

Rider 08-831

Overall Plan Changes

This *rider* modifies the terms of your Medex[®] certificate. Please keep this *rider* with your Medex certificate for easy reference.

The definition of “medically necessary” as described in Part 2 of your Medex certificate has been replaced with the following section:

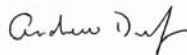
Medically Necessary (Medical Necessity)

To receive coverage under this Medex *contract*, all of your health care services must be *medically necessary* and appropriate for your health care needs. (The only exceptions to this are for: covered preventive and routine health care services.) For *covered services* eligible for benefits under *Medicare, Blue Cross and Blue Shield* decides which health care services that you receive (or you are planning to receive) are *medically necessary* and appropriate for coverage by using *Medicare’s* “reasonable and necessary” guidelines. For *covered services* eligible for benefits under Medex but not under *Medicare, Blue Cross and Blue Shield* decides which *covered services* are *medically necessary* and appropriate for you by using all of 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 for services covered by Medex only, furnished in accordance with *Blue Cross and Blue Shield* medical policy and *medical technology assessment guidelines*;
- essential to improve your net health outcome and as beneficial as any established alternatives that are covered by covered by this Medex *contract*;
- 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.

Blue Cross and Blue Shield of Massachusetts, Inc.


Andrew Dreyfus
President




Stephanie Lovell
Clerk/Secretary

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Overall Plan Changes

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.

All other provisions remain as described in your Medex certificate.


Rider 08-832
Termination for Non-Payment of Premium

This rider modifies the terms of your Direct-Billed Medex[®] Policy. Please keep this rider with your Direct-Billed Medex Policy for easy reference.


The terms related to non-payment of your premium as described in Part 10 of your Direct-Billed Medex Policy have been changed effective on January 1, 2013. If you fail to pay your full premium within 35 days after the due date, your Direct-Billed Medex coverage will be cancelled. The cancellation date will be the last date through which the premium is paid.

All other provisions remain as described in your Direct-Billed Medex Policy.

Blue Cross and Blue Shield of Massachusetts, Inc.


Andrew Dreyfus
President




Stephanie Lovell
Clerk/Secretary

R08-832 (1-1-13) to be attached to Direct-Billed Medex Bronze [ME-2 DB], Direct-Billed Medex Gold [ME-3 DB], Direct-Billed Medex Basic [ME-4 DB], Direct-Billed Medex Core [ME-11 DB], Direct-Billed Medex Silver [ME-12 DB], Direct-Billed Medex Standard [MXLO DB]

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Rider 08-833
Autism Spectrum Disorders

This *rider* modifies the terms of your Medex[®] certificate. Please keep this *rider* with your Medex certificate for easy reference.

The benefits described in your Medex *contract* have been changed.

Blue Cross and Blue Shield provides benefits for *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 *covered provider* who is an autism services provider. 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 supervised by a board certified behavior analyst.
- 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.

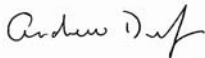
These *covered services* also include covered drugs and supplies that are furnished by a designated pharmacy when your prescription drug benefits are provided under this Medex plan.

Blue Cross and Blue Shield provides benefits for these *covered services* to the same extent as benefits are provided for similar *covered services* to diagnose and treat a physical condition. When these *covered services* are not covered by *Medicare*, *Blue Cross and Blue Shield* provides full benefits based on the *allowed charge*, provided the services are furnished by a health care provider who has a payment agreement with *Blue Cross and Blue Shield* or who has been designated for you by *Blue Cross and Blue Shield*.


(When *covered services* are furnished to treat an autism spectrum disorder, a “per visit” benefit limit will not apply.)

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

Blue Cross and Blue Shield of Massachusetts, Inc.


Andrew Dreyfus
President




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Clerk/Secretary

R08-833 (1-1-11) to be attached to Group and Direct-Billed Medex Certificates [ME-RXABDED, ME-OBRARX, ME-ABDED, ME-RXADED, ME-RXNODED, ME-CORE, ME 3 DB, ME 2 DB, ME 12 DB, MXLO DB, ME 4 DB, ME 11 DB, ME 11 DB]

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Autism Spectrum Disorders (continued)

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.

The term “*covered providers*” as defined in your Medex certificate has been changed to also include board certified behavior analysts employed by a covered facility or agency; or a board certified behavior analyst who has been designated for you and approved for coverage by *Blue Cross and Blue Shield*.

All other provisions remain as described in your Medex certificate.

Rider 08-836
Services Outside of the United States

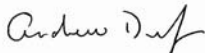
This rider modifies the terms of your Direct-Billed Medex[®] Policy. Please keep this rider with your Direct-Billed Medex Policy for easy reference.

The benefits described in your Direct-Billed Medex Policy for services received outside of the United States have been changed.


Medicare does not usually cover services that you receive outside of the United States. (See your *Medicare* handbook.) When *Medicare* does cover these services, you will receive Medex benefits as described in your Direct-Billed Medex Policy. When *Medicare* does not cover these services, your Direct-Billed Medex Policy provides both the Medex benefits and the benefits that are normally paid by *Medicare* for *covered services*. But, if you set up a residence outside of the United States, your Direct-Billed Medex Policy will not provide any benefits.

All other provisions remain as described in your Direct-Billed Medex Policy.

Blue Cross and Blue Shield of Massachusetts, Inc.


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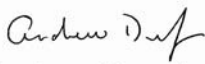
Rider 13-828
Low Protein Foods

This *rider* modifies the terms of your Medex[®] certificate. Please keep this *rider* with your Medex certificate for easy reference.


The benefit limit for low protein foods that are covered by this Medex plan has been changed from the amount described in your Medex certificate to \$5,000 in each calendar year. Once you reach the benefit limit, no more benefits will be provided for these services.

All other provisions remain as described in your Medex certificate.

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Rider 14-814 Rev.
Wellness Benefits

This rider modifies the terms of your Direct-Billed Medex[®] Policy. Please keep this rider with your Direct-Billed Medex Policy for easy reference.

The benefits described in your Direct-Billed Medex Policy have been expanded by adding wellness benefits.

Fitness Benefit

Blue Cross and Blue Shield provides benefits for some fees that you pay to privately-owned or privately-sponsored health clubs or fitness centers as a fitness benefit. *Blue Cross and Blue Shield* will reimburse you up to a total of \$150 each calendar year for fees that you paid for a health club membership and/or for fitness classes at a health club. (For a health club membership, you must have paid fees for at least four months for that calendar year in order to claim all or part of this fitness benefit.) The health clubs and fitness centers that are eligible for this benefit include: individual health clubs and fitness centers; YMCAs; YWCAs; Jewish Community Centers; Council on Aging sites; and municipal fitness centers. Your fitness benefit brochure tells you more about this benefit.

Blue Cross and Blue Shield will consider the date on which you file a claim for your fitness benefit the “incurred date,” unless your claim is for a health club membership and/or for fitness classes for the prior calendar year. In that case, the incurred date will be shown as December 31st of that prior year. This means that the incurred date reflects the calendar year for which you are claiming your fitness benefit.

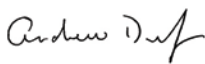
No benefits are provided for fees paid to (or for):

- Spas.
- Country clubs.
- Social clubs (such as ski clubs or hiking clubs).
- Sports teams or sports leagues.
- Instructional dance studios.

Weight Loss Program Benefit

Blue Cross and Blue Shield provides benefits for some costs or fees that you pay for weight loss programs. *Blue Cross and Blue Shield* will reimburse you up to \$150 each calendar year for fees that you paid in that year for hospital-based weight loss programs or for non-hospital-based

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Rider 14-814 Rev.
Wellness Benefits

weight loss programs designated by *Blue Cross and Blue Shield*. To find out which weight loss programs are designated by *Blue Cross and Blue Shield*, you may use the *Blue Cross and Blue Shield* internet website at www.bluecrossma.com. Or, you may call Medex Member Service. The toll-free telephone number is **1-800-258-2226**. (To use the Telecommunications Device for the Deaf, call 1-800-522-1254.)

Blue Cross and Blue Shield will consider the date on which you file a claim for your weight loss program benefit the “incurred date,” unless your claim is for weight loss program(s) for the prior calendar year. In that case, the incurred date will be shown as December 31st of that prior year. This means that the incurred date reflects the calendar year for which you are claiming your weight loss program benefit.

No benefits are provided for any costs or fees that you pay for:

- On-line weight loss programs.
- Any non-hospital-based weight loss program that is not designated by *Blue Cross and Blue Shield*.
- Individual nutrition counseling sessions. (See your Direct-Billed Medex Policy for your benefits for nutrition counseling services that are covered by *Medicare* and your Direct-Billed Medex Policy.)
- Pre-packaged meals; books; videos; scales; or other items that you buy.
- Any other items that are not included as part of a covered weight loss program.

Filing a Claim

To receive your fitness benefit 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. 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 and Blue Shield*. For a claim form or help to file a claim, you may call Medex Member Service. The toll-free telephone number is **1-800-258-2226**. (To use the Telecommunications Device for the Deaf, call 1-800-522-1254.) Or, you may use the *Blue Cross and Blue Shield* internet website at www.bluecrossma.com for help or to print a claim form.

All other provisions remain as described in your Direct-Billed Medex Policy.

Rider 15-806 Syringes and Needles

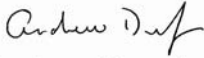
This *rider* modifies the terms of your Medex[®] *contract*. Please keep this *rider* with your Medex *contract* for easy reference.

The *outpatient* benefits that are described in your Medex *contract* have been changed.


Your Medex *contract* covers your cost to buy *medically necessary* syringes and needles that are furnished to you on and after July 13, 2006. You may obtain these covered supplies: from a covered health care provider during a visit; or from a pharmacy. For these covered supplies, you pay nothing. The only exception is when you buy these syringes and needles from a pharmacy and your Medex *contract* includes Medex pharmacy benefits. (In this case, these benefits will be paid under your Medex pharmacy program.)

All other provisions remain as described in your Medex *contract*.

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Direct-Billed Medex[®] Core Policy

Note to Buyer: This policy may not cover all of your medical expenses.

If you are a new Medex subscriber: You have 30 days from the date you receive this policy to review it. If you are not satisfied for any reason, you have the right to return the policy within 30 days and have your premium refunded.

Continuing Your Coverage

You have the right to continue this policy as long as: you pay your premiums on time; you do not make a material misrepresentation to *Blue Cross and Blue Shield*; and you continue to reside in Massachusetts.

***Blue Cross and Blue Shield* may change your benefits and/or your premium.** *Blue Cross and Blue Shield* will change your benefits automatically to coincide with any changes required under Massachusetts law regarding mandated benefits; and *Blue Cross and Blue Shield* may change your premium to correspond with these mandated benefit changes, if approved by the Commissioner of Insurance, in accordance with statutory and regulatory requirements. *Blue Cross and Blue Shield* may also change your premium in other instances if approved by the Commissioner of Insurance.

These changes will apply to all contracts of this type, not just to your *contract*.

If you purchase the Medex Core Plus plan, this Direct-Billed Medex Core policy is accompanied by the Medex Core Plus Rider. Please refer to the rider for a description of its benefits, as well as the limitations and exclusions that apply to benefits available in the Medex Core Plus Rider.



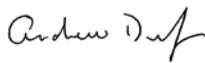
MASSACHUSETTS

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

Welcome to Medex

We are very pleased that you've selected a Blue Cross and Blue Shield plan. This document 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 to understand the terms and conditions of this contract, please contact us. We're here to help!

Blue Cross and Blue Shield of Massachusetts, Inc.


Andrew Dreyfus
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Clerk/Secretary

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

Translation and Interpretation Services

A language translator service is available when you call the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your health plan identification card. This service provides you with access to interpreters who are able to translate over 140 different languages. If you need these translation services, just tell the customer service representative when you call. Then during your call, *Blue Cross and Blue Shield* will use a language line service to access an interpreter who will assist in answering your questions or helping you to understand *Blue Cross and Blue Shield* procedures. (This interpreter is not an employee or designee of *Blue Cross and Blue Shield*.)

Traduction et interprétation en ligne

Un service de traduction et d'interprétation est disponible lorsque vous appelez le service clientèle de Blue Cross and Blue Shield au numéro gratuit figurant sur la carte d'identification de votre plan de santé. Ce service vous donne accès à des interprètes qui peuvent traduire dans plus de 140 langues. Si vous avez besoin de ces services, mentionnez-le à l'agent du service clientèle lorsque vous nous appelez. Ensuite, au cours de votre appel, Blue Cross and Blue Shield utilisera un service de traduction et d'interprétation en ligne pour joindre un interprète qui assurera la traduction des questions que vous poserez ou qui vous aidera à comprendre les procédures de Blue Cross and Blue Shield. (Cet interprète n'est pas un employé de Blue Cross and Blue Shield ni une personne mandatée par Blue Cross and Blue Shield.)

Sèvis Tradiksyon ak Entèpretasyon

Genyen yon sèvis tradiksyon ki disponib lè w rele biwo sèvis kliyan Blue Cross and Blue Shield nan nimewo telefòn gratis ki sou kat didantifikasyon plan asirans ou an Sèvis sa a ba w aksè a entèprèt ki ka tradwi plis ke 140 lang diferan. Si w ta bezwen itilize sèvis tradiksyon sa yo, senpleman di reprezantan sèvis kliyan an sa lè w rele. Epi lè w rele a, Blue Cross and Blue Shield pral itilize yon liy sèvis pou lang pou gen aksè a yon entèprèt ki pral ede w jwenn repons a keksyon ou genyen oswa ede w konprann pwosedi Blue Cross and Blue Shield yo. (Entèprèt sa a pa yon anplwaye Blue Cross and Blue Shield ni tou li pa mandate pa Blue Cross and Blue Shield.)

Servizio di traduzione e di interpretariato

Quando chiamate l'ufficio di assistenza clienti Blue Cross and Blue Shield al numero verde indicato sulla vostra tessera sanitaria avrete a disposizione un servizio di traduzione nella vostra lingua. Tramite tale servizio potrete accedere ad interpreti in grado di tradurre in oltre 140 lingue diverse. Qualora aveste bisogno di un servizio di traduzione, fatelo presente al rappresentante del servizio clienti durante la vostra chiamata; in questo caso Blue Cross and Blue Shield utilizzerà un servizio in linea di lingue straniere per chiamare un interprete che vi aiuterà a rispondere alle domande ed a comprendere le procedure Blue Cross and Blue Shield. (L'interprete non è un dipendente e non è selezionato da Blue Cross and Blue Shield.)

សេវាផ្នែកបកប្រែភាសាសរសេរ និងបកប្រែផ្ទាល់មាត់

សេវាផ្នែកបកប្រែភាសាអាចមានផ្តល់ជូនកាលណាអ្នកទូរស័ព្ទមកភារិយាល័យផ្នែកសេវាបំរើអតិថិជនរបស់ Blue Cross and Blue Shield តាមរយៈទូរស័ព្ទតបដំថ្ងៃដែលមាននៅក្នុងអត្តសញ្ញាណប័ណ្ណផែនការសុខភាពរបស់អ្នក ។ សេវានេះផ្តល់ឱ្យអ្នកទទួលបានភាពទាក់ទងដល់ក្រុមអ្នកបកប្រែភាសាជាច្រើនដែលមានលទ្ធភាពបកប្រែភាសាលើសពី ១៤០ ភាសាទៅទៀត ។ បើអ្នកត្រូវការសេវាផ្នែកបកប្រែភាសាទាំងនេះ គ្រាន់តែប្រាប់អ្នកតំណាងផ្នែកសេវាអតិថិជនកាលណាអ្នកទូរស័ព្ទមក ។ នៅពេលដែល អ្នកទូរស័ព្ទមក Blue Cross and Blue Shield នឹងប្រើបណ្តាញសេវាភាសា ដើម្បីរកអ្នកបកប្រែណា ម្នាក់ដែលគេនឹងជួយឆ្លើយសំណួររបស់អ្នក ឬជួយអ្នកឱ្យយល់អំពីទម្រង់ការរបស់ក្រុមហ៊ុន Blue Cross and Blue Shield ។ (អ្នកបកប្រែនេះមិនមែនជានិយោជក ឬអ្នកចាត់តាំងរបស់ Blue Cross and Blue Shield ទេ ។)

翻譯服務

當您以健康計劃識別卡上的免付費電話號碼致電 Blue Cross and Blue Shield 客戶服務辦公室之時，您就能獲得語言翻譯服務。這項服務能提供您 140 多種不同語言的翻譯服務。若您需要翻譯服務，在致電時告訴客戶服務代表即可。隨後 Blue Cross and Blue Shield 會利用一電話公司的語言服務專線找一個翻譯，為您釋疑或幫助您了解 Blue Cross and Blue Shield 程序。（此翻譯並非 Blue Cross and Blue Shield 的雇員或所指派的人。）

Υπηρεσίες Μετάφρασης και Διερμηνείας

Υπάρχει ξενόγλωσση υπηρεσία όταν τηλεφωνείτε στην εξυπηρέτηση πελατών της Blue Cross and Blue Shield στον ατελή αριθμό που αναγράφεται στην κάρτα του ασφαλιστικού σας προγράμματος. Η υπηρεσία αυτή σας παρέχει πρόσβαση σε διερμηνείς που μπορούν να μεταφράσουν 140 διαφορετικές γλώσσες. Αν χρειάζεστε μεταφραστικές υπηρεσίες, να το λέτε στον αντιπρόσωπο εξυπηρέτησης πελατών όταν τηλεφωνείτε. Στη συνέχεια, η Blue Cross and Blue Shield θα επικοινωνήσει με μια ξενόγλωσση τηλεφωνική υπηρεσία για να φέρει στο τηλέφωνο διερμηνέα που θα σας βοηθήσει για να πάρετε απάντηση στις ερωτήσεις σας ή για να καταλάβετε τις διαδικασίες του Blue Cross and Blue Shield. (Ο διερμηνέας δεν είναι υπάλληλος ούτε αντιπρόσωπος της Blue Cross and Blue Shield.)

Услуги по письменным и устным переводам

Позвонив в отдел обслуживания клиентов медицинского плана Blue Cross and Blue Shield по бесплатному телефону, указанному в вашем удостоверении клиента плана, вы можете воспользоваться услугами переводчика. В распоряжении наших клиентов имеются переводчики, работающие с более чем 140 языками. Если вы нуждаетесь в переводе, сообщите об этом ответившему на ваш звонок сотруднику отдела обслуживания клиентов плана. В этом случае план Blue Cross and Blue Shield свяжется с переводчиком службы переводов, который переведет для вас ответы на ваши вопросы и поможет вам понять правила, действующие в плане Blue Cross and Blue Shield. (Такой переводчик не является сотрудником или назначенным лицом плана Blue Cross and Blue Shield.)

خدمات الترجمة التحريرية و الشفوية

عندما تتصل بقسم خدمة العميل لدى Blue Cross and Blue Shield على الرقم المجاني الذي تجده مطبوعاً على بطاقة تأمينك الصحي، تستطيع الاستفادة من خدمة الترجمة. توفر لك هذه الخدمة إمكانية الاتصال بمتترجمين لأكثر من 140 لغة. إذا كنت في حاجة إلى الترجمة، عليك فقط بإخبار موظف خدمة العميل عندما تتصل. و أثناء اتصالك، ستستخدم Blue Cross and Blue Shield خدمات ترجمة على الهاتف للاتصال بالمتترجم الذي سيساعد في الإجابة على أسئلتك أو يساعدك على فهم إجراءات Blue Cross and Blue Shield. (هذا المترجم ليس موظفاً أو معيناً من قبل Blue Cross and Blue Shield.)

ຫ້ອງການຊ່ອຍ ບໍລິການດ້ານແປພາສາ

ນິນາຍພາສາຈະຊ່ອຍທ່ານໄດ້ ເມື່ອໂທລະສັບໄປຫາ ຫ້ອງການຊ່ອຍລູກຄ້າ ຂອງ Blue Cross and Blue Shield ທີ່ນີໂທລະສັບໂທລີ ຢູ່ໃນບັດສູງກະລາບຂອງທ່ານ. ໃນ ຫ້ອງການບໍລິການນີ້ນິນາຍພາສາ ທີ່ສາມາດແປຫລາຍກວ່າ 140 ພາສາໃຫ້ທ່ານ. ຫາກທ່ານຕ້ອງການ ບໍລິການນີ້, ບອກໃຫ້ຜູ້ຕາງໜ້າຊ່ອຍລູກຄ້າ ເມື່ອທ່ານໂທໄປ. ໃນຍາມທ່ານໂທໄປຫາ , Blue Cross and Blue Shield ຈະໃຊ້ ສາຍໂທລະສັບສາຍນຶ່ງ ຫານາຍພາສາ ທີ່ຈະຊ່ອຍທ່ານຕອບຄໍາຖາມທລີ ຊ່ອຍ ທ່ານ ໃຫ້ເຂົ້າໃຈການແມ່ນໍາຂອງ Blue Cross and Blue Shield. (ນາຍພາສາ ຜູ້ນີ້ບໍ່ແມ່ນ ຜະນິກງານ ທລີຜູ້ແມ່ນໍາຂອງ Blue Cross and Blue Shield.)

Servicio de Traducción e Interpretación

Disponemos de un servicio de traductores para cuando usted llame a la oficina de atención al cliente de Blue Cross and Blue Shield al número de teléfono de la línea gratuita que figura en su tarjeta de identificación del plan de salud. A través de este servicio, usted tiene acceso a intérpretes que pueden traducir a más de 140 idiomas diferentes. Si usted necesita este servicio de traducción, simplemente solicítelo al representante de atención al cliente al hacer su llamada. Durante su llamada telefónica, Blue Cross and Blue Shield utilizará un servicio de línea de idiomas para ponerlo en contacto con un intérprete que lo ayudará a responder sus preguntas o a entender los procedimientos de Blue Cross and Blue Shield. (Este intérprete no es un empleado de Blue Cross and Blue Shield, ni ha sido designado por Blue Cross and Blue Shield.)

Serviço de Tradução e Interpretação

O serviço de apoio aos clientes da Blue Cross and Blue Shield tem disponível um serviço de tradução, quando telefona para o número grátis indicado no seu cartão de identificação do plano de saúde. Este serviço dá acesso a intérpretes em mais de 140 idiomas diferentes. Se necessitar destes serviços de tradução, comunique-o ao representante do serviço de clientes que o atender via telefone. Então, durante a sua chamada, a Blue Cross and Blue Shield utilizará um intérprete de um serviço de interpretação por telefone, que o ajudará a obter respostas às suas questões ou a entender os procedimentos da Blue Cross and Blue Shield. (Este intérprete não é um funcionário da Blue Cross and Blue Shield.)

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Introduction

Blue Cross and Blue Shield certifies that you have the right to benefits according to the terms of this Direct-Billed Medex *contract*. Your Medex identification card will identify you to a provider as a person who has the right to the benefits that are described in this Direct-Billed Medex *contract*. *Blue Cross and Blue Shield* will provide the benefits that are described in this Direct-Billed Medex *contract*. This is the case as long as you are enrolled under this Direct-Billed Medex *contract* when you receive *covered services*. And, the premium that you owe for these benefits has been paid to *Blue Cross and Blue Shield*.

This Direct-Billed Medex Policy is part of the *contract* between you and Blue Cross and Blue Shield of Massachusetts, Inc. to provide benefits to you (the *member*). It explains your benefits. And, it explains the terms of your membership under this Direct-Billed Medex *contract*. You should read this Direct-Billed Medex *contract* to familiarize yourself with the main provisions. And you should keep it handy for reference. The words that are in italics have special meanings. They are described in Part 2. Also, *Blue Cross and Blue Shield* provides benefits to supplement your *Medicare* insurance. *Blue Cross and Blue Shield* provides these benefits for most services that are covered by *Medicare* Part A and/or Part B. For this reason, you should also read the most current edition of your *Medicare* handbook (Medicare & You). This will help you to fully understand your benefits. This is a book that is put out by *Medicare*. This book describes the benefits that you get under that program. It also describes the restrictions that apply to your *Medicare* benefits. Your *Medicare* handbook also explains how you can get other booklets that deal with specific topics about your *Medicare* benefits. These topics include: payment for certain *outpatient hospital* services; dialysis services; home health care; hospice care; and mental health benefits.

Blue Cross and Blue Shield may change the benefits that are described in this Direct-Billed Medex *contract*. *Blue Cross and Blue Shield* may do so with approval by the Commissioner of Insurance. (See Part 9.) If this is the case, the change is described in a *rider*. *Blue Cross and Blue Shield* will supply you with any *riders* that apply to your benefits under this Direct-Billed Medex *contract*. Please keep any *riders* with your Direct-Billed Medex *contract* for easy reference.

Before you use your benefits, you should remember that there are limitations or exclusions. Be sure to read the limitations and exclusions on your benefits. They are described in Parts 4, 5 and 6.

You are eligible to enroll in Direct-Billed Medex only if you meet all of the following requirements:

- You reside in Massachusetts.
- You are eligible for *Medicare* Part A and *Medicare* Part B. And, you are enrolled in Part B.

Introduction

- You do not have another direct-billed *Medicare* supplement plan in force that this plan will duplicate. Before this plan goes into effect, you must send written notice to *Blue Cross and Blue Shield*. The notice must state that you intend to cancel that other direct-billed *Medicare* supplement plan.
- If you are under age 65, the disability that qualifies you for *Medicare* is not permanent kidney failure.

If you are covered by Medicaid, you may or may not be eligible to enroll in a Direct-Billed Medex plan. Counseling services are available in Massachusetts. They will provide advice concerning: your purchase of *Medicare* supplement insurance and medical assistance through the state Medicaid program. This includes benefits as a Qualified *Medicare* Beneficiary (QMB) and a Specified Low-Income *Medicare* Beneficiary (SLMB).

You may call the Massachusetts Executive Office of Elder Affairs insurance counseling program. You can reach them at **1-800-243-4636**. Or, you may write to that office at the following address for more information:

**One Ashburton Place, 5th Floor
Boston, Massachusetts 02108**

Member Services

Identification Cards

When you enroll for coverage under this Direct-Billed Medex *contract*, you will receive a Medex identification card. This card is for identification purposes only. While you are a *member*, you must show your identification card to the provider before you receive *covered services*. If your identification card is lost or stolen, you should contact Medex Member Service. They will send you a new Medex identification card. Or, you may also use the online member self-service option that is located at www.bluecrossma.com.

Making an Inquiry and/or Resolving Medex Claim Problems or Concerns

For help to understand the terms of this Direct-Billed Medex *contract* or to resolve a Medex problem or concern, you may call Medex Member Service at **1-800-258-2226**. (To use the Telecommunications Device for the Deaf, call 1-800-522-1254.) A customer service representative will work with you. They will help you understand your Medex benefits. Or, they will work with you to resolve your problem or concern. They will do this as quickly as possible.

You can call Medex Member Service Monday through Friday from 8:00 a.m. to 6:00 p.m. (Eastern Time). Or, you can write to: Blue Cross and Blue Shield of Massachusetts, Inc., Member Services, P.O. Box 9130, North Quincy, MA 02171-9130.

Blue Cross and Blue Shield will keep a record of each inquiry that you (or someone on your behalf) makes. These records include the responses to each inquiry. They will be kept for two years. They may be reviewed by the Commissioner of Insurance. And, they may also be reviewed by the Massachusetts Department of Public Health.

Note: For more information about *Blue Cross and Blue Shield's* inquiry process and the formal grievance review process, see Part 8. For general information about your *Medicare* benefits, you should call the toll-free help line at **1-800-633-4227** (1-800-MEDICARE). Or, you may look on the internet website at www.medicare.gov. Or, to use the Telecommunications Device for the Deaf, call 1-877-486-2048. However, if you have a problem or concern about a *Medicare* claim, you should call the telephone number that appears on your Medicare Summary Notice for help in resolving your claim problem.

Requesting Medical Policy Information—To receive all of the benefits that are described in your Direct-Billed Medex *contract* for *covered services* that are not eligible for benefits under *Medicare*, your treatment must conform to *Blue Cross and Blue Shield's* medical policy guidelines that are in effect at the time the services or supplies are furnished. To check for a *Blue Cross and Blue Shield*

Member Services

medical policy, you can go online and log on to **www.bluecrossma.com**. Or, you may call Medex Member Service to request a copy of the information.

Office of Patient Protection

The Office of Patient Protection of the Massachusetts Department of Public Health can provide information about health care plans in Massachusetts. Some of the information that this office can provide includes:

- A health plan report card. This health care report card contains information and data that provide a basis by which health insurance plans may be evaluated and compared by consumers. Also available are: health plan employer data that is collected for the National Committee on Quality Assurance; and a list of sources that can provide information about member satisfaction and the quality of health care services that are offered by health care plans.
- Information about physicians who are voluntarily and/or involuntarily disenrolled by a health plan during the prior calendar year.
- A chart that compares the premium revenue that has been used for health care services for the most recent year for which the information is available.
- A report that provides information for health care plan grievances and external appeals for the previous calendar year.

To request any of this information, you may contact the Office of Patient Protection. You may do so by calling **1-800-436-7757**. Or, you may fax a request to **1-617-624-5046**. This information is also available on the Office of Patient Protection's internet website **www.mass.gov/hpc/opp**.

Part 1 Schedule of Benefits

Do not rely on this chart alone. It merely highlights some of the benefits that are available to a *member* who is enrolled under: *Medicare* Hospital Insurance (Part A); *Medicare* Medical Insurance (Part B); and this Direct-Billed Medex *contract*. Be sure to read the most current edition of your *Medicare* handbook. Also, be sure to read the explanations that are in Part 4 and the limitations and exclusions that are in Part 5, as well as all provisions of this Direct-Billed Medex *contract*.

Medicare Provides	Medex Provides	Your Cost*	Page
Admissions for <i>Inpatient</i> Medical and Surgical Care			
In a general <i>hospital</i>: Full semiprivate benefits less the Part A <i>deductible</i> for day 1-60 and Part A <i>coinsurance</i> for day 61-90 per <i>benefit period</i> ; and full semiprivate benefits less the Part A <i>coinsurance</i> for 60 <i>Medicare</i> lifetime reserve days	In a general <i>hospital</i>: The Part A <i>coinsurance</i> for day 61-90 per <i>benefit period</i> ; the Part A <i>coinsurance</i> for any <i>Medicare</i> lifetime reserve days used; then after <i>Medicare</i> days are used up, full semiprivate benefits for up to 365 days per lifetime	In a general <i>hospital</i>: The Part A <i>deductible</i> for day 1-60 and nothing for day 61-90 per <i>benefit period</i> ; the Part A <i>deductible</i> for any <i>Medicare</i> lifetime reserve days used; and after <i>Medicare</i> days are used up, nothing for up to 365 days per lifetime; then all charges	27
Physician and other covered professional provider services: Full benefits less the Part B <i>deductible</i> and Part B <i>coinsurance</i> for as many days as are <i>medically necessary</i>	Physician and other covered professional provider services: The Part B <i>coinsurance</i> (full benefits when covered by Medex only) for as many days as are <i>medically necessary</i>	Physician and other covered professional provider services: The Part B <i>deductible</i> (nothing when covered by Medex only) for as many days as are <i>medically necessary</i>	28
Ambulance Services			
Full benefits less the Part B <i>deductible</i> and Part B <i>coinsurance</i>	The Part B <i>coinsurance</i>	The Part B <i>deductible</i>	29
Cardiac Rehabilitation			
Full benefits less the Part B <i>deductible</i> and Part B <i>coinsurance</i>	The Part B <i>coinsurance</i>	The Part B <i>deductible</i>	30
Chiropractor Services			
Full benefits less the Part B <i>deductible</i> and Part B <i>coinsurance</i>	The Part B <i>coinsurance</i>	The Part B <i>deductible</i>	30

*Benefits for *covered services* are provided based on the *allowed charge*. You may have to pay any amount over the *allowed charge*. (See Parts 2 and 9.)

Part 1 Schedule of Benefits

Medicare Provides	Medex Provides	Your Cost*	Page
Diabetic Testing Materials, Drugs, Enteral Formulas and Food Products			
When covered by Medicare , full benefits less the Part B <i>deductible</i> and Part B <i>coinsurance</i>	When covered by Medicare , the Part B <i>coinsurance</i>	When covered by Medicare , the Part B <i>deductible</i>	30
When not covered by Medicare , nothing	When not covered by Medicare , full benefits for: diabetic testing materials; certain enteral formulas; and low protein food products for up to \$2,500 per calendar year	When not covered by Medicare , nothing for diabetic testing materials and certain enteral formulas; and all charges after <i>Blue Cross and Blue Shield</i> has paid \$2,500 per calendar year for low protein food products	30
Dialysis Services			
Full benefits less the Part B <i>deductible</i> and Part B <i>coinsurance</i>	The Part B <i>coinsurance</i>	The Part B <i>deductible</i>	31
Durable Medical Equipment and Prosthetic Devices			
Full benefits less the Part B <i>deductible</i> and Part B <i>coinsurance</i>	The Part B <i>coinsurance</i>	The Part B <i>deductible</i>	31
Emergency Medical Outpatient Services			
Full benefits less the Part B <i>deductible</i> and Part B <i>coinsurance</i>	The Part B <i>coinsurance</i>	The Part B <i>deductible</i>	32
Home Health Care			
For home health care visits , full benefits	For home health care visits , nothing	For home health care visits , nothing**	32
For durable medical equipment covered by Medicare , full benefits less the Part B <i>deductible</i> (when applicable) and Part B <i>coinsurance</i>	For durable medical equipment covered by Medicare , the Part B <i>coinsurance</i>	For durable medical equipment covered by Medicare , the Part B <i>deductible</i> (when applicable)	32

*Benefits for *covered services* are provided based on the *allowed charge*. You may have to pay any amount over the *allowed charge*. (See Parts 2 and 9.)

**These services are covered in full by *Medicare* as long as *Medicare* conditions are met.

Part 1 Schedule of Benefits

Medicare Provides	Medex Provides	Your Cost*	Page
Hospice Services			
When covered by Medicare , full benefits for most services	When Medicare does not provide full benefits , the difference between the amount Medicare pays and the <i>allowed charge</i>	When covered by Medicare , nothing	32
When not covered by Medicare , nothing	When not covered by Medicare , full benefits	When not covered by Medicare , nothing	32
Lab Tests, X-Rays and Other Tests			
Full benefits less the Part B <i>deductible</i> and Part B <i>coinsurance</i>	The Part B <i>coinsurance</i>	The Part B <i>deductible</i>	33
Medical Care (clinic, office and home visits)			
Full benefits less the Part B <i>deductible</i> and Part B <i>coinsurance</i>	The Part B <i>coinsurance</i>	The Part B <i>deductible</i>	33
Mental Health Treatment for Biologically-Based <i>Mental or Nervous Conditions</i>***			
<i>Inpatient admissions in a general or mental hospital</i> : Full semiprivate benefits less the Part A <i>deductible</i> for day 1-60 and Part A <i>coinsurance</i> for day 61-90 per <i>benefit period</i> ; and full semiprivate benefits less the Part A <i>coinsurance</i> for 60 <i>Medicare</i> lifetime reserve days (Benefits in a mental <i>hospital</i> are limited to 190 days per lifetime)	<i>Inpatient admissions in a general or mental hospital</i> : The Part A <i>coinsurance</i> for day 61-90 per <i>benefit period</i> ; the Part A <i>coinsurance</i> for any <i>Medicare</i> lifetime reserve days used; then after <i>Medicare</i> days are used up, full semiprivate benefits for up to 365 days per lifetime	<i>Inpatient admissions in a general or mental hospital</i> : The Part A <i>deductible</i> for day 1-60 and nothing for day 61-90 per <i>benefit period</i> ; the Part A <i>deductible</i> for any <i>Medicare</i> lifetime reserve days used; and after <i>Medicare</i> days are used up, nothing for up to 365 days per lifetime; then all charges	34

*Benefits for *covered services* are provided based on the *allowed charge*. You may have to pay any amount over the *allowed charge*. (See Parts 2 and 9.)

***Treatment for rape-related mental or emotional conditions is covered to the same extent as biologically-based conditions.

Part 1 Schedule of Benefits

Medicare Provides	Medex Provides	Your Cost*	Page
Mental Health Treatment for Biologically-Based <i>Mental or Nervous Conditions</i>** (continued)			
<i>Inpatient physician and other covered professional mental health provider services:</i> Full benefits less the Part B <i>deductible</i> and Part B <i>coinsurance</i> for as many days as are <i>medically necessary</i>	<i>Inpatient physician and other covered professional mental health provider services:</i> The Part B <i>coinsurance</i> (full benefits when covered by Medex only) for as many days as are <i>medically necessary</i>	<i>Inpatient physician and other covered professional mental health provider services:</i> The Part B <i>deductible</i> (nothing when covered by Medex only) for as many days as are <i>medically necessary</i>	35
<i>Outpatient treatment:</i> Full benefits less the Part B <i>deductible</i> and Part B <i>coinsurance</i> (nothing for services not covered by <i>Medicare</i>)	<i>Outpatient treatment:</i> The Part B <i>coinsurance</i> (full benefits when covered by Medex only) for as many visits as are <i>medically necessary</i>	<i>Outpatient treatment:</i> The Part B <i>deductible</i> (nothing when covered by Medex only) for as many visits as are <i>medically necessary</i>	35
Mental Health Treatment for Non-Biologically-Based <i>Mental or Nervous Conditions</i> not included in above section (includes drug addiction and alcoholism)			
<i>Inpatient admissions in a general or mental hospital:</i> Full semiprivate benefits less the Part A <i>deductible</i> for day 1-60 and Part A <i>coinsurance</i> for day 61-90 per <i>benefit period</i> ; and full semiprivate benefits less the Part A <i>coinsurance</i> for 60 <i>Medicare</i> lifetime reserve days (Benefits in a mental <i>hospital</i> are limited to 190 days per lifetime)	<i>Inpatient admissions in a general or mental hospital:</i> The Part A <i>coinsurance</i> for day 61-90 per <i>benefit period</i> ; the Part A <i>coinsurance</i> for any <i>Medicare</i> lifetime reserve days used; then after <i>Medicare</i> days are used up, full semiprivate benefits for up to 365 days per lifetime in a general <i>hospital</i> and for up to 60 days per calendar year in a mental <i>hospital</i> , less any days in a mental <i>hospital</i> already covered by <i>Medicare</i> or Medex in that calendar year	<i>Inpatient admissions in a general or mental hospital:</i> The Part A <i>deductible</i> for day 1-60 and nothing for day 61-90 per <i>benefit period</i> ; the Part A <i>deductible</i> for any <i>Medicare</i> lifetime reserve days used; and after <i>Medicare</i> days are used up, nothing for up to 365 days per lifetime in a general <i>hospital</i> and for up to 60 days per calendar year in a mental <i>hospital</i> ; then all charges	35

*Benefits for *covered services* are provided based on the *allowed charge*. You may have to pay any amount over the *allowed charge*. (See Parts 2 and 9.)

***Treatment for rape-related mental or emotional conditions is covered to the same extent as biologically-based conditions.

Part 1 Schedule of Benefits

Medicare Provides	Medex Provides	Your Cost*	Page
Mental Health Treatment for Non-Biologically-Based <i>Mental or Nervous Conditions</i> (continued)			
<i>Inpatient physician and other covered professional mental health provider services:</i> Full benefits less the Part B <i>deductible</i> and Part B <i>coinsurance</i> for as many days as are <i>medically necessary</i>	<i>Inpatient physician and other covered professional mental health provider services:</i> The Part B <i>coinsurance</i> for <i>Medicare</i> and Medex <i>covered services</i> for as many days as are <i>medically necessary</i> in a general or mental <i>hospital</i> ; full benefits for as many days as are <i>medically necessary</i> in a general <i>hospital</i> and for up to 60 days per calendar year in a mental <i>hospital</i> when covered by Medex only	<i>Inpatient physician and other covered professional mental health provider services:</i> The Part B <i>deductible</i> for <i>Medicare</i> and Medex <i>covered services</i> for as many days as are <i>medically necessary</i> in a general or mental <i>hospital</i> ; nothing for as many days as are <i>medically necessary</i> in a general <i>hospital</i> and for up to 60 days per calendar year in a mental <i>hospital</i> when covered by Medex only; then all charges	36
<i>Outpatient treatment:</i> Full benefits less the Part B <i>deductible</i> and Part B <i>coinsurance</i> (nothing for services that are not covered by <i>Medicare</i>)	<i>Outpatient treatment:</i> The Part B <i>coinsurance</i> for as many visits as are <i>medically necessary</i> for <i>Medicare</i> and Medex <i>covered services</i> ; and full benefits when covered by Medex only for up to 24 visits per calendar year	<i>Outpatient treatment:</i> The Part B <i>deductible</i> for <i>Medicare</i> and Medex <i>covered services</i> for as many visits as are <i>medically necessary</i> ; and nothing for up to 24 visits per calendar year when covered by Medex only; then all charges	36
Oxygen and Equipment			
Full benefits less the Part B <i>deductible</i> and Part B <i>coinsurance</i>	The Part B <i>coinsurance</i>	The Part B <i>deductible</i>	37
Podiatry Care			
Full benefits less the Part B <i>deductible</i> and Part B <i>coinsurance</i>	The Part B <i>coinsurance</i>	The Part B <i>deductible</i>	37

*Benefits for *covered services* are provided based on the *allowed charge*. You may have to pay any amount over the *allowed charge*. (See Parts 2 and 9.)

Part 1 Schedule of Benefits

Medicare Provides	Medex Provides	Your Cost*	Page
Preventive Health Services			
For bone mass density testing: Full benefits less the Part B <i>deductible</i> and Part B <i>coinsurance</i> for procedures to identify bone mass, detect bone loss or determine bone quality, including a <i>physician's</i> interpretation of the results, according to frequency limits set by <i>Medicare</i>	For bone mass density testing: The Part B <i>coinsurance</i> for procedures to identify bone mass, detect bone loss or determine bone quality, including a <i>physician's</i> interpretation of the results, according to frequency limits set by <i>Medicare</i>	For bone mass density testing: The Part B <i>deductible</i> for procedures to identify bone mass, detect bone loss or determine bone quality according to frequency limits set by <i>Medicare</i>	38
For diabetes self-management training services: Full benefits less the Part B <i>deductible</i> and Part B <i>coinsurance</i>	For diabetes self-management training services: The Part B <i>coinsurance</i>	For diabetes self-management training services: The Part B <i>deductible</i>	38
For family planning: Nothing	For family planning: Full benefits	For family planning: Nothing	39
For glaucoma tests: Full benefits less the Part B <i>deductible</i> and Part B <i>coinsurance</i> for one glaucoma test every 12 months for a high risk <i>member</i>	For glaucoma tests: The Part B <i>coinsurance</i> for one glaucoma test every 12 months for a high risk <i>member</i>	For glaucoma tests: The Part B <i>deductible</i> for one glaucoma test every 12 months for a high risk <i>member</i>	39
For routine colorectal cancer screening: Full benefits less the Part B <i>deductible</i> and Part B <i>coinsurance</i> for one fecal-occult blood test per year for a <i>member</i> age 50 or older, one flexible sigmoidoscopy every four years for a <i>member</i> age 50 or older, one colonoscopy every two years for a high risk <i>member</i> of any age and other screening tests that <i>Medicare</i> determines appropriate	For routine colorectal cancer screening: The Part B <i>coinsurance</i> for one fecal-occult blood test per year for a <i>member</i> age 50 or older, one flexible sigmoidoscopy every four years for a <i>member</i> age 50 or older, one colonoscopy every two years for a high risk <i>member</i> of any age and other screening tests that <i>Medicare</i> determines appropriate	For routine colorectal cancer screening: The Part B <i>deductible</i> for one fecal-occult blood test per year for a <i>member</i> age 50 or older, one flexible sigmoidoscopy every four years for a <i>member</i> age 50 or older, one colonoscopy every two years for a high risk <i>member</i> of any age and other screening tests that <i>Medicare</i> determines appropriate	40

*Benefits for *covered services* are provided based on the *allowed charge*. You may have to pay any amount over the *allowed charge*. (See Parts 2 and 9.)

WORDS IN ITALICS ARE DEFINED IN PART 2.

Part 1 Schedule of Benefits

Medicare Provides	Medex Provides	Your Cost*	Page
Preventive Health Services (continued)			
For routine cardiovascular screening: Full benefits less the Part B <i>deductible</i> and Part B <i>coinsurance</i> for cholesterol tests and other tests to check blood fat (lipid) levels once every five years	For routine cardiovascular screening: The Part B <i>coinsurance</i> for cholesterol tests and other tests to check blood fat (lipid) levels once every five years	For routine cardiovascular screening: The Part B <i>deductible</i> for cholesterol tests and other tests to check blood fat (lipid) levels once each five years	39
For routine GYN exams and routine Pap smear tests covered by Medicare: Full benefits less the Part B <i>coinsurance</i> (the Part B <i>deductible</i> does not apply) for one routine GYN exam, including a routine Pap smear test, every two years (one per year for a <i>member</i> at high risk for cervical or vaginal cancer)	For routine GYN exams and routine Pap smear tests covered by Medicare: The Part B <i>coinsurance</i> (the Part B <i>deductible</i> does not apply) for one routine GYN exam, including a routine Pap smear test, every two years (one per year for a <i>member</i> at high risk for cervical or vaginal cancer)	For routine GYN exams and routine Pap smear tests covered by Medicare: Nothing for one routine GYN exam, including a routine Pap smear test, every two years (one per year for a <i>member</i> at high risk for cervical or vaginal cancer)	40
For routine GYN exams and routine Pap smear tests not covered by Medicare: Nothing	For routine GYN exams and routine Pap smear tests not covered by Medicare: Full benefits for one routine Pap smear test per calendar year; and nothing for routine GYN exams	For routine GYN exams and routine Pap smear tests not covered by Medicare: Nothing for one routine Pap smear test per calendar year; and all charges for routine GYN exams	40
For routine mammograms: Full benefits less the Part B <i>coinsurance</i> (the Part B <i>deductible</i> does not apply) for one baseline mammogram between age 35 through 39 and one routine mammogram per year for a <i>member</i> age 40 or older	For routine mammograms: The Part B <i>coinsurance</i> (the Part B <i>deductible</i> does not apply) for one baseline mammogram between age 35 through 39 and one routine mammogram per year for a <i>member</i> age 40 or older	For routine mammograms: Nothing for one baseline mammogram between age 35 through 39; and one routine mammogram per year for a <i>member</i> age 40 or older	41

*Benefits for *covered services* are provided based on the *allowed charge*. You may have to pay any amount over the *allowed charge*. (See Parts 2 and 9.)

Part 1 Schedule of Benefits

Medicare Provides	Medex Provides	Your Cost*	Page
Preventive Health Services (continued)			
For routine prostate cancer screening: Full benefits less the Part B <i>deductible</i> and Part B <i>coinsurance</i> for one digital rectal exam and one prostate specific antigen (PSA) blood test per year for a <i>member</i> age 50 or older and other screening tests <i>Medicare</i> determines appropriate	For routine prostate cancer screening: The Part B <i>coinsurance</i> for one digital rectal exam and one prostate specific antigen (PSA) blood test per year for a <i>member</i> age 50 or older and other screening tests <i>Medicare</i> determines appropriate	For routine prostate cancer screening: The Part B <i>deductible</i> for one digital rectal exam and one prostate specific antigen (PSA) blood test per year for a <i>member</i> age 50 or older and other screening tests <i>Medicare</i> determines appropriate	41
For a Medicare approved smoking cessation program: Full benefits less the Part B <i>deductible</i> and Part B <i>coinsurance</i>	For a Medicare approved smoking cessation program: The Part B <i>coinsurance</i>	For a Medicare approved smoking cessation program: The Part B <i>deductible</i>	41
For a “one time” Medicare approved routine physical exam: Full benefits less the Part B <i>deductible</i> and Part B <i>coinsurance</i>	For a “one time” Medicare approved routine physical exam: The Part B <i>coinsurance</i>	For a “one time” Medicare approved routine physical exam: The Part B <i>deductible</i>	41
	Starting January 1, 2011, this one time “Welcome to <i>Medicare</i> ” physical exam is covered in full by <i>Medicare</i> as long as <i>Medicare</i> conditions are met. In addition to this one time physical exam, <i>Medicare</i> provides full benefits for a yearly wellness exam.		
Radiation and X-Ray Therapy			
Full benefits less the Part B <i>deductible</i> and Part B <i>coinsurance</i>	The Part B <i>coinsurance</i>	The Part B <i>deductible</i>	42
Second Opinions			
Full benefits less the Part B <i>deductible</i> and Part B <i>coinsurance</i>	The Part B <i>coinsurance</i>	The Part B <i>deductible</i>	42

*Benefits for *covered services* are provided based on the *allowed charge*. You may have to pay any amount over the *allowed charge*. (See Parts 2 and 9.)

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<i>Medicare Provides</i>	<i>Medex Provides</i>	<i>Your Cost*</i>	Page
Short-Term Rehabilitation Therapy (physical therapy, occupational therapy and speech/language therapy)			
Full benefits less the Part B <i>deductible</i> and Part B <i>coinsurance</i> for services covered by <i>Medicare</i>	The Part B <i>coinsurance</i> (full benefits for certain services not covered by <i>Medicare</i>)	The Part B <i>deductible</i> (nothing for services covered by Medex only)	42
Surgery as an <i>Outpatient</i>			
Full benefits less the Part B <i>deductible</i> and Part B <i>coinsurance</i>	The Part B <i>coinsurance</i>	The Part B <i>deductible</i>	42

*Benefits for *covered services* are provided based on the *allowed charge*. You may have to pay any amount over the *allowed charge*. (See Parts 2 and 9.)

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Definitions

The following terms are shown in italics in this Direct-Billed Medex *contract*. These terms will give you a better understanding of your benefits.

Accident

Any bodily injury that you sustain as the direct result of an *accident*. This does not include any injury that is the result of a: disease; bodily infirmity; or any other cause. *Blue Cross and Blue Shield* provides benefits as described in this Direct-Billed Medex *contract* for treatment of *accidents*.

Allowed Charge

The charge that is used to calculate payment of the Medex benefits that are described in this Direct-Billed Medex *contract*. The *allowed charge* depends on whether a service is: eligible for benefits under *Medicare*; or eligible for benefits under Medex only.

- For a service that is eligible for benefits under *Medicare*, the term *allowed charge* has the same meaning as fee schedule amount, payment rate or reasonable charge does under *Medicare*. *Medicare* sets the *allowed charge* for a service. They set it according to a special formula. (See your *Medicare* handbook for details.) You may have to pay the amount of the actual charge that is more than the *allowed charge*. (See Part 9.)
- For a service that is eligible for benefits under Medex only, for *covered providers* that have a payment agreement with *Blue Cross and Blue Shield*, the *allowed charge* is based on the provisions of that provider's payment agreement. In general, when you share in the cost for *covered services*, the calculation for the amount that you pay is based on the initial full *allowed charge* for the provider. This amount that you pay is generally not subject to future adjustments—up or down. This is the case even though the provider's payment may be subject to future adjustments for such things as: provider contractual settlements; risk-sharing settlements; and fraud or other operations. In most cases, you do not have to pay the amount of the actual charge that is more than the *allowed charge*. But, you must pay this excess amount when: *covered services* are furnished by professional providers and you could have received benefits or services from someone else without charge; or you have received or will receive payment from another person or insurance company. Once these payments from the other person or insurance company have been applied to your provider balances and have been used up, you do not have to pay the excess charge.

For *covered providers* that do not have a payment agreement with *Blue Cross and Blue Shield*, the *allowed charge* is the provider's actual charge.

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Benefit Period

A way of measuring your use of services under *Medicare* and/or *Medex*. A *benefit period* starts on the first day (that is not part of a prior *benefit period*) on which you receive *covered services* as an *inpatient*: in a *hospital*; or in a *skilled nursing facility*. It ends once you have gone 60 days in a row without being an *inpatient* in a *hospital*, *skilled nursing facility* or in a similar facility.

Blood Deductible

The non-replacement fee for the first three pints or units of blood or packed red blood cells that you use each calendar year. A *hospital* or *skilled nursing facility* cannot charge you for any of the first three pints of blood. This is the case when: you personally replace the blood; or you arrange to have it replaced by another person or organization. *Blue Cross and Blue Shield* provides benefits as described in this Direct-Billed *Medex contract* for the *blood deductible*.

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 to take action called for under this Direct-Billed *Medex contract*.

Coinsurance

The portion of the *Medicare* allowed amount for covered services that *Medicare* does not pay. There are two types of *Medicare coinsurance*, Part A and Part B.

Medicare Part A Coinsurance

There are three types of Part A *coinsurance*:

- The *inpatient hospital daily coinsurance* for covered *hospital* services that you receive from the 61st through the 90th day in each *benefit period*. This is equal to one fourth of the Part A *deductible*.
- The *inpatient hospital daily coinsurance* for each of your 60 *hospital inpatient* reserve days. This is equal to one half of the Part A *deductible*.
- The extended care services daily *coinsurance* for *inpatient skilled nursing facility* services that you receive from the 21st through the 100th day in each *benefit period* when these services are covered by *Medicare*. This is equal to one eighth of the Part A *deductible*.

The Part A *coinsurance* is determined by the dates on which you receive covered *inpatient* care. A *benefit period* may continue over more than one calendar year. If this is the case, then the Part A *coinsurance* may change with the new calendar year. *Blue Cross and Blue Shield* provides benefits as described in this

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Direct-Billed Medex *contract* for the Part A *coinsurance*. *Blue Cross and Blue Shield* provides these benefits for *inpatient hospital* services.

Medicare Part B Coinsurance

For most *Medicare* Part B covered services, the Part B *coinsurance* is equal to 20% of the *Medicare* allowed amount. However, for certain *outpatient hospital*, *skilled nursing facility* and mental health center services, *Medicare* pays a set dollar amount (payment rate). This payment rate reflects the wages in the area where you get the services. (See your *Medicare* handbook for details.)

Blue Cross and Blue Shield provides benefits as described in this Direct-Billed Medex *contract* for the Part B *coinsurance*. This is usually 20% of the *Medicare* allowed amount (or a fixed copayment amount) for each *covered service*.

Note: When *Blue Cross and Blue Shield* provides benefits for the Part B *coinsurance* for *outpatient* services that you receive at a *hospital*, the actual amount that is paid to the *hospital* depends on whether the *hospital* has a payment agreement with *Blue Cross and Blue Shield*. You will not owe the *hospital* any portion of the Part B *coinsurance* for *covered services*.

Contract

This Direct-Billed Medex *contract*. This includes your Direct-Billed Medex Policy. It also includes: any *riders* or other changes to this Direct-Billed Medex *contract*; and your enrollment form. This Direct-Billed Medex *contract* will be governed by and construed according to the laws of the Commonwealth of Massachusetts. This is the case except as preempted by federal law.

You hereby expressly acknowledge your understanding that this *contract* constitutes a contract that is solely between you and Blue Cross and Blue Shield of Massachusetts, Inc. (*Blue Cross and Blue Shield*), which is an independent corporation that operates 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 that are created under this *contract*. This paragraph will not create any additional obligations whatsoever on the part

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of *Blue Cross and Blue Shield* other than those obligations that are created under other provisions of this *contract*.

Covered Provider

A health care provider for which *Blue Cross and Blue Shield* provides benefits under this Direct-Billed Medex *contract* when *covered services* are furnished to you. This Direct-Billed Medex *contract* tells you the kinds of providers that are covered. (See Part 9.) Except as stated otherwise, the health care provider must be eligible to provide services that are covered by *Medicare*. Health care providers that may furnish *covered services* to you include: ambulance services; ambulatory surgical facilities; cardiac rehabilitation centers; certified registered nurse anesthetists; chiropractors; Christian Science sanatoriums; chronic disease *hospitals*; clinical specialists in psychiatric and mental health nursing; community health centers; comprehensive outpatient rehabilitation facilities; day care centers; dentists; detoxification facilities; diagnostic imaging facilities; dialysis facilities; *durable medical equipment* suppliers; general *hospitals*; home health agencies; home infusion therapy providers; hospice providers; licensed audiologists; licensed dietitian nutritionists; licensed independent clinical social workers; licensed mental health counselors; licensed speech-language pathologists; *Medicare* certified independent labs; mental health centers; mental *hospitals*; nurse midwives; nurse practitioners; occupational therapists; optometrists; physical therapists; *physician* assistants; *physicians*; podiatrists; psychologists; rehabilitation *hospitals*; rural health clinics; *skilled nursing facilities*; and any other *Medicare covered providers* that are not listed in this section, but for which *Blue Cross and Blue Shield* provides benefits. For services that are eligible for benefits under Medex, but not under *Medicare*, this also includes mental health providers other than those listed in this section when designated by *Blue Cross and Blue Shield* to furnish *covered services* to you.

Blue Cross and Blue Shield provides benefits as described in this Direct-Billed Medex *contract* for services that are furnished by providers that do not have an agreement with *Blue Cross and Blue Shield*. (See Part 9 for more information.) But, if you want to find out if a health care provider has a payment agreement with *Blue Cross and Blue Shield*, you may call Medex Member Service.

Note: If you are looking for more specific information regarding your *physicians*, the Massachusetts Board of Registration in Medicine may have a profile available at www.massmedboard.org.

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Covered Services

The health care services or supplies for which *Blue Cross and Blue Shield* provides benefits as described in this Direct-Billed Medex *contract*. This includes any *riders* to this Direct-Billed Medex *contract*. These health care services or supplies must be furnished by *covered providers* in order for you to receive the benefits that are provided under this Direct-Billed Medex *contract*. (See Part 9 for more information about *covered providers*.)

Custodial Care

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

- Care that is given primarily by medically-trained personnel for a *member* who shows no significant improvement response despite extended or repeated treatment; or
- Care that is given for a condition that is not likely to improve, even if the *member* receives attention of medically-trained personnel; or
- Care that is given for the maintenance and monitoring of an established treatment program, when no other aspects of treatment require an acute level of care; or
- Care that is given for the purpose of meeting personal needs. This care could be provided by persons without medical training, such as assistance with mobility, dressing, bathing, eating and preparation of special diets and taking medications; or
- Care that is given to maintain the *member's* or anyone else's safety. (*Custodial care* does not mean care that is given to maintain the *member's* or anyone else's safety when that *member* is an *inpatient* in a psychiatric unit.)

Note: For *covered services* that are eligible for benefits under *Medicare*, *Blue Cross and Blue Shield* uses *Medicare's* guidelines to determine if a type of care is considered to be *custodial care*.)

Deductible

The amount of the *Medicare allowed charge* that must be paid before *Medicare* benefits start. There are two types of *deductibles*, Part A and Part B. *Medicare* sets the amounts of the Part A and Part B *deductibles*. They may change as *Medicare* costs go up. (Your *Medicare* handbook tells you the amount of the *deductibles*.) The Part A *deductible* must be paid once each *benefit period*. The Part B *deductible* must be paid once each calendar year. *Blue Cross and Blue Shield* **does not** provide benefits under this Direct-Billed Medex *contract* for the Part A or Part B *deductible*.

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Diagnostic Lab Tests

The examination or analysis of tissues, liquids or wastes from the body. This also includes: the taking and interpretation of 12-lead electrocardiograms; and all standard electroencephalograms.

Diagnostic X-Ray and Other Imaging Tests

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 include: 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.

Durable Medical Equipment

Medicare approved equipment that: can stand repeated use; serves a medical purpose; is not useful if you are not ill or injured; and can be used in the home. Some examples of items that are covered by *Medicare* and for which *Blue Cross and Blue Shield* provides benefits as described in Part 4 include: hospital beds; commodes; wheelchairs; canes; crutches; walkers; respirators; inhalators; nebulizers; oxygen equipment; glucometers; and supplies such as oxygen that are necessary for the effective use of *durable medical equipment*.

Note: Items such as artificial arms, legs and eyes that meet the definition of *durable medical equipment* are covered by *Medicare* as prosthetic devices. (See your *Medicare* handbook for more information.)

Effective Date

The date, as shown on *Blue Cross and Blue Shield's* records, on which your membership under this Direct-Billed Medex *contract* starts. Or, the date on which a change to this Direct-Billed Medex *contract* takes effect.

Emergency Medical Care

Medical, surgical or psychiatric care that you need immediately due to the sudden onset of a condition manifesting itself by symptoms of sufficient severity, including severe pain, which are severe enough that the lack of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing your 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, result in 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.

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This also includes treatment of *mental or nervous 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 a plan to harm another person.

Note: For *covered services* that are eligible for benefits under *Medicare*, *Blue Cross and Blue Shield* uses *Medicare's* guidelines or decisions to determine whether your condition requires *emergency medical care*.

Hospital

A *hospital* as defined by *Medicare* and that is approved for payment as a *hospital* by *Medicare*; or that is licensed as a *hospital* by the appropriate jurisdiction where it is located. The term “*hospital*” does not include a: convalescent nursing home; rest facility; or facility for the aged that primarily furnishes *custodial care*, which includes training in activities of daily living.

Blue Cross and Blue Shield provides benefits as described in this Direct-Billed Medex contract for *hospital* services that are covered by Medex only. This means that *Medicare* does not make any payment for these services.

Inpatient

A registered bed patient in a facility. A patient who is kept overnight in a *hospital* solely for observation is not considered a registered *inpatient*. This is true even though the patient uses a bed. In this case, the patient is considered an *outpatient*.

Medical Technology Assessment Guidelines

For *covered services* that are eligible for benefits under Medex but not under *Medicare*, the guidelines that *Blue Cross and Blue Shield* uses to assess whether a technology improves health outcomes such as: length of life; or ability to function. (For *covered services* that are eligible for benefits under *Medicare*, *Blue Cross and Blue Shield* uses *Medicare's* guidelines to make this assessment.) These guidelines include the following five criteria:

- 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 Food and Drug Administration (FDA). Any approval that is granted as an interim step in the FDA regulatory process is not sufficient. Except as required by law, *Blue Cross and Blue Shield* may limit benefits for drugs, biological products and

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devices to those specific indications, conditions and methods of use that are 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 that are 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 that are related to a: disease; injury; illness; or condition. In addition, there should be evidence or a convincing argument that is 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. It should improve the net outcome as much as or more than established alternatives. And, it must be as cost effective as any established alternatives that achieve a similar health outcome.
- The improvement must be attainable outside of the investigational setting. When it is used under the usual conditions of medical practice, the technology should be reasonably expected to improve health outcomes to a degree that is comparable to that published in the medical literature.

Medically Necessary

All *covered services* except for preventive health services must be *medically necessary* and appropriate for your specific health care needs. This means that all *covered services* must be consistent with generally accepted principals of professional medical practice. For *covered services* that are eligible for benefits under *Medicare, Blue Cross and Blue Shield* decides which services are *medically necessary* and appropriate for you. *Blue Cross and Blue Shield* does this by using *Medicare's* "reasonable and necessary" guidelines. For *covered services* that are eligible for benefits under Medex but not under *Medicare, Blue Cross and Blue Shield* decides which *covered services* are *medically necessary* and appropriate for you. *Blue Cross and Blue Shield* does this by using the following guidelines. All health care services must be required to diagnose or to treat your: illness; injury; symptom; complaint; or condition. And, they must also be:

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- Consistent with the diagnosis and treatment of your condition; and for services that are covered by Medex only, they must be furnished in accordance with *Blue Cross and Blue Shield* medical policy and *medical technology assessment guidelines*.
- Essential to improve your net health outcome; and as beneficial as any established alternatives that are covered by this Direct-Billed Medex *contract*. This means that for services that are covered by Medex only, if *Blue Cross and Blue Shield* determines that your treatment is more costly than an alternative treatment, benefits are provided for the amount that would have been provided for the least expensive alternative treatment that meets your needs. In this case, you pay the difference between the claim payment and the actual charge.
- As cost effective as any established alternatives; and consistent with the level of skilled services that are furnished.
- Furnished in the least intensive type of medical care setting that is required by your medical condition.

It is not a service that: is furnished solely for your convenience or religious preference or for the convenience of your family or health care provider; 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.

Medicare

The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

Medicare Eligible Expenses

Expenses that are covered by *Medicare* to the extent that they are recognized as reasonable and necessary by *Medicare*. (See your *Medicare* handbook for details.)

Member

You, the person who has the right to the benefits that are described in this Direct-Billed Medex *contract*.

Mental or Nervous Conditions

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

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Definitions

Outpatient

A patient who is not a registered bed patient in a facility. For example, a patient who is at a health center, provider's office, surgical day care unit or ambulatory surgical facility is considered an *outpatient*. A patient who is kept overnight in a *hospital* solely for observation is also considered an *outpatient*. This is true even though the patient uses a bed.

Physician

A *physician* as defined by *Medicare*. Or, a person who is licensed as a *physician* by the appropriate jurisdiction where he or she is located.

Blue Cross and Blue Shield provides benefits as described in this Direct-Billed Medex contract for *physician* services that are covered by Medex only. This means that *Medicare* does not make any payment for these services.

Rider

An amendment that changes the terms that are described in this Direct-Billed Medex contract. *Blue Cross and Blue Shield* may change the terms of your Direct-Billed Medex contract. For example, a *rider* may change the amount that you must pay for certain services. Or, it may add or limit the benefits that are provided by *Blue Cross and Blue Shield* under this Direct-Billed Medex contract. A *rider* describes the material change that is made to your Direct-Billed Medex contract. *Blue Cross and Blue Shield* will supply you with any *riders* that apply to your benefits under this Direct-Billed Medex contract. You should keep any *riders* with your Direct-Billed Medex contract.

Room and Board

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.

Sickness

An illness or disease of a *member* for which expenses are incurred: on or after your *effective date*; and while this Direct-Billed Medex contract is in force.

Skilled Nursing Facility

A *skilled nursing facility* as defined by *Medicare*. The term “*skilled nursing facility*” does not include a: convalescent nursing home; rest facility; or facility for the aged that primarily furnishes *custodial care*. This includes training in activities of daily living.

When you are in a *skilled nursing facility*, *Blue Cross and Blue Shield* provides benefits as described in this Direct-Billed Medex contract for the *Medicare* Part A

Part 2

Definitions

blood deductible. But Blue Cross and Blue Shield does not provide benefits under this Direct-Billed Medex contract for room and board and special services in a skilled nursing facility.

Special Services

The services and supplies that a facility normally furnishes to its patients for diagnosis or treatment while the patient is in the facility. *Special services* include 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 that are 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.
- Whole blood; packed red blood cells; and the administration of infusions and transfusions. These do not include the cost of: blood donor fees; or blood storage fees that are not eligible for benefits under *Medicare*.
- Internal prostheses (artificial replacements of parts of the body) that are part of an operation. These include things such as: hip joints; skull plates; prosthetic lenses, which include intraocular lenses; and pacemakers. They do not include things such as: ostomy bags; artificial limbs or eyes; hearing aids; or airplane splints.

Part 3

Emergency Medical Services

Obtaining Emergency Medical Services

Both *Medicare* and *Blue Cross and Blue Shield* provide benefits for emergency medical services. These benefits are provided as described in this Direct-Billed Medex *contract*. These emergency medical services may include *inpatient* or *outpatient* services by providers that are qualified to furnish *emergency medical care* and services that are needed to evaluate or to 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. For assistance, call your local emergency medical service system by dialing the emergency telephone access number 911, or the local emergency telephone number. You will not be denied benefits for medical and transportation services described in this Direct-Billed Medex *contract* that you incur as a result of your emergency medical condition.

You usually need emergency medical services because of the sudden onset of a condition manifesting itself by symptoms of sufficient severity, including severe pain, which are severe enough that the lack of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing your 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, result in 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.

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. For example, your condition may require that you be admitted directly from the emergency room for *inpatient emergency medical care* in that *hospital*. If this is the case, you do not have to obtain approval from *Blue Cross and Blue Shield* before you are admitted. Or, your emergency room provider may recommend transfer for *inpatient* care in another facility or *outpatient* follow up care instead. In any case, both *Medicare* and *Blue Cross and Blue Shield* provide benefits for post-stabilization care. These benefits are provided as described in this Direct-Billed Medex *contract*.

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Emergency Medical Services

Filing a Claim for Emergency Medical Services

When you receive covered emergency care services that are eligible for benefits under both *Medicare* and Medex, *Medicare* processes your claim first. Then, *Blue Cross and Blue Shield* usually gets the claim from *Medicare* so you do not have to file a claim. However, there may be times when you will have to file a claim. See Part 7 for more information about filing a claim for repayment.

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Covered Services

You have the right to the benefits that are described in this section. This is the case except as limited or excluded in other sections of this Direct-Billed Medex *contract*. (See Part 5 for a description of your benefits for services that are received outside of the United States.) Also, be sure to read the most current edition of your *Medicare* handbook. This is because in most cases, *Blue Cross and Blue Shield* provides benefits only for services that are eligible for benefits under *Medicare* Part A and/or Part B. Your *Medicare* handbook explains the benefits that you get under the *Medicare* program. It also describes the restrictions that apply to your *Medicare* benefits.

Admissions for *Inpatient* Medical and Surgical Care

Hospital Services

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for all of the available *Medicare* days in a *benefit period*. This is the case when you are an *inpatient* in a *hospital* other than a mental *hospital*. After you have used all of your *Medicare* days in a *benefit period*, *Blue Cross and Blue Shield* provides full benefits based on the *allowed charge* for: semiprivate *room and board*; and *special services*. (If you have a right to *Medicare hospital inpatient* reserve days, then you must use these days before *Blue Cross and Blue Shield* provides benefits after the 90th day in a *benefit period*.) *Blue Cross and Blue Shield* provides these benefits for up to a lifetime total of 365 days. This is the case when you are an *inpatient* in a general, chronic disease or rehabilitation *hospital*.

Note: Any lifetime days that you use in a general, chronic disease or rehabilitation *hospital* for medical and/or surgical care will reduce the number of lifetime days that are available in a general or mental *hospital* for treatment of any *mental or nervous conditions*. (See “Mental Health and Substance Abuse Treatment” later on in Part 4.)

Christian Science Sanatorium Services

When you are an *inpatient* in a Christian Science sanatorium that is operated, or listed and certified, by the First Church of Christ, Scientist, in Boston, Massachusetts, *Blue Cross and Blue Shield* provides benefits for *hospital* services as described in Part 4.

Note: *Medicare* provides full semiprivate benefits less the Part A daily *coinsurance* for up to 30 days in each *benefit period* when you are in a *skilled nursing facility*. But, *Blue Cross and Blue Shield* does not provide benefits for the *Medicare* Part A *coinsurance* for these 30 days.

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Covered Services

Coverage for Blood as an *Inpatient* in a *Hospital* or *Skilled Nursing Facility*

Blue Cross and Blue Shield provides benefits for the *Medicare* Part A *blood deductible* (if it has not already been met). This is the case when you are an *inpatient* in a *hospital* or *skilled nursing facility*. *Blue Cross and Blue Shield* also provides benefits for the *Medicare* Part B *blood deductible*. (See “Coverage for Blood as an *Outpatient* in a *Hospital*” later on in Part 4.) You have to meet only one Part A or Part B *blood deductible* each calendar year. (See your *Medicare* handbook for details.)

Note: A *hospital* or *skilled nursing facility* cannot charge you for any of the first three pints of blood that you personally replace or that you arrange to have replaced by another person or organization.

Physician and Other Covered Professional Provider Services

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for all *inpatient* services that are covered by *Medicare*. This is the case when the services are furnished by a *physician* or another *Medicare* covered professional provider. This includes a: podiatrist; certified registered nurse anesthetist; nurse midwife or nurse practitioner. *Blue Cross and Blue Shield* provides these benefits for as many days as are *medically necessary* for your condition.

Medicare has restrictions on certain types of services. These restrictions are described in your *Medicare* handbook. For example, in most cases *Medicare* does not provide benefits for dentists’ services. When it does, *Blue Cross and Blue Shield* also provides benefits based on the *allowed charge* for these *covered services*. But, even when *Medicare* does not provide benefits for the dentist’s services, *Medicare* and *Blue Cross and Blue Shield* do provide benefits for *inpatient hospital* charges as described earlier in Part 4. This is the case when *Medicare* determines that a medical condition or the severity of a dental procedure requires that you be admitted to a *hospital* as an *inpatient* in order for the dentist’s services to be safely performed. Some examples of serious medical conditions are: hemophilia; and heart disease. (See Part 5, “Dental Care.”)

When they are not covered by *Medicare*, *Blue Cross and Blue Shield* also provides full benefits based on the *allowed charge* for certain *inpatient* services that are furnished by a *physician* (for example, stem cell transplants for breast cancer). *Blue Cross and Blue Shield* provides these benefits for as many days as are *medically necessary* for your condition.

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Covered Services

Women's Health and Cancer Rights

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for breast reconstruction in connection with a mastectomy. *Blue Cross and Blue Shield* provides these benefits 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 medical care services to treat 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.

Human Organ and Stem Cell ("Bone Marrow") Transplants

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for human organ and stem cell transplants **only** when they are eligible for benefits under *Medicare*. There is one exception. *Blue Cross and Blue Shield* provides full benefits based on the *allowed charge* for one or more stem cell 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. (These stem cell transplants are not eligible for benefits under *Medicare*.) For covered transplants, benefits include: *room and board* and *special services*; *physician services*; *hospital* and *physician* services for the harvesting of the donor's organ or stem cells when the recipient is a *member* ("harvesting" includes the surgical removal of the donor's organ or stem cells and related *medically necessary* services and/or tests that are required to perform the transplant itself); and drug therapy during the transplant procedure to prevent rejection of the transplanted organ/tissue or stem cells.

Ambulance Services

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for:

- *Medicare* approved ambulance transport to an emergency medical facility for *accident* treatment or for *emergency medical care*. For example, covered ambulance services include transport from an *accident* scene or to a *hospital* due to symptoms of a heart attack. (See your *Medicare* handbook for details.)

Note: If you need assistance at the onset of an emergency medical condition that in your judgment requires *emergency medical care*, call your local emergency medical service system by dialing the emergency telephone access number 911, or the local emergency telephone number.

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- Other *medically necessary Medicare* approved ambulance transport by an ambulance service. This is to take you to or from a *hospital* or another covered facility.

Cardiac Rehabilitation

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for *outpatient* cardiac rehabilitation when these services are furnished by a *Medicare covered provider*.

Chiropractor Services

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for chiropractic services when they are furnished by a chiropractor. These benefits are limited to manual manipulation of the spine. This is to correct a subluxation that can be shown by x-ray.

No benefits are provided for x-rays or other services that are furnished by a chiropractor.

Coverage for Blood as an *Outpatient* in a *Hospital*

Blue Cross and Blue Shield provides benefits for the *Medicare Part B blood deductible* (if it has not already been met). This is the case when you are an *outpatient* in a *hospital*. *Blue Cross and Blue Shield* also provides benefits for the *Medicare Part A blood deductible*. (See “Coverage for Blood as an *Inpatient* in a *Hospital* or *Skilled Nursing Facility*” earlier in Part 4.) You have to meet only one Part A or Part B *blood deductible* each calendar year. (See your *Medicare* handbook for details.)

Note: A *hospital* cannot charge you for any of the first three pints of blood that you personally replace or that you arrange to have replaced by another person or organization.

Diabetic Testing Materials, Drugs, Enteral Formulas and Food Products

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for certain diabetic testing materials, drugs and enteral formulas. *Blue Cross and Blue Shield* provides full benefits based on the *allowed charge* for: enteral formulas that are not covered by *Medicare Part B*; and low protein food products. *Blue Cross and Blue Shield* limits these benefits to:

- Materials to test for the presence of blood sugar when they are ordered by a *physician*; and glucometers as described below for *durable medical equipment* and prosthetic devices.

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- Note:** *Blue Cross and Blue Shield* provides full benefits based on the *allowed charge* for materials to test for the presence of urine sugar. These diabetic testing materials are not covered by *Medicare* Part B.
- Drugs that are covered by *Medicare* Part B. These include: drugs that must be given to you by a *Medicare covered provider* (including a home infusion therapy provider); antigens; clotting factors for a *member* with hemophilia; erythropoietin; drugs that are used for immunosuppressive therapy; injectable drugs that are used for osteoporosis for homebound menopausal women; and chemotherapy and anti-emetic drugs that you can take by yourself.
 - Enteral formulas for home use that are *medically necessary* to treat malabsorption that is caused by: Crohn's disease; chronic intestinal pseudo-obstruction; gastroesophageal reflux; gastrointestinal motility; ulcerative colitis; and inherited diseases of amino acids and organic acids. *Blue Cross and Blue Shield* provides full benefits based on the *allowed charge* for these formulas. This is the case when they are not covered by *Medicare* Part B.
 - Food products that are modified to be low protein when they are *medically necessary* to treat inherited diseases of amino acids and organic acids. These food products are not covered by *Medicare*. *Blue Cross and Blue Shield* provides these benefits for up to \$2,500 in each calendar year. You must pay all charges that are more than this \$2,500 benefit limit in each calendar year. You may buy these food products directly from a distributor.

Dialysis Services

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for: *outpatient* dialysis treatment and self-dialysis training services when they are furnished by a *Medicare covered provider*; and for home dialysis services.

Durable Medical Equipment and Prosthetic Devices

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for: *durable medical equipment*; and prosthetic devices that are needed to take the place of an internal body organ. This includes: prosthetic lenses for a *member* who lacks the organic lens of the eye due to surgical removal or congenital absence; prosthetic contact lenses; and intraocular lenses and one pair of cataract eyeglasses or cataract contact lenses after covered cataract surgery. (Prosthetic lenses, including intraocular lenses are not covered as described in this section when they are furnished by the *hospital* as a *special service*.) Covered items also include: breast prostheses (including mastectomy bras); urinary catheters; orthopedic shoes that are part of a leg brace;

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therapeutic/molded shoes and shoe inserts if you have severe diabetic foot disease; and artificial arms, legs and eyes.

No benefits are provided for: cataract sunglasses when you get them in addition to the regular untinted prosthetic lenses; dental plates; or other dental devices.

Emergency Medical *Outpatient* Services

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for the following services when they are furnished by a *Medicare covered provider*. This includes a nurse practitioner:

- *Emergency medical care*.
- *Accident* treatment.

These benefits are also provided for first non-dental accident treatment (such as first aid and reduction of swelling) when it is furnished by a dentist. (See Part 5, “Dental Care”).

Note: At the onset of an emergency medical condition that in your judgment requires *emergency medical care*, you should go to the nearest emergency room. For assistance, call your local emergency medical service system by dialing the emergency telephone access number 911, or the local emergency telephone number.

Home Health Care

Medicare provides full benefits based on the *allowed charge* for *Medicare* approved home health care when it is furnished by a *Medicare* covered home health care provider. (See your *Medicare* handbook for information about the home health care services that are covered by *Medicare*.) Also, after *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for *durable medical equipment* that is supplied as part of *Medicare* approved home health care services.

Hospice Services

When *Medicare* does not provide full benefits for hospice services, *Blue Cross and Blue Shield* provides benefits for the difference between the amount that *Medicare* pays and the amount that it allows for these services.

When *Medicare* does not provide any benefits for hospice services, *Blue Cross and Blue Shield* provides full benefits based on the *allowed charge* for hospice services as required by state law. This is the case when these services are furnished by (or arranged and billed by) a hospice provider. “Hospice services” means: pain control and symptom relief; and supportive and other care for a *member* who is terminally ill. (The patient is expected to live six months or less.)

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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*. These services may be furnished at home, in the community and in facilities. These hospice benefits include:

- Services that are 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 is care that is furnished to the hospice patient in order to relieve the family or primary care person from care giving functions.
- Bereavement services. These are services that are provided to the family or primary care person after the death of the hospice patient. They can include: contacts; counseling; communication; and correspondence.

Lab Tests, X-Rays and Other Tests

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for *outpatient diagnostic lab tests, diagnostic x-ray and other imaging tests* and other diagnostic tests when they are furnished by a *Medicare covered provider*. This includes a nurse practitioner.

Medical Care *Outpatient* Visits

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for medical care to diagnose or treat your illness or injury when the care is furnished by a *Medicare covered provider*. This includes a nurse practitioner or optometrist. These *covered services* include: clinic, office and home visits; follow up medical care that is related to an accidental injury or medical emergency; medical nutrition therapy services; hormone replacement therapy for peri- and post-menopausal women; medical exams to fit prosthetic lenses when these lenses are covered by *Medicare*; and non-dental services that are furnished by a dentist, but only if the services would normally be covered when they are furnished by a *physician*. (See Part 5, “Dental Care.”) This also includes: monitoring and medication management for *members* who are taking psychiatric drugs; and neuropsychological assessment services. (These services may also be furnished by a *Medicare* covered mental health provider.)

Mental Health and Substance Abuse Treatment

Blue Cross and Blue Shield provides benefits for:

- Services to diagnose and/or treat a biologically-based *mental or nervous condition*.

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“Biologically-based *mental or nervous 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; and any biologically-based *mental or nervous conditions* appearing 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 in consultation with the Commissioner of the Division of Insurance.

- Treatment of rape-related mental or emotional disorders for: victims of a rape; or victims of an assault with intent to rape.
- Services to diagnose and/or treat other *mental or nervous conditions* (including drug addiction and alcoholism).

No benefits are provided for: psychiatric services for a condition that is not a *mental or nervous condition*; residential or other care that is *custodial care*, or for services and/or programs that are not *medically necessary* to treat your condition. Some examples of services and programs that are not covered include (but are not limited to): “outward bound-type,” “wilderness” or “ranch” programs; and services that are performed in educational, vocational or recreational settings.

Biologically-Based *Mental or Nervous Conditions* and Rape-Related Conditions—*Blue Cross and Blue Shield* provides benefits for biologically-based *mental or nervous conditions* and rape-related conditions as follows:

- After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for all of the available *Medicare* days in a *benefit period*. This is the case when you are an *inpatient* in a general or mental *hospital*. After you have used all of your *Medicare* days in a *benefit period* (or you have used all of your 190 *Medicare* lifetime days in a mental *hospital*), *Blue Cross and Blue Shield* provides full benefits based on the *allowed charge* for: semiprivate *room and board*; and *special services*. (If you have a right to *Medicare hospital inpatient* reserve days, then you must use these days before *Blue Cross and Blue Shield* provides benefits after the 90th day in a *benefit period*.) *Blue Cross and Blue Shield* provides these benefits for up to a lifetime total of 365 days. This is the case when you are an *inpatient* in a general or mental *hospital*.

Note: Any lifetime days that you use in a general or mental *hospital* for treatment of any *mental or nervous condition* will reduce the number of lifetime days that are available in a general, chronic disease or rehabilitation *hospital* for medical and/or surgical care. (See “Admissions for *Inpatient* Medical and Surgical Care” earlier in Part 4.)

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- After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for *inpatient* services when they are furnished by a: *physician* (who is a specialist in psychiatry); or psychologist. When the services are not covered by *Medicare*, *Blue Cross and Blue Shield* provides full benefits based on the *allowed charge* for services that are furnished by a: *physician* (who is a specialist in psychiatry); psychologist; or clinical specialist in psychiatric and mental health nursing. (*Medicare* does not provide any benefits for services that are furnished by a clinical specialist in psychiatric and mental health nursing.) *Blue Cross and Blue Shield* provides these benefits for as many days as are *medically necessary* for your condition.
- After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for *outpatient* services that are furnished by a *Medicare* covered mental health provider. When the services are not covered by *Medicare*, *Blue Cross and Blue Shield* provides full benefits based on the *allowed charge* for services that are furnished by a: *physician* (who is a specialist in psychiatry); psychologist; licensed independent clinical social worker; clinical specialist in psychiatric and mental health nursing; or licensed mental health counselor. (*Medicare* does not provide any benefits for services that are furnished by a: clinical specialist in psychiatric and mental health nursing; or licensed mental health counselor.) *Blue Cross and Blue Shield* provides these benefits for as many visits as are *medically necessary* for your condition.

Other Mental or Nervous Conditions (Including Drug Addiction and Alcoholism)—*Blue Cross and Blue Shield* provides benefits as described below for treatment of all other *mental or nervous conditions* (including drug addiction and alcoholism) that are not described in the prior section. *Blue Cross and Blue Shield* provides these benefits as follows:

- After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for all of the available *Medicare* days in a *benefit period*). This is the case when you are an *inpatient* in a general or mental *hospital*. After you have used all of your *Medicare* days in a *benefit period* (or all of your 190 *Medicare* lifetime days in a mental *hospital*), *Blue Cross and Blue Shield* provides full benefits based on the *allowed charge* for: *semiprivate room and board*; and *special services*. (If you have a right to *Medicare hospital inpatient* reserve days, then you must use these days before *Blue Cross and Blue Shield* provides benefits after the 90th day in a *benefit period*.)

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Blue Cross and Blue Shield provides these benefits for:

- Up to 60 days in each calendar year. This is the case when you are an *inpatient* in a mental *hospital*, less any days in a mental *hospital* that were already covered by *Medicare* or Medex in that same calendar year. In certain cases, using these days will reduce the Medex lifetime days that are available in a mental *hospital*. (See below.)
- Up to a lifetime total of 365 days. This is the case when you are an *inpatient* in a general or, in certain cases, a mental *hospital*.

Note: Any lifetime days that you use in a general or mental *hospital* for treatment of any *mental or nervous condition* will reduce the number of lifetime days that are available in a general, chronic disease or rehabilitation *hospital* for medical and/or surgical care. (See “Admissions for *Inpatient* Medical and Surgical Care” earlier in Part 4.)

- After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for *inpatient* services that are furnished by a: *physician* (who is a specialist in psychiatry); or psychologist. When the services are not covered by *Medicare*, *Blue Cross and Blue Shield* provides full benefits based on the *allowed charge* for services that are furnished by a: *physician* (who is a specialist in psychiatry); psychologist; or clinical specialist in psychiatric and mental health nursing. (*Medicare* does not provide any benefits for services that are furnished by a clinical specialist in psychiatric and mental health nursing.) *Blue Cross and Blue Shield* provides these benefits for as many days as are *medically necessary* for your condition. This is the case when you are an *inpatient* in a general hospital. *Blue Cross and Blue Shield* provides benefits for up to 60 days in each calendar year when you are an *inpatient* in a mental *hospital*.
- After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for *outpatient* services that are furnished by a *Medicare* covered mental health provider. When the services are not covered by *Medicare*, *Blue Cross and Blue Shield* provides full benefits based on the *allowed charge* for services by a: *physician* (who is a specialist in psychiatry); psychologist; licensed independent clinical social worker; clinical specialist in psychiatric and mental health nursing; or licensed mental health counselor. (*Medicare* does not provide any benefits for services that are furnished by a: clinical specialist in psychiatric and mental health nursing; or licensed mental health counselor.) *Blue Cross and Blue Shield* provides these benefits for up to 24 visits in each calendar year.

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Intermediate Mental Health Care Services—There are times when you will require *covered services* that are more intensive than the typical *outpatient* services. But, these services may not require that you be admitted for 24-hour *hospital* care. Since these services are covered by both *Medicare* and Medex, *Medicare* determines if you need this type of care. These “intermediate” mental health care services that may be approved by *Medicare* include (but are not limited to): acute residential treatment; partial *hospital* programs; or intensive outpatient programs.

Oxygen and Equipment

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for oxygen and oxygen equipment when it is furnished by a *Medicare covered provider*. These items are classified under the same category as *durable medical equipment* under *Medicare*. (See your *Medicare* handbook for more information.)

Podiatry Care

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for non-routine podiatry (foot) care when it is furnished by a *physician* or podiatrist. These benefits may include:

- *Diagnostic lab tests*.
- Diagnostic x-rays.
- Surgery that is an integral part of the treatment of foot injury.
- Other *medically necessary* foot care such as treatment for hammertoe and osteoarthritis.

No benefits are provided for routine foot care services. This is the case unless they are covered by *Medicare*. Some examples of *Medicare* covered routine foot care services are: trimming of corns, trimming of nails and other hygienic care when the care is *medically necessary* because you have systemic circulatory disease (such as diabetes); and treatment of warts. Also, no benefits are provided for certain non-routine foot care services and supplies. Some examples are: treatment of flat feet or partial dislocations in the feet; foot orthotics, arch supports, shoe (foot) inserts, orthopedic and corrective shoes that are not part of a leg brace (except as described earlier in Part 4 for *durable medical equipment* and prosthetic devices); and fittings, castings and other services that are related to devices for the feet.

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Covered Services

Preventive Health Services

Blue Cross and Blue Shield provides benefits under this Direct-Billed Medex contract for preventive health services that are covered by *Medicare*. Some examples are described below. (See your *Medicare* handbook for more details about all of the preventive health services that are covered by *Medicare*.) Also, *Blue Cross and Blue Shield* provides benefits for family planning services as described below. These services are not covered by *Medicare*.

Bone Mass Density Testing

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for bone mass density testing when it is furnished by a *Medicare covered provider*. These benefits are provided for procedures to: identify bone mass; detect bone loss; or determine bone quality. This includes a *physician's* interpretation of the results, according to frequency limits set by *Medicare*.

Blue Cross and Blue Shield provides benefits for bone mass density testing to a *member*:

- Who is estrogen-deficient and at clinical risk for osteoporosis;
- With vertebral abnormalities;
- Who is receiving long-term glucocorticoid steroid therapy;
- With primary hyperparathyroidism; or
- Who is being monitored to assess the response to or the efficiency of an approved osteoporosis drug therapy.

Diabetes Self-Management Training Services

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for diabetes self-management training services when they are furnished by a *Medicare covered provider*.

Blue Cross and Blue Shield provides these benefits **only** when the *physician* who is managing your diabetic condition certifies that these services are needed under a comprehensive plan of care that is related to your diabetic condition. This is to ensure therapy compliance. It is also to provide you with the skills and knowledge that are necessary to take part in the proper self-management of your diabetic condition. This includes skills that are related to the self-administration of injectable drugs.

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Covered Services

Family Planning

Blue Cross and Blue Shield provides full benefits based on the *allowed charge* for family planning services when they are furnished by a: general *hospital*; community health center; *physician*; nurse practitioner; or nurse midwife. (These services are not covered by *Medicare*.) These benefits include:

- Consultations, exams, procedures and medical services that are related to the use of all contraceptive methods to prevent pregnancy and that have been approved by the United States Food and Drug Administration (FDA).
- Injection of birth control drugs. This includes the prescription drug when it is supplied by the provider during the visit.
- Insertion of a levonorgestrel implant system. This includes the implant system itself.
- IUDs, diaphragms and other prescription contraceptive methods that have been approved by the FDA. This is the case when the items are supplied by the provider during the visit.
- Genetic counseling.

No benefits are provided for: services that are related to achieving pregnancy through a surrogate (gestational carrier); and non-prescription birth control preparations (for example, condoms, birth control foams, jellies and sponges).

Glaucoma Tests

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for one glaucoma test each 12 months when the test is furnished by a *physician* (who is an ophthalmologist) or by an optometrist. These benefits are provided for a *member* who *Medicare* determines to be at high risk for glaucoma. For example, you are considered to be at high risk for glaucoma if you: have diabetes; or have a family history of glaucoma.

Routine Cardiovascular Screening

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for cholesterol tests and other tests to check blood fat (lipid) levels once each five years.

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Covered Services

Routine Colorectal Cancer Screening

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for routine colorectal cancer screening when it is furnished by a *Medicare covered provider*. This includes a nurse practitioner. These *covered services* include:

- One fecal-occult blood test every year for a *member* who is age 50 or older.
- One flexible sigmoidoscopy every four years for a *member* who is age 50 or older.
- One colonoscopy every two years for a *member* of any age. This is the case when the *member* is at high risk for developing colorectal cancer as determined by *Medicare*.
- Other colorectal cancer screening tests and procedures and changes to tests and procedures according to frequency limits set by *Medicare*. This is the case when *Medicare* determines that such tests and procedures are appropriate.

Routine GYN Exams and Routine Pap Smear Tests

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for one routine GYN exam, including a routine Pap smear test, every two years. There is one exception when *Blue Cross and Blue Shield* provides benefits more often. After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for one routine GYN exam, including a routine Pap smear test, every year. This is the case when a *member* is at high risk for developing cervical or vaginal cancer as determined by *Medicare*. These routine GYN exams and routine Pap smear tests must be furnished by a *physician* or another *Medicare covered provider*. This includes a nurse midwife or nurse practitioner.

Blue Cross and Blue Shield provides full benefits based on the *allowed charge* for one routine Pap smear test in each calendar year. This is the case when *Medicare* does not provide benefits for these tests. But, *Blue Cross and Blue Shield* **does not** provide benefits for routine GYN exams that are not covered by *Medicare*.

Note: *Blue Cross and Blue Shield* provides benefits for diagnostic GYN exams as described earlier in Part 4 for medical care *outpatient* visits. *Blue Cross and Blue Shield* also provides benefits for diagnostic Pap smear tests as described earlier in Part 4 for lab tests.

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Covered Services

Routine Mammograms

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for routine mammograms when they are furnished by a *physician* or another *Medicare covered provider*. This includes a nurse midwife. These benefits are limited to:

- One baseline mammogram during the five-year period a *member* is age 35 through 39.
- One routine mammogram every year for a *member* who is age 40 or older.

No benefits are provided for the routine clinic visit or office visit charge. This is the case unless the mammogram is furnished during a covered routine GYN exam.

Note: *Blue Cross and Blue Shield* provides benefits for diagnostic mammograms as described earlier in Part 4 for x-rays.

Routine Prostate Cancer Screening

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for routine prostate cancer screening when it is furnished by a *Medicare covered provider*. These benefits include one digital rectal exam and one prostate specific antigen (PSA) blood test each year for a *member* who is age 50 or older.

Note: *Blue Cross and Blue Shield* may also provide these benefits for other prostate cancer screening tests. This is the case when *Medicare* determines that such tests are appropriate.

Smoking Cessation Program

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for a *Medicare* approved smoking cessation program. This program consists of a maximum of two smoking cessation attempts each year when ordered by a *physician* and furnished by a *Medicare covered provider*. This includes up to four intermediate or intensive sessions for each attempt. (See your *Medicare* handbook for details.)

“One Time” Routine Physical Exam

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for one routine physical exam and an electrocardiogram when these services are furnished by a *physician* or another *Medicare covered provider*. This includes a nurse practitioner. Note: Starting January 1, 2011, this one time “Welcome to *Medicare*” physical exam is covered in full by *Medicare* as long as *Medicare* conditions are met. In addition to this one time physical exam, *Medicare* provides full benefits for a yearly wellness exam.

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Covered Services

Radiation and X-Ray Therapy

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for radiation and x-ray therapy when they are furnished by a *Medicare covered provider*. This includes a nurse practitioner.

Second Opinions

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for an *outpatient* second opinion about your medical care or a second surgical opinion when it is furnished by a *physician*. This may include a third opinion. This is the case when the second opinion differs from the first.

Short-Term Rehabilitation Therapy

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for *outpatient* short-term rehabilitation therapy when it is furnished by a *Medicare covered provider*. This includes: physical therapy; speech/language therapy; occupational therapy; or an organized program of these combined services. *Medicare* has restrictions on certain types of short-term rehabilitation therapy services. They are described in your *Medicare* handbook. *Blue Cross and Blue Shield* also provides benefits for *medically necessary* services to diagnose and treat speech, hearing and language disorders, including when furnished by a licensed audiologist or licensed speech-language pathologist. (However, no benefits are provided when these services are furnished in a school-based setting.)

Surgery as an *Outpatient*

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for *outpatient* surgery that is approved by *Medicare* when it is furnished by a *physician* or another *Medicare covered provider*. This includes a nurse practitioner.

Women's Health and Cancer Rights

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for breast reconstruction in connection with a mastectomy. *Blue Cross and Blue Shield* provides these benefits 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 medical care services to treat 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.

Part 4

Covered Services

Human Organ and Stem Cell (“Bone Marrow”) Transplants

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for human organ and stem cell (“bone marrow”) transplants **only** when they are eligible for benefits under *Medicare*. There is one exception. *Blue Cross and Blue Shield* provides full benefits based on the *allowed charge* for one or more stem cell 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. (These stem cell transplants are not eligible for benefits under *Medicare*.) For covered transplants, benefits include: *hospital special services*; *physician services*; *hospital* and *physician* services for the harvesting of the donor’s organ or stem cells when the recipient is a *member* (“harvesting” includes the surgical removal of the donor’s organ or stem cells and related *medically necessary* services and/or tests that are required to perform the transplant itself); and drug therapy during the transplant procedure to prevent rejection of the transplanted organ/tissue or stem cells.

Oral Surgery

Benefits for oral surgery are limited to *Medicare* approved oral surgery. Some examples are: reduction of a dislocation or fracture of the jaw or facial bone; and excision of a benign or malignant tumor of the jaw. *Blue Cross and Blue Shield* provides benefits for services when they are furnished by a: dentist; or surgical day care unit or ambulatory surgical facility. This is the case when *Medicare* determines that a medical condition or the severity of a dental procedure makes it necessary that you be a patient in a surgical day care unit or ambulatory surgical facility. This is in order for the surgery to be safely performed. Some examples of serious medical conditions are: hemophilia; and heart disease. (See Part 5, “Dental Care.”)

Anesthesia

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for anesthesia services that are related to covered surgery. This includes anesthesia that is administered by a: *physician* other than the attending *physician*; or certified registered nurse anesthetist.

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Limitations and Exclusions

The *covered services* that are described in this Direct-Billed Medex *contract* are limited or excluded as follows:

Admissions Before a *Member's Effective Date*

The benefits that are described in this Direct-Billed Medex *contract* are provided only for *covered services* that are furnished on or after your *effective date*. If you are already an *inpatient* in a *hospital* (or another covered health care facility) on your *effective date*, *Blue Cross and Blue Shield* will provide benefits starting on your *effective date*. But, these benefits are subject to all the provisions that are described in this Direct-Billed Medex *contract*.

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 that is connected to military service. They also include programs that are 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. *Blue Cross and Blue Shield* does not provide supplemental benefits for *covered services* that are not eligible for benefits under *Medicare*. Also, no benefits are provided if you could have received governmental benefits by applying for them on time.

Blood and Related Fees

No benefits are provided for blood donor fees. But, Medex does provide benefits for whole blood and blood components and blood storage fees that are eligible for benefits under *Medicare*. These benefits include the non-replacement fee for the first three pints or units of blood that you use in each calendar year (the *blood deductible*).

Cosmetic Services and Procedures

Benefits for cosmetic services are limited to reconstructive surgery. This non-dental surgery is meant to improve or to give 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. This also includes surgery to correct a deformity or disfigurement that was caused by an accidental injury.

No benefits are provided for cosmetic services as described above if these services are not eligible for benefits under *Medicare*. Also, 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 a *mental or nervous condition*. For example, no

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Limitations and Exclusions

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; and liposuction.

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

No benefits are provided for dental care that is not eligible for benefits under *Medicare*.

Exams/Treatment Required by a Third Party

No benefits are provided for physical, psychiatric and psychological exams, treatments and related services that are required by third parties. Some examples of *non-covered services* are: immunizations; exams and tests that are required for recreational activities, employment, insurance and school; and court-ordered exams and services, except for *medically necessary* services.

Experimental Services and Procedures

The benefits that are described in this Direct-Billed Medex *contract* are provided only when *covered services* are furnished in accordance with *medical technology assessment guidelines*. No benefits are provided for health care charges that are received for or related to care that *Blue Cross and Blue Shield* considers to be experimental services or procedures. The fact that a treatment is offered as a last resort does not mean that benefits will be provided for it. There are two exceptions. As required by law, *Blue Cross and Blue Shield* does provide benefits for:

- One or more stem cell 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. (These stem cell transplants are not eligible for benefits under *Medicare*.)
- Certain drugs that are used on an off label basis. Some examples are: drugs used to treat cancer; and drugs used to treat HIV/AIDS.

Note: For *covered services* that are not eligible for benefits under *Medicare* but are eligible for benefits under Medex, *Blue Cross and Blue Shield* determines whether a service is furnished in accordance with *medical technology assessment guidelines*.

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Eye Exams/Eyewear

No benefits are provided for: eyeglasses and contact lenses; or exams that are needed to prescribe, fit or change them. The only exceptions are described in Part 4.

Foot Care

No benefits are provided for:

- Routine foot care services. This is the case unless they are covered by *Medicare*. Some examples of *Medicare* covered routine foot care services are: trimming of corns, trimming of nails and other hygienic care when the care is *medically necessary* because you have systemic circulatory disease (such as diabetes); and treatment of warts.
- Certain non-routine foot care services and supplies such as: treatment of flat feet or partial dislocations in the feet; foot orthotics, arch supports, shoe (foot) inserts, orthopedic and corrective shoes that are not part of a leg brace (except as described in Part 4 for *durable medical equipment* and prosthetic devices); and fittings, castings and other services that are related to devices for the feet.

Hearing Aids

No benefits are provided for hearing aids or exams that are needed to prescribe, fit or change them.

Human Organ and Stem Cell (“Bone Marrow”) Transplants

No benefits are provided for the harvesting of the donor’s organ or stem cells. This is the case when the recipient is **not** a *member*.

Immunizations and Shots

No benefits are provided for immunizations and shots. This is the case unless they are required because of an injury or immediate risk of infection.

Note: *Medicare* provides full benefits for: pneumococcal vaccine and its administration; and influenza vaccine and its administration. (See your *Medicare* handbook for details.)

Medical Devices, Appliances, Materials and Supplies

No benefits are provided for medical devices, appliances, materials and supplies. The only exceptions are described in Part 4. Some examples of non-covered items are: air conditioners; air purifiers; arch supports; bath seats; bed pans; bath tub grip bars; chair lifts; computers; dehumidifiers; dentures; elevators; foot orthotics; hearing aids; heating pads; hot water bottles; humidifiers; orthopedic and corrective shoes that are not part of a leg brace; raised toilet seats; and in most

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cases, shoe (foot) inserts. But, benefits are provided for therapeutic/molded shoes and shoe inserts for a *member* with severe diabetic foot disease.

Missed Appointments

No benefits are provided for charges for appointments that you do not keep. *Physicians* and other providers may charge you if you do not keep your scheduled appointments. They may do so if you do not give reasonable notice to the office. You must pay for these charges. Appointments that you do not keep are not counted against any visit or dollar limits for benefits described in this Direct-Billed Medex *contract*.

Non-Covered Providers

Unless otherwise specified, *Blue Cross and Blue Shield* provides benefits under this Direct-Billed Medex *contract* only for *covered services* when they are furnished by providers who are eligible to provide services that are covered by *Medicare*. No benefits are provided for any services and supplies furnished by the kinds of providers that **are not** covered under this Direct-Billed Medex *contract*. Any service or supply eligible for benefits under Medex, but not under *Medicare* must be approved by *Blue Cross and Blue Shield* for payment for the specific *covered service*. This Direct-Billed Medex *contract* specifies the kinds of providers that are covered. (See Part 9, “Providers.”)

Non-Covered Services

No benefits are provided for:

- Any service or supply that is not described as a *covered service* in this Direct-Billed Medex *contract*. Some examples of non-*covered services* are: acupuncture; prescription drugs (except when covered by *Medicare* as described in Part 4 or administered to an *inpatient* or *outpatient* in a health care facility covered under this Direct-Billed Medex *contract*); and voluntary sterilization.
- Any service or supply that is not eligible for benefits under *Medicare* Part A and/or Part B. The only exceptions are described in Part 4.
- Services that would normally be eligible for benefits under Medex only, but do not conform with *Blue Cross and Blue Shield's* medical policy and *medical technology assessment guidelines*.
- Services or supplies that you received when you were not enrolled under this Direct-Billed Medex *contract*.
- Any service or supply that is furnished along with a non-*covered service*.

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- Services and supplies that are not considered *medically necessary*. The only exceptions are for the preventive health services that are described in Part 4.
- Services that are furnished to someone other than the patient. This is the case except as described in Part 4 for: hospice services; and the harvesting of a donor's organ or stem cells when the recipient is a *member*.
- Services that are furnished to all patients due to a facility's routine admission requirements.
- A service that is made necessary by an act of war that takes place after your *effective date*.
- The travel time and related expenses of a provider.
- A service for which you are not required to pay or for which you would not be required to pay if you did not have this Direct-Billed Medex *contract*.
- A provider's charge to file a claim. Also, a provider's charge to transcribe or copy your medical records.
- A provider's charge for: shipping and handling; or taxes.
- A separate fee for services that are 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 in another health care facility beyond the discharge time that is determined by *Blue Cross and Blue Shield*.

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 other examples of non-covered items or services are: telephone; radio; television; and personal care services.

Private Duty Nursing

No benefits are provided for private duty nursing services.

Private Room Charges

For covered *room and board*, *Blue Cross and Blue Shield* provides benefits that are based on the semiprivate room rate. If a private room is used, you must pay any charges that are more than the semiprivate room rate. This is the case unless: *Medicare* provides benefits for private room charges when *Medicare* determines that a private room is *medically necessary* for you; or when services are eligible for benefits under Medex only, *Blue Cross and Blue Shield* provides benefits for

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Limitations and Exclusions

private room charges when *Blue Cross and Blue Shield* determines that a private room is *medically necessary* for you.

Refractive Eye Surgery

No benefits are provided for refractive eye surgery for conditions that can be corrected by means other than surgery. This type of surgery includes radial keratotomy.

Reversal of Voluntary Sterilization

No benefits are provided for the reversal of sterilization.

Routine Physical Exams and Tests

No benefits are provided for routine physical exams and tests. This is the case except for the preventive health services that are described in Part 4.

Services and Supplies After a *Member's* Termination Date

No benefits are provided for services and supplies that are furnished after your termination date under this Direct-Billed Medex *contract*. There is one exception. *Blue Cross and Blue Shield* will continue to provide the benefits that are described in this Direct-Billed Medex *contract* for *inpatient* services. *Blue Cross and Blue Shield* will do so **only if** you are receiving covered *inpatient* care on your termination date. In this case, *Blue Cross and Blue Shield* will continue to provide these benefits until: all the Medex benefits that are allowed under this Direct-Billed Medex *contract* have been used up; or the date of discharge, whichever comes first.

Services Furnished by Immediate Family or Members of Your Household

No benefits are provided for a *covered service* that is furnished to you by a provider who is a member of your immediate family or household. (Also, if you are a provider, no benefits are provided for services that you furnish to yourself.) The only exceptions are for items such as covered drugs and biologicals for which *Blue Cross and Blue Shield* provides benefits when they are used by a provider while furnishing a *covered service*. "Immediate family" means any of the following members of your family or household:

- 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 the purposes of providing *covered services*, an in-law

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Limitations and Exclusions

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.
- Those persons who share a common abode with you as part of a single family unit (members of your household). They include domestic employees and others who live together as a single family unit. A roomer or boarder is not included.

Note: For the purposes of this exclusion, 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).

Services Received Outside the United States

Medicare usually does not provide benefits for services received outside the United States or its territories. (See your *Medicare* handbook for details.) When it does, *Blue Cross and Blue Shield* provides the Medex benefits for *covered services* as described in this Direct-Billed Medex *contract*. When it does not, *Blue Cross and Blue Shield* does not provide any benefits for these services. Also, if you set up a residence outside the United States or its territories, *Blue Cross and Blue Shield* will not provide any benefits.

Skilled Nursing Facility Services

No benefits are provided for *room and board* and *special services* when you are in a *skilled nursing facility*.

Part 6

Other Party Liability

Coordination of Benefits (COB)

Blue Cross and Blue Shield will coordinate payment of *covered services* with hospital, medical, dental, health or other plans (except for *Medicare*) 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 under this Direct-Billed Medex *contract*, you must notify *Blue Cross and Blue Shield* if you add or change health plan coverage. Upon 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 Direct-Billed Medex *contract* is secondary, no 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 the secondary payor. To do this, *Blue Cross and Blue Shield* relies on Massachusetts law. This includes the COB regulations that are issued by the Massachusetts Division of Insurance. A copy of these rules is available from *Blue Cross and Blue Shield* upon request. Unless otherwise required by law, coverage under this Direct-Billed Medex *contract* will be secondary when another plan provides you with coverage for health care services.

Blue Cross and Blue Shield will not provide any more benefits than those that are already described in this Direct-Billed Medex *contract*. *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 from any appropriate person, insurance company or other organization.

Note: If you fail to comply with the provisions of this COB section, payment of your claim may be denied.

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Other Party Liability

Blue Cross and Blue Shield Rights to Recover Benefit Payment

Subrogation and Reimbursement of Benefit Payments

If you are injured by any act or omission of another person, the benefits under this Direct-Billed Medex *contract* 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 that you receive is described as payment for other than health care expenses. The amount that you must reimburse *Blue Cross and Blue Shield* will not be reduced by any attorney's fees or expenses that you incur.

Member Cooperation

You must give *Blue Cross and Blue Shield* information and help. This means that 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 that you sustained by an act or omission of another person(s) for which *Blue Cross and Blue Shield* paid benefits. You must not do anything that might limit *Blue Cross and Blue Shield's* right to full reimbursement.

Workers' Compensation

No benefits are provided for health care services that are furnished to treat an illness or injury that *Blue Cross and Blue Shield* determines was work related. This is the case even if you have an agreement with the workers' compensation carrier that releases them from paying for the claims.

All employers provide their employees with workers' compensation or similar insurance. This is done to protect employees in case of a work-related illness or injury. All health care claims for a work-related illness or injury must be billed to the employer's workers' compensation carrier. It is up to you to use the workers' compensation insurance. If *Blue Cross and Blue Shield* pays for any work-related health care services, *Blue Cross and Blue Shield* has the right to get paid back from the party that legally must pay for the health care claims. *Blue Cross and Blue Shield* also has the right, where possible, to reverse payments made to providers.

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Other Party Liability

If you have recovered any benefits from a workers' compensation insurer (or from an employer liability plan), *Blue Cross and Blue Shield* has the right to recover from you the amount of benefits it has paid for your health care services. This is the case even if:

- the workers' compensation benefits are in dispute or are made by means of a settlement or compromise;
- no final determination is made that an injury or illness was sustained in the course of or resulted from your employment;
- the amount of workers' compensation due to medical or health care is not agreed upon or defined by you or the workers' compensation carrier; or
- the medical or health care benefits are specifically excluded from the workers' compensation settlement or compromise.

If *Blue Cross and Blue Shield* is billed in error for these services, you must promptly call or write Medex Member Service.

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When the Provider Files a Claim

For Medicare Part A covered services, *hospitals, skilled nursing facilities* and other *covered providers* must submit claims to *Medicare* for you. You do not have to file claims for these services.

For Medicare Part B covered services and supplies, *physicians* and other *covered providers* must file *Medicare* claims for you. This is the case even if they do not agree or are not required to accept assignment. They must file a claim within one year of the date on which they furnished the service and/or supply to you. Or, they will be subject to certain penalties. (See Part 9, “Payment of Claims for Medicare Part B Covered Services and Supplies.” Also, see your *Medicare* handbook for an explanation of the assignment method and the non-assignment method of paying *Medicare* Part B claims.)

When you receive *covered services* that are eligible for benefits under *Medicare* Part B, *Medicare* processes your claim first. Then, *Blue Cross and Blue Shield* usually gets the claim from *Medicare*. This is so you do not have to file a claim.

For services and supplies that are covered by Medex only, *physicians* and other *covered providers* that have an agreement with *Blue Cross and Blue Shield* will file a claim for you. Just tell the provider that you are a *member*. And show him or her your Medex identification card. Also, be sure to give the provider any other information that is needed to file your claim. You must properly inform your provider. You must do so within 30 days after you receive the *covered service*. If you do not, then benefits will not have to be provided. *Blue Cross and Blue Shield* will pay the provider directly for *covered services*.

When the Member Files a Claim

There are times when you will have to file a claim for *Medicare* and/or Medex benefits. Some examples are described below. The 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 the provider.

You should not have to file a claim for *Medicare* Part A benefits. This is the case unless you receive *hospital* or other health care facility services outside of the United States; and these services are covered by *Medicare*. When you have to file a claim for *Medicare* Part A benefits, you will receive a Medicare Summary Notice. You will receive this notice when your claim has been processed.

You have to file a Medicare claim for Part B benefits when:

- You want a formal Part B coverage determination. This is for services and/or supplies that are not covered by *Medicare*.

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- Your *physician* or another provider refuses to file a claim for you for *covered services* that are eligible for benefits under *Medicare*, even though it is required by law.
- You receive services outside of the United States; and these services are covered by *Medicare*.

When you have to file a claim for *Medicare* Part B benefits, you must remember to send the claim to the *Medicare* carrier for the state where you received the services. You will receive a Medicare Summary Notice. You will receive this notice when your claim has been processed. (Your *Medicare* handbook explains how to file *Medicare* claims. It also tells you what claim forms you will need.)

You have to file a Medex claim when:

- You receive *covered services* that are eligible for benefits under *Medicare*. And, *Blue Cross and Blue Shield* does not get the claim from *Medicare*.
- You get materials to test for the presence of urine sugar or you get enteral formulas that are covered by Medex only. Or, you get low protein food products. (Materials to test for the presence of blood sugar, including glucometers, and in some cases enteral formulas are covered by both *Medicare* Part B and Medex. For this reason, if the provider does not file a claim for you, then you will have to file a claim for your *Medicare* benefits. You must do so before you file a claim for your Medex benefits for these items.)
- You receive a service that is covered by Medex only from a provider that does not have an agreement with *Blue Cross and Blue Shield*.
- You receive services outside of the United States that are covered by both *Medicare* and Medex. In this case, in addition to itemized bills with the date that you received the services, you must get the medical notes for these services. You must first send the claim to *Medicare*. When your claim has been processed, *Medicare* will send you a notice. Then, you will have to file a claim for your Medex benefits.

When you have to file a claim for your Medex benefits, you must:

- Fill out a Medex claim form; and attach original itemized bills that show the date on which you received the services;
- Attach the notice that you receive from *Medicare* to the Medex claim form. You must do this if the *covered services* are also eligible for benefits under *Medicare*; and
- Mail the claim to Medex Member Service. *Blue Cross and Blue Shield* will then process your claim for Medex benefits.

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You can get Medex claim forms from Medex Member Service. *Blue Cross and Blue Shield* will mail to you all the forms that you will need. They will mail these forms to you within 15 days after they receive notice that you obtained some service or supply for which you may be paid. (In the event that *Blue Cross and Blue Shield* fails to comply with this provision or, within 45 days of receiving your claim, fails to send you a check or a notice in writing of why your claim is not being paid or a notice that asks you for more information about your claim, you may be paid interest on your claim. *Blue Cross and Blue Shield* will pay you interest on the claim payment (if any). This is in addition to the claim payment itself. This is the case when the claim is for a *covered service* by a *hospital* or other health care facility or other covered non-professional provider that does not have a payment agreement with *Blue Cross and Blue Shield*. This interest will be accrued beginning 45 days after *Blue Cross and Blue Shield* receives your claim. And, it will be paid at the rate of 1½% for each month, but no more than 18% in a year. This interest payment provision does not apply to a claim which *Blue Cross and Blue Shield* is investigating because of suspected fraud.)

Time Limit for Filing a Claim

When you have to file a *Medicare* claim, you must do so within the time periods that are described in your *Medicare* handbook. When you have to file a Medex claim, you must do so within two years of the date on which you received the *covered service*. *Blue Cross and Blue Shield* will not have to provide benefits for services and/or supplies for which a claim is submitted after this two year period.

Timeliness of Claim Payments

Within 30 calendar days after *Blue Cross and Blue Shield* receives a completed request for Medex benefits or payment, a decision will be made. And, when it is appropriate, payment will be made to the provider (or payment will be made to you if you sent in the claim) for your claim to the extent of your Medex benefits that are described in this Direct-Billed Medex *contract*. Or, you and/or the provider will be sent a notice in writing. The notice will explain why your claim is not being paid in full or in part.

If the request for Medex benefits or payment is not complete or if more information is needed to make a final determination for the claim, *Blue Cross and Blue Shield* will ask for the information. Or, *Blue Cross and Blue Shield* will ask for the records that it needs. *Blue Cross and Blue Shield* will do so within 30 calendar days of receiving the request for Medex benefits or payment. This additional information must be provided to *Blue Cross and Blue Shield*. It must be provided within 45 calendar days of this request.

If the additional information is provided to *Blue Cross and Blue Shield* within 45 calendar days of the request, a decision will be made within the time that is

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remaining in the original 30-day claim determination period. Or, a decision will be made within 15 calendar days of the date on which the additional information is received, whichever is later.

If the additional information is not provided to *Blue Cross and Blue Shield* within 45 calendar days of the request, the claim for Medex benefits or payment will be denied. If the additional information is submitted after this 45 days, then it may be viewed as a new claim for Medex benefits or payment. In this case, a decision will be made within 30 days as described previously in this section.

***Blue Cross and Blue Shield* Will Send You a Written Explanation**

Each time that *Blue Cross and Blue Shield* processes a Medex claim for you on which you owe a balance or for which Medex benefits were denied, *Blue Cross and Blue Shield* will send you an Explanation of Your Medex Benefits. It will tell you how your balance was calculated. Or, it will tell you why your Medex benefits were denied. However, *Blue Cross and Blue Shield* **will not** send you an Explanation of Your Medex Benefits each time that *Blue Cross and Blue Shield* processes a Medex claim for you on which you do not owe a balance. Instead, once each year, *Blue Cross and Blue Shield* will send you a statement. This one statement will list in detail all the Medex claims that *Blue Cross and Blue Shield* paid during the preceding calendar year on which you do not owe a balance.

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You have the right to a review when you disagree with a decision by *Blue Cross and Blue Shield* to deny payment for services that may be eligible for benefits under Medex, or if you have a complaint about the care or service that you received from *Blue Cross and Blue Shield* or from a *covered provider*.

Making an Inquiry and/or Resolving Medex Claim Problems or Concerns

Most Medex problems or concerns can be handled with just one phone call. (See page 3 for more information about *Member Services*.) For help to resolve a Medex problem or concern, you should first call Medex Member Service. You may call them at **1-800-258-2226**. A customer service representative will work with you. They will help you understand your Medex benefits. Or, they will work with you to resolve your problem or concern. They will do this 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: the terms of your Direct-Billed Medex *contract*; the policies and procedures that support the *contract*; the provider's input; as well as your understanding and expectation of benefits. *Blue Cross and Blue Shield* will use every opportunity to be reasonable in finding a solution that makes sense for all parties. And, *Blue Cross and Blue Shield* may use an individual case management approach when it is judged to be appropriate. *Blue Cross and Blue Shield* will follow its standard business practices guidelines when resolving your problem or concern.

If you disagree with the decision that is given to you by the customer service representative or if *Blue Cross and Blue Shield* has not responded within three working days of receiving your inquiry, you may request a review through *Blue Cross and Blue Shield's* formal internal grievance program. If this is the case, *Blue Cross and Blue Shield* will notify you of the steps that you may follow in order to request a formal internal grievance review.

The formal grievance review process that is described below will be followed when your request for a review is because *Blue Cross and Blue Shield* has determined that a service or supply is not *medically necessary* for your condition.

Note: *Medicare* has its own policies and procedures for handling appeals and grievances. See "*Medicare Appeals and Grievances*" below for information about resolving *Medicare* problems and concerns.

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Formal Grievance Review

Internal Formal Grievance Review

How to Request a Grievance Review—In order to request a formal review from *Blue Cross and Blue Shield's* internal Member Grievance Program, you (or your authorized representative) have three options.

- The preferred option is for you to send your grievance in writing. You must send it to:

Member Grievance Program
Blue Cross and Blue Shield of Massachusetts, Inc.
One Enterprise Drive
Quincy, MA 02171-2126
Fax: 1-617-246-3616

Blue Cross and Blue Shield will let you know that your request was received. They will do so by sending you a written confirmation. They will send it within 15 calendar days.

- Or, you may send your grievance to *Blue Cross and Blue Shield's* Member Grievance Program internet address **grievances@bcbsma.com**. *Blue Cross and Blue Shield* will let you know that your request was received. They will do so by sending you a confirmation. They will send it immediately by e-mail.
- Or, you may call *Blue Cross and Blue Shield's* Member Grievance Program. You may call them at **1-800-472-2689**. When your request is made by telephone, *Blue Cross and Blue Shield* will send you a written account of the grievance. They will send it 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 as needed; and they will let you know in writing of the decision or the outcome of the review. If your grievance is regarding termination of 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 coverage does not apply to: services that are limited by dollar or visit maximums and that exceed those maximums; *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 on which you were told of the service denial or the date on which you were told of the claim denial.

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Office of Patient Protection—The Office of Patient Protection of the Massachusetts Department of Public Health is also available to provide *members* with information and/or reports about grievances. To contact the Office of Patient Protection, you may call **1-800-436-7757** or you may fax a request to **1-617-624-5046**. Or, you can visit the Office of Patient Protection’s internet website **www.mass.gov/hpc/opp**.

What to Include in a Grievance Review Request—Your request for a formal grievance review should include: the name and identification number of the *member* who is 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. If *Blue Cross and Blue Shield* needs to review the medical records and treatment information that relate to your 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. This includes 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. (When you are an *inpatient*, a health care provider may act as your authorized representative to ask for an expedited grievance review. You do not have to designate the health care provider in writing.)

Who Handles the Grievance Review—All grievances are reviewed by individuals who are knowledgeable about *Blue Cross and Blue Shield* and the issues that are involved in the grievance. The individuals who will review your grievance will be those who did not participate 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 *medical necessity* denial, at least one grievance reviewer is an individual who is an actively practicing health care professional in the same or similar specialty that usually treats the medical condition, performs the procedure or provides treatment that is the subject of your grievance.

Response Time—The review and response for *Blue Cross and Blue Shield’s* formal internal grievance review will be completed within 30 calendar days. Every reasonable effort will be made to speed up the review of grievances that involve

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health care services that are soon to be obtained by the *member*. (When the grievance review is for services that you have already obtained and it requires a review of your medical 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 calendar days after you are asked for it, *Blue Cross and Blue Shield* may make a final decision about your grievance without that medical information.)

Note: If your grievance review began after an inquiry, the 30-day response time will begin on the day that you tell *Blue Cross and Blue Shield* that you disagree with *Blue Cross and Blue Shield's* answer and that you would like a formal grievance review.

Blue Cross and Blue Shield may extend the time frame to complete a grievance review with your permission. *Blue Cross and Blue Shield* may do this in cases when *Blue Cross and Blue Shield* and the *member* agree that additional time is required to fully investigate and respond to the grievance. A grievance that is not acted upon within the specified time frames will be considered to be 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 coverage for all or part of a health care service or supply, *Blue Cross and Blue Shield's* response will explain the reasons. It will give you the specific medical and scientific reasons for the denial. And it will also give you a description of alternative treatment, health care services and supplies that would be covered and information about requesting an external review.

Grievance Records—*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—In place of the formal grievance review that is described above, you have the right to request an “expedited” review right away. This is the case when your situation is for immediate or urgently-needed services. *Blue Cross and Blue Shield* will review and respond to grievances for immediate or urgently-needed services as follows:

- When your grievance review concerns medical care or treatment for which waiting for a response under the grievance review timeframes that is described above would seriously jeopardize your life or health or your ability to regain maximum function as determined by *Blue Cross and Blue Shield* or your *physician*, or if your *physician* says that you will have severe pain that cannot

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be adequately managed without the care or treatment that is the subject of the grievance review, *Blue Cross and Blue Shield* will review your grievance. And, *Blue Cross and Blue Shield* will notify you of the decision. They will do so within 72 hours after your request is received.

- When a grievance review is requested while the *member* is an *inpatient*, *Blue Cross and Blue Shield* will complete the review and make a decision regarding the request. *Blue Cross and Blue Shield* will do so before the patient is discharged from that *inpatient* stay. Coverage for those services that are in dispute will continue until this review is completed.
- A decision to deny payment for health care services may be reversed within 48 hours. This is the case if the *member's* attending *physician* certifies that a denial for those health care services would create a substantial risk of serious harm to the *member* if the *member* were to wait for the outcome of the normal grievance process.
- A grievance review that is requested by a *member* with a terminal illness will be completed within five working days of receiving the request. In this case, if the expedited review results in a denial for health care services or treatment, *Blue Cross and Blue Shield* will send a letter to the *member* within five working days that explains the specific medical and scientific reasons for the denial and a description of alternative treatment, health care services and supplies that would be covered and information about requesting a hearing. When the *member* requests a hearing, the hearing will be held within ten days. (Or, the hearing will be held within five working days if the attending *physician* determines after consultation with *Blue Cross and Blue Shield's* Medical Director and based on standard medical practice that the effectiveness of the health care service, supply or treatment would be materially reduced if it were not furnished at the earliest possible date.) You and/or your authorized representative(s) may attend this hearing.

External Review From the Office of Patient Protection

For all grievances, you must first go through *Blue Cross and Blue Shield's* formal internal grievance process as described above, unless *Blue Cross and Blue Shield* has failed to comply with the time frames for the internal appeal process 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. In some cases, you are then entitled to a voluntary external review. You are not required to pursue an external review. Your decision whether to pursue it will not affect your other coverage. *Blue Cross and Blue Shield's* grievance review may deny coverage for all or part of a health care service or supply. When you are denied a service or supply because *Blue Cross and Blue*

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Shield has determined that the service or supply is not *medically necessary*, you have the right to an external review. If you receive a denial letter from *Blue Cross and Blue Shield* for this reason, the letter will tell you what steps you should take to file a request for an external grievance review. The review will be conducted by a review agency under contract with the Office of Patient Protection of the Massachusetts Department of Public Health.

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 and Blue Shield*. In addition, you must send the required \$25 fee to pay for your portion of the cost of the review. *Blue Cross and Blue Shield* will be charged the rest of the cost by the Commonwealth of Massachusetts. (Your portion of the cost may be waived by the Commonwealth of Massachusetts in the case of extreme financial hardship.) **If you decide to request an external review, you must file your request within the four months after your receipt of the denial letter from *Blue Cross and Blue Shield*.**

You (or your authorized representative) also have the right to request an “expedited” external review. This request 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.

If your grievance is regarding termination of coverage for concurrent services that were previously approved by *Blue Cross and Blue Shield*, you may request approval to have the disputed coverage continue until the external grievance review process is completed. To do this, you must make your request before the end of the second working day after your receipt of the denial letter from *Blue Cross and Blue Shield*. The request may be approved if it is determined that not continuing these services may pose substantial harm to your health. In the event that coverage is approved to continue, you will not be charged for those health care services, regardless of the outcome of your grievance review. This continuation of coverage does not apply to services: that are limited by day, dollar or visit maximums and that exceed those maximums; that are *non-covered services*; or that are services that were received prior to the time that you requested the external grievance review.

To contact the Office of Patient Protection, you may call **1-800-436-7757**. Or, you may fax a request to **1-617-624-5046**. Or, you can visit the Office of Patient Protection’s website **www.mass.gov/hpc/opp**.

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External Review Process—As required by state regulations, the Office of Patient Protection will determine whether or not your request is eligible for an external review. If it is determined that your request is not eligible, you (or your authorized representative) will be notified within ten working days of the receipt of your request. In the case of an expedited external review, you will be notified within 72 hours of the receipt of your request. The notice sent to you will explain the reasons why your request is not eligible for an external review. The fee that you paid for the review will also be refunded to you with this notice.

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 and Blue Shield* along with a copy of your signed medical information release form.

In some cases, the review agency may need more information about your grievance. If this is the case, they will request it from *Blue Cross and Blue Shield*, you or your authorized representative and, in the case of an expedited grievance, require that it be returned within 24 hours. In the case of a regular review, the information will be required within three working days.

External Review Decision—As required by state regulations, 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 and Blue Shield* within 60 calendar days of the request. If the agency determines additional time is needed to fully and fairly evaluate the request, the agency will notify you and *Blue Cross and Blue Shield* of the extended review period.

In the case of an expedited review, you will be notified of their decision within four working days. This four-day period starts when the external review agency is assigned to your case.

If the review agency overturns *Blue Cross and Blue Shield's* decision in whole or in part, *Blue Cross and Blue Shield* will send you (or your authorized 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 (a) what steps or procedures you must take (if any) to obtain the requested coverage or services; (b) the date by which *Blue Cross and Blue Shield* will pay for or authorize the requested services; and (c) the name and telephone number of the person at *Blue Cross and Blue Shield* who will make sure your grievance is resolved.

The decision made by way of the external review process will be accepted as final.

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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.

Appeals Process for Rhode Island Services

You may also have the right to appeal as described in this section. This is the case when a claim is denied as being not *medically necessary*. If so, these rights are in addition to the other rights to appeal that you have as described in other parts of this Direct-Billed Medex *contract*.

The following provisions apply only to a *member* who is planning to obtain services in Rhode Island that *Blue Cross and Blue Shield* has determined are not *medically necessary*.

Blue Cross and Blue Shield decides which *covered services* are *medically necessary* by using its *medical necessity* guidelines. Some of the *covered services* that are described in this Direct-Billed Medex *contract* may not be *medically necessary* for you. If *Blue Cross and Blue Shield* has determined that services are not *medically necessary* for you, you have the right to the following appeals process:

Reconsideration—Reconsideration is the first step in this appeals process. If you receive a letter denying payment for your health care services, you may request that *Blue Cross and Blue Shield* reconsider its decision by writing to: Member Grievance Program, Blue Cross and Blue Shield of Massachusetts, Inc., One Enterprise Drive, Quincy, MA 02171-2126. You must submit your reconsideration request within 180 days of the adverse decision. Along with your letter, you should include any information that supports your request. *Blue Cross and Blue Shield* will review your request and let you know the outcome of your reconsideration request. *Blue Cross and Blue Shield* will do this within 15 calendar days after receipt of all necessary information.

Appeal—An appeal is the second step in this process. If *Blue Cross and Blue Shield* continues to deny benefits for all or part of the original service, you may request an appeal. You must do this within 60 days of receiving the reconsideration denial letter. 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. In accordance with 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 *physician* who may review your file on your behalf. Your *physician* may review, interpret and disclose any or all of that information to you. Once received by *Blue Cross and Blue Shield*, your appeal will be reviewed by a provider in the same specialty as your attending provider. *Blue Cross and Blue*

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Shield will notify you of the outcome of your appeal within 15 calendar days of receiving all necessary information.

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 and Blue Shield*. If you request this voluntary external appeal, Rhode Island requires you be responsible for half of the cost of the appeal and *Blue Cross and Blue Shield* will be responsible 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 and Blue Shield of Massachusetts, Inc., One Enterprise Drive, Quincy, MA 02171-2126. Along with your request, you must state your reason(s) for your disagreement with *Blue Cross and Blue Shield's* decision. And, you must 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 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* portion 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.

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 or nervous 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. You may do so by contacting *Blue Cross and Blue Shield* at the telephone number that is shown in your letter. *Blue Cross and Blue Shield* will notify you of the result of your expedited appeal. *Blue Cross and Blue Shield* will do this within two working days or 72 hours, whichever is sooner, of its receipt. 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 and Blue Shield of Massachusetts, Inc., 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

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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 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* portion 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. They will do this 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 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. In addition, *Blue Cross and Blue Shield* will repay you for your share of the cost for the external appeal. *Blue Cross and Blue Shield* will do this within 60 days of the receipt of the notice of the final appeal decision.

Medicare Appeals and Grievances

If you do not agree with a decision by *Medicare* on the amount that *Medicare* has paid on a claim or whether the services you received are covered by *Medicare*, you have the right to appeal the decision. The steps you should take to appeal the decision are explained in your *Medicare* handbook. You may also look on the internet website at www.medicare.gov for more detailed information about the *Medicare* appeals process.

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Other *Contract* Provisions

Payment of Claims for *Medicare* Part B Covered Services and Supplies

Claims for *Medicare* Part B covered services and supplies are paid under the assignment method. Or, they are paid under the non-assignment method.

The Assignment Method

When this method is used, both you and the provider agree that the provider will accept the *allowed charge* that is set by *Medicare* as payment in full for *Medicare* Part B covered services and supplies.

Under this method, payment is sent to the provider by both *Medicare* and *Blue Cross and Blue Shield*.

The Non-Assignment Method

When you or the provider does not agree to use the assignment method, your claim will be paid under the non-assignment method.

Except as described below, your provider **does not** have to accept the *allowed charge* that is set by *Medicare* as the total payment for the *covered services* that are described in this Direct-Billed Medex *contract* when claims are paid under the non-assignment method. In these cases, you may have to pay the provider any charge above the *allowed charge* that is set by *Medicare*.

Under this method, payment is sent to you by both *Medicare* and *Blue Cross and Blue Shield*. It is up to you to pay the provider.

For a *covered service* that is eligible for benefits under *Medicare* Part B, you will have to pay the amount above the *allowed charge* that is set by *Medicare*. This is the case when you or your provider does not agree to accept assignment on the claim for that service. There are some exceptions to this rule.

You will not have to pay the amount that is more than the *allowed charge* that is set by *Medicare* when:

- You receive covered ambulance services from a Massachusetts ambulance service. This is the case even when the ambulance service does not agree to accept assignment on the claim for these services.
- You receive *covered services* that are eligible for benefits under *Medicare* from a Massachusetts *physician*. This is true whether or not the *physician* has an agreement with *Blue Cross and Blue Shield*. Or, you receive *covered services* that are eligible for benefits under *Medicare* from another professional provider that does have an agreement with *Blue Cross and Blue Shield*. This is the case even when the *physician* or other professional provider does not agree to accept assignment on the claim for these services. But, *Blue Cross and Blue*

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Shield will not provide benefits that are in excess of any limits that are stated in this Direct-Billed Medex *contract*.

Access to and Confidentiality of Your Medical Records

Blue Cross and Blue Shield and health care providers may, in accordance with applicable law, have access to all medical records and related information that is needed by *Blue Cross and Blue Shield* or health care providers. *Blue Cross and Blue Shield* may collect information from health care providers or other insurance companies. This is to help *Blue Cross and Blue Shield* administer the benefits that are described in this Direct-Billed Medex *contract*. This is also to get facts on the quality of care that is provided under this and other health care contracts. In accordance with law, *Blue Cross and Blue Shield* and health care providers may use this information. And *Blue Cross and Blue Shield* may disclose it to necessary persons and entities as follows:

- For administering benefits (including coordination of benefits with other insurance plans); 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*.
- For bona fide medical research according to the regulations of the U.S. Department of Health and Human Services and the Food and Drug Administration for the protection of human subjects.
- As required by law or valid court order.
- As required by government or regulatory agencies.

Note: To get a copy of *Blue Cross and Blue Shield's* Commitment to Confidentiality statement, you may call Medex Member Service at **1-800-258-2226**.

Blue Cross and Blue Shield will not share information about you with the Medical Information Bureau (MIB). Except as described above, *Blue Cross and Blue Shield* will keep all information confidential and not disclose it without your consent.

You have the right to get the information that *Blue Cross and Blue Shield* collects about you. You may also ask *Blue Cross and Blue Shield* to correct any information that you believe is not correct. *Blue Cross and Blue Shield* may charge a reasonable fee for copying records. This is the case unless your request is because *Blue Cross and Blue Shield* is terminating your benefits under this Direct-Billed Medex *contract*.

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Acts of Providers

Blue Cross and Blue Shield is not liable for the acts or omissions by any individuals or institutions that furnish care or services to you. In addition, a provider who has a payment agreement with *Blue Cross and Blue Shield* or another health care provider does **not** act as an agent on behalf of or for *Blue Cross and Blue Shield*. And, *Blue Cross and Blue Shield* does not act as an agent for providers that have a payment agreement with *Blue Cross and Blue Shield* or other health care providers.

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. It is not up to *Blue Cross and Blue Shield* to find a provider for you. *Blue Cross and Blue Shield* is not responsible if a provider refuses to furnish services to you.

Blue Cross and Blue Shield does not guarantee that you will be admitted to any facility or that you will get a special type of room or service. If you are admitted to a facility, you will be subject to all of its rules. This includes its rules on admission, discharge and the availability of services.

Assignment of Benefits

You cannot assign any benefit or monies that are due under this Direct-Billed Medex *contract* 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 that are provided under this Direct-Billed Medex *contract* to another person or organization.

Authorized Representative

You may choose to have another person act on your behalf concerning your benefits under this Direct-Billed Medex *contract*. 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 certain situations, *Blue Cross and Blue Shield* may consider your health care facility or your *physician* to be your authorized representative. For example, *Blue Cross and Blue Shield* may tell your *hospital* that a proposed *inpatient* admission has been approved. Or, *Blue Cross and Blue Shield* may ask your *physician* for more information if more is needed to make a decision. Or, *Blue Cross and Blue Shield* will consider the provider to be your authorized representative for *emergency medical care* services. *Blue Cross and Blue Shield* will continue to send benefit payments and written communications regarding Direct-Billed Medex coverage in accordance with *Blue Cross and Blue Shield's* standard practices. This is the case unless *Blue Cross and Blue Shield* is specifically requested to do otherwise.

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Note: You can get a form to designate an authorized representative from Medex Member Service.

Benefits for Pre-Existing Conditions

Your benefits under this Direct-Billed Medex *contract* are 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 membership under this Direct-Billed Medex *contract* without a pre-existing condition restriction. But, benefits for these services are subject to all the provisions that are described in this Direct-Billed Medex *contract*.

Changes to This *Contract*

Blue Cross and Blue Shield may change a part of this Direct-Billed Medex *contract*. This is the case if the change is approved by the Commissioner of Insurance. For example, a change may be made to the amount that you must pay for certain services. Or, a change may be made to add benefits. These changes will apply to all contracts of this type. These changes will not apply just to your Direct-Billed Medex *contract*. Each time a change is made, *Blue Cross and Blue Shield* will send you a notice. The notice will usually be included with your bill. The notice will describe the change that is being made. It will also give the *effective date* of the change. When a material change is made to this Direct-Billed Medex *contract*, *Blue Cross and Blue Shield* will also send you a *rider* that describes the change.

If you are already an *inpatient* on the *effective date* of the change, *Blue Cross and Blue Shield* **will not** apply the change to you until you are discharged from that *inpatient* stay.

Note: The benefits that are provided under this Direct-Billed Medex *contract* for *Medicare deductible* and *coinsurance* amounts will be changed automatically. This will be done to coincide with any *Medicare* changes. Premiums may be modified to correspond with such changes if they are approved by the Commissioner of Insurance.

Changes to Your Premium

The amount that you pay directly to *Blue Cross and Blue Shield* for your benefits under this Direct-Billed Medex *contract* is called your “premium.” *Blue Cross and Blue Shield* will send you a bill that will tell you the amount to pay. The bill will also tell you the date on which your payment is due. Whether or not you receive the bill, you must pay the amount that is due on time.

Blue Cross and Blue Shield may change your premium. If *Blue Cross and Blue Shield* does change your premium, the change must be approved by the

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Commissioner of Insurance. The change will apply to all contracts of this type. The change will not apply just to your Direct-Billed Medex *contract*. When *Blue Cross and Blue Shield* files a rate request with the Division of Insurance, *Blue Cross and Blue Shield* will let you know the amount of the request. *Blue Cross and Blue Shield* will enclose a notice with your bill. Or, *Blue Cross and Blue Shield* will send you a separate letter.

Charges for Services That Are Not *Medically Necessary*

You may receive treatment that is otherwise covered as a Medex benefit as described in this Direct-Billed Medex *contract*. But, this treatment is not *medically necessary* for you. In this case, you might be charged for the treatment by the provider. *Blue Cross and Blue Shield* will defend you from a claim for payment for this treatment. *Blue Cross and Blue Shield* will do this if it is furnished by a provider that has a payment agreement with *Blue Cross and Blue Shield*; and that agreement keeps the provider from charging for services that are not *medically necessary*. This does not apply if you were told, knew or reasonably should have known before you received the treatment that it was not *medically necessary*. If you want *Blue Cross and Blue Shield* to defend you in this case, you must let *Blue Cross and Blue Shield* know. You must do this within ten days of the date that the lawsuit to collect for the services is started. Also, you must work with *Blue Cross and Blue Shield* in the defense. If it is judged in the action that the services were *medically necessary*, *Blue Cross and Blue Shield* will provide benefits for them.

Counting *Inpatient* Days

When computing the number of days of benefits that you have under this Direct-Billed Medex *contract*, *Blue Cross and Blue Shield* counts the day of admission. But, *Blue Cross and Blue Shield* does not count the day of discharge.

Providers

This Direct-Billed Medex *contract* tells you the kinds of providers that are covered. **The kinds of providers that are covered under this Direct-Billed Medex *contract* are:**

- ***Hospitals and other facilities.*** These include, but are not limited to: ambulatory surgical facilities; cardiac rehabilitation centers; Christian Science sanatoriums; chronic disease *hospitals*; community health centers; comprehensive outpatient rehabilitation facilities; day care centers; detoxification facilities; free-standing diagnostic imaging facilities; free-standing dialysis facilities; general *hospitals*; *Medicare* certified independent labs; mental health centers; mental *hospitals*; rehabilitation *hospitals*; rural health clinics; and *skilled nursing facilities*.

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Note: *Medicare* does not provide any benefits for services and supplies that are furnished by a *hospital* or another health care facility that does not participate with *Medicare*. There is one exception. *Medicare* provides benefits for *emergency medical care* that you receive in a *hospital* or dialysis facility that does not participate with *Medicare*. This is the case **only when** *Medicare* determines that a *Medicare* participating *hospital* or dialysis facility is not reasonably available.

Blue Cross and Blue Shield provides benefits for *covered services* (including equipment and supplies for home dialysis) that you receive at a *hospital* or dialysis facility that does not participate with *Medicare*. *Blue Cross and Blue Shield* provides the same benefits to which you would have been entitled from Medex had you been in a *hospital* or dialysis facility that participates with *Medicare*. If you have used all of your regular *Medicare* days in a *benefit period* and all of your *Medicare hospital inpatient* reserve days, *Blue Cross and Blue Shield* will provide full semiprivate benefits based on the *allowed charge* for *emergency medical care* in a *hospital* that does not participate with *Medicare*. *Blue Cross and Blue Shield* will provide these benefits under your 365 lifetime days.

- **Professional providers.** These include, but are not limited to; certified registered nurse anesthetists; chiropractors; clinical specialists in psychiatric and mental health nursing; dentists; licensed dietitian nutritionists; licensed independent clinical social workers; licensed mental health counselors; nurse midwives; nurse practitioners; occupational therapists; optometrists; physical therapists; *physician* assistants; *physicians*; podiatrists; and psychologists.
- **Other health care providers.** These include, but are not limited to: ambulance services; *durable medical equipment* suppliers; home health agencies; home infusion therapy providers; and hospice providers;

Note: *Medicare* does not provide any benefits for services and supplies that are furnished by a: home health agency, home infusion therapy provider or hospice provider that does not participate with *Medicare*; or by a *durable medical equipment* supplier that has not been approved by *Medicare* and that does not have a *Medicare* supplier number.

Covered Services in Massachusetts

Unless stated otherwise, *Blue Cross and Blue Shield* provides the benefits that are described in this Direct-Billed Medex *contract* only when *covered services* are furnished by providers that are eligible to provide services that are covered by *Medicare*. The providers that furnish the services do not have to have an agreement with *Blue Cross and Blue Shield* in order for benefits to be provided.

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Covered Services Outside of Massachusetts

Unless stated otherwise, *Blue Cross and Blue Shield* provides the benefits that are described in this Direct-Billed Medex *contract* only when *covered services* are furnished by providers that are eligible to provide services that are covered by *Medicare*. The providers that furnish the services do not have to have an agreement with *Blue Cross and Blue Shield* in order for benefits to be provided. This is the case as long as the provider is approved or licensed under applicable state law to furnish these services.

No benefits are provided for services by the following providers when the services are furnished outside of Massachusetts:

- Clinical specialists in psychiatric and mental health nursing;
- Licensed independent clinical social workers (when the services are covered by Medex only);
- Licensed mental health counselors; and
- Psychologists (when the services are covered by Medex only).

Quality Assurance Programs

Blue Cross and Blue Shield uses quality assurance programs. These programs are designed to improve the quality of health care and services that are provided to *members*. These quality assurance programs affect different aspects of health care such as: disease treatment; and health promotion and service (for example, providing discounts on bicycle safety helmets). From time to time, *Blue Cross and Blue Shield* may add or change the quality assurance programs that it uses. This is to ensure that you continue to receive high-quality health care and services.

Note: For more information about these programs, you may call Medex Member Service at **1-800-258-2226**.

Management and technology solutions have been implemented: to assist *Blue Cross and Blue Shield* anticipate the health care needs of *members*; and to resolve issues quickly and accurately. While the *member* is still on the telephone with a *Blue Cross and Blue Shield* customer service representative, a call can be made directly to a health care provider to try to resolve Medex claim problems.

Utilization Review Program

For *covered services* that are eligible for benefits under *Medicare*, *Medicare* evaluates the necessity and appropriateness of the services. Then, *Blue Cross and Blue Shield* relies on the decision made by *Medicare*.

For *covered services* that are eligible for benefits under Medex only, utilization review is the approach that *Blue Cross and Blue Shield* uses to evaluate the

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necessity and appropriateness of many different services. This approach employs a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. These techniques include: post payment review; and concurrent review and discharge planning.

Note: For more information about the utilization review program, you may call Medex Member Service at **1-800-258-2226**.

Blue Cross and Blue Shield applies *medical technology assessment guidelines* to develop its clinical guidelines and utilization review criteria. In developing these, *Blue Cross and Blue Shield* carefully assesses a treatment in order to determine that it is:

- Consistent with generally accepted principals of professional medical practice; and
- Required to diagnose or to treat your illness, injury, symptom, complaint or condition; and
- Essential to improve your net health outcome; and as beneficial as any established alternatives that are covered by this Direct-Billed Medex *contract*; and
- As cost effective as any established alternatives; and 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.

Blue Cross and Blue Shield reviews clinical guidelines and utilization review criteria. *Blue Cross and Blue Shield* does this periodically to reflect new treatments, applications and technologies. As new drugs are approved by the Food and Drug Administration (FDA), *Blue Cross and Blue Shield* reviews their safety, effectiveness and overall value on an ongoing basis. While a new drug is being reviewed, it will not be covered under this Direct-Billed Medex *contract*.

Concurrent Review and Discharge Planning

Concurrent Review means that while you are an *inpatient* and usually after your *Medicare* days have been used up or when your stay is not eligible for benefits under *Medicare*, *Blue Cross and Blue Shield* will monitor and review the health care services that you receive to make sure that you still need *inpatient* coverage in that facility.

In some cases, *Blue Cross and Blue Shield* may determine, upon review, that you will need to continue *inpatient* coverage in that facility beyond the number of days that were first thought to be required for your condition. When *Blue Cross and*

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Blue Shield makes this decision, *Blue Cross and Blue Shield* will call the health care facility to let the facility know the coverage approval status of the review. This phone call will be made within one working day of receiving all necessary information. *Blue Cross and Blue Shield* will also send a written (or electronic) letter to you and the facility to explain the decision. This letter will be sent within one working day of the phone call to the facility. This letter 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 on which the approved services will begin.

In other cases, based on *medical necessity* determination, *Blue Cross and Blue Shield* may determine that you no longer need *inpatient* coverage in that facility. Or, you may no longer need *inpatient* coverage at all. *Blue Cross and Blue Shield* will make this decision within one working day of receiving all necessary information. *Blue Cross and Blue Shield* will call the health care facility to let the facility know of the decision. And, *Blue Cross and Blue Shield* will discuss plans for continued coverage in a health care setting that better meets your needs. This phone call will be made within 24 hours of the coverage decision. For example, your condition may no longer require *inpatient* coverage in a *hospital*, but still may require skilled nursing coverage. If this is the case, your *physician* may decide to transfer you to a *skilled nursing facility*. Any proposed plans will be discussed with you by your *physician*. All arrangements for discharge planning will be confirmed in writing with you. *Blue Cross and Blue Shield* will send this written (or electronic) explanation to you and the facility within one working day of the phone call to the facility.

If you choose to stay in the facility after you have been notified by your provider or *Blue Cross and Blue Shield* that *inpatient* coverage is no longer *medically necessary*, no more benefits are provided. (There may be an exception to this during the formal review process. See Part 8.) In this case, you must pay all charges for the rest of that *inpatient* stay, starting from the date the written notice is sent to you.

Reconsideration of Adverse Determination—When *Blue Cross and Blue Shield* determines that *inpatient* coverage is not *medically necessary* for your condition, your health care provider may ask for that decision to be reconsidered. In this case, *Blue Cross and Blue Shield* will arrange for a review to be conducted between your provider and a clinical peer reviewer. This review will be conducted within one working day of the request for a review. If the initial decision is not reversed, you (or the health care provider for you) may request a formal review. See Part 8 for the formal review process. (You may ask for a formal review even though your health care provider has not requested a reconsideration review.)

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Note: In some instances, *Blue Cross and Blue Shield* may begin the concurrent review and discharge planning process before your *Medicare* days in that facility are used up. This is to make sure that once *Medicare* benefits are no longer available to you and these services are covered by Medex only, you will continue to receive care in the health care setting that best meets your needs.

Time Limit for Legal Action

Before pursuing a legal action against *Blue Cross and Blue Shield* for any claim under this Direct-Billed Medex *contract*, you must complete *Blue Cross and Blue Shield's* formal internal grievance review (see Part 8). You may, but do not need to, pursue an external review prior to pursuing a legal action.

If, after completing the grievance review, you choose to bring legal action against *Blue Cross and Blue Shield*, this action must be brought within two years after the cause of action arises. For example, if you are filing a legal action because you were denied a service or a claim for benefits under this Direct-Billed Medex *contract*, 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 on which you were first sent a notice of the service or claim denial. Going through the internal formal grievance process does not extend the two-year limit for filing a lawsuit. However, if you choose to pursue a voluntary external review, the days from the date on which your request is received by the external reviewer until the date on which you receive the response are not counted toward the two-year limit.

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Enrollment and Termination

Eligibility for Coverage

You are eligible to enroll under this Direct-Billed Medex *contract* only if you meet **all** of the following requirements:

- You reside in Massachusetts.
- You are eligible for *Medicare* Part A and *Medicare* Part B; and you are enrolled in *Medicare* Part B.

Note: If you drop Part A or Part B of *Medicare*, *Blue Cross and Blue Shield* **will not** provide that portion of the benefits that are normally paid by *Medicare*. But, *Blue Cross and Blue Shield* will still provide the Medex benefits that are available for *covered services* as described in this Direct-Billed Medex *contract*.

- You do not have another direct-billed *Medicare* supplement plan in force that this plan will duplicate. Before this plan goes into effect, you must send written notice to *Blue Cross and Blue Shield*. The notice must state that you intend to cancel that other direct-billed *Medicare* supplement plan.
- If you are under age 65, the disability that qualifies you for *Medicare* is not permanent kidney failure.

If you are covered by Medicaid, you may or may not be eligible to enroll in a Direct-Billed Medex plan. Counseling services are available in Massachusetts. They will provide advice concerning your purchase of *Medicare* supplement insurance and medical assistance through the state Medicaid program. This includes benefits as a Qualified *Medicare* Beneficiary (QMB) and a Specified Low-Income *Medicare* Beneficiary (SLMB). You may call the Massachusetts Executive Office of Elder Affairs insurance counseling program. You can reach them at **1-800-243-4636**. Or, you may write to that office at the following address for more information:

**One Ashburton Place, 5th Floor
Boston, Massachusetts 02108**

Making Membership Changes

If you want to ask for a membership change or you need to change your name or mailing address, you should call or write Medex Member Service. They will send you any special forms that you may need.

You must request the membership change within 30 days of the reason for the change. All membership changes or any additions are allowed only when they comply with the conditions that are outlined in this Direct-Billed Medex *contract* and in *Blue Cross and Blue Shield's* Manual of Underwriting Guidelines.

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Loss of Eligibility for Coverage Under This *Contract*

You are no longer eligible for membership under this Direct-Billed Medex *contract* when:

- You lose your *Medicare* Part A and Part B coverage. In this case, you may be eligible to transfer your coverage to another health care plan that is offered by *Blue Cross and Blue Shield*. This coverage may be for a lower level of benefits than you have under this Direct-Billed Medex *contract* and *Medicare* combined. You can transfer your coverage by: sending *Blue Cross and Blue Shield* a letter that you wish to do so within 63 days after your termination date of membership under this Direct-Billed Medex *contract*; and paying the applicable premium. *Blue Cross and Blue Shield* will answer any questions that you may have at that time.
- You no longer reside in Massachusetts. Any premiums that were paid beyond your termination date will be sent back to you.
- You fail to pay your premium to *Blue Cross and Blue Shield* within 60 days after it is due. If *Blue Cross and Blue Shield* does not receive the full premium on or before the due date, *Blue Cross and Blue Shield* will stop claim payments. *Blue Cross and Blue Shield* will do so as of the last date through which the premium is paid. If *Blue Cross and Blue Shield* does not receive the full premium within 60 days after the due date, *Blue Cross and Blue Shield* will cancel this Direct-Billed Medex *contract*. The termination date will be the last date through which the premium is paid.

In any of these situations, your membership under this Direct-Billed Medex *contract* will be terminated as of the date on which you lose eligibility.

Termination by the *Member*

Your membership under this Direct-Billed Medex *contract* ends when you choose to cancel your Direct-Billed Medex *contract*. You may do so at any time for any reason. To do so, you must contact *Blue Cross and Blue Shield*. *Blue Cross and Blue Shield* will cancel your Direct-Billed Medex *contract* on the date that *Blue Cross and Blue Shield* receives your request. Or, *Blue Cross and Blue Shield* will cancel your Direct-Billed Medex *contract* on a future date of your choice. In any case, any premiums that were paid beyond your termination date will be sent back to you.

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Termination by *Blue Cross and Blue Shield*

You do not have to worry that *Blue Cross and Blue Shield* will cancel you 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 membership under this Direct-Billed Medex *contract* **only when** you made some material misrepresentation to *Blue Cross and Blue Shield*. For example, you gave false or misleading information on the enrollment application form. Or, you misused the Medex identification card by letting another person who is not enrolled under this Direct-Billed Medex *contract* attempt to get benefits. Termination will go back to the date of that material misrepresentation. Any premiums that were paid beyond that date will be sent back to you. But, first *Blue Cross and Blue Shield* will subtract from this amount any payments that were made for claims that you incurred since your termination date. If *Blue Cross and Blue Shield* has paid more for claims than you have paid in premiums during the same time period, *Blue Cross and Blue Shield* has the right to collect the excess from you.

If You Are Entitled to Medicaid

If you become covered by Medicaid (Title XIX of the Social Security Act), you may request *Blue Cross and Blue Shield* to suspend your Direct-Billed Medex coverage and your Direct-Billed Medex premiums.

If you want *Blue Cross and Blue Shield* to suspend your Direct-Billed Medex coverage and your Direct-Billed Medex premiums indefinitely because you are covered by Medicaid, you must notify *Blue Cross and Blue Shield*. You must do so within 90 days after the date you become covered by Medicaid.

When *Blue Cross and Blue Shield* receives your notice, any premiums that were paid beyond your Medicaid effective date will be sent back to you. But, first *Blue Cross and Blue Shield* will subtract from this amount any payments that were made for claims that you incurred since your Medicaid effective date. If *Blue Cross and Blue Shield* has paid more for claims than you have paid in premiums during the same time period, *Blue Cross and Blue Shield* has the right to collect the excess from you.

If you lose your Medicaid coverage, *Blue Cross and Blue Shield* will automatically reinstate your Direct-Billed Medex *contract*. This will be done as of the date on which you become ineligible for Medicaid. *Blue Cross and Blue Shield* will do so as long as *Blue Cross and Blue Shield* is notified within 90 days after the date on which you lose your Medicaid coverage. You must pay *Blue Cross and Blue Shield* the applicable premiums back to the date on which you become ineligible for Medicaid.

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When *Blue Cross and Blue Shield* reinstates your Direct-Billed Medex *contract*, you will be able to use your benefits as of your date of reinstatement. You will not have to wait to qualify for them. This is the case even if you are being treated for a pre-existing condition. You will have the same coverage. Or, you will have coverage that is very similar to the coverage that you had before you became eligible for Medicaid. Also, your premium will be the same as it would have been, had you not had your coverage suspended.

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