## Schedule of Benefits

### Blue Care® Elect [Plan Option]

This is the Schedule of Benefits that is a part of your Subscriber Certificate. This chart describes the cost share amounts that you 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

#### Deductible

Your deductible per plan year is:

This deductible applies to all covered services except in-network preventive health services, prescription drugs and supplies, and certain covered services as noted in this chart.

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>$[____] per member</td>
<td>$[____] per family</td>
</tr>
</tbody>
</table>

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.

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

Your out-of-pocket maximum per plan year is:

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.

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>$[____] per member</td>
<td>$[____] per family</td>
</tr>
</tbody>
</table>

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.

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

#### Admissions for Inpatient Medical and Surgical Care

<table>
<thead>
<tr>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>[____] [after deductible]</td>
<td>[40%] after deductible</td>
</tr>
</tbody>
</table>

Your Cost Is:

- In a General Hospital
  - Hospital services
  - Physician and other covered professional provider services
- In a Chronic Disease Hospital
  - (same as admissions in a General Hospital)
- In a Rehabilitation Hospital (60-day benefit limit per member per calendar year)
  - Hospital services
  - Physician and other covered professional provider services

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

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>In-Network Benefits Your Cost Is:</th>
<th>Out-of-Network Benefits Your Cost Is:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Medical Outpatient Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(continued)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 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 by another specialist or other covered provider (non-hospital), including a physician assistant or nurse practitioner designated by the health plan as specialty care</td>
<td>$[____] copayment per visit [after deductible]</td>
<td>20% after deductible</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospice Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient hospice services for terminally ill</td>
<td>[20%] after deductible</td>
<td>[40%] after deductible</td>
</tr>
<tr>
<td><strong>Infertility Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Inpatient</strong> services</td>
<td>See Admissions for Inpatient Medical and Surgical Care</td>
<td>See Admissions for Inpatient Medical and Surgical Care</td>
</tr>
<tr>
<td>• <strong>Outpatient</strong> surgical services</td>
<td>See Surgery as an Outpatient</td>
<td>See Surgery as an Outpatient</td>
</tr>
<tr>
<td>• <strong>Outpatient</strong> lab tests and x-rays</td>
<td>See Lab Tests, X-Rays, and Other Tests</td>
<td>See Lab Tests, X-Rays, and Other Tests</td>
</tr>
<tr>
<td>• <strong>Outpatient</strong> medical care services</td>
<td>See Medical Care Outpatient Visits</td>
<td>See Medical Care Outpatient Visits</td>
</tr>
<tr>
<td><strong>Lab Tests, X-Rays, and Other Tests</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(diagnostic services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Outpatient</strong> lab tests</td>
<td>[No charge] after deductible</td>
<td>[20%] after deductible</td>
</tr>
<tr>
<td>• <strong>Outpatient</strong> x-rays and other imaging tests (other than advanced imaging tests)</td>
<td>[No charge] after deductible</td>
<td>[20%] after deductible</td>
</tr>
<tr>
<td>• <strong>Outpatient</strong> advanced imaging tests (CT scans, MRIs, PET scans, nuclear cardiac imaging)</td>
<td>$[____] copayment per category of test per service date after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>• Other outpatient tests and preoperative tests</td>
<td>[No charge] after deductible</td>
<td>[20%] after deductible</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>In-Network Benefits Your Cost Is:</th>
<th>Out-of-Network Benefits Your Cost Is:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health and Substance Use Treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient admissions in a General Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital services</td>
<td>[____] [after deductible]</td>
<td>[40%] after deductible</td>
</tr>
<tr>
<td>Physician and other covered professional provider services</td>
<td>[____] [after deductible]</td>
<td>[40%] after deductible</td>
</tr>
<tr>
<td>• Inpatient admissions in a Mental Hospital or Substance Use Facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility services</td>
<td>[____] [after deductible]</td>
<td>[40%] after deductible</td>
</tr>
<tr>
<td>Physician and other covered professional provider services</td>
<td>[____] [after deductible]</td>
<td>[40%] after deductible</td>
</tr>
<tr>
<td>• Outpatient services</td>
<td>$[____] copayment per visit [after deductible]</td>
<td>20% after deductible</td>
</tr>
<tr>
<td><strong>Oxygen and Respiratory Therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Oxygen and equipment for its administration</td>
<td>[20%] [after deductible]</td>
<td>[40%] after deductible</td>
</tr>
<tr>
<td>• Outpatient respiratory therapy</td>
<td>See Medical Care Outpatient Visits</td>
<td>See Medical Care Outpatient Visits</td>
</tr>
<tr>
<td><strong>Podiatry Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient lab tests and x-rays</td>
<td>See Lab Tests, X-Rays, and Other Tests</td>
<td>See Lab Tests, X-Rays, and Other Tests</td>
</tr>
<tr>
<td>• Outpatient surgical services</td>
<td>See Surgery as an Outpatient</td>
<td>See Surgery as an Outpatient</td>
</tr>
<tr>
<td>• Outpatient medical care services</td>
<td>See Medical Care Outpatient Visits</td>
<td>See Medical Care Outpatient Visits</td>
</tr>
<tr>
<td><strong>Prescription Drugs and Supplies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Retail Pharmacy</td>
<td>See your Blue Cross and Blue Shield Drug Plan</td>
<td>See your Blue Cross and Blue Shield Drug Plan</td>
</tr>
<tr>
<td>• Mail Order Pharmacy</td>
<td>See your Blue Cross and Blue Shield Drug Plan</td>
<td>See your Blue Cross and Blue Shield Drug Plan</td>
</tr>
<tr>
<td><strong>Preventive Health Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 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)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine medical exams and immunizations</td>
<td>No charge</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Routine tests</td>
<td>No charge</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Preventive dental care for members under age 18 for treatment of cleft lip/cleft palate</td>
<td>No charge</td>
<td>20% after deductible</td>
</tr>
</tbody>
</table>

This chart shows your cost share for covered services. You must pay all charges in excess of a benefit limit.
This chart shows your cost share for covered services. You must pay all charges in excess of a benefit limit.
### Schedule of Benefits (continued)

**Covered Services**

<table>
<thead>
<tr>
<th>Second Opinions</th>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient</strong> second and third opinions</td>
<td>See Medical Care Outpatient Visits</td>
<td>See Medical Care Outpatient Visits</td>
</tr>
</tbody>
</table>

**Short-Term Rehabilitation Therapy**

(physical, occupational, and speech therapy)

Includes habilitation services

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>In-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient</strong> services (100-visit benefit limit per member per calendar year for physical and occupational therapy, except for autism; a benefit limit does not apply for speech therapy)</td>
<td>$[____] copayment per visit [after deductible]</td>
</tr>
</tbody>
</table>

**Speech, Hearing, and Language Disorder Treatment**

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>In-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient</strong> diagnostic tests</td>
<td>See Lab Tests, X-Rays, and Other Tests</td>
</tr>
<tr>
<td><strong>Outpatient</strong> speech therapy</td>
<td>See Short-Term Rehabilitation Therapy</td>
</tr>
<tr>
<td><strong>Outpatient</strong> medical care services</td>
<td>See Medical Care Outpatient Visits</td>
</tr>
</tbody>
</table>

**Surgery as an Outpatient**

(excludes removal of impacted teeth whether or not the teeth are imbedded in the bone)

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>In-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient</strong> day surgery</td>
<td>[____] [after deductible]</td>
</tr>
<tr>
<td>Physician and other covered professional provider services</td>
<td>[____] [after deductible]</td>
</tr>
<tr>
<td>Ambulatory surgical facility services</td>
<td>[____] [after deductible]</td>
</tr>
<tr>
<td>Sterilization procedure for a female member when performed as the primary procedure for family planning reasons</td>
<td>No charge (deductible does not apply)</td>
</tr>
<tr>
<td>Office and health center surgical services</td>
<td>$[____] copayment per visit [after deductible]</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery as an Outpatient (continued)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Office and health center surgical services</td>
<td>$[____] copayment per visit [after deductible]</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>by another specialist or other covered provider (non-hospital), including a physician assistant or nurse practitioner designated by the health plan as specialty care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TMJ Disorder Treatment</td>
<td>See Lab Tests, X-Rays, and Other Tests</td>
<td>See Lab Tests, X-Rays, and Other Tests</td>
</tr>
<tr>
<td>• Outpatient x-rays</td>
<td>See Surgery as an Outpatient</td>
<td>See Surgery as an Outpatient</td>
</tr>
<tr>
<td>• Outpatient surgical services</td>
<td>See Short-Term Rehabilitation Therapy</td>
<td>See Short-Term Rehabilitation Therapy</td>
</tr>
<tr>
<td>• Outpatient physical therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient medical care services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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): $[___] copayment
  - Tier 2 (preferred brand): $[___] copayment
  - Tier 3 (non-preferred): $[___] copayment

- **Mail Order Pharmacy** (90-day supply)
  - Tier 1 (generic): $[___] copayment
  - Tier 2 (preferred brand): $[___] copayment
  - Tier 3 (non-preferred): $[___] copayment

[Your drug deductible is the first $250 of covered retail pharmacy charges per member ($500 per family) per calendar year.]

**Note:** The cost share for birth control drugs, diaphragms, and other birth control devices that are classified as Tier 1 drugs or supplies will be waived (except when your health plan is a grandfathered health plan under the Affordable Care Act). Refer to your Subscriber Certificate for other times when your cost share for covered drugs and supplies will be waived.

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:

<table>
<thead>
<tr>
<th>Overall Member Cost Share Provisions</th>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your <em>out-of-pocket maximum</em> per plan year is:</td>
<td>The <em>out-of-pocket maximum</em> is the most you could pay during your annual coverage period for your share of the costs for <em>covered services</em>.</td>
<td></td>
</tr>
<tr>
<td>This <em>out-of-pocket maximum</em> is a total of the <em>deductible</em>, <em>copayments</em>, and <em>coinsurance</em> you pay for services and supplies covered by your <em>Blue Cross and Blue Shield PPO</em> health plan.</td>
<td>$[____] per member</td>
<td>$(____) per member</td>
</tr>
<tr>
<td>This prescription drug <em>out-of-pocket maximum</em> is a total of the <em>deductible</em>, <em>copayments</em>, and <em>coinsurance</em> you pay for drugs and supplies covered by your <em>Blue Cross and Blue Shield Drug Plan</em>.</td>
<td>$[____] per family</td>
<td>$(____) per family</td>
</tr>
<tr>
<td>The family <em>out-of-pocket maximum</em> can be met by eligible costs incurred by any combination of <em>members</em> enrolled under the same family plan. But, no one <em>member</em> will have to pay more than the per <em>member</em> <em>out-of-pocket maximum</em>.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

All other provisions remain as described in your Subscriber Certificate.
Blue Cross and Blue Shield of Massachusetts, Inc.

Blue Care® Elect Preferred Provider Plan

Subscriber Certificate
Welcome to Blue Cross and Blue Shield!

We are very pleased that you’ve selected Blue Cross and Blue Shield of Massachusetts, Inc. This Subscriber Certificate is a comprehensive description of your benefits, so it includes some technical language. It also explains your responsibilities — and our responsibilities — in order for you to receive the full extent of your coverage. If you need any help understanding the terms and conditions of your health plan, please contact us. We’re here to help!
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: ATENCION: 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 nirmeno Sèvis Manm nan ki sou kat Identifikasyon w lan (Sèvis pou Malantandan 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 (телефон: 711).

Arabic/دبيس:
- اتصل إذا كنت تتحدث اللغة العربية، فتوفر خدمات المساعدة اللغوية مجّانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة حويتك (TTY: 711).

Mon-Khmer, Cambodian/ខ្មែរ: បើអ្នកស្លាប់ភាសាខ្មែរ អាចបានជាមួយនឹងសេវាជួយជំនួយភាសាខ្មែរ ដោយសរសេរ្តេបែកនឹងសេវាជួយជំនួយភាសាខ្មែរ តាមលេខេបែកនឹងសេវាជួយជំនួយភាសាខ្មែរ (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).

Greek/Ελληνικά: ΠΡΟΣΟХΗ: 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 uzupełnionych pod numer podany na identyfikatorze (TTY: 711).

Hindi/हिंदी: ध्यान दें: यदि आप हिंदी बोलते हैं, तो भाषा सहायता सेवाएं, आप के लिए निश्चित प्रारंभिक मदद हैं। सदस्य सेवाओं को आपके आई.डी. कोड पर दिए गए नंबर पर कॉल करें (टी.टी.वाई. : 711).

Gujarati/ગુજરાતી: ધ્યાન આપો: તમે ગુજરાતી બોલતા હો, તો તમને ભાષાની સહાયતા સેવાઓ સામે છે. તમારા આઈ.ડી. કોડ પર આપેલ નંબર પર Member Service ને કોલ કરો (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ト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）。


Persian/پارسیان: توجه: اگر زبان شما فارسی است، خدمات کمک زبانی ب صورت رایگان در اختیار شما قرار می‌گیرد با شماره تلفن مندرج پرویز (TTY: 711).

Lao/ລາວ: ປໍ່າPLEMENT ເພື່ອ ບໍລິຫ້ານ ປະທານ ພົນດົງ, ຜຶ່ງມີບໍລິຫ້ານລາວທີ່ພິninger ປະທານ ພົນດົງໄດ້. ຜຶ່ງຊ່ວຍການບໍລິຫ້ານສາມາດກ່ຽວກັບທ່ານໄດ້ໂອນເທິງທີ່ກ່ຽວກັບ (TTY: 711).

Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k’ehji yánilt’i’go saad bee yát’i’ ê t’aádíjík’i bee nik’a’a’dooowolgo ê ná’ahoot’i’. Díí bee anítaáhíí ninaaltsoos bine’déé’ nóomba biká’ígíijí’ béésh bee hodíílnih (TTY: 711).
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Introduction

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

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

WORDS IN ITALICS ARE EXPLAINED IN PART 2.
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

WORDS IN ITALICS ARE EXPLAINED IN PART 2.
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.

WORDS IN ITALICS ARE EXPLAINED IN PART 2.
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, effective January 1, 2023, real-time cost estimates will be available for a limited number of covered services. Then, as of January 1, 2024, real-time 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](http://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](http://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

**WORDS IN ITALICS ARE EXPLAINED IN PART 2.**
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 copayment 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.

WORDS IN ITALICS ARE EXPLAINED IN PART 2.
**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 your 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
Part 2 — **Explanation of Terms** (continued)

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.

*WORDS IN ITALICS ARE EXPLAINED IN PART 2.*
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.
Part 2 – Explanation of Terms (continued)

- 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

WORDS IN ITALICS ARE EXPLAINED IN PART 2.
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.)

WORDS IN ITALICS ARE EXPLAINED IN PART 2.
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
Part 5 – **Covered Services** (continued)

**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

WORDS IN ITALICS ARE EXPLAINED IN PART 2.
IMPORTANT: Refer to the Schedule of Benefits for your plan option for the cost share amounts that you must pay for covered services and for the benefit limits that may apply to specific covered services. Once you reach your benefit limit for a specific covered service, no more benefits are provided by Blue Cross and Blue Shield for those services or supplies.

are provided for: services that are furnished by school personnel under an individualized education 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.

WORDS IN ITALICS ARE EXPLAINED IN PART 2.
IMPORTANT: Refer to the Schedule of Benefits for your plan option for the cost share amounts that you must pay for covered services and for the benefit limits that may apply to specific covered services. Once you reach your benefit limit for a specific covered service, no more benefits are provided by Blue Cross and Blue Shield for those services or supplies.

- 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.

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 medical
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.

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 provider know when your coverage...
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.

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.

For the list of gender affirming services that are covered by this health plan, please refer to the Blue Cross and Blue Shield medical policies. 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.

No benefits are provided for: services and procedures that are not considered by Blue Cross and Blue Shield to be medically necessary for gender affirmation surgery as listed in the Blue Cross and Blue Shield medical policies; and any services to reverse gender affirmation treatment.

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.)

WORDS IN ITALICS ARE EXPLAINED IN PART 2.
IMPORTANT: Refer to the Schedule of Benefits for your plan option for the cost share amounts that you must pay for covered services and for the benefit limits that may apply to specific covered services. Once you reach your benefit limit for a specific covered service, no more benefits are provided by Blue Cross and Blue Shield for those services or supplies.

### 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.

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...
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.

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.
- **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
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 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 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
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.

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.
- 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.
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 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 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.)

WORDS IN ITALICS ARE EXPLAINED IN PART 2.
IMPORTANT: Refer to the Schedule of Benefits for your plan option for the cost share amounts that you must pay for covered services and for the benefit limits that may apply to specific covered services. Once you reach your benefit limit for a specific covered service, no more benefits are provided by Blue Cross and Blue Shield for those services or supplies.

- 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.

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.

WORDS IN ITALICS ARE EXPLAINED IN PART 2.
Part 5 – **Covered Services** (continued)

**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.

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**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 *Diagnostic and Statistical Manual of Mental Disorders* that are scientifically recognized and approved by the Commissioner of the Department of Mental Health.
- Rape-related mental or emotional disorders for victims of a rape or victims of an assault with intent to rape.
- Non-biologically-based mental, behavior, or emotional disorders of enrolled dependent children who are under age 19. This coverage includes pediatric specialty mental health care that is furnished by a *mental health provider* who has a recognized expertise in specialty pediatrics. (This coverage is not limited to those disorders that substantially interfere with or limit the way the child functions or how 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 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.

WORDS IN ITALICS ARE EXPLAINED IN PART 2.
IMPORTANT: Refer to the Schedule of Benefits for your plan option for the cost share amounts that you must pay for covered services and for the benefit limits that may apply to specific covered services. Once you reach your benefit limit for a specific covered service, no more benefits are provided by Blue Cross and Blue Shield for those services or supplies.

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 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.
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.

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 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
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.

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 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.
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 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.

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 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”).
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.

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.)

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
**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.

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

- The drug or supply is prescribed for your use while you are an outpatient.
- The drug or supply is purchased from a pharmacy that is approved by *Blue Cross and Blue Shield* for payment for the specific covered drug and/or supply. This means that for most covered drugs and supplies, you may buy your drug or supply from any covered retail pharmacy. However, for 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](http://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](http://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* 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](http://www.bluecrossma.org).
**Part 5 – Covered Services**

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

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**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: 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](http://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” for your coverage for contraceptive implant systems and IUDs.

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*WORDS IN ITALICS ARE EXPLAINED IN PART 2.*
IMPORTANT: Refer to the Schedule of Benefits for your plan option for the cost share amounts that you must pay for covered services and for the benefit limits that may apply to specific covered services. Once you reach your benefit limit for a specific covered service, no more benefits are provided by Blue Cross and Blue Shield for those services or supplies.

- 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.
- 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.

WORDS IN ITALICS ARE EXPLAINED IN PART 2.
IMPORTANT: Refer to the Schedule of Benefits for your plan option for the cost share amounts that you must pay for covered services and for the benefit limits that may apply to specific covered services. Once you reach your benefit limit for a specific covered service, no more benefits are provided by Blue Cross and Blue Shield for those services or supplies.

- 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 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.
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.

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.

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

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.

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.
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.

- IUDs, diaphragms, and other prescription contraceptive methods that have been approved by the U.S. Food and Drug Administration (FDA), when the items are supplied during the visit.
- Genetic counseling.

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.

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.

WORDS IN ITALICS ARE EXPLAINED IN PART 2.
IMPORTANT: Refer to the Schedule of Benefits for your plan option for the cost share amounts that you must pay for covered services and for the benefit limits that may apply to specific covered services. Once you reach your benefit limit for a specific covered service, no more benefits are provided by Blue Cross and Blue Shield for those services or supplies.

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.

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.

WORDS IN ITALICS ARE EXPLAINED IN PART 2.
Part 5 – **Covered Services** (continued)

**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.

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**Qualified Clinical Trials for Treatment of Cancer**

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

No benefits are provided for:

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

**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).

*WORDS IN ITALICS ARE EXPLAINED IN PART 2.*
IMPORTANT: Refer to the Schedule of Benefits for your plan option for the cost share amounts that you must pay for covered services and for the benefit limits that may apply to specific covered services. Once you reach your benefit limit for a specific covered service, no more benefits are provided by Blue Cross and Blue Shield for those services or supplies.

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.)

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
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.

*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 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):
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.

— **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. 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
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.

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.)

− 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

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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.

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 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.

Exception for covered services furnished by a virtual care team primary care provider type: 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 not the same as the lowest cost share level that you would pay for similar services when they are furnished by a preferred

WORDS IN ITALICS ARE EXPLAINED IN PART 2.
IMPORTANT: Refer to the Schedule of Benefits for your plan option for the cost share amounts that you must pay for covered services and for the benefit limits that may apply to specific covered services. Once you reach your benefit limit for a specific covered service, no more benefits are provided by Blue Cross and Blue Shield for those services or supplies.

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 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 not 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. There is one exception. This health plan will continue to provide coverage for inpatient covered services, but only if you are receiving covered inpatient care on your termination date. In this case, coverage will continue to be provided until all the benefits allowed by your health plan have been used up or the date of discharge, whichever comes first. But, this does not apply if your coverage in this health plan is canceled for misrepresentation or fraud.

Services Furnished to Immediate Family
No benefits are provided for a covered service that is furnished by a health care provider to 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.

WORDS IN ITALICS ARE EXPLAINED IN PART 2.
Part 6 – **Limitations and Exclusions** (continued)

- 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

WORDS IN ITALICS ARE EXPLAINED IN PART 2.
Part 8 – Other Health Plan Provisions (continued)

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

WORDS IN ITALICS ARE EXPLAINED IN PART 2.
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.

Words in italics are explained in Part 2.
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.

WORDS IN ITALICS ARE EXPLAINED IN PART 2.
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

WORDS IN ITALICS ARE EXPLAINED IN PART 2.
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; 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.

*WORDS IN ITALICS ARE EXPLAINED IN PART 2.*
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

WORDS IN ITALICS ARE EXPLAINED IN PART 2.
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 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.

WORDS IN ITALICS ARE EXPLAINED IN PART 2.
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 96). 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.

WORDS IN ITALICS ARE EXPLAINED IN PART 2.
• 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...
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(s) in 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.
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.

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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 nimewò Sèvis Manm nan ki sou kat Idantitikasyon w lan (Sèvis pou Malantandan 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/دير: 
النبذة: إذا كنت تتحدث اللغة العربية، فتوفر خدمات المساعدة اللغوية مجانية بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هويةك (جهاز الهاتف النصي للضم والركم “TTY” 711).

Mon-Khmer, Cambodian/េ: ការព្យាបាលជាមួយអំពីការជួយប្រឈមជាប្រចាំថ្ងៃ ឬអំពីការអោយប្រឈមនិស្សិតមនុស្សចិត្ត ឬសកម្មភាពជាមួយអំពីការជួយប្រឈម ការដោយសារមូលដ្ឋានសម្រាប់ប្រទេសមួយ (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).

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 हिंदी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए निष्ठुल उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वाई.: 711).

Gujarati/ગુજરાતી: ધ્યાન આપો: તમે જો ગુજરાતી બોલતા હો, તો તમને ભાષાસાહેબ સહાયતા સેવા દ્વારા મૂલ્યનું ઉપલબ્ધ છે. તમારા આઈ.ડી. કાર્ડ પર આપણી નંબર પર Member Service ને કોલ કરો (TTY: 711).


Lao/ພາສາລາວ: ແທໍ່ນໍາມິດ: ເຈັດໜ້າທໍາລ່າຍວ່າ, ຊຸດຖະບົດຊາຍຊ່ວຍຄວາມຄູ້ມາຮູ້ພຽງພາດ ກ່ຽວກັບຊອກຊາຍຊ່ວຍຄວາມຄູ້ມາຮູ້ພຽງພາດທີ່ເຮັດຂໍ້ມູນໃນເງິນທີ່ຂາຍ (TTY: 711).

Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k’ehjí yáñílti’i’go saad bee yát’i’ éi t’aájiíłk’e bee niká’a’doodwolgo éí ná’ahoot’i’. Díí bee anítahíí binaaltsoos bine’déé’ nóömba biká’ígííjí’ béeesh 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](http://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](http://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.)

**WORDS IN ITALICS ARE EXPLAINED IN PART 8.**
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: 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.

WORDS IN ITALICS ARE EXPLAINED IN PART 8.
• 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...
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.

*WORDS IN ITALICS ARE EXPLAINED IN PART 8.*
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, effective January 1, 2023, real-time cost estimates will be available for a limited number of covered services. Then, as of January 1, 2024, real-time 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.

WORDS IN ITALICS ARE EXPLAINED IN PART 8.
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.
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 designates 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](http://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.

WORDS IN ITALICS ARE EXPLAINED IN PART 8.
**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. 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, 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 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 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 Cross and Blue Shield receives your completed enrollment form.

- You had prior creditable health care coverage. 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. 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 Cross and Blue Shield. You must also send any other documentation or statements that Cross and Blue Shield may ask that you send in order for 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 Cross and Blue Shield is true, correct, and complete.

During the enrollment process, 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, 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](http://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.