Schedule of Benefits

Preferred Blue® PPO

$2,000 Deductible

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

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

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

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

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

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

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

Overall Member Cost Share Provisions	In-Network Benefits	Out-of-Network Benefits
Deductible Your *deductible* per *plan year* is: This *deductible* applies to all *covered services* except in-network 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*.	
	\$2,000 per *member* \$4,000 per family	\$4,000 per *member* \$8,000 per family
	Your *deductible* payments will count toward both the in-network *deductible* and the out-of-network *deductible*.	
	The family *deductible* can be met by eligible costs incurred by any combination of *members* enrolled under the same family plan. But, no one *member* will have to pay more than the per *member deductible*.	
Out-of-Pocket Maximum 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*.	
	\$6,850 per *member* \$13,700 per family	\$7,500 per *member* \$15,000 per family
	Your cost-share amounts will count toward both the in-network *out-of-pocket maximum* and the out-of-network *out-of-pocket maximum*.	
	The family *out-of-pocket maximum* can be met by eligible costs incurred by any combination of *members* enrolled under the same family plan. But, no one *member* will have to pay more than the per *member out-of-pocket maximum*.	
Overall Benefit Maximum	None	

Covered Services		In-Network Benefits **Your Cost Is:**	Out-of-Network Benefits **Your Cost Is:**
Admissions for Inpatient Medical and Surgical Care	· In a General Hospital		
	Hospital services	\$250 *copayment* per admission after *deductible*	20% after *deductible*
	Physician and other covered professional provider services	No charge after *deductible*	20% after *deductible*
	· In a Chronic Disease Hospital	(same as admissions in a General Hospital)	(same as admissions in a General Hospital)
	· In a Rehabilitation Hospital (60-day *benefit limit* per *member* per calendar year)		
	Hospital services	No charge after *deductible*	20% after *deductible*
	Physician and other covered professional provider services	No charge after *deductible*	20% after *deductible*

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

Covered Services		In-Network Benefits Your Cost Is:	Out-of-Network Benefits Your Cost Is:
Admissions for Inpatient Medical and Surgical Care (continued)	· In a Skilled Nursing Facility (100-day *benefit limit* per *member* per calendar year)		
	Facility services	No charge after *deductible*	20% after *deductible*
	Physician and other covered professional provider services	No charge after *deductible*	20% after *deductible*
Ambulance Services (ground or air ambulance transport)	· Emergency ambulance	No charge after *deductible*	same as in-network benefits
	· Other ambulance	No charge after *deductible*	20% after *deductible*
Cardiac Rehabilitation	*Outpatient* services	$35 *copayment* per visit after *deductible*	20% after *deductible*
Chiropractor Services (for *members* of any age)	· *Outpatient* lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	· *Outpatient* medical care services, including spinal manipulation (a *benefit limit* does not apply)	$35 *copayment* per visit after *deductible*	20% after *deductible*
Dialysis Services	*Outpatient* services and home dialysis	No charge after *deductible*	20% after *deductible*
Durable Medical Equipment	· Covered medical equipment rented or purchased for home use	20% after *deductible*	40% after *deductible*
	· One breast pump per birth (rented or purchased)	No charge (*deductible* does not apply)	20% after *deductible*
		No coverage is provided for hospital-grade breast pumps.	
Early Intervention Services	*Outpatient* intervention services for eligible child from birth through age two	No charge (*deductible* does not apply)	No charge (*deductible* does not apply)
Emergency Medical Outpatient Services	· Emergency room services	$250 *copayment* per visit after *deductible*; *copayment* waived if held for observation or admitted within 24 hours	same as in-network benefits
	· Hospital outpatient department services	$35 *copayment* per visit after *deductible*	20% after *deductible*

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

Covered Services		In-Network Benefits Your Cost Is:	Out-of-Network Benefits Your Cost Is:
Emergency Medical Outpatient Services (continued)	· Office, health center, and home services		
	by a family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, or multi-specialty provider group; or by any physician assistant or nurse practitioner	$35 *copayment* per visit after *deductible*	20% after *deductible*
	by another specialist or other *covered provider* (non-hospital)	$35 *copayment* per visit after *deductible*	20% after *deductible*
Home Health Care	Home care program	No charge after *deductible*	20% after *deductible*
Hospice Services	*Inpatient* or *outpatient* hospice services for terminally ill	No charge after *deductible*	20% after *deductible*
Infertility Services	· *Inpatient* services	See Admissions for Inpatient Medical and Surgical Care	See Admissions for Inpatient Medical and Surgical Care
	· *Outpatient* surgical services	See Surgery as an Outpatient	See Surgery as an Outpatient
	· *Outpatient* lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	· *Outpatient* medical care services	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits
Lab Tests, X-Rays, and Other Tests (diagnostic services)	· *Outpatient* lab tests	$40 *copayment* per service date after *deductible*	20% after *deductible*
	· *Outpatient* x-rays	$50 *copayment* per service date after *deductible*	20% after *deductible*
	· *Outpatient* advanced imaging tests (CT scans, MRIs, PET scans, nuclear cardiac imaging)	$250 *copayment* per category of test per service date after *deductible*	20% after *deductible*
	· Other *outpatient* tests and preoperative tests	No charge after *deductible*	20% after *deductible*
Maternity Services and Well Newborn Inpatient Care (includes $90/$45 for childbirth classes; *deductible* does not apply)	· Maternity services		
	Facility services (*inpatient* and *outpatient covered services*)	$250 *copayment* per admission after *deductible* for *inpatient* services, otherwise no charge after *deductible*	20% after *deductible*
	Physician and other covered professional provider services (includes delivery and postnatal care)	No charge after *deductible*	20% after *deductible*

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

Covered Services		In-Network Benefits Your Cost Is:	Out-of-Network Benefits Your Cost Is:
Maternity Services and Well Newborn Inpatient Care (continued)	· Prenatal care	No charge (*deductible* does not apply)	20% after *deductible*
	· Well newborn care during enrolled mother's maternity admission	No charge (*deductible* does not apply)	20% (*deductible* does not apply)
Medical Care Outpatient Visits (includes syringes and needles dispensed during a visit)	· Office, health center, and home medical services by a family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, limited services clinic, or multi-specialty provider group; or by any physician assistant or nurse practitioner	$35 *copayment* per visit after *deductible*; all cost share waived for total of two diabetic visits per *member* per calendar year	20% after *deductible*
	by another specialist or other *covered provider* (non-hospital)	$35 *copayment* per visit after *deductible*; all cost share waived for total of two diabetic visits per *member* per calendar year	20% after *deductible*
	· Hospital outpatient medical services	$35 *copayment* per visit after *deductible*; all cost share waived for total of two diabetic visits per *member* per calendar year	20% after *deductible*
Medical Formulas	Certain medical formulas and low protein foods	See Prescription Drugs and Supplies	See Prescription Drugs and Supplies
Mental Health and Substance Abuse Treatment	· *Inpatient* admissions in a General Hospital Hospital services	$250 *copayment* per admission after *deductible*	20% after *deductible*
	Physician and other covered professional provider services	No charge after *deductible*	20% after *deductible*
	· *Inpatient* admissions in a Mental Hospital or Substance Abuse Facility Facility services	$250 *copayment* per admission after *deductible*	20% after *deductible*
	Physician and other covered professional provider services	No charge after *deductible*	20% after *deductible*
	· *Outpatient* services	$35 *copayment* per visit after *deductible*	20% after *deductible*

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

Covered Services		In-Network Benefits Your Cost Is:	Out-of-Network Benefits Your Cost Is:
Oxygen and Respiratory Therapy	· Oxygen and equipment for its administration	No charge after *deductible*	20% after *deductible*
	· *Outpatient* respiratory therapy	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits
Podiatry Care	· *Outpatient* lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	· *Outpatient* surgical services	See Surgery as an Outpatient	See Surgery as an Outpatient
	· *Outpatient* medical care services	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits
Prescription Drugs and Supplies Drug Formulary (includes syringes and needles Note: The list of value drugs is available from the health plan. These drugs are commonly prescribed for *members* with certain chronic conditions to prevent or avoid developing serious health problems.	· Retail Pharmacy (30-day supply) Tier 1 (low cost generic): Tier 2 (other generic): Tier 3 (preferred brand): Tier 4 (non-preferred):	 $25 *copayment* $50 *copayment* $150 *copayment* $225 *copayment*	 $50 *copayment* $100 *copayment* $300 *copayment* $450 *copayment*
		This cost share is waived for in-network Tier 1 and Tier 2 birth control drugs and devices; certain in-network preventive drugs as required by federal law; Tier 1, Tier 2, and Tier 3 smoking cessation drugs and aids; insulin infusion pumps; and certain orally-administered anticancer drugs.	
	· Mail Service Pharmacy (90-day supply) <u>Certain Value Drugs for Asthma, Diabetes, and Coronary Artery Disease</u> Tier 1 (low cost generic): Tier 2 (other generic): Tier 3 (preferred brand): Tier 4 (non-preferred):	 $25 *copayment* $50 *copayment* $150 *copayment* $675 *copayment*	 Not covered; you pay all charges
		These *covered services* include value drugs for depression associated with any of these conditions.	
	<u>Other Covered Drugs and Supplies</u> Tier 1 (low cost generic): Tier 2 (other generic): Tier 3 (preferred brand): Tier 4 (non-preferred):	 $50 *copayment* $100 *copayment* $300 *copayment* $675 *copayment*	 Not covered; you pay all charges
		This cost share is waived for Tier 1 and Tier 2 birth control drugs and devices; Tier 1, Tier 2, and Tier 3 smoking cessation drugs and aids; certain preventive drugs as required by federal law; 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		In-Network Benefits Your Cost Is:	Out-of-Network Benefits Your Cost Is:
Preventive Health Services	· Routine pediatric care (ten visits first year of life, three visits second year of life, two visits age 2, and one visit per calendar year age 3 and older)		
	Routine medical exams and immunizations	No charge	20% after *deductible*
	Routine tests	No charge	20% after *deductible*
		These *covered services* include (but are not limited to): routine exams; immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning.	
	· Preventive dental care for *members* under age 18 for treatment of cleft lip/cleft palate	No charge	20% after *deductible*
	· Routine adult care		
	Routine medical exams and immunizations (one exam per *member* per calendar year)	No charge	20% after *deductible*
	Routine tests	No charge	20% after *deductible*
		These *covered services* include (but are not limited to): routine exams; immunizations; routine lab tests and x-rays; routine mammograms (may be subject to age and frequency requirements); blood tests to screen for lead poisoning; and routine colonoscopies.	
	· Routine GYN care		
	Routine GYN exams (one exam per *member* per calendar year)	No charge	20% after *deductible*
	Routine Pap smear tests (one test per *member* per calendar year)	No charge	20% after *deductible*
	· Family planning	No charge	20% after *deductible*

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

Covered Services		In-Network Benefits Your Cost Is:	Out-of-Network Benefits Your Cost Is:
Preventive Health Services (continued)	· Routine hearing care Routine hearing exams/tests	No charge	20% after *deductible*
	Newborn hearing screening tests	No charge	20% after *deductible*
	Hearing aids/related services for *members* age 21 or younger ($2,000 for one hearing aid per hearing-impaired ear every 36 months)	No charge	20% after *deductible*
	· Routine vision care Routine vision exams (one exam per *member* every 24 months, except every 12 months until end of calendar month *member* turns age 19)	No charge	20% after *deductible*
	Vision supplies/related services	See your vision supplies *rider* for coverage for *members* until end of calendar month *member* turns age 19	See your vision supplies *rider* for coverage for *members* until end of calendar month *member* turns age 19
Prosthetic Devices	· Ostomy supplies	No charge after *deductible*	20% after *deductible*
	· Artificial limb devices (includes repairs) and other external prosthetic devices	20% after *deductible*	40% after *deductible*
Radiation Therapy and Chemotherapy	*Outpatient* services	No charge after *deductible*	20% after *deductible*
Second Opinions	*Outpatient* second and third opinions	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits
Short-Term Rehabilitation Therapy (physical, occupational, and speech therapy) Includes habilitation services	*Outpatient* services (separate 60-visit *benefit limits* for rehabilitation and habilitation services per *member* per calendar year for physical and occupational therapy except for autism; no *benefit limit* applies for speech therapy)	$35 *copayment* per visit after *deductible*	20% after *deductible*

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

Covered Services		In-Network Benefits Your Cost Is:	Out-of-Network Benefits Your Cost Is:
Speech, Hearing, and Language Disorder Treatment	· *Outpatient* diagnostic tests	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	· *Outpatient* speech therapy	See Short-Term Rehabilitation Therapy	See Short-Term Rehabilitation Therapy
	· *Outpatient* medical care services	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits
Surgery as an Outpatient (includes removal of impacted teeth that are fully or partially imbedded in the bone)	· *Outpatient* day surgery Hospital surgical day care unit or outpatient department services	$250 *copayment* per admission after *deductible*	20% after *deductible*
	Ambulatory surgical facility services	$250 *copayment* per admission after *deductible*	20% after *deductible*
	Physician and other covered professional provider services	No charge after *deductible*	20% after *deductible*
	· Sterilization procedure for a female *member* when performed as the primary procedure for family planning reasons	No charge (*deductible* does not apply)	20% after *deductible*
	· Office and health center surgical services by a family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, or multi-specialty provider group; or by any physician assistant or nurse practitioner	$35 *copayment* per visit after *deductible*; all cost share waived for total of two diabetic visits per *member* per calendar year	20% after *deductible*
	by another specialist or other *covered provider* (non-hospital)	$35 *copayment* per visit after *deductible*; all cost share waived for total of two diabetic visits per *member* per calendar year	20% after *deductible*
TMJ Disorder Treatment	· *Outpatient* x-rays	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	· *Outpatient* surgical services	See Surgery as an Outpatient	See Surgery as an Outpatient
	· *Outpatient* physical therapy	See Short-Term Rehabilitation Therapy	See Short-Term Rehabilitation Therapy
	· *Outpatient* medical care services	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits

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.
Preferred Blue PPO Preferred Provider Plan Subscriber Certificate

Rider
Vision Supplies

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

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

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

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

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

Rider
Vision Supplies

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

This *rider* does not change your benefits for: routine vision exams; contact lenses that are needed to treat keratoconus; or 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.

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.

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*:**
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*."

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

Preferred Blue® PPO Preferred Provider Plan

Subscriber Certificate

MASSACHUSETTS

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.

Andrew Dreyfus
President

Stephanie Lovell
Clerk/Secretary

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

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

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

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

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

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

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

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

Arabic/عربية:

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

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

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

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

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

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

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

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

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

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

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

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

Persian/پارسیان:

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

Lao/ພາສາລາວ: ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວ,ໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: **711**).

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

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Introduction

This Subscriber Certificate explains your health care coverage and the terms of your enrollment in this *Blue Cross Blue Shield HMO Blue* Preferred Blue PPO 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 Preferred Blue PPO health plan, you may enroll as a *group member* under a *group contract*. Or, you may enroll directly under an *individual contract*. The contract for coverage in this health plan is a prepaid ("insured") preferred provider plan. *Blue Cross 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.

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

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

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

Part 1

Member Services

Your Primary Care Provider

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

How to Determine a Preferred Physician's Specialty

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

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

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

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

Your Health Care Network

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

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

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

Your Identification Card

After you enroll in this health plan, you will receive an identification (ID) card. The ID card will identify you as a person who has the right to coverage in this health plan. The ID card is for identification purposes only. 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.com**. 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 9134, North Quincy, MA 02171-9134.

If You Are Enrolled as an Individual Member

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

Discrimination Is Against the Law

Blue Cross 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, One Enterprise Drive, Quincy, MA 02171-2126; or by phone at 1-800-472-2689 (TTY: 711); or by fax at 1-617-246-3616; or by email at civilrightscoordinator@bcbsma.com. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights online at ocrportal.hhs.gov; or by mail at U.S. Department of

Health and Human Services, 200 Independence Avenue, SW, Room 509F HHH Building, Washington, DC 20201; or by phone at 1-800-368-1019 or 1-800-537-7697 (TDD). Complaint forms are available at www.hhs.gov.

Your Rights under Mental Health Parity Laws

This health plan provides coverage for *medically necessary* mental health and substance abuse treatment according to federal and state mental health parity laws. The financial requirements and treatment limits for your mental health or substance abuse 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 abuse 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 abuse 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.

How You Can Request an Estimate for Proposed Covered Services

You 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.com.** 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*.

The Office of Patient Protection

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

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

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

Part 2

Explanation of Terms

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

Allowed Charge (Allowed Amount)

Blue Cross 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. If your health care provider charges you more than the *allowed amount*, you may have to pay the difference (see below).

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

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

- **For Health Care Providers Outside of Massachusetts with a Local Payment Agreement.** For health care providers outside of Massachusetts who have a payment agreement with the local Blue Cross and/or Blue Shield Plan, the *allowed charge* is the "negotiated price" that the local Blue Cross and/or Blue Shield Plan passes on to *Blue Cross 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.**

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

- **For Other Health Care Providers.** For health care providers who do not have a PPO payment agreement with *Blue Cross Blue Shield HMO Blue* or for health care providers outside of Massachusetts who do not have a payment agreement with the local Blue Cross and/or Blue Shield Plan, the *allowed charge* is based on 150% of the Medicare reimbursement rate. If there is no established Medicare reimbursement rate, the *allowed charge* is based on the amount determined by using current publicly-available data reflecting fees typically reimbursed for the *covered service*, adjusted for geographic differences. (There may be times when the Medicare reimbursement rate is not available for part of a claim for *covered services*. When this happens, the *allowed charge* will be based on the lesser of: the total of the Medicare reimbursement rate for the part for which there is a Medicare reimbursement rate plus the provider's actual charge for the part for which there is no Medicare reimbursement rate; or the amount determined by using the current publicly-available data described above for all parts of the claim for the *covered services*.) *Blue Cross Blue Shield HMO Blue* has the discretion to determine what current publicly-available data it deems applicable, by using the data maintained by a third party of its choice. In no event will the *allowed charge* be more than the health care provider's actual charge. However, the *allowed charge* may sometimes be less than the health care provider's actual charge. If this is the case, you will be responsible for the amount of the *covered provider's* actual charge that is in excess of the *allowed charge* ("*balance billing*"). This is in addition to your *deductible* and/or your *copayment* and/or your *coinsurance*, whichever applies. For this reason, you may wish to discuss charges with your health care provider before you receive *covered services*. There are a few exceptions. This provision does not apply to: *emergency medical care* such as care you receive at an emergency room of a general hospital or by hospital-based emergency medicine physicians, or as an *inpatient*; ambulance transport for *emergency medical care*; *covered services* furnished by hospital-based anesthetists, pathologists, or radiologists; or *covered services* for which there is no established *allowed charge* (such as services received outside the United States). For these *covered services*, the full amount of the health care provider's actual charge is used to calculate your claim payment.

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

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.

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

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

Blue Cross 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 he or she furnishes 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 shows the amount of your *copayment*. It also shows those *covered services* for which you must pay a *copayment*. (Also refer to *riders*—if there are any—that apply to coverage in this health plan.)

Covered Providers

To receive the highest benefit level under this health plan (your in-network benefits), you must obtain your health care services and supplies from *covered providers* who participate in your PPO health care network.

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

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

- **Hospital and Other Covered Facilities.** These kinds of health care providers are: alcohol and drug treatment facilities; ambulatory surgical facilities; chronic disease hospitals (sometimes referred to as a chronic care or long term care hospital for *medically necessary covered services*); community health centers; day care centers; detoxification facilities; free-standing diagnostic imaging facilities; free-standing dialysis facilities; free-standing radiation therapy and chemotherapy facilities; general hospitals; independent labs; 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 alcohol and drug counselor I providers; licensed applied behavioral analysts; licensed audiologists; licensed dietitian nutritionists (or a dietitian or a nutritionist or a dietitian nutritionist who is licensed or certified by the state in which the provider practices); licensed hearing instrument specialists; licensed independent clinical social workers; licensed marriage and family therapists; licensed mental health counselors; licensed speech-language pathologists; nurse midwives; nurse practitioners; occupational therapists; optometrists; physical therapists; physicians; physician assistants; podiatrists; psychiatric nurse practitioners; psychologists; and urgent care centers.

- **Other Covered Health Care Providers.** These kinds of health care providers are: ambulance services; appliance companies; cardiac rehabilitation centers; early intervention providers; home health agencies; home infusion therapy providers; hospice providers; mail service 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 *covered providers* and, when it is required, approved by *Blue Cross Blue Shield HMO Blue*.

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 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). The *Schedule of Benefits* for your plan option shows 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 the examination or analysis of tissues, liquids, or wastes from the body. These covered tests also include (but are not limited to): the taking and interpretation of 12-lead electrocardiograms; all 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-rays and other imaging tests*. These *covered services* include: fluoroscopic tests and their interpretation; and the taking and interpretation of roentgenograms and other imaging studies that are recorded as a permanent picture, such as film. Some examples of imaging tests are: magnetic resonance imaging (MRI); and computerized axial tomography (CT scans). These types of tests also include diagnostic tests that require the use of radioactive drugs.

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 abuse, 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 his or her 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 his or her 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 his or her 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.

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 overnight 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.

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.com**. (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.

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 his or her 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 drug addiction and alcoholism. The illnesses or diseases that qualify as *mental conditions* are listed in the latest edition, at the time you receive treatment, of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.

Mental Health Providers

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

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, or in other covered outpatient settings, or at home. Note: You are an *outpatient* when you are kept overnight 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.

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.

Primary Care Provider

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

Rider

Blue Cross 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 may receive all of your health care services and supplies. Your *service area* includes all counties in the Commonwealth of Massachusetts. In addition, for

those *members* who are living or traveling outside of Massachusetts (but within the United States) this health plan provides access to the local Blue Cross and/or Blue Shield Plan's PPO health care networks.

Special Services (Hospital and Facility Ancillary Services)

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

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

Subscriber

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

Urgent Care

This health plan provides coverage for *urgent care*. This is medical, surgical, or psychiatric care, other than *emergency medical care*, that you need right away. This is care that you need to prevent serious deterioration of your health when an unforeseen illness or injury occurs. In most cases, *urgent care* will be brief diagnostic care and treatment to stabilize your condition. (For purposes of filing a claim or a formal *appeal* or *grievance* review, *Blue Cross 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

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 abuse, 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.

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*.

Part 4

Utilization Review Requirements

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

Pre-Service Approval Requirements

There are certain health care services or supplies that must be approved for you by *Blue Cross Blue Shield HMO Blue*. A health care provider who participates in your health care network should request a pre-service approval on your behalf. (You must request this review if the health care provider does not start the process for you.) For the pre-service review, *Blue Cross 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.

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

Referrals for Specialty Care

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

Pre-Service Review for Outpatient Services

To receive all of your coverage for certain *outpatient* health services and supplies, you must obtain a pre-service approval from *Blue Cross 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 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 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.com. 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.

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.

Exception: If your admission is for substance abuse 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 27) 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. *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

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

Admissions for Inpatient Medical and Surgical Care

General and Chronic Disease Hospital Admissions

Except for an admission for *emergency medical care* or for maternity care, you and your health care provider must receive approval from *Blue Cross 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 39.) 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.

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.

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*. 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 34 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, any in-network *deductible*, *copayment*, and/or *coinsurance*, whichever applies to you, will be waived for a

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.

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

- Anesthesia services that are related to covered surgery. This includes those services that are furnished for you by a physician other than the attending physician; or by a certified registered nurse anesthetist.
- Radiation and x-ray therapy that is furnished for you by a physician. This includes: radiation therapy using isotopes, radium, radon, or other ionizing radiation; and x-ray therapy for cancer or when used in place of surgery.
- Chemotherapy (drug therapy for cancer) that is furnished for you by a physician.
- Interpretation of *diagnostic x-ray and other imaging tests*, *diagnostic lab tests*, and diagnostic machine tests, when these tests are furnished by a physician or by a podiatrist instead of by a hospital-based radiologist or pathologist who is an employee of the hospital. (When these services are furnished by a radiologist or pathologist who is an employee of the hospital, coverage is provided as a *special service* of the hospital.)
- Medical care that is furnished for you by a physician; or by a nurse practitioner; or by a podiatrist. This includes medical care furnished for you by a physician other than the attending physician to treat an uncommon aspect or complication of your illness or injury. This health plan will cover medical care furnished for you by two or more physicians at the same time. But, this is the case only when *Blue Cross 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

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.

admitted as an *inpatient* for *emergency medical care* and your treatment is taken over immediately by another physician.

- Pediatric specialty care. This is care that is furnished for you by a *covered provider* who has a recognized expertise in specialty pediatrics.
- Second surgical opinions. These services must be furnished for you by a physician. This includes a third opinion when the second opinion differs from the first.

Rehabilitation Hospital Admissions

You and your health care provider must receive approval from *Blue Cross 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

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.

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 taxi or chair car service; or to transport you to or from your medical appointments.

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.

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.

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 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 (except when they are covered by this health plan as a fitness benefit); 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.) In this case, once you reach the *benefit limit*, no more benefits will be provided for these services. 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.

Cleft Lip and Cleft Palate Treatment

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

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

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

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

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

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.

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; and back braces.
- Orthopedic and corrective shoes that are part of a leg brace.
- Hospital beds; wheelchairs; crutches; and walkers.
- Glucometers. These are covered when the device is *medically necessary* for you due to your type of diabetic condition. (See “Prescription Drugs and Supplies” for your coverage for diabetic testing materials.)
- Visual magnifying aids; and voice-synthesizers. These are covered only for a legally blind *member* who has insulin dependent, insulin using, gestational, or non-insulin dependent diabetes.
- Insulin injection pens. (Your benefits for these items are provided as a prescription drug benefit when you buy them from a pharmacy. See “Prescription Drugs and Supplies.”)

These *covered services* include one breast pump for each birth (other than a hospital grade breast pump) that you buy or rent from an appliance company or from a provider who is designated by *Blue Cross 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. If an in-network *deductible* and/or *coinsurance* would normally apply to these *covered services*, both the *deductible* and *coinsurance* will be waived for your in-network benefits for a covered breast pump. Or, if you choose to obtain the breast pump from a

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.

non-*preferred provider*, you must pay your *deductible*, when it applies, and 20% *coinsurance*. (If your health plan is a grandfathered health plan under the Affordable Care Act, a *deductible* and/or *coinsurance* that would normally apply to you for durable medical equipment will still apply for a covered breast pump.) No benefits are provided for a hospital grade breast pump.

From time to time, the equipment or supplies that are covered by this health plan may change. This change will be based on *Blue Cross 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.)

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 an overnight observation stay or being admitted for *inpatient* care within 24 hours. (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.

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.

Home Health Care

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

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

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

No benefits are provided for: meals, personal comfort items, and housekeeping services; *custodial care*; treatment of *mental conditions*; 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 his or her 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.

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.

Infertility Services

This health plan covers services to diagnose and treat infertility for a *member* who has not been able to conceive or produce conception during a period of one year. *Blue Cross Blue Shield HMO Blue* may approve coverage for infertility services in two other situations: when the *member* has been diagnosed with cancer and, after treatment, the *member* is expected to become infertile; or when a *member* is age 35 or older and has not been able to conceive or produce conception during a period of six months. 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 assessment criteria*.** (See page 15 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.

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

Coverage for Prescription Drugs

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

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

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.

(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 when they are furnished for you by a *covered provider*. This coverage includes:

- *Diagnostic lab tests*.
- Diagnostic machine tests such as pulmonary function tests and holter monitoring.
- *Diagnostic x-ray and other imaging tests*.
- 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. These tests include: *diagnostic lab tests*; *diagnostic x-ray and other imaging tests*; and diagnostic machine tests (such as pulmonary function 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 Inpatient 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.

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.

- Delivery of one or more than one baby. This includes prenatal and postnatal medical care that is furnished for you by a physician; or by a nurse midwife. Your benefits for prenatal and postnatal medical care that is 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 when they are furnished for you by a general hospital; or by a community health center. Your benefits for these services are based on the date the care is received.
- Standby attendance that is furnished for you by a physician (who is a pediatrician), when a known or suspected complication threatening your health or the health of your child requires that a pediatrician be present during the delivery.
- Childbirth classes for up to $90 for one childbirth course for each covered pregnant *member* and up to $45 for each refresher childbirth course. Pregnant *members* are encouraged to attend the childbirth course that is recommended by their physician or by their health care facility or by their nurse midwife. You must pay the full cost of the childbirth course. After you complete the course, call the *Blue Cross 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 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.

Well Newborn Inpatient Care

This health plan covers well newborn care when it is furnished during the covered *inpatient* maternity stay. 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 from the hospital 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.

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.

Medical Care Outpatient Visits

This health plan covers *outpatient* care to diagnose or treat your medical condition when the services or supplies are furnished for you by a *covered provider*. This may include (but is not limited to): a physician; or a nurse practitioner; or an optometrist; or a licensed dietitian nutritionist. These services may be furnished in the provider's office or at a covered facility or, as determined appropriate by *Blue Cross 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 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 a physician. Refer to the *Schedule of Benefits* for your plan option for your cost share amount when you receive *covered services* at a limited services clinic.
- Medical exams and contact lenses that are needed to treat keratoconus. This includes the cost of the fitting of these contact lenses.
- 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.
- Allergy testing. (This includes tests that you need such as PRIST, RAST, and scratch tests.)
- Injections. This includes the administration of injections that you need such as allergy shots or other *medically necessary* injections. 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* 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

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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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.com**.

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

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

Telehealth Services

This health plan also covers certain health care services you receive from a *Blue Cross Blue Shield HMO Blue* approved telehealth physician or practitioner using a telecommunications system. The telehealth provider will use an audio and video telecommunications system that permits a two-way, real-time communication between you and your health care provider. These telehealth services are available when you prefer not to go to a physician's office or a health facility for an in-person visit for any reason. You may see a telehealth provider online or by mobile device 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 have a general health and wellness concern. For covered telehealth services, your in-network cost share (such as *deductible*, *copayment*, and/or *coinsurance*) is the same as the lowest cost share level for a preferred physician's office visit. Or, if you use an approved telehealth provider that does not have a PPO payment agreement for your health plan, you will pay the out-of-network *coinsurance* after any *deductible*. **To find a telehealth provider approved by *Blue Cross Blue Shield HMO Blue*, you can look in your provider**

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directory. Or, you can call the *Blue Cross Blue Shield HMO Blue* customer service office for help at the toll-free number shown on your health plan ID card.

No benefits are provided for telehealth services furnished by a physician or other health care provider that is not approved by *Blue Cross Blue Shield HMO Blue* as a telehealth provider for your health plan.

Medical Formulas

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

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

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

Mental Health and Substance Abuse 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 abuse disorders (drug addiction and alcoholism); 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 he or she interacts with others.) If a child who is under age 19 is receiving an ongoing course of treatment, this coverage will continue to be provided after the child's 19th birthday until that ongoing

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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*; and services and/or programs that are not *medically necessary* to treat your *mental condition*. Services and programs that are not covered by this health plan, and that do not constitute intermediate care, include (but are not limited to): services that are performed in educational, vocational, or recreational settings; and "outward bound-type," "wilderness," "camp," or "ranch" programs. These types of non-covered programs may be in residential or nonresidential settings. They may include therapeutic elements and/or clinical staff services as well as vocational, educational, problem solving, and/or recreational activities. These programs may have educational accreditation. The staff may include some licensed mental health providers who may provide some therapy. No benefits are provided for any services furnished along with one of these non-covered programs. For example, no benefits are provided for therapy and/or psychotherapy furnished along with one of these non-covered programs.

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*; 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, clinically managed detoxification services, or crisis stabilization services. 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, or in-home therapy services. Your coverage for these services is considered to be an *outpatient* benefit.

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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*.

You may also receive mental health and substance abuse care from a *Blue Cross Blue Shield HMO Blue* approved physician or practitioner using a telecommunications system. The telehealth provider will use an audio and video telecommunications system that permits a two-way, real-time communication between you and your health care provider. These telehealth services are available when you prefer not to go to a physician's office or a health facility for an in-person visit for any reason. You may see a telehealth provider online or by mobile device when you need care for conditions or symptoms such anxiety and depression. For covered telehealth services, your cost share (such as *deductible*, *copayment*, and/or *coinsurance*) is the same cost share that you would pay for an office visit for mental health and/or substance abuse care. **To find a telehealth provider approved by *Blue Cross Blue Shield HMO Blue*, you can look in your provider directory. Or, you can call the *Blue Cross Blue Shield HMO Blue* customer service office for help at the toll-free number shown on your health plan ID card.** No benefits are provided for telehealth services furnished by a physician or other health care provider that is not approved by *Blue Cross Blue Shield HMO Blue* as a telehealth provider for your health plan.

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.

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*

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tests; diagnostic x-rays; surgery and necessary postoperative care; and other *medically necessary* foot care such as treatment for hammertoe and osteoarthritis.

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

Prescription Drugs and Supplies

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.com**.

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.com**.

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.

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, 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.com**.

Mail Service 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 service pharmacy. To find out if your covered drug or supply qualifies for the mail service pharmacy benefit, you can check with the mail service pharmacy. Or, you can call the *Blue Cross Blue Shield HMO Blue* customer service office.

Covered Drugs and Supplies
This drug coverage is provided for:

- Drugs that require a prescription by law and are furnished in accordance with *Blue Cross Blue Shield HMO Blue medical technology assessment criteria*. These covered drugs include: birth control drugs; oral diabetes medication that influences blood sugar levels; hormone replacement therapy drugs for peri- and post-menopausal *members*; certain drugs used on an off-label basis (such as: drugs used to treat cancer; and drugs used to treat HIV/AIDS); abuse-deterrent opioid drug products on a basis not less favorable than non-abuse deterrent opioid drug products; oral antibiotics for the treatment of Lyme disease; and drugs for HIV associated lipodystrophy syndrome.
- Injectable insulin and disposable syringes and needles needed for its administration, whether or not a prescription is required. (When a *copayment* applies to your pharmacy coverage, if insulin, syringes, and needles are bought at the same time, you pay two *copayments*: one for the insulin; and one for the syringes and needles.)
- Materials to test for the presence of sugar when they are ordered for you by a physician for home use. These include (but are not limited to): blood glucose monitoring strips; ketone strips; lancets; urine glucose testing strips; normal, low, and high calibrator solution/chips; and dextrostik or glucose test strips. (You may obtain these testing supplies from a covered pharmacy or appliance company.) See "Durable Medical Equipment" for your coverage for glucometers.

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.

- 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.com**.
- Prescription birth control drugs and contraceptive methods (such as diaphragms) that have been approved by the U.S. Food and Drug Administration (FDA). 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), unless 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.
- Prescription prenatal vitamins and pediatric vitamins with fluoride.
- Prescription dental topical fluoride, rinses, and gels.
- Smoking and tobacco cessation drugs and aids (such as nicotine gum and patches) for two 90-day treatments for each *member* in each calendar year, when they are prescribed for you by a health care provider. Your cost share will be waived for generic drugs and aids (or for a preferred brand-name drug or aid 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 drug or aid 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.

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

Non-Covered Drugs and Supplies

No benefits are provided for:

- Anorexiants; non-sedating antihistamines; ophthalmic drug solutions to treat allergies; inhaled topical nasal steroids; or proton pump inhibitors obtained on or after January 1, 2019, except for prescription proton pump inhibitors that are prescribed for *members* under age 18 or that are prescribed as part of a combination drug used to treat helicobacter pylori. From time to time, *Blue Cross 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,

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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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.com**.

- Pharmaceuticals that you can buy without a prescription, except as described in this Subscriber Certificate or in your Pharmacy Program booklet.
- Medical supplies such as dressings and antiseptics.
- The cost of delivering drugs to you.
- Combination vitamins that require a prescription, except for: prescription prenatal vitamins; and pediatric vitamins with fluoride.
- Drugs and supplies that you buy from a non-designated mail service 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.

Preventive Health Services

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

Routine Pediatric Care

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

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

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.

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

Important Note: You have the right to full in-network coverage (provided the services are furnished by a *preferred provider*) for preventive health services as required by the Affordable Care Act and related regulations. For a complete description of these preventive health services, you can call the *Blue Cross 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.com**. 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.

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 34). This coverage includes (but is not limited to) periodic oral exams, cleanings, and fluoride treatments furnished by a dentist or other *covered provider*.

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

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

- Routine medical exams and related routine lab tests and x-rays. Your coverage for a routine physical exam is limited to one visit for each *member* in a calendar year.
- Appropriate immunizations as recommended by the Advisory Committee on Immunization Practices. This coverage includes, but is not limited to: flu shots; and travel immunizations.
- Blood tests to screen for lead poisoning as required by state law.
- Routine mammograms. This coverage is limited to 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.
- Routine prostate-specific antigen (PSA) blood tests. This coverage is limited to one test each calendar year for a *member* who is age 40 or older.
- Routine sigmoidoscopies and barium enemas.
- Routine colonoscopies.
- Preventive health services and screenings as recommended by the U.S. Preventive Services Task Force and the U.S. Department of Health and Human Services.
- Other routine services furnished in line with *Blue Cross Blue Shield HMO Blue medical policies*.

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.

Important Note: You have the right to full in-network coverage (provided the services are furnished by a *preferred provider*) for preventive health services as required by the Affordable Care Act and related regulations. For a complete description of these preventive health services, you can call the *Blue Cross 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.com**. The provisions described in this paragraph do not apply to you if your health plan is a grandfathered health plan under the Affordable Care Act.

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

Women's Preventive Health Services
All female *members* have coverage for women's preventive health services as recommended by the U.S. Department of Health and Human Services. These types of preventive health services include: yearly well-woman visits; domestic violence screening; human papillomavirus (HPV) DNA testing; screening for human immunodeficiency virus (HIV) infection; birth control methods and counseling (see "Family Planning"); screening for gestational diabetes; and breastfeeding support and breast pumps (see "Durable Medical Equipment"). For a complete description of these covered preventive health services, you can call the *Blue Cross 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.com. **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 levonorgestrel implant system. This includes the implant system itself.

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

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

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 Inpatient Care" for your *inpatient* coverage for newborn hearing screening tests.)

- **Hearing Aids and Related Services for Members Age 21 and Younger.** This includes hearing aids and *covered services* related to a covered hearing aid when the *covered services* are furnished by a *covered provider*, such as a licensed audiologist or licensed hearing instrument specialist, for a *member* age 21 or younger (from birth through age 21). 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. **Your coverage for the hearing aid device itself is limited to $2,000 for one hearing aid for each hearing-impaired ear every 36 months.** If you choose a hearing aid device that costs more than this $2,000 *benefit limit*, you will have to pay the balance of the cost of the device that is in excess of the *benefit limit*. (This *benefit limit* does not apply for any *covered services* related to the hearing aid.) No benefits are provided for replacement hearing aid batteries.

Routine Vision Care

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

Vision Supplies

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

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

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

Wellness Rewards

While you are enrolled in this health plan, you may be eligible to receive wellness rewards for some fees that you pay to participate in qualified fitness programs and/or weight loss programs.

(When you are enrolled in this health plan as a *group member*, your *group* may exclude these Wellness Rewards health benefits from your *group* health plan and instead may provide a separate Wellness Participation Program to you, as permitted by law. If this applies to you, your yearly evidence of coverage packet will include this information.)

- **Fitness Benefit.** Your health plan will reimburse you for your costs for monthly membership fees for three consecutive months of one family or individual health club membership or, as an alternative, for up to 10 fitness classes taken by any combination of *subscriber*, spouse, and/or dependent children enrolled under the same *Blue Cross Blue Shield HMO Blue* plan, at a qualified health club during a calendar year. You can claim this fitness benefit once each calendar year. For information about what you need to do to be eligible for this fitness benefit and how to claim your fitness benefit, refer to your fitness program benefit materials. This fitness benefit applies for fees paid to: privately-owned or privately-sponsored health clubs or fitness facilities, including individual health clubs and fitness centers; YMCAs; YWCAs; Jewish Community Centers; and municipal fitness centers. No fitness benefit is provided for any health club initiation fees or fees or costs that you pay for: personal training sessions; country clubs; social clubs (such as ski or hiking clubs); sports teams or leagues; spas; instructional dance studios; and martial arts schools.

- **Weight Loss Program Benefit.** Your health plan will reimburse you for your costs for up to three months for participation in qualified weight loss program(s) each calendar year. A qualified weight loss program is a hospital-based weight loss program or a non-hospital-based weight loss program designated by *Blue Cross Blue Shield HMO Blue*. You can claim this three-month weight loss program benefit once each calendar year for any combination of *members* (such as the *subscriber*, spouse, and/or dependent children) enrolled under the same *Blue Cross Blue Shield HMO Blue* plan. To find out which weight loss program(s) are designated by *Blue Cross Blue Shield HMO Blue*, you can log on to the *Blue Cross Blue Shield HMO Blue* Web site at **www.bluecrossma.com**. Or, 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. No weight loss program benefit is provided for any fees or costs that you pay for: online weight loss programs; any non-hospital-based weight loss program not designated by *Blue Cross Blue Shield HMO Blue*; individual nutrition counseling sessions (see "Medical Care Outpatient Visits" for your coverage for nutritional counseling); pre-packaged meals, books, videos, scales, or other items or supplies bought by the *member*; and any other items not included as part of a weight loss class or weight loss course.

To receive your fitness benefit and/or your weight loss program benefit, you must file a claim no later than March 31st after the year for which you are claiming your benefit. If you file your claim during the calendar year for which you are claiming your benefit, the date on which you file the claim will be considered the incurred date. But, if you file your claim after the year for which you are claiming your benefit, the incurred date will be shown as December 31st of the prior year. This means that the incurred date reflects the

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

calendar year for which you are claiming your benefit. To file a claim, you must: fill out a claim form; attach your original itemized paid receipt(s); and mail the claim to *Blue Cross Blue Shield HMO Blue*. For a claim form or help to file a claim, 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.com** to print a claim form.

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.
- 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.

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.

Qualified Clinical Trials for Treatment of Cancer

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

No benefits are provided for:

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

Other Approved Clinical Trials

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

Radiation Therapy and Chemotherapy

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

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

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.

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

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.com**.

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

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

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.

option describes the separate *benefit limits* that apply for these *covered services*. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.)

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

Speech, Hearing, and Language Disorder Treatment

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

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

Surgery as an Outpatient

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

- Routine circumcision.
- Voluntary termination of pregnancy (abortion).
- Voluntary sterilization procedures. To provide coverage for the women's preventive health services as recommended by the U.S. Department of Health and Human Services, any in-network *deductible*, *copayment*, and/or *coinsurance*, whichever applies to you, will be waived for a sterilization procedure furnished for a female *member* when it is performed as the primary procedure for family planning reasons. Or, if you choose to have this service performed by a non-*preferred provider*, you must pay your *deductible*, when it applies, and 20% *coinsurance*. This provision does not apply to you if your health plan is a grandfathered health plan under the Affordable Care Act. 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

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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 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 34 for the treatment of conditions of cleft lip and cleft palate.)

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.

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

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

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

· Necessary postoperative care that you receive after covered *inpatient* or *outpatient* surgery.
· Anesthesia services that are related to covered surgery. This includes anesthesia that is administered by a physician other than the attending physician; or by a certified registered nurse anesthetist.
· Restorative dental services and orthodontic treatment or prosthetic management therapy for a *member* who is under age 18 to treat conditions of cleft lip and cleft palate. (See page 34 for more information.) If a *copayment* normally applies for office surgery, the office visit *copayment* will be waived for these *covered services*. Any *deductible* and *coinsurance* will still apply.

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

Coverage for Self Injectable and Certain Other Drugs Furnished in an Office or Health Center
There are self injectable and certain other prescription drugs used for treating your medical condition that are covered by this health plan only when these covered drugs are furnished by a covered pharmacy, even when a non-pharmacy health care provider administers the covered drug for you during a covered office or health center visit. For your coverage for these drugs, see "Prescription Drugs and Supplies." **No benefits are provided for the cost of these drugs when the drug is furnished by a non-pharmacy health care provider.** For a list of these drugs, you can call the *Blue Cross 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.com**. (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.)

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.

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.

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

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

Part 6

Limitations and Exclusions

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

Admissions That Start Before Effective Date

This health plan provides coverage only for those *covered services* that are furnished on or after your *effective date*. If you are already an *inpatient* in a hospital (or in another covered health care facility) on your *effective date*, you or your health care provider must call *Blue Cross 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, as defined in *BlueCross 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: acupuncture; 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 an educational, vocational, or recreational setting; or an "outward bound-type," "wilderness," "camp," or "ranch" program. Also, a service furnished along with one of these non-covered programs, whether or not the service is usually a *covered service*.
- 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 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 or taxes.
- 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*.

Personal Comfort Items

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

Private Room Charges

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

Services and Supplies Furnished After Termination Date

No benefits are provided for services and supplies that are furnished after your termination date in this health plan. There is one exception. This health plan will continue to provide coverage for *inpatient covered services*, but only if you are receiving covered *inpatient* care on your termination date. In this case, coverage will continue to be provided until all the benefits allowed by your health plan have been used up or the date of discharge, whichever comes first. But, this does not apply if your coverage in this health plan is canceled for misrepresentation or fraud.

Services Furnished to Immediate Family

No benefits are provided for a *covered service* that is furnished by a health care provider to himself or herself or to a member of his or her 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 his or her wife's (or husband's) brother or sister.)

· Grandparent or grandchild.

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

Part 7

Other Party Liability

Coordination of Benefits (COB)

Blue Cross 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.

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

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, 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

You may choose to have another person act on your behalf concerning your health care coverage in this health plan. You must designate this person in writing to *Blue Cross Blue Shield HMO Blue*. Or, if you are not able to do this, a person such as a conservator, a person with power of attorney, or a family member may be your authorized representative. 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. You can get a form to designate an authorized representative from the *Blue Cross Blue Shield HMO Blue* customer service office. (See Part 1.)

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*.)

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 **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 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* 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), Floating Hospital for Children at Tufts Medical Center, Nashoba Valley Medical Center, and Massachusetts Eye and Ear Infirmary.
- You would normally pay the highest in-network cost share amount for *covered services* furnished at the comprehensive cancer or pediatric facility where you are receiving your care; or the comprehensive cancer or pediatric facility is not in the health plan's network.
- 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* tiered network plan, **but only when** your *group* offers you a choice to enroll only in a tiered network plan in which your comprehensive cancer or pediatric facility is at the highest cost share level or it is not part of the health plan's network; 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.com**. Just follow the steps to request a form.

If *Blue Cross Blue Shield HMO Blue* determines you are eligible for this coverage, your cost share amount will be at the second highest in-network 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 in-network 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-Preferred Providers

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

- You receive *emergency medical care.*
- You receive *covered services* that are not reasonably available from a *preferred provider* (see "*covered provider*" in Part 2 of this Subscriber Certificate) and you had prior approval from *Blue Cross Blue Shield HMO Blue* to obtain these *covered services*. Or, you receive *covered services* from a *covered provider* before a preferred network is established for that type of provider.
- You are traveling outside of Massachusetts and you receive *covered services* from a type of *covered provider* for which the local Blue Cross and/or Blue Shield Plan has not, in the opinion of *Blue Cross Blue Shield HMO Blue*, established an adequate PPO health care network.
- You receive *medically necessary covered services* while you are at a preferred hospital or other preferred facility and you do not have a reasonable opportunity to choose to have your *covered services* furnished by a *preferred provider*. For example, you receive *covered services* from a non-preferred hospital-based anesthetist, pathologist, or radiologist while you are at a preferred hospital.
- You are a *member* who is in the second or third trimester of pregnancy and your health care provider is involuntarily disenrolled from your health care network for a reason other than a quality-related reason or fraud. 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 postnatal visit.
- You are a *member* with a terminal illness and your health care provider is involuntarily disenrolled from your health care network for a reason other than a quality-related reason or fraud. 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.)
- 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 postnatal visit or, for a *member* with a terminal illness, until the *member's* death. (For a *member* with a terminal illness, this coverage is provided only when the *member* is expected to live six months or less as determined by a physician.)

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

Services in a Disaster

Blue Cross Blue Shield HMO Blue is not liable if events beyond its control—such as war, riot, public health emergency, 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.

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

When the Provider Files a Claim

The health care provider will file a claim for you when you receive a *covered service* from a *covered provider* who has a payment agreement with *Blue Cross Blue Shield HMO Blue*. Or, for *covered services* you receive outside of Massachusetts, a health care provider will file a claim for you when he or she 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 *covered provider* who does not have a payment agreement with *Blue Cross Blue Shield HMO Blue* or a *covered provider* outside of Massachusetts who does not have a payment agreement with the local Blue Cross and/or Blue Shield Plan. The health care provider may ask you to pay the entire charge at the time of the visit or at a later time. It is up to you to pay your health care provider. To file a claim to *Blue Cross 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 two years 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 two-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

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 representative) have three options:

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

of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Or, you may fax your request to 1-617-246-3616. *Blue Cross 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**.

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. You must designate this person in writing to *Blue Cross Blue Shield HMO Blue*. Or, if you are not able to do this, a person such as a conservator, a person with power of attorney, or a family member may be your authorized representative. Or, he or she may appoint another party to be the authorized representative. (When you are an *inpatient*, a health care provider may act as your authorized representative to ask for an expedited review. In this case, you do not have to designate the health care provider in writing.)

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 decisions regarding the subject of your review, 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 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 representative) are requesting an expedited external review at the same time you (or your authorized 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 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 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 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**.

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 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 representative) will be notified of the name of the review agency. This notice will also state whether or not your case is being reviewed on an expedited basis. This notice will also be sent to *Blue Cross 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 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 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.

Appeals Process for Rhode Island Residents or Services

You may also have the right to *appeal* as described in this section when your claim is denied as being not *medically necessary* for you. If so, these rights are in addition to the other rights to *appeal* that you have as described in other parts of this Subscriber Certificate. The following provisions apply only to:

- A *member* who lives in Rhode Island and that *member* is planning to obtain services which *Blue Cross Blue Shield HMO Blue* has determined are not *medically necessary*.
- A *member* who lives outside of Rhode Island and that *member* is planning to obtain services in Rhode Island which *Blue Cross Blue Shield HMO Blue* has determined are not *medically necessary*.

Blue Cross Blue Shield HMO Blue decides which *covered services* are *medically necessary* for you by using its *medical necessity* guidelines. Some of the services that are described in this Subscriber Certificate may not be *medically necessary* for you. **If *Blue Cross Blue Shield HMO Blue* has determined that a service is not *medically necessary* for you, you have the right to the following *appeals* process:**

Reconsideration
A reconsideration is the first step in this process. If you receive a letter from *Blue Cross Blue Shield HMO Blue* that denies payment for your health care services, you may ask that *Blue Cross Blue Shield HMO Blue* reconsider its decision. You must do this by writing to: Member Appeal and Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. You must send your request within 180 days of *Blue Cross Blue Shield HMO Blue's* adverse decision. Along with your letter, you should include any information that will support your request. *Blue Cross Blue Shield HMO Blue* will review your request. *Blue Cross Blue Shield HMO Blue* will let you know the outcome of your request within 15 calendar days after it has received all information needed for the review.

Appeal
An *appeal* is the second step in this process. If *Blue Cross Blue Shield HMO Blue* continues to deny coverage for all or part of the original service, you may request an *appeal*. You must do this within 60 days of the date that you receive the reconsideration denial letter from *Blue Cross Blue Shield HMO Blue*. Your *appeal* request should include any information that supports your *appeal*. You may also inspect and add information to your *Blue Cross Blue Shield HMO Blue* case file to prepare your *appeal*. In accordance with

Rhode Island state law, if you wish to review the information in your *Blue Cross Blue Shield HMO Blue* case file, you must make your request in writing and you must include the name of a physician who may review your case file on your behalf. Your physician may review, interpret, and disclose any or all of that information to you. Once received by *Blue Cross Blue Shield HMO Blue*, your *appeal* will be reviewed by a health care provider in the same specialty as your attending provider. *Blue Cross Blue Shield HMO Blue* will notify you of the outcome of your *appeal* within 15 calendar days after it has received all information needed for the *appeal*.

External Appeal
If your *appeal* is denied, you have the right to present your case to an appeals agency that is designated by Rhode Island and not affiliated with *Blue Cross Blue Shield HMO Blue*. If you request this voluntary external *appeal*, Rhode Island requires that you pay for half of the cost of the *appeal* and *Blue Cross Blue Shield HMO Blue* will pay for the remaining half. The notice you receive from *Blue Cross Blue Shield HMO Blue* about your *appeal* will advise you of: the name of the appeals agency that is designated by Rhode Island; and your share of the cost for an external *appeal*. To file an external *appeal*, you must make your request in writing to: Member Appeal and Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Along with your request, you must: state your reason(s) for your disagreement with *Blue Cross Blue Shield HMO Blue's* decision; and enclose a check made payable to the designated appeals agency for your share of the cost for the external *appeal*.

Within five working days after *Blue Cross Blue Shield HMO Blue* receives your written request and payment for the *appeal*, *Blue Cross Blue Shield HMO Blue* will forward your request to the external appeals agency. *Blue Cross Blue Shield HMO Blue* will also send its portion of the fee and your entire *Blue Cross Blue Shield HMO Blue* case file. The external appeals agency will notify you in writing of the decision within ten working days of receiving all necessary information.

Expedited Appeal
If your situation is an emergency, you have the right to an "expedited" *appeal* at all three levels of *appeal* as stated above. An emergency is defined as the sudden onset of a medical or *mental condition* that in the absence of immediate medical attention could reasonably be expected to result in placing your health or your ability to regain maximum function in serious jeopardy or, in your physician's opinion, would result in severe pain. You may request an expedited reconsideration or *appeal* by calling *Blue Cross Blue Shield HMO Blue* at the phone number shown in your letter. *Blue Cross Blue Shield HMO Blue* will notify you of the result of your expedited *appeal* within two working days or 72 hours of its receipt, whichever is sooner, or such shorter time period as required by federal law. If your *appeal* is denied, you have the right to request an expedited external *appeal*. The notice you receive from *Blue Cross Blue Shield HMO Blue* about your *appeal* will advise you of: the name of the appeals agency that is designated by Rhode Island; and the amount that Rhode Island requires you pay for your share of the cost for an expedited external *appeal*. To request an expedited external *appeal*, you must send your request in writing to: Member Appeal and Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Your request should state your reason(s) for your disagreement with the decision and include signed documentation from your provider that describes the emergency nature of your treatment. In addition, you must also enclose a check made payable to the designated appeals agency for your share of the cost for the expedited external *appeal*.

Within two working days after the receipt of your written request and payment for the *appeal*, *Blue Cross Blue Shield HMO Blue* will forward your request to the external appeals agency along with *Blue Cross Blue Shield HMO Blue's* portion of the fee and your entire *Blue Cross Blue Shield HMO Blue* case file. The external appeals agency will notify you in writing of the decision within two working days or 72 hours, whichever is sooner, of receiving your request for a review.

External Appeal Final Decision

If the external appeals agency upholds the original decision of *Blue Cross Blue Shield HMO Blue*, this completes the *appeals* process for your case. But, if the external appeals agency reverses *Blue Cross Blue Shield HMO Blue's* decision, the claim in dispute will be reprocessed by *Blue Cross Blue Shield HMO Blue* upon receipt of the notice of the final *appeal* decision. In addition, *Blue Cross Blue Shield HMO Blue* will repay you for your share of the cost for the external *appeal* within 60 days of the receipt of the notice of the final *appeal* decision.

Part 11

Group Policy

This part applies to you when you enroll in this health plan as a *group member*. Under a *group contract*, the *subscriber's group* has an agreement with *Blue Cross 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.

Eligibility and Enrollment for Group Coverage

Eligible Employee

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

Eligible Spouse

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

Former Spouse

In the event of a divorce or a legal separation, the person who was the spouse of the *subscriber* prior to the divorce or legal separation will remain eligible for coverage in this health plan under the *subscriber's group contract*, whether or not the judgment was entered prior to the *effective date* of the *group contract*. This health plan coverage is provided with no additional *premium* other than the normal cost of covering a current spouse. The former spouse will remain eligible for this coverage only until the *subscriber* is no longer required by the judgment to provide health insurance for the former spouse or the *subscriber* or former spouse remarries, whichever comes first. In these situations, *Blue Cross 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 his or her *group contract*. "Eligible dependents" include the *subscriber's* (or *subscriber's* spouse's) children until the end of the calendar month in which the child turns age 26. To be an eligible dependent, the child is not required to live with the *subscriber* or the *subscriber's* spouse, be a dependent on the *subscriber's* or spouse's tax return, or be a full-time student. These eligible dependents may include:

- A newborn child. The *effective date* of coverage for a newborn child will be the child's date of birth provided that the *subscriber* formally notifies the *plan sponsor* within 30 days of the date of birth. (A claim for a *member's* maternity admission may be considered by *Blue Cross 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 he or she assumes custody of a child for the purpose of adoption, the child's health care services for injury or sickness will be covered from the date of custody. (This coverage is provided without a waiting period or pre-existing condition restriction.) This includes the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth. The coverage for these services is subject to all of the provisions of 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, his or her 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 his or her 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 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 under the *subscriber's group contract* will continue to be covered after he or she 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 his or her 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.

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 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 under the *group contract* when:

- The employee and/or his or her 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 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 in this health plan under a *group contract* 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 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.

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 91). 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 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.

- **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 his or her *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 his or her 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 he or she returns 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 he or she returns 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 he or she continues 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 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 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 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 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, 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 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* 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 *contract* as the primary payor of your health care benefits. For more help, contact your *plan sponsor*.)

Dual Medicare Eligibility

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

Part 12

Individual Policy

This part applies to you when you enroll in this health plan as a direct pay *member* (and not as a *group member* under a *group contract*). Under an *individual contract*, the *subscriber* has an agreement with *Blue Cross Blue Shield HMO Blue* to provide the *subscriber* and his or her 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.

Eligibility and Enrollment for Individual Coverage

Eligible Individual

You are eligible for coverage in this health plan under an *individual contract* as long as you are a resident of Massachusetts. A "resident" is a person who lives in Massachusetts as shown by evidence that is considered acceptable by *Blue Cross 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.

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, he or she 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 his or her *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 his or her 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 his or her *individual contract*. Eligible dependents must meet all of the same eligibility conditions as described above for an eligible individual. However, a dependent child may live outside of Massachusetts to attend school as long as he or she has 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 he or she assumes custody of a child for the purpose of adoption, the child's health care services for injury or sickness will be covered from the date of custody. (This coverage is provided without a waiting period or pre-existing condition restriction.) This includes the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth. The coverage for these services is subject to all of the provisions of 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, his or her 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 his or her 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 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 under the *subscriber's individual contract* will continue to be covered after he or she 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 his or her 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.

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 the State.** Your coverage in this health plan under an *individual contract* will end when you move permanently out of Massachusetts. In this case, you may be able to enroll in another Blue Cross and/or Blue Shield Plan's health plan. For help, you can call the *Blue Cross 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 his or her *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.

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.

Printed at Blue Cross and Blue Shield of Massachusetts, Inc.

MASSACHUSETTS

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

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.

Andrew Dreyfus
President

1937

Stephanie Lovell
Clerk/Secretary

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

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

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

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

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

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

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

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

Arabic/ةيبر:

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

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

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

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

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

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

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

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

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

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

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

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

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

Lao/ພາສາລາວ: ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວ,ໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: **711**).

Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'dééʼ nóomba biká'ígíijį' 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.com**. 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*

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*.

- 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.com.

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.

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

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

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 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. *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.

Authorized Representative
You may choose to have another person act on your behalf during the grievance review process. You must designate this person in writing to *Blue Cross and Blue Shield*. Or, if you are not able to do this, a person such as a conservator, a person with power of attorney, or a family member may be your authorized representative. Or, he or she may appoint another party to be the 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.

Appeals Process for Rhode Island Residents or Services

You may also have the right to an appeal as described in this section when a claim is denied as being not *necessary and appropriate*. Your right to this appeal is in addition to the other rights to appeal as described earlier in this Dental Blue Policy. You have the right to this appeal only if you (1) live outside of Rhode Island; and (2) you want to obtain services in Rhode Island that *Blue Cross and Blue Shield* has determined are not *necessary and appropriate* for you.

The first step in this process is a reconsideration. If you receive a letter from *Blue Cross and Blue Shield* that denies payment for your services, you may ask that *Blue Cross and Blue Shield* reconsider its decision. To do this, you must send a letter to ask for this review to: Member Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Your letter must be sent within 180 days of *Blue Cross and Blue Shield's* adverse decision. Along with your letter, you should send any information that will support your request. *Blue Cross and Blue Shield* will review your request and let you know the outcome within 15 calendar days after they have received all information needed for the review.

The second step is an appeal. If *Blue Cross and Blue Shield* continues to deny benefits for all or a part of the service, you may ask for an appeal. You must ask for this appeal within 60 days of the date that you

receive the reconsideration denial letter from *Blue Cross and Blue Shield*. Your appeal request should include any information that supports your appeal. You may also inspect and add information to your *Blue Cross and Blue Shield* case file to prepare your appeal. According to Rhode Island state law, if you wish to review the information in your *Blue Cross and Blue Shield* case file, you must make your request in writing and you must include the name of a dentist who may review your case file on your behalf. Your dentist may review, interpret, and disclose any or all of that information to you. Once *Blue Cross and Blue Shield* receives your appeal, your appeal will be reviewed by a dentist in the same specialty as your attending dentist. *Blue Cross and Blue Shield* will notify you of the outcome of your appeal within 15 calendar days after they have received all information needed for the appeal.

If your appeal is denied, you have the right to present your case to an appeals agency that is designated by Rhode Island and not affiliated with *Blue Cross and Blue Shield*. If you request this voluntary external appeal, Rhode Island requires that you pay for half of the cost of the appeal. *Blue Cross and Blue Shield* will pay for the remaining half. The notice you receive from *Blue Cross and Blue Shield* about your appeal will advise you of: the name of the appeals agency that is designated by Rhode Island; and your share of the cost for an external appeal. To file an external appeal, you must make your request in writing to: Member Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Along with your request, you must: state your reason(s) for why you disagree with *Blue Cross and Blue* Shield's decision; and enclose a check made payable to the designated appeals agency for your share of the cost for the external appeal. Within five working days after *Blue Cross and Blue Shield* receives your written request and payment for the appeal, *Blue Cross and Blue Shield* will forward your request to the external appeals agency. *Blue Cross and Blue Shield* will also send their part of the fee and your entire *Blue Cross and Blue Shield* case file. The external appeals agency will notify you in writing of the decision within ten working days of receiving all necessary information.

If your situation is an emergency, you have the right to an "expedited" appeal at all three levels of appeal as stated above. You may request an expedited reconsideration or appeal by calling *Blue Cross and Blue Shield* at the phone number shown in your letter. *Blue Cross and Blue Shield* will notify you of the result of your expedited appeal within two working days or 72 hours of its receipt, whichever is sooner. If your appeal is denied, you have the right to request an expedited external appeal. The notice you receive from *Blue Cross and Blue Shield* about your appeal will advise you of: the name of the appeals agency that is designated by Rhode Island; and the amount that Rhode Island requires you pay for your share of the cost for an expedited external appeal. To request an expedited external appeal, you must send your request in writing to: Member Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Your request should state your reason(s) for why you disagree with the decision and include signed documentation from your dentist that describes the emergency nature of your treatment. In addition, you must also enclose a check made payable to the designated appeals agency for your share of the cost for the expedited external appeal. Within two working days after the receipt of your written request and payment for the appeal, *Blue Cross and Blue Shield* will forward your request to the external appeals agency along with *Blue Cross and Blue Shield's* part of the fee and your entire *Blue Cross and Blue Shield* case file. The external appeals agency will notify you in writing of the decision within two working days or 72 hours, whichever is sooner, of receiving your request for a review.

If the external appeals agency upholds the original decision of *Blue Cross and Blue Shield*, this completes the appeals process for your case. But, if the external appeals agency reverses *Blue Cross and Blue Shield's* decision, the claim in dispute will be reprocessed by *Blue Cross and Blue Shield* upon receipt of the notice of the final appeal decision. And, *Blue Cross and Blue Shield* will repay you for your share of the cost for the external appeal within 60 days of the receipt of the notice of the final appeal decision.

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, 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

You may choose to have another person act on your behalf concerning your benefits under this Dental Blue Policy. You must designate this person in writing to *Blue Cross and Blue Shield*. Or, if you are not able to do this, a person such as a conservator, a person with power of attorney, or a family member may be your authorized representative. In some cases, *Blue Cross and Blue Shield* may consider your dentist or other health care provider 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, *Blue Cross and Blue Shield* may ask your dentist or physician for information if more is needed for *Blue Cross and Blue Shield* to make a decision. *Blue Cross and Blue Shield* will continue to send benefit payments and written communications regarding your dental benefits according to *Blue Cross and Blue Shield's* standard practices, unless you specifically ask *Blue Cross and Blue Shield* to do otherwise. You can get a form to designate an authorized representative from the *Blue Cross and Blue Shield* customer service office.

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* 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

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.

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

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, 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.