

# Schedule of Benefits

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## HMO Blue New England

\$3,000 Deductible with Copayment

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 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 **HMO Blue New England**. The *service area* where your *covered services* will be furnished includes all counties in Massachusetts, Connecticut, Maine, New Hampshire, Rhode Island, and Vermont. 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*.

**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                                                                                                                                                                                                                                   |                                                                                           |                                                                                                                                                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Deductible</b>                                                                                                                                                                                                                                                      |                                                                                           | The <i>deductible</i> is the cost you have to pay for certain <i>covered services</i> during your annual coverage period before benefits will be paid for those <i>covered services</i> .                                                                  |
| Your <i>deductible</i> per plan year is:                                                                                                                                                                                                                               |                                                                                           | \$3,000 per member<br>\$6,000 per family                                                                                                                                                                                                                   |
| This <i>deductible</i> applies to all <i>covered services</i> <u>except</u> preventive health services (other than vision supplies and related <i>covered services</i> ), prescription drugs and supplies, and certain <i>covered services</i> as noted in this chart. |                                                                                           | The family <i>deductible</i> can be met by eligible costs incurred by any combination of <i>members</i> enrolled under the same family plan. But, no one <i>member</i> will have to pay more than the per <i>member deductible</i> .                       |
| <b>Out-of-Pocket Maximum</b>                                                                                                                                                                                                                                           |                                                                                           | The <i>out-of-pocket maximum</i> is the most you could pay during your annual coverage period for your share of the costs for <i>covered services</i> .                                                                                                    |
| Your <i>out-of-pocket maximum</i> per plan year is:                                                                                                                                                                                                                    |                                                                                           | \$9,350 per member<br>\$18,700 per family                                                                                                                                                                                                                  |
| This <i>out-of-pocket maximum</i> is a total of the <i>deductible</i> , <i>copayments</i> , and <i>coinsurance</i> you pay for <i>covered services</i> .                                                                                                               |                                                                                           | The family <i>out-of-pocket maximum</i> can be met by eligible costs incurred by any combination of <i>members</i> enrolled under the same family plan. But, no one <i>member</i> will have to pay more than the per <i>member out-of-pocket maximum</i> . |
| <b>Overall Benefit Maximum</b>                                                                                                                                                                                                                                         |                                                                                           | None                                                                                                                                                                                                                                                       |
| Covered Services                                                                                                                                                                                                                                                       |                                                                                           | Your Cost Is:                                                                                                                                                                                                                                              |
| <b>Admissions for Inpatient Medical and Surgical Care</b>                                                                                                                                                                                                              | • In a General Hospital                                                                   |                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                        | <u>Hospital services</u>                                                                  | \$1,500 <i>copayment</i> per admission after <i>deductible</i>                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                        | <u>Physician and other covered professional provider services</u>                         | No charge after <i>deductible</i>                                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                        | • In a Chronic Disease Hospital                                                           | (same as admissions in a General Hospital)                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                                                                        | • In a Rehabilitation Hospital (60-day <i>benefit limit</i> per member per calendar year) |                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                        | <u>Hospital services</u>                                                                  | \$1,500 <i>copayment</i> per admission after <i>deductible</i>                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                        | <u>Physician and other covered professional provider services</u>                         | No charge after <i>deductible</i>                                                                                                                                                                                                                          |

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

| Covered Services                                                         |                                                                                                                                                                  | Your Cost Is:                                                                                                                          |
|--------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| <b>Admissions for Inpatient Medical and Surgical Care</b><br>(continued) | <ul style="list-style-type: none"> <li>In a Skilled Nursing Facility (100-day <i>benefit limit</i> per member per calendar year)</li> </ul>                      |                                                                                                                                        |
|                                                                          | <u>Facility services</u>                                                                                                                                         | \$1,500 <i>copayment</i> per admission after <i>deductible</i>                                                                         |
|                                                                          | <u>Physician and other covered professional provider services</u>                                                                                                | No charge after <i>deductible</i>                                                                                                      |
| <b>Ambulance Services</b><br>(ground or air ambulance transport)         | <ul style="list-style-type: none"> <li>Emergency ambulance</li> </ul>                                                                                            | No charge after <i>deductible</i>                                                                                                      |
|                                                                          | <ul style="list-style-type: none"> <li>Other ambulance</li> </ul>                                                                                                | No charge after <i>deductible</i>                                                                                                      |
| <b>Cardiac Rehabilitation</b>                                            | <i>Outpatient</i> services                                                                                                                                       | \$70 <i>copayment</i> per visit after <i>deductible</i>                                                                                |
| <b>Chiropractor Services</b><br>(for <i>members</i> of any age)          | <ul style="list-style-type: none"> <li><i>Outpatient</i> lab tests and x-rays</li> </ul>                                                                         | See Lab Tests, X-Rays, and Other Tests                                                                                                 |
|                                                                          | <ul style="list-style-type: none"> <li><i>Outpatient</i> medical care services, including spinal manipulation (a <i>benefit limit</i> does not apply)</li> </ul> | \$70 <i>copayment</i> per visit ( <i>deductible</i> does not apply)                                                                    |
| <b>Dialysis Services</b>                                                 | <i>Outpatient</i> services and home dialysis                                                                                                                     | No charge after <i>deductible</i>                                                                                                      |
| <b>Durable Medical Equipment</b>                                         | <ul style="list-style-type: none"> <li>Covered medical equipment rented or purchased for home use</li> </ul>                                                     | 20% after <i>deductible</i>                                                                                                            |
|                                                                          | <ul style="list-style-type: none"> <li>One breast pump per birth (rented or purchased), including related parts and supplies</li> </ul>                          | No charge ( <i>deductible</i> does not apply)                                                                                          |
|                                                                          |                                                                                                                                                                  | No coverage is provided for hospital-grade breast pumps.                                                                               |
| <b>Early Intervention Services</b>                                       | <i>Outpatient</i> intervention services for eligible child from birth through age two                                                                            | No charge ( <i>deductible</i> does not apply)                                                                                          |
| <b>Emergency Medical Outpatient Services</b>                             | <ul style="list-style-type: none"> <li>Emergency room services</li> </ul>                                                                                        | \$750 <i>copayment</i> per visit after <i>deductible</i> ; <i>copayment</i> waived if held for observation or admitted within 24 hours |
|                                                                          | <ul style="list-style-type: none"> <li>Hospital outpatient department services</li> </ul>                                                                        | No charge after <i>deductible</i>                                                                                                      |

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

| Covered Services                                                   |                                                                                                                                                                                                                                                                                                     | Your Cost Is:                                                       |
|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|
| <b>Emergency Medical Outpatient Services</b><br>(continued)        | <ul style="list-style-type: none"> <li>Office, health center, and home services<br/><br/>by your <u>primary care provider</u>; or by an <u>OB/GYN physician or nurse midwife</u>; or by a <u>physician assistant or nurse practitioner designated by the health plan as primary care</u></li> </ul> | \$45 <i>copayment</i> per visit ( <i>deductible</i> does not apply) |
|                                                                    | <ul style="list-style-type: none"> <li>by a network specialist or other <i>covered provider</i> (non-hospital), including a <u>physician assistant or nurse practitioner designated by the health plan as specialty care</u></li> </ul>                                                             | \$70 <i>copayment</i> per visit ( <i>deductible</i> does not apply) |
| <b>Home Health Care</b>                                            | Home care program                                                                                                                                                                                                                                                                                   | No charge after <i>deductible</i>                                   |
| <b>Hospice Services</b>                                            | <i>Inpatient</i> or <i>outpatient</i> hospice services for terminally ill                                                                                                                                                                                                                           | No charge after <i>deductible</i>                                   |
| <b>Infertility Services</b>                                        | <ul style="list-style-type: none"> <li><i>Inpatient</i> services</li> </ul>                                                                                                                                                                                                                         | See Admissions for Inpatient Medical and Surgical Care              |
|                                                                    | <ul style="list-style-type: none"> <li><i>Outpatient</i> surgical services</li> </ul>                                                                                                                                                                                                               | See Surgery as an Outpatient                                        |
|                                                                    | <ul style="list-style-type: none"> <li><i>Outpatient</i> lab tests and x-rays</li> </ul>                                                                                                                                                                                                            | See Lab Tests, X-Rays, and Other Tests                              |
|                                                                    | <ul style="list-style-type: none"> <li><i>Outpatient</i> medical care services</li> </ul>                                                                                                                                                                                                           | See Medical Care Outpatient Visits                                  |
| <b>Lab Tests, X-Rays, and Other Tests</b><br>(diagnostic services) | <ul style="list-style-type: none"> <li><i>Outpatient</i> lab tests<br/><br/>by a <u>general hospital</u></li> </ul>                                                                                                                                                                                 | \$75 <i>copayment</i> per service date after <i>deductible</i>      |
|                                                                    | <ul style="list-style-type: none"> <li>by other <i>covered providers</i></li> </ul>                                                                                                                                                                                                                 | \$15 <i>copayment</i> per service date after <i>deductible</i>      |
|                                                                    | <ul style="list-style-type: none"> <li><i>Outpatient</i> x-rays and other imaging tests (other than advanced imaging tests)<br/><br/>by a <u>general hospital</u></li> </ul>                                                                                                                        | \$150 <i>copayment</i> per service date after <i>deductible</i>     |
|                                                                    | <ul style="list-style-type: none"> <li>by other <i>covered providers</i></li> </ul>                                                                                                                                                                                                                 | \$25 <i>copayment</i> per service date after <i>deductible</i>      |

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

| Covered Services                                                                                                          | Your Cost Is:                                                                                                                                                                                        |                                                                                                                                                                                                    |
|---------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Lab Tests, X-Rays, and Other Tests</b> (continued)                                                                     | <ul style="list-style-type: none"> <li>Outpatient advanced imaging tests (CT scans, MRIs, PET scans, nuclear cardiac imaging)</li> </ul>                                                             |                                                                                                                                                                                                    |
|                                                                                                                           | by a general hospital                                                                                                                                                                                | \$500 copayment per category of test per service date after deductible                                                                                                                             |
|                                                                                                                           | by other covered providers                                                                                                                                                                           | \$250 copayment per category of test per service date after deductible                                                                                                                             |
|                                                                                                                           | <ul style="list-style-type: none"> <li>Other outpatient tests and preoperative tests</li> </ul>                                                                                                      |                                                                                                                                                                                                    |
|                                                                                                                           | by a general hospital                                                                                                                                                                                | No charge after deductible                                                                                                                                                                         |
|                                                                                                                           | by other covered providers                                                                                                                                                                           | No charge after deductible                                                                                                                                                                         |
| <b>Maternity Services and Well Newborn Care</b><br>(includes \$90/\$45 for childbirth classes; deductible does not apply) | <ul style="list-style-type: none"> <li>Maternity services</li> </ul>                                                                                                                                 |                                                                                                                                                                                                    |
|                                                                                                                           | Facility services (inpatient and outpatient covered services)                                                                                                                                        | \$1,500 copayment per admission after deductible for inpatient services, otherwise no charge after deductible                                                                                      |
|                                                                                                                           | Physician and other covered professional provider services (includes delivery and postnatal care)                                                                                                    | No charge after deductible                                                                                                                                                                         |
|                                                                                                                           | Prenatal care                                                                                                                                                                                        | No charge (deductible does not apply)                                                                                                                                                              |
|                                                                                                                           | Well newborn care during covered maternity admission                                                                                                                                                 | No charge (deductible does not apply)                                                                                                                                                              |
| <b>Medical Care Outpatient Visits</b><br>(includes syringes and needles dispensed during a visit)                         | <ul style="list-style-type: none"> <li>Office, health center, and home medical services</li> </ul>                                                                                                   |                                                                                                                                                                                                    |
|                                                                                                                           | by your primary care provider; or by an OB/GYN physician, nurse midwife, or limited services clinic; or by a physician assistant or nurse practitioner designated by the health plan as primary care | \$45 copayment per visit, except no charge per visit at a limited services clinic (deductible does not apply); all cost share waived for total of two diabetic visits per member per calendar year |
|                                                                                                                           | by a network specialist or other covered provider (non-hospital), including a physician assistant or nurse practitioner designated by the health plan as specialty care                              | \$70 copayment per visit (deductible does not apply); all cost share waived for total of two diabetic visits per member per calendar year                                                          |

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

\$3,000 Deductible with Copayment

| Covered Services                                     |                                                                                                          | Your Cost Is:                                                                                                                  |
|------------------------------------------------------|----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|
| <b>Medical Care Outpatient Visits</b><br>(continued) | • Hospital outpatient medical services                                                                   | No charge after <i>deductible</i> ; all cost share waived for total of two diabetic visits per <i>member</i> per calendar year |
|                                                      | • Acupuncture services (12-visit <i>benefit limit</i> per <i>member</i> per calendar year)               | \$70 <i>copayment</i> per visit ( <i>deductible</i> does not apply)                                                            |
| <b>Medical Formulas</b>                              | Certain medical formulas and low protein foods                                                           | No charge ( <i>deductible</i> does not apply)                                                                                  |
| <b>Mental Health and Substance Use Treatment</b>     | • <i>Inpatient</i> admissions in a General Hospital<br><u>Hospital services</u>                          | \$1,500 <i>copayment</i> per admission after <i>deductible</i>                                                                 |
|                                                      | <u>Physician and other covered professional provider services</u>                                        | No charge after <i>deductible</i>                                                                                              |
|                                                      | • <i>Inpatient</i> admissions in a Mental Hospital or Substance Use Facility<br><u>Facility services</u> | \$1,500 <i>copayment</i> per admission after <i>deductible</i>                                                                 |
|                                                      | <u>Physician and other covered professional provider services</u>                                        | No charge after <i>deductible</i>                                                                                              |
|                                                      | • <i>Outpatient</i> services                                                                             | \$45 <i>copayment</i> per visit, except no charge for hospital services ( <i>deductible</i> does not apply)                    |
|                                                      |                                                                                                          |                                                                                                                                |
| <b>Oxygen and Respiratory Therapy</b>                | • Oxygen and equipment for its administration                                                            | No charge after <i>deductible</i>                                                                                              |
|                                                      | • <i>Outpatient</i> respiratory therapy                                                                  | No charge after <i>deductible</i>                                                                                              |
| <b>Podiatry Care</b>                                 | • <i>Outpatient</i> lab tests and x-rays                                                                 | See Lab Tests, X-Rays, and Other Tests                                                                                         |
|                                                      | • <i>Outpatient</i> surgical services                                                                    | See Surgery as an Outpatient                                                                                                   |
|                                                      | • <i>Outpatient</i> medical care services                                                                | See Medical Care Outpatient Visits                                                                                             |

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

| Covered Services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                    | Your Cost Is:                                                                                                                                                                                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prescription Drugs and Supplies</b><br>Drug Formulary (includes syringes and needles)<br>Includes Mail Order with Retail Choice Program<br>Includes No Cost Generic Medications for select drugs that are used to treat certain chronic conditions such as depression, cholesterol, diabetes, and high blood pressure and cardiac conditions. For these covered drugs, you pay nothing at both retail and mail order (any <i>deductible, copayment, and/or coinsurance</i> do not apply). The list of no cost generic medications is available from the health plan and may change from time to time. Please check for updates. | <ul style="list-style-type: none"> <li>Retail Pharmacy (30-day supply)<br/> Tier 1 (low cost generic):<br/> Tier 2 (other generic):<br/> Tier 3 (preferred brand):<br/> Tier 4 (non-preferred):<br/> Tier 5 (preferred brand specialty<sup>†</sup>):<br/> Tier 6 (non-preferred specialty<sup>†</sup>):</li> </ul> | \$10 <i>copayment</i><br>\$45 <i>copayment</i><br>\$150 <i>copayment</i><br>\$225 <i>copayment</i><br>50% but no more than \$350 per supply<br>50% but no more than \$500 per supply                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <sup>†</sup> must be purchased from an approved retail specialty pharmacy                                                                                                                                                                                                                                          | This cost share is waived for Tier 1 and Tier 2 birth control drugs and devices; certain preventive drugs as required by federal law; insulin infusion pumps; and certain orally-administered anticancer drugs. |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <ul style="list-style-type: none"> <li>Mail Order Pharmacy (90-day supply)</li> </ul> <b>Other Covered Drugs and Supplies</b><br>Tier 1 (low cost generic):<br>Tier 2 (other generic):<br>Tier 3 (preferred brand):<br>Tier 4 (non-preferred):                                                                     | \$20 <i>copayment</i><br>\$90 <i>copayment</i><br>\$300 <i>copayment</i><br>\$675 <i>copayment</i>                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                    | This cost share is waived for Tier 1 and Tier 2 birth control drugs and devices; certain preventive drugs as required by federal law; and certain orally-administered anticancer drugs.                         |
| <b>Preventive Health Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <ul style="list-style-type: none"> <li>Routine pediatric care</li> </ul>                                                                                                                                                                                                                                           |                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <u>Routine medical exams and immunizations</u>                                                                                                                                                                                                                                                                     | No charge                                                                                                                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <u>Routine tests</u>                                                                                                                                                                                                                                                                                               | No charge                                                                                                                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <u>Annual mental health wellness exams</u>                                                                                                                                                                                                                                                                         | These <i>covered services</i> include (but are not limited to): routine exams; immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning.                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <ul style="list-style-type: none"> <li>Preventive dental care for <i>members</i> under age 18 for treatment of cleft lip/cleft palate</li> </ul>                                                                                                                                                                   | No charge                                                                                                                                                                                                       |

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

| Covered Services                              |                                                                                                                                                            | Your Cost Is:                                                                                                                                                                                                        |
|-----------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Preventive Health Services</b> (continued) | • Routine adult care                                                                                                                                       |                                                                                                                                                                                                                      |
|                                               | <u>Routine medical exams and immunizations</u>                                                                                                             | No charge                                                                                                                                                                                                            |
|                                               | <u>Routine tests</u>                                                                                                                                       | No charge                                                                                                                                                                                                            |
|                                               |                                                                                                                                                            | These <i>covered services</i> include (but are not limited to): routine exams; immunizations; routine lab tests and x-rays; routine mammograms; blood tests to screen for lead poisoning; and routine colonoscopies. |
|                                               | <u>Annual mental health wellness exams</u>                                                                                                                 | No charge                                                                                                                                                                                                            |
|                                               | • Routine GYN care                                                                                                                                         |                                                                                                                                                                                                                      |
|                                               | <u>Routine GYN exams</u><br>(one exam per <i>member</i> per calendar year)                                                                                 | No charge                                                                                                                                                                                                            |
|                                               | <u>Routine Pap smear tests</u><br>(one test per <i>member</i> per calendar year)                                                                           | No charge                                                                                                                                                                                                            |
|                                               | • Family planning                                                                                                                                          | No charge                                                                                                                                                                                                            |
|                                               | • Routine hearing care                                                                                                                                     |                                                                                                                                                                                                                      |
|                                               | <u>Routine hearing exams/tests</u>                                                                                                                         | No charge                                                                                                                                                                                                            |
|                                               | <u>Newborn hearing screening tests</u>                                                                                                                     | No charge                                                                                                                                                                                                            |
|                                               | <u>Hearing aids/related services for <i>members</i> pf any age (\$2,000 for one hearing aid per hearing-impaired ear every 36 months)</u>                  | No charge                                                                                                                                                                                                            |
|                                               | • Routine vision care                                                                                                                                      |                                                                                                                                                                                                                      |
|                                               | <u>Routine vision exams</u><br>(one exam per <i>member</i> every 24 months, except every 12 months until end of calendar month <i>member</i> turns age 19) | No charge                                                                                                                                                                                                            |
|                                               | <u>Vision supplies/related services</u>                                                                                                                    | See your vision supplies <i>rider</i> for coverage for <i>members</i> until end of calendar month <i>member</i> turns age 19                                                                                         |
|                                               | • Ostomy supplies                                                                                                                                          | No charge after <i>deductible</i>                                                                                                                                                                                    |
|                                               | • Artificial limb devices (includes repairs) and other external prosthetic devices                                                                         | 20% after <i>deductible</i>                                                                                                                                                                                          |

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

| Covered Services                                                                                                               |                                                                                                                                                                                                                                                                                     | Your Cost Is:                                                       |
|--------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|
| <b>Radiation Therapy and Chemotherapy</b>                                                                                      | <ul style="list-style-type: none"> <li>• <i>Outpatient</i> hospital and free-standing radiation and chemotherapy facility services</li> </ul>                                                                                                                                       | No charge after <i>deductible</i>                                   |
|                                                                                                                                | <ul style="list-style-type: none"> <li>• Office and health center services<br/><br/>by your <i>primary care provider</i> or by a <i>physician assistant</i> or <i>nurse practitioner</i> designated by the health plan as <i>primary care</i></li> </ul>                            | \$45 <i>copayment</i> per visit ( <i>deductible</i> does not apply) |
|                                                                                                                                | <ul style="list-style-type: none"> <li>by a network specialist or other covered provider (non-hospital), including a <i>physician assistant</i> or <i>nurse practitioner</i> designated by the health plan as <i>specialty care</i></li> </ul>                                      | \$70 <i>copayment</i> per visit ( <i>deductible</i> does not apply) |
| <b>Second Opinions</b>                                                                                                         | <i>Outpatient</i> second and third opinions                                                                                                                                                                                                                                         | See Medical Care Outpatient Visits                                  |
| <b>Short-Term Rehabilitation Therapy</b><br>(physical, occupational, and speech therapy)<br><br>Includes habilitation services | <i>Outpatient</i> services (separate 60-visit <i>benefit limits</i> for rehabilitation and habilitation services per <i>member</i> per calendar year for physical and occupational therapy except for autism and Down syndrome; no <i>benefit limit</i> applies for speech therapy) | \$70 <i>copayment</i> per visit after <i>deductible</i>             |
| <b>Speech, Hearing, and Language Disorder Treatment</b>                                                                        | <ul style="list-style-type: none"> <li>• <i>Outpatient</i> diagnostic tests</li> </ul>                                                                                                                                                                                              | See Lab Tests, X-Rays, and Other Tests                              |
|                                                                                                                                | <ul style="list-style-type: none"> <li>• <i>Outpatient</i> speech therapy</li> </ul>                                                                                                                                                                                                | See Short-Term Rehabilitation Therapy                               |
|                                                                                                                                | <ul style="list-style-type: none"> <li>• <i>Outpatient</i> medical care services</li> </ul>                                                                                                                                                                                         | See Medical Care Outpatient Visits                                  |

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

| Covered Services                                                                                                         |                                                                                                                                                                                                   | Your Cost Is:                                                                                                                                                   |
|--------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Surgery as an Outpatient</b><br>(includes removal of impacted teeth that are fully or partially imbedded in the bone) | <ul style="list-style-type: none"> <li>• <i>Outpatient</i> day surgery</li> </ul>                                                                                                                 | \$750 <i>copayment</i> per admission after <i>deductible</i>                                                                                                    |
|                                                                                                                          | <u>Hospital surgical day care unit or outpatient department services</u>                                                                                                                          |                                                                                                                                                                 |
|                                                                                                                          | <u>Ambulatory surgical facility services</u>                                                                                                                                                      | \$750 <i>copayment</i> per admission after <i>deductible</i>                                                                                                    |
|                                                                                                                          | <u>Physician and other covered professional provider services</u>                                                                                                                                 | No charge after <i>deductible</i>                                                                                                                               |
|                                                                                                                          | <ul style="list-style-type: none"> <li>• Sterilization procedure for a female <i>member</i> when performed as the primary procedure for family planning reasons</li> </ul>                        | No charge ( <i>deductible</i> does not apply)                                                                                                                   |
|                                                                                                                          | <ul style="list-style-type: none"> <li>• Office and health center surgical services</li> </ul>                                                                                                    |                                                                                                                                                                 |
|                                                                                                                          | by your <u>primary care provider</u> ; or by an <u>OB/GYN physician or nurse midwife</u> ; or by a <u>physician assistant or nurse practitioner designated by the health plan as primary care</u> | \$45 <i>copayment</i> per visit ( <i>deductible</i> does not apply); all cost share waived for total of two diabetic visits per <i>member</i> per calendar year |
|                                                                                                                          | by a network specialist or <u>other covered provider (non-hospital)</u> , including a <u>physician assistant or nurse practitioner designated by the health plan as specialty care</u>            | \$70 <i>copayment</i> per visit ( <i>deductible</i> does not apply); all cost share waived for total of two diabetic visits per <i>member</i> per calendar year |
| <b>TMJ Disorder Treatment</b>                                                                                            | <ul style="list-style-type: none"> <li>• <i>Outpatient</i> x-rays</li> </ul>                                                                                                                      | See Lab Tests, X-Rays, and Other Tests                                                                                                                          |
|                                                                                                                          | <ul style="list-style-type: none"> <li>• <i>Outpatient</i> surgical services</li> </ul>                                                                                                           | See Surgery as an Outpatient                                                                                                                                    |
|                                                                                                                          | <ul style="list-style-type: none"> <li>• <i>Outpatient</i> physical therapy</li> </ul>                                                                                                            | See Short-Term Rehabilitation Therapy                                                                                                                           |
|                                                                                                                          | <ul style="list-style-type: none"> <li>• <i>Outpatient</i> medical care services</li> </ul>                                                                                                       | See Medical Care Outpatient Visits                                                                                                                              |

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

## Rider Vision Supplies

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

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

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

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

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

## Rider Vision Supplies

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

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

All other provisions remain as described in your Subscriber Certificate.

## Rider Prescription Drugs

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

The *outpatient* benefits described in your Subscriber Certificate for covered drugs and supplies have been changed.

When you buy a covered drug, the pharmacist will give you a generic equivalent of the prescribed drug whenever it is allowed. If you choose to buy the brand-name drug instead of the generic drug equivalent, your out-of-pocket costs will be more. For these covered brand-name drugs, your cost will be calculated based on your benefits for the generic drug equivalent. This means that your cost share amount (*copayment* and/or *coinsurance*, whichever applies) will be the same cost share amount that you would have paid for the covered generic drug equivalent.

In addition to your cost share amount, you must pay the difference between the *allowed charge* for the brand-name drug and the *allowed charge* for the generic drug equivalent. All costs that you pay for these covered drugs will count towards your *out-of-pocket maximum*.

**Important Note:** When your plan option includes a *deductible* that applies for prescription drugs, this provision does not apply until the *deductible* has been met.

All other provisions remain as described in your Subscriber Certificate.

# Wellness Participation Program

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

## Fitness Reimbursement

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

Reimbursement is provided for:

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

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

## Weight Loss Program Reimbursement

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

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



## How to Claim Your Reimbursement

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

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

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

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

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

## Rider

# Virtual Care Team Model

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

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

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

For *outpatient covered services* furnished by your virtual care team *primary care provider*, you will pay nothing (any *deductible*, *copayment* and/or *coinsurance* does not apply). The only exception is when you are enrolled in a qualified HSA-compliant high deductible health plan. In this case, your *deductible* will still apply to *covered services* as described in the *Schedule of Benefits* and/or *riders* for your plan option. For *outpatient covered services* furnished by a virtual care team *covered provider* that is not your *primary care provider* or when your *primary care provider* refers you to any other *covered provider*, you will pay your applicable cost share (*deductible*, *copayment* and/or *coinsurance*).

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

This *rider* does not change the cost share amount you will pay for telehealth services as described in your Subscriber Certificate, which includes any *riders* that apply to your coverage in this health plan.

All other provisions remain as described in your Subscriber Certificate.

**Rider**  
**Reproductive Health Care Services**

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

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

**Reproductive Health Care Services**

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

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

**Abortion and Abortion-Related Care**

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

As required by state law, any *deductible*, *copayment*, and/or *coinsurance*, whichever applies to you, will be waived for these *covered services*. The only exceptions are when you are enrolled in a qualified HSA-compliant high deductible health plan or you are enrolled in the catastrophic health plan HMO Blue Essential. In this case, your *deductible* will apply to these *covered services*. Otherwise, any cost share amounts will not apply.

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

All other provisions remain as described in your Subscriber Certificate.

## Rider

# Prescription Drugs for Chronic Conditions

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

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

Beginning on your health plan renewal date on or after July 1, 2025, as required by state law, this health plan has identified at least one generic drug and at least one brand name drug from its Drug Formulary that is used in the treatment of certain chronic conditions. For these identified covered drugs, you may pay a lower cost share than the amount that is described in your *Schedule of Benefits* and/or *riders* that apply to your coverage in this health plan.

The list of chronic conditions and the identified drugs are described in *Blue Cross Blue Shield HMO Blue's* chronic condition management drug list. For help to find out which chronic conditions and which identified drugs are on this list, you can call the *Blue Cross Blue Shield HMO Blue* customer service office. The toll free phone number to call is shown on your ID card. Or, you can also go online and log on to the *Blue Cross Blue Shield HMO Blue* Web site at [www.bluecrossma.org](http://www.bluecrossma.org). This list of chronic conditions and identified drugs may change from time to time (but not more than annually, except in instances where a drug is taken off the market by the drug manufacturer or if the price is substantially changed by the drug manufacturer or if a drug is removed from the *Blue Cross Blue Shield HMO Blue* Drug Formulary). Please check for updates.

- **Identified Generic Drugs.** In most cases, this health plan will provide full benefits for the generic drug(s) identified by the health plan that is used in the treatment for the specific chronic condition (any *deductible*, *copayment*, and/or *coinsurance* will not apply). The only exception is when you are enrolled in a qualified HSA-compliant high deductible health plan. In this case, your *deductible* may apply to the covered generic drug\*.
- **Identified Brand Name Drugs.** For the brand name drug(s) identified by the health plan that is used in the treatment for the specific chronic condition, in most cases, any *deductible* and/or *coinsurance* will not apply. If a *copayment* applies to your prescription drug benefits for all other brand name drugs covered under this health plan, the *copayment* amount that you will pay for these identified brand name drugs will not exceed \$25 for each 30-day supply. (In no event will the *copayment* for these identified brand name drugs exceed the *copayment* that applies for all other brand name drugs; or, if your *copayment* for all other brand name drugs is *less* than this amount, you will pay that lower amount for each 30-day supply of the identified brand name drug.). When you are enrolled in a qualified HSA-compliant high deductible health plan, in addition to any *copayment*, your *deductible* may also apply to the covered drug\*.

This coverage for identified brand name drugs includes at least one of each major type of injectable insulin: rapid-acting; short-acting; intermediate-acting; long-acting; ultra long-acting; and pre-mixed.

## Rider

# Prescription Drugs for Chronic Conditions

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\*When you are enrolled in a qualified HSA-compliant high deductible health plan, the overall *deductible* will not apply if the identified drug is classified as a preventive drug as required by federal law or if your specific plan option includes a provision to waive the overall *deductible* for drugs classified as preventive health drugs that are listed on the *Blue Cross Blue Shield HMO Blue* Drug Formulary (refer to the *Schedule of Benefits* for your plan option and/or any *riders* that apply to your coverage in this health plan).

IMPORTANT NOTE: This *rider* does not change the cost share amount that you will pay for all other covered drugs and supplies. Refer to your Subscriber Certificate for your cost share amount for other covered drugs and supplies and for the times when the cost share for certain other covered drugs and supplies will be waived. If your health plan includes another *rider* that changes your prescription drug benefits, those prescription drug benefits apply for all other covered drugs.

If your health plan includes a Prescription Drugs *rider* where the *member's* out-of-pocket costs will be more when the *member* chooses to obtain the brand-name drug instead of the generic drug equivalent when there is a generic drug equivalent available, and if that drug is one of the identified covered drugs on *Blue Cross Blue Shield HMO Blue's* chronic condition management drug list, the cost share calculation provisions described in that *rider* will continue to apply.

Except as described above for a separate *rider* and/or *Schedule of Benefits* provision for preventive health drugs, this *rider* will supersede any provisions to the contrary that may be described in other *riders*—if there are any—that apply to your coverage in this health plan.

All other provisions remain as described in your Subscriber Certificate.

**Rider**  
**Cost Share Assistance Pharmacy Program**

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

The *outpatient* benefits described in your Subscriber Certificate for covered drugs and supplies have been changed.

Your health plan includes a cost share assistance program for certain specialty drugs and/or supplies. Cost share assistance is a process in which the health plan facilitates your enrollment in a program where drug manufacturers provide financial support to *members* by reducing or removing cost share applied to a drug and/or supply.

For covered drugs and supplies that are eligible under this cost share assistance program, the initial cost share amount that is provided will be equal to 30% of the total cost of the drug or supply.

When you enroll for cost share assistance with a drug manufacturer for an eligible covered drug or supply, the initial cost share amount will be either reduced or removed. In these cases, cost share assistance is provided by a drug manufacturer on the initial cost share. This means that your final cost share amount will be calculated based off of the initial cost share amount minus the drug manufacturer's cost share assistance. The final cost share amount that you will pay is described in the cost share assistance drug list.

If you choose not to enroll for cost share assistance with a drug manufacturer for an eligible covered drug or supply, the initial cost share amount will not be reduced or removed and your cost share amount will be higher. This means that the final cost share amount that you will pay is equal to 30% of the total cost of the drug or supply.

There may be times when you cannot enroll for cost share assistance with a drug manufacturer for a certain covered drug or supply that may otherwise be eligible under this cost share assistance program. Some examples of when this will occur include (but are not limited to): when the drug or supply is not approved by the Food and Drug Administration to treat your condition; or, when the drug or supply has specific age restrictions that you do not meet. In these cases, the provisions of this cost share assistance program will not apply, and you will pay the cost share amount that applies for all other covered drugs and supplies as described in your *Schedule of Benefits* and/or *riders*.

The cost share amounts that you pay for these drugs and supplies as described above will count toward your *out-of-pocket maximum*.

To obtain the cost share assistance drug list that describes the drugs and/or supplies eligible for cost share assistance and their applicable cost share, you can call the *Blue Cross Blue Shield HMO Blue* customer service office. The toll-free phone number is shown on your ID card. Or, you may log on to the *Blue Cross Blue Shield HMO Blue* internet Web site at [www.bluecrossma.org](http://www.bluecrossma.org). The list of these specialty drugs and supplies may change from time to time.

This *rider* does not change the cost share amount that you will pay for all other covered drugs and supplies. Refer to your *Schedule of Benefits* and/or *riders* for your cost share amount for other covered drugs and supplies.

All other provisions remain as described in your Subscriber Certificate.

## Schedule of Dental Benefits

### Pediatric Essential Benefits

This is the *Schedule of Dental Benefits* that is a part of your Dental Blue Policy. This schedule describes the dental services that are covered by your Dental Blue Policy for *members* who are eligible for pediatric essential dental benefits. It also shows the cost-sharing amounts you must pay for these *covered services*. Do not rely on this schedule alone. **You should read all parts of your Dental Blue Policy to become familiar with the key points. Be sure to read the descriptions of covered services and the limitations and exclusions.** You should keep your Dental Blue Policy and this *Schedule of Dental Benefits* 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 your Dental Blue Policy.

#### Who Is Eligible for Pediatric Essential Dental Benefits

The dental benefits described in this *Schedule of Dental Benefits* are provided for a *member* only until the end of the calendar month in which the *member* turns age 19.

#### Annual Deductible

|                                                |                                                                                                                                                                                             |
|------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Your <i>deductible</i> each <i>plan year</i> : | \$50 per <i>member</i> (no more than \$150 for three or more <i>members</i> who are eligible for pediatric essential dental benefits and who are enrolled under the same family membership) |
|------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

The *deductible* is the cost you have to pay during the annual coverage period (as shown above) before benefits will be paid. The *deductible* applies to Group 2 and Group 3 services only. A *deductible* does not apply to Group 1 services or to Orthodontic services. See the chart that starts on the next page for how much you pay for *covered services* you receive after you meet the *deductible* (when it applies).

#### Annual Out-of-Pocket Maximum

|                                                           |                                                                                                                                                                                            |
|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Your <i>out-of-pocket maximum</i> each <i>plan year</i> : | \$350 per <i>member</i> (no more than \$700 for two or more <i>members</i> who are eligible for pediatric essential dental benefits and who are enrolled under the same family membership) |
|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Your *out-of-pocket maximum* is the most you could pay during the annual coverage period (as shown above) for your share of the costs for *covered services*—your cost-sharing amounts. This *out-of-pocket maximum* helps you plan for health care expenses. Even though you pay the following costs, they do not count toward your *out-of-pocket maximum*: your *premiums*; any *balance-billed* charges; all costs for dental services for *members* who are not eligible for pediatric essential dental benefits; and all services this dental plan does not cover.

## Schedule of Dental Benefits (continued)

### Pediatric Essential Benefits

#### Annual Overall Benefit Limit for What the Plan Pays

|                             |      |
|-----------------------------|------|
| Your overall benefit limit: | None |
|-----------------------------|------|

You do not have an overall benefit limit for pediatric essential dental benefits. But, there are limits that apply for specific *covered services*, such as for periodic oral exams. Some of these limits are described in this *Schedule of Dental Benefits* in the chart that starts below. **Do not rely on this chart alone.** Your dental policy along with this *Schedule of Dental Benefits* fully describes all of the limits and exclusions that apply for your dental benefits. Be sure to read all parts of your dental policy.

#### What You Pay for Covered Services—Your Cost-Sharing Amounts

You should be sure to read all parts of your dental policy—including this *Schedule of Dental Benefits*—to understand the requirements that you must follow to receive your dental benefits. You will receive these dental benefits as long as:

- You are a *member* who is eligible to receive pediatric essential dental benefits.
- Your dental service is a *covered service* as described in this *Schedule of Dental Benefits*.
- Your dental service is *necessary and appropriate*.
- Your dental service conforms to *Blue Cross and Blue Shield utilization review* guidelines.
- You use a *participating dentist* to get a *covered service*. (The only exceptions are noted in your dental policy.)

| Covered Services for Members Under Age 19                  |                                                                                                                                                                                                                                                                                                                                                                                                        | Your Cost Is*:                                       |
|------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|
| <b>Group 1—Preventive Services and Diagnostic Services</b> |                                                                                                                                                                                                                                                                                                                                                                                                        | No charge                                            |
| Oral exams                                                 | <ul style="list-style-type: none"> <li>• One complete initial oral exam per provider or location (includes initial history and charting of teeth and supporting structures)</li> <li>• Periodic or routine oral exams; twice in a calendar year</li> <li>• Oral exams for a <i>member</i> under age three; twice in a calendar year</li> <li>• Limited oral exams; twice in a calendar year</li> </ul> |                                                      |
| X-rays                                                     | <ul style="list-style-type: none"> <li>• Single tooth x-rays; no more than one per visit</li> <li>• Bitewing x-rays; twice in a calendar year</li> <li>• Full mouth x-rays; once in three calendar years per provider or location</li> <li>• Panoramic x-rays; once in three calendar years per provider or location</li> </ul>                                                                        |                                                      |
| Routine dental care                                        | <ul style="list-style-type: none"> <li>• Routine cleaning, minor scaling, and polishing of the teeth; twice in a calendar year</li> <li>• Fluoride treatments; once in 90 days</li> <li>• Sealants; once per tooth in three years per provider or location (sealants over restored tooth surfaces not covered)</li> <li>• Space maintainers</li> </ul>                                                 |                                                      |
| <b>Group 2—Basic Restorative Services</b>                  |                                                                                                                                                                                                                                                                                                                                                                                                        | 25% of <i>allowed charge</i> after <i>deductible</i> |
| Fillings                                                   | <ul style="list-style-type: none"> <li>• Amalgam (silver) fillings; one filling per tooth surface in 12 months</li> <li>• Composite resin (white) fillings; one filling per tooth surface in 12 months</li> </ul>                                                                                                                                                                                      |                                                      |

## Schedule of Dental Benefits (continued)

### Pediatric Essential Benefits

| Covered Services for Members Under Age 19             |                                                                                                                                                                                                                                                                                                    | Your Cost Is*:                                       |
|-------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|
| <b>Group 2—Basic Restorative Services</b> (continued) |                                                                                                                                                                                                                                                                                                    | 25% of <i>allowed charge</i> after <i>deductible</i> |
| Root canal treatment                                  | <ul style="list-style-type: none"> <li>• Root canals on permanent teeth; once per tooth</li> <li>• Vital pulpotomy</li> <li>• Retreatment of prior root canal on permanent teeth; once per tooth in 24 months</li> <li>• Root end surgery on permanent teeth; once per tooth</li> </ul>            |                                                      |
| Crowns (see also Group 3)                             | <ul style="list-style-type: none"> <li>• Prefabricated stainless steel crowns; once per tooth (primary and permanent)</li> </ul>                                                                                                                                                                   |                                                      |
| Gum treatment                                         | <ul style="list-style-type: none"> <li>• Periodontal scaling and root planing; once per quadrant in 36 months</li> <li>• Periodontal surgery; once per quadrant in 36 months</li> </ul>                                                                                                            |                                                      |
| Prosthetic maintenance                                | <ul style="list-style-type: none"> <li>• Repair of partial or complete dentures and bridges; once in 12 months</li> <li>• Reline or rebase partial or complete dentures; once in 24 months</li> <li>• Recementing of crowns, inlays, onlays, and fixed bridgework; once per tooth</li> </ul>       |                                                      |
| Oral surgery                                          | <ul style="list-style-type: none"> <li>• Simple tooth extractions; once per tooth</li> <li>• Erupted or exposed root removal; once per tooth</li> <li>• Surgical extractions; once per tooth (approval required for complete, boney impactions)</li> <li>• Other necessary oral surgery</li> </ul> |                                                      |
| Other necessary services                              | <ul style="list-style-type: none"> <li>• Dental care to relieve pain (palliative care)</li> <li>• General anesthesia for covered oral surgery</li> </ul>                                                                                                                                           |                                                      |
| <b>Group 3—Major Restorative Services</b>             |                                                                                                                                                                                                                                                                                                    | 50% of <i>allowed charge</i> after <i>deductible</i> |
| Crowns                                                | <ul style="list-style-type: none"> <li>• Resin crowns; once per tooth in 60 months</li> <li>• Porcelain/ceramic crowns; once per tooth in 60 months</li> <li>• Porcelain fused to metal/high noble crowns; once per tooth in 60 months</li> </ul>                                                  |                                                      |
| Tooth replacement                                     | <ul style="list-style-type: none"> <li>• Removable complete or partial dentures, including services to fabricate, measure, fit, and adjust them; once in 84 months</li> <li>• Fixed prosthetics, only if there is no other less expensive adequate dental service; once in 60 months</li> </ul>    |                                                      |
| Other necessary services                              | <ul style="list-style-type: none"> <li>• Occlusal guards when necessary; once in calendar year</li> <li>• Fabrication of an athletic mouth guard</li> </ul>                                                                                                                                        |                                                      |

## Schedule of Dental Benefits (continued)

### Pediatric Essential Benefits

| Covered Services for Members Under Age 19                                                      |                                                                                                                                                                                                      | Your Cost Is*:               |
|------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|
| <b>Orthodontic Services</b>                                                                    |                                                                                                                                                                                                      | 50% of <i>allowed charge</i> |
| Medically necessary orthodontic care that has been preauthorized for a qualified <i>member</i> | <ul style="list-style-type: none"><li>• Braces for a <i>member</i> who has a severe and handicapping malocclusion</li><li>• Related orthodontic services for a <i>member</i> who qualifies</li></ul> |                              |

**\*Important Note:** Your benefits will be calculated based on the *allowed charge*. In most cases, you will not have to pay charges that are more than the *allowed charge* when you use a *participating dentist* to furnish *covered services*. But, when you use a *non-participating dentist*, you may also have to pay all charges that are in excess of the *allowed charge* for *covered services*. This is called “*balance billing*.” Refer to your dental policy for a more complete description of “*allowed charge*.”

# **Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.**

---

Health Maintenance Organization

## *Subscriber Certificate*



**MASSACHUSETTS**

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

## Welcome to Blue Cross Blue Shield HMO Blue!

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

### Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.



Sarah Iselin  
President



Donald Savery  
Clerk/Secretary

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

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

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

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

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

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

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

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

**Arabic/عبر:**

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

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

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

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

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

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

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

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

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

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

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

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

**Persian/پارسیان:**

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

**Lao/ພາສາລາວ:** ຂໍຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາຜ່ານບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: **711**).

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

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# Introduction

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This Subscriber Certificate explains your health care coverage and the terms of your enrollment in this *Blue Cross Blue Shield HMO Blue* health plan. It describes your responsibilities to receive health care coverage and *Blue Cross Blue Shield HMO Blue'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 Cross Blue Shield HMO Blue* 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”) health maintenance contract. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue*; and you follow all of the requirements to receive this health care coverage. *Blue Cross Blue Shield HMO Blue* is located at: 101 Huntington Avenue, Suite 1300, Boston, Massachusetts 02199-7611.

*Blue Cross Blue Shield HMO Blue* 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.

As a *member* of this *Blue Cross Blue Shield HMO Blue* health plan, you will be asked to choose (or designate) a *primary care provider* who participates in your health care network. Your *primary care provider* will furnish most of your health care and, when it is needed, will arrange for or coordinate your other *covered services*. Except for *emergency medical care*, you have also agreed that you will receive all of your health care from providers who participate in your health care network. This health plan will **not** cover services or supplies that you receive from a health care provider who does not participate in your health care network. The only exceptions are described in this Subscriber Certificate in Part 8.

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

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### Your Primary Care Provider

At the time you enroll in this *Blue Cross Blue Shield HMO Blue* health plan, you will be required to choose (or designate) a *primary care provider* who participates in your health care network. You have the right to choose (or designate) any *primary care provider* who participates in your health care network and who is available to accept you or your family members. **The *Schedule of Benefits* for your plan option will tell you the name of your health care network.** The provider directory that is provided for your specific plan option lists all of the *primary care providers* who participate in your health care network. You can choose a *primary care provider* who is an internist, a family practitioner, a pediatrician, a nurse practitioner, or a physician assistant. Your *primary care provider* will furnish most of your health care and, when it is needed, will arrange for or coordinate other *covered services*. (Your *primary care provider* is often referred to as your “PCP.”) Usually, different *members* of a family have different health care needs. For this reason, each *member* of a family may choose a different *primary care provider*. Your choice is important. Your choice will determine who you will see for most of your health care and where you will receive it. This is because a *primary care provider* will most often send their patients to network specialists who are affiliated with the *primary care provider’s* network hospital or medical group. **Your choice is also important because it may impact the costs that you pay for some health care services.** As soon as you enroll and you choose your *primary care provider*, you should make an appointment with your *primary care provider*. This will allow your *primary care provider* to get to know your medical history and to give you medical attention and treatment that is tailored to your needs.

### When You Need Help to Choose a Primary Care Provider

*Blue Cross Blue Shield HMO Blue* can help you choose your *primary care provider*. If you need help, call the *Blue Cross Blue Shield HMO Blue* customer service office. The toll free phone number to call is shown on your ID card. You can also call the toll free phone number that is shown in the HMO Blue provider directory that applies for your specific plan option. Or, you can call the Find a Doctor support line at **1-800-821-1388**.

### When You Want to Change Your Primary Care Provider

You may change your *primary care provider*. All you have to do is call or write to the *Blue Cross Blue Shield HMO Blue* customer service office. Or, you can make this change online by using the *Blue Cross Blue Shield HMO Blue* member self service option. To change your *primary care provider* online, log on to the *Blue Cross Blue Shield HMO Blue* Web site at **[www.bluecrossma.org](http://www.bluecrossma.org)**. Just follow the steps to change your “PCP.”

### When Your Primary Care Provider Disenrolls from the Network

If your *primary care provider* disenrolls from the health care network, *Blue Cross Blue Shield HMO Blue* will send you a written notice at least 30 days before your *primary care provider’s* disenrollment date. The notice will tell you how to choose a new *primary care provider*. In most cases, *Blue Cross Blue Shield HMO Blue* will continue to provide coverage for *covered services* you receive from your *primary care provider* for up to 30 days past the *primary care provider’s* disenrollment date. (If you do not choose a new *primary care provider* within 30 days, *Blue Cross Blue Shield HMO Blue* may choose one for you. *Blue Cross Blue Shield HMO Blue* will let you know if a new *primary care provider* is chosen for you.)

## Your Health Care Network

To receive all of your health plan coverage, you must obtain your health care services and supplies from providers who participate in the health care network for your specific plan option. **The *Schedule of Benefits* for your plan option will tell you the name of your health care network.** The provider directory that is provided for your specific plan option lists the health care providers who participate in your health care network. The health care providers that participate in your health care network are referred to as “*covered providers*” or “*network providers*.” If you need *emergency medical care*, this health plan will cover those services even when they are furnished by a health care provider who is not a *network provider*. See Part 8 in this Subscriber Certificate for a few other times when this health plan may cover services or supplies that you receive from a provider who does not participate in your health care network. Except as described in this Subscriber Certificate, this health plan will **not** cover any services or supplies that you receive from providers who do not participate in the health care network for your specific plan option.

### 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* Find a Doctor support line at **1-800-821-1388**.
- Use the *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* for help. To ask for this help, you can call the *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Your Service Area

If you are traveling outside of your *service area* and you need *emergency medical care* (or *urgent care*), 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 local Blue Cross and/or Blue Shield Plan. Or, you can also use the internet. To use the online “Blue National Doctor & Hospital Finder,” log on to **www.bcbs.com**. 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* customer service office. They will send you a new card. Or, you can use the *Blue Cross Blue Shield HMO Blue* Web site to ask for a new ID card. To use the *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* customer service office. A *Blue Cross Blue Shield HMO Blue* customer service representative will work with you to resolve your problem or concern as quickly as possible. *Blue Cross Blue Shield HMO Blue* will keep a record of each inquiry you, or someone on your behalf, makes to *Blue Cross Blue Shield HMO Blue*. *Blue Cross Blue Shield HMO Blue* 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 55058, Boston, MA 02205-5058.

### **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 55058, Boston, MA 02205-5058.

## **Discrimination Is Against the Law**

*Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* does not exclude people or treat them differently because of race; color; national origin; age; disability; sex; sexual orientation; or gender identity.

*Blue Cross Blue Shield HMO Blue* provides:

- Free aids and services to people with disabilities to communicate effectively with *Blue Cross Blue Shield HMO Blue*. 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 Blue Shield HMO Blue* customer service office. The toll free phone number to call is shown on your ID card.

If you believe that *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* Civil Rights Coordinator: by mail at Civil Rights Coordinator, Blue Cross Blue Shield of Massachusetts, 101 Huntington Avenue, Suite 1300, Boston, Massachusetts 02199-7611; 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](mailto: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](http://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](http://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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue*, you must follow the formal review procedures outlined in Part 10.

**Note:** As required by the Affordable Care Act, the catastrophic health plan HMO Blue Essential exempts three *primary care provider* medical visits from the *deductible*.

## 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* customer service office. The toll free phone number to call is shown on your ID card. *Blue Cross Blue Shield HMO Blue* will give you a cost estimate within two working days of the date your request is received. *Blue Cross Blue Shield HMO Blue*'s response will include an estimate of the maximum *allowed charge* and your cost share amount, if there is any, for the proposed *covered service*, and your health care provider's network status.

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

You can also call the *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue*'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 Blue Shield HMO Blue* is required to provide a disclosure notice to you that includes the following:

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

- Information on whether copayment amounts, if any, apply toward your *deductible* and/or the *out-of-pocket maximum* amounts.

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

## **Delivery of Summary of Payments Forms**

You will receive a Summary of Health Plan Payments explanation form when you have a cost share (such as a *deductible*, a *copayment*, or a *coinsurance*) that applies for *covered services* or when *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue*, you may:

- Have the Summary of Health Plan Payments explanation form mailed to the *member's* address that is on file with *Blue Cross Blue Shield HMO Blue*. (*Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* member self service option. To check online, log on to the *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* within three working days of receiving the request. If you enroll in another *Blue Cross Blue Shield HMO Blue* health plan or a health plan offered by Blue Cross and Blue Shield of Massachusetts, Inc., you should call the *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue*.

## **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

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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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* uses depends on the type of health care provider that furnishes the *covered service* to you.

- **For Network Providers.** For health care providers who have an HMO Blue payment agreement with Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc., the *allowed charge* is based on the provisions of that health care provider’s network payment agreement for your specific plan option. (When you are enrolled in a New England plan option, this also applies for health care providers who have a network payment agreement with one of the New England Blue Cross and/or Blue Shield Plans with which Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. has arranged for the Blue Cross and/or Blue Shield Plan to provide access to *covered services* to *members*.) **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 *network 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 Blue Shield HMO Blue* will calculate your cost share amount based on the lesser amount—this means the *network provider’s* actual charge instead of the *allowed charge* will be used to calculate your cost share. The claim payment made to the *network provider* will be the full amount of the *allowed charge* less your cost share amount.

When you are enrolled in a limited provider network plan, these *allowed charge* provisions also apply for a health care provider who has an HMO Blue payment agreement but who is not in the limited provider network for your specific plan option. There is one exception. For a health care provider who declined to participate in the limited provider network, see the “For Other Health Care Providers” paragraph on the next page.

- **For Health Care Providers Outside of Massachusetts with a Local Payment Agreement.** For non-network 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 Blue Shield HMO Blue*. (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 Blue Shield HMO Blue* to the local Blue Cross and/or Blue Shield Plan is a discount from the provider’s billed charges. However, a number of local Blue Cross and/or Blue Shield Plans can determine only an estimated price at the time your claim is paid. Any such estimated price is based on expected settlements, withholds, any other contingent payment arrangements and non-claims transactions, such as interest on provider advances, with the provider (or with a specific group of providers) of the local Blue Cross and/or Blue Shield Plan in the area where services are received. In addition, some local Blue Cross and/or Blue Shield Plans’ payment agreements with providers do not give a comparable discount for all claims. These local Blue Cross and/or Blue Shield Plans elect to smooth out the effect of their payment agreements with providers by applying an average discount to claims. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. Local Blue Cross and/or Blue Shield Plans that use these estimated or averaging methods to calculate the negotiated price may prospectively adjust their estimated or average prices to correct for overestimating or underestimating past prices. However, the amount you pay is considered a final price. **In most cases for covered services furnished by these health care providers, you pay only your deductible and/or your copayment and/or your coinsurance, whichever applies.**

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

### **Patient Protections Against Surprise Billing**

Under federal law, 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-network provider at certain network 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-network 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 Blue Shield HMO Blue* uses the QPA as the recognized amount to calculate your claim payment. For *covered services* furnished in a state other than Massachusetts, *Blue Cross Blue Shield HMO Blue* 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. (If a non-network 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-network 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, *Blue Cross Blue Shield HMO Blue* uses the health care provider’s actual charge to calculate your claim payment. **For *covered services* furnished by these health care providers, you pay only your deductible and/or your copayment and/or your coinsurance, whichever applies.** Any cost share amounts that you pay for these *covered services* will count toward your *deductible* (if applicable) and your *out-of-pocket maximum*.

Exception: For health care providers who do not have a payment agreement with *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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.

Exception for members enrolled in a limited provider network plan: For a covered health care provider who has an HMO Blue payment agreement with *Blue Cross Blue Shield HMO Blue*, but who has declined to participate in the limited provider network for your specific plan option, *Blue Cross Blue Shield HMO Blue* uses the health care provider’s actual charge, or a lower charge that has been negotiated with the health care provider, to calculate your claim payment. **For *covered services***

**furnished by these health care providers, you pay only your *deductible* and/or your *copayment* and/or your *coinsurance*, whichever applies.**

### **Pharmacy Providers**

*Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* from pharmacy providers or vendors.

### **Appeal**

An *appeal* is something you do if you disagree with a *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* decision to stop coverage for services that you are receiving. For example, you may ask for an *appeal* if *Blue Cross Blue Shield HMO Blue* 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.

### **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 Blue Shield HMO Blue**

Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. is the not-for-profit managed care subsidiary of Blue Cross and Blue Shield of Massachusetts, Inc. *Blue Cross Blue Shield HMO Blue* is licensed by the Commonwealth of Massachusetts as a health maintenance organization (HMO) to arrange for the coordinated delivery of health care services to its *members*. The term "Plan" is often used to refer to Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. "*Blue Cross Blue Shield HMO Blue*" and "*Plan*" also means an employee or designee of Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. (including Blue Cross and Blue Shield of Massachusetts, Inc. or another Blue Cross and/or Blue Shield Plan) who is authorized to make decisions or take action called for by this health plan. This also means, for example, that *Blue Cross Blue Shield HMO Blue* policies, programs, documents, tools, and administrative areas may mean the policies, programs, documents, tools, and administrative areas of Blue Cross and Blue Shield of Massachusetts, Inc. or another designee. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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.

Blue Cross and Blue Shield of Massachusetts, Inc. is the parent company of Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. (*Blue Cross Blue Shield HMO Blue*). Blue Cross and Blue Shield of

Massachusetts, Inc. has entered into a management contract with *Blue Cross Blue Shield HMO Blue* to provide administrative services. Blue Cross and Blue Shield of Massachusetts, Inc. will not be responsible for or have any contractual obligations with respect to this health plan. “Blue Cross and Blue Shield of Massachusetts, Inc.” also means an employee or designee of Blue Cross and Blue Shield of Massachusetts, Inc. who is authorized to make decisions or take action called for by this health plan.

### Coinsurance

For some *covered services*, you may have to pay a *coinsurance*. This means the cost that you pay for these *covered services* (your “cost share amount”) will be calculated as a percentage. When a *coinsurance* does apply to a specific *covered service*, *Blue Cross Blue Shield HMO Blue* will calculate your cost share amount based on the health care provider’s actual charge or the *Blue Cross Blue Shield HMO Blue 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue 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 show 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 (Network Providers)

To receive your health plan coverage, all of your health care services and supplies must be furnished by health care providers who participate in the health care network for your specific plan option. (The only exceptions are described in Part 8 of this Subscriber Certificate.) **The *Schedule of Benefits* for your plan option will tell you the name of your health care network.** The provider directory that is provided for your specific plan option lists the health care providers that participate in your health care network. These covered health care providers are referred to as “*covered providers*” or “*network providers*.” A *covered provider* (or *network provider*) is a health care provider who has a written HMO Blue payment agreement with, or that has been designated by, Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. to provide access to *covered services* to *members* enrolled in your specific plan option. (Or, when you are enrolled in a New England plan option, the health care provider has a network payment agreement with one of the New England Blue Cross and/or Blue Shield Plans to furnish *covered services* to *members*.) To find out if a health care provider participates in your 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 recovery coaches; 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 Blue Shield HMO Blue*.

### Covered Services

This Subscriber Certificate and your *Schedule of Benefits* describe the health care services and supplies for which *Blue Cross Blue Shield HMO Blue* 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 health care providers who participate in the health care network for your specific plan option and, when it is required, arranged for or coordinated by your *primary care provider* or approved by *Blue Cross Blue Shield HMO Blue*. (See Part 8 in this Subscriber Certificate for the few times when this health plan may cover services and supplies that you receive from a health care provider who does not participate in your health care network.)

### Custodial Care

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

- Care that is given primarily by medically-trained personnel for a *member* who shows no significant improvement response despite extended or repeated treatment; or
- Care that is given for a condition that is not likely to improve, even if the *member* receives attention of medically-trained personnel; or
- Care that is given for the maintenance and monitoring of an established treatment program, when no other aspects of treatment require an acute level of care; or

- Care that is given for the purpose of meeting personal needs which could be provided by persons without medical training, such as assistance with mobility, dressing, bathing, eating and preparation of special diets, and taking medications.

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

### Deductible

For some *covered services*, you may have to pay a *deductible* before you will receive benefits from this health plan. When your plan option includes a *deductible*, the amount that is put toward your *deductible* is generally calculated based on the health care provider's actual charge or the *Blue Cross Blue Shield HMO Blue 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-*network providers* will be calculated based on the recognized amount and will contribute toward satisfying your *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 Blue Shield HMO Blue utilization review* program. (See Part 4.)
- The costs you pay that are more than the *Blue Cross Blue Shield HMO Blue 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue*. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue's* records, on which your coverage in this health plan starts. Or, it means the date on which a change to your coverage in this health plan takes effect.

### Emergency Medical Care

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

- placing your life or health or the health of another (including an unborn child) in serious jeopardy; or
- serious impairment of bodily functions; or
- serious dysfunction of any bodily organ or part; or,
- as determined by a provider with knowledge of your condition, severe pain that cannot be managed without such care.

Some examples of conditions that require *emergency medical care* are: suspected heart attacks; strokes; poisoning; loss of consciousness; convulsions; and suicide attempts. This also includes treatment of *mental conditions* when: you are admitted as an *inpatient* as required under Massachusetts General Laws, Chapter 123, Section 12; you seem very likely to endanger yourself as shown by a serious suicide attempt, a plan to commit suicide, or behavior that shows that you are not able to care for yourself; or you seem very likely to endanger others as shown by an action against another person that could cause serious physical injury or death or by a plan to harm another person.

For purposes of filing a claim or the formal *appeal* and *grievance* review (see Parts 9 and 10 of this Subscriber Certificate), *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue*. The term “*group*” refers to the corporation, partnership, individual proprietorship, or other organization that has an agreement for *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* to provide the *subscriber* and their enrolled dependents with access to health care services and benefits. The *group* will make payments to *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue*. The *group* is the *subscriber's* agent and is not the agent of *Blue Cross Blue Shield HMO Blue*. 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue*. 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 HMO Blue, Inc. (*Blue Cross Blue Shield HMO Blue*), 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 Blue Shield HMO Blue* to use the Blue Cross and Blue Shield Service Marks in the Commonwealth of Massachusetts, and that *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* and that no person, entity, or organization other than *Blue Cross Blue Shield HMO Blue* will be held accountable or liable to you or your *group* on your behalf for any of *Blue Cross Blue Shield HMO Blue's* obligations to you created under the *group contract*. This paragraph will not create any additional obligations whatsoever on the part of *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* to provide the *subscriber* and their enrolled dependents with access to health care services and benefits. The *subscriber* will make payments to *Blue Cross Blue Shield HMO Blue* for coverage in this health plan. *Blue Cross Blue Shield HMO Blue* 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.

**Important Note:** If you enroll in this health plan as an individual *member* through the Massachusetts Health Connector, the *subscriber* has an agreement with the Health Connector. The *subscriber* will usually make payments to the Health Connector for coverage in this health plan. The Health Connector will send all notices to the *subscriber*.

You hereby expressly acknowledge your understanding that an *individual contract* constitutes a contract solely between you and Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. (*Blue Cross Blue Shield HMO Blue*), 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 Blue Shield HMO Blue* to use the Blue Cross and Blue Shield Service Marks in the Commonwealth of Massachusetts, and that *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* and that no person, entity, or organization other than *Blue Cross Blue Shield HMO Blue* will be held accountable or liable to you for any of *Blue Cross Blue Shield HMO Blue*’s obligations to you created under an *individual contract*. This paragraph will not create any additional obligations whatsoever on the part of *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue medical policy* that applies. Each health care service or supply must also meet the *Blue Cross Blue Shield HMO Blue 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 Blue Shield HMO Blue*’s assessment of the quality of the scientific and clinical evidence that is published in peer reviewed journals. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue*’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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue medical policy*, you can go online and log on to the *Blue Cross Blue Shield HMO Blue* Web site at **[www.bluecrossma.org](http://www.bluecrossma.org)**. (Your health care provider can also access a policy by using the *Blue Cross Blue Shield HMO Blue* provider Web site.) Or, you can call the *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue 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 Blue Shield HMO Blue* may limit coverage for drugs, biological products, and devices to those specific indications, conditions, and methods of use approved by the FDA.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed English-language journals. The qualities of the body of studies and the consistency of the results are considered in evaluating the evidence. The evidence should demonstrate that the technology can measurably alter the physiological changes related to a disease, injury, illness, or condition. In addition, there should be evidence or a convincing argument based on established medical facts that the measured alterations affect health outcomes. Opinions and evaluations by national medical associations, consensus panels, and other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence upon which they are based.
- The technology must improve the net health outcome. The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
- The technology must be as beneficial as any established alternatives. The technology should improve the net outcome as much as or more than established alternatives. The technology must be as cost effective as any established alternative that achieves a similar health outcome.
- The improvement must be attainable outside the investigational setting. When used under the usual conditions of medical practice, the technology should be reasonably expected to improve health outcomes to a degree comparable to that published in the medical literature.

*Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* has the discretion to determine which health care services and supplies that you receive (or you are planning to receive) are *medically necessary* and appropriate for coverage. It will do this by 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 Blue Shield HMO Blue 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 Blue Shield HMO Blue*;
- Consistent with the level of skilled services that are furnished and furnished in the least intensive type of medical care setting that is required by your medical condition; and
- Not more costly than an alternative service or sequence of services at least as likely to produce the same therapeutic or diagnostic results to diagnose or treat your illness, injury, or disease.

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

### **Member**

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

### **Mental Conditions**

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

### **Mental Health Providers**

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

## **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 Blue Shield HMO Blue 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 Blue Shield HMO Blue* utilization review program. (See Part 4.)
- The costs you pay that are more than the *Blue Cross Blue Shield HMO Blue 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-*network providers* will contribute toward satisfying your *out-of-pocket maximum* amount. (See Part 2, “Allowed Charge” for an explanation of these services.)

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

The *out-of-pocket maximum* is indexed to the average national premium growth and the amount may be increased annually. This means that your *out-of-pocket maximum* amount may increase from time to time, as determined by *Blue Cross Blue Shield HMO Blue*. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue*. 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 Blue Shield HMO Blue*. The total amount of your monthly *premium* is provided to you in the yearly evidence of coverage packet that is issued by *Blue Cross Blue Shield HMO Blue*. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue*. *Blue Cross Blue Shield HMO Blue* may change your *premium*. Each time *Blue Cross Blue Shield HMO Blue* changes the *premium* for coverage in this health plan, *Blue Cross Blue Shield HMO Blue* 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. (If you enrolled in this health plan through the Massachusetts Health Connector, see Part 11 or Part 12, whichever applies to you, for information.)

## **Primary Care Provider**

To receive coverage under this health plan, you will be required to choose (or designate) a *primary care provider* to furnish your primary medical care and to arrange for or coordinate other *covered services*. Your *primary care provider* can be a network physician who is an internist, family practitioner, or pediatrician, or a network nurse practitioner, or a network physician assistant. You have the right to choose (or designate) any *primary care provider* who participates in your health care network and who is available to accept you or your family *members*. The provider directory for your specific plan option lists the network primary care providers. See Part 1 for information on how to contact *Blue Cross Blue Shield HMO Blue* if you need help to choose a *primary care provider* or to find a listing of your health care network. The network *primary care provider* who you chose (or designate) is often referred to as your “PCP.” Certain other network primary care providers have agreed to be “on call” for your *primary care provider* at times when they are not available. These are known as “covering primary care providers.” This health plan provides the same coverage for these covering primary care providers that it provides for your *primary care provider*.

At any time, you may change your *primary care provider* from a physician to a nurse practitioner or a physician assistant who is listed in your provider directory as a primary care provider. (See Part 1 in this Subscriber Certificate for help on how to change your *primary care provider*.) When you choose (or

WORDS IN ITALICS ARE EXPLAINED IN PART 2.

designate) a nurse practitioner or a physician assistant as your *primary care provider*, all of the same provisions that apply to a *primary care provider* who is a physician will apply.

### Rider

*Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 will receive all of your health care services and supplies. This means that no coverage will be provided for health care services or supplies that you receive outside of your *service area*, except as described in Part 3 of this Subscriber Certificate for: *emergency medical care*; and *urgent care*. Your *service area* is described in the *Schedule of Benefits* for your plan option.

### 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 (or one pair of eyeglasses instead) 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 (as described in the *Blue Cross Blue Shield HMO Blue medical policy* for behavioral health continuum of care) care, other than *emergency medical care*, that you need right away. This is care that if deferred more than 72 hours could be expected to result in serious deterioration of your health, impairment of your ability to regain maximum function, and/or severe pain 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* uses to evaluate the necessity and appropriateness of your health care services and supplies. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* understands the need for concern about underutilization. *Blue Cross Blue Shield HMO Blue* shares this concern with its *members* and health care providers. *Blue Cross Blue Shield HMO Blue* does not compensate individuals who conduct *utilization review* activities based on denials. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue 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

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You do not need a referral from your health care provider or an approval from *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* within 48 hours of your admission. (A health care facility that participates in your health care network should call *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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.

When you are traveling outside of your *service area*, you may require emergency medical services or you may need *urgent care*. You usually need *urgent care* because an unforeseen illness or injury occurs and based on your location, you are not able to obtain treatment from your *primary care provider* or from a covered health care provider who participates in your health care network. Your health plan will cover *urgent care* when you are temporarily outside of your *service area*. If you are traveling outside of your *service area* and you need *urgent care*, you should go to the nearest appropriate health care facility. Then, after you receive that *urgent care*, you must call the *Blue Cross Blue Shield HMO Blue* customer service office. You must make this call within 48 hours of receiving the *urgent care*. The *Blue Cross Blue Shield*

*HMO Blue* toll free phone number to call is shown on your ID card. (Your health plan will cover one follow up visit outside of your *service area* if you need it. This one follow up visit does not need prior approval from *Blue Cross Blue Shield HMO Blue* as long as you are still outside of your *service area* when you receive these services.)

## **Post-Stabilization Care**

After your emergency medical condition has been evaluated and stabilized in the hospital emergency room, you may be ready to go home. Or, you may require further care. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue*. (A health care facility that participates in your health care network should call *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue*. (A health care facility that participates in your health care network should call *Blue Cross Blue Shield HMO Blue* for you.) This call must be made within 48 hours of your admission. This is required so that *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* to obtain an approval when the type of care that you need requires an approval from *Blue Cross Blue Shield HMO Blue*. (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 Blue Shield HMO Blue*. (When you receive *emergency medical care* outside of your *service area*, you will receive coverage for one follow up visit outside of your *service area*, if you need it. This one follow up visit does not need a referral from your *primary care provider* or a pre-service approval from *Blue Cross Blue Shield HMO Blue* as long as you are still outside of your *service area* when you receive these services.)

## Part 4

# Utilization Review Requirements

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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 Blue Shield HMO Blue*. A health care provider who participates in your health care network will request a pre-service approval on your behalf. For the pre-service review, *Blue Cross Blue Shield HMO Blue* will consider your health care provider to be your authorized representative. ***Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* when a pre-service approval is required. Otherwise, you will have to pay all charges for those health care services and/or supplies.

**Important Note:** You do not need a referral from your *primary care provider* or a prior approval from *Blue Cross Blue Shield HMO Blue* or from any other person (including your *primary care provider*) in order for you to access obstetrical care or gynecological care from any *network provider* that specializes in this type of care. The *network provider* may be required to comply with certain pre-service approval requirements. For example, pre-approval may be required from *Blue Cross Blue Shield HMO Blue* for *inpatient* admissions other than for maternity care. For a list of *network providers* who specialize in this type of care, you can call the *Blue Cross Blue Shield HMO Blue* customer service office. See Part 1 for information on how you can contact *Blue Cross Blue Shield HMO Blue*.

### Referrals for Specialty Care

In most cases, your *primary care provider* will furnish your health care. But, if you and your *primary care provider* decide that you need to see a specialist for *covered services*, your *primary care provider* will refer you to a network specialist. The specialist will usually be one your *primary care provider* knows and is probably someone affiliated with your *primary care provider's* hospital or medical group.

### When You Need a Referral to a Specialist

Except as described below in this section, you will need to have an approved referral from your *primary care provider* before you receive *outpatient* specialty care from a network specialist. You will need a referral in order for you to receive coverage from this health plan. When you need a referral to receive care from a network specialist, your *primary care provider* will obtain an approval from *Blue Cross Blue Shield HMO Blue* for you. Your referral may be time limited. Or, in some cases, your *primary care provider* may authorize a “standing” referral for specialty care with a network specialist. Your *primary care provider* will do this when they determine that the referrals are appropriate and the network specialist agrees to the treatment plan. The network specialist will provide your *primary care provider* with necessary clinical and administrative information on a regular basis. A referral authorizes specific services (and may authorize a specific number of visits) that will be needed to diagnose, evaluate, or treat your condition. It is up to you to comply with any limits set out in the *Blue Cross Blue Shield HMO Blue* referral approval. It is up to your

## Part 4 – **Utilization Review Requirements** (continued)

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*covered provider* to get additional referrals or approvals from *Blue Cross Blue Shield HMO Blue* for related services.

There are a few times when you do not need to have a referral from your *primary care provider* for you to receive coverage from this health plan. You do **not** need a referral for the following *covered services*.

- *Emergency medical care.*
- *Covered services* that are furnished for you by an obstetrician, a gynecologist, or a nurse midwife; or gynecological and related services that are furnished for you by a family practitioner. This includes: a covered routine annual gynecological (GYN) exam and any services that are required as a result of the exam; and evaluations and health care services that result from acute or emergency gynecological conditions. For these *covered services*, you will not have to pay any more than you would normally pay if you had received an approved referral from your *primary care provider*. But, prior approval is required from *Blue Cross Blue Shield HMO Blue* for: *inpatient* admissions (other than those for emergency or maternity care); and all infertility treatment.
- *Covered services* that are furnished by a limited services clinic.
- Acupuncture services.
- Chiropractor services. (A pre-service approval may be required. See below.)
- Lab tests, x-rays, and other covered tests.
- Maternity services, including prenatal and postnatal care; postpartum depression and major depressive disorder screenings; and childbirth classes.
- Mental health and substance use treatment. (A pre-service approval may be required. See below.)
- Methadone maintenance treatment that is furnished for opioid dependence.
- Covered preventive dental care.
- Covered routine vision exams.
- *Covered services* that are furnished by a *Blue Cross Blue Shield HMO Blue* designated telehealth vendor. (Except as described above in this section, you will need to have an approved referral from your *primary care provider* before you receive covered telehealth visits for *outpatient* specialty care from a network specialist that is not a designated telehealth vendor.)
- *Urgent care* that is received outside of your *service area*.

(If you are enrolled in a New England plan option, the health care services that need a referral from your *primary care provider* may vary based on the state where your *primary care provider* is located.)

From time to time, *Blue Cross Blue Shield HMO Blue* may change the list of *covered services* that require an approved referral from your *primary care provider*. Your *primary care provider* or other *covered provider* can tell you if your *covered service* needs a referral. When a material change is made to these requirements, *Blue Cross Blue Shield HMO Blue* will let you know about the change at least 60 days before it becomes effective. To check the requirements, you can use the online *Blue Cross Blue Shield HMO Blue* member self service option. To do this, log on to the *Blue Cross Blue Shield HMO Blue* Web site at **www.bluecrossma.org**. Just follow the steps to check your benefits.

If you are enrolled in an Access Blue plan option, these referral requirements do not apply. This means that an approved referral from your *primary care provider* is **not** required for you to receive coverage for specialty care that is furnished by a network specialist. But, a pre-service approval may be required as described below in this Part 4.

### **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 Blue Shield HMO Blue*. A provider who participates in your health care network will request this approval on your behalf. During the pre-service review, *Blue Cross Blue*

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*Shield HMO Blue* will determine if your proposed health care services or supplies should be covered as *medically necessary* for your condition. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* customer service office or using the online *Blue Cross Blue Shield HMO Blue* member self service option. To check online, log on to the *Blue Cross Blue Shield HMO Blue* Web site at [www.bluecrossma.org](http://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 Blue Shield HMO Blue*, you can call the *Blue Cross Blue Shield HMO Blue* customer service office.

(If you are enrolled in a New England plan option, the health care services that need a pre-service approval may vary based on the state where your *primary care provider* is located.)

From time to time, *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* may ask for the results of a face-to-face clinical evaluation or of a second opinion. If *Blue Cross Blue Shield HMO Blue* does need more information, *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* asks for must be provided to *Blue Cross Blue Shield HMO Blue* within 45 calendar days of the request. If this information or these records are not provided to *Blue Cross Blue Shield HMO Blue* within these 45 calendar days, your proposed coverage will be denied. If *Blue Cross Blue Shield HMO Blue* receives this information or these records within this time frame, *Blue Cross Blue Shield HMO Blue* will make a decision within two working days of the date it is received.

### Coverage Approval

If through the pre-service review *Blue Cross Blue Shield HMO Blue* determines that your proposed health care service, supply, or course of treatment should be covered as *medically necessary* for your condition,

*Blue Cross Blue Shield HMO Blue* will call the health care provider. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* determines that your proposed health care service, supply, or course of treatment should **not** be covered as *medically necessary* for your condition, *Blue Cross Blue Shield HMO Blue* will call the health care provider. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* will send a written (or electronic) notice to you and to the health care provider. This notice will explain *Blue Cross Blue Shield HMO Blue's* coverage decision. This notice will include: information related to the details about your coverage denial; the reasons that *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* has denied the request; any alternative treatment or health care services and supplies that would be covered; *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* reconsider its decision when *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue'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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* will determine if the health care setting is suitable to treat your condition. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue*. 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* and provides the initial treatment plan within 48 hours of your admission. Concurrent Review (see page 33) 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 Blue Shield HMO Blue* in order for your *inpatient* care to be covered by this health plan.

### Missing Information

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

### Coverage Approval

If *Blue Cross Blue Shield HMO Blue* determines that the proposed setting for your health care is suitable, *Blue Cross Blue Shield HMO Blue* will call the health care facility. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* determines that the proposed setting is not *medically necessary* for your condition, *Blue Cross Blue Shield HMO Blue* will call the health care facility. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* will send a written (or electronic) notice to you and to the facility. This notice will explain *Blue Cross Blue Shield HMO Blue's* coverage decision. This notice will include: information related to the details about your coverage denial; the reasons that *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* has denied the request; any alternative treatment or health care services and supplies that would be covered; *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* reconsider its decision when *Blue Cross Blue Shield HMO Blue* has determined that *inpatient* coverage is not *medically necessary* for your condition. In this case, *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* decision be reconsidered.

### **Concurrent Review and Discharge Planning**

Concurrent Review means that while you are an *inpatient*, *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* makes this decision (within one working day of receiving all necessary information), *Blue Cross Blue Shield HMO Blue* will let the health care facility know of the coverage approval status of the review. *Blue Cross Blue Shield HMO Blue* will do this within one working day of making this decision. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* will make this decision within one working day of receiving all necessary information. (If the calendar day following a submitted request for post-acute care services is not a working day, and if the post-acute care facility or agency is open to new admissions and has indicated that they will accept your admission (and their applicable pre-admission screening and resident review required under federal law is complete), then prior approval from *Blue Cross Blue Shield HMO Blue* will not be required and coverage for post-acute care services will be provided for that time period. Concurrent Review of the admission will start on the next business day. When this happens, *Blue Cross Blue Shield HMO Blue* will not retroactively deny coverage for post-acute care services received before Concurrent Review, unless the claim was a result of fraud, waste, or abuse.) *Blue Cross Blue Shield HMO Blue* will call the health care facility to let them know of this decision. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* that *inpatient* coverage is no longer *medically necessary*. But, if you do, *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue*.

### **Reconsideration of Adverse Determination**

Your health care provider may ask that *Blue Cross Blue Shield HMO Blue* reconsider its decision when *Blue Cross Blue Shield HMO Blue* has determined that continued *inpatient* coverage is not *medically necessary* for your condition. In this case, *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* may require that there be a written agreement between the patient (or the patient's family or guardian) and *Blue Cross Blue Shield HMO Blue*. *Blue Cross Blue Shield HMO Blue* may also require that there be an agreement between the health care provider and *Blue Cross Blue Shield HMO Blue* to furnish the services that are approved through this alternative treatment plan.

## Part 5

# Covered Services

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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.) **To receive all of your benefits, you must be sure to obtain your health care services and supplies from providers who participate in your health care network. And when it is required, you must receive a referral from your primary care provider or a pre-service approval from Blue Cross Blue Shield HMO Blue.** (See Part 4.) Of course if you need *emergency medical care*, this health plan will cover those services even when they are furnished by a health care provider who does not participate in your health care network. (See Part 8 in this Subscriber Certificate for a few other times when this health plan may cover your services or supplies even when they are furnished by covered health care providers who do not participate in your health care network.)

## 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 Blue Shield HMO Blue* as outlined in this Subscriber Certificate before you enter a general or chronic disease hospital for *inpatient* care. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 47.) 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 Blue Shield HMO Blue* 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.

### **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

**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 Blue Shield HMO Blue* for those services or supplies.

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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 Blue Shield HMO Blue 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 Blue Shield HMO Blue* asking for approval for the surgery. No benefits are provided for the orthodontic services, except as described in this Subscriber Certificate on page 40 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 *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. 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.

**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 Blue Shield HMO Blue* for those services or supplies.

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- 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* if they ask for one. The physician who furnishes this consultation for you must be an expert in a different medical sub-specialty than the attending physician. This health plan will cover only the attending physician if the consultant is an expert in the same medical sub-specialty as the attending physician.
- Intensive care services. These services must be furnished for you by a physician other than the attending physician; or by a nurse practitioner. This means services that you need for only a limited number of hours to treat an uncommon aspect or complication of your illness or injury.
- Emergency admission services. These services must be furnished for you by a physician; or by a nurse practitioner. This means that a complete history and physical exam is performed before you are admitted as an *inpatient* for *emergency medical care* and your treatment is taken over immediately by another physician.
- Pediatric specialty care. This is care that is furnished for you by a *covered provider* who has a recognized expertise in specialty pediatrics.
- Second opinions. These services must be furnished for you by a physician. This includes a third opinion when the second opinion differs from the first.

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

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### **Rehabilitation Hospital Admissions**

You and your health care provider must receive approval from *Blue Cross Blue Shield HMO Blue* as outlined in this Subscriber Certificate before you enter a rehabilitation hospital for *inpatient* care. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue*, 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* as outlined in this Subscriber Certificate before you enter a skilled nursing facility for *inpatient* care. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue*, 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 Blue Shield HMO Blue* to be *medically necessary* for you.) This coverage includes: semiprivate *room and board* and *special services* furnished for you by the facility; and medical care furnished for you by a physician or by a nurse practitioner.

## **Ambulance Services**

This health plan covers ambulance transport. This coverage includes:

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

**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*

**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 Blue Shield HMO Blue* for those services or supplies.

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*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 health plan.

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

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

This coverage for autism spectrum disorders does not affect an obligation to provide services to an individual under an individualized family service plan, an individualized education program, or an individualized service plan. This means that, for services related to autism spectrum disorders, no benefits are provided for: services that are furnished by school personnel under an individualized education 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 Blue Shield HMO Blue* must determine through medical documentation that you meet

**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 Blue Shield HMO Blue* for those services or supplies.

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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. Your coverage for these services may have a *benefit limit*. If it does, 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 service is *medically necessary*.

## 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.
- 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.

**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 Blue Shield HMO Blue* for those services or supplies.

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## 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 *network provider* or a *non-network 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 *network provider* or a *non-network provider*. There are a few exceptions. When you are enrolled in a high deductible health plan with a health savings account or you are enrolled in the catastrophic health plan HMO Blue Essential, your *deductible* will apply to these *covered services*. Otherwise, any cost share amounts will not apply for these *covered services*.

These *covered services* also include covered drugs and supplies that are furnished by a covered pharmacy when your prescription drug coverage is provided under this health 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; 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.

## Down Syndrome Treatment

This health plan covers *medically necessary* services to treat Down syndrome when the *covered services* are furnished by a *covered provider*. This coverage 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.

**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 Blue Shield HMO Blue* for those services or supplies.

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- Physical therapy; speech/language therapy; occupational therapy; or an organized program of these combined services (see “Short-Term Rehabilitation Therapy”). When physical, speech/language, and/or occupational therapy is furnished as part of the treatment of Down syndrome, a *benefit limit* will not apply to these services.

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.

## **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 Blue Shield HMO Blue* 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 a network appliance company or from a provider who is designated by *Blue Cross Blue Shield HMO Blue* 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 a *deductible* and/or *coinsurance* would normally apply to any of these *covered services*, both the *deductible* and *coinsurance* will be waived. (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 Blue Shield HMO Blue*’s periodic review of its *medical policies* and *medical technology assessment criteria* to reflect new applications and technologies. You can call the *Blue Cross Blue Shield HMO Blue* customer service office for help to find out what is covered. (See Part 1.)

WORDS IN ITALICS ARE EXPLAINED IN PART 2.

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*Blue Cross Blue Shield HMO Blue* will decide whether to rent or buy durable medical equipment. If *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* determines that you chose durable medical equipment that costs more than what you need for your medical condition, benefits will be provided only for those costs that would have been paid for the least expensive equipment that meets your needs. In this case, you must pay all of the health care provider's charges that are more than the *Blue Cross Blue Shield HMO Blue* 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 Blue*

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*Shield HMO Blue* as outlined in this Subscriber Certificate and in the *Blue Cross Blue Shield HMO Blue 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 Blue Shield HMO Blue* before you obtain services. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue medical policy* and meet *Blue Cross Blue Shield HMO Blue medical technology assessment criteria*.**

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

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

## Home Health Care

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

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

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

## Universal Postpartum Home Visiting Services

This health plan provides universal postpartum home visiting services for *members* who are birthing people or caregivers with newborns. This includes (but is not limited to): screenings for unmet health needs including reproductive health services; maternal and infant nutritional needs; and emotional health supports, including postpartum depression supports. These *covered services* must be furnished by a qualified health professional with maternal and pediatric health training. At least one postpartum visit must occur at the *member's* home or a mutually agreed upon location within eight weeks postpartum. This health plan will

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provide full coverage (any *deductible*, *copayment*, and/or *coinsurance* will not apply) for the covered postpartum home visit. The only exceptions are when you are enrolled in a high deductible health plan with a health savings account or when you are enrolled in the catastrophic health plan HMO Blue Essential. In this case, your *deductible* will apply to these *covered services*. Within Massachusetts, this coverage will be provided in accordance with the operational standards that have been set by the Massachusetts Department of Public Health to establish and administer a statewide system of programs providing universal postpartum home visiting services. Until such time as the Massachusetts Department of Public Health establishes this program, *members* may access *medically necessary* postpartum home visiting services from *Blue Cross Blue Shield HMO Blue* home health care providers.

**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.)

## 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 as described in the *Blue Cross Blue Shield HMO Blue medical policy*. To receive coverage for infertility services, they must be *medically necessary* for you, furnished by a *covered provider*, and approved by *Blue Cross Blue Shield HMO Blue* as outlined in this Subscriber Certificate and in the *Blue Cross Blue Shield HMO Blue medical policy*. You and your health care provider must receive approval from *Blue Cross Blue Shield HMO Blue* before you obtain infertility services. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue medical policy* and meet *Blue Cross Blue Shield HMO Blue medical technology***

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**assessment criteria.** (See page 18 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 Blue Shield HMO Blue medical policy*.
- Infertility technologies, such as: in vitro fertilization and embryo placement; gamete intrafallopian transfer; zygote intrafallopian transfer; natural oocyte retrieval intravaginal fertilization; and intracytoplasmic sperm injection.
- Cryopreservation and storage of reproductive tissue as outlined in the *Blue Cross Blue Shield HMO Blue medical policy*.

### **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), except as otherwise described in the *Blue Cross Blue Shield HMO Blue medical policy*; 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 Blue Shield HMO Blue 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),

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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 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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

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appropriate tests. This health plan will cover more visits that are furnished by a *covered provider* only if *Blue Cross Blue Shield HMO Blue* 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 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 Blue Shield HMO Blue'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.
- *Medically necessary* pasteurized donor human milk and donor human milk-derived products for a covered infant when a written order is issued by a licensed medical practitioner. The milk must be obtained from a human milk bank that meets the quality guidelines of the Massachusetts Department of Public Health. The covered infant must be: under the age of six months; and undergoing treatment in an *inpatient* setting for a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis or a congenital or acquired condition that may benefit from the use of such human breast milk as determined by the Massachusetts Department of Public Health; and medically or physically unable to receive maternal breast milk or participate in breastfeeding, or whose mother is medically or physically unable, despite receiving lactation support, to produce maternal breast milk in sufficient quantities or caloric density.
- 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 Blue Shield HMO Blue* 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

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or nurse midwife. You can call the *Blue Cross Blue Shield HMO Blue* 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.

### **Screenings for Postpartum Depression and Major Depressive Disorders.**

For postnatal *members*, this health plan also provides coverage for postpartum depression and major depressive disorder screenings. A postnatal individual is: an individual who is within twelve months of giving birth; or an individual who is a biological parent or an adoptive or foster parent that is within twelve months from assuming care of a child; or is an individual who has lost a pregnancy due to a stillbirth, miscarriage, or a medical termination within the previous twelve months. All postnatal *members* who receive health care services from a *covered provider*, including the infant's pediatrician, shall be offered these screenings. If a *member* agrees to these screenings, the *covered provider* shall ensure that the *member* is appropriately screened in line with evidence-based guidelines. If it is determined by the health care professional that the *member* is likely to be suffering from postpartum depression or major depressive disorder, the health care provider shall discuss available treatments, including pharmacological treatments, and shall appropriately refer the *member* to a mental health clinician (see "Mental Health and Substance Use Treatment"). These screenings are part of a regular visit with a health care provider and will not be subject to separate cost sharing. (See "Home Health Care" for your coverage for universal postpartum home visiting services.)

### **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.

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

### **Medical Care Outpatient Visits**

This health plan covers *outpatient* care to diagnose or treat your medical condition when the services or supplies are furnished for you by a *covered provider*. This may include (but is not limited to): a physician; or a nurse practitioner; or an optometrist; or a licensed dietitian nutritionist. These services may be furnished

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in the provider's office or at a covered facility or, as determined appropriate by *Blue Cross Blue Shield HMO Blue*, 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; and health education services.

### **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 or a referral from your *primary care provider* 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 Blue Shield HMO Blue* 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 your *primary care provider*. 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 Blue Shield HMO Blue 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*. You do not need a referral from your *primary care provider* to receive this care. 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.)
- 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. If a *copayment*

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would normally apply to your visit, it is waived if the visit is only to administer the injection. (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 Blue Shield HMO Blue* customer service office. Or, you can log on to the *Blue Cross Blue Shield HMO Blue* Web site at **www.bluecrossma.org**. (There may be times when these covered drugs are prohibited by law to be furnished to you by a covered pharmacy and must be sent directly by the pharmacy to a non-pharmacy health care provider to administer during a covered visit. Benefits for the cost of these drugs will be provided as part of the covered visit. For these *covered services*, the cost share amount you will pay is the cost share amount that applies for the *outpatient* visit.)

- 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. You do not need a referral from your *primary care provider* to receive this care. For these *covered services*, this health plan will provide full coverage. The only exceptions are when you are enrolled in a high deductible health plan with a health savings account or you are enrolled in the catastrophic health plan HMO Blue Essential. In this case, your *deductible* will apply to these *covered services*. Otherwise, any cost share amounts will not apply for these *covered services*.

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.

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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.)

## 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 19<sup>th</sup> 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.

**No benefits** are provided for:

- Psychiatric services for a condition that is not a *mental condition*.
- Residential or other care that is *custodial care*.

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- 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*.

#### **Coverage for Opioid Antagonists**

This health plan covers opioid antagonists that are used in the reversal of overdoses caused by opioids (such as morphine or heroin). You do not need prior approval from *Blue Cross Blue Shield HMO Blue* or a prescription to obtain covered opioid antagonists.

Opioid antagonists that are dispensed to you upon discharge by the health care facility in which they were prescribed will be covered under the health plan's medical benefits. In most cases, this health plan will provide full coverage (any *deductible*, *copayment*, and/or *coinsurance* will not apply) for covered opioid antagonists furnished under the medical benefits. The only exceptions are when you are enrolled in a high deductible health plan with a health savings account or when you are enrolled in the catastrophic health plan HMO Blue Essential. In this case, your *deductible* will apply to these *covered services*.

Your benefits for these items are provided as a prescription drug benefit when you buy them from a pharmacy or when they are dispensed by a pharmacist. See "Prescription Drugs and Supplies."

#### **Coverage for Substance Use Recovery Coaches**

This health plan will provide full coverage (any *deductible*, *copayment*, and/or *coinsurance* will not apply) for *covered services* furnished by a licensed recovery coach. The only exceptions are when you are enrolled in a high deductible health plan with a health savings account or when you are enrolled in the catastrophic health plan HMO Blue Essential. In this case, your *deductible* will apply to these *covered services*. You do not need prior approval from *Blue Cross Blue Shield HMO Blue* to obtain *covered services* from a licensed recovery coach.

#### **Inpatient Services**

Usually, to receive coverage for *inpatient* services, you and your *mental health provider* must receive approval from *Blue Cross Blue Shield HMO Blue* as outlined in this Subscriber Certificate before you enter a hospital or other covered facility. (See Part 4 for these requirements.) *Blue Cross Blue Shield HMO Blue* will let you and your *mental health provider* know when your coverage is approved. When *inpatient* care is approved by *Blue Cross Blue Shield HMO Blue*, 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*;

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

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

- Community-Based Acute Treatment (CBAT) programs that provide mental health care in a staff-secure setting on a 24-hour basis, with sufficient clinical staffing to ensure the *member's* safety, while providing intensive therapeutic services including (but not limited to): daily medication monitoring; psychiatric assessment; nursing availability; specializing (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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue*. (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

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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 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.

WORDS IN ITALICS ARE EXPLAINED IN PART 2.

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- 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.

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 Blue Shield HMO Blue* is not able to conduct concurrent review of continued *medical necessity* (see Part 4), including a program that has a pre-defined length of care or stay; a program that provides only meetings or activities that are not based on an individualized treatment plan; and a program that focuses solely on the improvement of interpersonal or other skills, rather than on treatment that is focused on symptom reduction and functional recovery for specific *mental conditions*.

### **Outpatient Services**

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

**Important Note:** For more information on Mental Health and Substance Use Treatment, refer to the *Blue Cross Blue Shield HMO Blue medical policy* for behavioral health continuum of care.

## **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.

WORDS IN ITALICS ARE EXPLAINED IN PART 2.

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## **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”).

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 health 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

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described in this Subscriber Certificate for “Prosthetic Devices”), and fittings, castings, and other services related to devices for the feet.

## **Prescription Drugs and Supplies**

This health 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 Blue Shield HMO Blue* Drug Formulary as a covered drug or supply. For certain covered drugs, you must have prior approval from *Blue Cross Blue Shield HMO Blue* in order for you to receive this drug coverage. A covered pharmacy will tell you if your drug needs prior approval from *Blue Cross Blue Shield HMO Blue*. 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* customer service office. Or, you can look on the internet Web site at **www.bluecrossma.org**.

### **The Drug Formulary**

The *Blue Cross Blue Shield HMO Blue* Drug Formulary is a list of *Blue Cross Blue Shield HMO Blue* approved drugs and supplies. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* Drug Formulary, including the most current list of those drugs which are not included on the formulary, by calling the *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* Web site at **www.bluecrossma.org**.

### **The Drug Formulary Exception Process**

Your drug coverage includes a Drug Formulary Exception Process. This process allows your prescribing health care provider to ask for an exception from *Blue Cross Blue Shield HMO Blue*. This exception is to ask for coverage for a drug that is not on the *Blue Cross Blue Shield HMO Blue* Drug Formulary. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue*, you will receive coverage for the drug that is not on the *Blue Cross Blue Shield HMO Blue* Drug Formulary. For this drug,

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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 Blue Shield HMO Blue* customer service office. The toll free phone number to call is shown on your ID card. A *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* Web site at [www.bluecrossma.org](http://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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* customer service office.

### **Mail Order with Retail Choice Program**

Some plan options include the Mail Order with Retail Choice Program. The *Schedule of Benefits* for your plan option will tell you when you have this program. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.) If your health plan includes this program, the Mail Order with Retail Choice Program applies for certain covered maintenance drugs. These drugs are shown on the *Blue Cross Blue Shield HMO Blue* drug list. When you buy any one of these maintenance drugs from a covered retail pharmacy, this health plan covers only two fills of the same drug within a 365-day period. In order to receive coverage for more fills of the same drug from a covered retail pharmacy, you will be asked to choose whether you want to continue to receive your drug fills from the retail pharmacy or whether you will receive your drug fills from the covered mail order pharmacy. After you buy your first fill of the listed drug from the retail pharmacy, you will receive a letter from *Blue Cross Blue Shield HMO Blue* that will tell you how to make your choice. If you do not make a choice before you buy a third fill, the covered mail order pharmacy will automatically qualify as your choice. No retail pharmacy coverage will be provided for more than two fills of the same drug unless you have chosen the retail pharmacy option. To find out which maintenance drugs are on the drug list, you can call the *Blue Cross Blue Shield HMO Blue* customer service office. The toll free phone number to call is shown on your ID card. Or, you can also go online and log on to the *Blue Cross Blue Shield HMO Blue* Web site at [www.bluecrossma.org](http://www.bluecrossma.org). This list of drugs may change from time to time. For example, this list of drugs may change as new drugs become available. Please check for updates when a drug is prescribed for you for the first time. Or, *Blue Cross Blue Shield HMO Blue* may change the classes of drugs that are on this drug list. In this case, *Blue Cross Blue Shield HMO Blue* will send you a notice.

### **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 Blue Shield HMO Blue medical technology assessment criteria*. These covered drugs include, but are not limited to: birth control drugs; oral diabetes medication that influences blood sugar levels; hormone

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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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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.
- 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.

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- 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 certain preventive drugs as recommended and supported by the Health Resources and Services Administration and the U.S. Preventive Services Task Force. 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:

- Anorexiant; non-sedating antihistamines; ophthalmic drug solutions to treat allergies; inhaled topical nasal steroids; 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; or glucagon-like peptide-1 (GLP-1) receptor agonists and GLP-1 receptor agonist combination products, except for GLP-1s that are FDA approved to treat diabetes or, in certain situations, for GLP-1s that may be prescribed for other conditions as specifically outlined in the *Blue Cross Blue Shield HMO Blue* Drug Formulary that applies to your coverage in this health plan or applicable *Blue Cross Blue Shield HMO Blue* medical policy. From time to time, *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* customer service office. The toll free phone number to call is shown on your ID card. Or, you can also go online and log on to the *Blue Cross Blue Shield HMO Blue* Web site at [www.bluecrossma.org](http://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.
- Combination vitamins that require a prescription, except for: prescription prenatal vitamins; and pediatric vitamins with fluoride.
- Drugs and supplies that you buy from a retail pharmacy that is not covered by this health plan. The only exception is when you are traveling outside of your *service area* and a covered retail pharmacy is not reasonably available to you. In this case, you may fill your prescription at any retail pharmacy. But, you must pay all charges at the time you buy your drug. Then, you should call the *Blue Cross Blue Shield HMO Blue* customer service office for a claim form to file your claim. *Blue Cross Blue Shield HMO Blue* will repay you, less the amount you would normally pay for covered drugs and supplies.
- 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 Blue Shield HMO Blue* for payment for the specific covered drug and/or supply.

**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 Blue Shield HMO Blue* for those services or supplies.

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## **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, or arranged, by the child’s *primary care provider* and is in line with applicable *Blue Cross Blue Shield HMO Blue medical policies*. 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 Blue Shield HMO Blue 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 coverage 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 Blue Shield HMO Blue* customer service office. The toll free phone number to call is shown on your ID card. Or, you can also go online and log on to the *Blue Cross Blue Shield HMO Blue* Web site at **[www.bluecrossma.org](http://www.bluecrossma.org)**. The provisions described in this paragraph do not apply to you if your health plan is a grandfathered health plan under the Affordable Care Act.

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

### **Annual Mental Health Wellness Exams**

This health plan covers mental health wellness exams for at least one exam for each *member* in each calendar year. This coverage may be furnished by the child’s *primary care provider* or by other *covered providers*, including *mental health providers*. For these *covered services*, this health plan will provide full 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 Blue Shield HMO Blue* for those services or supplies.

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

### **Preventive Dental Care**

This health plan covers preventive dental care for a *member* who is under age 18 and who is being treated for conditions of cleft lip and cleft palate (see page 40). This coverage includes (but is not limited to) periodic oral exams, cleanings, and fluoride treatments furnished by a network 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 Blue Shield HMO Blue medical policies*. This coverage includes:

- Routine medical exams and related routine lab tests and x-rays that your *primary care provider* decides are suitable for you.
- 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. Your health care provider may also recommend further diagnostic examinations for breast cancer (such as diagnostic mammography, digital breast tomosynthesis, breast magnetic resonance imaging, or breast ultrasound) to evaluate an abnormality in the breast that is seen or suspected from a screening examination for breast cancer, or that is detected by another means of examination, or that is suspected based on the *member's* medical history or family medical history. Your coverage for these *covered services* is the same as routine mammograms. (For all other *outpatient* diagnostic tests, your cost share will apply.) There is one exception. If you have been previously diagnosed with breast cancer and you receive the above diagnostic imaging services, this health plan will provide full coverage (any *deductible*, *copayment*, and/or *coinsurance* will not apply), unless you are enrolled in a *Blue Cross Blue Shield HMO Blue “Saver”* high deductible health plan or the catastrophic health plan HMO Blue Essential. In this case, your overall *deductible* will apply (any *copayment* and/or *coinsurance* will not apply).

**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 Blue Shield HMO Blue* for those services or supplies.

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- Routine prostate-specific antigen (PSA) blood tests. This coverage includes at least 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 Blue Shield HMO Blue medical policies*.

**Important Note:** You have the right to full coverage 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 Blue Shield HMO Blue* customer service office. The toll free phone number to call is shown on your ID card. Or, you can also go online and log on to the *Blue Cross Blue Shield HMO Blue* Web site at [www.bluecrossma.org](http://www.bluecrossma.org). The provisions described in this paragraph do not apply to you if your health plan is a grandfathered health plan under the Affordable Care Act.

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

#### **Annual Mental Health Wellness Exams**

This health plan covers mental health wellness exams for at least one exam for each *member* in each calendar year. This coverage may be furnished by a *covered provider*, including *mental health providers*. For these *covered services*, this health plan will provide full coverage.

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

#### **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

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the *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* Web site at [www.bluecrossma.org](http://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 health plan.**

### **Routine Gynecological (GYN) Exams**

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

### **Family Planning**

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

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

**Important Note:** You have the right to full coverage for family planning services as required by state law.

**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.)

**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 Blue Shield HMO Blue* for those services or supplies.

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

### **Routine Vision Care**

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

### **Vision Supplies**

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

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

### **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 Blue Shield HMO Blue* 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.

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- 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 health plan and it does not include pharmacy coverage, 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* claim payment.

## **Qualified Clinical Trials for Treatment of Cancer**

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

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 Blue Shield HMO Blue* for those services or supplies.

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- 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 to you if your health plan is a grandfathered health plan under the Affordable Care Act.)

### **Radiation Therapy and Chemotherapy**

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

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

### **Coverage for Orally-Administered Chemotherapy Drugs**

In most cases, this health plan will provide full coverage for 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*.

### **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 Blue Shield HMO Blue* customer service office. Or, you can log on to the *Blue Cross Blue Shield HMO Blue* Web site at [www.bluecrossma.org](http://www.bluecrossma.org). (There may be times when these covered drugs are prohibited by law to be furnished to you by a covered pharmacy and must be sent directly by the pharmacy to a non-pharmacy health care provider to administer during a covered visit. Benefits for the cost of these drugs will be provided as part of the covered visit. For these *covered services*, the cost share amount you will pay is the cost share amount that applies for the *outpatient* visit.)

**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 Blue Shield HMO Blue* for those services or supplies.

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## Second Opinions

This health plan covers an *outpatient* second opinion about your medical care 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; or when any of these services are furnished to treat Down syndrome. 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 Blue Shield HMO Blue* to be *medically necessary* for you.

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

## What Are Rehabilitation and Habilitation Services

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

**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 Blue Shield HMO Blue* for those services or supplies.

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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 *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. This is the case even if your health plan is a grandfathered health plan under the Affordable Care Act. This provision does not apply for hospital services. For all situations except as described in this paragraph, the cost share amount for elective surgery will still apply.
- Endoscopic procedures.
- Surgical procedures. This includes emergency and scheduled surgery. This coverage includes (but is not limited to):
  - **Reconstructive surgery.** This means non-dental surgery that is meant to improve or give you back bodily function or to correct a functional physical impairment that was caused by: a birth defect; a prior surgical procedure or disease; or an accidental injury. It also includes surgery to correct a deformity or disfigurement that was caused by an accidental injury. This coverage includes surgery to correct or repair disturbances of body composition caused by HIV associated lipodystrophy syndrome, when the *covered provider* has determined that this treatment is necessary to correct, repair, or lessen the effects of HIV associated lipodystrophy syndrome. 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 Blue Shield HMO Blue 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

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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 Blue Shield HMO Blue* asking for approval for the surgery. No benefits are provided for the orthodontic services, except as described in this Subscriber Certificate on page 40 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 (or one pair of eyeglasses instead) 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 40 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.

**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 Blue Shield HMO Blue* for those services or supplies.

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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 Blue Shield HMO Blue* customer service office. Or, you can log on to the *Blue Cross Blue Shield HMO Blue* Web site at [www.bluecrossma.org](http://www.bluecrossma.org). (There may be times when these covered drugs are prohibited by law to be furnished to you by a covered pharmacy and must be sent directly by the pharmacy to a non-pharmacy health care provider to administer during a covered visit. Benefits for the cost of these drugs will be provided as part of the covered visit. For these *covered services*, the cost share amount you will pay is the cost share amount that applies for the *outpatient* visit.) Note: 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 Blue Shield HMO Blue network provider* or by a *Blue Cross Blue Shield HMO Blue* designated telehealth vendor. Telehealth services are synchronous or asynchronous communications (audio, video, or other approved electronic media or telecommunications technology including, but not limited to: interactive audio-video technology; remote patient monitoring devices; audio-only telephone; and online adaptive interviews) between you and the health care provider. Your health care provider will work with you to determine if a telehealth visit is medically appropriate for your health care needs or if an in-person visit is required. These services are available for medically appropriate *covered services*, including services to diagnose and/or treat *mental conditions*. The cost share amount that you will pay depends on the health care provider that furnishes the *covered service* to you. (See below.) For covered telehealth services, you will not have to pay any more than you would normally pay for the same in-person *covered service* with your health care provider. In 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 Network Provider**

When medically appropriate telehealth services are furnished by a *Blue Cross Blue Shield HMO Blue network 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

**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 Blue Shield HMO Blue* for those services or supplies.

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covered telehealth services may be lower than your in-person cost share. If this is the case, this will be described in a *rider*. Except as described in Part 4 for certain services, you will need to have an approved referral from your *primary care provider* before you receive *outpatient* specialty care from a network specialist.

#### **Telehealth Services with a Designated Telehealth Vendor**

You may use a *Blue Cross Blue Shield HMO Blue* 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. You do not need a referral from your *primary care provider* for covered *outpatient* telehealth services with a *Blue Cross Blue Shield HMO Blue* designated telehealth vendor.

When medically appropriate *outpatient* telehealth services are furnished by a *Blue Cross Blue Shield HMO Blue* designated telehealth vendor, your cost share (such as *deductible*, *copayment*, and/or *coinsurance*) is the same telehealth cost share when they are furnished by your *primary care provider* (if you are enrolled in an Options tiered network plan, your cost share is the same as the lowest cost share level for a primary care provider office visit) or *mental health 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 *outpatient* telehealth services with a *Blue Cross Blue Shield HMO Blue* designated telehealth vendor may be lower than your in-person cost share for a primary care provider office visit. If this is the case, this will be described in a *rider*.

Exception for members with a virtual care team *primary care provider*: When your specific plan option includes the “Virtual Care Team Model” *rider* and you choose (or designate) a *Blue Cross Blue Shield HMO Blue* virtual care team *covered provider* as your *primary care provider*, your cost share for *outpatient* telehealth services furnished by a *Blue Cross Blue Shield HMO Blue* designated telehealth vendor is not the same cost share for *outpatient* telehealth services as described above.

For *outpatient* telehealth services furnished by a *Blue Cross Blue Shield HMO Blue* 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* that is not a virtual care team *primary care provider* as described in your *Schedule of Benefits* and/or *riders* that apply to your coverage in this health plan. Or, when you are enrolled in an Options tiered network plan, your cost share is the same telehealth cost share as an Enhanced Benefits Tier primary care provider office visit 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 Blue Shield HMO Blue* designated telehealth vendor may be lower than described in this section. If this is the case, this will be described in a *rider*.

**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 Blue Shield HMO Blue* for those services or supplies.

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## **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

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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 Blue Shield HMO Blue*. (See Part 4.) This health plan will provide coverage starting on your *effective date* but only if *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue's* criteria for coverage in certain situations (such as *medically necessary* gender affirming services), as defined in *Blue Cross Blue Shield HMO Blue 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue medical technology assessment criteria*. No benefits are provided for health care charges that are received for or related to care that *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue medical policies*.
- A service or supply that does not conform to *Blue Cross Blue Shield HMO Blue medical technology assessment criteria*.
- A service or supply that is not considered by *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* for payment for the specific service or supply.
- A service or supply that is obtained outside of your *service area*, except for *emergency medical care* and *urgent care*. This exclusion applies even when a student is going to school outside of your *service area*.

- 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 Blue Shield HMO Blue*.
- 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. At certain times, this health plan may cover a private room charge. This coverage is provided only when *Blue Cross Blue Shield HMO Blue* determines that a private room is *medically necessary* for you. If a private room is used but not approved in advance by *Blue Cross Blue Shield HMO Blue*, you must pay all costs that are more than the semiprivate room rate.

## **Services and Supplies Furnished After Termination Date**

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

Exception for *inpatient* admissions prior to January 1, 2025: For *inpatient* admissions that begin prior to January 1, 2025, this health plan will continue to provide coverage for services and supplies that are furnished after your termination date. When you are *inpatient* in a hospital, payment to the hospital may be based on a "Diagnosis Related Grouping" (DRG). In this case, the hospital's DRG payment that is approved by *Blue Cross Blue Shield HMO Blue* will be paid to the hospital. This amount will be paid by *Blue Cross*

*Blue Shield HMO Blue* even when your coverage in this health plan ends during your admission. When payment to the hospital is based on a DRG and you are not enrolled in a New England plan option, no benefits are provided for other services and/or supplies that are furnished during that same *inpatient* admission. For all other *inpatient* admissions, coverage will continue for *covered services* that are furnished during that same *inpatient* admission until all the benefits allowed by your health plan have been used up or the date of discharge, whichever comes first. But, this exception does not apply if your coverage in this health plan is canceled for misrepresentation or fraud.

### **Services Furnished to Immediate Family**

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

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

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

## Part 7

# Other Party Liability

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### Coordination of Benefits (COB)

*Blue Cross Blue Shield HMO Blue* will coordinate payment of *covered services* with hospital, medical, dental, health, or other plans under which you are covered. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* if you add or change health plan coverage. Upon *Blue Cross Blue Shield HMO Blue's* request, you must also supply *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* decides which is the primary and secondary payor. To do this, *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* will not provide any more coverage than what is described in this Subscriber Certificate. *Blue Cross Blue Shield HMO Blue* will not provide duplicate benefits for *covered services*. If *Blue Cross Blue Shield HMO Blue* pays more than the amount that it should have under COB, then you must give that amount back to *Blue Cross Blue Shield HMO Blue*. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue'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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* will not be reduced by any attorney's fees or expenses that you incur.

WORDS IN ITALICS ARE EXPLAINED IN PART 2.

### **Member Cooperation**

You must give *Blue Cross Blue Shield HMO Blue* information and help. This means you must complete and sign all necessary documents to help *Blue Cross Blue Shield HMO Blue* get this money back. This also means that you must give *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* paid benefits. You must not do anything that might limit *Blue Cross Blue Shield HMO Blue*'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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* pays for any work-related health care services, *Blue Cross Blue Shield HMO Blue* has the right to get paid back from the party that legally must pay for the health care claims. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* is billed in error for these services, you must promptly call or write to the *Blue Cross Blue Shield HMO Blue* customer service office.

## Part 8

# Other Health Plan Provisions

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### Access to and Confidentiality of Medical Records

*Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* or health care providers. *Blue Cross Blue Shield HMO Blue* may collect information from health care providers or from other insurance companies or the *plan sponsor* (for *group members*). *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue*.
- 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 of Massachusetts, Inc.
- As required by the *subscriber's group* or by its auditors to make sure that *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* will not share information about you with the Medical Information Bureau (MIB). *Blue Cross Blue Shield HMO Blue* respects your right to privacy. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* collects about you. You may also ask *Blue Cross Blue Shield HMO Blue* to correct any of this information that you believe is not correct. *Blue Cross Blue Shield HMO Blue* may charge you a reasonable fee for copying your records, unless your request is because *Blue Cross Blue Shield HMO Blue* is declining or terminating your coverage in this health plan.

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

### Acts of Providers

*Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* or any other health care

provider does not act as an agent on behalf of or for *Blue Cross Blue Shield HMO Blue*. And, *Blue Cross Blue Shield HMO Blue* does not act as an agent for health care providers who participate in your health care network and have payment agreements with *Blue Cross Blue Shield HMO Blue* or for any other health care providers.

*Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* is not responsible if a provider refuses to furnish services to you. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue*'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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* know in writing by completing the appropriate form(s). To get copies of these forms, you can call the *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* Web site at [www.bluecrossma.org](http://www.bluecrossma.org) to get a copy of these forms. In some cases, *Blue Cross Blue Shield HMO Blue* may consider your health care facility or your physician or other health care provider to be your authorized representative. For example, *Blue Cross Blue Shield HMO Blue* may tell your hospital that a proposed *inpatient* admission has been approved. Or, *Blue Cross Blue Shield HMO Blue* may ask your physician for more information if more is needed for *Blue Cross Blue Shield HMO Blue* to make a decision. *Blue Cross Blue Shield HMO Blue* will consider the health care provider to be your authorized representative for *emergency medical care*. *Blue Cross Blue Shield HMO Blue* will continue to send benefit payments and written communications regarding your health care coverage according to *Blue Cross Blue Shield HMO Blue*'s standard practices, unless you specifically ask *Blue Cross Blue Shield HMO Blue* to do otherwise.

### **Changes to Health Plan Coverage**

*Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* makes a material change to your coverage in this health plan, *Blue Cross Blue Shield HMO Blue* will send a notice about the change at least 60 days before the *effective date* of the change. The notice will be sent to the *subscriber* or, when you are enrolled in this health plan as a *group member*, to the *plan sponsor*. The notice from *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue*. (If you enrolled in this health plan through the Massachusetts Health Connector, see Part 11 or Part 12, whichever applies to you, for information.)

There may be times when the provisions of your coverage in this health plan change but *Blue Cross Blue Shield HMO Blue* is not able to provide prior notice of the change as described above. These changes may be made by *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue*. 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue applies medical technology assessment criteria and medical necessity guidelines when it develops its clinical guidelines, utilization review criteria, and medical policies. Blue Cross Blue Shield HMO Blue reviews its clinical guidelines, utilization review criteria, and medical policies from time to time. Blue Cross Blue Shield HMO Blue 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 Blue Shield HMO Blue 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.

## **Continuity of Care Access for Cancer and Pediatric Facilities**

When you enroll in a **limited or tiered network plan** under a *group contract* and your *group* is a **small employer group**, you may be eligible for continuity of care coverage if you are receiving an active course

of care for a serious illness that you began before your *effective date* in the limited or tiered network plan. To be eligible for this continuity of care coverage, you must meet all of the following conditions:

- You began an active course of care for a serious illness (such as cancer or cystic fibrosis) at a comprehensive cancer or pediatric facility on or after May 1, 2012 but before your *effective date* in the *Blue Cross Blue Shield HMO Blue* limited or tiered network plan. A “comprehensive cancer or pediatric facility” means: Dana-Farber Cancer Institute, Boston Children’s Hospital, Shriners Hospitals for Children (Boston and Springfield), Nashoba Valley Medical Center, and Massachusetts Eye and Ear Infirmary.
- The comprehensive cancer or pediatric facility is not in the health plan’s network; or, for a tiered network plan, you would normally pay the highest cost share amount for *covered services* furnished at the comprehensive cancer or pediatric facility where you are receiving your care.
- Your active course of care, if it were disrupted, would cause you an undue hardship. This means, for example, a disruption could endanger your life, or cause you suffering or pain, or result in a substantial change to your treatment plan.

If you meet all of the conditions stated above, you are eligible for this coverage until the end of the 12-month period that starts on the *subscriber’s effective date* in the *Blue Cross Blue Shield HMO Blue* limited or tiered network plan, **but only when** your *group* offers you a choice to enroll only in a limited or tiered network plan in which your comprehensive cancer or pediatric facility either is not part of the health plan’s network or, for a tiered network plan, it is at the highest cost share level; and your care is not available from another provider in the health plan’s network. If you think you are eligible for this coverage, you or your health care provider must send a completed continuity of care form to *Blue Cross Blue Shield HMO Blue*. You can get a copy of this form by calling customer service at the toll free phone number that is shown on your ID card. Or, you can log on to the *Blue Cross Blue Shield HMO Blue* Web site at [www.bluecrossma.org](http://www.bluecrossma.org). Just follow the steps to request a form.

If you are enrolled in a limited network plan and *Blue Cross Blue Shield HMO Blue* determines you are eligible for this coverage, your cost share amount for *covered services* will be the same that would apply to a comparable network provider. If *Blue Cross Blue Shield HMO Blue* determines you are not eligible for this coverage, no benefits will be provided.

If you are enrolled in a tiered network plan and *Blue Cross Blue Shield HMO Blue* determines you are eligible for this coverage, your cost share amount will be at the second highest cost share level when the comprehensive cancer or pediatric facility is at the highest cost share level. Or, your cost share amount will be at the lowest cost share level when the comprehensive cancer or pediatric facility is not part of the health plan’s network. If *Blue Cross Blue Shield HMO Blue* determines you are not eligible for this coverage, you must pay the cost share amount you would normally pay for *covered services* furnished at a comprehensive cancer or pediatric facility.

## **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 Blue Shield HMO Blue* customer service office for more help if this applies to you.

## **Member Cooperation**

You agree to provide *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* uses quality assurance programs. These programs are designed to improve the quality of health care and the services that are provided to *Blue Cross Blue Shield HMO Blue members*. These programs affect different aspects of health care. This may include, for example, health promotion. From time to time, *Blue Cross Blue Shield HMO Blue* may add or change the programs that it uses. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* customer service office. The toll free phone number to call is shown on your ID card. Some of the clinical programs that *Blue Cross Blue Shield HMO Blue* 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-Participating Providers**

By enrolling in this health plan, you have agreed to receive all of your health care services and supplies from health care providers who participate in your health care network. But, there are a few times when 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. These times are 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 will receive coverage from this health plan **only when**:

- You receive *emergency medical care*.

- You receive *urgent care* outside of your *service area*.
- 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.
- Your condition requires *covered services* that cannot be furnished by a health care provider who participates in your health care network and your *primary care provider* refers you to a health care provider who does not participate in your health care network for the *covered services*. In addition to your *primary care provider*’s referral, *Blue Cross Blue Shield HMO Blue* must approve the referral in writing before you receive the services. You should not obtain any services from a health care provider who does not participate in your health care network until you check with your *primary care provider* or with *Blue Cross Blue Shield HMO Blue*.
- You receive *medically necessary covered services* while you are at a network hospital or other covered facility and you do not have a reasonable opportunity to choose to have your *covered services* furnished by a *network provider*. For example, you receive *covered services* from a non-network hospital-based anesthetist, pathologist, or radiologist while you are at a network 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.)

### **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 *primary care provider* disenrolls from your health care network. In this case, this health plan will provide coverage for *covered services* you continue to receive from that health care provider for up to 30 days after the provider disenrolls from your health care network.
- 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* to arrange for or coordinate access to health care services and coverage for its *members*. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* for any claim under this health plan, you must complete the *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue*, 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 Blue Shield HMO Blue* unless you file your action within two years after the date of the decision of the final internal *appeal* of the service or claim denial.

## Part 9

# Filing a Claim

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

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

You can get claim forms from the *Blue Cross Blue Shield HMO Blue* customer service office. (See Part 1.) *Blue Cross Blue Shield HMO Blue* 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.

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 Blue Shield HMO Blue* will include the address to mail your claim.) You can get help with filing your claim by calling the service center at **1-800-810-BLUE**.

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

## **Timeliness of Claim Payments**

Within 30 calendar days after *Blue Cross Blue Shield HMO Blue* receives a completed request for coverage or payment, *Blue Cross Blue Shield HMO Blue* will make a decision. When appropriate, *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* needs more information to make a final determination for your claim, *Blue Cross Blue Shield HMO Blue* will ask for the information or records it needs. *Blue Cross Blue Shield HMO Blue* will make this request within 30 calendar days of the date that *Blue Cross Blue Shield HMO Blue* received the request for coverage or payment. This additional information must be provided to *Blue Cross Blue Shield HMO Blue* within 45 calendar days of this request.

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

## Part 10

# Appeal and Grievance Program

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You have the right to a full and fair review when you disagree with a decision that is made by *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* may use an individual consideration approach when *Blue Cross Blue Shield HMO Blue* judges it to be appropriate. *Blue Cross Blue Shield HMO Blue* will follow its standard guidelines when it resolves your problem or concern.

If after speaking with a *Blue Cross Blue Shield HMO Blue* customer service representative, you still disagree with a decision that is given to you, you may request a formal review through the *Blue Cross Blue Shield HMO Blue* Member Appeal and Grievance Program. You may also request a formal review if *Blue Cross Blue Shield HMO Blue* has not responded to you within three working days of receiving your inquiry. If this does happen, *Blue Cross Blue Shield HMO Blue* 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, 101 Huntington Avenue, Suite 1300, Boston, Massachusetts 02199-7611. Or, you may fax your request to 1-617-246-3616. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* Member Appeal and Grievance Program e-mail address ***grievances@bcbsma.com***. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* Member Appeal and Grievance Program at **1-800-472-2689**. When your request is made by phone, *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* will research the case in detail. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue*, the disputed coverage will continue until this review process is completed. This continuation of your coverage does not apply to services: that are limited by a day, dollar, or visit *benefit limit* and that exceed the *benefit limit*; that are non-covered services; or that were received prior to the time you requested the formal review. It also does not apply if your request for a review was not received on a timely basis, based on the course of the treatment.

All requests for an *appeal* or a *grievance* review must be received by *Blue Cross Blue Shield HMO Blue* 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](http://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 Blue Shield HMO Blue* makes about your coverage or about the amount *Blue Cross Blue Shield HMO Blue* will pay for your health care services or drugs. For example, your doctor may have to contact *Blue Cross Blue Shield HMO Blue* and ask for a coverage decision before you receive proposed services. Or, a coverage decision is made when *Blue Cross Blue Shield HMO Blue* decides what is covered and how

much you will pay for services you have already received. In some cases, *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue*.

When you make an *appeal* about a *medical necessity* coverage decision, *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* needs to review your medical records and you have not provided your consent, *Blue Cross Blue Shield HMO Blue* will promptly send you an authorization form to sign. You must return this signed form to *Blue Cross Blue Shield HMO Blue*. 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* provider, *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue*.

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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue*'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 Blue Shield HMO Blue* may extend the 30-calendar-day time frame to complete a review when both *Blue Cross Blue Shield HMO Blue* and the *member* agree that additional time is required to fully investigate and respond to the request. *Blue Cross Blue Shield HMO Blue* may also extend the 30-calendar-day time frame when the review requires your medical records and *Blue Cross Blue Shield HMO Blue* needs your authorization to get these records. The 30-day response time will not include the days from when *Blue Cross Blue Shield HMO Blue* sends you the authorization form to sign until it receives your signed authorization form. If *Blue Cross Blue Shield HMO Blue* does not receive your authorization within 30 working days after your request for a review is received, *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* that you disagree with *Blue Cross Blue Shield HMO Blue*'s answer and would like an internal formal review.

### **Written Response for an Appeal or Grievance Review**

Once the review is completed, *Blue Cross Blue Shield HMO Blue* will let you know in writing of the decision or the outcome of the review. If *Blue Cross Blue Shield HMO Blue* continues to deny coverage for all or part of a health care service or supply, *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* has denied the request; any alternative treatment or health care services and supplies that would be covered; *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* has and that are relevant to your *appeal* or *grievance*. These copies will be free of charge. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* will complete the review and make a decision regarding the request before you are discharged from that *inpatient* stay.
- *Blue Cross Blue Shield HMO Blue*’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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* has denied the request; any alternative treatment or health care services and supplies that would be covered; *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue*’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 Blue Shield HMO Blue* internal formal *appeal* and *grievance* review process as described above, unless *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue*. 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 Blue Shield HMO Blue*, will tell you about your fee. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue*.**

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 Blue Shield HMO Blue*, 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 Blue Shield HMO Blue*. 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](http://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 Blue Shield HMO Blue* 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

WORDS IN ITALICS ARE EXPLAINED IN PART 2.

basis. This notice will also be sent to *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue*'s decision in whole or in part, *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* will pay for or authorize the requested services; and the name and phone number of the person at *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* has and that are relevant to your *appeal* or *grievance*. These copies will be free of charge.

## Part 11

# Group Policy

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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 Blue Shield HMO Blue* to provide its *group members* with access to health care services and benefits. The *group* will make payments to *Blue Cross Blue Shield HMO Blue* for its *group members* for coverage in this health plan. The *group* should also deliver to its *group members* all notices from *Blue Cross Blue Shield HMO Blue*. The *group* is the *subscriber's* agent and is not the agent of *Blue Cross Blue Shield HMO Blue*. 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.

**Important Note:** If you enrolled in this health plan through the Massachusetts Health Connector, your *group* has a contract with the Health Connector and not *Blue Cross Blue Shield HMO Blue*. The *group* makes payments to the Health Connector for your coverage in this health plan. The Health Connector will send all notices to the *subscriber*. You must call the Health Connector directly for any questions about: your enrollment in this health plan; your *premium* payments; and any membership changes you need to make such as a change to your name or address. For any questions about your health plan coverage or your claims, you can call the *Blue Cross Blue Shield HMO Blue* customer service office.

## Eligibility and Enrollment for Group Coverage

### Eligible Employee

An employee is eligible to enroll in this health plan as a *subscriber* under a *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*.
- The employee resides in the *service area* (or lives and/or works within a reasonable distance from the *service area*).

### 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*.) In order to enroll for coverage in this health plan, the eligible spouse must also reside in the *service area* (or live within a reasonable distance from the *service area*).

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

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

### **Eligible Dependents**

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

- A newborn child. The *effective date* of coverage for a newborn child will be the child's date of birth provided that the *subscriber* formally notifies the *plan sponsor* within 30 days of the date of birth. (A claim for a *member's* maternity admission may be considered by *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* through the *plan sponsor* not more than 30 days after the date the child would normally lose eligibility. Also, *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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.

In all of these cases, the child must reside in the *service area* or, except for a full-time student, live within a reasonable distance from the *service area*.

**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 themselves or an eligible dependent (including a spouse) for coverage in this health plan under a *group contract* on the initial *group* eligibility date because they or the eligible dependent has other health plan coverage as defined by federal law. (This is referred to as “qualified” coverage.) In this case, the employee and the eligible dependent may enroll under the *group contract* if the employee or the eligible dependent at a later date loses that other qualified health plan coverage due to any one of the following reasons.

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

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

### **New Dependents**

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

### **Special Enrollment Time Requirement**

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

### **Qualified Medical Child Support Order**

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

### **Open Enrollment Period**

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

### **Other Membership Changes**

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

## **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 105). 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 Blue Shield HMO Blue* health plan or a health plan offered by Blue Cross and Blue Shield of Massachusetts, Inc. For help, you can call the *Blue Cross Blue Shield HMO Blue* customer service office. They will tell you which health plans are available to you.

- **You Move Out of Your Service Area.** Your coverage in this health plan under a *group contract* will end when you move permanently out of your *service area*. In this case, if you are still eligible for *group* coverage, you may be eligible to transfer your coverage to another health plan that is offered by your *group*. (Contact your *plan sponsor* for help.) Or, if you are not eligible for *group* coverage, you may be able to enroll in another Blue Cross and/or Blue Shield Plan's HMO plan. For help, you can call the *Blue Cross Blue Shield HMO Blue* customer service office. They will help you with your options.
- **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 Blue Shield HMO Blue* within 30 days of the due date. In this case, *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* or Blue Cross and Blue Shield of Massachusetts, Inc. (If you enrolled in this health plan through the Massachusetts Health Connector, the *group* makes payments to the Health Connector. The Health Connector will send all notices to the *subscriber* related to non-payment of your *premium* and termination.)
- **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 Blue Shield HMO Blue* must receive the termination request not more than 30 days after the *subscriber's* termination date.

#### **Termination of Group Coverage by Blue Cross Blue Shield HMO Blue**

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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* is canceling the *group contract*. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue*.

- **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 Blue Shield HMO Blue* or Blue Cross and Blue Shield of Massachusetts, 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 Blue Shield HMO Blue* requests related to your coverage in this health plan, *Blue Cross Blue Shield HMO Blue* may terminate your coverage.
- **This Health Plan Is Discontinued.** Your coverage in this health plan will be canceled if *Blue Cross Blue Shield HMO Blue* discontinues this health plan. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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

If you lose eligibility for coverage in this health plan under a *group contract* due to a plant closing or a partial plant closing (as defined by law) in Massachusetts, you may continue coverage under the *group contract* 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 contract*. If you become eligible for coverage under another employer sponsored health plan at any time before the 39-week extension period ends, continued coverage in this health plan under the *group contract* under these provisions also ends.

### **Continuation of Group Coverage under Federal or State Law**

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

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

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

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

### **Additional Continued Coverage for Disabled Employees**

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

### **Special Rules for Retired Employees**

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

Lifetime continued coverage in this health plan for retired employees will end if the *group* cancels its agreement with *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* (or the Massachusetts Health Connector) 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 Blue Shield HMO Blue* 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 health plan 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

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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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* for coverage in this health plan under an *individual contract*. For questions about enrollment and billing, you can call the *Blue Cross Blue Shield HMO Blue* customer service office.

**Important Note:** If you enrolled in this health plan through the Massachusetts Health Connector, the *subscriber* has an agreement with the Health Connector and not *Blue Cross Blue Shield HMO Blue*. The *subscriber* will usually make payments to the Health Connector for coverage in this health plan. The Health Connector will send all notices to the *subscriber*. You must call the Health Connector directly for any questions about: your enrollment in this health plan; your *premium* payments; and any membership changes you need to make such as a change to your name or address. For any questions about your health plan coverage or your claims, you can call the *Blue Cross Blue Shield HMO Blue* 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 meet each of the following conditions:

- 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 Blue Shield HMO Blue*. This means *Blue Cross Blue Shield HMO Blue* 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.
- You live in the health plan’s Massachusetts *service area*.

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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* customer service office.)

### **Former Spouse**

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

### **Eligible Dependents**

The *subscriber* may enroll eligible dependents for coverage in this health plan under their *individual contract*. Eligible dependents must meet all of the same eligibility conditions as described above for an eligible individual. However, a dependent child may live outside of the Massachusetts *service area* 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 Blue Shield HMO Blue* within 30 days of the date of birth. (A claim for a *member’s* maternity admission may be considered by *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* not more than 30 days after the date the child would normally lose eligibility. Also, *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* receives your completed enrollment form.

- You had prior creditable health care coverage. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 health plan under an *individual contract*, you must complete an enrollment application. Send your completed application to *Blue Cross Blue Shield HMO Blue*. You must also send any other documentation or statements that *Blue Cross Blue Shield HMO Blue* may ask that you send in order for *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* is true, correct, and complete.

During the enrollment process, *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* that it needs to verify your eligibility for an *individual contract*, *Blue Cross Blue Shield HMO Blue* will deny your enrollment request. Once you are enrolled in this health plan, each year prior to your health plan renewal date, *Blue Cross Blue Shield HMO Blue* may check and verify that you are still eligible for coverage under an *individual contract*.

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

If your enrollment request is denied or your coverage is canceled, *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue*. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* policies. (If you enrolled in this health plan through the Massachusetts Health Connector, the Health Connector's policies may apply in addition to or in place of *Blue Cross Blue Shield HMO Blue* policies. If this applies to you, you must call the Health Connector directly for any questions about any membership changes you need to make such as a change to your name or address.)

## **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 Blue Shield HMO Blue* health plan or a health plan offered by Blue Cross and Blue Shield of Massachusetts, Inc. For help, you can call the *Blue Cross Blue Shield HMO Blue* customer service office. They will tell you which health plans are available to you.
- **You Move Out of Your Service Area.** Your coverage in this health plan under an *individual contract* will end when you move permanently out of your *service area*. In this case, you may be able to enroll in another Blue Cross and/or Blue Shield Plan's HMO plan. For help, you can call the *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue*. The termination date will be effective 15 days after the date that *Blue Cross Blue Shield HMO Blue* receives the termination request. Or, the *subscriber* may ask for a specific termination date. In this case, *Blue Cross Blue Shield HMO Blue* must receive the request at least 15 days before that requested termination date. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* within 35 days after it is due. If *Blue Cross Blue Shield HMO Blue* does not get the full *premium* on or before the due date, *Blue Cross Blue Shield HMO Blue* will stop claim payments as of the last date through which the *premium* is paid. Then, if *Blue Cross Blue Shield HMO Blue* does not get the full *premium* within this required time period, *Blue Cross Blue Shield HMO Blue* 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. (If you enrolled in this health plan through the Massachusetts

Health Connector, you make your payments to the Health Connector. The Health Connector will send all notices to the subscriber related to non-payment of your *premium*.)

### **Termination of Individual Coverage by Blue Cross Blue Shield HMO Blue**

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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue* is canceling your *individual contract*. *Blue Cross Blue Shield HMO Blue* 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 Blue Shield HMO Blue* 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 Blue Shield HMO Blue*.
- **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 Blue Shield HMO Blue* or Blue Cross and Blue Shield of Massachusetts, 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 Blue Shield HMO Blue* requests related to your coverage in this health plan, *Blue Cross Blue Shield HMO Blue* may terminate your coverage.
- **This Health Plan Is Discontinued.** Your coverage in this health plan will be canceled if *Blue Cross Blue Shield HMO Blue* discontinues this health plan. *Blue Cross Blue Shield HMO Blue* may discontinue this health plan for any reason as of a date approved by the Massachusetts Commissioner of Insurance.

### **Medicare Program**

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

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# Dental Blue Policy

This *Blue Cross and Blue Shield* Dental Blue Policy explains your dental benefits and the terms of your enrollment for these dental benefits. It describes your responsibilities to receive dental benefits and *Blue Cross and Blue Shield's* responsibilities to you. **This Dental Blue Policy has a *Schedule of Dental Benefits* that includes the list of *covered services* and the cost-sharing amounts you must pay for *covered services*. It also describes the *member age restriction* to receive these dental benefits.** You should read all parts of this Dental Blue Policy, including your *Schedule of Dental 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 8 of this Dental Blue Policy.

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## Blue Cross and Blue Shield of Massachusetts, Inc.

  
Sarah Iselin  
President



  
Donald Savery  
Clerk/Secretary

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

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## Dental Blue Policy (continued)

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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 nimewo Sèvis Manm nan ki sou kat Idantifikasyon w lan (Sèvis pou Malantandan TTY: 711).

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

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

**Arabic/عربي:**

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

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

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

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

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

## Dental Blue Policy (continued)

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

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

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

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

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

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

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

**Persian/پارسیان:**

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

**Lao/ພາສາລາວ:** ຂໍຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: **711**).

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

### Part 1 Dental Benefits

You will receive the dental benefits described in this Dental Blue Policy as long as:

- You are a *member* who is eligible to receive these dental benefits.
- Your dental service is a *covered service*.
- Your dental service is *necessary and appropriate* as determined by *Blue Cross and Blue Shield*.
- Your dental service conforms to *Blue Cross and Blue Shield* dental guidelines and *utilization review*.
- You use a *participating dentist* to get a *covered service* (except as noted below).

**Important Note:** The term “you” refers to the *member* who has the right to the dental benefits described in this Dental Blue Policy. **The age restriction for a *member* to receive these dental benefits is shown in your *Schedule of Dental Benefits* that is part of this Dental Blue Policy.**

#### Obtaining Services from a Participating Dentist

In most cases, the dental benefits described in this Dental Blue Policy are provided only when you get *covered services* from a *participating dentist*. **To find a *participating dentist*, you should use the most current directory of dentists for the area where you choose to get your dental care.** To find a *participating dentist* in Massachusetts or in Rhode Island, look in the most up to date Dental Blue Directory of Providers. To find a *participating dentist* in other areas, look in the most up to date Out-of-Area Dental Provider Directory. If you need help to find a *participating dentist*, you can call the *Blue Cross and Blue Shield* customer service office. Or, you can call the Physician Selection Service at 1-800-821-1388. You can also use the online provider directory search that is on the *Blue Cross and Blue Shield* internet Web site at [www.bluecrossma.org](http://www.bluecrossma.org). Before you get your dental care, you should check with your dentist to make sure he or she is still a *participating dentist*.

There will be a few times when you may not be able to use a *participating dentist*. If this does happen, *Blue Cross and Blue Shield* will provide benefits for *covered services* you get from a non-*participating dentist*. These few times include **only when:**

- You have an emergency and a *participating dentist* is not reasonably available to you.
- You are outside Massachusetts and a *participating dentist* is not reasonably available to you.
- You are a *member* with a terminal illness and your *participating dentist* is involuntarily disenrolled as a *Blue Cross and Blue Shield participating dentist* for other than quality-related reasons or fraud. In this case, *Blue Cross and Blue Shield* will continue to provide benefits for *covered services* in connection with the terminal illness until the *member's* death. (Terminally ill means the *member* is expected to live six months or less as determined by a physician.)

If you need care outside Massachusetts and you use a non-*participating dentist*, the dentist must be licensed in a jurisdiction having licensing requirements substantially similar to those in Massachusetts. And, he or she must meet the same educational and clinical standards that *Blue Cross and Blue Shield* has for a *participating dentist*. **When benefits are provided for the non-*participating dentist*, you will be responsible for the amount of the dentist's charge that is in excess of the *allowed charge*. This *balance bill* is in addition to the cost sharing amounts you must pay.**

Except as described in this section, no benefits are provided for services that are furnished by a non-*participating dentist*.

#### What You Pay for Covered Services

The cost-sharing amount you pay for a *covered service* (such as a *deductible*, a *copayment*, and/or *coinsurance*) is shown in your *Schedule of Dental Benefits*. It also describes the age restriction for a *member*

## Dental Blue Policy (continued)

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to receive these dental benefits. Do not rely on this schedule alone. Be sure to read all parts of your Dental Blue Policy to understand the requirements that you must follow to receive all of your dental benefits. You should also read the descriptions of *covered services* and the limitations and exclusions that apply for these dental benefits. These provisions are fully described in your Dental Blue Policy.

### Pre-Treatment Estimates

You do not need a pre-approval for dental services in order to get your dental benefits. But, your dentist may choose to send a pre-treatment estimate request to *Blue Cross and Blue Shield* in order to determine the extent to which your proposed dental services are covered. A pre-treatment estimate is a detailed description of the service that the dentist plans to perform and it includes the charge for the service. *Blue Cross and Blue Shield* recommends that your dentist send a pre-treatment estimate request for a service that he or she expects to cost more than \$250. *Blue Cross and Blue Shield* will let you and your dentist know about your benefits for the services reported. A pre-treatment estimate is made based on current benefits and eligibility for these benefits. A pre-treatment estimate is not a guarantee of claim payment. Your dental benefits are paid based on the benefits and eligibility provisions that are in effect at the time the service is completed and a claim is sent for payment. If your dentist does not send a pre-treatment estimate request, *Blue Cross and Blue Shield* will decide your dental benefits based on a review of those services and the standards that are considered generally accepted dental practice.

### Multi-Stage Dental Procedures

For some dental services, such as root canals and crowns, you will need to visit the dentist more than one time for it to be completed. These services will be covered by this Dental Blue Policy **only** if you are an eligible *member* on the date the *covered service* is completed. You do not have to be eligible for these benefits on the date the service is started. But, if your coverage under this Dental Blue Policy ends before the date the service is completed, no benefits are provided for the entire service.

### How Your Benefits Are Calculated

*Blue Cross and Blue Shield* calculates the payment of your dental benefits based on the *allowed charge*. The *allowed charge* depends on the type of dental provider that you use for your *covered services*.

- **Participating dentists:** For *covered services* that are furnished by a dentist who has a payment arrangement to provide dental services to eligible *members* covered by this Dental Blue Policy, *Blue Cross and Blue Shield* will calculate your benefits based on the provisions of the *participating dentist's* payment agreement and the contract rate that is in effect at the time the *covered service* is furnished. This contract rate is referred to as the dentist's *allowed charge*. **In most cases, you do not have to pay the amount of the participating dentist's actual charge that is in excess of the allowed charge.** But, there are certain times when you will have to pay the difference between the *allowed charge* and the *participating dentist's* actual charge (this is known as "*balance billing*"). You will have to pay this *balance bill* if any of the following situations happen: (1) you and your dentist decide to use a procedure that is more expensive than a less costly but approved alternative and *Blue Cross and Blue Shield* provides benefits toward the cost of the procedure with the lower fee; or (2) you could have received benefits or services from someone else without a charge or you have received or will receive payment from another person or insurance company until those benefits are used up; or (3) you receive services from more than one dentist for the same procedure or for procedures furnished in a series during a planned course of treatment and *Blue Cross and Blue Shield* has paid the amount that would have been provided had only one dentist furnished all of the services.
- **Non-participating dentists:** For *covered services* that are furnished by a non-participating dentist, *Blue Cross and Blue Shield* will calculate your dental benefits based on the usual and customary charge (also referred to as the "*allowed charge*"). The usual and customary charge is based on 80% of

the *Blue Cross and Blue Shield* Maximum Allowable Charge for each specific *covered service*, but no more than 80% of the dentist's actual charge. The usual and customary charge is less than the dentist's actual charge. **You will be responsible for the amount of the dentist's actual charge that is in excess of the usual and customary charge (known as “balance billing”).** You must pay this *balance bill* amount in addition to your cost-sharing amounts.

### Covered Services

Your *Schedule of Dental Benefits* describes the dental services that are covered by this Dental Blue Policy for eligible *members*. It also describes the age restrictions and the frequency limits for *covered services*.

### Excluded Services and Charges

No benefits are provided under this Dental Blue Policy for:

- Cast restorations, copings, or attachments for installing overdentures, including associated endodontic procedures such as root canals, precision attachments, semiprecision attachments, or copings.
- Drugs, pharmaceuticals, biologicals, or other prescription agents or products.
- Duplicate dentures or bridges.
- Fillings on tooth surfaces where a sealant was applied within the prior 12 months.
- Free care; or care that would be free if you were not covered under this Dental Blue Policy.
- Incomplete procedures or treatments.
- Lab tests or bacteriological tests.
- Labial veneers.
- Nitrous oxide or sedation.
- Nutrition counseling.
- Photographs.
- Sealants that are applied to permanent premolar or molar surfaces that have decay or fillings.
- Implants or transplants, or any related surgical or restorative procedures.
- A charge that is for, or related to, a service that *Blue Cross and Blue Shield* considers to be experimental. The service must be documented by controlled studies that determine its merits (such as its safety) and include sufficient follow-up studies.
- A charge that is for a service, supply, procedure, or appliance for reasons such as theft, abuse, misuse, misplacement, loss, improper fit, allergies, breakage, or ingestion.
- A charge for a visit that you do not keep. A dentist may charge you if you fail to keep your planned visit if you do not give his or her office reasonable notice.
- A charge for a service for which you have the right to benefits under government programs. These programs include: the Veterans Administration for an illness or injury connected to military service; and 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 to be furnished in a public facility. Except for Medicaid or Medicare, no benefits are provided if you could have received governmental benefits by applying for them on time.
- A consultation by a dentist who also performs the service.
- A method of treatment that is more costly than is usually provided. If *Blue Cross and Blue Shield* determines that your service is more costly than another acceptable alternative service, *Blue Cross and Blue Shield* will provide benefits for the least expensive but acceptable alternative service that meets your needs. In this case, you pay the difference between the *Blue Cross and Blue Shield allowed amount* and the dentist's actual charge (*balance bill*).
- A separate charge for occlusal analysis, pulp vitality testing, or pulp capping. These services are usually performed as part of another *covered service*.
- A service, supply, procedure, or appliance that is furnished along with, in preparing for, or as a result of a non-covered service.

## Dental Blue Policy (continued)

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- A service, supply, procedure, or appliance that is furnished to someone other than the patient.
- A service and a related service, supply, procedure, or appliance that is required by a third party.
- A service, supply, procedure, or appliance to stabilize teeth when it is due to periodontal disease.
- A service, supply, procedure, or appliance to diagnose or treat temporomandibular joint disorders or muscular pain, including grinding of the teeth.
- A service, supply, procedure, or appliance when its sole purpose is to increase the height of teeth or to restore occlusion.
- A service, supply, procedure, or appliance that is cosmetic in nature or meant primarily to change or improve your appearance.
- A service, supply, procedure, or appliance to treat congenital anomalies.
- Any service, supply, procedure, or appliance that is not described as a *covered service*.
- A service, supply, procedure, or appliance furnished after your termination date under this Dental Blue Policy.
- A service, supply, procedure, or appliance furnished by a dentist to himself or herself or to a member of his or her immediate family. “Immediate family” means any of the following members of a dentist’s family: spouse or spousal equivalent; parent, child, brother or sister (by birth or adoption); stepparent, stepchild, stepbrother or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law or sister-in-law (for purposes of this exclusion, an in-law relationship does not exist between the dentist and the spouse of his or her wife’s or husband’s brother or sister); and grandparent or grandchild. The immediate family members listed above will still be considered immediate family after the marriage which created the relationship is ended by divorce or death.
- A dentist’s charge for shipping and handling or taxes.
- A dentist’s charge to file a claim. Also, a dentist’s charge to transcribe or copy your dental records.

### Part 2 Member Services

#### How to Get Help for Questions

*Blue Cross and Blue Shield* can help you to understand the terms of your Dental Blue Policy. 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 as a *group member* under this Dental Blue 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 Blue Shield of Massachusetts, Member Service, P.O. Box 9134, North Quincy, MA 02171-9134.
- **If You Are Enrolled as a Direct Pay Individual Member:** If you enrolled as a *direct pay individual member* under this Dental Blue 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 Blue Shield of Massachusetts, Member Service, P.O. Box 9140, North Quincy, MA 02171-9140.

#### When You Need Help to Find a Participating Dentist

A *Blue Cross and Blue Shield* customer service representative can help you find a *participating dentist*. The toll-free phone number is shown on your ID card. Or, you can call the Physician Selection Service at 1-800-821-1388. You can also use the online provider directory “Find a Doctor” that is on the *Blue Cross and Blue Shield* internet Web site at [www.bluecrossma.org](http://www.bluecrossma.org).

#### 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 911 or your local emergency phone number. You can also see a *participating dentist* when you have a dental emergency. You should ask your dentist how to contact him or her in an emergency. If you are away from home, you can call the *Blue Cross and Blue Shield* customer service office for help to find a *participating dentist* in the area.

#### 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.

## Dental Blue Policy (continued)

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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](mailto: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](http://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](http://www.hhs.gov).

### Part 3 Claims Filing Procedures

#### Filing a Claim

Your *participating dentist* will file a claim for you when you receive a *covered service*. Just tell the *participating dentist* that you are a *member*. Show the *participating dentist* your ID card. Also, be sure to give the dentist any other information that is needed to file your claim. You must properly inform your dentist within 30 days after you receive the *covered service*. If you do not, benefits will not have to be provided. *Blue Cross and Blue Shield* will pay the *participating dentist* directly for *covered services*.

You may have to file your claim when you receive a *covered service* from a *non-participating dentist*. The *non-participating dentist* 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 the *non-participating dentist*. To file a dental claim, 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. When you have to file a claim, you can get claim forms from the *Blue Cross and Blue Shield* customer service office. *Blue Cross and Blue Shield* will mail to you all applicable forms within 15 days after receiving notice that you obtained some service or supply for which you may be paid. You must file a claim within two years of the date you received the *covered service*. *Blue Cross and Blue Shield* will not have to provide benefits for *covered services* for which a claim is submitted after this two-year period.

#### Timeliness of Claim Payments

Within 30 calendar days after *Blue Cross and Blue Shield* receives a completed request for benefits or payment, *Blue Cross and Blue Shield* will make a decision. When appropriate, *Blue Cross and Blue Shield* will make a payment to the *participating dentist* (or to you in certain cases) for your claim to the extent of your dental benefits. Or, *Blue Cross and Blue Shield* will send you and/or the dentist a notice in writing of why your claim is not being paid in full or in part. If the request for benefits or payment is not complete or, if *Blue Cross and Blue Shield* needs more information to make a final determination for the claim, *Blue Cross and Blue Shield* will ask for the information or records it needs. In this case, *Blue Cross and Blue Shield* will send their request within 30 calendar days of the date that they received the request for benefits or payment. The additional information they need must be provided to *Blue Cross and Blue Shield* within 45 calendar days of the date their request is sent. If the additional information is provided to *Blue Cross and Blue Shield* within 45 calendar days of their 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 they receive the additional information, whichever is later. If the additional information is not provided to *Blue Cross and Blue Shield* within 45 calendar days of their request, the request for benefits 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 request for benefits or payment. In this case, *Blue Cross and Blue Shield* will make a decision within 30 days as described earlier in this section.

### Part 4 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 benefits or payment for a dental service; or you disagree with how your claim was paid; or you have a complaint about the service you received from *Blue Cross and Blue Shield* or a *participating dentist*; or you are denied coverage in this Dental Blue Policy; or your Dental Blue Policy is canceled or discontinued by *Blue Cross and Blue Shield* for reasons other than nonpayment of *premium*.

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

#### What to Do if You Have a Claim Problem or Complaint

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 *Blue Cross and Blue Shield* ID card. A customer service representative will work with you to help you understand your dental benefits or to resolve your problem or concern as quickly as possible. When resolving a problem or concern, *Blue Cross and Blue Shield* will consider all aspects of the particular case. This includes looking at: all of the provisions of this Dental Blue Policy; the policies and procedures that support this Dental Blue Policy; the dental provider's input; and your understanding and expectation of dental benefits. *Blue Cross and Blue Shield* will use every opportunity to be reasonable in finding a solution that makes sense for all parties. *Blue Cross and Blue Shield* 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 the decision that is given to you, you may request a review through *Blue Cross and Blue Shield's* formal grievance program. You may also request this type of review if *Blue Cross and Blue Shield* has not responded within three working days of receiving your inquiry. If this happens, *Blue Cross and Blue Shield* will notify you and let you know the steps you may follow to request a formal grievance review.

#### When and How to Request a Formal Grievance Review

To request a formal grievance review from the *Blue Cross and Blue Shield* Member Grievance Program, 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 grievance in writing to Member Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Or, you may fax your grievance to 1-617-246-3616. *Blue Cross and Blue Shield* will let you know that your request was received by sending you a written confirmation within 15 calendar days.
- **To send an e-mail.** You may send your grievance by e-mail to *Blue Cross and Blue Shield* Member Grievance Program at [grievances@bcbsma.com](mailto: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.
- **To make a telephone call.** You may call the *Blue Cross and Blue Shield* Member Grievance Program at 1-800-472-2689. When your request is made by phone, *Blue Cross and Blue Shield* will send you a written account of the grievance within 48 hours of your phone call.

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

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

### **What to Include in a Grievance Review Request**

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

### **Choosing an Authorized Representative**

You may choose to have another person act on your behalf during the 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 services, a health care professional who has knowledge about your dental 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, he or she may appoint someone else to act as your authorized representative.

### **Who Handles the Grievance Review**

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

### **Response Time**

The review and response for *Blue Cross and Blue Shield's* formal grievance review will be completed within 30 calendar days. If your grievance review begins after an inquiry, the 30-day response time will begin on the day you tell *Blue Cross and Blue Shield* that you disagree with *Blue Cross and Blue Shield's* answer and would like a formal grievance review. Every reasonable effort will be made to speed up the review of grievances that involve dental services that are soon to be obtained by the *member*. With your permission, *Blue Cross and Blue Shield* may extend the 30-calendar-day time frame to complete a grievance review. This will happen in those cases when *Blue Cross and Blue Shield* and the *member* agree that additional time is required to fully investigate and respond to the grievance. *Blue Cross and Blue Shield*

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

### **Written Response**

Once the grievance review is completed, *Blue Cross and Blue Shield* will let you know in writing of the decision or the outcome of the review. If *Blue Cross and Blue Shield* continues to deny benefits for all or part of a service, *Blue Cross and Blue Shield* will send an explanation to you. This notice will include: information related to the details of your grievance; the reasons that *Blue Cross and Blue Shield* has denied the request and the applicable terms of your Dental Blue Policy; the specific medical and scientific reasons for which *Blue Cross and Blue Shield* has denied the request; any alternative treatment or services and supplies that would be covered; and *Blue Cross and Blue Shield* clinical guidelines that apply and were used and any review criteria.

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

### **Expedited Review for Immediate or Urgently-Needed Services**

You may have the right to request an “expedited” grievance review. You can do this when your grievance review concerns care for which waiting for a response under the grievance review time frames 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. You may also request an expedited review if your physician says you will have severe pain that cannot be adequately managed if you do not receive the care that is the subject of the grievance review. If you request an expedited review, *Blue Cross and Blue Shield* will review your grievance and notify you of the decision within 72 hours after your request is received, or such shorter time period as required by federal law.

### Part 5 Other General Provisions

#### **Access to and Confidentiality of Dental and Medical Records**

*Blue Cross and Blue Shield* and health care and dental providers may, in accordance with applicable law, have access to all of your medical and dental records and related information that is needed by *Blue Cross and Blue Shield* or the health care or dental providers. *Blue Cross and Blue Shield* may collect information from health care and dental providers or from other insurance companies or, for *group members*, from the *plan sponsor*. *Blue Cross and Blue Shield* will use this information to help them administer the benefits described in this Dental Blue Policy. They will also use it to get facts on the quality of care that is provided under this and other health care and dental plans. In accordance with law, *Blue Cross and Blue Shield* and health care and dental providers may use this information, and may disclose it to necessary persons and entities as follows: (1) for administering benefits (including coordination of benefits with other insurance or health benefit plans), disease management programs, managing care, quality assurance, utilization management, the prescription drug history program, grievance and claims review activities, or other specific business, professional, or insurance functions for *Blue Cross and Blue Shield*; (2) for bona fide medical research according to the regulations of the U.S. Department of Health and Human Services and the U.S. Food and Drug Administration for the protection of human subjects; (3) as required by law or valid court order; (4) as required by government or regulatory agencies; and (5) for *group members*, as required by the *subscriber's group* or by its auditors to make sure that *Blue Cross and Blue Shield* is administering this Dental Blue Policy properly.

*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 under this Dental Blue Policy.

**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 Dentists**

*Blue Cross and Blue Shield* is not liable for the acts or omissions by any dentist or other provider that furnishes care or services to you. A *participating dentist* or any other 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 *participating dentist* or 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 under this Dental Blue Policy 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 under this Dental Blue Policy to another person or organization. There is one exception. If Medicaid has already paid the 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 benefits under this Dental Blue Policy. 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. He or she 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. In some cases, *Blue Cross and Blue Shield* may consider your dentist to be your authorized representative. For example, *Blue Cross and Blue Shield* may tell your dentist about the extent of your dental benefits for services reported on a pre-treatment estimate or may ask your dentist for more information if more is needed to make a determination about your dental benefits. *Blue Cross and Blue Shield* will consider the dentist to be your authorized representative for emergency services. *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 this Dental Blue Policy

*Blue Cross and Blue Shield* (or the *plan sponsor* when you are a *group member*) may change the provisions of this Dental Blue Policy. For example, a change may be made to your cost-sharing amounts for certain *covered services*. When *Blue Cross and Blue Shield* makes a material change to your Dental Blue Policy, *Blue Cross and Blue Shield* will send a notice about the change at least 60 days before the effective date of the change. This notice will describe the change being made. It will also give the effective date of the change. *Blue Cross and Blue Shield* will send this notice to the *subscriber* or to the *plan sponsor* when you are enrolled as a *group member*. When you are enrolled as a *group member*, the *plan sponsor* should deliver to its *group members* all notices from *Blue Cross and Blue Shield*.

### Coordination of Benefits (COB)

*Blue Cross and Blue Shield* will coordinate payment of *covered services* with hospital, medical, dental, health, or other plans under which you are covered. *Blue Cross and Blue Shield* will do this to make sure that the cost of your health care services is not paid more than once. Other plans include: personal injury insurance; automobile insurance, including medical payments coverage; homeowner's insurance; and other plans that cover hospital or medical expenses. You must include information on your enrollment forms about other health plans under which you are covered. Once you are enrolled for coverage under this Dental Blue Policy, 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 under this Dental Blue Policy is secondary, no dental benefits will be provided until after the primary payor determines its share, if any, of the liability. *Blue Cross and Blue Shield* decides which is the primary and secondary payor. To do this, *Blue Cross and Blue Shield* relies on Massachusetts law, including the COB regulations issued by the Massachusetts Division of Insurance. A copy of these rules is available from *Blue Cross and Blue Shield*.

## Dental Blue Policy (continued)

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upon request. Unless otherwise required by law, the benefits of this Dental Blue Policy will be secondary when another plan provides you with benefits for dental services.

*Blue Cross and Blue Shield* will not provide any more dental benefits than those that are described in this Dental Blue Policy. *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 Note:** If you fail to comply with the provisions of this COB section, payment of your claim may be denied.

### Pre-Existing Conditions

Your benefits are not limited based on medical conditions that are present on or before your effective date under this Dental Blue Policy. This means that *covered services* will be covered from your effective date. There is no pre-existing condition restriction or waiting period to receive benefits. But, benefits for *covered services* are subject to all the provisions of your Dental Blue Policy.

### Quality Assurance Programs

*Blue Cross and Blue Shield* uses quality assurance and training programs and performance measures that are designed to ensure accuracy in claims processing. *Blue Cross and Blue Shield* also uses management and technology solutions to help customer service representatives resolve issues quickly and accurately.

### Subrogation and Reimbursement of Benefit Payments

If you are injured by any act or omission of another person, the benefits provided under this Dental Blue Policy 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 dental 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 Dental Blue Policy, you must complete the *Blue Cross and Blue Shield* formal grievance review. If, after you complete the grievance review, you choose to bring a legal action against *Blue Cross and Blue Shield*, you must bring this action within two years after the cause of the action arises. For example, if you are filing a legal action because you were denied a service or a claim for benefits under this Dental Blue Policy, 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 appeal of the service or claim denial. Going through the formal grievance review process does not extend the two-year limit for filing a lawsuit.

### Part 6 Group Policy

This Part 6 applies to you when you enroll as a *group member* for coverage under this Dental Blue Policy. This means that the *subscriber's group* has an agreement (a group contract) with *Blue Cross and Blue Shield* to provide its *group members* with access to the dental benefits described in this Dental Blue Policy. The *group* must pay monthly *premiums* to *Blue Cross and Blue Shield* on behalf of its *group members* for this coverage. 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 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 as a *subscriber* for *group* coverage as long as he or she meets the rules on length of service, active employment, and number of hours worked that the *plan sponsor* has set to determine eligibility for *group* coverage. For details, contact your *plan sponsor*.

#### Eligible Spouse

The *subscriber* may enroll an eligible spouse for coverage under his or her *group* membership. An “eligible spouse” includes the *subscriber's* legal spouse. A legal civil union spouse, where applicable, is eligible to enroll for coverage under the *subscriber's group* membership 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 under the *subscriber's group* membership, whether or not the judgment was entered prior to the effective date of the *subscriber's group* membership. This coverage is provided with no additional *premium* other than the normal cost of covering a current spouse. The former spouse will remain eligible for this coverage **only** until: the *subscriber* is no longer required by the judgment to provide health care coverage for the former spouse; or the *subscriber* or former spouse remarries, whichever comes first. *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 under a separate membership within the *subscriber's group*, provided the divorce judgment requires that the *subscriber* provide health care coverage for the former spouse. This is true even if the *subscriber's* new spouse is not enrolled for coverage under the *subscriber's group* membership.

### Domestic Partner

As determined by the *plan sponsor*, the *subscriber* may have the option to enroll an eligible domestic partner (instead of an eligible spouse) under his or her *group* membership. **This eligibility option applies to you only when your Dental Blue Policy includes a domestic partner rider. If your Dental Blue Policy does not include a domestic partner rider, this section does not apply to you.** A “domestic partner” is a person with whom the *subscriber* has entered into an exclusive relationship. This means that both the *subscriber* and domestic partner: are 18 years of age or older and of legal age of consent in the state where they reside; are competent to enter into a legal contract; share the same residence and must intend to continue to do so; are jointly responsible for basic living costs; are in a relationship of mutual support, caring, and commitment in which they intend to remain; are not married to anyone else; and are not related to each other by adoption or blood to a degree of closeness that would otherwise bar marriage in the state in which they live. A “domestic partner” may also include a person with whom the *subscriber* has registered as a domestic partner with any governmental domestic registry (whether or not all of the conditions stated above have been met). If the *subscriber* enrolls an eligible domestic partner under his or her *group* membership, the domestic partner’s dependent children are eligible for coverage to the same extent that the *subscriber’s* dependent children are eligible for coverage under his or her *group* membership. If the *subscriber* terminates the domestic partnership, an enrolled former domestic partner (and any enrolled children of a former domestic partner) may have the option to continue *group* coverage to the extent that federal or Massachusetts law would usually apply.

### Eligible Dependents

The *subscriber* may enroll eligible dependents for coverage under his or her *group* membership. “Eligible dependents” include the *subscriber’s* or spouse’s (or if applicable, legal civil union spouse’s or domestic partner’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 spouse (or if applicable, legal civil union spouse or domestic partner); or be a dependent on the *subscriber’s* or spouse’s (or if applicable, legal civil union spouse’s or domestic partner’s) tax return; or be a full-time student. These eligible dependents may include:

- A newborn child. The effective date of coverage for a newborn child will be the child’s date of birth provided that the *subscriber* formally notifies the *plan sponsor* within 30 days of the date of birth.
- 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 membership as of the date he or she assumes custody of a child for the purpose of adoption, the child’s dental benefits will be provided from the date of custody. This coverage is provided without a waiting period or pre-existing condition restriction.
- 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* membership. And, as long as that enrolled child is an eligible dependent, his or her children are also eligible for coverage under the *subscriber’s group* membership. The dependent child’s spouse is **not** eligible to enroll as a dependent for coverage under the *subscriber’s group* membership.

An eligible dependent may also include:

- A person under age 26 who is not the *subscriber’s* or spouse’s (or if applicable, legal civil union spouse’s or domestic partner’s) child but who qualifies as a dependent of the *subscriber* under the Internal Revenue Code. In this case, when the dependent loses his or her dependent status under the Internal Revenue Code, that dependent will continue to be eligible as a dependent under the *subscriber’s group* membership for two years after the end of the calendar year in which he or she

last qualified as a dependent under the Internal Revenue Code or until the dependent turns age 26, whichever comes first.

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

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

### Enrollment Periods for Group Coverage

#### Initial Enrollment

You may enroll for coverage under a *group* membership 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* membership. 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 under a *group* membership on your initial eligibility date, you may enroll 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 under a *group* membership on his or her initial *group* eligibility date, federal or Massachusetts law may allow the eligible employee and/or his or her eligible dependents to enroll when:

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

These rights are known as your "special enrollment rights." 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 himself or herself or an eligible dependent (including a spouse) for coverage under a *group* membership on the initial *group* eligibility date because he or she or the eligible dependent has other health plan coverage as defined by federal law. This is referred to as "qualified" coverage. In this case, the employee and the eligible dependent may enroll for coverage under

the *group* membership 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 under a *group* membership. If the new dependent is gained by birth, adoption, or placement for adoption, enrollment under the *group* membership will be retroactive to the date of birth or the date of adoption or the date of placement for adoption. But, the time requirement described below must be 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 events occur: the date you lose your other coverage; the date the *subscriber* gains a new dependent; the date 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 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 notify your *plan sponsor* and request enrollment 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 for *group* coverage. 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 *group* 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 under his or her *group* membership 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.

### Open Enrollment Period

If you choose not to enroll for *group* coverage 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 *group* coverage 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 membership to a family membership) 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* membership. **If you want to ask for a membership change or you need to change your name or mailing address, you should call or write to your *plan sponsor*.** The *plan sponsor* will send you any special forms 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 *group* coverage and they comply with the conditions outlined in this Dental Blue Policy 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 *group* coverage ends, your *group* coverage will be terminated as of the date you lose eligibility. Your eligibility for *group* coverage ends when:

- The *subscriber* loses eligibility for coverage with the *group*. This means: the *subscriber's* hours are reduced; or the *subscriber* leaves the job; or the *subscriber* no longer meets the rules that are set by the *group* for *group* coverage. 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* membership.
- 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 under a *group* membership 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 under a *group* membership once they reach age 65.
- The *plan sponsor* fails to pay the *group premium* to *Blue Cross and Blue Shield* within 30 days of the due date. In this case, *Blue Cross and Blue Shield* will notify you in writing of the termination of your *group* coverage in accordance with the Code of Massachusetts Regulations. This notice will give you information about the termination of your *group* coverage. It will also tell you about your options for coverage offered by *Blue Cross and Blue Shield* or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
- The *group* terminates (or does not renew) its *group* contract with *Blue Cross and Blue Shield*.

### **Termination of Group Coverage by the Subscriber**

Your *group* coverage will end when the *subscriber* chooses to cancel his or her *group* membership 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 will not be canceled because you are using your benefits or because you will need more *covered services* in the future. *Blue Cross and Blue Shield* will cancel your *group* coverage **only when**:

- You have committed misrepresentation or fraud to *Blue Cross and Blue Shield*. For example, you gave false or misleading information on the enrollment form. Or, you misused your ID card by letting another person who was not enrolled for *group* coverage attempt to get benefits. In this case, the termination of your *group* coverage may go back to your effective date or, it may go back to the date of the misrepresentation or fraud. The termination date will be determined by *Blue Cross and Blue Shield*, subject to applicable federal law. Or, in some cases *Blue Cross and Blue Shield* may limit your benefits.
- You commit acts of physical or verbal abuse that pose a threat to, or a threat to the health of, health care and dental 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, termination of your *group* coverage will follow the procedures approved by the Massachusetts Commissioner of Insurance.
- You fail to comply in a material way with any provisions of this Dental Blue Policy. For example, if you fail to provide information that *Blue Cross and Blue Shield* requests related to your coverage under this Dental Blue Policy, *Blue Cross and Blue Shield* may terminate your *group* coverage.
- *Blue Cross and Blue Shield* discontinues this Dental Blue Policy 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* coverage.

### **Continuation of Group Coverage**

#### **Limited Extension of Group Coverage under State Law**

If you lose eligibility for *group* coverage due to a plant closing or a partial plant closing (as defined by law) in Massachusetts, you may continue *group* coverage 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 *group* coverage. If you become eligible for coverage under another employer sponsored health plan at any time before the 39-week extension period ends, continued *group* coverage under these provisions also ends.

#### **Continuation of Group Coverage under Federal or State Law**

When you are no longer eligible for *group* coverage, 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 your *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 *group* coverage due to one of the following reasons.

- Termination of employment (for reasons other than gross misconduct).
- Reduction of work hours.
- Divorce or legal separation. (In the event of divorce or legal separation, a spouse is eligible to keep coverage under the employee's *group* membership. This is the case only until the employee is no longer required by law to provide health care coverage for the former spouse or the employee or former spouse remarries, whichever comes first. The former spouse's eligibility for continued *group*

coverage will start on the date of divorce, even if he or she continues coverage under the employee's *group* membership. While the former spouse continues coverage under the employee's *group* membership, 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* membership for an additional *premium* cost.)

- 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.

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

### **Additional Continued Group Coverage for Disabled Employees**

At the time of the employee's termination of employment or reduction in hours (or within 60 days of the qualifying event under federal law), if an employee or his or her eligible dependent is determined to be disabled under Title II or Title XVI of the Social Security Act, continued *group* coverage will be available for up to 29 months from the date of the qualifying event. The *premium* cost for the additional 11 months may be up to 150% of the *premium* rate. If during these 11 months eligibility for disability is lost, *group* coverage may cancel before the 29 months is completed. You should contact your *plan sponsor* for more help about continued *group* 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 *group* coverage as a result of a bankruptcy proceeding (Title 11 of the United States Code) is also eligible to continue *group* coverage as provided by COBRA or under Massachusetts state law. A retired employee and/or the surviving spouse of a deceased retired employee may enroll for lifetime continued *group* coverage as of the date of the bankruptcy proceeding, provided that the loss of *group* eligibility occurs within one year before the date on which the bankruptcy proceeding begins. Or, if *group* eligibility is lost within one year after the date on which the bankruptcy proceeding begins, they may enroll for lifetime continued *group* coverage as of the date *group* eligibility is lost. Spouses and/or eligible dependents of these retired employees may enroll for continued *group* coverage until the retired employee dies. Once the retired employee dies, his or her surviving spouse and/or eligible dependents may enroll for up to an additional 36 months of continued *group* coverage beyond the date of the retired employee's death. Lifetime continued *group* coverage for retired employees will end if the *group* cancels its agreement with *Blue Cross and Blue Shield* to provide its *group members* with *group* coverage or for any of the other reasons described below in "Termination of Continued Group Coverage."

### **Enrollment for Continued Group Coverage**

To enroll for continued *group* coverage, 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 *group* coverage. (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 *premium* costs.
- 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 dental benefits under this Dental Blue Policy. In this case, *group* coverage may continue under another health plan. Contact your *plan sponsor* for more information.

### Part 7 Individual Policy

This Part 7 applies to you when you are enrolled as a direct pay *member* under this Dental Blue Policy, and not as a *group member*. As a direct pay *member*, the *subscriber* has an agreement (a contract) with *Blue Cross and Blue Shield* to provide the *subscriber* and his or her enrolled eligible spouse and other enrolled eligible dependents with access to the dental benefits described in this Dental Blue Policy. The *subscriber* must pay a monthly *premium* to *Blue Cross and Blue Shield* for this coverage.

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 an 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 to enroll as a *subscriber* for direct pay coverage 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 the eligible individual who is requesting to enroll as a direct pay *subscriber* is under age 18, the enrollment form must be completed by the parent or guardian. In this case, the person who is executing the direct pay contract is not eligible for benefits under the direct pay membership. But, he or she will be responsible for acting on behalf of the *subscriber* as necessary and pay the monthly *premium* as described in this Dental Blue Policy. The person who executes the direct pay contract will be considered the *subscriber*’s authorized representative.

##### Eligible Spouse

The *subscriber* may enroll an eligible spouse for coverage under his or her direct pay membership. 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 under the *subscriber*’s direct pay membership. This coverage may continue **only** until: the *subscriber* is no longer required by the divorce judgment to provide health care coverage for the former spouse; or the *subscriber* or former spouse remarries, whichever comes first. In either case, the former spouse may wish to enroll as a *subscriber* under his or her own direct pay membership. The *Blue Cross and Blue Shield* customer service office can help you with these options. *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.

### **Domestic Partner**

The *subscriber* may have the option to enroll an eligible domestic partner (instead of an eligible spouse) for coverage under his or her direct pay membership. **This eligibility option applies only when your Dental Blue Policy includes a domestic partner rider. If your Dental Blue Policy does not include a domestic partner rider, this section does not apply to you.** A “domestic partner” is a person with whom the *subscriber* has entered into an exclusive relationship. This means that both the *subscriber* and domestic partner: are 18 years of age or older and of legal age of consent in the state where they reside; are competent to enter into a legal contract; share the same residence and must intend to continue to do so; are jointly responsible for basic living costs; are in a relationship of mutual support, caring, and commitment in which they intend to remain; are not married to anyone else; and are not related to each other by adoption or blood to a degree of closeness that would otherwise bar marriage in the state in which they live. A “domestic partner” may also include a person with whom the *subscriber* has registered as a domestic partner with any governmental domestic registry (whether or not all of the conditions stated above have been met). If the *subscriber* enrolls an eligible domestic partner under his or her direct pay membership, the domestic partner's dependent children are eligible for coverage to the same extent that the *subscriber's* dependent children are eligible for coverage under his or her direct pay membership.

### **Eligible Dependents**

The *subscriber* may enroll eligible dependents for coverage under his or her direct pay membership. 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 he or she has not moved out of Massachusetts permanently. “Eligible dependents” include the *subscriber's* or spouse's (or if applicable, legal civil union spouse's or domestic partner'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 spouse (or if applicable, legal civil union spouse or domestic partner); or be a dependent on the *subscriber's* or spouse's (or if applicable, legal civil union spouse's or domestic partner's) tax return; or be a full-time student. These eligible dependents may include:

- A newborn child. The effective date of coverage for a newborn child will be the child's date of birth provided that the *subscriber* formally notifies *Blue Cross and Blue Shield* within 30 days of the date of birth.
- 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 membership as of the date he or she assumes custody of a child for the purpose of adoption, the child's dental benefits will be provided from the date of custody. This coverage is provided without a waiting period or pre-existing condition restriction.
- 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* direct pay membership. And, as long as that enrolled child is an eligible dependent, his or her children are also eligible for coverage under the *subscriber's* direct pay membership. The dependent child's spouse is **not** eligible to enroll as a dependent for coverage under the *subscriber's* direct pay membership.

An eligible dependent may also include:

- A person under age 26 who is not the *subscriber's* or spouse's (or if applicable, legal civil union spouse's or domestic partner's) child but who qualifies as a dependent of the *subscriber* under the Internal Revenue Code. In this case, when the dependent loses his or her dependent status under the Internal Revenue Code, that dependent will continue to be eligible as a dependent under the *subscriber's* direct pay membership for two years after the end of the calendar year in which he or she last qualified as a dependent under the Internal Revenue Code or until the dependent turns age 26, whichever comes first.
- A child recognized under a 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 his or her own living and who is enrolled for coverage under the *subscriber's* direct pay membership will continue to be covered after he or she would otherwise lose dependent eligibility under the *subscriber's* direct pay membership, so long as the child continues to be mentally or physically incapable of earning his or her own living. In this case, the *subscriber* must make arrangements with *Blue Cross and Blue Shield* not more than 30 days after the date the child would normally lose eligibility. Also, *Blue Cross and Blue Shield* must be given any medical or other information that it may need to determine if the child can maintain coverage under the *subscriber's* direct pay membership. From time to time, *Blue Cross and Blue Shield* may conduct reviews that will require a statement from the attending physician. This is to confirm that the child is still an eligible disabled dependent child.

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

### Enrolling for Individual Coverage

#### Open Enrollment Period

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

#### Enrollment Process

To apply for coverage under a direct pay membership, you must complete an enrollment application and send it 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

WORDS IN ITALICS ARE EXPLAINED IN PART 8.

## Dental Blue Policy (continued)

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eligible to enroll under a direct pay membership. You must make sure that all of the information that you include on these forms is true, correct, and complete. Your right to coverage under a direct pay membership 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 under a direct pay membership. This means that when you apply for coverage, you may be required to provide evidence that you are a resident of Massachusetts. Examples of evidence to show that you are a resident can be a copy of your lease or rental agreement, a mortgage bill, or a utility bill. If you are not a citizen of the United States, *Blue Cross and Blue Shield* may also require that you provide official U.S. immigration documentation. You will also be asked to provide information about your prior health plan(s), and you may be required to provide a copy of your certificate(s) of health plan coverage. If you fail to provide information to *Blue Cross and Blue Shield* that it needs to verify your eligibility for a direct pay membership, *Blue Cross and Blue Shield* will deny your enrollment request. Once you are enrolled under a direct pay membership, each year prior to your renewal date, *Blue Cross and Blue Shield* may check and verify that you are still eligible for coverage under a direct pay membership.

*Blue Cross and Blue Shield* may deny your enrollment for coverage, or cancel your coverage, under a direct pay membership 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 under a direct pay membership.
- You committed misrepresentation or fraud to *Blue Cross and Blue Shield* about your eligibility for coverage under a direct pay membership.
- 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 under a direct pay membership 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 under a direct pay membership.

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 under a direct pay membership. This information will be made available, upon request, to the Massachusetts Commissioner of Insurance.

### **Membership Changes**

Generally, the *subscriber* may make changes (for example, change from a membership that covers only one person to a family membership) 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* direct pay Dental Blue 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 designated open enrollment period to make the change. All changes are allowed only when they comply with the conditions outlined in the Dental Blue Policy and with *Blue Cross and Blue Shield* policies.

### Termination of Individual Coverage

#### Loss of Eligibility for Direct Pay Coverage

When your eligibility for direct pay coverage ends, your direct pay coverage will be terminated as of the date you lose eligibility. Your eligibility for direct pay coverage ends when:

- You lose your status as an eligible dependent under the *subscriber's* direct pay membership.
- You move out of Massachusetts.

Each year prior to your renewal date, *Blue Cross and Blue Shield* may ask you for information to verify that you are still eligible for coverage under a direct pay membership. If you are no longer eligible for direct pay coverage or you do not provide the requested information, your coverage will be canceled as of your renewal date. *Blue Cross and Blue Shield* will send you a letter that will tell you the specific reason(s) for which your coverage under the direct pay membership is canceled.

#### Termination of Direct Pay Coverage by the Subscriber

Your direct pay coverage will end when:

- The *subscriber* chooses to cancel his or her direct pay membership. 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 his or her *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 direct pay coverage. The termination date will be the last date through which the *premium* is paid.

#### Termination of Direct Pay Coverage by Blue Cross and Blue Shield

Your direct pay coverage will not be canceled because you are using your benefits or because you will need more *covered services* in the future. *Blue Cross and Blue Shield* will cancel your direct pay coverage **only** when:

- You have committed misrepresentation or fraud to *Blue Cross and Blue Shield*. For example, you gave false or misleading information on the enrollment form. Or, you misused your ID card by letting another person who was not enrolled for coverage attempt to get benefits. In this case, the termination of your direct pay Dental Blue Policy may go back to your effective date or, it may go back to the date of the misrepresentation or fraud. The termination date will be determined by *Blue Cross and Blue Shield*. Or, in some cases *Blue Cross and Blue Shield* may limit your benefits.
- You commit acts of physical or verbal abuse that pose a threat to, or a threat to the health of, health care and dental 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 Dental Blue Policy. For example, if you fail to provide information that *Blue Cross and Blue Shield* requests related to your coverage under this Dental Blue Policy, *Blue Cross and Blue Shield* may terminate your coverage.
- *Blue Cross and Blue Shield* discontinues this Dental Blue Policy. *Blue Cross and Blue Shield* may discontinue this Dental Blue Policy for any reason as of a date approved by the Massachusetts Commissioner of Insurance.

## Dental Blue Policy (continued)

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In the event that *Blue Cross and Blue Shield* cancels your coverage, a notice will be sent to you that will tell you the specific reason(s) that *Blue Cross and Blue Shield* is canceling your direct pay coverage.

### Part 8

## Explanation of Terms

The following words are shown in italics in this Dental Blue Policy, your *Schedule of Dental Benefits*, and any *riders* that apply to your benefits under this Dental Blue Policy. The meaning of these words will help you understand your dental benefits.

### Allowed Charge (Allowed Amount)

The maximum reimbursement amount for a specific *covered service* that is used to calculate your cost-sharing amounts and payment of your dental benefits. It is the dollar amount assigned for a *covered service* based on various pricing mechanisms. In most cases when you use a *participating dentist* for *covered services*, you do not have to pay the amount of the *participating dentist's* actual charge that is in excess of the **allowed charge**. But when you use a *non-participating dentist* for *covered services*, you will have to pay the amount of the dentist's actual charge that is in excess of the **allowed charge**. **This amount is in addition to your cost-sharing amounts.** (See "How Your Benefits Are Calculated" in Part 1.)

### Balance Billing

There may be certain times when a dentist will bill you for the difference between his or her charge and the *allowed charge*. This is called *balance billing*. In most cases, a *participating dentist* cannot *balance bill* you for *covered services*. (See "How Your Benefits Are Calculated" in Part 1.) A *non-participating dentist* can *balance bill* you for costs that are in excess of the *allowed charge*. **This balance bill is in addition to your cost-sharing amounts.**

### Blue Cross and Blue Shield

Blue Cross and Blue Shield of Massachusetts, Inc. This includes an employee or designee of *Blue Cross and Blue Shield* who is authorized to make decisions or take action called for under this Dental Blue Policy. *Blue Cross and Blue Shield* has full discretionary authority to interpret this Dental Blue Policy. This includes determining the amount, form, and timing of benefits, conducting reviews to determine whether your dental care is *necessary and appropriate*, and resolving any other matters regarding your right to benefits for *covered services* as described in this Dental Blue Policy. All determinations by *Blue Cross and Blue Shield* with respect to benefits under this Dental Blue Policy will be conclusive and binding unless it can be shown that the interpretation or determination was arbitrary and capricious.

### Coinsurance

The cost you may have to pay for a *covered service* (your cost-sharing amount). A *coinsurance* will be calculated as a percentage (for example, 20%). When a *coinsurance* applies to a specific *covered service*, your cost-sharing amount will be calculated based on the *allowed charge* or the dentist's actual charge if it is less than the *allowed charge*. Your *Schedule of Dental Benefits* shows your cost-sharing amounts.

### Copayment

The cost you may have to pay for a *covered service* (your cost-sharing amount). A *copayment* is a fixed dollar amount. In most cases, a *participating dentist* will collect the *copayment* from you at the time the *covered service* is furnished. But, when the dentist's actual charge at the time of furnishing the *covered service* is less than your *copayment*, you pay only the dentist's actual charge. 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 *Schedule of Dental Benefits* shows your cost-sharing amounts.

### Covered Services

The dental care covered by this Dental Blue Policy and for which *Blue Cross and Blue Shield* will provide benefits. To be a *covered service* for benefits, each of the following conditions must be met:

- It must be listed as a *covered service* in this Dental Blue Policy; and
- The person who had the service must be a *member* who is eligible for these dental benefits; and
- The service is *necessary and appropriate* as determined by *Blue Cross and Blue Shield*; and
- The service conforms to *Blue Cross and Blue Shield* dental guidelines and *utilization review*; and
- The service is furnished by a *participating dentist* (except as noted in Part 1).

### Deductible

The cost you may have to pay for certain *covered services* before you receive dental benefits under this Dental Blue Policy. A *deductible* is calculated based on the *allowed charge* or the dentist's actual charge if it is less than the *allowed charge*. Your *Schedule of Dental Benefits* shows the amount of your *deductible*, if there is one. It also shows the *covered services* for which the *deductible* must be paid before you will receive dental benefits. There are some costs you pay that do not count toward the *deductible*. These costs that do **not** count are:

- The *copayments* and/or *coinsurance* you pay.
- The costs you pay for your Dental Blue Policy.
- The costs you pay that are more than the *allowed charge (balance billing)*.
- The costs you pay when your benefits are reduced or denied because you did not follow the requirements of your Dental Blue Policy.

### How a Family Deductible Is Calculated

When a family *deductible* applies to your dental benefits, the family *deductible* can be met by eligible costs incurred by any combination of family *members* that are covered under the same membership. But, no one *member* will have to pay more than the "per member" *deductible* amount.

### Group

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 dental benefits as described in this Dental Blue Policy. The group should deliver to its *group members* notices from *Blue Cross and Blue Shield*. The *group* is your agent and is not the agent of *Blue Cross and Blue Shield*.

### Member

A person who is enrolled and eligible for coverage under this Dental Blue Policy. A *member* may be the *subscriber* or his or her enrolled eligible spouse or any other enrolled eligible dependent.

### Necessary and Appropriate

*Covered services* must meet *Blue Cross and Blue Shield* *necessary and appropriate* criteria for coverage. *Blue Cross and Blue Shield* has the discretion to determine whether your dental care is *necessary and appropriate* for you. It will do this by referring to the following criteria:

- The dental service must be consistent with the prevention and treatment of oral disease or with the diagnosis and treatment of teeth that are decayed or fractured, or where the supporting structure is weakened by disease;
- The dental service must be furnished in accordance with standards of good dental practice; and
- The dental service is not solely for your convenience or the convenience of your dentist.

In some cases, *Blue Cross and Blue Shield* may review dental records describing your condition and treatment. *Blue Cross and Blue Shield* staff, including dental consultants, will review the treatment plan

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objectively and determine whether coverage is available under this Dental Blue Policy, and whether these services are *necessary and appropriate* for you. Based on *Blue Cross and Blue Shield's* findings, *Blue Cross and Blue Shield* may determine that a service is not *necessary and appropriate* for you, even if your dentist has recommended, approved, prescribed, ordered, or furnished the service.

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

The maximum cost-sharing amount that you will have to pay for certain *covered services*. Your *Schedule of Dental Benefits* 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-sharing amounts you pay that will count toward the *out-of-pocket maximum*. Once the cost-sharing amounts 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 *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 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 costs you pay for your Dental Blue Policy.
- The costs you pay that are more than the *allowed charge (balance billing)*.
- The costs you pay when your benefits are reduced or denied because you did not follow the requirements of this Dental Blue Policy.

### How a Family Out-of-Pocket Maximum Is Calculated

When a family *out-of-pocket maximum* applies for your dental benefits, the family *out-of-pocket maximum* can be met by eligible cost-sharing amounts paid for any combination of family *members* that are covered under the same membership. But, no one *member* will have to pay more than the “per *member*” *out-of-pocket maximum* amount.

### Participating Dentist

A dentist or dental provider group that has a written payment agreement with, or has been designated by, *Blue Cross and Blue Shield* to provide dental services to *members* enrolled under this Dental Blue Policy. This includes a hygienist employed by a *participating dentist*.

### Plan Sponsor

When you are enrolled 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 not sure who your *plan sponsor* is, you should ask the *subscriber's* employer.

### Plan Year

The period of time that may be used to calculate your *deductible* and *out-of-pocket maximum* amounts. It starts on your original effective date of coverage under this Dental Blue Policy and continues for 12 consecutive months or until your next annual renewal date (or when you are a *group member*, your *group's* next annual renewal date), whichever comes first. A new *plan year* begins each 12-month period on your renewal date. If you do not know when your *plan year* begins, you can ask *Blue Cross and Blue Shield* or, if you are a *group member*, your *plan sponsor*. Your *Schedule of Dental Benefits* shows the time frame for which the *deductible* and *out-of-pocket maximum* applies (for example, each *plan year* or each calendar year).

### Premium

The monthly cost of your coverage. Your monthly *premium* will be provided to you in the yearly evidence of coverage packet that is issued by *Blue Cross and Blue Shield*. To receive the benefits described in this

## Dental Blue Policy (continued)

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Dental Blue Policy, the *premium* owed for your coverage must be paid to *Blue Cross and Blue Shield*. Your *premium* may change from time to time. Each time *Blue Cross and Blue Shield* changes your *premium*, *Blue Cross and Blue Shield* will notify you or, when you are enrolled as a *group member*, the *subscriber's group* on your behalf before the change takes place.

### Rider

*Blue Cross and Blue Shield* or, when you are enrolled as a *group member*, your *group* may change the terms of your Dental Blue Policy. If a material change is made to your Dental Blue Policy, it is described in a *rider*. For example, a *rider* may add to or limit the benefits provided by your Dental Blue Policy. *Blue Cross and Blue Shield* will supply you with *riders* (if there are any) that apply to your dental benefits. You should keep these *riders* with this Dental Blue Policy and your *Schedule of Dental Benefits* so that you can refer to them.

### Schedule of Dental Benefits

This Dental Blue Policy includes a *Schedule of Dental Benefits*. It describes the cost-sharing amounts you must pay for each *covered service* (such as a *deductible*, or a *copayment*, or a *coinsurance*). And, it includes important information about your *deductible* and your *out-of-pocket maximum*. It also describes the benefit limits that apply for certain *covered services*. **Be sure to read all parts of this Dental Blue Policy and your *Schedule of Dental Benefits* so you can understand your dental benefits.** You should be sure to read the descriptions of *covered services* and exclusions that are described in Part 1 of this Dental Blue Policy and in your *Schedule of Dental Benefits*.

### Subscriber

The eligible person who signs the enrollment form at the time of enrollment for coverage.

### Utilization Review

The review process that *Blue Cross and Blue Shield* uses to evaluate the *necessity and appropriateness* of a dental service. To do this, *Blue Cross and Blue Shield* uses clinical guidelines and *utilization review* criteria that are designed to monitor the use of, or evaluate the clinical necessity and appropriateness of the service. This process is designed to encourage appropriate care, not less care. To develop its clinical guidelines and *utilization review* criteria, *Blue Cross and Blue Shield* assesses each service to determine that it is: consistent with the prevention and treatment of tooth decay and other forms of oral disease, or with the treatment of teeth that are decayed or fractured or where the supporting structure is weakened by disease; consistent with standards of good dental practice; and as cost effective as any established alternative. Periodically, *Blue Cross and Blue Shield* reviews its policies, clinical guidelines, and review criteria to reflect new treatments, applications, and technologies.

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