attached to and made part of
Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
Health Maintenance Organization Subscriber Certificate
HMO (1-1-2022)

Schedule of Benefits

HMO Blue New England

Total Deductible with Rx

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	
Deductible Your *deductible* per *plan year* is: This *deductible* applies to all *covered services* except preventive health services (other than vision supplies and related *covered services*), prescription drugs and supplies, and certain *covered services* as noted in this chart.	The *deductible* is the cost you have to pay for certain *covered services* during your annual coverage period before benefits will be paid for those *covered services*. $3,500 per *member* $7,000 per family The family *deductible* can be met by eligible costs incurred by any combination of *members* enrolled under the same family plan. But, no one *member* will have to pay more than the per *member deductible*.
Out-of-Pocket Maximum Your *out-of-pocket maximum* per *plan year* is: This *out-of-pocket maximum* is a total of the *deductible*, *copayments*, and *coinsurance* you pay for *covered services*.	The *out-of-pocket maximum* is the most you could pay during your annual coverage period for your share of the costs for *covered services*. $3,500 per *member* $7,000 per family The family *out-of-pocket maximum* can be met by eligible costs incurred by any combination of *members* enrolled under the same family plan. But, no one *member* will have to pay more than the per *member out-of-pocket maximum*.
Overall Benefit Maximum	None

Covered Services		**Your Cost Is:**
Admissions for Inpatient Medical and Surgical Care	· In a General Hospital	
	Hospital services	No charge after *deductible*
	Physician and other covered professional provider services	No charge after *deductible*
	· In a Chronic Disease Hospital	(same as admissions in a General Hospital)
	· In a Rehabilitation Hospital (60-day *benefit limit* per *member* per calendar year)	
	Hospital services	No charge after *deductible*
	Physician and other covered professional provider services	No charge after *deductible*

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:
Admissions for Inpatient Medical and Surgical Care (continued)	· In a Skilled Nursing Facility (100-day *benefit limit* per *member* per calendar year)	
	Facility services	No charge after *deductible*
	Physician and other covered professional provider services	No charge after *deductible*
Ambulance Services (ground or air ambulance transport)	· Emergency ambulance	No charge (*deductible* does not apply)
	· Other ambulance	No charge (*deductible* does not apply)
Cardiac Rehabilitation	*Outpatient* services	No charge after *deductible*
Chiropractor Services (for *members* of any age)	· *Outpatient* lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests
	· *Outpatient* medical care services, including spinal manipulation (a *benefit limit* does not apply)	No charge after *deductible*
Dialysis Services	*Outpatient* services and home dialysis	No charge after *deductible*, except *deductible* does not apply to home dialysis
Durable Medical Equipment	· Covered medical equipment rented or purchased for home use	No charge after *deductible*
	· One breast pump per birth (rented or purchased), including related parts and supplies	No charge (*deductible* does not apply)
		No coverage is provided for hospital-grade breast pumps.
Early Intervention Services	*Outpatient* intervention services for eligible child from birth through age two	No charge (*deductible* does not apply)
Emergency Medical Outpatient Services	· Emergency room services	No charge after *deductible*
	· Hospital outpatient department services	No charge after *deductible*
	· Office, health center, and home services	
	by your *primary care provider*; or by an OB/GYN physician or nurse midwife; or by a physician assistant or nurse practitioner designated by the health plan as primary care	No charge after *deductible*

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:
Emergency Medical Outpatient Services (continued)	· Office, health center, and home services	
	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	No charge after *deductible*
Home Health Care	Home care program	No charge (*deductible* does not apply)
Hospice Services	*Inpatient* or *outpatient* hospice services for terminally ill	No charge (*deductible* does not apply)
Infertility Services	· *Inpatient* services	See Admissions for Inpatient Medical and Surgical Care
	· *Outpatient* surgical services	See Surgery as an Outpatient
	· *Outpatient* lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests
	· *Outpatient* medical care services	See Medical Care Outpatient Visits
Lab Tests, X-Rays, and Other Tests (diagnostic services)	· *Outpatient* lab tests	
	by a general hospital	No charge after *deductible*
	by other *covered providers*	No charge after *deductible*
	· *Outpatient* x-rays and other imaging tests (other than advanced imaging tests)	
	by a general hospital	No charge after *deductible*
	by other *covered providers*	No charge after *deductible*
	· *Outpatient* advanced imaging tests (CT scans, MRIs, PET scans, nuclear cardiac imaging)	
	by a general hospital	No charge after *deductible*
	by other *covered providers*	No charge after *deductible*
	· Other *outpatient* tests and preoperative tests	
	by a general hospital	No charge after *deductible*
	by other *covered providers*	No charge after *deductible*

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:
Maternity Services and Well Newborn Care (includes $90/$45 for childbirth classes; *deductible* does not apply)	· Maternity services Facility services (*inpatient* and *outpatient covered services*)	No charge after *deductible* for *inpatient* services, otherwise no charge
	Physician and other covered professional provider services (includes delivery and postnatal care)	No charge (*deductible* does not apply)
	· Prenatal care	No charge (*deductible* does not apply)
	· Well newborn care during covered maternity admission	No charge (*deductible* does not apply)
Medical Care Outpatient Visits (includes syringes and needles dispensed during a visit)	· Office, health center, and home medical services 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	No charge after *deductible*; 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	No charge after *deductible*; all cost share waived for total of two diabetic visits per *member* per calendar year
	· Hospital outpatient medical services	No charge after *deductible*; all cost share waived for total of two diabetic visits per *member* per calendar year
	· Acupuncture services (12-visit *benefit limit* per *member* per calendar year)	No charge after *deductible*
Medical Formulas	Certain medical formulas and low protein foods	No charge (*deductible* does not apply)

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

Covered Services		Your Cost Is:
Mental Health and Substance Use Treatment	· *Inpatient* admissions in a General Hospital	
	Hospital services	No charge after *deductible*
	Physician and other covered professional provider services	No charge after *deductible*
	· *Inpatient* admissions in a Mental Hospital or Substance Use Facility	
	Facility services	No charge after *deductible*
	Physician and other covered professional provider services	No charge after *deductible*
	· *Outpatient* services	No charge after *deductible*
Oxygen and Respiratory Therapy	· Oxygen and equipment for its administration	No charge after *deductible*
	· *Outpatient* respiratory therapy	No charge after *deductible*
Podiatry Care	· *Outpatient* lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests
	· *Outpatient* surgical services	See Surgery as an Outpatient
	· *Outpatient* medical care services	See Medical Care Outpatient Visits
Prescription Drugs and Supplies Drug Formulary (includes syringes and needles) Includes Mail Order with Retail Choice Program	· Retail Pharmacy (30-day supply) Tier 1 (low cost generic): Tier 2 (other generic): Tier 3 (preferred brand): Tier 4 (non-preferred): Tier 5 (preferred brand specialty†): Tier 6 (non-preferred specialty†): †must be purchased from an approved retail specialty pharmacy	 $10 *copayment* $45 *copayment* $150 *copayment* $225 *copayment* 50% but no more than $350 per supply 50% but no more than $500 per supply 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.

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:
Prescription Drugs and Supplies (continued) 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 *deductible*, *copayment*, and/or *coinsurance* 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.	· Mail Order Pharmacy (90-day supply) Tier 1 (low cost generic): Tier 2 (other generic): Tier 3 (preferred brand): Tier 4 (non-preferred):	 $20 *copayment* $90 *copayment* $300 *copayment* $675 *copayment*
		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.
Preventive Health Services	· Routine pediatric care Routine medical exams and immunizations	No charge
	Routine tests	No charge
		These *covered services* include (but are not limited to): routine exams; immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning.
	· Preventive dental care for *members* under age 18 for treatment of cleft lip/cleft palate	No charge
	· Routine adult care Routine medical exams and immunizations	No charge
	Routine tests	No charge
		These *covered services* include (but are not limited to): routine exams; immunizations; routine lab tests and x-rays; routine mammograms (may be subject to age and frequency requirements); blood tests to screen for lead poisoning; and routine colonoscopies.

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:
Preventive Health Services (continued)	· Routine GYN care Routine GYN exams (one exam per *member* per calendar year)	No charge
	Routine Pap smear tests (one test per *member* per calendar year)	No charge
	· Family planning	No charge
	· Routine hearing care Routine hearing exams/tests	No charge
	Newborn hearing screening tests	No charge
	Hearing aids/related services for *members* of any age ($2,000 for one hearing aid per hearing-impaired ear every 36 months)	No charge
	· Routine vision care Routine vision exams (one exam per *member* every 24 months, except every 12 months until end of calendar month *member* turns age 19)	No charge
	Vision supplies/related services	See your vision supplies *rider* for coverage for *members* until end of calendar month *member* turns age 19
Prosthetic Devices	· Ostomy supplies	No charge after *deductible*
	· Artificial limb devices (includes repairs) and other external prosthetic devices	No charge after *deductible*
Radiation Therapy and Chemotherapy	· *Outpatient* hospital and free-standing radiation and chemotherapy facility services	No charge after *deductible*

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:
Radiation Therapy and Chemotherapy (continued)	· Office and health center services by your *primary care provider* or by a physician assistant or nurse practitioner designated by the health plan as primary care	No charge after *deductible*
	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	No charge after *deductible*
Second Opinions	*Outpatient* second and third opinions	See Medical Care Outpatient Visits
Short-Term Rehabilitation Therapy (physical, occupational, and speech therapy) Includes habilitation services	*Outpatient* services (separate 60-visit *benefit limits* for rehabilitation and habilitation services per *member* per calendar year for physical and occupational therapy except for autism; no *benefit limit* applies for speech therapy)	No charge after *deductible*
Speech, Hearing, and Language Disorder Treatment	· *Outpatient* diagnostic tests	See Lab Tests, X-Rays, and Other Tests
	· *Outpatient* speech therapy	See Short-Term Rehabilitation Therapy
	· *Outpatient* medical care services	See Medical Care Outpatient Visits
Surgery as an Outpatient (includes removal of impacted teeth that are fully or partially imbedded in the bone)	· *Outpatient* day surgery Hospital surgical day care unit or outpatient department services	No charge after *deductible*
	Ambulatory surgical facility services	No charge after *deductible*
	Physician and other covered professional provider services	No charge after *deductible*

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:
Surgery as an Outpatient (continued)	· Sterilization procedure for a female *member* when performed as the primary procedure for family planning reasons	No charge (*deductible* does not apply)
	· Office and health center surgical services by your *primary care provider*; or by an OB/GYN physician or nurse midwife; or by a physician assistant or nurse practitioner designated by the health plan as primary care	No charge after *deductible*; 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	No charge after *deductible*; all cost share waived for total of two diabetic visits per *member* per calendar year
TMJ Disorder Treatment	· *Outpatient* x-rays	See Lab Tests, X-Rays, and Other Tests
	· *Outpatient* surgical services	See Surgery as an Outpatient
	· *Outpatient* physical therapy	See Short-Term Rehabilitation Therapy
	· *Outpatient* 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*.

attached to and made part of
Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
Health Maintenance Organization Subscriber Certificate

Rider
Virtual Care Team Model

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

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

All other provisions remain as described in your Subscriber Certificate.

attached to and made part of
Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
Health Maintenance Organization Subscriber Certificate

Rider
Prescription Drugs

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

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.

attached to and made part of
Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
Health Maintenance Organization Subscriber Certificate

Rider

Cost Share Assistance Pharmacy Program

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**. 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.

attached to and made part of
Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
Health Maintenance Organization Subscriber Certificate

Rider
Vision Supplies

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

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

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

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

Covered Vision Supplies	**Your Cost Is:**
· Prescription lenses (one set of lenses per *member* per calendar year)	No charge after *deductible*
	These *covered services* include: glass, plastic, or polycarbonate lenses; all lens powers (single vision, bifocal, trifocal, lenticular); fashion and gradient tinting; oversized and glass-grey #3 prescription sunglass lenses; scratch resistant coating; ultraviolet protective and anti-reflective coating; blended segment lenses; intermediate vision lenses; progressive lenses; photochromic glass lenses; plastic photosensitive lenses; polarized lenses; and hi-index lenses.
· Frames (once per *member* per calendar year)	No charge after *deductible*
· Prescription contact lenses (once per *member* per calendar year, in lieu of eyeglasses)	No charge after *deductible*
	These *covered services* include elective contact lenses (conventional or disposable). Coverage for non-elective contact lenses (in lieu of other eyewear) is also provided for the *medically necessary* treatment of the following conditions: pathological myopia; aphakia; anisometropia; aniridia; corneal disorders; post-traumatic disorders; and irregular astigmatism.
· Low vision supplies	No charge after *deductible*
	Low vision is a significant loss of vision, but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the *member's* remaining vision. These *covered services* include: low vision aids such as high-power spectacles, magnifiers, and telescopes. (Benefits for low vision evaluations and follow-up care visits are provided as described for Medical Care Outpatient Visits in your Subscriber Certificate.)

Rider
Vision Supplies

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

This *rider* does not change your benefits for: routine vision exams; contact lenses that are needed to treat keratoconus or, beginning on your health plan renewal date on or after January 1, 2021, rigid gas permeable scleral contact lenses for *members* with certain conditions as outlined in the *Blue Cross 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.

Wellness Participation Program

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

Fitness Reimbursement

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

Reimbursement is provided for:

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

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

Weight Loss Program Reimbursement

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

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

How to Claim Your Reimbursement

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

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

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

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

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

attached to and made part of
Blue Cross and Blue Shield of Massachusetts, Inc.
Dental Blue Policy
BCBS-DENT (1-1-2014)

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 *deductible* each *plan year*:	$50 per *member* (no more than $150 for three or more *members* 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 *out-of-pocket maximum* each *plan year*:	$350 per *member* (no more than $700 for two or more *members* 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.

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*:
Group 1— Preventive Services and Diagnostic Services		No charge
Oral exams	· One complete initial oral exam per provider or location (includes initial history and charting of teeth and supporting structures) · Periodic or routine oral exams; twice in a calendar year · Oral exams for a *member* under age three; twice in a calendar year · Limited oral exams; twice in a calendar year	
X-rays	· Single tooth x-rays; no more than one per visit · Bitewing x-rays; twice in a calendar year · Full mouth x-rays; once in three calendar years per provider or location · Panoramic x-rays; once in three calendar years per provider or location	
Routine dental care	· Routine cleaning, minor scaling, and polishing of the teeth; twice in a calendar year · Fluoride treatments; once in 90 days · Sealants; once per tooth in three years per provider or location (sealants over restored tooth surfaces not covered) · Space maintainers	
Group 2—Basic Restorative Services		25% of *allowed charge* after *deductible*
Fillings	· Amalgam (silver) fillings; one filling per tooth surface in 12 months · Composite resin (white) fillings; one filling per tooth surface in 12 months	

Schedule of Dental Benefits (continued)

Pediatric Essential Benefits

Covered Services for Members Under Age 19		Your Cost Is*:
Group 2—Basic Restorative Services (continued)		25% of *allowed charge* after *deductible*
Root canal treatment	· Root canals on permanent teeth; once per tooth · Vital pulpotomy · Retreatment of prior root canal on permanent teeth; once per tooth in 24 months · Root end surgery on permanent teeth; once per tooth	
Crowns (see also Group 3)	· Prefabricated stainless steel crowns; once per tooth (primary and permanent)	
Gum treatment	· Periodontal scaling and root planing; once per quadrant in 36 months · Periodontal surgery; once per quadrant in 36 months	
Prosthetic maintenance	· Repair of partial or complete dentures and bridges; once in 12 months · Reline or rebase partial or complete dentures; once in 24 months · Recementing of crowns, inlays, onlays, and fixed bridgework; once per tooth	
Oral surgery	· Simple tooth extractions; once per tooth · Erupted or exposed root removal; once per tooth · Surgical extractions; once per tooth (approval required for complete, boney impactions) · Other necessary oral surgery	
Other necessary services	· Dental care to relieve pain (palliative care) · General anesthesia for covered oral surgery	
Group 3—Major Restorative Services		50% of *allowed charge* after *deductible*
Crowns	· Resin crowns; once per tooth in 60 months · Porcelain/ceramic crowns; once per tooth in 60 months · Porcelain fused to metal/high noble crowns; once per tooth in 60 months	
Tooth replacement	· Removable complete or partial dentures, including services to fabricate, measure, fit, and adjust them; once in 84 months · Fixed prosthetics, only if there is no other less expensive adequate dental service; once in 60 months	
Other necessary services	· Occlusal guards when necessary; once in calendar year · Fabrication of an athletic mouth guard	

Schedule of Dental Benefits (continued)

Pediatric Essential Benefits

Covered Services for Members Under Age 19		Your Cost Is*:
Orthodontic Services		50% of *allowed charge*
Medically necessary orthodontic care that has been preauthorized for a qualified *member*	· Braces for a *member* who has a severe and handicapping malocclusion · Related orthodontic services for a *member* who qualifies	

***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.*"