern.

When medically appropriate *outpatient* telehealth services are furnished by a *Blue Cross and Blue Shield* designated telehealth vendor, your cost share (such as *deductible*, *copayment*, and/or *coinsurance*) is the same as the lowest cost share level that you would pay for similar services when they are furnished by a preferred physician for *outpatient* medical care or by a preferred *mental health provider* for mental health and substance use care. Your *Schedule of Benefits* describes your cost share amount. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.) Your cost share for covered *outpatient* telehealth services with a *Blue Cross and Blue Shield* designated telehealth vendor may be lower than your in-person cost share with a *covered provider*. If this is the case, this will be described in a *rider*.

<u>Exception for *covered services* furnished by a virtual care team primary care provider type</u>: When your specific plan option includes the "Virtual Care Team Model" *rider* and you receive *covered services* from a *Blue Cross and Blue Shield* virtual care team primary care provider type, your cost share for *outpatient* telehealth services furnished by a *Blue Cross and Blue Shield* designated telehealth vendor is <u>not</u> the same as the lowest cost share level that you would pay for similar services when they are furnished by a preferred physician for *outpatient* medical care. For *outpatient* telehealth services furnished by a *Blue Cross and Blue Shield* designated telehealth vendor, your cost share is the same telehealth cost share that you would pay for *covered services* furnished by a primary care provider type that is not a virtual care team primary care provider type as described in your *Schedule of Benefits* and/or *riders* that apply to your coverage in this health plan. Your cost share for covered *outpatient* telehealth services with a *Blue Cross*

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

---

and Blue Shield designated telehealth vendor may be lower than described in this paragraph. If this is the case, this will be described in a *rider*.

TMJ Disorder Treatment

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

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

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

Part 6

Limitations and Exclusions

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

Admissions That Start Before Effective Date

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

Benefits from Other Sources

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

Cosmetic Services and Procedures

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

There may be services that are usually considered cosmetic services but that meet *Blue Cross and Blue Shield's* criteria for coverage in certain situations, as defined in *Blue Cross and Blue Shield medical policies* or *medical technology assessment criteria*.

Custodial Care

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

Dental Care

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

Educational Testing and Evaluations

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

Exams or Treatment Required by a Third Party

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

Experimental Services and Procedures

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

- One or more stem cell ("bone marrow") transplants for a *member* who has been diagnosed with breast cancer that has spread. The *member* must meet the eligibility standards that have been set by the Massachusetts Department of Public Health.
- Certain drugs that are used on an off-label basis. Some examples of these drugs are: drugs used to treat cancer; drugs used to treat HIV/AIDS; and, long-term antibiotic therapy drugs for the treatment of Lyme disease, if the drug has been approved by the U.S. Food and Drug Administration (FDA) to treat other infectious diseases. (See "Home Health Care" for your coverage for long-term antibiotic therapy treatment of Lyme disease.)

Eyewear

No benefits are provided for eyeglasses and contact lenses, except as described as a *covered service* in Part 5 or in your *Schedule of Benefits* and/or *riders*.

Medical Devices, Appliances, Materials, and Supplies

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

- Devices such as: air conditioners; air purifiers; arch supports; bath seats; bed pans; bath tub grip bars; chair lifts; computerized communication devices (except for those that are described in Part 5);

computers; computer software; dehumidifiers; dentures; elevators; foot orthotics; hearing aids (except for those that are described in Part 5); heating pads; hot water bottles; humidifiers; orthopedic and corrective shoes that are not part of a leg brace; raised toilet seats; and shoe (foot) inserts.

- Special clothing, except for: gradient pressure support aids for lymphedema or venous disease; clothing needed to wear a covered device (for example, mastectomy bras and stump socks); and therapeutic/molded shoes and shoe inserts for a *member* with severe diabetic foot disease.
- Self-monitoring devices, except for certain devices that *Blue Cross and Blue Shield* decides would give a *member* having particular symptoms the ability to detect or stop the onset of a sudden life-threatening condition.

Missed Appointments

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

Non-Covered Providers

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

Non-Covered Services

No benefits are provided for:

- A service or supply that is not described as a *covered service*. Some examples of non-*covered services* are: private duty nursing; and reversal of sterilization.
- A service or supply that is furnished along with a non-*covered service*.
- A service or supply that does not conform to *Blue Cross and Blue Shield medical policies*.
- A service or supply that does not conform to *Blue Cross and Blue Shield medical technology assessment criteria*.
- A service or supply that is not considered by *Blue Cross and Blue Shield* to be *medically necessary* for you. The only exceptions are for: certain routine or other preventive health care services or supplies; certain covered voluntary health care services or supplies; and donor suitability for bone marrow transplant.
- A service or program, including a residential program, that is furnished in educational or vocational settings; or, services and/or programs that are not considered to be *inpatient* services, intermediate treatments, or *outpatient* services as described in this Subscriber Certificate. The only exception is for *outpatient covered services* to diagnose and/or treat *mental conditions* when these services are furnished by a *covered provider* along with one of these programs.
- A program for which *Blue Cross and Blue Shield* is not able to conduct concurrent review of continued *medical necessity* (see Part 4), including a program that has a pre-defined length of care or stay.
- A service or supply that is furnished by a health care provider who has not been approved by *Blue Cross and Blue Shield* for payment for the specific service or supply.
- A service or supply that is furnished to someone other than the patient, except as described in this Subscriber Certificate for: hospice services; and the harvesting of a donor's organ (or tissue) or stem cells when the recipient is a *member*. This coverage includes the surgical removal of the donor's

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

- A service or supply that you received when you were not enrolled in this health plan. (The only exception is for routine nursery charges that are furnished during a covered maternity admission and certain other newborn services.)
- A service or supply that is furnished to all patients due to a facility's routine admission requirements.
- A service or supply that is related to achieving pregnancy through a surrogate (gestational carrier).
- Refractive eye surgery for conditions that can be corrected by means other than surgery. This type of surgery includes radial keratotomy.
- Whole blood; packed red blood cells; blood donor fees; and blood storage fees.
- A health care provider's charge for shipping and handling, taxes, or travel expenses.
- A health care provider's charge to file a claim for you. Also, a health care provider's charge to transcribe or copy your medical records.
- A separate fee for services furnished by: interns; residents; fellows; or other physicians who are salaried employees of the hospital or other facility.
- Expenses that you have when you choose to stay in a hospital or another health care facility beyond the discharge time that is determined by *Blue Cross and Blue Shield*.
- Costs related to activities such as fitness or weight loss programs. Even though this health plan does <u>not</u> include health benefits for these costs, reimbursement for participation in qualified wellness programs may be available under a separate Wellness Participation Program *rider*. If this is the case, refer to your *rider* for information about qualified wellness program reimbursement.
- A service or supply that is either not legal or not legal in the location where performed or provided.

Personal Comfort Items

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

Private Room Charges

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

Services and Supplies Furnished After Termination Date

No benefits are provided for services and supplies that are furnished after your termination date in this health plan unless otherwise required by law.

<u>Exception for *inpatient* admissions prior to January 1, 2025</u>: For *inpatient* admissions that begin prior to January 1, 2025, this health plan will continue to provide coverage for *inpatient covered services*, but only if you are receiving covered *inpatient* care on your termination date. In this case, coverage will continue to be provided until all the benefits allowed by your health plan have been used up or the date of discharge, whichever comes first. But, this exception does not apply if your coverage in this health plan is canceled for misrepresentation or fraud.

Services Furnished to Immediate Family

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

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

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

Part 7

Other Party Liability

Coordination of Benefits (COB)

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

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

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

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

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

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

Subrogation and Reimbursement of Benefit Payments

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

Member Cooperation

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

Workers' Compensation

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

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

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

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

Part 8

Other Health Plan Provisions

Access to and Confidentiality of Medical Records

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

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

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

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

Acts of Providers

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

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

Assignment of Benefits

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

Authorized Representative and Legal Representative

You may choose to have another person act on your behalf concerning your health care coverage in this health plan. Some examples are a designated authorized representative or a documented legal representative. An authorized representative is a person you have chosen to help with your health care issues and to whom *Blue Cross and Blue Shield* is allowed to disclose and discuss your protected health information (PHI). An authorized representative is not a person who has legal authority to act on your behalf. A legal representative is a person who has legal authority to act on your behalf in making decisions about your health care. They may be someone who has legal authority for: power of attorney for health care; guardianship; conservatorship; executor of estate; or health care proxy. A legal representative may also be a person documented through a court order to act on your behalf in making decisions about your health care. To designate an authorized representative or document a legal representative, you must let *Blue Cross and Blue Shield* know in writing by completing the appropriate form(s). To get copies of these forms, you can call the *Blue Cross and Blue Shield* customer service office. The toll free phone number to call is shown on your ID card. You may also log on to the *Blue Cross and Blue Shield* Web site at **www.bluecrossma.org** to get a copy of these forms. In some cases, *Blue Cross and Blue Shield* may consider your health care facility or your physician or other health care provider to be your authorized representative. For example, *Blue Cross and Blue Shield* may tell your hospital that a proposed *inpatient* admission has been approved. Or, *Blue Cross and Blue Shield* may ask your physician for more information if more is needed for *Blue Cross and Blue Shield* to make a decision. *Blue Cross and Blue Shield* will consider the health care provider to be your authorized representative for *emergency medical care*. *Blue Cross and Blue Shield* will continue to send benefit payments and written communications regarding your health care coverage according to *Blue Cross and Blue Shield's* standard practices, unless you specifically ask *Blue Cross and Blue Shield* to do otherwise.

Changes to Health Plan Coverage

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

There may be times when the provisions of your coverage in this health plan change but *Blue Cross and Blue Shield* is not able to provide prior notice of the change as described above. These changes may be made by *Blue Cross and Blue Shield* as a result of events beyond its control such as: war; riot; national emergency; terrorist attack; public health emergency; pandemic; or natural disaster. When this happens, *Blue Cross and Blue Shield* will make a determination to provide services under this health plan based on the severity of the event and the needs of its *members* enrolled under this health plan during this time. For example, *Blue Cross and Blue Shield* may temporarily eliminate the cost share amount that you must pay for certain *covered services* such as your *copayment* or your *deductible* or your *coinsurance*.

Charges for Non-Medically Necessary Services

You may receive health care services that would otherwise be covered by this health plan, except that these services are not determined to be *medically necessary* for you by *Blue Cross and Blue Shield*. This health plan does not cover health care services or supplies that are not *medically necessary* for you. If you receive care that is not *medically necessary* for you, you might be charged for the care by the health care provider. A provider who has a payment agreement with *Blue Cross and Blue Shield* has agreed not to charge you for services that are not *medically necessary*, unless you were told, knew, or reasonably should have known before you received this treatment that it was not *medically necessary*.

Clinical Guidelines and Utilization Review Criteria

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

Disagreement with Recommended Treatment

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

Mandates for Residents or Services Outside of Massachusetts

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

Member Cooperation

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

Pre-Existing Conditions

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

Quality Assurance Programs

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

- A breast cancer screening program. It encourages female *members* who are over 50 to have mammograms.
- A cervical cancer screening program. It helps to get more female *members* who are age 18 and older to have a Pap smear test.
- A program that furnishes outreach and education to pregnant *members*. It adds to the care that the *member* gets from an obstetrician or nurse midwife.
- A program that promotes timely postnatal checkups.
- Diabetes management and education. This helps diabetic *members* to self-manage their diabetes. It also helps to identify high-risk *members* and helps to assess their ongoing needs.
- Congestive heart failure disease management, education, and monitoring.

Services Furnished by Non-Preferred Providers

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

- You receive *emergency medical care.*
- You receive services to diagnose or treat the 2019 novel coronavirus disease (COVID-19). See Part 5, "COVID-19 Testing and Treatment" for your coverage for these services.
- You receive *covered services* that are not reasonably available from a *preferred provider* (see "*covered provider*" in Part 2 of this Subscriber Certificate) and you had prior approval from *Blue Cross and Blue Shield* to obtain these *covered services*. Or, you receive *covered services* from a *covered provider* before a preferred network is established for that type of provider.
- You are traveling outside of Massachusetts and you receive *covered services* from a type of *covered provider* for which the local Blue Cross and/or Blue Shield Plan has not, in the opinion of *Blue Cross and Blue Shield*, established an adequate PPO health care network.
- You receive *medically necessary covered services* while you are at a preferred hospital or other preferred facility and you do not have a reasonable opportunity to choose to have your *covered services* furnished by a *preferred provider*. For example, you receive *covered services* from a non-preferred hospital-based anesthetist, pathologist, or radiologist while you are at a preferred hospital.
- You receive certain *covered services* that are protected from surprise billing as described in Part 2. (See "Allowed Charge" for more information.)
- You are a newly enrolled *group member* who is having an ongoing course of treatment from a physician (or a primary care provider that is a nurse practitioner or physician assistant) who does not participate in your health care network, and your *group* only offers its employees a choice of health insurance plans in which your physician (or your primary care provider that is a nurse practitioner or physician assistant) does not participate as a *covered provider*. In this case, this health plan will provide coverage for *covered services* you get from that health care provider up to 30 days from your *effective date* or, for a *member* who is in the second or third trimester of pregnancy, up through the first post-partum visit or, for a *member* with a terminal illness, until the *member's* death. (For a *member* with a terminal illness, this coverage is provided only when the *member* is expected to live six months or less as determined by a physician.)

This health plan will also provide in-network benefits in the event Medicare is your primary payor (as allowed by federal law) and you receive *covered services* from a non-*preferred provider* outside of Massachusetts and that provider accepts Medicare assignment, whether or not the provider participates with the local Blue Cross and/or Blue Shield Plan. (Medicare assignment is an agreement by the provider to accept the Medicare-approved amount as payment in full for services furnished.)

When Your Provider Disenrolls (or is Involuntarily Disenrolled) From the Network

If your provider disenrolls from the network for a reason other than a quality-related reason or fraud, this health plan will provide coverage for *covered services* that you receive from a health care provider who does not participate in your health care network. As required by law, this continuity of care coverage is described below in this section. If you receive *covered services* from a covered health care provider who does not participate in your health care network, you may receive coverage from this health plan **only when**:

- Your provider disenrolls from your health care network and you are a *member* who is receiving *covered services* for the situations listed below. If this is the case, this health plan will notify you that the health care provider is no longer part of the health care network.
  - You are undergoing a course of treatment for a serious and complex condition; you are undergoing a course of institutional or *inpatient* care; or you are scheduled to undergo non-elective surgery (including postoperative care). This health plan will also notify you of your right to request to continue to have benefits provided for *covered services* from that health care provider for up to 90 days after the provider disenrolls from your health care network or when the course of treatment is completed, whichever comes first.
  - You are pregnant and undergoing a course of treatment for the pregnancy. This health plan will also notify you of your right to request to continue to have benefits provided for *covered services* from that health care provider for up to 90 days after the provider disenrolls from your health care network or through your first post-partum visit, whichever is longer.
  - You are determined to be terminally ill. This health plan will also notify you of your right to request to continue to have benefits provided for *covered services* from that health care provider for as long as the *covered services* are needed.
- Your provider is involuntarily disenrolled from your health care network and you are a *member* who is in the second or third trimester of pregnancy. In this case, this health plan will provide coverage for *covered services* you get from that health care provider for your pregnancy up through the first post-partum visit.
- Your provider is involuntarily disenrolled from your health care network and you are a *member* with a terminal illness. In this case, this health plan will provide coverage for *covered services* you get from that health care provider for the terminal illness. (This coverage is continued only when the terminally ill *member* is expected to live six months or less as determined by a physician.

Services in a Disaster

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

There may be times when *Blue Cross and Blue Shield* provides coverage for services and/or supplies due to events beyond its control that are not described in this Subscriber Certificate. (See "Changes to Health Plan Coverage" in this Part 8 for more information.)

Time Limit for Legal Action

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

Part 9

Filing a Claim

When the Provider Files a Claim

The health care provider will file a claim for you when you receive a *covered service* from a *covered provider* who has a payment agreement with *Blue Cross and Blue Shield*. Or, for *covered services* you receive outside of Massachusetts, a health care provider will file a claim for you when they have a payment agreement with the local Blue Cross and/or Blue Shield Plan. Just tell the health care provider that you are a *member* and show the health care provider your ID card. Also, be sure to give the health care provider any other information that is needed to file your claim. You must properly inform your health care provider within 30 days after you receive the *covered service*. If you do not, coverage will not have to be provided. *Blue Cross and Blue Shield* will pay the health care provider directly for *covered services* when the provider has a payment agreement with *Blue Cross and Blue Shield* or with the local Blue Cross and/or Blue Shield Plan. (When you are outside the United States, Puerto Rico, and the U.S. Virgin Islands and the Blue Cross Blue Shield Global Core Service Center has arranged your *inpatient* admission, the hospital should file the claim for you. In this case, the hospital will usually bill you only for your *deductible* and/or your *copayment* and/or your *coinsurance*, whichever applies. But, if you paid the hospital's actual charge in full at the time of the service, you must submit a claim as described in the section below.)

When the Member Files a Claim

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

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

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

When you receive *covered services* outside the United States, Puerto Rico, and the U.S. Virgin Islands, you must file your claim to the Blue Cross Blue Shield Global Core Service Center. (The Blue Cross Blue

Shield Global Core Claim Form you receive from *Blue Cross and Blue Shield* will include the address to mail your claim.) You can get help with filing your claim by calling the service center at **1-800-810-BLUE**.

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

Timeliness of Claim Payments

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

Missing Information

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

- **Missing Information Received Within 45 Days.** If the additional information is provided to *Blue Cross and Blue Shield* within 45 calendar days of *Blue Cross and Blue Shield's* request, *Blue Cross and Blue Shield* will make a decision within the time remaining in the original 30-day claim determination period. Or, *Blue Cross and Blue Shield* will make the decision within 15 calendar days of the date that the additional information is received by *Blue Cross and Blue Shield*, whichever is later.

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

Part 10

Appeal and Grievance Program

You have the right to a full and fair review when you disagree with a decision that is made by *Blue Cross and Blue Shield* to deny a request for coverage or payment for services; or you disagree with how your claim was paid; or you are denied coverage in this health plan; or your coverage is canceled or discontinued by *Blue Cross and Blue Shield* for reasons other than nonpayment of *premium*. You also have the right to a full and fair review when you have a complaint about the care or service you received from *Blue Cross and Blue Shield* or from a provider who participates in your health care network. Part 10 explains the process for handling these types of problems and concerns.

When making a determination under this health plan, *Blue Cross and Blue Shield* has full discretionary authority to interpret this Subscriber Certificate and to determine whether a health service or supply is a *covered service* under this health plan. All determinations by *Blue Cross and Blue Shield* with respect to benefits under this health plan will be conclusive and binding unless it can be shown that the interpretation or determination was arbitrary and capricious.

Inquiries and/or Claim Problems or Concerns

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

Blue Cross and Blue Shield will consider all aspects of the particular case when resolving a problem or concern. This includes looking at: all of the provisions of this health plan; the policies and procedures that support this health plan; the health care provider's input; and your understanding of coverage by this health plan. *Blue Cross and Blue Shield* may use an individual consideration approach when *Blue Cross and Blue Shield* judges it to be appropriate. *Blue Cross and Blue Shield* will follow its standard guidelines when it resolves your problem or concern.

If after speaking with a *Blue Cross and Blue Shield* customer service representative, you still disagree with a decision that is given to you, you may request a formal review through the *Blue Cross and Blue Shield* Member Appeal and Grievance Program. You may also request a formal review if *Blue Cross and Blue Shield* has not responded to you within three working days of receiving your inquiry. If this does happen, *Blue Cross and Blue Shield* will notify you and let you know the steps you may follow to request a formal review.

Appeal and Grievance Review Process

Internal Formal Review

How to Request an Internal Formal Appeal or Grievance Review

To request an internal formal *appeal* or *grievance* review, you (or your authorized or legal representative) have three options:

- **To write or send a fax.** The preferred option is for you to send your request for an *appeal* or a *grievance* review in writing to: **Member Appeal and Grievance Program, Blue Cross Blue Shield**

of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Or, you may fax your request 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. When you send your request, you should be sure to include any documentation that will help the review.

- **To send an e-mail.** You may send your request for an *appeal* or a *grievance* review to the *Blue Cross and Blue Shield* Member Appeal and Grievance Program e-mail 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. When you send your request, you should be sure to include any documentation that will help the review.

- **To make a telephone call.** You may call the *Blue Cross and Blue Shield* Member Appeal and Grievance Program at **1-800-472-2689**. When your request is made by phone, *Blue Cross and Blue Shield* will send you a written account of your request for an *appeal* or a *grievance* review within 48 hours of your phone call.

Before you make an *appeal* or file a *grievance*, you should read "What to Include in an Appeal or Grievance Review Request" that shows later in this section.

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

All requests for an *appeal* or a *grievance* review must be received by *Blue Cross and Blue Shield* within 180 calendar days of the date of treatment, event, or circumstance which is the cause of your dispute or complaint, such as the date you were told of the service denial or claim denial.

Office of Patient Protection
The Massachusetts Office of Patient Protection can help *members* with information and reports about health plan appeals and complaints. To contact that office, you can call **1-800-436-7757**. Or, you can fax a request to **1-617-624-5046**. Or, you can go online and log on to the Office of Patient Protection's Web site at **www.mass.gov/hpc/opp**.

What to Include in an Appeal or Grievance Review Request
Your request for an internal formal *appeal* or *grievance* review should include: the name, ID number, and daytime phone 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.

- **Appealing a Coverage Decision.** A "coverage decision" is a decision that *Blue Cross and Blue Shield* makes about your coverage or about the amount *Blue Cross and Blue Shield* will pay for your health care services or drugs. For example, your doctor may have to contact *Blue Cross and Blue Shield* and ask for a coverage decision before you receive proposed services. Or, a coverage decision is made when *Blue Cross and Blue Shield* decides what is covered and how much you will pay for services you have already received. In some cases, *Blue Cross and Blue Shield* might decide a service or drug is not covered or is no longer covered for you. You can make an *appeal* if you disagree with a coverage decision made by *Blue Cross and Blue Shield*.

When you make an *appeal* about a *medical necessity* coverage decision, *Blue Cross and Blue Shield* will review your health plan contract and the policies and procedures that are in effect for your *appeal* along with medical treatment information that will help in the review. Some examples of the medical information that will help *Blue Cross and Blue Shield* review your *appeal* may include: medical records related to your *appeal*, provider consultation and office notes, and related lab or other test results. If *Blue Cross and Blue Shield* needs to review your medical records and you have not provided your consent, *Blue Cross and Blue Shield* will promptly send you an authorization form to sign. You must return this signed form to *Blue Cross and Blue Shield*. It will allow for the release of your medical records. You 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 *appeal*, including the identity of any experts who were consulted.

If you disagree with how your claim was paid or you are denied coverage for a specific health care service or drug, you can make an *appeal* about the coverage decision. *Blue Cross and Blue Shield* will review the health plan contract that is in effect for your *appeal* to see if all of the rules were properly followed and to see if the service or drug is specifically excluded or limited by your health plan. The *appeal* decision will be based on the terms of your health plan contract. For example, if a service is excluded or limited by your health plan contract, no benefits can be provided even if the services are *medically necessary* for you. For this reason, you should be sure to review all parts of your health plan contract for any coverage limits and exclusions. These parts include your Subscriber Certificate and *Schedule of Benefits* and *riders* (if there are any) that apply for your health plan contract.

- **Filing a Grievance.** You can file a *grievance* when you have a complaint about the care or service you received from *Blue Cross and Blue Shield* or from a health care provider who participates in your health care network. Some examples of these types of problems are: you are unhappy with the quality of the care you have received; you are having trouble getting an appointment or waiting too long to get care; or you are unhappy with how the customer service representative has treated you. If you submit a formal *grievance* about the quality of care you received from a *Blue Cross and Blue Shield* provider, *Blue Cross and Blue Shield* will contact you to obtain your permission to contact the provider (if your permission is not included in your formal *grievance*). For this type of *grievance*, *Blue Cross and Blue Shield* will investigate the *grievance* with your permission, but the results of any provider peer review are confidential. For this reason, you will not receive the results of this type of investigation.

Choosing an Authorized Representative
You may choose to have another person act on your behalf during the *appeal* or *grievance* review process. Except as described below, you must designate this person in writing to *Blue Cross and Blue Shield*.

If your claim is for *urgent care* or *emergency medical care* services, a health care professional who has knowledge about your medical condition may act as your authorized representative. In this case, you do not have to designate the health care professional in writing. If you are not able to designate another person to act on your behalf, then a conservator, a person with power of attorney, or a family member may act as your authorized representative. Or, they may appoint someone else to act as your authorized representative.

Who Handles the Appeal or Grievance Review

All *appeals* and *grievances* are reviewed by professionals who are knowledgeable about *Blue Cross and Blue Shield* and the issues involved in the *appeal* or *grievance*. The professionals who will review your *appeal* or *grievance* will be different from those who participated in *Blue Cross and Blue Shield's* prior decision regarding the subject of your *appeal* or *grievance*, nor will they work for anyone who did. When a review is related to a *medical necessity* denial, at least one reviewer will be an individual who is an actively practicing health care professional in the same or similar specialty who usually treats the medical condition or performs the procedure or provides treatment that is the subject of your review.

Response Time for an Appeal or Grievance Review

The review and response for an internal formal *appeal* or *grievance* review will be completed within 30 calendar days. Every reasonable effort will be made to speed up the review for requests that involve health care services that are soon to be obtained by the *member*.

Blue Cross and Blue Shield may extend the 30-calendar-day time frame to complete a review when both *Blue Cross and Blue Shield* and the *member* agree that additional time is required to fully investigate and respond to the request. *Blue Cross and Blue Shield* may also extend the 30-calendar-day time frame when the review requires your medical records and *Blue Cross and Blue Shield* needs 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 *Blue Cross and Blue Shield* does not receive your authorization within 30 working days after your request for a review is received, *Blue Cross and Blue Shield* may make a final decision about your request without that medical information. In any case, for a 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 request for a review.

An *appeal* or *grievance* that is not acted upon within the time frames specified by applicable federal or state law will be considered resolved in favor of the *member*.

Important Note: If your *appeal* or *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 an internal formal review.

Written Response for an Appeal or Grievance Review

Once the 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. This notice will include: information related to the details of your *appeal* or *grievance*; the reasons that *Blue Cross and Blue Shield* has denied the request and the applicable terms of your coverage in this health plan; the specific medical and scientific reasons for which *Blue Cross and Blue Shield* has denied the request; any alternative treatment or health care services and supplies that would be covered; *Blue Cross and Blue Shield* clinical guidelines that apply and were used and any review criteria; and how to request an external review.

Appeal and Grievance Review Records

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 *appeal* or *grievance*. These copies will be free of charge. *Blue Cross and Blue Shield* will maintain a record of all formal *appeals* and *grievances*, including the response for each review, for up to seven years.

Expedited Review for Immediate or Urgently-Needed Services
In place of the internal formal review as described above in this section, 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 respond to formal requests for a review for immediate or urgently-needed services as follows:

- When your request for a review concerns medical care or treatment for which waiting for a response under the review time frames described above would seriously jeopardize your life or health or your ability to regain maximum function as determined by *Blue Cross and Blue Shield* or your physician, or if your physician says that you will have severe pain that cannot be adequately managed without the care or treatment that is the subject of the review, *Blue Cross and Blue Shield* will review your request and notify you of the decision within 72 hours after your request is received, or such shorter time period as required by federal law.
- When a formal review is requested while you are an *inpatient*, *Blue Cross and Blue Shield* will complete the review and make a decision regarding the request before you are discharged from that *inpatient* stay.
- *Blue Cross and Blue Shield's* decision to deny payment for health care services, including durable medical equipment, may be reversed within 48 hours if your attending physician certifies to *Blue Cross and Blue Shield* that a denial for those health care services would create a substantial risk of serious harm to you if you were to wait for the outcome of the normal formal review process. Your physician can also request the reversal of a denial for durable medical equipment earlier than 48 hours by providing more specific information to *Blue Cross and Blue Shield* about the immediate and severe harm to you.
- A formal review requested by a *member* with a terminal illness will be completed by *Blue Cross and Blue Shield* within five working days of receiving the request. In this case, if the expedited review results in a denial for health care services or treatment, *Blue Cross and Blue Shield* will send a letter to the *member* within five working days. This letter will include: information related to the details of the request for a review; the reasons that *Blue Cross and Blue Shield* has denied the request and the applicable terms of your coverage in this health plan; the specific medical and scientific reasons for which *Blue Cross and Blue Shield* has denied the request; any alternative treatment or health care services and supplies that would be covered; *Blue Cross and Blue Shield* clinical guidelines that apply and were used and any review criteria; and how to request a hearing. When the *member* requests a hearing, the hearing will be held within ten days. (Or, it will be held within five working days if the attending physician determines after consultation with *Blue Cross and Blue Shield's* Medical Director and based on standard medical practice that the effectiveness of the health care service, supply, or treatment would be materially reduced if it were not furnished at the earliest possible date.) You and/or your authorized or legal representative(s) may attend this hearing.

External Review

You must first go through the *Blue Cross and Blue Shield* internal formal *appeal* and *grievance* review process as described above, unless *Blue Cross and Blue Shield* has failed to comply with the time frames for the internal formal review or if you (or your authorized or legal representative) are requesting an expedited external review at the same time you (or your authorized or legal representative) are requesting an expedited internal review. The *Blue Cross and Blue Shield* internal formal review decision may be to continue to deny all or part of your coverage in this health plan. When you are denied coverage for 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. You are not required to pursue an external review. Your decision whether to pursue an external review will not affect your other coverage. If you receive a denial letter from *Blue Cross and Blue Shield* in response to your internal formal review, the letter will tell you what steps you can take to file a request for an external review. The external review will be conducted by a review agency under contract with the Massachusetts Office of Patient Protection.

How to Request an External Review

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 or legal 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 fee required to pay for your portion of the cost of the review. The form, as well as the denial letter from *Blue Cross and Blue Shield*, will tell you about your fee. *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 four months after you receive the denial letter from *Blue Cross and Blue Shield*.**

You (or your authorized or legal representative) also have the right to request an "expedited" external review. When requesting an expedited external review, you 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. You (or your authorized or legal representative) also have the right to request an expedited external review at the same time that you file a request for an expedited internal formal review.

If your request for a review 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 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 review. This continuation of coverage does not apply to services: that are limited by a day, dollar, or visit *benefit limit* and that exceed the *benefit limit*; that are non-*covered services*; or that were received prior to the time you requested the external review.

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

External Review Process

The Office of Patient Protection will screen all requests for an external review. They will begin this screening within 48 hours of receiving a request for an expedited external review and within five business days for all other external review requests. The Office of Patient Protection will determine if your request for an external review: has been submitted as required by state regulation and described above; does not involve a service or benefit that is excluded by your health plan as explicitly stated in your health plan contract; and results from an adverse determination, except that no adverse determination is necessary when *Blue Cross and Blue Shield* has failed to comply with the timelines for an internal *appeal* or *grievance* review or if you (or your authorized or legal representative) are requesting an expedited external review at the same time you are requesting an expedited internal formal review.

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 or legal 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.

External Review Decisions and Notice

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 or legal representative) and to *Blue Cross and Blue Shield* within 45 calendar days of receiving the referral from the Office of Patient Protection. In the case of an expedited review, you will be notified of their decision within 72 hours. This 72-hour period starts when the review agency receives your case from the Office of Patient Protection.

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 or legal 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: what steps or procedures you must take (if any) to obtain the requested coverage or services; the date by which *Blue Cross and Blue Shield* will pay for or authorize the requested services; and the name and phone number of the person at *Blue Cross and Blue Shield* who will make sure your *appeal* or *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 *appeal* or *grievance*. These copies will be free of charge.

Part 11

Group Policy

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

Eligibility and Enrollment for Group Coverage

Eligible Employee

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

Eligible Spouse

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

Former Spouse

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

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

Eligible Dependents

The *subscriber* may enroll eligible dependents for coverage in this health plan under their *group contract*. "Eligible dependents" include the *subscriber's* (or *subscriber's* spouse's) children until the end of the calendar month in which the child turns age 26. To be an eligible dependent, the child is not required to live with the *subscriber* or the *subscriber's* spouse, be a dependent on the *subscriber's* or spouse's tax return, or be a full-time student. These eligible dependents may include:

- A newborn child. The *effective date* of coverage for a newborn child will be the child's date of birth provided that the *subscriber* formally notifies the *plan sponsor* within 30 days of the date of birth. (A claim for a *member's* maternity admission may be considered by *Blue Cross and Blue Shield* to be this notice when the *subscriber's* coverage is a family plan.) This health plan provides coverage for newborn infants for injury and sickness. This includes the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth. The coverage for these services is subject to all of the provisions of this health plan.
- An adopted child. The *effective date* of coverage for an adopted child will be the date of placement of the child 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 they assume custody of a child for the purpose of adoption, the child's health care services for injury or sickness will be covered from the date of custody. (This coverage is provided without a waiting period or pre-existing condition restriction.) This includes the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth. The coverage for these services is subject to all of the provisions of this health plan.
- A newborn infant of an enrolled dependent child immediately from the moment of birth and continuing after, until the enrolled dependent child is no longer eligible as a dependent.

If an eligible dependent child is married, the dependent child can enroll for coverage under the *subscriber's group contract*. And, as long as that enrolled child is an eligible dependent, their children are also eligible for coverage under the *subscriber's group contract*. The dependent child's spouse is **not** eligible to enroll as a dependent for coverage under the *subscriber's group contract*.

An eligible dependent may also include:

- A person under age 26 who is not the *subscriber's* (or *subscriber's* spouse's) child but who qualifies as a dependent of the *subscriber* under the Internal Revenue Code. When the dependent loses their dependent status under the Internal Revenue Code, that dependent will continue to be eligible as a dependent for coverage in this health plan under the *subscriber's group contract* for two years after the end of the calendar year in which they last qualified as a dependent under the Internal Revenue Code or until the dependent turns age 26, whichever comes first.
- A child recognized under a Qualified Medical Child Support Order as having the right to enroll for health care coverage.
- A disabled dependent child age 26 or older. A dependent child who is mentally or physically incapable of earning their own living and who is enrolled under the *subscriber's group contract* will continue to be covered after they would otherwise lose dependent eligibility under the *subscriber's group contract*, so long as the child continues to be mentally or physically incapable of earning their own living. In this case, the *subscriber* must make arrangements with *Blue Cross and Blue Shield* through the *plan sponsor* not more than 30 days after the date the child would normally lose eligibility. Also, *Blue Cross and Blue Shield* must be given any medical or other information that it may need to determine if the child can maintain coverage in this health plan under the *subscriber's group contract*. From time to time, *Blue Cross and Blue Shield* may conduct reviews that will require a statement from the attending physician. This is to confirm that the child is still an eligible disabled dependent child.

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

Enrollment Periods for Group Coverage

Initial Enrollment

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

Special Enrollment

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

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

These rights are known as your "special enrollment rights." There may be additional special enrollment rights as a result of changes required by federal law. For example, these changes may include special enrollment rights for: individuals who are newly eligible for coverage as a result of changes to dependent eligibility; and/or individuals who are newly eligible for coverage as a result of the elimination of a lifetime maximum.

Loss of Other Qualified Coverage

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

- The employee or the eligible dependents (including a spouse) cease to be eligible for the other qualified health plan. For example, this could mean that the loss of the other qualified health plan was due to: the loss of the spouse's coverage; the death of the spouse; divorce; loss of dependent status; or involuntary termination. This includes when an employee or eligible dependent is covered under a Medicaid plan or a state Children's Health Insurance Program plan and coverage is terminated as a result of loss of eligibility for that coverage.
- The employer that is sponsoring the other qualified group health plan coverage ceases to make employer contributions for the other group health plan coverage.
- The employee or the eligible dependents (including a spouse) exhaust their continuation of group coverage under the other qualified group health plan.

- The prior qualified health plan was terminated due to the insolvency of the health plan carrier.

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

New Dependents

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

Special Enrollment Time Requirement

To exercise your special enrollment rights, you must notify your *plan sponsor* no later than 30 days after the date when any one of the following situations occur: the date on which the loss of your other coverage occurs or the date on which the *subscriber* gains a new dependent; or the date on which the *subscriber* receives notice that a dependent child who was not previously eligible is newly eligible for coverage as a result of changes to dependent eligibility; or the date on which you receive notice that you are newly eligible for coverage as a result of the elimination of a lifetime maximum. For example, if your coverage under another health plan is terminated, you must request enrollment for coverage in this health plan under a *group contract* within 30 days after your other health care coverage ends. Upon request, the *plan sponsor* will send you any special forms you may need. If you do not request enrollment within 30 days, you will have to wait until the *group's* next open enrollment period to enroll under a *group contract*. You also have special enrollment rights related to termination of coverage under a state Children's Health Insurance Program plan or a Medicaid plan or eligibility for assistance under a Medicaid plan or a state Children's Health Insurance Program plan. When this situation applies, you must notify your *plan sponsor* to request coverage no later than 60 days after the coverage terminates or the employee or eligible dependent is determined to be eligible for assistance.

Qualified Medical Child Support Order

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

Open Enrollment Period

If you choose not to enroll for coverage in this health plan under a *group contract* within 30 days of your initial *group* eligibility date, you may enroll during your *group's* open enrollment period. The open enrollment period is the time each year during which eligible persons may enroll for or change coverage for the next year. The open enrollment period is announced by the *group* to all eligible employees. To enroll for coverage in this health plan under a *group contract* during this enrollment period, you must complete the enrollment form provided in the *group's* enrollment packet and return it to the *group* no later than the date specified in the *group's* enrollment packet.

Other Membership Changes

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

Termination of Group Coverage

Loss of Eligibility for Group Coverage

When your eligibility for a *group contract* ends, your coverage in this health plan under the *group contract* will be terminated as of the date you lose eligibility (subject to the continuation of coverage provisions described on page 97). You will not be eligible for coverage in this health plan under a *group contract* when any one of the following situations occurs.

- **Subscriber's Group Eligibility Ends.** Your coverage in this health plan under a *group contract* will end when the *subscriber* loses eligibility for the *group's* health care coverage. This means: the *subscriber's* hours are reduced; or the *subscriber* leaves the job; or the *subscriber* no longer meets the rules that are set by the *group* for coverage under the *group contract*. (You will also lose eligibility for *group* coverage if you are an enrolled dependent when the *subscriber* dies.)

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

- **You Turn Age 65 and Become Eligible for Medicare.** Your coverage in this health plan under a *group contract* will end when you reach age 65 and become eligible for Medicare (Part A and Part B). However, as allowed by federal law, the *subscriber* (and the spouse and/or dependents) may have the option of continuing coverage in this health plan under a *group contract* when the *subscriber* remains as an actively working employee after reaching age 65. You should review all options available to you with the *plan sponsor*. (Medicare eligible *subscribers* who retire and/or their spouses are not eligible to continue coverage in this health plan under a *group contract* once they reach age 65.)

- **Your Group Fails to Pay Premiums.** Your coverage in this health plan under a *group contract* will end when the *plan sponsor* fails to pay the *group premium* to *Blue Cross and Blue Shield* within 30 days of the due date. In this case, *Blue Cross and Blue Shield* will notify you in writing of the termination of your *group* coverage in accordance with the Code of Massachusetts Regulations. This notice will give you information about the termination of your *group* coverage and your options for coverage offered by *Blue Cross and Blue Shield* or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

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

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

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

- **You Commit Misrepresentation or Fraud.** Your coverage in this health plan will be canceled, or in some cases *Blue Cross and Blue Shield* may limit your benefits, if you have committed misrepresentation or fraud. For example, you gave false or misleading information on the enrollment form. Or, you misused your ID card by letting another person who was not enrolled in this health plan attempt to get coverage. Your coverage in this health plan may be terminated when the fraud or misrepresentation is discovered or, as permitted by law, back to your *effective date* or the date of the misrepresentation or fraud. Your coverage in this health plan may be terminated retroactive to a date in the past (rather than on a current or future date) only if you committed fraud or made an intentional misrepresentation of a material fact. The termination date will be determined by *Blue Cross and Blue Shield*.

- **You Commit Acts of Physical or Verbal Abuse.** Your coverage in this health plan will be canceled if you commit acts of physical or verbal abuse that pose a threat to, or a threat to the health of, health care providers or other *members* or employees of *Blue Cross and Blue Shield* or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc., and these acts are not related to your physical condition or *mental condition*. In this case, this termination will follow the procedures that have been approved by the Massachusetts Commissioner of Insurance.

- **You Fail to Comply with Plan Provisions.** Your coverage in this health plan will be canceled if you fail to comply in a material way with any provision of the *group contract*. For example, if you fail to provide information that *Blue Cross and Blue Shield* requests related to your coverage in this health plan, *Blue Cross and Blue Shield* may terminate your coverage.

- **This Health Plan Is Discontinued.** Your coverage in this health plan will be canceled if *Blue Cross and Blue Shield* discontinues this health plan. *Blue Cross and Blue Shield* may discontinue this health plan for any reason as of a date approved by the Massachusetts Commissioner of Insurance.

Continuation of Group Coverage
Family and Medical Leave Act
An employee may continue coverage in this health plan under a *group contract* as provided by the Family and Medical Leave Act. The Family and Medical Leave Act will generally apply to you if your *group* has 50 or more employees. For more information, contact your *plan sponsor*. If the employee chooses to continue *group* coverage during a qualifying leave, the employee will be given the same health care

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

If coverage in this health plan under the *group contract* is discontinued due to non-payment of *premium*, the employee's coverage will be restored when they return 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 they return to work. This includes: new or additional waiting periods; waiting for an open enrollment period; or passing a medical exam to reinstate coverage. You should contact your *plan sponsor* with any questions that you may have about your coverage during a leave of absence.

Limited Extension of Group Coverage under State Law

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

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

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

Continuation of Group Coverage under Federal or State Law

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

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

spouse may be eligible to continue *group* coverage in this health plan under a separate *group contract* for additional *premium*.)
- Death of the *subscriber*.
- *Subscriber's* entitlement to Medicare benefits.
- Loss of status as an eligible dependent.

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

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

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

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

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

Enrollment for Continued Group Coverage
In order to enroll for continued *group* coverage in this health plan, you must complete an Election Form. The completed election form must be returned to the office at the address on the form. The form must be returned within 60 days from your date of termination of *group* coverage or your notification of

eligibility, whichever is later. If you do not return the completed form, it will be considered a waiver. And, you will not be allowed to continue coverage in this health plan under a *group contract*. (The 60 days will be counted from the date of the eligibility notice to the postmarked date of the mailed election form.)

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

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

Medicare Program

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

Under Age 65 with End Stage Renal Disease (ESRD)

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

Under Age 65 with Other Disability

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

Age 65 or Older

If your *group* employs 20 or more employees and if you are age 65 or older and are eligible for Medicare only because of age, this health plan will provide benefits before Medicare benefits as long as you have chosen this health plan as your primary payor. This can be the case only if you are an actively employed *subscriber* or the enrolled spouse of the actively employed *subscriber*. (If you are actively employed at the time you reach age 65 and become eligible for Medicare, you must choose between Medicare and this *contract* as the primary payor of your health care benefits. For more help, contact your *plan sponsor*.)

Dual Medicare Eligibility

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

Part 12

Individual Policy

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

Eligibility and Enrollment for Individual Coverage

Eligible Individual

You are eligible for coverage in this health plan under an *individual contract* as long as you are a resident of Massachusetts. A "resident" is a person who lives in Massachusetts as shown by evidence that is considered acceptable by *Blue Cross and Blue Shield*. This means *Blue Cross and Blue Shield* may ask you for evidence such as a lease or rental agreement, a mortgage bill, or a utility bill. The fact that you are in a nursing home, a hospital, or other institution does not by itself mean you are a resident. And, you are not a resident if you come to Massachusetts to receive medical care or to attend school but you still have residency outside of Massachusetts.

If you are under age 18 and you are requesting to enroll as a *subscriber*, the enrollment form must be completed by your parent or guardian. In this case, the person who is executing the contract (your parent or guardian) is not eligible for benefits under your coverage in this health plan. But, they will be responsible for acting on behalf of the *subscriber* as necessary and for paying the monthly *premium* for your coverage. The person who executes the contract will be considered your authorized representative.

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

Eligible Spouse

The *subscriber* may enroll an eligible spouse for coverage in this health plan under their *individual contract*. An "eligible spouse" includes the *subscriber's* legal spouse or legal civil union spouse. An eligible spouse must also meet all of the same eligibility conditions as described above for an eligible individual. (If the spouse is eligible for Medicare, this health plan cannot be issued to the spouse. You should use the Guide to Health Insurance for People with Medicare to find a health plan that is designed to supplement Medicare. To ask for a copy of the Guide, you can call the *Blue Cross and Blue Shield* customer service office.)

Former Spouse

In the event of a divorce or a legal separation, the person who was the spouse of the *subscriber* prior to the divorce or legal separation may maintain coverage in this health plan under the *subscriber's* *individual contract*. This coverage may continue only until: the *subscriber* is no longer required by the divorce judgment to provide health insurance for the former spouse; or the *subscriber* or former spouse remarries. In either case, the former spouse may wish to enroll as a *subscriber* under their own *individual contract*. The *Blue Cross and Blue Shield* customer service office can help you with these options. In these situations, *Blue Cross and Blue Shield* must be notified within 30 days of a change to the former spouse's address. Otherwise, *Blue Cross and Blue Shield* will not be liable for any acts or omissions due to having the former spouse's incorrect address on file.

Eligible Dependents

The *subscriber* may enroll eligible dependents for coverage in this health plan under their *individual contract*. Eligible dependents must meet all of the same eligibility conditions as described above for an eligible individual. However, a dependent child may live outside of Massachusetts to attend school as long as they have not moved out of Massachusetts permanently. "Eligible dependents" include the *subscriber's* (or *subscriber's* spouse's) children until the end of the calendar month in which the child turns age 26. To be an eligible dependent, the child is not required to live with the *subscriber* or the *subscriber's* spouse, be a dependent on the *subscriber's* or spouse's tax return, or be a full-time student. These eligible dependents may include:

- A newborn child. The *effective date* of coverage for a newborn child will be the child's date of birth provided that the *subscriber* formally notifies *Blue Cross and Blue Shield* within 30 days of the date of birth. (A claim for a *member's* maternity admission may be considered by *Blue Cross and Blue Shield* to be this notice when the *subscriber's* coverage is a family plan.) This health plan provides coverage for newborn infants for injury and sickness. This includes the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth. The coverage for these services is subject to all of the provisions of this health plan.
- An adopted child. The *effective date* of coverage for an adopted child will be the date of placement of the child 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 they assume custody of a child for the purpose of adoption, the child's health care services for injury or sickness will be covered from the date of custody. (This coverage is provided without a waiting period or pre-existing condition restriction.) This includes the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth. The coverage for these services is subject to all of the provisions of this health plan.
- A newborn infant of an enrolled dependent child immediately from the moment of birth and continuing after, until the enrolled dependent child is no longer eligible as a dependent.

If an eligible dependent child is married, the dependent child can enroll for coverage under the *subscriber's individual contract*. And, as long as that enrolled child is an eligible dependent, their children are also eligible for coverage under the *subscriber's individual contract*. The dependent child's spouse is **not** eligible to enroll as a dependent for coverage under the *subscriber's individual contract*.

An eligible dependent may also include:

- A person under age 26 who is not the *subscriber's* (or the *subscriber's* spouse's) child but who qualifies as a dependent of the *subscriber* under the Internal Revenue Code. When the dependent loses their dependent status under the Internal Revenue Code, that dependent will continue to be eligible as a dependent for coverage in this health plan under the *subscriber's individual contract* for two years after the end of the calendar year in which they last qualified as a dependent under the Internal Revenue Code or until the dependent turns age 26, whichever comes first.
- A child recognized under a Qualified Medical Child Support Order as having the right to enroll for health care coverage.

- A disabled dependent child age 26 or older. A dependent child who is mentally or physically incapable of earning their own living and who is enrolled under the *subscriber's individual contract* will continue to be covered after they would otherwise lose dependent eligibility under the *subscriber's individual contract*, so long as the child continues to be mentally or physically incapable of earning their own living. In this case, the *subscriber* must make arrangements with *Blue Cross and Blue Shield* not more than 30 days after the date the child would normally lose eligibility. Also, *Blue Cross and Blue Shield* must be given any medical or other information that it may need to determine if the child can maintain coverage in this health plan under the *subscriber's individual contract*. From time to time, *Blue Cross and Blue Shield* may conduct reviews that will require a statement from the attending physician. This is to confirm that the child is still an eligible disabled dependent child.

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

Enrollment Periods

Open Enrollment Period

If you are an eligible individual, you can enroll for coverage in this health plan under an *individual contract* only during a designated open enrollment period, except when any of the special enrollment situations as described below apply to you. For information about open enrollment periods and when they occur, you may contact the *Blue Cross and Blue Shield* customer service office.

Special Enrollment

If any one of the following special enrollment situations applies, you may enroll for coverage in this health plan under an *individual contract*, without waiting for a designated open enrollment period. In any of these situations, you will be enrolled within 30 days of the date that *Blue Cross and Blue Shield* receives your completed enrollment form.

- You had prior creditable health care coverage. *Blue Cross and Blue Shield* must receive your enrollment request within 63 days of the termination date of the prior health care coverage.
- You have a qualifying event, including (but not limited to): marriage; birth or adoption of a child; court-ordered care of a child; loss of coverage as a dependent under a group or government health plan; or any other event as may be designated by the Commissioner of Insurance. *Blue Cross and Blue Shield* receives your enrollment request within 63 days of the event or within 30 days of the event if coverage is for an eligible dependent.
- You have been granted a waiver by the Office of Patient Protection to enroll outside of the open enrollment period.

Enrollment Process

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

During the enrollment process, *Blue Cross and Blue Shield* will check and verify each person's eligibility for coverage in this health plan under an *individual contract*. This means that when you apply for coverage, you may be required to provide evidence that you are a resident of Massachusetts. Examples of evidence to show that you are a resident can be a copy of your lease or rental agreement, a mortgage bill, or a utility bill. If you are not a citizen of the United States, *Blue Cross and Blue Shield* may also require that you provide official U.S. immigration documentation. You will also be asked to provide information about your prior health plan(s), and you may be required to provide a copy of your certificate(s) of health plan coverage. If you fail to provide the information to *Blue Cross and Blue Shield* that it needs to verify your eligibility for an *individual contract*, *Blue Cross and Blue Shield* will deny your enrollment request. Once you are enrolled in this health plan, each year prior to your health plan renewal date, *Blue Cross and Blue Shield* may check and verify that you are still eligible for coverage under an *individual contract*.

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

- You fail to provide information to *Blue Cross and Blue Shield* that it needs to verify your eligibility for coverage in this health plan under an *individual contract*.
- You committed misrepresentation or fraud to *Blue Cross and Blue Shield* about your eligibility for coverage in this health plan under an *individual contract*.
- You made at least three or more late payments for your health plan(s) in a 12-month period.
- You voluntarily ended your coverage in this health plan within the past 12 months on a date that is not your renewal date. But, this does not apply if you had creditable coverage (as defined by state law) continuously up to a date not more than 63 days prior to the date of your request for enrollment in this health plan under an *individual contract*.

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

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

Membership Changes

Generally, the *subscriber* may make membership changes (for example, change from a plan that covers only one person to a family plan) only if the *subscriber* has a change in family status. This includes a change such as: marriage or divorce; birth, adoption or change in custody of a child; death of an enrolled spouse or dependent; or the loss of an enrolled dependent's eligibility under the *subscriber's individual contract*. If you want to ask for a membership change or you need to change your name or mailing address, you should call or write to *Blue Cross and Blue Shield*. *Blue Cross and Blue Shield* will send you any special forms that you may need. You must request a membership change within 30 days of the reason for the change. Or, if the newly eligible person had prior creditable coverage (as defined by state law), the change must be requested within 63 days of the termination date of the prior qualified health care coverage. If you do not request the change within the time required, you will have to wait until the next annual open enrollment period to make the change. All changes are allowed only when they comply with the conditions outlined in the *individual contract* and with *Blue Cross and Blue Shield* policies.

Termination of Individual Coverage

Loss of Eligibility for Individual Coverage

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

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

- **You Move Out of the State.** Your coverage in this health plan under an *individual contract* will end when you move permanently out of Massachusetts. In this case, you may be able to enroll in another Blue Cross and/or Blue Shield Plan's health plan. For help, you can call the *Blue Cross and Blue Shield* customer service office. They will help you with your options.

Termination of Individual Coverage by the Subscriber

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

- **Subscriber Terminates Coverage.** The *subscriber* may cancel coverage in this health plan under an *individual contract* at any time and for any reason. To do this, the *subscriber* must send a written request to *Blue Cross and Blue Shield*. The termination date will be effective 15 days after the date that *Blue Cross and Blue Shield* receives the termination request. Or, the *subscriber* may ask for a specific termination date. In this case, *Blue Cross and Blue Shield* must receive the request at least 15 days before that requested termination date. *Blue Cross and Blue Shield* will return to the *subscriber* any *premiums* that are paid for a time after the termination date.

- **Subscriber Fails to Pay Premiums.** Your coverage in this health plan under an *individual contract* will be terminated when the *subscriber* fails to pay their *premium* to *Blue Cross and Blue Shield* within 35 days after it is due. If *Blue Cross and Blue Shield* does not get the full *premium* on or before the due date, *Blue Cross and Blue Shield* will stop claim payments as of the last date through which the *premium* is paid. Then, if *Blue Cross and Blue Shield* does not get the full *premium* within this required time period, *Blue Cross and Blue Shield* will cancel your coverage in this health plan under an *individual contract*. The termination date will be the last date through which the *premium* is paid.

Termination of Individual Coverage by Blue Cross and Blue Shield

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

- **You Commit Misrepresentation or Fraud.** Your coverage in this health plan will be canceled, or in some cases *Blue Cross and Blue Shield* may limit your benefits, if you have committed misrepresentation or fraud. For example, you gave false or misleading information on the enrollment form. Or, you misused your ID card by letting another person who was not enrolled in this health plan attempt to get coverage. Your coverage in this health plan may be terminated when the fraud or misrepresentation is discovered or, as permitted by law, back to your *effective date* or the date of the misrepresentation or fraud. Your coverage in this health plan may be terminated retroactive to a date in the past (rather than on a current or future date) only if you committed fraud or made an intentional misrepresentation of a material fact. The termination date will be determined by *Blue Cross and Blue Shield*.

- **You Commit Acts of Physical or Verbal Abuse.** Your coverage in this health plan will be canceled if you commit acts of physical or verbal abuse that pose a threat to, or a threat to the health of, health care providers or other *members* or employees of *Blue Cross and Blue Shield* or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc., and these acts are not related to your physical condition or *mental condition*. In this case, this termination will follow the procedures that have been approved by the Massachusetts Commissioner of Insurance.

- **You Fail to Comply with Plan Provisions.** Your coverage in this health plan will be canceled if you fail to comply in a material way with any provision of the *individual contract*. For example, if you fail to provide information that *Blue Cross and Blue Shield* requests related to your coverage in this health plan, *Blue Cross and Blue Shield* may terminate your coverage.

- **This Health Plan Is Discontinued.** Your coverage in this health plan will be canceled if *Blue Cross and Blue Shield* discontinues this health plan. *Blue Cross and Blue Shield* may discontinue this health plan for any reason as of a date approved by the Massachusetts Commissioner of Insurance.

Medicare Program

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

MASSACHUSETTS

Wellness Participation Program

Under this Wellness Participation Program, you may be reimbursed for some fees you pay to participate in qualified fitness programs and/or weight loss programs.

Fitness Reimbursement

Blue Cross Blue Shield of Massachusetts will reimburse you up to **$150 each calendar year** for costs you pay to participate in a qualified fitness program. You can claim this fitness reimbursement for fees paid by any combination of members (such as the subscriber, spouse, and/or dependent children) enrolled under the same Blue Cross Blue Shield of Massachusetts health plan. A qualified fitness program includes services, activities, and products that provide cardiovascular and strength-training benefits.

Reimbursement is provided for:

- Full-service health clubs where you use a variety of cardiovascular and strength-training equipment for fitness.
- Fitness studios where you take instructor-led group classes such as yoga, pilates, zumba, kickboxing, cross-fit, and indoor cycling/spinning.
- Virtual/online memberships, subscriptions, programs, or classes for fitness using a digital platform.
- Cardiovascular and strength-training equipment for fitness that is purchased for use in the home. This reimbursement is not provided for items that are considered to be recreational equipment and/or sports equipment (such as kayaks, inline skates, ice skates, trampolines, and fitness clothing).

No reimbursement will be provided for any initiation fees or fees or costs you pay for: personal training sessions; country clubs; social clubs (such as ski, tennis, or hiking clubs); sports camps, leagues, or teams; spas; instructional dance studios; pool-only facilities; ski passes; and martial arts schools.

Weight Loss Program Reimbursement

Blue Cross Blue Shield of Massachusetts will reimburse you up to **$150 each calendar year** for costs you pay to participate in a qualified weight loss program. You can claim this weight loss program reimbursement for fees paid by any combination of members (such as the subscriber, spouse, and/or dependent children) enrolled under the same Blue Cross Blue Shield of Massachusetts health plan. A qualified weight loss program is a hospital-based or a non-hospital-based weight loss program that focuses on weight loss by modifying eating and physical activity habits and that requires participation in behavioral/lifestyle counseling with nutritionists, registered dieticians, exercise physiologists or other certified health professionals in multiple sessions throughout enrollment in the program. Program delivery and counseling may be in-person, over the phone, or online.

No reimbursement will be provided for any fees or costs you pay for: weight loss programs that do not include sessions with a health professional to support progress toward your weight loss goals; individual nutrition counseling sessions; pre-packaged meals; books; videos; scales; or other weight loss related items or supplies.

How to Claim Your Reimbursement

To be reimbursed for participation in a qualified wellness program, you must submit your reimbursement request to Blue Cross Blue Shield of Massachusetts no later than March 31st after the year for which you are claiming your reimbursement. To request your reimbursement, you must:

- Fill out a fitness program/weight loss program reimbursement claim form.
- Follow the instructions to submit the completed claim to Blue Cross Blue Shield of Massachusetts.

Reimbursement requests may be mailed to Blue Cross Blue Shield of Massachusetts or submitted online (when available). For additional information on how to file a claim or to get a claim form, log on to the Blue Cross Blue Shield of Massachusetts Web site at **www.bluecrossma.org**.

Be sure to keep your original itemized and paid receipts for qualified fees in the event that Blue Cross Blue Shield of Massachusetts asks you for them.

Important Note: Your Blue Cross Blue Shield of Massachusetts health plan does not include health benefits for costs related to activities such as fitness or weight loss programs. This separate Wellness Participation Program offers reimbursement for participation in qualified wellness programs.

Rider

Virtual Care Team Model

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

The in-network *outpatient* benefits described in your Subscriber Certificate for certain *covered services* have been changed.

Your health plan includes a tech-enabled care delivery model where virtual care team *covered providers* furnish certain *covered services*, including primary care with integrated mental health and/or substance use care within the patient care team, via traditional and/or digital platforms (such as: mobile app; web portal; telephone; and/or text message). This care delivery model offers a comprehensive and coordinated experience and virtual engagement with seamless navigation to in-person care when applicable.

For in-network *outpatient covered services* furnished by a virtual care team primary care provider type such as a family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, or by a physician assistant or nurse practitioner designated by the health plan as primary care, you will pay nothing (any *deductible*, *copayment* and/or *coinsurance* does not apply). The only exception is when you are enrolled in a qualified HSA-compliant high deductible health plan. In this case, your *deductible* will still apply to *covered services* as described in the *Schedule of Benefits* and/or *riders* for your plan option. For in-network *outpatient covered services* furnished by a virtual care team *covered provider* not described above or by any other *covered provider*, you will pay your applicable cost share (*deductible*, *copayment* and/or *coinsurance*).

To find a virtual care team *covered provider* or to learn more about a specific virtual care team's care delivery model, including information about mental health care management, see "When You Need Help to Find a Health Care Provider" in your Subscriber Certificate or call customer service. The toll free phone number to call is shown on your ID card.

This *rider* does <u>not</u> change the cost share amount you will pay for: telehealth services as described in your Subscriber Certificate, which includes any *riders* that apply to your coverage in this health plan; or out-of-network *outpatient* benefits.

All other provisions remain as described in your Subscriber Certificate.

attached to and made part of
Blue Cross and Blue Shield of Massachusetts, Inc.
Blue Care Elect Preferred Provider Plan Subscriber Certificate

Rider

Reproductive Health Care Services

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

The below new section for "Reproductive Health Care Services" has been added to Part 5, "Covered Services" as follows:

Reproductive Health Care Services

Under this health plan, you have the right to access reproductive health care services when they are furnished for you by a *covered provider* in a location where it is legal to perform such services. As required by state law, this coverage includes: supplies, care and services of a medical, behavioral health, mental health, surgical, psychiatric, therapeutic, diagnostic, preventive, rehabilitative or supportive nature relating to pregnancy; contraception; assisted reproduction; miscarriage management; or termination of pregnancy (abortion).

Except as described below for abortion and abortion-related care, your coverage for covered reproductive health care services is provided to the same extent as coverage is provided for similar *covered services* to treat other physical conditions. (Your *Schedule of Benefits* describes your cost share amount. Also refer to *riders*—if there are any—that apply to your coverage in this health plan.)

Abortion and Abortion-Related Care

This health plan covers abortion and abortion-related care when the services are furnished for you by a *covered provider* in a location where it is legal to perform such services. Coverage for an abortion includes: surgical services and certain prescription drugs related to a medication abortion (when prescription drug benefits are provided under this health plan); and abortion-related care as defined by Massachusetts Division of Insurance guidance. *Covered services* for abortion-related care include (but are not limited to): pre- and post-abortion medical services and diagnostic tests.

As required by state law, this health plan provides full coverage for these *covered services*. You pay nothing for in-network and out-of-network benefits. (Any *deductible*, *copayment*, and/or *coinsurance* that you would normally pay will not apply.) The only exception is when you are enrolled in a qualified HSA-compliant high deductible health plan. In this case, your *deductible* will apply to these *covered services*. Otherwise, any cost share amounts will not apply.

Note: If your employer is a church or qualified church-controlled organization, these services may not be available to you. To find out, you can check with your employer. Also refer to *riders*—if there are any—that apply to your coverage in this health plan.

All other provisions remain as described in your Subscriber Certificate.

Rider

Transportation and Lodging

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

The benefits described in your Subscriber Certificate for certain *covered services* have been changed.

For *members* seeking surgical or medication-assisted voluntary termination of pregnancy (abortion) services when access to these *covered services* is restricted or not available in the *member's* state as a result of state law, this health plan will cover transportation (automobile, airplane, train, or bus) and lodging costs when the *member* must travel more than 100 miles from their residence to a *covered provider* in their *service area* that can furnish the *covered service*. This coverage is provided up to a $2,500 annual benefit maximum for each eligible *member*. Your annual benefit maximum is accrued on a calendar year or a *plan year* basis and aligns with the calculation of your *deductible* (if there is one) and *out-of-pocket maximum* as described in your *Schedule of Benefits* and/or applicable *riders*.

This additional coverage for transportation and lodging costs is available for the *member* who is receiving the *covered service* and one companion if the companion's presence is necessary to allow the *member* to receive *covered services*.

Whether or not this coverage includes a per-day maximum benefit payment, the coverage provided for lodging expenses will not exceed $50 each day for each eligible person (*member* and companion) up to $100 total each day.

If you are a *member* who is traveling by automobile to a covered facility for *covered services*, costs that you pay for a rental car, mileage, parking, and/or tolls are eligible for reimbursement. Reimbursement for mileage costs will be calculated based on the standard mileage rates for the use of a car for medical purposes that are issued by the Internal Revenue Service and that are in effect for the time period in which the *covered service* is received. Costs that you pay for taxi and/or rideshare services are also eligible for reimbursement.

If you are a *member* who is traveling by airplane to a covered facility for *covered services*, airfare must be for a regularly scheduled commercial flight (coach class only). Airfare expenses will count toward any annual and/or lifetime benefit maximum (if one applies), but are <u>not</u> subject to any per-day maximum benefit payment.

Once any benefit maximum payments for transportation and lodging costs as described in this *rider* have been reached, no more benefits will be provided for these costs.

Any *copayments* and *coinsurance* that normally apply for *covered services* do <u>not</u> apply for covered transportation and lodging costs. The only exception is when you are enrolled in a qualified HSA-compliant high deductible health plan. In this case, your in-network *deductible* as described in the *Schedule of Benefits* and/or *riders* for your plan option must also apply to covered transportation and lodging costs.

To be reimbursed for eligible transportation and lodging costs, you must submit your reimbursement request to *Blue Cross and Blue Shield*. To request your reimbursement, you must:

- Fill out a reimbursement claim form.
- Follow the instructions to submit the completed claim to *Blue Cross and Blue Shield*.

Reimbursement requests may be mailed to *Blue Cross and Blue Shield* or submitted online (when available). For additional information on how to file a claim or to get a claim form, you can log on to the internet Web site at **www.bluecrossma.org**.

Be sure to keep your original itemized and paid receipts for qualified eligible expenses. You will need these receipts as you complete your claim form for submission; you will also need them in the event that *Blue Cross and Blue Shield* asks you for them.

No reimbursement benefits are provided for: taxes; tips and/or gratuities; travel outside of the United States; alcohol and/or tobacco purchases; entertainment (such as, but not limited to, movies, visits to museums, additional mileage for sightseeing); expenses for persons other than the *member* who is receiving the *covered service* and their covered companion as described above; costs for lodging in any location other than a hotel or motel; meals; personal care items (such as, but not limited to, shampoo, deodorant, toothbrush); souvenirs (such as, but not limited to, T-shirts, sweatshirts, toys); telephone calls; childcare; lost wages; and other items and services that are not considered expenses for medical care under Internal Revenue Code section 213(d) for reimbursement under the Internal Revenue Service's (IRS) guidelines for qualified expenses.

All other provisions remain as described in your Subscriber Certificate.

Rider

Domestic Partner Eligibility

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

The eligibility provisions described in your Subscriber Certificate have been changed.

A *subscriber* may enroll a domestic partner for coverage under his or her membership. A "domestic partner" is a person of either sex with whom the *subscriber* has entered into an exclusive relationship. This means that both the *subscriber* and domestic partner: are 18 years of age or older and of legal age of consent; are competent to enter into a legal contract; share the same residence and must intend to continue to do so; are jointly responsible for basic living costs; are in a relationship of mutual support, caring, and commitment in which they intend to remain; are not married to anyone else; and are not related to each other by adoption or blood to a degree of closeness that would otherwise bar marriage in the state in which they live. A "domestic partner" may also include a person with whom the *subscriber* has registered as a domestic partner with any governmental domestic registry (whether or not all of the conditions stated above have been met).

If the *subscriber* enrolls the domestic partner in his or her health plan, the domestic partner's dependent children are eligible for coverage to the same extent that the *subscriber's* dependent children are eligible for coverage in his or her health plan.

(A domestic partner and an eligible spouse may not be enrolled under the same membership at the same time.)

If the *subscriber* terminates the domestic partnership, the former domestic partner (and any enrolled children of the former domestic partner) may continue coverage in the *subscriber's* health plan. They may do so to the extent that federal or state law would usually apply.

All other provisions remain as described in your Subscriber Certificate.

Student Health Policy

You are enrolled in the student health plan sponsored by the institution of higher education (the *group*) that has entered into an agreement (a *group* "contract") with Blue Cross and Blue Shield of Massachusetts, Inc. to provide health care benefits to eligible students and their eligible dependents. Your *plan sponsor* is the institution of higher education.

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

Eligibility and Enrollment for Student Health Plan Coverage

Eligible Student

You are eligible for coverage under the *group's* 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 the *group's* student health plan by the *group*. The *group* may allow an eligible student to waive enrollment in the *group's* 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 student health plan. For enrollment information or details about waiving coverage in the *group's* student health plan, you must contact the *group*. You must also contact the *group* if you would like to request the *group's* written policy regarding partial year student enrollment.

Premium Payments

For coverage in the *group's* 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* for your coverage in the *group's* student health plan. For more information about your *premium* or if you would like to request the *group's* written policy regarding *premium* refunds, you must contact the *group*.

Eligible Spouse

An eligible student who is enrolled in the *group's* student health plan may enroll an eligible spouse for coverage under his or her student health plan membership. 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 student health plan membership to the extent that a legal civil union spouse is determined eligible by the *group*. For more details, contact your *plan sponsor*.)

Former Spouse

In the event of a divorce or a legal separation, the person who was the spouse of the enrolled student prior to the divorce or legal separation will remain eligible for coverage under the enrolled student's student health plan membership, whether or not the judgment was entered prior to the *effective date* of the enrolled student's student health plan membership. This coverage is provided with no additional *premium* other than the normal cost of covering a current spouse. The former spouse will remain eligible for this coverage **only** until the 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* must be notified within 30 days of a change to the enrolled student's former spouse's address. Otherwise, *Blue Cross and Blue Shield* 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 student health plan membership with the *group*, provided the divorce judgment requires that the enrolled student provide health insurance for the former spouse. This is true even if the enrolled student's new spouse is not enrolled under the enrolled student's student health plan membership.

Domestic Partner

As determined by the *group*, an enrolled student may have the option to enroll an eligible domestic partner (instead of an eligible spouse) under his or her student health plan membership. (If the *group's* student health plan does not include a domestic partner *rider*, this section does not apply to you.) A "domestic partner" is a person with whom the enrolled student has entered into an exclusive relationship. This means that both the enrolled student and domestic partner: are 18 years of age or older and of legal age of consent in the state where they reside; are competent to enter into a legal contract; share the same residence and must intend to continue to do so; are jointly responsible for basic living costs; are in a relationship of mutual support, caring, and commitment in which they intend to remain; are not married to anyone else; and are not related to each other by adoption or blood to a degree of closeness that would otherwise bar marriage in the state in which they live. A "domestic partner" may also include a person with whom the enrolled student has registered as a domestic partner with any governmental domestic registry (whether or not all of the conditions stated above have been met). If the enrolled student enrolls an eligible domestic partner under his or her student health plan membership, the domestic partner's dependent children are eligible for coverage to the same extent that the enrolled student's dependent children are eligible for coverage under his or her student health plan membership. If the enrolled student terminates the domestic partnership, the former domestic partner and any children of a former domestic partner are no longer eligible for coverage.

Eligible Dependents

An eligible student who is enrolled in the *group's* student health plan may enroll eligible dependents under his or her student health plan membership. "Eligible dependents" include the enrolled student's (or his or her spouse's or, if applicable, domestic partner's) children who are under age 26. To be an eligible dependent, a child under age 26 is not required to live with the enrolled student or the enrolled student's spouse (or domestic partner), be a dependent on the enrolled student's or the spouse's (or domestic partner's) tax return, or be a full-time student. 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.) The group's student health plan provides coverage for newborn infants for injury and sickness. This includes the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth. The coverage for these services is subject to all of the provisions of the *group's* student health plan.
- An adopted child. The *effective date* of coverage for an adopted child will be the date of placement with the enrolled student for the purpose of adoption. The *effective date* of coverage for an adoptive child who has been living with the enrolled student and for whom the enrolled student has been getting foster care payments will be the date the petition to adopt is filed. If the enrolled student is enrolled under a family plan as of the date he or she assumes custody of a child for the purpose of adoption, the child's health care services for injury or sickness will be covered from the date of custody. (This coverage is provided without a waiting period or pre-existing condition restriction.) This includes the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities and premature birth. The coverage for these services is subject to all of the provisions of the *group's* student health plan.
- A newborn infant of an enrolled dependent child immediately from the moment of birth and continuing after, until the enrolled dependent child is no longer eligible as a dependent.

If an eligible dependent child is married, the dependent child can enroll for coverage under the enrolled student's membership. And, as long as that enrolled child is an eligible dependent, his or her children are also eligible for coverage under the enrolled student's membership. The dependent child's spouse is **not** eligible to enroll as a dependent for coverage under the enrolled student's membership.

An eligible dependent may also include:

- A person under age 26 who is not the enrolled student's (or the student's spouse's or, if applicable, domestic partner's) child but who qualifies as a dependent of the enrolled student under the Internal Revenue Code. When the 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 the *group's* student health plan under the enrolled student's membership 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.
- A child recognized under a Medical Child Support Order as having the right to enroll for health care coverage.
- A disabled dependent child age 26 or older. 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 membership will continue to be covered after he or she would otherwise lose dependent eligibility for coverage under the enrolled student's membership, 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 with *Blue Cross and Blue Shield* not more than 30 days after the date the child would normally lose eligibility. Also, *Blue Cross and Blue Shield* must be given any medical or other

information that it may need to determine if the child can maintain coverage in the *group's* student health plan under the enrolled student'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 child.

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

Membership Changes

Generally, the enrolled student may make membership changes (for example, change from a student-only 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 student health plan 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 to 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 *group* to make a change. All changes are allowed only when they comply with the eligibility and enrollment rules set by the *plan sponsor* for the *group's* student health plan and they must also comply with applicable laws and regulations.

Termination of Coverage

When your eligibility for the *group's* student health plan ends, your coverage in this health plan will be terminated as of the date you lose eligibility. Your eligibility ends 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 membership, their coverage will also be terminated as of the date the student loses eligibility for coverage in the *group's* student health plan. The coverage for the student's enrolled spouse and/or dependents will also be terminated in the event the enrolled student dies.
- You are enrolled as a dependent and you lose your status as an eligible dependent under the enrolled student's membership.

Whether you are the enrolled student or you are the enrolled student's spouse or other enrolled dependent, your coverage in this health plan will end when:

- The *group* fails to pay your *premium* for your coverage in the *group's* student health plan to *Blue Cross and Blue Shield* within 30 days of the due date.
- The *group's* contract with *Blue Cross and Blue Shield* is terminated (or is not renewed).
- You commit misrepresentation or fraud to *Blue Cross and Blue Shield*. For example, you misused the ID card by letting another person not enrolled in the *group's* student health plan attempt to get coverage. Termination will go back to your *effective date*. Or, it will go back to the date of the misrepresentation or fraud, as determined by *Blue Cross and Blue Shield*, subject to applicable federal law. Or, in some cases *Blue Cross and Blue Shield* may limit your benefits.
- You commit acts of physical or verbal abuse that pose a threat to, or a threat to the health of, health care providers or other *members* or employees of *Blue Cross and Blue Shield* or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc., and these acts are not related to your physical condition or *mental condition*. In this case, this termination will follow the procedures that have been approved by the Massachusetts Commissioner of Insurance.

- You fail to comply in a material way with any provision of this health plan. For example, if you fail to provide information that *Blue Cross and Blue Shield* requests related to your coverage in this health plan, *Blue Cross and Blue Shield* may terminate your coverage.
- *Blue Cross and Blue Shield* discontinues this health plan. *Blue Cross and Blue Shield* may discontinue this health plan for any reason as of a date approved by the Massachusetts Commissioner of Insurance.

Medicare Program

Generally, the benefits that are available under the *group's* 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 the *group's* 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.

All other provisions remain as described in your Subscriber Certificate.

Schedule of Benefits

Blue Care® Elect

Preferred Student Health Plan

This is the *Schedule of Benefits* that is a part of your Subscriber Certificate. This chart describes the cost share amounts that you will have to pay for *covered services*. It also shows the *benefit limits* that apply for *covered services*. Do not rely on this chart alone. **Be sure to read all parts of your Subscriber Certificate to understand the requirements you must follow to receive all of your coverage. You should also read the descriptions of *covered services* and the limitations and exclusions that apply for this coverage.** All words that show in italics are explained in Part 2. **To receive the highest level of coverage, you must obtain your health care services and supplies from *covered providers* who participate in your health plan's provider network.** Also, for some health care services, you may have to have an approved referral from your *primary care provider* or approval from your health plan in order for you to receive coverage from your health plan. These requirements are fully outlined in Part 4. If a referral or an approval is required, you should make sure that you have it before you receive your health care service. Otherwise, you may have to pay all costs for the health care service.

Your health plan's provider network is the **PPO** provider network. See Part 1 for information about how to find a provider in your health care network.

The following definitions will help you understand your cost share amounts and how they are calculated.

- A ***deductible*** is the cost you may have to pay for certain *covered services* you receive during your annual coverage period before benefits are paid by the health plan. This chart shows the dollar amount of your *deductible* and the *covered services* for which you must first pay the *deductible*.
- A ***copayment*** is the fixed dollar amount you may have to pay for a *covered service*, usually when you receive the *covered service*. This chart shows the times when you will have to pay a *copayment*.
- A ***coinsurance*** is the percentage (for example, 20%) you may have to pay for a *covered service*. This chart shows the times, if there are any, when you will have to pay *coinsurance*.

Your cost share will be calculated based on the *allowed charge* or the provider's actual charge if it is less than the *allowed charge*. You will not have to pay charges that are more than the *allowed charge* when you use a *covered provider* who participates in your health care network to furnish *covered services*. **But, when you use an out-of-network provider, you may also have to pay all charges that are in excess of the *allowed charge* for *covered services*. This is called "*balance billing*." These balance billed charges are in addition to the cost share you have to pay for *covered services*. (Exceptions to this paragraph are explained in Part 2.)**

IMPORTANT NOTE: The provisions described in this *Schedule of Benefits* may change. If this happens, the change is described in a *rider*. Be sure to read each *rider* (if there are any) that applies to your coverage in this health plan to see if it changes this *Schedule of Benefits*.

The explanation of any special provisions as noted by an asterisk can be found after this chart.

Overall Member Cost Share Provisions	**In-Network Benefits**	**Out-of-Network Benefits**
Deductible	The *deductible* is the cost you have to pay for certain *covered services* during your annual coverage period before benefits will be paid for those *covered services*.	
Your *deductible* per *plan year* is:	$0 per *member* $0 per family	$250 per *member* No family limit
This *deductible* applies to all out-of-network benefits <u>except</u> prescription drugs and supplies and certain *covered services* as noted in this chart.	Any costs you pay for in-network benefits will <u>not</u> be applied toward the out-of-network *deductible*.	
	The family *deductible* can be met by eligible costs incurred by any combination of *members* enrolled under the same family plan. But, no one *member* will have to pay more than the per *member deductible*.	
Out-of-Pocket Maximum	The *out-of-pocket maximum* is the most you could pay during your annual coverage period for your share of the costs for *covered services*.	
Your *out-of-pocket maximum* per *plan year* is:	See your Out-of-Pocket Maximum Rider for this amount.	
This *out-of-pocket maximum* is a total of the *deductible*, *copayments*, and *coinsurance* you pay for *covered services*, excluding costs for prescription drugs and supplies. See your *Blue Cross and Blue Shield* Drug Plan for your *out-of-pocket maximum* for prescription drugs and supplies.	The family *out-of-pocket maximum* can be met by eligible costs incurred by any combination of *members* enrolled under the same family plan. But, no one *member* will have to pay more than the per *member out-of-pocket maximum*.	
Overall Benefit Maximum	None	

Covered Services		**In-Network Benefits** **Your Cost Is:**	**Out-of-Network Benefits** **Your Cost Is:**
Admissions for Inpatient Medical and Surgical Care	• In a General Hospital <u>Hospital services</u>	No charge	20% after *deductible*
	<u>Physician and other covered professional provider services</u>	No charge	20% after *deductible*
	• In a Chronic Disease Hospital	(same as admissions in a General Hospital)	(same as admissions in a General Hospital)
	• In a Rehabilitation Hospital (60-day *benefit limit* per *member* per calendar year) <u>Hospital services</u>	No charge	20% after *deductible*
	<u>Physician and other covered professional provider services</u>	No charge	20% after *deductible*

This chart shows your cost share for *covered services*. You must pay all charges in excess of a *benefit limit*.

Covered Services		In-Network Benefits **Your Cost Is:**	Out-of-Network Benefits **Your Cost Is:**
Admissions for Inpatient Medical and Surgical Care (continued)	• In a Skilled Nursing Facility (100-day *benefit limit* per *member* per calendar year)		
	Facility services	No charge	20% after *deductible*
	Physician and other covered professional provider services	No charge	20% after *deductible*
Ambulance Services (ground or air ambulance transport)	• Emergency ambulance	No charge	same as in-network benefits
	• Other ambulance	No charge	20% after *deductible*
Cardiac Rehabilitation	*Outpatient* services	See your Outpatient Copayment Rider for this amount	20% after *deductible*
Chiropractor Services (for *members* of any age)	• *Outpatient* lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	• *Outpatient* medical care services, including spinal manipulation (a *benefit limit* does not apply)	See your Outpatient Copayment Rider for this amount	20% after *deductible*
Dialysis Services	*Outpatient* services and home dialysis	No charge	20% after *deductible*
Durable Medical Equipment	• Covered medical equipment rented or purchased for home use	No charge	20% after *deductible*
	• One breast pump per birth (rented or purchased), including related parts and supplies	No charge	20% after *deductible*
		No coverage is provided for hospital-grade breast pumps.	
Early Intervention Services	*Outpatient* intervention services for eligible child from birth through age two	No charge	No charge (*deductible* does not apply)
Emergency Medical Outpatient Services	• Emergency room services	$100 *copayment* per visit; *copayment* waived if held for observation or admitted within 24 hours	same as in-network benefits
	• Hospital outpatient department services	See your Outpatient Copayment Rider for this amount	20% after *deductible*

This chart shows your cost share for *covered services*. You must pay all charges in excess of a *benefit limit*.

Covered Services		In-Network Benefits **Your Cost Is:**	Out-of-Network Benefits **Your Cost Is:**
Emergency Medical Outpatient Services (continued)	• Office, health center, and home services		
	by a family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, or multi-specialty provider group; or by a physician assistant or nurse practitioner designated by the health plan as primary care	See your Outpatient Copayment Rider for this amount	20% after *deductible*
	by another specialist or other *covered provider* (non-hospital), including a physician assistant or nurse practitioner designated by the health plan as specialty care	See your Outpatient Copayment Rider for this amount	20% after *deductible*
Home Health Care	Home care program	No charge	20% after *deductible*
Hospice Services	*Inpatient* or *outpatient* hospice services for terminally ill	No charge	20% after *deductible*
Infertility Services	• *Inpatient* services	See Admissions for Inpatient Medical and Surgical Care	See Admissions for Inpatient Medical and Surgical Care
	• *Outpatient* surgical services	See Surgery as an Outpatient	See Surgery as an Outpatient
	• *Outpatient* lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	• *Outpatient* medical care services	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits
Lab Tests, X-Rays, and Other Tests (diagnostic services)	• *Outpatient* lab tests	No charge	20% after *deductible*
	• *Outpatient* x-rays and other imaging tests (other than advanced imaging tests)	No charge	20% after *deductible*
	• *Outpatient* advanced imaging tests (CT scans, MRIs, PET scans, nuclear cardiac imaging)	$25 *copayment* per category of test per service date	20% after *deductible*
	• Other *outpatient* tests and preoperative tests	No charge	20% after *deductible*

This chart shows your cost share for *covered services*. You must pay all charges in excess of a *benefit limit*.

Covered Services		In-Network Benefits Your Cost Is:	Out-of-Network Benefits Your Cost Is:
Maternity Services and Well Newborn Care (includes $90/$45 for childbirth classes; *deductible* does not apply)	• Maternity services Facility services (*inpatient* and *outpatient covered services*)	No charge	20% after *deductible*
	Physician and other covered professional provider services (includes delivery and postnatal care)	No charge	20% after *deductible*
	• Prenatal care	No charge	20% after *deductible*
	• Well newborn care during covered maternity admission	No charge	20% (*deductible* does not apply)
Medical Care Outpatient Visits (includes syringes and needles dispensed during a visit)	• Office, health center, and home medical services by a family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, limited services clinic, or multi-specialty provider group; or by a physician assistant or nurse practitioner designated by the health plan as primary care	See your Outpatient Copayment Rider for this amount	20% after *deductible*
	by another specialist or other *covered provider* (non-hospital), including a physician assistant or nurse practitioner designated by the health plan as specialty care	See your Outpatient Copayment Rider for this amount	20% after *deductible*
	• Hospital outpatient medical services	See your Outpatient Copayment Rider for this amount	20% after *deductible*
	• Acupuncture services (12-visit *benefit limit* per *member* per calendar year)	See your Outpatient Copayment Rider for this amount	20% after *deductible*
Medical Formulas	Certain medical formulas and low protein foods	See Prescription Drugs and Supplies	See Prescription Drugs and Supplies

This chart shows your cost share for *covered services*. You must pay all charges in excess of a *benefit limit*.

Covered Services		In-Network Benefits **Your Cost Is:**	Out-of-Network Benefits **Your Cost Is:**
Mental Health and Substance Use Treatment	• *Inpatient* admissions in a General Hospital Hospital services	 No charge	 20% after *deductible*
	Physician and other covered professional provider services	No charge	20% after *deductible*
	• *Inpatient* admissions in a Mental Hospital or Substance Use Facility Facility services	 No charge	 20% after *deductible*
	Physician and other covered professional provider services	No charge	20% after *deductible*
	• *Outpatient* services	See your Outpatient Copayment Rider for this amount	20% after *deductible*
Oxygen and Respiratory Therapy	• Oxygen and equipment for its administration	No charge	20% after *deductible*
	• *Outpatient* respiratory therapy	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits
Podiatry Care	• *Outpatient* lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	• *Outpatient* surgical services	See Surgery as an Outpatient	See Surgery as an Outpatient
	• *Outpatient* medical care services	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits
Prescription Drugs and Supplies	• Retail Pharmacy	See your *Blue Cross and Blue Shield* Drug Plan	See your *Blue Cross and Blue Shield* Drug Plan
	• Mail Order Pharmacy	See your *Blue Cross and Blue Shield* Drug Plan	See your *Blue Cross and Blue Shield* Drug Plan
Preventive Health Services	• Routine pediatric care (ten visits first year of life, three visits second year of life, two visits age 2, and one visit per calendar year age 3 and older) Routine medical exams and immunizations	 No charge	 20% after *deductible*
	Routine tests	No charge	20% after *deductible*
		These *covered services* include (but are not limited to): routine exams; immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning.	
	Annual mental health wellness exams	No charge	No charge (*deductible* does not apply)

This chart shows your cost share for *covered services*. You must pay all charges in excess of a *benefit limit*.

Covered Services		In-Network Benefits **Your Cost Is:**	Out-of-Network Benefits **Your Cost Is:**
Preventive Health Services (continued)	• Preventive dental care for *members* under age 18 for treatment of cleft lip/cleft palate	No charge	20% after *deductible*
	• Routine adult care Routine medical exams and immunizations (one exam per *member* per calendar year)	No charge	20% after *deductible*
	Routine tests	No charge	20% after *deductible*
		These *covered services* include (but are not limited to): routine exams; immunizations; routine lab tests and x-rays; routine mammograms; blood tests to screen for lead poisoning; and routine colonoscopies.	
	Annual mental health wellness exams	No charge	No charge (*deductible* does not apply)
	• Routine GYN care Routine GYN exams (one exam per *member* per calendar year)	No charge	20% after *deductible*
	Routine Pap smear tests (one test per *member* per calendar year)	No charge	20% after *deductible*
	• Family planning	No charge	20% after *deductible*
	• Routine hearing care Routine hearing exams/tests	No charge	20% after *deductible*
	Newborn hearing screening tests	No charge	20% after *deductible*
	Hearing aids/related services for *members* age 21 or younger ($2,000 for one hearing aid per hearing-impaired ear every 36 months)	No charge	20% after *deductible*

This chart shows your cost share for *covered services*. You must pay all charges in excess of a *benefit limit*.

Covered Services		In-Network Benefits **Your Cost Is:**	Out-of-Network Benefits **Your Cost Is:**
Preventive Health Services (continued)	• Routine vision care Routine vision exams (one exam per *member* every 24 months, except every 12 months until end of calendar month *member* turns age 19)	No charge	20% after *deductible*
	Vision supplies/related services	See your vision supplies *rider* for coverage for *members* until end of calendar month *member* turns age 19	See your vision supplies *rider* for coverage for *members* until end of calendar month *member* turns age 19
Prosthetic Devices	• Ostomy supplies	No charge	20% after *deductible*
	• Artificial limb devices (includes repairs) and other external prosthetic devices	No charge	20% after *deductible*
Radiation Therapy and Chemotherapy	*Outpatient* services	No charge	20% after *deductible*
Second Opinions	*Outpatient* second and third opinions	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits
Short-Term Rehabilitation Therapy (physical, occupational, and speech therapy) Includes habilitation services	*Outpatient* services (separate 60-visit *benefit limits* for rehabilitation and habilitation services per *member* per calendar year for physical and occupational therapy except for autism; no *benefit limit* applies for speech therapy)	See your Outpatient Copayment Rider for this amount	20% after *deductible*
Speech, Hearing, and Language Disorder Treatment	• *Outpatient* diagnostic tests	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	• *Outpatient* speech therapy	See Short-Term Rehabilitation Therapy	See Short-Term Rehabilitation Therapy
	• *Outpatient* medical care services	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits
Surgery as an Outpatient (includes removal of impacted teeth that are fully or partially imbedded in the bone)	• *Outpatient* day surgery Hospital surgical day care unit or outpatient department services	No charge	20% after *deductible*
	Ambulatory surgical facility services	No charge	20% after *deductible*
	Physician and other covered professional provider services	No charge	20% after *deductible*

This chart shows your cost share for *covered services*. You must pay all charges in excess of a *benefit limit*.

Covered Services		In-Network Benefits **Your Cost Is:**	Out-of-Network Benefits **Your Cost Is:**
Surgery as an Outpatient (continued)	• Sterilization procedure for a female *member* when performed as the primary procedure for family planning reasons	No charge	20% after *deductible*
	• Office and health center surgical services		
	by a family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, or multi-specialty provider group; or by a physician assistant or nurse practitioner designated by the health plan as primary care	See your Outpatient Copayment Rider for this amount	20% after *deductible*
	by another specialist or other *covered provider* (non-hospital), including a physician assistant or nurse practitioner designated by the health plan as specialty care	See your Outpatient Copayment Rider for this amount	20% after *deductible*
TMJ Disorder Treatment	• *Outpatient* x-rays	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	• *Outpatient* surgical services	See Surgery as an Outpatient	See Surgery as an Outpatient
	• *Outpatient* physical therapy	See Short-Term Rehabilitation Therapy	See Short-Term Rehabilitation Therapy
	• *Outpatient* medical care services	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits

Note: Your health plan includes in-network benefits for Christian Science services. The cost share amount you pay for *covered services* you receive from a Christian Science sanatorium, practitioner, or nurse is the same that applies for similar *covered services* when they are furnished by a preferred hospital, preferred physician, or preferred nurse practitioner for in-network benefits.

This chart shows your cost share for *covered services*. You must pay all charges in excess of a *benefit limit*.

attached to and made part of
Blue Cross and Blue Shield of Massachusetts, Inc.
Blue Care Elect Preferred Provider Plan Subscriber Certificate

Rider

Inpatient Coinsurance

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

The cost share amount you pay for *inpatient covered services* as shown in your *Schedule of Benefits* has been changed as follows:

For in-network covered *inpatient* admissions, you will pay 20% *coinsurance*. Or, for out-of-network covered *inpatient* admissions, you will pay 40% *coinsurance* after any *deductible*.

All other provisions remain as described in your Subscriber Certificate.

Rider
Diagnostic Tests

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

The cost share amount you pay for *outpatient* diagnostic tests as shown in your *Schedule of Benefits* has been changed as follows:

Covered Services		In-Network Benefits **Your Cost Is:**	Out-of-Network Benefits **Your Cost Is:**
Lab Tests, X-Rays, and Other Tests (diagnostic services)	• *Outpatient* lab tests	$10 *copayment* per service date	20% after any *deductible*
	• *Outpatient* x-rays and other imaging tests (other than advanced imaging tests)	$10 *copayment* per service date	20% after any *deductible*
	• *Outpatient* advanced imaging tests (CT scans, MRIs, PET scans, nuclear cardiac imaging)	20%	40% after any *deductible*
	• Other *outpatient* tests and preoperative tests	No charge	20% after any *deductible*

All other provisions remain as described in your Subscriber Certificate.

Rider
Deductible

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

The overall *deductible* described in your Subscriber Certificate has been eliminated. This means that you no longer have to pay a *deductible* before this health plan will provide benefits for *covered services*.

All other provisions remain as described in your Subscriber Certificate.

Rider
Outpatient Copayment

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

The in-network *copayment* amount you pay for *outpatient covered services* (other than those described in the note below) has been changed from the *copayment* amount shown in your *Schedule of Benefits* to a $10 *copayment* per visit. Refer to your *Schedule of Benefits* for a description of the *covered services* for which this *copayment* applies.

Note: This *rider* does not change the cost share amount you will pay for: emergency room visits; diagnostic tests (such as lab tests, x-rays, advanced imaging tests, and other diagnostic tests); prescription drugs and supplies; and *outpatient* day surgery.

All other provisions remain as described in your Subscriber Certificate.

Rider
Out-of-Pocket Maximum

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

The *out-of-pocket maximum* as shown in your *Schedule of Benefits* has been changed as follows:

Overall Member Cost Share Provisions	In-Network Benefits	Out-of-Network Benefits
Out-of-Pocket Maximum	The *out-of-pocket maximum* is the most you could pay during your annual coverage period for your share of the costs for *covered services*.	
Your *out-of-pocket maximum* per *plan year* is:	$4,500 per *member* $9,000 per family	
This *out-of-pocket maximum* is a total of the *deductible*, *copayments*, and *coinsurance* you pay for *covered services*, including cost share amounts you pay for prescription drugs and supplies covered by your *Blue Cross and Blue Shield* Drug Plan.	The family *out-of-pocket maximum* can be met by eligible costs incurred by any combination of *members* enrolled under the same family plan. But, no one *member* will have to pay more than the per *member out-of-pocket maximum*.	

All other provisions remain as described in your Subscriber Certificate.

Rider
Routine Vision Exams

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

The *outpatient* benefits described in your Subscriber Certificate for routine vision exams have been changed.

Your health plan covers one routine vision exam per *member* every 12 months.

All other provisions remain as described in your Subscriber Certificate.

Rider

Vision Supplies

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

The *outpatient* benefits described in your Subscriber Certificate for routine vision care have been changed by adding coverage for vision supplies for *members* until the end of the calendar month in which the *member* turns age 19.

This health plan covers certain vision supplies and *covered services* related to covered vision supplies when they are furnished by a *covered provider*, such as an ophthalmologist or an optometrist, for a *member* until the end of the calendar month in which the *member* turns age 19. These *covered services* include: prescription eyeglasses (lenses and/or frames) or, in lieu of eyeglasses, prescription contact lenses; low vision supplies; and the measurement, fitting, and adjustments of covered vision supplies.

This chart describes the cost share amounts that you must pay for *covered services*. It also shows the *benefit limits* that apply for *covered services*.

Covered Vision Supplies	In-Network Benefits **Your Cost Is:**	Out-of-Network Benefits **Your Cost Is:**
• Prescription lenses (one set of lenses per *member* per calendar year)	35%	55% after *deductible*
	These *covered services* include: glass, plastic, or polycarbonate lenses; all lens powers (single vision, bifocal, trifocal, lenticular); fashion and gradient tinting; oversized and glass-grey #3 prescription sunglass lenses; scratch resistant coating; ultraviolet protective and anti-reflective coating; blended segment lenses; intermediate vision lenses; progressive lenses; photochromic glass lenses; plastic photosensitive lenses; polarized lenses; and hi-index lenses.	
• Frames (once per *member* per calendar year)	35%	55% after *deductible*
• Prescription contact lenses (once per *member* per calendar year, in lieu of eyeglasses)	35%	55% after *deductible*
	These *covered services* include elective contact lenses (conventional or disposable). Coverage for non-elective contact lenses (in lieu of other eyewear) is also provided for the *medically necessary* treatment of the following conditions: pathological myopia; aphakia; anisometropia; aniridia; corneal disorders; post-traumatic disorders; and irregular astigmatism.	
• Low vision supplies	35%	55% after *deductible*
	Low vision is a significant loss of vision, but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the *member's* remaining vision. These *covered services* include: low vision aids such as high-power spectacles, magnifiers, and telescopes. (Benefits for low vision evaluations and follow-up care visits are provided as described for Medical Care Outpatient Visits in your Subscriber Certificate.)	

Rider
Vision Supplies

No benefits are provided for: sunglasses not requiring a prescription; safety glasses; replacement of lost or broken lenses or frames; and, except as described in this *rider*, special procedures such as orthoptics, vision training, subnormal vision aids, and similar procedures and devices.

This *rider* does not change your benefits for: routine vision exams; contact lenses that are needed to treat keratoconus or, beginning on your health plan renewal date on or after January 1, 2021, rigid gas permeable scleral contact lenses for *members* with certain conditions as outlined in the *Blue Cross and Blue Shield medical policy*; or intraocular lenses that are implanted after corneal transplant, cataract surgery, or other covered eye surgery, when the natural eye lens is replaced.

All other provisions remain as described in your Subscriber Certificate.

MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Prescription Drug Plan

This Subscriber Certificate explains your prescription drug coverage and the terms of your enrollment in this *Blue Cross and Blue Shield* prescription drug plan. It describes your responsibilities to receive prescription drug coverage and *Blue Cross and Blue Shield's* responsibilities to you. This Subscriber Certificate also has a Prescription Drugs Rider. Your Prescription Drugs Rider shows the cost share amounts that you must pay for covered drugs and supplies (such as a *deductible* or a *copayment*) you obtain from a pharmacy. You should read all parts of this Subscriber Certificate and your Prescription Drugs Rider to become familiar with the key points. You should keep them handy so that you can refer to them. The words that are shown in italics have special meanings. These words are explained in Part 8 of this Subscriber Certificate.

Table of Contents

(continued on next page)

Blue Cross and Blue Shield of Massachusetts, Inc.

Sarah Iselin
President

1937

Donald Savery
Clerk/Secretary

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

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call Member Services at the number on your ID Card (TTY: **711**).

Spanish/Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).

Portuguese/Português: ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

Chinese/简体中文: 注意：如果您讲中文，我们可向您免费提供语言协助服务。请拨打您 ID 卡上的号码联系会员服务部（TTY 号码：**711**）。

Haitian Creole/Kreyòl Ayisyen: ATANSYON: Si ou pale kreyòl ayisyen, sèvis asistans nan lang disponib pou ou gratis. Rele nimewo Sèvis Manm nan ki sou kat Idantitifkasyon w lan (Sèvis pou Malantandan TTY: **711**).

Vietnamese/Tiếng Việt: LƯU Ý: Nếu quý vị nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cung cấp cho quý vị miễn phí. Gọi cho Dịch vụ Hội viên theo số trên thẻ ID của quý vị (TTY: **711**).

Russian/Русский: ВНИМАНИЕ: если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Позвоните в отдел обслуживания клиентов по номеру, указанному в Вашей идентификационной карте (телетайп: **711**).

Arabic/ةيبر:

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هُويتك (جهاز الهاتف النصي للصم والبكم "TTY": **711**).

Mon-Khmer, Cambodian/ខ្មែរ: ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិក តាមលេខនៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (TTY: **711**)។

French/Français: ATTENTION : si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le Service adhérents au numéro indiqué sur votre carte d'assuré (TTY : **711**).

Italian/Italiano: ATTENZIONE: se parlate italiano, sono disponibili per voi servizi gratuiti di assistenza linguistica. Chiamate il Servizio per i membri al numero riportato sulla vostra scheda identificativa (TTY: **711**).

Korean/한국어: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드에 있는 전화번호(TTY: **711**)를 사용하여 회원 서비스에 전화하십시오.

Greek/Ελληνικά: ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε την Υπηρεσία Εξυπηρέτησης Μελών στον αριθμό της κάρτας μέλους σας (ID Card) (TTY: **711**).

Polish/Polski: UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej. Należy zadzwonić do Działu obsługi ubezpieczonych pod numer podany na identyfikatorze (TTY: **711**).

Hindi/हिंदी: ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए नि:शुल्क उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वाई.: **711**).

Gujarati/ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમને ભાષાકીય સહાયતા સેવાઓ વિના મૂલ્યે ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર આપેલા નંબર પર Member Service ને કૉલ કરો (TTY: **711**).

Tagalog/Tagalog: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tawagan ang Mga Serbisyo sa Miyembro sa numerong nasa iyong ID Card (TTY: **711**).

Japanese/日本語: お知らせ：日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。IDカードに記載の電話番号を使用してメンバーサービスまでお電話ください（TTY: **711**）。

German/Deutsch: ACHTUNG: Wenn Sie Deutsche sprechen, steht Ihnen kostenlos fremdsprachliche Unterstützung zur Verfügung. Rufen Sie den Mitgliederdienst unter der Nummer auf Ihrer ID-Karte an (TTY: **711**).

Persian/پارسیان:

توج: اگر زبان شما فارسی است، خدمات کمک زبانی ب صورت رایگان در اختیار شما قرار می گیرد. با شمار تلفن مندرج بر روی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: **711**).

Lao/ພາສາລາວ: ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: **711**).

Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k’ehjí yáníłt’i’go saad bee yát’i’ éí t’áájíík’e bee níká’a’doowołgo éí ná’ahoot’i’. Díí bee anítahígí ninaaltsoos bine’déé’ nóomba biká’ígíiji̧’ béésh bee hodíílnih (TTY: **711**).

Part 1
Pharmacy Benefits

This prescription drug plan covers certain drugs and supplies that are furnished by a covered pharmacy. This coverage is provided **only** when all of the following criteria are met:

- The drug or supply is listed on the *Blue Cross and Blue Shield* Drug Formulary as a covered drug or supply. For certain covered drugs, you must have prior approval from *Blue Cross and Blue Shield* in order for you to receive this drug coverage. A covered pharmacy will tell you if your drug needs prior approval from *Blue Cross and Blue Shield.* They will also tell you how to request this approval.
- The drug or supply is prescribed for your use while you are an outpatient.
- The drug or supply is purchased from a pharmacy that is approved by *Blue Cross and Blue Shield* for payment for the specific covered drug and/or supply. This means that for most covered drugs and supplies, you may buy your drug or supply from any covered retail pharmacy. However, for some specialty drugs and supplies, you may need to buy your drug or supply from covered pharmacies that specialize in treating specific diseases and that have been approved by *Blue Cross and Blue Shield* for payment for that specific specialty drug or supply. For a list of these specialty drugs and supplies and where to buy them, you can call the *Blue Cross and Blue Shield* customer service office. Or, you can look on the internet Web site at **www.bluecrossma.org**.

The Drug Formulary

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

The Drug Formulary Exception Process

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

Member Costs for Covered Drugs and Supplies

The Prescription Drugs Rider that is part of this Subscriber Certificate describes the cost share amounts that you must pay for covered drugs and supplies. **Your Prescription Drugs Rider will tell you the amount of your drug *deductible*, *copayment* and/or *coinsurance*, whichever applies for your prescription drug coverage.** (*Blue Cross and Blue Shield* may have payment arrangements with pharmacy providers that may result in rebates on covered drugs and supplies. The cost that you pay for a covered drug or supply is determined at the time you buy the drug or supply. The cost that you pay will not be adjusted for any later rebates, settlements, or other monies paid to *Blue Cross and Blue Shield* from pharmacy providers or vendors.)

Buying Covered Drugs and Supplies

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

Mail Order Pharmacy Benefits

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

Covered Drugs and Supplies

This prescription drug coverage is provided for:

- Drugs that require a prescription by law and are furnished in accordance with *Blue Cross and Blue Shield medical technology assessment criteria*. These covered drugs include, but are not limited to: birth control drugs; oral diabetes medication that influences blood sugar levels; hormone replacement therapy drugs for peri- and post-menopausal *members*; certain drugs used on an off-label basis (such as: drugs used to treat cancer; and drugs used to treat HIV/AIDS); abuse-deterrent opioid drug products on a basis not less favorable than non-abuse deterrent opioid drug products; non-opiate drugs and supplies that are considered to be alternative medication treatment options to opiate products for pain management; oral antibiotics for the treatment of Lyme disease; and drugs for HIV associated lipodystrophy syndrome.
- Injectable insulin and disposable syringes and needles needed for its administration, whether or not a prescription is required. (When a *copayment* applies to your prescription drug coverage, if insulin, syringes, and needles are bought at the same time, you pay two *copayments*: one for the insulin; and one for the syringes and needles.)
- Materials to test for the presence of sugar when they are ordered for you by a physician for home use. These include (but are not limited to): blood glucose monitoring strips; ketone strips; lancets; urine glucose testing strips; normal, low, and high calibrator solution/chips; and dextrostik or glucose test strips. (You may obtain these testing supplies from a covered pharmacy or appliance company.)
- Insulin injection pens.
- Insulin infusion pumps and related pump supplies. (You will obtain the insulin infusion pump from an appliance company instead of a pharmacy.)
- Syringes and needles when they are *medically necessary* for you.
- 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.)
- Drugs that do not require a prescription by law ("over-the-counter" drugs), if any, that are listed on the *Blue Cross and Blue Shield* Drug Formulary as a covered drug. Your Pharmacy Program booklet will list the over-the-counter drugs that are covered, if there are any. Or, you can go online and log on to the *Blue Cross and Blue Shield* Web site at **www.bluecrossma.org**.

- Prescription birth control drugs and contraceptive methods (such as diaphragms) that have been approved by the U.S. Food and Drug Administration (FDA). As required by state law, this coverage is provided for up to a 3-month supply for the first fill of the covered drug or other method and up to a 12-month supply for additional fills of the same prescription. (The 12-month supply may be issued all at once or over the course of the 12-month period.) Your cost share will be waived for generic birth control drugs and methods (or for a brand-name drug or method when a generic is not available or not medically appropriate for you). This is the case even if your health plan is a grandfathered health plan under the Affordable Care Act. If you choose to use a brand-name birth control drug or method when a generic is available or appropriate for you, you will have to pay your cost share. See "Family Planning" in your Blue Care Elect PPO medical plan for your coverage for contraceptive implant systems and IUDs.
- Prescription prenatal vitamins and pediatric vitamins with fluoride.
- Prescription dental topical fluoride, rinses, and gels.
- Smoking and tobacco cessation products (this includes drugs and aids such as nicotine gum, patches, lozenges, inhaler systems, nasal sprays, and oral medications) for up to a 168-day supply for each type of product for each *member* in each calendar year, when they are prescribed for you by a health care provider. (These products are typically dispensed in lesser day supply quantities over the course of the calendar year.) Your cost share will be waived for generic products (or for a preferred brand-name product when a generic is not available), unless your health plan is a grandfathered health plan under the Affordable Care Act. If you choose to use a brand-name product when a generic is available, you will have to pay your cost share. Your Blue Care Elect PPO medical plan coverage for "Preventive Health Services" includes smoking and tobacco cessation counseling as recommended by the U.S. Preventive Services Task Force, unless your health plan is a grandfathered health plan under the Affordable Care Act.
- Prescription opioid antagonist drugs that block and reverse the effects of opioids that are used for the emergency treatment of a known or suspected overdose (such as morphine or heroin). Except for auto injection devices, this health plan will provide full coverage for all forms of these covered drugs. For auto injection devices, you will have to pay your cost share.

Important Note: Your *deductible*, *copayment*, and/or *coinsurance* (whichever applies to you) will be waived for: insulin infusion pumps; orally-administered anticancer prescription drugs to kill or slow the growth of cancerous cells; drugs to treat the 2019 novel coronavirus disease (COVID-19); and, when your health plan is a non-grandfathered health plan under the Affordable Care Act, certain preventive drugs as recommended and supported by the Health Resources and Services Administration, and the U.S. Preventive Services Task Force.

An overall lifetime benefit limit will not apply for your prescription drug coverage. In addition, 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; non-sedating antihistamines; ophthalmic drug solutions to treat allergies; inhaled topical nasal steroids; or proton pump inhibitors, except for prescription proton pump inhibitors that are prescribed for *members* under age 18 or that are prescribed as part of a combination drug used to treat helicobacter pylori. From time to time, *Blue Cross and Blue Shield* may change this list of non-covered drugs and supplies. When a material change is made to this list of non-covered drugs and supplies, *Blue Cross and Blue Shield* will let the *subscriber* (or the *subscriber's group* on your behalf when you are enrolled in this health plan as a *group member*) know about the change at least 60 days before the change becomes effective. For more information, you can call the *Blue Cross and Blue*

Shield customer service office. The toll free phone number to call is shown on your ID card. Or, you can also go online and log on to the *Blue Cross and Blue Shield* Web site at **www.bluecrossma.org**.
- Pharmaceuticals you can buy without a prescription, except as described in this Subscriber Certificate or in your Pharmacy Program booklet.
- Medical supplies such as dressings and antiseptics.
- The cost of delivering drugs to you.
- Combination vitamins that require a prescription, except for: prescription prenatal vitamins; and pediatric vitamins with fluoride.
- Drugs and supplies you buy from any pharmacy that is not approved by *Blue Cross and Blue Shield* for payment for the specific covered drug and/or supply.
- Drugs and supplies you buy from a non-participating retail pharmacy, except for covered drugs obtained from a pharmaceutical company, from a non-covered retail pharmacy outside Massachusetts when the drugs are not reasonably available from a covered pharmacy, or to treat the 2019 novel coronavirus disease (COVID-19).
- Drugs and supplies you buy from a non-designated mail order pharmacy.
- Drugs and supplies dispensed by non-pharmacy providers such as physician assistants, home health care providers, and visiting nurses, except as otherwise described in this Subscriber Certificate.
- Drugs and supplies not *medically necessary* for you (except for preventive drugs and birth control drugs and devices).
- Drugs and supplies that are not furnished in accordance with *Blue Cross and Blue Shield medical policy* and *medical technology assessment criteria*, 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).
- Drugs and supplies that are either not legal or not legal in the location where provided.

Part 2

Member Services

How to Get Help for Questions

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

- **If You Are Enrolled Under a Group Policy:** If you are enrolled in this plan as a *group member* under a *group* policy, you can call Monday through Friday from 8:00 a.m. to 8:00 p.m. (Eastern Time). The toll free phone number to call is shown on your ID card. (For TTY, call 711.) Or, you can write to: Blue Cross and Blue Shield of Massachusetts, Inc., Member Service, P.O. Box 9134, North Quincy, MA 02171-9134.

- **If You Are Enrolled Under an Individual Policy:** If you enrolled in this plan under an individual policy, you can call Monday through Friday from 8:00 a.m. to 6:00 p.m. (Eastern Time). The toll free phone number to call is shown on your ID card. (For TTY, call 711.) Or, you can write to: Blue Cross and Blue Shield of Massachusetts, Inc., Member Service, P.O. Box 9140, North Quincy, MA 02171-9140.

What to Do in an Emergency

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. You can do this 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 your health plan.

Discrimination Is Against the Law

Blue Cross and Blue Shield complies with applicable federal civil rights laws and does not discriminate on the basis of race; color; national origin; age; disability; sex; sexual orientation; or gender identity. *Blue Cross and Blue Shield* does not exclude people or treat them differently because of race; color; national origin; age; disability; sex; sexual orientation; or gender identity.

Blue Cross and Blue Shield provides:

- Free aids and services to people with disabilities to communicate effectively with *Blue Cross and Blue Shield*. These aids and services may include qualified sign language interpreters and written information in other formats (such as in large print).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call the *Blue Cross and Blue Shield* customer service office. The toll free phone number to call is shown on your ID card.

If you believe that *Blue Cross and Blue Shield* has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with the *Blue Cross and Blue Shield* Civil Rights Coordinator: by mail at Civil Rights Coordinator, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126; or by phone at 1-800-472-2689 (TTY: 711); or by fax at 1-617-246-3616; or by email at civilrightscoordinator@bcbsma.com. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights online at ocrportal.hhs.gov; or by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F HHH Building, Washington, DC 20201; or by phone at 1-800-368-1019 or 1-800-537-7697 (TDD). Complaint forms are available at www.hhs.gov.

Your Rights under Mental Health Parity Laws

This health plan provides coverage for *medically necessary* mental health and substance use treatment according to federal and state mental health parity laws. The financial requirements and treatment limits for your mental health or substance use coverage can be no more restrictive than those for your medical and surgical coverage. This means that the cost share amounts (a *copayment*, *coinsurance*, or *deductible*) for services to treat mental health and substance use will be the same or less than those for comparable medical and surgical services. Also, the review and authorization of services to treat mental health or substance use will be handled in a way that is comparable to the review and authorization of medical and surgical services. If *Blue Cross and Blue Shield* makes a decision to deny or reduce authorization of a service, you will receive a letter that explains the reason for the denial or reduction. *Blue Cross and Blue Shield* will send you or your health care provider a copy of the criteria used to make this decision, at your request.

You should be sure to read all parts of your Subscriber Certificate to understand your health plan coverage. If you believe that *Blue Cross and Blue Shield* is not compliant with these mental health parity laws, you can make a complaint to the Massachusetts Division of Insurance (the Division) Consumer Services Section. A complaint can be made by phone or in writing. To send a written complaint, you must use the Division's "Insurance Complaint Form." You can request a copy of this form from the Division by phone or by mail. You can also find this form on the Division's Web site at http://www.mass.gov/ocabr/consumer/insurance/file-a-complaint/filing-a-complaint.html. To make a complaint by phone, call 1-877-563-4467 or 1-617-521-7794. If you do make your complaint by phone, you must follow up your phone call by sending your complaint in writing to the Consumer Services Section. When you make a complaint, you must include: your name and address; the nature of your complaint; and your signature authorizing the release of any information about the complaint to help the Division with its review.

In addition to filing a written complaint with the Division, you must file an *appeal* with *Blue Cross and Blue Shield* to have your denial or reduction in coverage reviewed. This may be necessary to protect your right to continued coverage while you wait for an *appeal* decision. To file an *appeal* with *Blue Cross and Blue Shield*, you must follow the formal review procedures outlined in Part 4.

How You Can Request an Estimate for Proposed Covered Services

As required by state law, you or your authorized representative may request an estimate of the costs you will have to pay when your health care provider proposes an *inpatient* admission, procedure, or other covered service. You can request this cost estimate in writing using an online form or by phone. To send an online written request, log on to the *Blue Cross and Blue Shield* Web site at **www.bluecrossma.org**. Just follow the steps to request a cost estimate for health care services you are planning to receive. To request an estimate by phone, call the *Blue Cross and Blue Shield* customer service office. The toll free phone number to call is shown on your ID card. *Blue Cross and Blue Shield* will give you a cost estimate within two working days of the date your request is received. *Blue Cross and Blue Shield's* response will include an estimate of the maximum allowed charge and your cost share amount, if there is any, for the proposed covered service, and your health care provider's network status.

For Services Furnished on or After January 1, 2023. In addition to the above cost estimate, as required by federal law, you or your authorized representative may request a real-time estimate of personalized cost sharing information through *Blue Cross and Blue Shield's* internet-based self-service tool before you receive *covered services*, including prescription drugs when pharmacy coverage is administered by *Blue Cross and Blue Shield*. This self-service tool will help you to understand how costs for *covered services* are determined by this health plan. To begin your cost estimate, you can log on to the *Blue Cross and Blue Shield* Web site at **www.bluecrossma.org**. Just follow the steps to request this cost estimate.

You can also call the *Blue Cross and Blue Shield* customer service office to request the same real-time cost estimate information over the telephone. The toll free phone number to call is shown on your ID card. If you need a paper copy of a cost estimate, you can call the *Blue Cross and Blue Shield* customer service office. This information will be made available to you within two business days.

For items or services covered under this health plan, *Blue Cross and Blue Shield's* internet-based self service tool will include the following information:

- Cost-sharing liability at the time of the cost estimate (such as *deductible*, *copayment*, and/or *coinsurance*).
- Accumulated amounts such as any accrued *deductible* and/or *out-of-pocket maximum* amounts.
- Negotiated rates based on network provider payments.
- Out-of-network allowed amounts, including the maximum this health plan will pay for an out-of-network provider.
- List of items and services covered under this health plan that are subject to bundled payment arrangements, including costs for these bundled *covered services*.
- Notice of plan requirements that apply such as pre-service approval, referrals, pre-admission review or other plan provisions.

For each cost estimate, *Blue Cross and Blue Shield* is required to provide a disclosure notice to you that includes the following:

- Information disclosing that out-of-network providers may *balance bill members* for the difference between what the provider bills and the *member's* cost share amount (*copayment*, *deductible* or *coinsurance*) and if and when *balance billing* is permitted under state or federal law.
- A statement that your health care provider's actual charge for your specific *covered service* may be different from the cost estimate.
- A statement that the cost estimate is not a guarantee of coverage.
- Information on whether copayment amounts, if any, apply toward your *deductible* and/or the *out-of-pocket maximum* amounts.

As required by federal law, real-time cost estimates will be available for all *covered services.* The provisions described above do not apply to you if your health plan is a grandfathered health plan under the Affordable Care Act.

Delivery of Summary of Payments Forms

You will receive a Summary of Health Plan Payments explanation form when you have a cost share (such as a *deductible*, a *copayment*, or a *coinsurance*) that applies for covered services or when *Blue Cross and Blue Shield* denies coverage for all or part of a health care service or supply. This Summary of Health Plan Payments explanation form will usually be mailed to the *member* at the address that is on file for the *subscriber*. However, there are a few additional ways you may choose to receive your Summary of Health Plan Payments explanation forms. Upon submitting your request in writing to *Blue Cross and Blue Shield*, you may:

- Have the Summary of Health Plan Payments explanation form mailed to the *member's* address that is on file with *Blue Cross and Blue Shield*. (*Blue Cross and Blue Shield* is not required to maintain more than one alternate address for a *member*.)
- Access the Summary of Health Plan Payments explanations by using the online *Blue Cross and Blue Shield* member self service option. To check online, log on to the *Blue Cross and Blue Shield* Web site at **www.bluecrossma.org**. Just follow the steps to sign-up for paperless statements.

When a *member* selects an alternate method of receipt as described above, this selection will remain in effect until the *member* submits a request in writing for a different method. Your request for a different method will be completed by *Blue Cross and Blue Shield* within three working days of receiving the request. If you enroll in another *Blue Cross and Blue Shield* health plan or a health plan offered by Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc., you should call the *Blue Cross and Blue Shield* customer service office as this may affect the delivery of your Summary of Health Plan Payments explanation forms.

There may be certain times when you may request not to receive a Summary of Health Plan Payments explanation form for a certain health care service or supply. This request must be made by phone or in writing to *Blue Cross and Blue Shield*.

Office of Patient Protection

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

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

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

Part 3

Claim Filing Procedures

Filing a Claim

You do not have to file a claim when you buy covered drugs and supplies from a participating pharmacy. Just tell the pharmacy that you are a *member*. You also need to show them your *Blue Cross and Blue Shield* ID 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. (If *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 coverage or payment, *Blue Cross and Blue Shield* will make a decision. When appropriate, *Blue Cross and Blue Shield* will make a payment to the pharmacy (or to you in certain cases) for your claim to the extent of your coverage. Or, *Blue Cross and Blue Shield* will send you and/or the pharmacy a notice in writing of why your claim is not being paid in full or in part. If the request for coverage or payment is not complete or if *Blue Cross and Blue Shield* needs more information to make a final determination for your claim, *Blue Cross and Blue Shield* will ask for the information or records it needs within 30 calendar days of the date that *Blue Cross and Blue Shield* received the request for coverage or payment. This additional information must be provided to *Blue Cross and Blue Shield* within 45 calendar days of this request. If the additional information is provided to *Blue Cross and Blue Shield* within 45 calendar days of *Blue Cross and Blue Shield's* request, *Blue Cross and Blue Shield* will make a decision within the time remaining in the original 30-day claim determination period. Or, *Blue Cross and Blue Shield* will make the decision within 15 calendar days of the date the additional information is received by *Blue Cross and Blue Shield*, whichever is later. If the additional information is not provided to *Blue Cross and Blue Shield* within 45 calendar days of *Blue Cross and Blue Shield's* request, the claim for coverage or payment will be denied by *Blue Cross and Blue Shield*. If the additional information is submitted to *Blue Cross and Blue Shield* after these 45 days, then it may be viewed by *Blue Cross and Blue Shield* as a new claim for coverage or payment. In this case, *Blue Cross and Blue Shield* will make a decision within 30 days as described in this section.

Part 4

Appeal and Grievance Program

You have the right to a full and fair review when you disagree with a decision that is made by *Blue Cross and Blue Shield* to deny a request for coverage or payment for a drug or supply; or you disagree with how your claim was paid; or you are denied coverage in this prescription drug plan; or your coverage is canceled or discontinued by *Blue Cross and Blue Shield* for reasons other than nonpayment of *premium*. You also have the right to a full and fair review when you have a complaint about the care or service you received from *Blue Cross and Blue Shield* or from a participating pharmacy. Part 4 explains the process for handling these types of problems and concerns.

When making a determination under this prescription drug plan, *Blue Cross and Blue Shield* has full discretionary authority to interpret this prescription drug plan contract and to determine whether a health service or supply is a *covered service* under this prescription drug plan. All determinations by *Blue Cross and Blue Shield* with respect to benefits under this prescription drug plan will be conclusive and binding unless it can be shown that the interpretation or determination was arbitrary and capricious.

Inquiries and/or Claim Problems or Concerns

Most problems or concerns can be handled with just one phone call. For help to resolve a problem or concern, you should first call the *Blue Cross and Blue Shield* customer service office. The toll free phone number to call is shown on your ID card. A customer service representative will work with you to help you understand your coverage or to resolve your problem or concern as quickly as possible. *Blue Cross and Blue Shield* will consider all aspects of the particular case when resolving a problem or concern. This includes looking at: all of the provisions of this prescription drug plan; the policies and procedures that support this prescription drug plan; the health care provider's input; and your understanding of coverage by this prescription drug plan. *Blue Cross and Blue Shield* may use an individual consideration approach when *Blue Cross and Blue Shield* judges it to be appropriate. *Blue Cross and Blue Shield* will follow its standard guidelines when it resolves your problem or concern. If after speaking with a *Blue Cross and Blue Shield* customer service representative, you still disagree with a decision that is given to you, you may request a formal review through the *Blue Cross and Blue Shield* Member Appeal and Grievance Program. You may also request a formal review if *Blue Cross and Blue Shield* has not responded to you within three working days of receiving your inquiry. If this does happen, *Blue Cross and Blue Shield* will notify you and let you know the steps you may follow to request a formal review.

Appeal and Grievance Review Process

Internal Formal Review

How to Request an Internal Formal Appeal or Grievance Review

To request an internal formal *appeal* or *grievance* review, you (or your authorized or legal representative) have three options.

- **To write or send a fax.** The preferred option is for you to send your request for an *appeal* or a *grievance* review in writing to: Member Appeal and Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Or, you may fax your request 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. When you send your request, you should be sure to include any documentation that will help the review.

- **To send an e-mail.** You may send your request for an *appeal* or a *grievance* review to the *Blue Cross and Blue Shield* Member Appeal and Grievance Program e-mail 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. When you send your request, you should be sure to include any documentation that will help the review.

- **To make a telephone call.** You may call the *Blue Cross and Blue Shield* Member Appeal and Grievance Program at 1-800-472-2689. When your request is made by phone, *Blue Cross and Blue Shield* will send you a written account of your request for an *appeal* or a *grievance* review within 48 hours of your phone call.

Before you make an *appeal* or file a *grievance*, you should read "What to Include in an Appeal or Grievance Review Request" that shows later in this section.

Once your *appeal* or *grievance* request is received, *Blue Cross and Blue Shield* will research the case in detail. *Blue Cross and Blue Shield* will ask for more information if it is needed and let you know in writing of the review decision or the outcome of the review.

All requests for an *appeal* or a *grievance* review must be received by *Blue Cross and Blue Shield* within 180 calendar days of the date of treatment, event, or circumstance which is the cause of your dispute or complaint, such as the date you were told of the service denial or claim denial.

Office of Patient Protection
The Massachusetts Office of Patient Protection can help *members* with information and reports about health plan appeals and complaints. To contact that office, you can call 1-800-436-7757. Or, you can fax a request to 1-617-624-5046. Or, you can go online and log on to the Office of Patient Protection's Web site at www.mass.gov/hpc/opp.

What to Include in an Appeal or Grievance Review Request
Your request for an internal formal *appeal* or *grievance* review should include: the name, ID number, and daytime phone 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.

- **Appealing a Coverage Decision.** A "coverage decision" is a decision that *Blue Cross and Blue Shield* makes about your coverage or about the amount *Blue Cross and Blue Shield* will pay for your health care services or drugs. For example, your doctor may have to contact *Blue Cross and Blue Shield* and ask for a coverage decision before you receive proposed drugs or supplies. Or, a coverage decision is made when *Blue Cross and Blue Shield* decides what is covered and how much you will pay for drugs or supplies you have already received. In some cases, *Blue Cross and Blue Shield* might decide a drug or supply is not covered or is no longer covered for you. You can make an *appeal* if you disagree with a coverage decision made by *Blue Cross and Blue Shield*.

  When you make an *appeal* about a *medical necessity* coverage decision, *Blue Cross and Blue Shield* will review your prescription drug plan contract and the policies and procedures that are in effect for your *appeal* along with medical treatment information that will help in the review. Some examples of the medical information that will help *Blue Cross and Blue Shield* review your *appeal* may include: medical records related to your *appeal*, provider consultation and office notes, and related lab or other test results. If *Blue Cross and Blue Shield* needs to review your medical records and you have not provided your consent, *Blue Cross and Blue Shield* will promptly send you an authorization form to sign. You must return this signed form to *Blue Cross and Blue Shield*. It will allow for the release of your medical records. You 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 *appeal*, including the identity of any experts who were consulted.

If you disagree with how your claim was paid or you are denied coverage for a specific drug or supply, you can make an *appeal* about the coverage decision. *Blue Cross and Blue Shield* will review the prescription drug plan contract that is in effect for your *appeal* to see if all of the rules were properly followed and to see if the drug or supply is specifically excluded or limited by your prescription drug plan. The *appeal* decision will be based on the terms of your prescription drug plan contract. For example, if a drug is excluded or limited by your prescription drug plan contract, no benefits can be provided even if the drugs are *medically necessary* for you. For this reason, you should be sure to review all parts of your prescription drug plan contract for any coverage limits and exclusions. These parts include your Subscriber Certificate and Prescription Drug Rider and *riders* (if there are any) that apply for your prescription drug plan contract.

- **Filing a Grievance.** You can file a *grievance* when you have a complaint about the care or service you received from *Blue Cross and Blue Shield* or from a participating pharmacy. Some examples of these types of problems are: you are unhappy with the quality of the care you have received; you are waiting too long to get a drug or supply; or you are unhappy with how the customer service representative has treated you. If you submit a formal *grievance* about the quality of care you received from a participating pharmacy, *Blue Cross and Blue Shield* will contact you to obtain your permission to contact the pharmacy (if your permission is not included in your formal *grievance*). For this type of *grievance*, *Blue Cross and Blue Shield* will investigate the *grievance* with your permission, but the results of any provider peer review are confidential. For this reason, you will not receive the results of this type of investigation.

Choosing an Authorized Representative
You may choose to have another person act on your behalf during the *appeal* or *grievance* review process. Except as described below, you must designate this person in writing to *Blue Cross and Blue Shield*.

If your claim is for emergency medical care services, a health care professional who has knowledge about your medical condition may act as your authorized representative. In this case, you do not have to designate the health care professional in writing. If you are not able to designate another person to act on your behalf, then a conservator, a person with power of attorney, or a family member may act as your authorized representative. Or, they may appoint someone else to act as your authorized representative.

Who Handles the Appeal or Grievance Review
All *appeals* and *grievances* are reviewed by professionals who are knowledgeable about *Blue Cross and Blue Shield* and the issues involved in the *appeal* or *grievance*. The professionals who will review your *appeal* or *grievance* will be different from those who participated in *Blue Cross and Blue Shield's* prior decision regarding the subject of your *appeal* or *grievance*, nor will they work for anyone who did. When a review is related to a *medical necessity* denial, at least one reviewer will be an individual who is an actively practicing health care professional in the same or similar specialty who usually treats the medical condition or performs the procedure or provides treatment that is the subject of your review.

Response Time for an Appeal or Grievance Review
The review and response for an internal formal *appeal* or *grievance* review will be completed within 30 calendar days. Every reasonable effort will be made to speed up the review for requests that involve health care services that are soon to be obtained by the *member*. *Blue Cross and Blue Shield* may extend the 30-calendar-day time frame to complete a review when both *Blue Cross and Blue Shield* and the *member* agree that additional time is required to fully investigate and respond to the request. *Blue Cross and Blue Shield* may also extend the 30-calendar-day time frame when the review requires your medical records and *Blue Cross and Blue Shield* needs 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 *Blue Cross and Blue Shield* does not receive your authorization

within 30 working days after your request for a review is received, *Blue Cross and Blue Shield* may make a final decision about your request without that medical information. In any case, for a 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 request for a review.

An *appeal* or *grievance* that is not acted upon within the time frames specified by applicable federal or state law will be considered resolved in favor of the *member*.

Important Note: If your *appeal* or *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 an internal formal review.

Written Response for an Appeal or Grievance Review
Once the 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. This notice will include: information related to the details of your *appeal* or *grievance*; the reasons that *Blue Cross and Blue Shield* has denied the request and the applicable terms of your coverage in this prescription drug plan; the specific medical and scientific reasons for which *Blue Cross and Blue Shield* has denied the request; any alternative treatment or health care services or supplies that would be covered; *Blue Cross and Blue Shield* clinical guidelines that apply and were used and any review criteria; and how to request an external review.

Appeal and Grievance Review Records
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 *appeal* or *grievance*. These copies will be free of charge. *Blue Cross and Blue Shield* will maintain a record of all formal *appeals* and *grievances*, including the response for each review, for up to seven years.

Expedited Review for Immediate or Urgently-Needed Services
In place of the internal formal review as described above in this section, 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 respond to formal requests for a review for immediate or urgently-needed services as follows:

- When your request for a review concerns medical care or treatment for which waiting for a response under the review time frames described above would seriously jeopardize your life or health or your ability to regain maximum function as determined by *Blue Cross and Blue Shield* or your physician, or if your physician says that you will have severe pain that cannot be adequately managed without the care or treatment that is the subject of the review, *Blue Cross and Blue Shield* will review your request and notify you of the decision within 72 hours after your request is received, or such shorter time period as required by federal law.
- *Blue Cross and Blue Shield's* decision to deny payment for drugs or supplies may be reversed within 48 hours if your attending physician certifies to *Blue Cross and Blue Shield* that a denial for those drugs or supplies would create a substantial risk of serious harm to you if you were to wait for the outcome of the normal formal review process.
- A formal review requested by a *member* with a terminal illness will be completed by *Blue Cross and Blue Shield* within five working days of receiving the request. In this case, if the expedited review results in a denial for drugs or supplies, *Blue Cross and Blue Shield* will send a letter to the *member* within five working days. This letter will include: information related to the details of the request for a review; the reasons that *Blue Cross and Blue Shield* has denied the request and the applicable terms of your coverage in this prescription drug plan; the specific medical and scientific reasons for which

Blue Cross and Blue Shield has denied the request; any alternative treatment or health care services and supplies that would be covered; *Blue Cross and Blue Shield* clinical guidelines that apply and were used and any review criteria; and how to request a hearing. When the *member* requests a hearing, the hearing will be held within ten days. (Or, it will be held within five working days if the attending physician determines after consultation with *Blue Cross and Blue Shield's* Medical Director and based on standard medical practice that the effectiveness of the drug or supply would be materially reduced if it were not furnished at the earliest possible date.) You and/or your authorized or legal representative(s) may attend this hearing.

External Review

You must first go through the *Blue Cross and Blue Shield* internal formal *appeal* and *grievance* review process as described above, unless *Blue Cross and Blue Shield* has failed to comply with the time frames for the internal formal review or if you (or your authorized or legal representative) are requesting an expedited external review at the same time you (or your authorized or legal representative) are requesting an expedited internal review. The *Blue Cross and Blue Shield* internal formal review decision may be to continue to deny all or part of your coverage in this prescription drug plan. When you are denied coverage for a drug or supply because *Blue Cross and Blue Shield* has determined that the drug or supply is not *medically necessary*, you have the right to an external review. You are not required to pursue an external review. Your decision whether to pursue an external review will not affect your other coverage. If you receive a denial letter from *Blue Cross and Blue Shield* in response to your internal formal review, the letter will tell you what steps you can take to file a request for an external review. The external review will be conducted by a review agency under contract with the Massachusetts Office of Patient Protection.

How to Request an External Review

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 or legal 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 fee required to pay for your portion of the cost of the review. The form, as well as the denial letter from *Blue Cross and Blue Shield*, will tell you about your fee. *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 four months after you receive the denial letter from *Blue Cross and Blue Shield*.**

You (or your authorized or legal representative) also have the right to request an "expedited" external review. When requesting an expedited external review, you 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. You (or your authorized or legal representative) also have the right to request an expedited external review at the same time that you file a request for an expedited internal formal review.

To contact the Office of Patient Protection, you can call toll free at 1-800-436-7757. Or, you can fax a request to 1-617-624-5046. Or, you can go online and log on to the Office of Patient Protection's Web site at www.mass.gov/hpc/opp.

External Review Process

The Office of Patient Protection will screen all requests for an external review. They will begin this screening within 48 hours of receiving a request for an expedited external review and within five business days for all other external review requests. The Office of Patient Protection will determine if your request for an external review: has been submitted as required by state regulation and described above; does not involve a service or benefit that is excluded by your prescription drug plan as explicitly stated in your prescription drug plan contract; and results from an adverse determination, except that no adverse determination is necessary when *Blue Cross and Blue Shield* has failed to comply with the timelines for an internal *appeal* or *grievance* review or if you (or your authorized or legal representative) are requesting an expedited external review at the same time you are requesting an expedited internal formal review. 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 or legal 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.

External Review Decisions and Notice

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 or legal representative) and to *Blue Cross and Blue Shield* within 45 calendar days of receiving the referral from the Office of Patient Protection. In the case of an expedited review, you will be notified of their decision within 72 hours. This 72-hour period starts when the review agency receives your case from the Office of Patient Protection.

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 or legal 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: what steps or procedures you must take (if any) to obtain the requested coverage or services; the date by which *Blue Cross and Blue Shield* will pay for or authorize the requested services; and the name and phone number of the person at *Blue Cross and Blue Shield* who will make sure your *appeal* or *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 *appeal* or *grievance*. These copies will be free of charge.

Part 5

Other Plan Provisions

Access to and Confidentiality of Medical Records

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

- For administering coverage (including coordination of benefits with other insurance plans); disease management programs; managing care; quality assurance; utilization management; the prescription drug history program; *appeal* 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 (FDA) for the protection of human subjects.
- As required by law or valid court order.
- As required by government or regulatory agencies.
- As necessary for the operations of Blue Cross and Blue Shield of Massachusetts, Inc.
- As required by the *subscriber's group* or by its auditors to make sure that *Blue Cross and Blue Shield* is administering your coverage in this prescription drug plan properly. (This applies only when you are enrolled in this prescription drug plan as a *group member*.)

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

Important Note: To get a copy of *Blue Cross and Blue Shield's* Commitment to Confidentiality statement ("Notice of Privacy Practices"), call the *Blue Cross and Blue Shield* customer service office.

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 provider who has a payment agreement with *Blue Cross and Blue Shield* or any other health care provider does not act as an agent on behalf of or for *Blue Cross and Blue Shield*. And, *Blue Cross and Blue Shield* does not act as an agent for a provider who has a payment agreement with *Blue Cross and Blue Shield* or for any other 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.

Assignment of Benefits

You cannot assign any benefit or monies due from 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 by this prescription drug plan to another person or organization. There is one exception. If Medicaid has already paid the health care provider, you can assign your benefits to Medicaid.

Authorized Representative and Legal Representative

You may choose to have another person act on your behalf concerning your prescription drug coverage. Some examples are a designated authorized representative or a documented legal representative. An authorized representative is a person you have chosen to help with your health care issues and to whom *Blue Cross and Blue Shield* is allowed to disclose and discuss your protected health information (PHI). An authorized representative is not a person who has legal authority to act on your behalf. A legal representative is a person who has legal authority to act on your behalf in making decisions about your health care. They may be someone who has legal authority for: power of attorney for health care; guardianship; conservatorship; executor of estate; or health care proxy. A legal representative may also be a person documented through a court order to act on your behalf in making decisions about your health care. To designate an authorized representative or document a legal representative, you must let *Blue Cross and Blue Shield* know in writing by completing the appropriate form(s). To get copies of these forms, you can call the *Blue Cross and Blue Shield* customer service office. The toll free phone number to call is shown on your ID card. You may also log on to the *Blue Cross and Blue Shield* Web site at **www.bluecrossma.org** to get a copy of these forms. In some cases, *Blue Cross and Blue Shield* may consider your health care provider to be your authorized representative. Or, *Blue Cross and Blue Shield* may ask your physician for more information if more is needed for *Blue Cross and Blue Shield* to make a decision. *Blue Cross and Blue Shield* will consider the health care provider to be your authorized representative for emergency medical care. *Blue Cross and Blue Shield* will continue to send benefit payments and written communications regarding your prescription drug coverage according to *Blue Cross and Blue Shield's* standard practices, unless you specifically ask *Blue Cross and Blue Shield* to do otherwise.

Changes to This Plan

Blue Cross and Blue Shield may change the provisions of your coverage in this prescription drug plan. (When you are enrolled in this plan as a *group member*, the *plan sponsor* may also change a part of the *group* policy.) For example, a change may be made to the cost share amount that you must pay for certain covered drugs and supplies. When *Blue Cross and Blue Shield* makes a material change to your coverage in this prescription drug plan, *Blue Cross and Blue Shield* will send a notice about the change at least 60 days before the *effective date* of the change. The notice will be sent to the *subscriber*. Or, when you are enrolled in this plan as a *group member*, to the *plan sponsor*. The notice from *Blue and Cross Blue Shield* will describe the change being made. It will also give the effective date of the change. (If you are enrolled as a *group member*, the *plan sponsor* should deliver to its *group members* all notices from *Blue Cross and Blue Shield*.)

There may be times when the provisions of your coverage in this prescription drug plan change but *Blue Cross and Blue Shield* is not able to provide prior notice of the change as described above. These changes may be made by *Blue Cross and Blue Shield* as a result of events beyond its control such as: war; riot; national emergency; terrorist attack; public health emergency; pandemic; or natural disaster. When this happens, *Blue Cross and Blue Shield* will make a determination to provide services under this prescription drug plan based on the severity of the event and the needs of its *members* enrolled under this prescription drug plan during this time. For example, *Blue Cross and Blue Shield* may temporarily eliminate the cost share amount that you must pay for certain covered drugs and supplies such as your *copayment* or your *deductible* or your *coinsurance*.

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 in this prescription drug plan, you must notify *Blue Cross and Blue Shield* if you add or change health plan coverage. Upon *Blue Cross and Blue Shield's* request, you must also supply *Blue Cross and Blue Shield* with information about other plans that may provide you with coverage for health care services.

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

Blue Cross and Blue Shield will not provide any more prescription drug benefits than those already described in this prescription drug plan Subscriber Certificate. *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.

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

Pre-Existing Conditions

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

Subrogation and Reimbursement of Benefit Payments

If you are injured by any act or omission of another person, the benefits under this prescription 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 that you must reimburse to *Blue Cross and Blue Shield* will not be reduced by any attorney's fees or expenses that you incur. 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.

Time Limit for Legal Action

Before you pursue a legal action against *Blue Cross and Blue Shield* for any claim under this prescription drug plan, you must complete the *Blue Cross and Blue Shield* internal formal review. You may, but you do not need to, complete an external review before you pursue a legal action. If, after you complete the formal review, you choose to bring a legal action against *Blue Cross and Blue Shield*, you must bring this action within two years after the cause of the action arises. For example, if you are filing a legal action because you were denied a service or you were denied a claim for coverage from this prescription 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 of the decision of the final internal *appeal* of the service or claim denial.

Part 6

Group Policy

This Part 6 applies to you when you enroll in this health plan as a *group member.* Under a *group* policy, the *subscriber's group* has an agreement with *Blue Cross and Blue Shield* to provide its *group members* with access to health care services and benefits. The *group* will make payments to *Blue Cross and Blue Shield* for its *group members* for coverage in this prescription drug plan. The *group* should also deliver to its *group members* all notices from *Blue Cross and Blue Shield*. The *group* is the *subscriber's* agent. The *group* is not the agent of *Blue Cross and Blue Shield*. If you are enrolled as a *group member*, you should contact your *plan sponsor* for enrollment or billing questions.

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

Eligibility for Group Coverage

Eligible Employee

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

Eligible Spouse

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

Former Spouse

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

Eligible Dependents

The *subscriber* may enroll eligible dependents in this plan under their *group* policy. "Eligible dependents" include the *subscriber's* (or *subscriber's* spouse's) children until the end of the calendar month in which the child turns age 26. To be an eligible dependent, the child is not required to: live with the *subscriber* or the *subscriber's* spouse; or be a dependent on the *subscriber's* or spouse's tax return; or be a full-time student. These eligible dependents may include:

- A newborn child. The effective date of coverage for a newborn child will be the child's date of birth provided that the *subscriber* formally notifies the *plan sponsor* within 30 days of the date of birth. This plan provides prescription drug coverage for newborn infants for injury and sickness. This includes necessary drugs and supplies for the treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth. This prescription drug coverage is subject to all of the provisions of this plan.
- An adopted child. The effective date of coverage for an adopted child will be the date of placement of the child 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 they assume custody of a child for the purpose of adoption, the child's prescription drug coverage for injury or sickness will be provided from the date of custody. (This coverage is provided without a waiting period or pre-existing condition restriction.) This includes the necessary drugs and supplies for the treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth. This coverage is subject to all of the provisions of this plan.
- A newborn infant of an enrolled dependent child immediately from the moment of birth and continuing after, until the enrolled dependent child is no longer eligible as a dependent.

If an eligible dependent child is married, the dependent child can enroll for coverage under the *subscriber's group* policy. And, as long as that enrolled child is an eligible dependent, their children are also eligible for coverage under the *subscriber's group* policy. The dependent child's spouse is **not** eligible to enroll as a dependent for coverage under the *subscriber's group* policy.

An eligible dependent may also include:

- A person under age 26 who is not the *subscriber's* (or *subscriber's* spouse's) child but who qualifies as a dependent of the *subscriber* under the Internal Revenue Code. When the dependent loses their dependent status under the Internal Revenue Code, that dependent will continue to be eligible as a dependent for coverage in this health plan under the *subscriber's group* policy for two years after the end of the calendar year in which they last qualified as a dependent under the Internal Revenue Code or until the dependent turns age 26, whichever comes first.
- A child recognized under a Qualified Medical Child Support Order as having the right to enroll for health care coverage.
- A disabled dependent child age 26 or older. A dependent child who is mentally or physically incapable of earning their own living and who is enrolled under the *subscriber's group* policy will continue to be covered after they would otherwise lose dependent eligibility under the *subscriber's group* policy, so long as the child continues to be mentally or physically incapable of earning their 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 group* policy. 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.

Your *Blue Cross and Blue Shield* coverage consists of this prescription drug plan and your Blue Care Elect PPO medical plan. When your medical coverage allows for enrollment of a domestic partner or expands the maximum age for eligible dependents, the eligibility provisions of this prescription drug coverage will change to be the same eligibility provisions that apply for your medical coverage. Refer to any *riders* that are included as part of your evidence of coverage packet.

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

Enrollment Periods for Group Coverage

Initial Enrollment

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

Special Enrollment

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

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

These rights are known as your "special enrollment rights." There may be additional special enrollment rights as a result of changes required by federal law. For example, these changes may include special enrollment rights for: individuals who are newly eligible for coverage as a result of changes to dependent eligibility; and/or individuals who are newly eligible for coverage as a result of the elimination of a lifetime maximum.

Loss of Other Qualified Coverage

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

- The employee or the eligible dependents (including a spouse) cease to be eligible for the other qualified health plan. For example, this could mean that the loss of the other qualified health plan was due to: the loss of the spouse's coverage; the death of the spouse; divorce; loss of dependent status; or involuntary termination. This includes when an employee or eligible dependent is covered under a Medicaid plan or a state Children's Health Insurance Program plan and coverage is terminated as a result of loss of eligibility for that coverage.
- The employer that is sponsoring the other qualified group health plan coverage ceases to make employer contributions for the other group health plan coverage.

- The employee or the eligible dependents (including a spouse) exhaust their continuation of group coverage under the other qualified group health plan.
- The prior qualified health plan was terminated due to the insolvency of the health plan carrier.

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

New Dependents
If an eligible employee gains a new spouse or other new eligible dependent(s) due to marriage, adoption, placement for adoption, or birth, the employee and the spouse and/or the new dependent(s) may enroll for coverage in this prescription drug plan under a *group* policy. (If the new dependent is gained by birth, adoption, or placement for adoption, enrollment under the *group* policy 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 when any one of the following situations occur: the date on which the loss of your other coverage occurs; or the date on which the *subscriber* gains a new dependent; or the date on which the *subscriber* receives notice that a dependent child who was not previously eligible is newly eligible for coverage as a result of changes to dependent eligibility; or the date on which you receive notice that you are newly eligible for coverage as a result of the elimination of a lifetime maximum. For example, if your coverage under another health plan is terminated, you must request enrollment for coverage in this prescription drug plan under a *group* policy within 30 days after your other health care coverage ends. Upon request, the *plan sponsor* will send you any special forms you may need. If you do not request enrollment within 30 days, you will have to wait until the *group's* next open enrollment period to enroll under a *group* policy. You also have special enrollment rights related to termination of coverage under a state Children's Health Insurance Program plan or a Medicaid plan or eligibility for assistance under a Medicaid plan or a state Children's Health Insurance Program plan. When this situation applies, you must notify your *plan sponsor* to request coverage no later than 60 days after the coverage terminates or the employee or eligible dependent is determined to be eligible for assistance.

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

Open Enrollment Period
If you choose not to enroll for coverage in this health plan under a *group* policy within 30 days of your initial *group* eligibility date, you may enroll during your *group's* open enrollment period. The open enrollment period is the time each year during which eligible persons may enroll for or change coverage for the next year. The open enrollment period is announced by the *group* to all eligible employees. To enroll for coverage in this health plan under a *group* policy during this enrollment period, you must complete the enrollment form provided in the *group's* enrollment packet and return it to the *group* no later than the date specified in the *group's* enrollment packet.

Other Membership Changes

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

Termination of Group Coverage

Loss of Eligibility for Group Coverage

When your eligibility for a *group* policy ends, your *group* coverage in this plan will be terminated. Your eligibility for *group* coverage ends when:

- The *subscriber* loses eligibility for the *group's* health care coverage. This means: the *subscriber's* hours are reduced; or the *subscriber* leaves the job; or the *subscriber* no longer meets the rules that are set by the *group* for coverage under the *group* policy. You will also lose eligibility for *group* coverage if you are an enrolled dependent when the *subscriber* dies.
- You lose your status as a dependent under the *subscriber's group* policy. In this case, you may wish to enroll as a *subscriber* under an individual policy for health care coverage. For help, you can call the *Blue Cross and Blue Shield* customer service office. They will tell you which health plans are available to you.
- You reach age 65 and become eligible for Medicare (Part A and Part B). However, as allowed by federal law, the *subscriber* (and the spouse and/or dependents) may have the option of continuing coverage in this plan under a *group* policy when the *subscriber* remains as an actively working employee after reaching age 65. You should review all options available to you with the *plan sponsor*. Medicare eligible *subscribers* who retire and/or their spouses are not eligible to continue coverage in this plan under a *group* policy once they reach age 65.
- The *plan sponsor* fails to pay the *group premium* to *Blue Cross and Blue Shield* within 30 days of the due date. In this case, *Blue Cross and Blue Shield* will notify you in writing of the termination of your *group* coverage in accordance with the Code of Massachusetts Regulations. This notice will give you information about the termination of your *group* coverage. It will also tell you about your options for coverage offered by *Blue Cross and Blue Shield* or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
- The *group* terminates (or does not renew) its *group* contract with *Blue Cross and Blue Shield*.

Termination of Group Coverage by the Subscriber

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

Termination of Group Coverage by Blue Cross and Blue Shield

Your *group* coverage in this plan will not be canceled because you are using your coverage or because you will need more covered services in the future. *Blue Cross and Blue Shield* will cancel your *group* coverage in this plan **only when**:

- You commit misrepresentation or fraud. Your coverage in this plan will be canceled, or in some cases *Blue Cross and Blue Shield* may limit your benefits, if you have committed misrepresentation or fraud. For example, you gave false or misleading information on the enrollment form. Or, you misused your ID card by letting another person who was not enrolled in this plan attempt to get coverage. Your coverage in this plan may be terminated when the fraud or misrepresentation is discovered or, as permitted by law, back to your *effective date* or the date of the misrepresentation or fraud. Your coverage in this plan may be terminated retroactive to a date in the past (rather than on a current or future date) only if you committed fraud or made an intentional misrepresentation of a material fact. The termination date will be determined by *Blue Cross and Blue Shield*.

- You commit acts of physical or verbal abuse that pose a threat to, or a threat to the health of, health care providers or other *members* or employees of *Blue Cross and Blue Shield* or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc., and these acts are not related to your physical condition or mental condition. In this case, this termination will follow the procedures approved by the Massachusetts Commissioner of Insurance.
- You fail to comply in a material way with any provision of the *group* policy. For example, if you fail to provide information that *Blue Cross and Blue Shield* requests related to your coverage in this plan, *Blue Cross and Blue Shield* may terminate your coverage.
- *Blue Cross and Blue Shield* discontinues this plan for any reason as of a date approved by the Massachusetts Commissioner of Insurance.

If *Blue Cross and Blue Shield* cancels your *group* coverage, a notice will be sent to your *group* that will tell your *group* the specific reason(s) that *Blue Cross and Blue Shield* is canceling your *group* policy.

Continuation of Group Coverage

Limited Extension of Group Coverage under State Law

If you lose eligibility for coverage in this plan under a *group* policy due to a plant closing or a partial plant closing (as defined by law) in Massachusetts, you may continue coverage under the *group* policy as provided by state law. If this happens to you, you and your *group* will each pay your shares of the *premium* cost for up to 90 days after the plant closing. Then, to continue your *group* coverage for up to 39 more weeks, you will pay 100% of the *premium* cost. At this same time, you may also be eligible for continued *group* coverage under other state laws or under federal law (see below). If you are, the starting date for continued *group* coverage under all of these laws will be the same date. But, after the 90-day extension period provided by this state law ends, you may have to pay more *premium* to continue your coverage under the *group* policy. If you become eligible for coverage under another employer sponsored health plan at any time before the 39-week extension period ends, continued coverage in this plan under the *group* policy under these provisions also ends.

Continuation of Group Coverage under Federal or State Law

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

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

- Death of the *subscriber*.
- *Subscriber's* entitlement to Medicare benefits.
- Loss of status as an eligible dependent.

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

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

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 their eligible dependent is determined to be disabled under Title II or Title XVI of the Social Security Act, continued *group* coverage will be available for up to 29 months from the date of the qualifying event. The *premium* cost for the additional 11 months may be up to 150% of the *premium* rate. If during these 11 months eligibility for disability is lost, *group* coverage may cancel before the 29 months is completed. You should contact your *plan sponsor* for more help about continued coverage.

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

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

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

Part 7

Individual Policy

This Part 7 applies to you when you enroll in this prescription drug plan as a direct pay *member* (and not as a *group member* under a *group* policy). Under an individual policy, the *subscriber* has an agreement with *Blue Cross and Blue Shield* to provide the *subscriber* and their enrolled eligible spouse and other enrolled eligible dependents with access to prescription drug coverage. The *subscriber* will make payments to *Blue Cross and Blue Shield* for coverage in this prescription drug plan under an individual policy. For questions about enrollment and billing, you can call the *Blue Cross and Blue Shield* customer service office.

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

Eligibility for Individual Coverage

Eligible Individual

You are eligible for coverage in this plan under an individual policy as long as you are a resident of Massachusetts. A "resident" is a person who lives in Massachusetts as shown by evidence that is considered acceptable by *Blue Cross and Blue Shield*. This means *Blue Cross and Blue Shield* may ask you for evidence such as a lease or rental agreement, a mortgage bill, or a utility bill. The fact that you are in a nursing home, a hospital, or other institution does not by itself mean you are a resident. And, you are not a resident if you come to Massachusetts to receive medical care or to attend school but you still have residency outside of Massachusetts.

If you are under age 18 and you are requesting to enroll as a *subscriber*, the enrollment form must be completed by your parent or guardian. In this case, the person who is executing the contract (your parent or guardian) is not eligible for benefits under your coverage in the individual policy. But, they will be responsible for acting on behalf of the *subscriber* as necessary and for paying the monthly *premium* for your coverage. The person who executes the contract will be considered your authorized representative.

Eligible Spouse

The *subscriber* may enroll an eligible spouse for coverage in this plan under their individual policy. An "eligible spouse" includes the *subscriber's* legal spouse or legal civil union spouse. An eligible spouse must also meet all of the same eligibility conditions as described above for an eligible individual.

Former Spouse

In the event of a divorce or a legal separation, the person who was the spouse of the *subscriber* prior to the divorce or legal separation may maintain coverage in this plan under the *subscriber's* individual policy. This coverage may continue only until: the *subscriber* is no longer required by the divorce judgment to provide health insurance for the former spouse; or the *subscriber* or former spouse remarries. In either case, the former spouse may wish to enroll as a *subscriber* under their own individual policy. The *Blue Cross and Blue Shield* customer service office can help you with these options. In these situations, *Blue Cross* *and Blue Shield* must be notified within 30 days of a change to the former spouse's address. Otherwise, *Blue Cross and Blue Shield* will not be liable for any acts or omissions due to having the former spouse's incorrect address on file.

Eligible Dependents

The *subscriber* may enroll eligible dependents for coverage in this plan under their individual policy. Eligible dependents must meet all of the same eligibility conditions as described above for an eligible individual. However, a dependent child may live outside of Massachusetts to attend school as long as they have not moved out of Massachusetts permanently. "Eligible dependents" include the *subscriber's* (or the *subscriber's* spouse's) children until the end of the calendar month in which the child turns age 26. To be an eligible dependent, the child is not required to: live with the *subscriber* or the *subscriber's* spouse; or be a dependent on the *subscriber's* or spouse's tax return; or be a full-time student. These eligible dependents may include:

- A newborn child. The effective date of coverage for a newborn child will be the child's date of birth provided that the *subscriber* formally notifies *Blue Cross and Blue Shield* within 30 days of the date of birth. This plan provides prescription drug coverage for newborn infants for injury and sickness. This includes necessary drugs and supplies for the treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth. This prescription drug coverage is subject to all of the provisions of this plan.
- An adopted child. The effective date of coverage for an adopted child will be the date of placement of the child 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 they assume custody of a child for the purpose of adoption, the child's prescription drug coverage for injury or sickness will be provided from the date of custody. (This coverage is provided without a waiting period or pre-existing condition restriction.) This includes the necessary drugs and supplies for the treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth. This coverage is subject to all of the provisions of this plan.
- A newborn infant of an enrolled dependent child immediately from the moment of birth and continuing after, until the enrolled dependent child is no longer eligible as a dependent.

If an eligible dependent child is married, the dependent child can enroll for coverage under the *subscriber's* individual policy. And, as long as that enrolled child is an eligible dependent, their children are also eligible for coverage under the *subscriber's* individual policy. The dependent child's spouse is **not** eligible to enroll as a dependent for coverage under the *subscriber's* individual policy.

An eligible dependent may also include:

- A person under age 26 who is not the *subscriber's* (or *subscriber's* spouse's) child but who qualifies as a dependent of the *subscriber* under the Internal Revenue Code. When the dependent loses their dependent status under the Internal Revenue Code, that dependent will continue to be eligible as a dependent for coverage in this health plan under the *subscriber's* individual policy for two years after the end of the calendar year in which they last qualified as a dependent under the Internal Revenue Code or until the dependent turns age 26, whichever comes first.
- A child who is recognized under a Qualified Medical Child Support Order as having the right to enroll for health care coverage.
- A disabled dependent child age 26 or older. A dependent child who is mentally or physically incapable of earning their own living and who is enrolled under the *subscriber's* individual policy will continue to be covered after they would otherwise lose dependent eligibility under the *subscriber's* individual policy, so long as the child continues to be mentally or physically incapable of earning their 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* individual policy. 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.

Your *Blue Cross and Blue Shield* coverage consists of this prescription drug plan and your Blue Care Elect PPO medical plan. When your medical coverage allows for enrollment of a domestic partner or expands the maximum age for eligible dependents, the eligibility provisions of this prescription drug coverage will change to be the same eligibility provisions that apply for your medical coverage. Refer to any *riders* that are included as part of your evidence of coverage packet.

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

Enrolling for Individual Coverage

Open Enrollment Period

If you are an eligible individual, you can enroll for coverage in this plan only during a designated open enrollment period, except when any of the special enrollment situations as described below apply to you. For information about open enrollment periods and when they occur, you may contact the *Blue Cross and Blue Shield* customer service office.

Special Enrollment

If any one of the following special enrollment situations applies, you may enroll for coverage in this plan under an individual policy, without waiting for a designated open enrollment period. In any of these situations, you will be enrolled within 30 days of the date that *Blue Cross and Blue Shield* receives your completed enrollment form.

- You had prior creditable health care coverage. *Blue Cross and Blue Shield* must receive your enrollment request within 63 days of the termination date of the prior health care coverage.
- You have a qualifying event, including (but not limited to): marriage; birth or adoption of a child; court-ordered care of a child; loss of coverage as a dependent under a group or government health plan; or any other event as may be designated by the Commissioner of Insurance. *Blue Cross and Blue Shield* must receive your enrollment request within 63 days of the event or within 30 days of the event if coverage is for an eligible dependent.
- You have been granted a waiver by the Office of Patient Protection to enroll outside of the open enrollment period.

Enrollment Process

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

During the enrollment process, *Blue Cross and Blue Shield* will check and verify each person's eligibility for coverage in this plan under an individual policy. This means that when you apply for coverage, you may be required to provide evidence that you are a resident of Massachusetts. Examples of evidence to show that you are a resident can be a copy of your lease or rental agreement, a mortgage bill, or a utility bill. If you are not a citizen of the United States, *Blue Cross and Blue Shield* may also require that you provide official U.S. immigration documentation. You will also be asked to provide information about your prior health plan(s), and you may be required to provide a copy of your certificate(s) of health plan coverage. If you fail to provide information to *Blue Cross and Blue Shield* that it needs to verify your eligibility for an individual policy, *Blue Cross and Blue Shield* will deny your enrollment request. Once you are enrolled in this plan, each year prior to your plan renewal date, *Blue Cross and Blue Shield* may check and verify that you are still eligible for coverage under an individual policy.

Blue Cross and Blue Shield may deny your enrollment for coverage, or cancel your coverage, in this plan under an individual policy for any of the following reasons.

- You fail to provide information to *Blue Cross and Blue Shield* that it needs to verify your eligibility for coverage in this plan under an individual policy.
- You committed misrepresentation or fraud to *Blue Cross and Blue Shield* about your eligibility for coverage in this plan under an individual policy.
- You made at least three or more late payments for your health care plan(s) in a 12-month period.
- You voluntarily ended your coverage in this health plan within the past 12 months on a date that is not your renewal date. But, this does not apply if you had creditable coverage (as defined by state law) continuously up to a date not more than 63 days prior to the date of your request for enrollment in this plan under an individual policy.

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

Newly enrolled *members* will **not** have a waiting period before *Blue Cross and Blue Shield* will provide coverage as described in this prescription drug plan.

Membership Changes

Generally, the *subscriber* may make membership changes (for example, change from a plan that covers only one person to a family plan) only if the *subscriber* has a change in family status. This includes a change such as: marriage or divorce; birth, adoption or change in custody of a child; death of an enrolled spouse or dependent; or the loss of an enrolled dependent's eligibility under the *subscriber's* individual policy. If you want to ask for a membership change or you need to change your name or mailing address, you should call or write to *Blue Cross and Blue Shield. Blue Cross and Blue Shield* will send you any forms that you may need. You must request a membership change within 30 days of the reason for the change. Or, if the newly eligible person had prior creditable coverage (as defined by state law), the change must be requested within 63 days of the termination date of the prior health care coverage. If you do not request the change within the time required, you will have to wait until the next annual open enrollment period to make the change. All changes are allowed only when they comply with the conditions outlined in the individual policy and with *Blue Cross and Blue Shield* policies.

Termination of Individual Coverage

Loss of Eligibility for Individual Coverage

When your eligibility for an individual policy ends, your coverage in this plan will be terminated as of the date you lose eligibility. Your eligibility for coverage in this plan under an individual policy ends when:

- You lose your status as an eligible dependent under the *subscriber's* individual policy. In this case, you may wish to enroll as a *subscriber* under an individual policy for health care coverage. For help, you can call the *Blue Cross and Blue Shield* customer service office. They will tell you which health plans are available to you.
- You move out of Massachusetts.

Termination of Individual Coverage by the Subscriber

Your coverage in this plan under an individual policy will end when:

- The *subscriber* chooses to cancel their individual policy. To do this, the *subscriber* must send a written request to *Blue Cross and Blue Shield*. The termination date will be effective 15 days after the date that *Blue Cross and Blue Shield* receives the termination request. Or, the *subscriber* may ask for a specific termination date. In this case, *Blue Cross and Blue Shield* must receive the request at least 15 days before that requested termination date. *Blue Cross and Blue Shield* will return to the *subscriber* any *premiums* that are paid for a time after the termination date.
- The *subscriber* fails to pay their *premium* to *Blue Cross and Blue Shield* within 35 days after it is due. If *Blue Cross and Blue Shield* does not get the full *premium* on or before the due date, *Blue Cross and Blue Shield* will stop claim payments as of the last date through which the *premium* is paid. Then, if *Blue Cross and Blue Shield* does not get the full *premium* within this required time period, *Blue Cross and Blue Shield* will cancel your coverage in this plan. The termination date will be the last date through which the *premium* is paid.

Termination of Individual Coverage by Blue Cross and Blue Shield

Your coverage in this plan will not be canceled because you are using your coverage or because you will need more covered drugs or supplies in the future. *Blue Cross and Blue Shield* will cancel your coverage in this plan **only when**:

- You commit misrepresentation or fraud. Your coverage will be canceled, or in some cases *Blue Cross and Blue Shield* may limit your benefits, if you have committed misrepresentation or fraud. For example, you gave false or misleading information on the enrollment form. Or, you misused your ID card by letting another person who was not enrolled in this plan attempt to get coverage. Your coverage in this plan may be terminated when the fraud or misrepresentation is discovered or, as permitted by law, back to your *effective date* or the date of the misrepresentation or fraud. Your coverage in this plan may be terminated retroactive to a date in the past (rather than on a current or future date) only if you committed fraud or made an intentional misrepresentation of a material fact. The termination date will be determined by *Blue Cross and Blue Shield*.
- You commit acts of physical or verbal abuse that pose a threat to, or a threat to the health of, health care providers or other *members* or employees of *Blue Cross and Blue Shield* or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc., and these acts are not related to your physical condition or mental condition. In this case, this termination will follow the procedures approved by the Massachusetts Commissioner of Insurance.
- You fail to comply in a material way with any provision of this plan. For example, if you fail to provide information that *Blue Cross and Blue Shield* requests related to your coverage in this plan, *Blue Cross and Blue Shield* may terminate your coverage.
- *Blue Cross and Blue Shield* discontinues this plan. *Blue Cross and Blue Shield* may discontinue this plan for any reason as of a date approved by the Massachusetts Commissioner of Insurance.

In the event that *Blue Cross and Blue Shield* cancels your individual policy, a notice will be sent to you that will tell you the specific reason(s) that *Blue Cross and Blue Shield* is canceling your individual policy.

Part 8

Explanation of Terms

The following words are shown in italics in this Prescription Drug Plan Subscriber Certificate, your Prescription Drugs Rider, and any *riders* that apply to your coverage in this plan. The meaning of these words will help you understand your prescription drug benefits.

Appeal

An *appeal* is something you do if you disagree with a *Blue Cross and Blue Shield* decision to deny a request for coverage of health care services or drugs, or payment, in part or in full, for services or drugs you already received. You may also make an *appeal* if you disagree with a *Blue Cross and Blue Shield* decision to stop coverage for services that you are receiving. For example, you may ask for an *appeal* if *Blue Cross and Blue Shield* doesn't pay for a service, item, or drug that you think you should be able to receive. Part 4 explains what you have to do to make an *appeal*. It also explains the review process.

Blue Cross and Blue Shield

The term "*Blue Cross and Blue Shield*" refers to Blue Cross and Blue Shield of Massachusetts, Inc. It also refers to an employee or designee of *Blue Cross and Blue Shield* who is authorized to make decisions or take action called for under this prescription drug plan. *Blue Cross and Blue Shield* has full discretionary authority to interpret this prescription drug plan contract. This includes determining the amount, form, and timing of benefits, conducting *medical necessity* reviews, and resolving any other matters regarding your right to benefits for covered drugs and supplies as described in this prescription drug plan contract. All determinations by *Blue Cross and Blue Shield* with respect to benefits under this prescription drug plan will be conclusive and binding unless it can be shown that the interpretation or determination was arbitrary and capricious.

Coinsurance

For some covered drugs and supplies, you may have to pay a *coinsurance*. This means the cost that you pay for these covered drugs and supplies (your "cost share amount") will be calculated as a percentage. When a *coinsurance* does apply to a specific covered drug or supply, *Blue Cross and Blue Shield* will calculate your cost share amount based on the provider's actual charge or the *Blue Cross and Blue Shield* allowed charge, whichever is less (unless otherwise required by law). Your Prescription Drugs Rider shows the covered drugs and supplies for which you must pay a *coinsurance* (if there are any). If a *coinsurance* does apply, your Prescription Drugs Rider also shows the percentage that *Blue Cross and Blue Shield* will use to calculate your cost share amount. (Also refer to *riders*—if there are any—that apply to your coverage in this prescription drug plan.)

Copayment

For some covered drugs and supplies, you may have to pay a *copayment*. This means the cost that you pay for these covered drugs and supplies (your "cost share amount") is a fixed dollar amount. In most cases, a covered pharmacy will collect the *copayment* from you at the time they furnish the covered drug or supply. 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 (unless otherwise required by law). Any later charge adjustment—up or down—will not affect your *copayment* (or the cost you were charged at the time of the service if it was less than the *copayment*). Your Prescription Drugs Rider shows the amount of your *copayment*. It also shows the covered drugs and supplies for which you must pay a *copayment*. (Also refer to *riders*—if there are any—that apply to coverage in this prescription drug plan.)

Deductible

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

- Any *copayments* and/or *coinsurance* you pay.
- The costs you pay when your coverage is reduced or denied because you did not follow the requirements of the *Blue Cross and Blue Shield utilization review* program.
- The costs you pay that are more than the *Blue Cross and Blue Shield* allowed charge.

How a Family Deductible Is Calculated

When a family *deductible* applies to your prescription drug benefits, the family *deductible* can be met by eligible costs incurred by any combination of *members* enrolled under the same family membership. But, no one *member* will have to pay more than the "per *member*" *deductible* amount.

Grievance

A *grievance* is a type of oral or written complaint you make about care or service you received from *Blue Cross and Blue Shield* or from a provider who participates in your health care network. This type of complaint concerns the service you receive or the quality of your care. It does not involve a dispute with a coverage or payment decision. Part 4 explains what you have to do to file a *grievance*. It also explains the review process.

Group

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

Medical Policy

To receive your prescription drug coverage, your drugs and supplies must meet the criteria for coverage that are defined in each *Blue Cross and Blue Shield medical policy* that applies. Each drug or supply must also meet the *Blue Cross and Blue Shield medical technology assessment criteria*. (See below.) The policies and criteria that will apply are those that are in effect at the time you receive the health care service or supply. These policies are based upon *Blue Cross and Blue Shield's* assessment of the quality of the scientific and clinical evidence that is published in peer reviewed journals. *Blue Cross and Blue Shield* may also consider other clinical sources that are generally accepted and credible. (These sources may include specialty society guidelines, textbooks, and expert opinion.) These *medical policies* explain *Blue Cross and Blue Shield's* criteria for when a drug or supply is *medically necessary*, or is not *medically necessary*, or is investigational. These policies form the basis of coverage decisions. A policy may not exist for each drug or supply. If this is the case for a certain drug or supply, *Blue Cross and Blue Shield* may apply its *medical technology assessment criteria* and its *medical necessity* criteria to determine if the drug or supply is *medically necessary* or if it is not *medically necessary* or if it is investigational. To check for a *Blue Cross and Blue Shield medical policy*, you can go online and log on to the *Blue Cross and Blue Shield* Web site at **www.bluecrossma.org**. (Your health care provider can also access a policy by using the *Blue Cross and*

Blue Shield provider Web site.) Or, you can call the *Blue Cross and Blue Shield* customer service office. You can ask them to mail a copy to you.

Medical Technology Assessment Criteria

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

- The drug or supply must have final approval from the appropriate government regulatory bodies. A drug, biological product, or device must have final approval from the U.S. Food and Drug Administration (FDA). Any approval granted as an interim step in the FDA regulatory process is not sufficient. (The FDA Humanitarian Device Exemption is one example of an interim step.) Except as required by law, *Blue Cross and Blue Shield* may limit coverage for drugs, biological products, and devices to those specific indications, conditions, and methods of use approved by the FDA.
- The scientific evidence must permit conclusions concerning the effect of the drug, biological product, or device 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, biological product, or device 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, biological product, or device must improve the net health outcome. The drug, biological product, or device's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
- The drug, biological product, or device must be as beneficial as any established alternatives. The drug, biological product, or device should improve the net outcome as much as or more than established alternatives. The drug, biological product, or device 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.

Blue Cross and Blue Shield may also, as part of a "pilot" program, cover new drugs or supplies that are not otherwise described as a *covered service*. In these cases, the drugs or supplies that are covered under the pilot program must: be approved by the FDA; have published clinical literature showing safety and efficacy; and be reasonably expected to improve health outcomes.

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 (Medical Necessity)

To receive your prescription drug coverage, your prescription drugs and supplies must be *medically necessary* and appropriate for your health care needs. (The only exceptions are for preventive drugs and birth control drugs and devices that are covered by this prescription drug plan.) *Blue Cross and Blue Shield* has the discretion to determine which prescription drugs and supplies you receive (or you are planning to receive) are *medically necessary* and appropriate for coverage. It will do this by referring to the guidelines described below.

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

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

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

Member

The term "you" refers to any *member* who has the right to the coverage provided by this prescription drug plan. A *member* may be the *subscriber* or their enrolled eligible spouse (or former spouse, if applicable) or any other enrolled eligible dependent.

Out-of-Pocket Maximum (Out-of-Pocket Limit)

There is a maximum cost share amount that you will have to pay for covered drugs and supplies. This is referred to as an "*out-of-pocket maximum*." A *rider* will show the amount of your *out-of-pocket maximum* and the time frame for which it applies—such as each calendar year or each *plan year*. It will also describe the cost share amounts you pay that will count toward the *out-of-pocket maximum*. Once the cost share amounts you have paid that count toward the *out-of-pocket maximum* add up to the *out-of-pocket maximum* amount, you will receive full benefits based on the *Blue Cross and Blue Shield* allowed charge for more of these covered drugs or supplies during the rest of the time frame in which the *out-of-pocket maximum* provision applies. There are some costs that you pay that do not count toward the *out-of-pocket maximum*. These costs that do **not** count toward the *out-of-pocket maximum* are:

- The *premium* you pay for your prescription drug plan.
- The costs you pay when your coverage is reduced or denied because you did not follow the requirements of the *Blue Cross and Blue Shield utilization review* program.
- The costs you pay that are more than the *Blue Cross and Blue Shield* allowed charge.

How a Family Out-of-Pocket Maximum Is Calculated

When a family *out-of-pocket maximum* applies to your prescription drug benefits, the family *out-of-pocket maximum* can be met by eligible costs incurred by any combination of *members* enrolled under the same family membership. But, no one *member* will have to pay more than the "per *member*" *out-of-pocket maximum* amount.

Plan Sponsor

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

Plan Year

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

Premium

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

Rider

Blue Cross and Blue Shield and/or your *group* (when you are enrolled in this prescription drug plan as a *group member*) may change the terms of your coverage in this prescription drug plan. If a material change is made to your coverage in this prescription drug plan, it is described in a *rider*. For example, a *rider* may change the amount that you must pay for certain drugs or supplies such as the amount of your *copayment*. *Blue Cross and Blue Shield* will supply you with *riders* (if there are any) that apply to your coverage in this prescription drug plan. You should keep these *riders* with this Prescription Drug Plan Subscriber Certificate and your Prescription Drugs Rider so that you can refer to them.

Subscriber

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

Utilization Review

Under this prescription drug plan, this term refers to the programs that *Blue Cross and Blue Shield* uses to monitor the use of or evaluate the clinical necessity, appropriateness, and efficacy of prescription drugs and supplies. *Blue Cross and Blue Shield* applies *medical technology assessment criteria* to develop its clinical guidelines and *utilization review* criteria. These programs may include any or all of the following:

- Pre-approval of some drugs.
- Drug formulary management (compliance with the *Blue Cross and Blue Shield* Drug Formulary). This also includes quality care dosing which helps to monitor the quantity and dose of the drug that

you receive, based on Food and Drug Administration (FDA) recommendations and clinical information.

- Step therapy to help your health care provider furnish you with the appropriate drug treatment. (With step therapy, before coverage is approved for certain “second step” drugs, it is required that you first try an effective “first step” drug.)
- Post-payment review.

attached to and made part of
Blue Cross and Blue Shield of Massachusetts, Inc.
Subscriber Certificate

Rider
Prescription Drugs

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

Your cost share amount for covered drugs and supplies you buy from a covered pharmacy is:

- **Retail Pharmacy** (30-day supply)
  Tier 1 (generic): $10 *copayment*
  Tier 2 (preferred brand): $55 *copayment*
  Tier 3 (non-preferred): $75 *copayment*

- **Mail Order Pharmacy** (90-day supply)
  Tier 1 (generic): $20 *copayment*
  Tier 2 (preferred brand): $110 *copayment*
  Tier 3 (non-preferred): $225 *copayment*

Note: Refer to your Subscriber Certificate for the times when your cost share for covered drugs and supplies may be waived.

All other provisions remain as described in your Subscriber Certificate.

attached to and made part of
Blue Cross and Blue Shield of Massachusetts, Inc.
Subscriber Certificate

Rider

Prescription Drugs for Chronic Conditions

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

The *outpatient* benefits described in your Subscriber Certificate for certain covered drugs have been changed.

Beginning on your health plan renewal date on or after July 1, 2025, as required by state law, this health plan has identified at least one generic drug and at least one brand name drug from its Drug Formulary that is used in the treatment of certain chronic conditions. For these identified covered drugs, you may pay a lower cost share than the amount that is described in your *Schedule of Benefits* and/or *riders* that apply to your coverage in this health plan.

The list of chronic conditions and the identified drugs are described in *Blue Cross Blue Shield's* chronic condition management drug list. For help to find out which chronic conditions and which identified drugs are on this list, you can call the *Blue Cross Blue Shield* customer service office. The toll free phone number to call is shown on your ID card. Or, you can also go online and log on to the *Blue Cross Blue Shield* Web site at **www.bluecrossma.org**. This list of chronic conditions and identified drugs may change from time to time (but not more than annually, except in instances where a drug is taken off the market by the drug manufacturer or if the price is substantially changed by the drug manufacturer or if a drug is removed from the *Blue Cross Blue Shield* Drug Formulary). Please check for updates.

- **Identified Generic Drugs.** This health plan will provide full benefits for the generic drug(s) identified by the health plan that is used in the treatment for the specific chronic condition (any *deductible*, *copayment*, and/or *coinsurance* will not apply).

- **Identified Brand Name Drugs.** For the brand name drug(s) identified by the health plan that is used in the treatment for the specific chronic condition, any *deductible* and/or *coinsurance* will not apply. If a *copayment* applies to your prescription drug benefits for all other brand name drugs covered under this health plan, the *copayment* amount that you will pay for these identified brand name drugs will not exceed $25 for each 30-day supply. (In no event will the *copayment* for these identified brand name drugs exceed the *copayment* that applies for all other brand name drugs; or, if your *copayment* for all other brand name drugs is *less* than this amount, you will pay that lower amount for each 30-day supply of the identified brand name drug.).

  This coverage for identified brand name drugs includes at least one of each major type of injectable insulin: rapid-acting; short-acting; intermediate-acting; long-acting; ultra long-acting; and pre-mixed.

IMPORTANT NOTE: This *rider* does not change the cost share amount that you will pay for all other covered drugs and supplies. Refer to your Subscriber Certificate for your cost share amount for other covered drugs and supplies and for the times when the cost share for certain other covered drugs and supplies will be waived. If your health plan includes another *rider* that changes your prescription drug benefits, those prescription drug benefits apply for all other covered drugs.

Prescription Drugs for Chronic Conditions

If your health plan includes a Prescription Drugs *rider* where the *member's* out-of-pocket costs will be more when the *member* chooses to obtain the brand-name drug instead of the generic drug equivalent when there is a generic drug equivalent available, and if that drug is one of the identified covered drugs on *Blue Cross Blue Shield's* chronic condition management drug list, the cost share calculation provisions described in that *rider* will continue to apply.

Except as described above for a separate *rider* and/or *Schedule of Benefits* provision for preventive health drugs, this *rider* will supersede any provisions to the contrary that may be described in other *riders*—if there are any—that apply to your coverage in this health plan.

All other provisions remain as described in your Subscriber Certificate.