IAI

IMPORTANT ADMINISTRATIVE INFORMATION

MASSACHUSETTS

OCTOBER 2007

HEALTH CARE REFORM UPDATES

Health Care Reform Updates

As a result of new Massachusetts legislation that defines Minimum Creditable Coverage, we have conducted a careful review of our complete product portfolio. We are including a separate, detailed brochure (Product Portfolio and Benefit Design Update) with additional information on the new standards, the impact to individuals, and the impact to the plans offered by Blue Cross Blue Shield of Massachusetts.

Beginning with anniversaries after January 1, 2008, employers will be notified at least 60 days prior to their renewal if their medical plan does not meet the January 1, 2009, requirements and also the reason why. This will provide employers time to assess their current plan offerings and make decisions regarding benefit changes, if necessary. If you have any questions, please contact your Account Executive.

Fair Share Legislation Filing Status

Beginning October 1, 2007, filing begins for employer fair share contributions—an assessment that some businesses will need to pay as part of the Health Care Reform Act.

Employers with 11 or more full-time equivalent employees were sent filing instructions from the Division of Unemployment Assistance. The online filing will determine whether or not employers are liable for payment. The filing period runs through November 15 and the online filing system will be available year-round. Employers with questions about the filing process can contact the DUA's Fair Share Contribution Unit at **617-626-6080**, or visit **www.mass.gov/fairshare**.

GENERAL UPDATES

Partnership for Healthcare Excellence

Recently, Blue Cross Blue Shield of Massachusetts announced its involvement in a unique statewide effort to educate and motivate consumers to improve the safety and effectiveness of their own health care. The Partnership for Healthcare Excellence is a broad-based coalition with participants from every segment of the health care community and other organizations. Members include consumer associations, disease and advocacy organizations, doctors and insurers, business groups, labor, public health advocates, and other health care leaders.

The Partnership is the first statewide effort of its kind to focus exclusively on patients—helping them to play a greater role in improving the quality of their health care.

The goals of the Partnership are threefold:

- To educate the public about the variations in health care quality;
- To provide consumers with the information and tools they need to improve the quality of their own care; and
- To motivate a group of consumers to advocate for overall health care system change so that it becomes safer and more effective, for example, through the use of electronic medical records and e-prescribing.

Marilyn Schlein Kramer has been chosen as the Executive Director of the Partnership. She recently served as President and CEO of DxCG, Inc.—a health care information technology company and as a strategic consultant to several technology companies.

The Partnership will launch a multi-faceted public education campaign later this year including advertising, website, community and corporate partnerships, direct mail, and grassroots outreach to help engage consumers. Initially, these education efforts will focus on helping patients promote medication safety and prepare for a safe stay in the hospital, as well as educating patients on how to better communicate with their doctors.

If you have any questions about the Partnership for Healthcare Excellence, please contact your Account Executive.

Campaign for Patient Engagement in Health Care

Blue Cross Blue Shield of Massachusetts is hitting the airwaves with important—and useful—information for WBUR (90.9 FM) radio listeners with a series of spots that will air from September 17 through October 28. The messages are focused on getting patients to team up with their doctors to become more involved in their health care—and more involved in improving the quality of their health care.

This year's campaign offers tips on how to better prepare for doctor's appointments. The spots feature Dr. Patty Yoffe, a primary care physician with Harvard Vanguard Medical Associates and a network provider for Blue Cross Blue Shield of Massachusetts, who shares her own expertise and advice, encouraging listeners to bring lists of medications, take notes, and ask questions at their next doctor visit.

The campaign also includes a companion website for listeners, our members, and other visitors at **www.bluecrossma.com** to get more information on how to be an engaged patient and be better prepared for their doctor's appointments. Go to **www.bluecrossma.com/wbur2** to visit the site.

It builds on last year's WBUR campaign about "patient empowerment," which focused on patients partnering with doctors to improve their quality of care and, specifically, avoiding medication errors.

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Retiree Drug Subsidy Reconciliation

For accounts that have an RDS application with an end date of August 31, 2006, reconciliation of your interim costs with a final cost report must be completed by November 30, 2007. To assist you with this process we will be asking you to send us a Covered Retiree List from your application for comparison against the Blue Cross Blue Shield of Massachusetts retiree list to ensure only eligible members are included on the final cost reports. Also, you will need to contact us when your application is at the reconciliation step that allows the Final Cost Reports from ESI to be sent to CMS for your final steps. If you were not able to attend one of our training sessions held in August, please contact your Account Executive for copies of the presentation. You may also send requests to our new Retiree Drug Subsidy mailbox at **RDS@bcbsma.com**

NCQA Awards Quality Plus Distinction to Our Managed Care Products

Blue Cross Blue Shield of Massachusetts was recently awarded the National Committee for Quality Assurance's (NCQA) Quality Plus Distinction Status for the Physician & Hospital Quality (PHQ) standards for our managed care products. We are the first health plan in Massachusetts to have been awarded the status of Distinction in all three of these Quality Plus modules. The Quality Plus Program is a nationally recognized evaluation that purchasers, regulators, and consumers can use to assess which health plans have earned Distinction by meeting rigorous standards in the areas of Member Connections, Care Management & Health Improvement, and Physician & Hospital Quality.

The Physician & Hospital Quality standards evaluate how organizations measure the quality and cost of care provided by network physicians and hospitals. The standards are purposely set high to encourage organizations to continuously enhance their quality initiatives. We collaborated with the Massachusetts Health Quality Partners (MHQP), a broad-based coalition of physicians, hospitals, health plans, purchasers, consumers, and government agencies, to meet the needs of purchasers who have expressed a strong desire for such information. The status of Distinction helps recognize organizations to achieve the highest level of performance possible, reduce patient risk for untoward outcomes, and create an environment of continuous improvement.

NCQA is an independent, not-for-profit organization dedicated to measuring the quality of America's health care.

If you have any questions about our recent NCQA Award, please contact your Account Executive.

PRODUCT/NETWORK UPDATES

January 1, 2008, Product Enhancements and New Plan Offerings

In an effort to maintain the most cost effective coverage options and to meet January 1, 2009, Minimum Creditable Coverage requirements, we are making certain benefit design changes to our standard product portfolio, adding new plans, and closing other plans to new sales for individuals and employer groups with less than 50 employees. For a complete description of all these changes, please review the enclosed brochure (Product Portfolio and Benefit Design Update), as well as the Standard Plan Design Changes chart and new plan Fact Sheets. If you have any questions, please contact your Account Executive.

Voluntary Blue: Health Care Coverage for Non-Eligible Part-Time Employees

Under Massachusetts health care reform, employers with 11 or more full-time equivalent employees must give their qualifying part-time employees not covered by their employer's plan the option of directly purchasing health coverage on a pre-tax basis through an employer's Section 125 plan.

Meeting this mandate does not have to be an expensive administrative burden—not with Voluntary Blue.

Blue Cross Blue Shield of Massachusetts has worked with Benefit Concepts, an established administrative services company, to create a new service that can help you set up a special Section 125 plan and Premium Reimbursement Account (PRA) arrangement for these non-eligible part-time employees.

The PRA is used to hold money deducted pre-tax from part-time employees to pay and reimburse employees for their health care premiums on a pre-tax basis. The PRA is administered by Benefit Concepts.

And if you offer Blue Cross Blue Shield of Massachusetts coverage exclusively to your full-time employees and have 11 or more full-time employees, we will pay the one-time setup costs to get your solution up and running.

Benefit Concepts will validate reimbursement requests, administer payments to employees, and respond to PRA questions. You will pay the small monthly maintenance and per-employee fees directly to Benefits Concepts.

This value-added service can not only help you meet your obligations that are part of health care reform, but it will also allow both you and your employees to save on taxes as your employees direct some of their paycheck to buy health care on a pre-tax basis.

If you have questions about Voluntary Blue, please contact your broker or Account Executive.

Late Enrollment Penalty

In August, the Centers for Medicare and Medicaid Services (CMS) issued final guidelines regarding the Late Enrollment Penalty (LEP) for Part D members. As with Medicare Part B, Part D programs will have a penalty for anyone who did not promptly enroll in a "creditable" Part D plan or its equivalent when the person became eligible to be enrolled in Part D. "Creditable" coverage means that the benefits of the retiree's current prescription plan are actuarially equivalent or better than the standard Part D benefits. Since the Part D plan is only administered through private insurers such as Blue Cross Blue Shield of Massachusetts, the collection of the LEP data and the subsequent penalty amount will be administered through Blue Cross Blue Shield of Massachusetts for its members.

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As required by CMS regulations, in August we sent letters to our new Part D members to determine their prescription coverage prior to enrollment in our plan. If it is determined that the prior plan was not a "creditable" prescription program, we will be adding an LEP amount calculated and provided to us by CMS to the group premium. The LEP is calculated as 1% of the National Base Beneficiary Premium ($27.35 for 2007, 1% will be $00.27) for every month the member was eligible but not enrolled in a Part D program (or its equivalent). Members who are eligible for the Low Income Subsidy and members that age into a retiree plan on their 65th birthday will not be receiving these mailings.

If your Medicare beneficiary disagrees with the late enrollment penalty, he or she can ask Medicare to reconsider (review) its decision. For example, the individual might disagree with the penalty if they got/get extra help from Medicare to pay for prescription drug coverage in 2006 and/or 2007, or if they were not informed that they did not have creditable prescription drug coverage (as good as Medicare's). A notice explaining the right to a reconsideration of the late enrollment penalty is included with the LEP notice. Medicare beneficiaries must submit a reconsideration request within 60 days of the date of their notice.

Your members may also call our Member Service line at **1-800-200-4255** Monday through Sunday 8 a.m. – 8 p.m. TTY users should call **1-800-522-1254** Monday through Friday from 8 a.m. – 6 p.m. They can also get information by visiting **www.medicare.gov** on the web or by calling **1-800-MEDICARE** (**1-800-633-4227**). TTY users should call **1-877-486-2048**.

The LEP will appear as a separate line item on the premium bill. The employer will be responsible for determining what portion of the penalty its retiree will pay. The employer can either (a) pass on the entire penalty to its retiree, (b) cover a portion of the penalty based on the percentage of the premium it covers currently, or (c) choose to cover the entire penalty for the member.

Renewal Information on Medicare HMO Blue® and Medicare PPO Blue℠

The company has received the necessary approval for Medicare senior product plan benefits and rates (premiums) from the Centers for Medicare and Medicaid Services (CMS). In 2008 Blue Cross Blue Shield of Massachusetts will continue to offer our Medicare HMO Blue and Medicare PPO Blue and Blue MedicareRx℠ plans. We are also pleased to announce that we are adding Blue Medicare PFFS,℠ a Medicare Advantage Private Fee for Service plan option for January 1, 2008.

Blue Cross Blue Shield of Massachusetts Medicare Advantage HMO and PPO 2008 Annual Notice Of Change Benefit Summary

Subject to CMS Approval

Benefits	Cost Sharing in 2007	Cost Sharing in 2008
Inpatient Rehabilitation Hospital Services	**HMO Copay:** $25 per day (days 1-90), then 100% of the costs for days 91+. 0$ If you use your 60 lifetime reserve days.	**HMO Copay:** $100 per day (days 1-5) ($500 annual maximum)
	PPO Copay: In-network you pay: $25 per day (days 1-90), then you pay 100% of the costs for days 91+. Out-of-network you pay: $500 yearly deductible, then 20% of the cost. $0 If you use your 60 lifetime reserve days.	**PPO Copay:** In-network you pay: $100 per day (days 1-5) ($500 annual maximum) Out-of-network you pay: $500 yearly deductible, then 20% of the cost.

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Urgently Needed Care	**HMO Copay:** $10 each primary care visit $20 each specialty care visit $50 each emergency room visit Urgently Needed Care was available worldwide when medically necessary **PPO Copay:** In-network you pay: $15 for each physician of choice visit $25 for each other physician visit $50 for each emergency room visit Out-of-network you pay: $500 yearly deductible, then $40 for each physician office visit. Urgently Needed Care was available worldwide when medically necessary	**HMO Copay:** $10 each primary care visit $20 each specialty care visit Urgently Needed Care is available in the U.S. when you are either temporarily outside the plan's service area or in the service area **but the** network providers are not available. **PPO Copay:** In-network you pay: $15 for each physician of choice visit $25 for each other physician visit. Out-of-network you pay: $40 for each physician office visit. Urgently Needed Care is available in the U.S. when you are temporarily outside the plan's service area or in the service area **but the** network providers are not available.
Outpatient Breast MRI and PET Scan Diagnostic Services HMO Only	You pay $0	You pay $0 Prior authorization is required.
Self-Administered, Subcutaneous Injectable Medications— HMO and PPO	These self-administered medications may have been covered under your home infusion benefit at no cost to you.	For each 30-day prescription filled at a retail pharmacy you pay: **For PlusRx:** $10 for generic drugs $35 for Preferred Brand drugs $65 for Non-Preferred Brand drugs **For PremierRx:** $10 for generic drugs $28 for Preferred Brand drugs $58 for Non-Preferred Brand drugs These copayment amounts apply before you reach the Initial Coverage Limit of $2,510 in 2008. Log on to our website, www.bluecrossma.com/medicare for more information about our prescription coverage.

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Benefit Changes-Blue MedicareRx

Benefits	Cost Sharing in 2007	Cost Sharing in 2008
Medicare Part D Benefits	Catastrophic Coverage Levels start period: $3,850 paid in members out-of-pocket costs $2.15 for generic and the lesser of $5.35 or 5% for brand name drugs	Catastrophic Coverage Levels start period: $4,050 paid in members out-of-pocket costs $2.25 for generics and the lesser of $5.60 or 5% for brand name drugs

For information on your specific plan design and renewal rates, please contact your Account Executive.

New Blue Medicare Private Fee for Service Plan

Blue Cross Blue Shield of Massachusetts is also pleased to introduce our new Medicare Advantage Private Fee for Service plan (PFFS), Blue Medicare PFFS℠ available January 1, 2008. Our direct-pay PFFS plan will be offered with one Part D drug benefit option in 2008. Group offerings will be available with the standard drug plan options with coverage through the Medicare Part D coverage gap.

Our Medicare Advantage Private Fee for Service plan, Blue Medicare PFFS, is available in all counties in Massachusetts and nationally as an employer-sponsored program. It will be offered to group markets with our five standard Part D copay options.

This product will appeal to those who want the flexibility to manage their own health care and have the choice to select providers without referrals. Providers must agree to accept the plan's terms and conditions of payment to treat Blue Medicare membership. The terms will be posted on our provider portal later this fall. The 2008 premiums and benefits will be effective on January 1, 2008.

For more details on this new program, please contact your Account Executive.

Change in Clinical Review Criteria

As of January 1, 2008, we will be changing our clinical review criteria for medical and surgical from MCAP criteria to InterQual criteria. InterQual's criteria are nationally recognized for their clinical relevancy. They are currently used by many of our hospitals and providers, and by most Massachusetts managed care organizations.

Formulary Changes

As part of our continuing effort to provide affordable prescription medication benefits to all of our members, we have made some carefully considered changes to our covered medication list. These changes are based on clinical guidelines and on recommendations from our Pharmacy and Therapeutics Committee, which is made up of independently practicing physicians and pharmacists who are not employed by Blue Cross Blue Shield of Massachusetts.

Please review these changes carefully. We have added several medications to the list of covered drugs, and in addition, we are:

- Moving several medications to the list of non-covered drugs
- Moving several medications to the over-the-counter benefit-exclusion list
- Moving medications from Tier 2 to Tier 3
- Requiring step therapy for certain drugs
- Several multi-source brand medications moving to non-covered within the BlueValue Rx formulary
- Updating Medical Policy 433 (non-covered drug list)
- Updating Medical Policy 030 (proton pump inhibitors)
- Streamlining our authorization process

Additions to Our Covered Medications List

Category	Medication Name	Tier	Additional information
Epinephrine Emergency Kit	Twinject®´	Tier 2	
Growth Hormones	Humatrope®´ Omnitrope®´	Tier 2	Prior Authorization still required for all growth hormones
Levothyroxine Agents	Levothroid®´ Unithroid™	Tier 1	

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Medications Moving to Non-Covered Status

Category	Medication Name	Additional information
*Non-sedating antihistamines	Allegra® Allegra D® 12 Hour Allegra D® 24 Hour Fexofenadine	Loratadine (Claritin) is available over the counter in various dose forms Note: A formulary exception may be requested, but documentation will need to be provided demonstrating the use of an over-the-counter non-sedating antihistamine.
Topical Acne Treatments	Retin-A Micro® Gel Retin-A Micro® Pump	Tretinoin generic agents are covered at Tier 1
Diabetes Testing Supplies NOTE: One Touch® supplies not covered under the BlueValue Rx℠ pharmacy benefit.	B-D™ testing supplies Prestige® testing supplies TrueTrack® testing supplies	Accu-Check® supplies Assure Pro® supplies One Touch® supplies Precision Xtra™

*In the future we may exclude benefit coverage under subscriber certificates for all prescription non-sedating antihistamines due to the availability of several over-the-counter alternatives at pharmacies. Formulary exceptions will no longer be covered at that time. We will advise accounts and affected members in the case of any planned change to benefit coverage.

Medications Moving to the Over-the-Counter Benefit Exclusion List

Affected Medications

benzoyl peroxide (all generic forms)
Benzac® products
Benzagel® products
Benzashave® products
Binora®
Brevoxyl® products
Clinac™ products
Del-Aqua®
Desquam® products
EthexDerm™ products
Inova™
Lavoclen™ products
NeoBenz™ products
Oscion™ products
Seb-Gel® products
Triaz® products
Zaclir® products

OTC Equivalent Examples

benzoyl peroxide—various forms (all store brand products)
Clearasil® products
Fostex® products
Neutrogena® products
Oxy® products
PanOxyl® products
ZAPZYT® products

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Medications Moving from Tier 2 to Tier 3

Category	Medication Name	Additional information
Otic Antibiotics	Cipro® HC Floxin® Otic	Ciprodex®—Tier 2 Ofloxacin otic—Tier 1

New Step Therapy Requirements

Drugs for the Treatment Of Benign Prostatic Hyperplasia

Step:	To write a prescription for:	Prior Authorization will be granted if the member has:
Step 1	finasteride	No prior authorization required. This medication will pay at the point of sale
Step 2	Avodart® Proscar®	Either evidence of a Blue Cross Blue Shield of Massachusetts-paid claim or physician statement attesting that the member, excluding the use of sample medications, had tried and failed treatment with: • A Step 1 medication within the previous 180 days • A prior authorization/formulary exception request form is not required if the member meets these requirements.

Drugs for the Treatment of Diabetes

Step:	To write a prescription for:	Prior Authorization will be granted if the member has:
Step 1	All oral hypoglycemics, insulin products	No prior authorization required. This medication will pay at the point of sale
Step 2	Exubera® Janumet™ Januvia™	Either evidence of a Blue Cross Blue Shield of Massachusetts-paid claim or physician statement attesting that the member, excluding the use of sample medications, had tried and failed treatment with: • A Step 1 medication within the previous 180 days • A prior authorization/formulary exception request form is not required if the member meets these requirements.

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Drugs for the Treatment of Asthma

Step:	To write a prescription for:	Prior Authorization will be granted if the member has:
Step 1	Any first line medication used in the treatment of asthma (ex. inhaled and oral beta-adrenergics, inhaled corticosteroids, theophylline)	No prior authorization required. This medication will pay at the point of sale
Step 2	Advair Diskus® Advair® HFA Singulair®	Either evidence of a BCBSMA-paid claim or physician statement attesting that the member, excluding the use of sample medications, had tried and failed treatment with: • A Step 1 medication within the previous 180 days • A prior authorization/formulary exception request form is not required if the member meets these requirements.

BlueValue Rx Formulary Changes: Brand-Name** Medications Moving to Non-Covered Status

Multi-Source Brand Medication (Not Covered)	FDA Approved Generic Version of Medication
Ambien™	zolpidem tartrate
Effexor®	Venlafaxine hydrochloride
Lamisil®	Terbinafine hydrochloride
Norvasc®	amlodipine
Ponstel®	mefenamic acid
Pravachol®	pravastatin sodium
Toprol XL®	metoprolol succinate
Zithromax®	azithromycin
Zocor®	simvastatin
Zofran®	ondansetron hydrochloride
Zonegran®	zonisamide

**Branded medications will periodically move to the non-covered list within the BlueValue Rx formulary as FDA approved generic versions become available.

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Medical Policy Update: Non-Covered Drug List

Beginning January 1, 2008, we will require documented adverse effects or documented treatment failure of two (2) covered drugs (when available) prior to the authorization of coverage for a non-covered drug. Previously, we required the use of one (1) formulary agent. Individual consideration for each member will continue to be a part of our formulary exception process.

Medical Policy Update: Proton Pump Inhibitors

Beginning January 1, 2008, we will change the point-of-sale approval criteria for our proton pump inhibitor step therapy policy. The requirement of a paid claim for a member in the past 180 days for point-of-sale approval will be changed to 130 days. Therefore, if a member has not filled a prescription and generated a paid claim for a Step 2 or Step 3 agent within the past 130 days, they will be required to start again with a Step 1 agent, or apply for prior authorization for one of the other agents.

Streamlined Authorization Process

Based on feedback from our provider satisfaction surveys, we will now enable providers to request pharmacy prior authorizations over the phone in addition to the current fax-based process. The new phone-based approval process reduces the time it takes for a member to have access to medications that require prior authorization, and gives providers immediate feedback about whether the authorization has been approved or denied. This enhancement improves our ability to serve our customers and provide a safe, effective, and affordable pharmacy benefit.

If you have any questions about any of the pharmacy changes described, please contact your Account Executive.

Radiology Quality Initiative Expands to Medicare HMO Blue Product

In collaboration with American Imaging Management (AIM) we launched a Radiology Quality Initiative (RQI) for our commercial HMO and POS products in 2005. The program requires pre-certification for all elective, outpatient High Tech Radiology (HTR) studies from participating physicians, excluding those provided in the emergency department or services rendered in conjunction with outpatient surgery. In an effort to continue effectively managing HTR services and improve the health of our members by addressing the systemic issues that lead to overuse, underuse, misuse, and waste of health care services, we will expand our RQI initiative to include our Medicare HMO Blue product beginning on January 1, 2008. This program does not involve a change in covered benefits and complies with Centers for Medicare and Medicare Services (CMS) medical policy guidelines.

If you have any questions about the inclusion of Medicare HMO Blue in our RQI program, please contact your Account Executive.

New Requirements for Registration and Authorization of Chiropractic Services

As part of our ongoing effort to facilitate the delivery of high-quality, clinically appropriate care in a cost-effective manner, beginning on January 1, 2008, registration and authorization will be required for chiropractic services. Administered in collaboration with Healthways WholeHealth Networks, Inc. (HWHN), this program aims to improve the quality of care through the appropriate selection and use of chiropractic services.

The program will apply to members with a Blue Cross Blue Shield of Massachusetts-contracted primary care physician in our HMO Blue® New England, Network Blue® New England, and Blue Choice New England, and Blue Choice New England Plan 2 products who are treated by a Blue Cross Blue Shield of Massachusetts-contracted chiropractor.

Chiropractic Treatment Plan Assessment

New requirements for registration and authorization are as follows:

- Chiropractors will be required to register their patient's initial 12 visits with HWHN upon a member's first visit. These initial 12 visits will not require authorization.
- The treating chiropractor will need to obtain authorization for additional medically necessary services from HWHN in order to be reimbursed for visits beyond the initial 12. Prior to the 13th visit, the chiropractor will be required to submit information about the patient's treatment plan.
- As outlined in the member's Subscriber Certificate or Description of Benefits, to receive care, services must be medically necessary. The member's Subscriber Certificate or Description of Benefits may also include a limit on the number of visits allowed.
- Authorization for subsequent treatments will be granted if the services meet the clinical criteria developed in accordance with our standards for medical necessity.
- Chiropractors will submit registrations and authorizations by using HWHN's telephonic system or their Internet-based tool.

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In assessing our members' care plans, HWHN follows diagnosis-based clinical criteria to evaluate the selection of procedures and the duration and frequency of care. Furthermore, by reviewing treatment plans, HWHN can confirm that patients continue to demonstrate functional improvement as measured by outcome-assessment tools.

If you have any questions about these new requirements, please contact your Account Executive.

Behavioral Health Outcomes Management Program Participation

Effective January 1, 2008, members of HMO Blue New England, Blue Choice New England, Blue Choice New England Plan 2, and Network Blue New England receiving outpatient behavioral health treatment from a participating Massachusetts provider may also participate in our Behavioral Health Outcomes Measurement program. As outlined in the June IAI, this is a voluntary program that enables members to give their behavioral health providers real-time feedback on their behavioral health status through a self-administered, standardized, validated, patient-assessment questionnaire.

New Process for Authorization of Behavioral Health Outpatient Services

As of January 1st, 2008, Blue Cross Blue Shield of Massachusetts will no longer require members to obtain authorization for the first 12 outpatient behavioral health sessions with participating providers in a calendar year. This change applies to all managed care members except those with the Federal Employee Health Benefit Plan (FEP) or those with Medicare Advantage products.

Members are responsible for being aware of the total number of behavioral health sessions they have used within a calendar year and they will be responsible for payment if they will exceed the behavioral health visit benefit limit (subject to the parity exception) as outlined in their Subscriber Certificate. Because it is possible for members to have initial authorizations of 12 sessions with several providers within a given year, members receiving services from multiple behavioral health providers should review the details of their Subscriber Certificates to verify benefit limits and keep track of their outpatient behavioral health therapy visits. If a policy has a limitation on the number of covered behavioral health visits, Blue Cross Blue Shield of Massachusetts will not pay claims over the visit limit.

Here are some details about this change:

- Participating providers requesting outpatient behavioral health services beyond the initial 12 sessions must seek prior authorization.
- Out-of-Network (non-participating) providers will be required to obtain prior authorization for all behavioral health outpatient services.

If you have any questions about our Behavioral Health programs or coverage, please contact your Account Executive.

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Bariatric Surgery Privileging Program Expands to New England Managed Care Plans

Effective January 1, 2008, members in our HMO Blue New England, Blue Choice New England, Blue Choice New England Plan 2, and Network Blue New England will be added to our bariatric surgery privileging program. This means that Blue Cross Blue Shield of Massachusetts will pay for bariatric surgery related services for members in these plans with Massachusetts primary care physicians who elect to have their surgery in Massachusetts only if the services are received at privileged facilities. We will, however, pay for bariatric surgery procedures at non-privileged facilities for members enrolled in these plans who are authorized for surgery prior to January 1, 2008.

Members of our HMO Blue, Blue Choice Plan 1 and 2, Network Blue™ plans, Blue Care® Elect, and Indemnity plans have been included in our bariatric surgery privileging program since June 1, 2007.

To learn more about the program and to view a list of privileged facilities, visit **www.bluecrossma.com**, and go to **Find a Doctor** and select **Looking for Provider Quality** from the left column and then **Specialty Care**.

Healing with Grace and Spirit

Blue Cross Blue Shield of Massachusetts members are eligible for a 15% discount on all Original Healing Threads garments. Stylish and functional, Original Healing Threads garments are designed to empower patients undergoing medical treatment. Manufactured by Spirited Sisters, Inc., they are the brainchild of three sisters, two of whom battled cancer. Originally designed with cancer patients in mind, the idea proved so popular that the line has expanded to include patients recovering from heart or lung surgery, undergoing kidney dialysis, orthopedic patients, nursing mothers, and many more.

Members interested in purchasing Original Healing Threads may visit our website at **www.bluecrossma.com/discounts**, and should use coupon code BCBSMA. Members can also call Spirited Sisters, Inc.'s toll-free number at **1-877-647-3900**.

If you have any questions about this discount, please contact your Account Executive.

Living Healthy *Babies*® Materials Now Available in Spanish

Living Healthy *Babies*, our prenatal and child development and educational program, is now available in Spanish. This program offers members the resources they need to help keep themselves and their babies healthy, from preconception through the first year. In addition, when eligible members call **1-800-233-3344** to enroll in this program, they will have the option of registering for either the English or the Spanish version, (Para La Salud de Tu Bebé). To request Living Healthy *Babies* promotional materials for your office, please call your Provider Relations Manager at **1-800-316-BLUE (2583)**.

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