Date: 01/25/2018

To: WHOI MEDEX 2

Documents Provided: Subscriber Certificate(s) and Riders as of 01/25/2018

Attached are the Blue Cross Blue Shield of Massachusetts Subscriber Certificate(s) and associated riders for your health plan. While the Subscriber Certificate(s) and riders provide complete and detailed benefit information, they may not include information that you, as the sponsor of a group health plan, may need to comply with your statutory or regulatory notice obligations under ERISA or other applicable law. For example, these documents may not include all the information required under ERISA to be in a "summary plan description". In addition, these documents do not constitute a complete Evidence of Coverage as defined under Massachusetts state law and regulations.

Blue Cross and Blue Shield of Massachusetts, Inc. or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. administers your health plan benefits in accordance with the terms contained in this Subscriber Certificate(s) and associated riders. In the event of a dispute between any description prepared by you and the Subscriber Certificate(s) and associated riders, this Subscriber Certificate(s) and associated riders will govern.

The Subscriber Certificate(s) and associated riders are accurate as of 01/25/2018.

As you use this information, please keep in mind that Blue Cross and Blue Shield of Massachusetts, Inc. has a copyright on these documents. In addition, the use of these documents is for your plan administration purposes only. Please do not pass these documents on to any other person or entity for any other purpose unless authorized by Blue Cross and Blue Shield of Massachusetts, Inc. or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

Medex® 2

Certificate for Group Subscribers

With Benefits for the Medicare Part A and Part B Deductibles and Coinsurance

MASSACHUSETTS

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 understanding 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
President

Stephanie Lovell
Clerk/Secretary

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

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

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

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

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

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

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

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

Arabic/ةيبر:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table of Contents

Introduction

Blue Cross and Blue Shield certifies that you have the right to benefits according to the terms of this Medex *contract*. Your Medex identification card will identify you to a provider as a person who has the right to the benefits described in this Medex *contract*. This Medex *contract* is a prepaid ("insured") group health plan contract between the *member's group* and Blue Cross and Blue Shield of Massachusetts, Inc. (*Blue Cross and Blue Shield*) to provide health care benefits to participants of the group health plan sponsored by the *member's group*. *Blue Cross and Blue Shield* will provide the benefits that are described in this Medex *contract* as long as you are enrolled under this Medex *contract* when you receive *covered services* and the *premium* that your *group* owes for these benefits has been paid to *Blue Cross and Blue Shield*.

This Medex certificate is part of the *contract* between your *group* and Blue Cross and Blue Shield of Massachusetts, Inc., located at 101 Huntington Avenue, Suite 1300, Boston, Massachusetts 02199-7611, to provide benefits to you (the *member*). It explains your benefits and the terms of your membership under this Medex *contract*. You should read this Medex *contract* to familiarize yourself with the main provisions and keep it handy for reference. The words in italics have special meanings and are described in Part 2. Also, since *Blue Cross and Blue Shield* provides benefits to supplement your *Medicare* insurance for certain services covered by *Medicare* Part A and/or Part B, you should read the most current edition of your *Medicare* handbook (Medicare & You) to fully understand your benefits. This is a book put out by *Medicare* that describes the benefits you get under that program as well as 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.

Your *group* or *Blue Cross and Blue Shield* may change the benefits described in this Medex *contract*. (See Part 9.) If this is the case, the change is described in a *rider*. Your *group* or *Blue Cross and Blue Shield* can supply you with any *riders* that apply to your benefits under this Medex *contract*. Please keep any *riders* with your Medex *contract* for easy reference.

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

Member Services

Identification Cards

When you enroll for coverage under this 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 the *Blue Cross and Blue Shield* customer service office. 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 Medex *contract* or resolving a Medex problem or concern, you may call the *Blue Cross and Blue Shield* customer service office at **1-800-258-2226**. Or, if a different telephone number appears on your Medex identification card, you may call that number. (For TTY, call 711.) A customer service representative will work with you to help you understand your Medex benefits or resolve your problem or concern as quickly as possible.

You can call the *Blue Cross and Blue Shield* customer service office 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 Service, P.O. Box 9130, North Quincy, MA 02171-9130.

Blue Cross and Blue Shield will keep a record of each inquiry you (or someone on your behalf) makes. These records, including the responses to each inquiry, will be kept for two years. They may be reviewed by the Commissioner of Insurance and 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 the benefits described in your 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* medical policy, you can go online and log on to

www.bluecrossma.com. Or, you may call the *Blue Cross and Blue Shield* customer service office to request a copy of the information.

Discrimination Is Against the Law

Blue Cross and Blue Shield complies with applicable federal civil rights laws and does not discriminate on the basis of race; color; national origin; age; disability; sex; sexual orientation; or gender identity. *Blue Cross and Blue Shield* does not exclude people or treat them differently because of race; color; national origin; age; disability; sex; sexual orientation; or gender identity.

Blue Cross and Blue Shield provides:

- Free aids and services to people with disabilities to communicate effectively with *Blue Cross and Blue Shield*. These aids and services may include qualified sign language interpreters and written information in other formats (such as in large print).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call the *Blue Cross and Blue Shield* customer service office.

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

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 that contains information and data providing a basis by which health insurance plans may be evaluated and compared by consumers. Also available are health plan employer data 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 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 comparing 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 by calling **1-800-436-7757** or faxing 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 available to a *member* enrolled under *Medicare* Hospital Insurance (Part A), *Medicare* Medical Insurance (Part B) and this Medex *contract*. Be sure to read the most current edition of your *Medicare* handbook, the explanations in Part 4 and the limitations and exclusions in Part 5, as well as all provisions of this Medex *contract*.

Note: Your *group* or *Blue Cross and Blue Shield* may change these benefits. If this is the case, the change is described in a *rider*. Your *plan sponsor* or *Blue Cross and Blue Shield* can supply you with any applicable *riders*.

Medicare Provides	Medex Provides	Your Cost*	Page
Admissions for Inpatient Medical and Surgical Care			
In a general *hospital*: Full semiprivate benefits less the Part A *deductible* for day 1-60 and Part A *coinsurance* for day 61-90 per *benefit period*; and full semiprivate benefits less the Part A *coinsurance* for 60 *Medicare* lifetime reserve days	**In a general *hospital*:** The Part A *deductible* for day 1-60 and Part A *coinsurance* for day 61-90 per *benefit period*; the Part A *coinsurance* for any *Medicare* lifetime reserve days used; then after *Medicare* days are used up, full semiprivate benefits through the 365th day per *benefit period*	**In a general *hospital*:** Nothing through the 365th day per *benefit period*; then all charges	**23**
In a *skilled nursing facility* that participates with *Medicare*: Full semiprivate benefits for day 1-20 per *benefit period*; and full semiprivate benefits less the *Medicare* Part A *coinsurance* for day 21-100 per *benefit period*	**In a *skilled nursing facility* that participates with *Medicare*:** The Part A *coinsurance* for day 21-100 per *benefit period*; and $10 per day from day 101-365 per *benefit period*	**In a *skilled nursing facility* that participates with *Medicare*:** Nothing for day 1-100 per *benefit period*; and the charge over $10 per day from day 101-365 per *benefit period*; then all charges	**23**
In a *skilled nursing facility* that does not participate with *Medicare*: Nothing	**In a *skilled nursing facility* that does not participate with *Medicare*:** $8 per day for day 1-365 per *benefit period*	**In a *skilled nursing facility* that does not participate with *Medicare*:** The charge over $8 per day for day 1-365 per *benefit period*; then all charges	**23**

*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 EXPLAINED IN PART 2.

Medicare Provides	Medex Provides	Your Cost*	Page
Admissions for Inpatient Medical and Surgical Care (continued)			
***Physician* and other covered professional provider services:** Full benefits less the Part B *deductible* and Part B *coinsurance* for as many days as are *medically necessary*	***Physician* and other covered professional provider services:** The Part B *deductible* and Part B *coinsurance* (full benefits when covered by Medex only) for as many days as are *medically necessary*	***Physician* and other covered professional provider services:** Nothing for as many days as are *medically necessary*	**24**
Ambulance Services			
Full benefits less the Part B *deductible* and Part B *coinsurance*	The Part B *deductible* and Part B *coinsurance* for emergency transport only	Nothing for emergency transport; and the Part B *deductible* and Part B *coinsurance* for non-emergency transport	**25**
Chiropractor Services			
Full benefits less the Part B *deductible* and Part B *coinsurance*	The Part B *deductible* and Part B *coinsurance*	Nothing	**25**
Continued Active Care within 100 days after *hospital* discharge to treat a condition for which you were an *inpatient* in a *hospital* for at least three days in a row			
Full benefits less the Part B *deductible* and Part B *coinsurance* (includes: cardiac rehabilitation; drugs covered by *Medicare* Part B; medical care services; and *Medicare* approved short-term rehabilitation therapy)	The Part B *deductible* and Part B *coinsurance* (includes: cardiac rehabilitation; drugs covered by *Medicare* Part B; medical care services; and *Medicare* approved short-term rehabilitation therapy)	Nothing	**25**
Diabetic Testing Materials, Enteral Formulas and Food Products			
When covered by *Medicare*, full benefits less the Part B *deductible* and Part B *coinsurance*	**When covered by *Medicare*,** the Part B *deductible* and Part B *coinsurance*	**When covered by *Medicare*,** nothing	**26**

*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.)

Medicare Provides	Medex Provides	Your Cost*	Page
Diabetic Testing Materials, Enteral Formulas and Food Products (continued)			
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 *Blue Cross and Blue Shield* has paid $2,500 per calendar year for low protein food products	**26**
Dialysis Services			
Full benefits less the Part B *deductible* and Part B *coinsurance*	The Part B *deductible* and Part B *coinsurance*	Nothing	**27**
Emergency Medical Outpatient Services			
Full benefits less the Part B *deductible* and Part B *coinsurance*	The Part B *deductible* and Part B *coinsurance*	Nothing	**27**
Family Planning			
Nothing	Full benefits	Nothing	**27**
Home Health Care			
For home health care visits, full benefits	**For home health care visits,** nothing	**For home health care visits,** nothing**	**28**
For *durable medical equipment* covered by *Medicare*, full benefits less the Part B *deductible* (when applicable) and Part B *coinsurance*	**For *durable medical equipment* covered by *Medicare*,** nothing	**For *durable medical equipment* covered by *Medicare*,** the Part B *deductible* (when applicable) and Part B *coinsurance*	**28**
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 *allowed charge*	**When covered by *Medicare*,** nothing	**28**
When not covered by *Medicare*, nothing	**When not covered by *Medicare*,** full benefits	**When not covered by *Medicare*,** nothing	**28**

*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.

Medicare Provides	Medex Provides	Your Cost*	Page
Lab Tests, X-Rays and Other Tests			
Full benefits less the Part B *deductible* and Part B *coinsurance*	The Part B *deductible* and Part B *coinsurance*	Nothing	**28**
Mental Health Treatment for Biologically-Based Mental or Nervous Conditions* **			
Inpatient **admissions in a general or mental *hospital*:** Full semiprivate benefits less the Part A *deductible* for day 1-60 and Part A *coinsurance* for day 61-90 per *benefit period*; and full semiprivate benefits less the Part A *coinsurance* for 60 *Medicare* lifetime reserve days (Benefits in a mental *hospital* are limited to 190 days per lifetime)	***Inpatient*** **admissions in a general or mental *hospital*:** The Part A *deductible* for day 1-60 and Part A *coinsurance* for day 61-90 per *benefit period*; the Part A *coinsurance* for any *Medicare* lifetime reserve days used; then after *Medicare* days are used up, full semiprivate benefits through the 365th day per *benefit period*	***Inpatient*** **admissions in a general or mental *hospital*:** Nothing through the 365th day per *benefit period*; then all charges	**29**
Inpatient physician **and other covered professional mental health provider services:** Full benefits less the Part B *deductible* and Part B *coinsurance* for as many days as are *medically necessary*	***Inpatient physician*** **and other covered professional mental health provider services:** The Part B *deductible* and Part B *coinsurance* (full benefits when covered by Medex only) for as many days as are *medically necessary*	***Inpatient physician*** **and other covered professional mental health provider services:** Nothing for as many days as are *medically necessary*	**29**
Outpatient **treatment:** Full benefits less the Part B *deductible* and Part B *coinsurance* (nothing for services not covered by *Medicare*)	***Outpatient*** **treatment:** The Part B *deductible* and Part B *coinsurance* (full benefits when covered by Medex only) for as many visits as are *medically necessary*	***Outpatient*** **treatment:** Nothing for as many visits as are *medically necessary*	**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.)

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

Medicare Provides	Medex Provides	Your Cost*	Page
Mental Health Treatment for Non-Biologically-Based Mental or Nervous Conditions not included in above section (includes drug addiction and alcoholism)			
Inpatient **admissions in a general or mental *hospital*:** Full semiprivate benefits less the Part A *deductible* for day 1-60 and Part A *coinsurance* for day 61-90 per *benefit period*; and full semiprivate benefits less the Part A *coinsurance* for 60 *Medicare* lifetime reserve days (Benefits in a mental *hospital* are limited to 190 days per lifetime)	***Inpatient*** **admissions in a general or mental *hospital*:** The Part A *deductible* for day 1-60 and Part A *coinsurance* for day 61-90 per *benefit period*; the Part A *coinsurance* for any *Medicare* lifetime reserve days; then after *Medicare* days are used up, full semiprivate benefits through the 365th day per *benefit period* in a general *hospital* (up to 120 days per *benefit period* but up to at least 60 days per calendar year in a mental *hospital*), less any days in a *hospital* already covered by *Medicare* in that *benefit period* (or calendar year)	***Inpatient*** **admissions in a general or mental *hospital*:** Nothing through the 365th day per *benefit period* in a general *hospital*; and nothing for up to 120 days per *benefit period* (but up to at least 60 days per calendar year) in a mental *hospital*; then all charges	**30**
Inpatient physician **and other covered professional mental health provider services:** Full benefits less the Part B *deductible* and Part B *coinsurance* for as many days as are *medically necessary*	***Inpatient physician*** **and other covered professional mental health provider services:** The Part B *deductible* and Part B *coinsurance* for *Medicare* and Medex *covered services* for as many days as are *medically necessary* in a general or mental *hospital*; full benefits for as many days as are *medically necessary* in a general *hospital* and for up to 120 days per *benefit period* (but up to at least 60 days per calendar year) in a mental *hospital* when covered by Medex only	***Inpatient physician*** **and other covered professional mental health provider services:** Nothing for *Medicare* and Medex *covered services* for as many days as are *medically necessary* in a general or mental *hospital*; nothing for as many days as are *medically necessary* in a general *hospital* and for up to 120 days per *benefit period*, (but up to at least 60 days per calendar year) in a mental *hospital* when covered by Medex only; then all charges	**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.)

Medicare Provides	Medex Provides	Your Cost*	Page
Mental Health Treatment for Non-Biologically-Based Mental or Nervous Conditions (continued)			
***Outpatient* treatment:** Full benefits less the Part B *deductible* and Part B *coinsurance* (nothing for services not covered by *Medicare*)	***Outpatient* treatment:** The Part B *deductible* and Part B *coinsurance* for as many visits as are *medically necessary* for *Medicare* and Medex *covered services*; and full benefits when covered by Medex only for up to 24 visits per calendar year	***Outpatient* treatment:** Nothing for *Medicare* and Medex *covered services* for as many visits as are *medically necessary*; and nothing for up to 24 visits per calendar year for services covered by Medex only; then all charges	**31**
Occupational Therapist and Physical Therapist Services			
Full benefits less the Part B *deductible* and Part B *coinsurance* for *Medicare* approved occupational and physical therapy	The Part B *deductible* and Part B *coinsurance* for *Medicare* approved occupational and physical therapy	Nothing for *Medicare* approved occupational and physical therapy	**31**
Podiatry Care			
Full benefits less the Part B *deductible* and Part B *coinsurance*	The Part B *deductible* and Part B *coinsurance*	Nothing	**31**
Radiation and X-Ray Therapy			
Full benefits less the Part B *deductible* and Part B *coinsurance*	The Part B *deductible* and Part B *coinsurance*	Nothing	**32**
Routine Tests			
For routine mammograms: Full benefits less the Part B *coinsurance* (the Part B *deductible* does not apply) for one baseline mammogram between age 35 through 39 and one routine mammogram per year for a *member* age 40 or older	**For routine mammograms:** The Part B *coinsurance* (the Part B *deductible* does not apply) for one baseline mammogram between age 35 through 39 and one routine mammogram per year for a *member* 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 *member* age 40 or older	**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.)

Medicare Provides	Medex Provides	Your Cost*	Page
Routine Tests (continued)			
For routine Pap smear tests covered by *Medicare*: Full benefits less the Part B *coinsurance* (the Part B *deductible* does not apply) for one routine Pap smear test every two years (one per year for a *member* at high risk for cervical or vaginal cancer)	**For routine Pap smear tests covered by *Medicare*:** The Part B *coinsurance* (the Part B *deductible* does not apply) for one routine Pap smear test every two years (one per year for a *member* at high risk for cervical or vaginal cancer)	**For routine Pap smear tests covered by *Medicare*:** Nothing for one routine Pap smear test every two years (one per year for a *member* at high risk for cervical or vaginal cancer)	**32**
For routine Pap smear tests not covered by *Medicare*: Nothing	**For routine Pap smear tests not covered by *Medicare*:** Full benefits for one routine Pap smear test per calendar year	**For routine Pap smear tests not covered by *Medicare*:** Nothing for one routine Pap smear test per calendar year	**32**
Surgery as an Outpatient			
Full benefits less the Part B *deductible* and Part B *coinsurance*	The Part B *deductible* and Part B *coinsurance*	Nothing	**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.)

Part 2
Definitions

The following terms are shown in italics in this 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 Medex *contract* for treatment of *accidents*.

Allowed Charge

The charge that is used to calculate payment of the Medex benefits described in this 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 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 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 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—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 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 set by *Blue Cross and Blue Shield*. It is the amount that *Blue Cross and Blue Shield* determines to be in the range of fees most often made by similar providers for the same service or supply. This amount is usually less than the provider's

actual charge. **In this case, you must pay the amount that is more than the *allowed charge*.**

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 *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 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 that you personally replace or arrange to have replaced by another person or organization. *Blue Cross and Blue Shield* **does not** provide benefits for the *blood deductible* under this Medex *contract*.

Blue Cross and Blue Shield

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

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* 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 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 you receive covered *inpatient* care. If a *benefit period* continues over more than one calendar year, the Part A *coinsurance* may change with the new calendar year. *Blue Cross and Blue Shield* provides benefits as described in this Medex *contract* for the Part A *coinsurance*.

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) that 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 Medex *contract* for the Part B *coinsurance* (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 you receive at a *hospital*, the actual amount 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 Medex *contract*, including your Medex certificate, any *riders* or other changes to this Medex *contract*, your enrollment form and the agreement that *Blue Cross and Blue Shield* has with your *group* to provide benefits to you. This Medex *contract* will be governed by and construed according to the laws of the Commonwealth of Massachusetts, except as preempted by federal law.

You hereby expressly acknowledge your understanding that this *contract* constitutes a contract solely between the account (your *group*) on your behalf and Blue Cross and Blue Shield of Massachusetts, Inc. (*Blue Cross and Blue Shield*), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting *Blue Cross and Blue Shield* to use the Blue Cross and Blue Shield Service Marks in the Commonwealth of Massachusetts, and that *Blue Cross and Blue Shield* is not contracting as the agent of the Association. You further acknowledge and agree that your *group* has not entered into this *contract* on your behalf based upon representations by any person other than *Blue Cross and Blue Shield* and that no person, entity or organization other than *Blue Cross and Blue Shield* will be held accountable or liable to you or your *group* for any of *Blue Cross and Blue Shield's* obligations to you created under this *contract*. This paragraph will not create any additional obligations whatsoever on the part of *Blue Cross and Blue Shield* other than those obligations created under other provisions of this *contract*.

Covered Provider
A health care provider for which *Blue Cross and Blue Shield* provides benefits under this Medex *contract* when *covered services* are furnished to you. This Medex *contract* specifies the kinds of providers that are covered. (See Part 9.) Except as stated otherwise, the health care provider must: be eligible to provide services covered by *Medicare*; and have a payment agreement with *Blue Cross and Blue Shield*. 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;

dentists; detoxification facilities; diagnostic imaging facilities; dialysis facilities; general *hospitals*; home infusion therapy providers; hospice providers; licensed dietitian nutritionists; licensed independent clinical social workers; licensed mental health counselors; independent labs; mental health centers; mental *hospitals*; nurse midwives; nurse practitioners; occupational therapists; optometrists; physical therapists; *physicians*; podiatrists; psychologists; rehabilitation *hospitals*; and *skilled nursing facilities*. For services 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.

To find out if a health care provider has a payment agreement with *Blue Cross and Blue Shield*, you may call the *Blue Cross and Blue Shield* customer service office. (See Part 9 for those situations when *Blue Cross and Blue Shield* may cover services furnished by a health care provider that does not have a payment agreement with *Blue Cross and Blue Shield.*)

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**.

Covered Services

The health care services or supplies for which *Blue Cross and Blue Shield* provides benefits as described in this Medex *contract*, including any *riders* to this Medex *contract*. These health care services or supplies must be furnished by *covered providers* in order for you to receive the benefits provided under this 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 which could be provided by persons without medical training, such as assistance with mobility, dressing, bathing, eating and preparation of special diets and taking medications, 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* 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. (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* provides benefits as described in this Medex *contract* for the Part A and Part B *deductibles*.

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 covered by *Medicare* 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 Medex *contract* starts. Or, the date on which a change to this 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.

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 purposes of filing a claim for *covered services* eligible for benefits under Medex but not under *Medicare*, or the formal grievance review (see Parts 8 and 9), *Blue Cross and Blue Shield* considers "*emergency medical care*" to constitute "urgent care" as defined under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. However, for *covered services* 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*.

Group

Any corporation, partnership, individual proprietorship or other organization that has an agreement with *Blue Cross and Blue Shield* to provide health care benefits for a group of *members*. The *group* will make payment to *Blue Cross and Blue Shield* for covered *members* and will also deliver to the *members* all notices from *Blue Cross and Blue Shield*. The *group* is your agent and is not the agent of *Blue Cross and Blue Shield*.

Hospital

A *hospital* as defined by *Medicare* and approved for payment as a *hospital* by *Medicare*, or 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*, including training in activities of daily living.

Blue Cross and Blue Shield provides benefits as described in this 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 patient who is 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* 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* 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 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 devices to those specific indications, conditions and methods of use approved by the FDA.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed English-language journals. The qualities of the body of studies and the consistency of the results are considered in evaluating the evidence. The evidence should demonstrate that the technology can measurably alter the physiological changes related to a disease, injury, illness or condition. In addition, there should be evidence or a convincing argument based on established medical facts that the measured alterations affect health outcomes. Opinions and evaluations by national medical associations, consensus panels and other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence upon which they are based.
- The technology must improve the net health outcome. The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
- The technology must be as beneficial as any established alternatives. The technology should improve the net outcome as much as or more than established alternatives. The technology must be as cost effective as any established alternatives that achieve a similar health outcome.
- The improvement must be attainable outside the investigational setting. When used under the usual conditions of medical practice, the technology should be reasonably expected to improve health outcomes to a degree comparable to that published in the medical literature.

Medically Necessary

All *covered services* except 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* eligible for benefits under *Medicare*, *Blue Cross and Blue Shield* has the discretion to determine which services are *medically necessary* and appropriate for you. *Blue Cross and Blue Shield* does this by referring to *Medicare's* "reasonable and necessary" guidelines. For *covered services* eligible for benefits under Medex but not under *Medicare*, *Blue Cross and Blue Shield* has the discretion to determine which *covered services* are *medically necessary* and appropriate for you. *Blue Cross and Blue Shield* does this by referring to the following guidelines. All health care services must be required to diagnose or treat your: illness; injury; symptom; complaint; or condition. And, they must also be:

- 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 covered by this Medex *contract*. This means that for services 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 required by your medical condition.

It is not a service that: is furnished solely for your convenience or religious preference or 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 recognized as reasonable and necessary by *Medicare*. (See your *Medicare* handbook for details.)

Member
You, the person who has the right to the benefits described in this 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 you receive treatment, of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.

Outpatient
A patient who is not a registered bed patient in a facility. For example, a patient 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 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 Medex *contract* for *physician* services that are covered by Medex only. This means that *Medicare* does not make any payment for these services.

Plan Sponsor

The *plan sponsor* is usually your employer and is the same as the plan sponsor designated under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. If you are not sure who your *plan sponsor* is, contact your employer.

Premium

The total monthly cost of your benefits under this Medex *contract*. The *premium* amount is part of the agreement between *Blue Cross and Blue Shield* and the *group*. *Blue Cross and Blue Shield* may change your *premium* amount. Each time *Blue Cross and Blue Shield* changes the *premium*, *Blue Cross and Blue Shield* will notify your *group* before the change is effective. It is up to the *group* to notify you of any *premium* changes. The *group* may require that you pay all or a portion of this *premium* amount. In all cases, the *group* must pay the total *premium* charges owed for your benefits under this Medex *contract* to *Blue Cross and Blue Shield*. *Blue Cross and Blue Shield* is not responsible for providing benefits for a *group's member* if the *group* fails to make *premium* payments. In this case, *Blue Cross and Blue Shield* must provide notification to the *group's member*.

Rider

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

Room and Board

Your room, meals and general nursing services while you are an *inpatient*. This includes *hospital* services 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 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*, including training in activities of daily living.

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

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 hired by the facility to run the equipment.
- Drugs, medications, solutions, biological preparations and medical and surgical supplies 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, including 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 as described in this Medex *contract*. These emergency medical services may include *inpatient* or *outpatient* services by providers qualified to furnish *emergency medical care* and that are needed to evaluate or stabilize your emergency medical condition.

At the onset of an emergency medical condition that in your judgment requires *emergency medical care*, you should go to the nearest emergency room. If you need help, call 911. Or, call your local emergency phone number. You will not be denied benefits for medical and transportation services described in this 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 as described in this Medex *contract*.

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. But, there may be times when you will have to file a claim. See Part 7 for information about filing a claim for repayment.

Part 4

Covered Services

You have the right to the benefits described in this section, except as limited or excluded in other sections of this Medex *contract*. (See Part 5 for a description of your benefits for services received outside the United States.) Also, be sure to read the most current edition of your *Medicare* handbook since in most cases, *Blue Cross and Blue Shield* provides benefits only for services eligible for benefits under *Medicare* Part A and/or Part B. Your *Medicare* handbook explains the benefits you get under the *Medicare* program as well as 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 available *Medicare* days in a *benefit period* 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, you must use them before *Blue Cross and Blue Shield* provides benefits after the 90th day in a *benefit period*.) *Blue Cross and Blue Shield* provides these benefits through the 365th day of each *benefit period* when you are an *inpatient* in a general, chronic disease or rehabilitation *hospital*.

Note: Any days that you use in a *benefit period* in a general, chronic disease or rehabilitation *hospital* for medical and/or surgical care will reduce the number of days available in that same *benefit period* 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.)

Skilled Nursing Facility Services

When you are in a *skilled nursing facility* that participates with *Medicare*, after *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* through the 100th day in each *benefit period*. Then, *Blue Cross and Blue Shield* provides benefits for $10 a day from the 101st through the 365th day in each *benefit period*. *Medicare* and *Blue Cross and Blue Shield* will provide benefits for these services only if your stay meets all of *Medicare's* rules and regulations for a covered stay in a *skilled nursing facility*. For example, *Medicare* requires that you be in the *hospital* for at least three days in a row before being admitted to a *skilled nursing facility*. You will find these rules described in your *Medicare* handbook.

When you are in a *skilled nursing facility* that does not participate with *Medicare*, *Blue Cross and Blue Shield* provides benefits for $8 a day for up to 365 days in each *benefit period* as long as *Blue Cross and Blue Shield* determines that your stay would meet all of *Medicare's* rules and regulations for a covered stay in a *skilled nursing facility*.

Note: Benefits for covered *inpatient* care in all *skilled nursing facilities* are available for up to 365 days in each *benefit period*.

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 one of the following choices:

- *Hospital* services as described in Part 4; or
- The *Medicare* Part A daily *coinsurance* for *skilled nursing facility* services for up to 30 days in each *benefit period*.

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 covered by *Medicare* when furnished by a *physician* or another *Medicare* covered professional provider including 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. 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. When *Medicare* provides benefits for your *inpatient hospital* charges but does not provide benefits for the dentist's services, *Blue Cross and Blue Shield* provides full benefits based on the *allowed charge* for the dentist's *covered services*. (See Part 5, "Dental Care.")

When not covered by *Medicare*, *Blue Cross and Blue Shield* also provides full benefits based on the *allowed charge* for certain *inpatient* services 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.

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 *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.)

If you need help at the onset of an emergency medical condition that in your judgment requires *emergency medical care*, call 911. Or, call your local emergency phone number.

No benefits are provided for non-emergency ambulance transport. This includes: ambulance transport for a *mental or nervous condition*; taxi or chair car service; or transport to take you to or from medical appointments. (See your *Medicare* handbook about the benefits *Medicare* provides for non-emergency ambulance transport.)

Chiropractor Services

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

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

Continued Active Care After Hospital Discharge

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for *outpatient* services needed to continue active treatment of a condition for which you were an *inpatient* in a *hospital* for at least three days in a row. You must receive these services within 100 days after you are discharged. (See below for any exceptions to this requirement.) These services may include:

- Cardiac rehabilitation furnished by a *Medicare covered provider*.
- Drugs 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 for immunosuppressive therapy; injectable drugs for osteoporosis for homebound menopausal women; and chemotherapy and anti-emetic drugs you can take by yourself.

- Medical care furnished by a *Medicare covered provider* including a nurse practitioner or optometrist. This includes: clinic, office and home visits; follow up medical care related to an accidental injury or medical emergency; medical nutrition therapy services; medical exams to fit prosthetic lenses when these lenses are covered by *Medicare*; and non-dental services by a dentist only if the services would normally be covered when furnished by a *physician*. (See Part 5, "Dental Care.")

  Note: *Blue Cross and Blue Shield* also provides these benefits for hormone replacement therapy for peri- and post-menopausal women and monitoring and medication management for *members* taking psychiatric drugs and neuropsychological assessment services when furnished by a *Medicare* covered provider (including a mental health provider). These benefits are provided whether or not these services are for continued active care after an *inpatient hospital* stay as described above.

- Short-term rehabilitation therapy when approved by *Medicare* and 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. These restrictions are described in your *Medicare* handbook.

  Note: *Blue Cross and Blue Shield* also provides benefits for occupational therapy by an occupational therapist and physical therapy by a registered independent physical therapist even if you were not previously hospitalized as an *inpatient* or you do not otherwise meet the requirements described above. (See "Occupational Therapist and Physical Therapist Services" later on in Part 4.)

Diabetic Testing Materials, 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 and enteral formulas. *Blue Cross and Blue Shield* provides full benefits based on the *allowed charge* for: enteral formulas 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 ordered by a *physician* and glucometers.

  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.

- Enteral formulas for home use that are *medically necessary* to treat malabsorption caused by: Crohn's disease; chronic intestinal pseudo-obstruction; gastroesophageal reflux; gastrointestinal motility; ulcerative colitis; and inherited diseases of amino acids and organic

acids. *Blue Cross and Blue Shield* provides full benefits based on the *allowed charge* for these formulas when they are not covered by *Medicare* Part B.

- Food products modified to be low protein that 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 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 by a *Medicare covered provider* and for home dialysis services.

Emergency Medical Outpatient Services

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for the following services by a *Medicare covered provider* including 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) furnished by a dentist. (See Part 5, "Dental Care.")

At the onset of an emergency medical condition that in your judgment requires *emergency medical care*, you should go to the nearest emergency room. If you need help, call 911. Or, call your local emergency phone number.

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).

Home Health Care

Medicare provides full benefits based on the *allowed charge* for *Medicare* approved home health care by a *Medicare* covered home health care provider. (See your *Medicare* handbook for information about the home health care services covered by *Medicare*.)

No benefits are provided for *durable medical equipment* supplied as part of *Medicare* approved home health care services. (See your *Medicare* handbook about the benefits *Medicare* provides for *durable medical equipment*.)

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 *Medicare* pays and the amount 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 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). 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 furnished and/or arranged by the hospice provider. These may include services such as: *physician*, nursing, social, volunteer and counseling services; *inpatient* care; home health aide visits; drugs; and *durable medical equipment*.
- Respite care. This care is furnished to the hospice patient in order to relieve the family or primary care person from caregiving functions.
- Bereavement services. These services are provided to the family or primary care person after the death of the hospice patient. They can include: contacts; counseling; communication; and correspondence.

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 by a *Medicare covered provider* including a nurse practitioner.

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*. "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 available *Medicare* days in a *benefit period* 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, you must use them before *Blue Cross and Blue Shield* provides benefits after the 90th day in a *benefit period*.) *Blue Cross and Blue Shield* provides these benefits through the 365th day of each *benefit period* when you are an *inpatient* in a general or mental *hospital*.

  Note: Any days that you use in a *benefit period* in a general or mental *hospital* for treatment of any *mental or nervous condition* will reduce the number of days available in that same *benefit period* 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 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 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 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 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 by a clinical specialist in psychiatric and mental health nursing or a 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) 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 available *Medicare* days in a *benefit period* 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, you must use them before *Blue Cross and Blue Shield* provides benefits after the 90th day in a *benefit period*.) *Blue Cross and Blue Shield* provides these benefits: through the 365th day of each *benefit period* when you are an *inpatient* in a general *hospital*; and up to 120 days in each *benefit period* (but up to at least 60 days in each calendar year) when you are an *inpatient* in a mental *hospital*, less any days in a general or mental *hospital* already covered by *Medicare* in the same *benefit period* (or calendar year).

  Note: Any days that you use in a *benefit period* in a general or mental *hospital* for treatment of any *mental or nervous condition* will reduce the number of days available in that same *benefit period* 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 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 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 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 when you are an *inpatient* in a general or mental *hospital* when services are covered by both *Medicare* and Medex; and up to 120 days in each *benefit period*, (but up to at least 60 days in each calendar year) for services covered by Medex only 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 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 by a clinical specialist in psychiatric and mental health nursing or a licensed mental health counselor.) *Blue Cross and Blue Shield* provides these benefits for up to 24 visits in each calendar year.

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.

Occupational Therapist and Physical Therapist Services

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for occupational therapy by an occupational therapist and physical therapy by an independent registered physical therapist when approved by *Medicare*.

Note: *Blue Cross and Blue Shield* provides benefits for occupational and physical therapy furnished by a *hospital,* community health center or skilled nursing facility **only** if you were previously hospitalized as an *inpatient* and you meet the requirements described earlier in Part 4 for "Continued Active Care After Hospital Discharge."

Podiatry Care

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for non-routine podiatry (foot) care 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 such as trimming of corns, trimming of nails and other hygienic care except when they are covered by *Medicare* and *medically necessary* because you have systemic circulatory disease (such as diabetes). Also, no benefits are provided for 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; and fittings, castings and other services related to devices for the feet.

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 by a *Medicare covered provider* including a nurse practitioner.

Routine Tests

Routine Mammograms

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for routine mammograms when furnished by a *physician* or another *Medicare covered provider* including 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* age 40 or older.

No benefits are provided for the routine clinic visit or office visit charge.

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

Routine Pap Smear Tests

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for one 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 Pap smear test every year for a *member* at high risk for developing cervical or vaginal cancer as determined by *Medicare*. These routine Pap smear tests must be furnished by a *physician* or another *Medicare covered provider* including 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 when *Medicare* does not provide benefits for these tests.

No benefits are provided for the routine clinic visit or office visit charge.

Note: *Blue Cross and Blue Shield* provides benefits for diagnostic Pap smear tests as described earlier in Part 4 for lab tests.

Surgery as an Outpatient

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for *outpatient* surgery approved by *Medicare* when furnished by a *physician* or another *Medicare covered provider* including 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.

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 such as: 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 furnished by a: dentist; or surgical day care unit or ambulatory surgical facility 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 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 related to covered surgery. This includes anesthesia administered by a *physician* other than the attending *physician* or by a certified registered nurse anesthetist.

Part 5

Limitations and Exclusions

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

Admissions Before a Member's Effective Date

The benefits described in this Medex *contract* are provided only for *covered services* 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.* This is the case only if from the start of that *inpatient* stay until your *effective date* you were covered the whole time under a contract with a Blue Cross and/or Blue Shield Plan. But, these benefits are subject to all the provisions described in this 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 connected to military service. They also include programs set up by other local, state, federal or foreign laws or regulations that provide or pay for health care services and supplies or that require care or treatment to be furnished in a public facility. *Blue Cross and Blue Shield* does not provide supplemental benefits for *covered services* 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; and blood storage fees that are not eligible for benefits under *Medicare*. (See your *Medicare* handbook for details about the benefits *Medicare* provides.)

Consultations

No benefits are provided for consultations with your family or associates unless you are in a coma or you are uncommunicative due to a *mental or nervous condition* and the consultation is needed to determine a plan for your care.

Cosmetic Services and Procedures

Benefits for cosmetic services are limited to reconstructive surgery. This non-dental surgery is meant to improve or give back bodily function or 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, whether or not these services are meant to make you feel better about yourself or treat a *mental or nervous condition*. For example, no benefits are provided for: acne related services such as the removal of acne cysts, injections to raise acne scars, cosmetic surgery and dermabrasion or other procedures to plane the skin; electrolysis; hair removal or restoration; 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 not eligible for benefits under *Medicare*. This includes routine dental care, unless *Medicare* determines that a medical condition or the severity of a dental procedure requires that you be admitted to a *hospital* as an *inpatient* when you receive these services. Routine dental care includes filling, removal or replacement of teeth or structures that directly support the teeth.

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 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 described in this 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 to this exclusion. 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 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* not eligible for benefits under *Medicare* but eligible for benefits under Medex, *Blue Cross and Blue Shield* determines whether a service is furnished in accordance with *medical technology assessment guidelines*.

Eye Exams/Eyewear

No benefits are provided for eyeglasses and contact lenses, except as described in Part 4, or exams to prescribe, fit or change them.

Foot Care

No benefits are provided for:

- Routine foot care services such as trimming of corns, trimming of nails and other hygienic care except when they are covered by *Medicare* and *medically necessary* because you have systemic circulatory disease (such as diabetes).
- 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; and fittings, castings and other services related to devices for the feet.

Hearing Aids

No benefits are provided for hearing aids or exams 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 when the recipient **is not** a *member*.

Immunizations and Shots

No benefits are provided for immunizations and shots, 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 Care Outpatient Visits

No benefits are provided for *outpatient* medical care (for example, office visits) except as described in Part 4.

Medical Devices, Appliances, Materials and Supplies

No benefits are provided for medical devices, appliances, materials and supplies, except as otherwise 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 shoe (foot) inserts.

Also, no benefits are provided for *durable medical equipment* and prosthetic devices such as artificial arms, legs and eyes. There are a few exceptions to this exclusion. Benefits are provided as described in Part 4 for: diabetic testing materials, including glucometers (which are classified

under the same category as *durable medical equipment* when covered by *Medicare*); and *durable medical equipment* supplied as part of approved home dialysis or hospice services.

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 Medex *contract*.

Non-Covered Providers

Unless otherwise specified, *Blue Cross and Blue Shield* provides benefits under this Medex *contract* only for *covered services* furnished by providers: eligible to provide services covered by *Medicare*; that have a payment agreement with *Blue Cross and Blue Shield*; and that have been approved by *Blue Cross and Blue Shield* for payment for the specific *covered service*. No benefits are provided for any services and supplies furnished by the kinds of providers that **are not** covered under this Medex *contract*. This Medex c*ontract* 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 Medex *contract*. Some examples of non-*covered services* are: acupuncture; prescription drugs (except when covered by *Medicare* Part B as described in Part 4 or administered to an *inpatient* or *outpatient* in a health care facility covered under this Medex *contract*); and voluntary sterilization.
- Any service or supply that is not eligible for benefits under *Medicare* Part A and/or Part B, except as 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 Medex *contract*.
- Any service or supply furnished along with a non-*covered service*.
- Services and supplies that are not considered *medically necessary*. The only exceptions are for family planning, routine mammograms and routine Pap smear tests as described in Part 4.
- Services furnished to someone other than the patient, 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 furnished to all patients due to a facility's routine admission requirements.
- A service 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 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 by: interns, residents; fellows; or other *physicians* who are salaried employees of the *hospital* or other facility.
- Expenses that you have when you choose to stay in a *hospital* or another health care facility beyond the discharge time 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 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 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.

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, except for the routine mammograms and routine Pap smear tests described in Part 4.

Services and Supplies After a Member's Termination Date

No benefits are provided for services and supplies furnished after your termination date under this Medex *contract*. There is one exception to this exclusion. *Blue Cross and Blue Shield* will continue to provide the benefits described in this 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 allowed under this Medex *contract* have been used up or until the date of discharge, whichever comes first. This does not apply if your membership under this Medex *contract* is canceled for misrepresentation or fraud.

Services Furnished by Immediate Family or Members of Your Household

No benefits are provided for a *covered service* 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 purposes of providing *covered services*, an in-law relationship does not exist between the provider and the spouse of his or her wife's (or husband's) brother or sister.)
- Grandparent or grandchild.
- Those persons sharing 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 of the United States or its territories. (See your *Medicare* handbook for details.) When it does, *Blue Cross and Blue Shield* provides only the Medex benefits for *covered services* as described in this Medex *contract*. When it does not, *Blue Cross and Blue Shield* provides both the Medex benefits and the benefits normally paid by *Medicare* for *covered services* as described in this Medex *contract*. But, if you set up a residence outside the United States or its territories, *Blue Cross and Blue Shield* will not provide any benefits.

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 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 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 secondary payor. To do this, *Blue Cross and Blue Shield* relies on Massachusetts law, including the COB regulations issued by the Massachusetts Division of Insurance. A copy of these rules is available from *Blue Cross and Blue Shield* upon request. Unless otherwise required by law, coverage under this 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 already described in this 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 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.

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 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 you receive is described as payment for other than health care expenses. The amount you must reimburse *Blue Cross and Blue Shield* will not be reduced by any attorney's fees or expenses you incur.

Member Cooperation

You must give *Blue Cross and Blue Shield* information and help. This means you must complete and sign all necessary documents to help *Blue Cross and Blue Shield* get this money back. This also means that you must give *Blue Cross and Blue Shield* timely notice of all significant steps during negotiation, litigation, or settlement with any third party (such as filing a claim or lawsuit, initiation of settlement discussions, agreement to a settlement in principle, etc.) and before settling any claim arising out of injuries you sustained by an act or omission of another person(s) for which *Blue Cross and Blue Shield* paid benefits. You must not do anything that might limit *Blue Cross and Blue Shield's* right to full reimbursement.

Workers' Compensation

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

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

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

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

If *Blue Cross and Blue Shield* is billed in error for these services, you must promptly call or write the *Blue Cross and Blue Shield* customer service office.

Part 7

Filing a Claim

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, even if they do not agree or are not required to accept assignment. They must do so within one year of the date they furnished the service and/or supply to you or be subject to certain penalties. (See Part 9, "Payment of Claims for *Medicare* Part B Covered Services and Supplies" and 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* so you do not have to file a claim.

For services 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 within 30 days after you receive the *covered service*. If you do not, benefits will not have to be provided. *Blue Cross and Blue Shield* will pay the 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 unless you receive *hospital* or other health care facility services outside the United States that are covered by *Medicare*. When you have to file a claim for *Medicare* Part A benefits, you will receive a Medicare Summary 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 for services and/or supplies not covered by *Medicare*.
- Your *physician* or another provider refuses to file a claim for you for *covered services* eligible for benefits under *Medicare*, even though it is required by law.
- You receive services outside the United States that 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 when your claim has been processed. (Your *Medicare* handbook explains how to file *Medicare* claims and 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 receive *skilled nursing facility* services covered by Medex only and the *skilled nursing facility* does not file a claim to *Blue Cross and Blue Shield* for you. In this case, you must have the *skilled nursing facility* fill out a Level of Care Form for each month of your stay. This Level of Care Form must be attached to your Medex claim form along with your original itemized bills.
- You get materials to test for the presence of urine sugar, enteral formulas covered by Medex only or low protein food products. (Since 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, if the provider does not file a claim for you, you will have to file a claim for your *Medicare* benefits before you file a claim for your Medex benefits for these items.)
- You receive a service covered by Medex only from a provider that does not have an agreement with *Blue Cross and Blue Shield*.
- You receive services outside the United States that are covered by Medex. In this case, in addition to itemized bills with the date you received the services, you must get the medical notes for these services. If the *covered services* are also eligible for benefits under *Medicare*, 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 you received the services;
- Attach the notice you receive from *Medicare* to the Medex claim form if the *covered services* are also eligible for benefits under *Medicare*; and
- Mail the claim to the *Blue Cross and Blue Shield* customer service office. *Blue Cross and Blue Shield* will then process your claim for Medex benefits.

You can get Medex claim forms from the *Blue Cross and Blue Shield* customer service office. *Blue Cross and Blue Shield* will mail to you all applicable forms within 15 days after receiving notice that you obtained some service or supply for which you may be paid. (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 specified in your *Medicare* handbook. When you have to file a Medex claim, you must do so within two years of the date 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, where appropriate, payment will be made to the provider (or to you if you sent in the claim) for your claim to the extent of your Medex benefits described in this Medex *contract*. Or, you and/or the provider will be sent a notice in writing of 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 records it needs 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* 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 remaining in the original 30-day claim determination period or within 15 calendar days of the date 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.

Part 8

Grievance Program

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 you received from *Blue Cross and Blue Shield* or a *covered provider*.

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

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 2 for more information about Member Services.) For help resolving a Medex problem or concern, you should first call the *Blue Cross and Blue Shield* customer service office at **1-800-258-2226**. Or, if a different telephone number appears on your Medex identification card, you may call that number. A customer service representative will work with you to help you understand your Medex benefits or resolve your problem or concern as quickly as possible.

When resolving a problem or concern, *Blue Cross and Blue Shield* will consider all aspects of the particular case, including the terms of your Medex *contract*, the policies and procedures that support the Medex *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 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 given to you by the customer service representative or *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 you may follow to request a formal internal grievance review.

The formal grievance review process 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.

Formal Grievance Review

Internal Formal Grievance Review

How to Request a Grievance Review

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 to: **Member Grievance Program, Blue Cross and Blue Shield of Massachusetts, Inc., One Enterprise Drive, Quincy, MA 02171-2126**. Or, you may fax your request to 1-617-246-3616. *Blue Cross and Blue Shield* will let you know that your request was received by sending you a written confirmation within 15 calendar days.

- 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 by sending you a confirmation immediately by e-mail.

- Or, you may call *Blue Cross and Blue Shield's* Member Grievance Program 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 within 48 hours of your phone call.

Once your request is received, *Blue Cross and Blue Shield* will research the case in detail, ask for more information as needed and 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 you were told of the service denial or claim denial.

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 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* 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, including the identity of any experts who were consulted.

Authorized Representative
You may choose to have another person act on your behalf during the grievance review process. You must designate this person in writing to *Blue Cross and Blue Shield*. Or, if you are not able to do this, a person such as a conservator, a person with power of attorney or a family member may be your authorized representative. Or, he or she may appoint another party to be the authorized representative. (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 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 health care services that are soon to be obtained by the *member*. (When the grievance review is for services 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 you tell *Blue Cross and Blue Shield* that you disagree with *Blue Cross and Blue Shield's* answer and would like a formal grievance review.

Blue Cross and Blue Shield may extend the time frame to complete a grievance review, with your permission, 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 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 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 described above, you have the right to request an "expedited" review right away when your situation is for immediate or urgently-needed services. *Blue Cross and Blue Shield* will 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 described above would seriously jeopardize your life or health or your ability to regain maximum function as determined by *Blue Cross and Blue Shield* or your *physician*, or if your *physician* says that you will have severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance review, *Blue Cross and Blue Shield* will review your grievance and notify you of the decision 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 before the patient is discharged from that *inpatient* stay. Coverage for those services in dispute will continue until this review is completed.
- A decision to deny payment for health care services may be reversed within 48 hours 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 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 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 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**.

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.

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 Residents or Services

You may also have the right to appeal as described in this section 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 Medex *contract*.

The following provisions apply only to:

- A *member* who lives in Rhode Island and is planning to obtain services that *Blue Cross and Blue Shield* has determined are not *medically necessary*.
- A *member* who lives outside Rhode Island and 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 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 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 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 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 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 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 by contacting *Blue Cross and Blue Shield* at the telephone number shown in your letter. *Blue Cross and Blue Shield* will notify you of the result of your expedited appeal within two working days or 72 hours, 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 describes the emergency nature of your treatment. In addition, you must also enclose a check made payable to the designated appeals agency for your share of the cost for the expedited external appeal.

Within two working days after the receipt of your written request and payment for the appeal, *Blue Cross and Blue Shield* will forward your request to the external appeals agency along with *Blue Cross and Blue Shield's* 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 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 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.

Part 9

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 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* 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* set by *Medicare* as the total payment for the *covered services* described in this 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* 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* eligible for benefits under *Medicare* Part B, you will have to pay the amount above the *allowed charge* set by *Medicare* 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* 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* eligible for benefits under *Medicare* from a Massachusetts *physician* (whether or not the *physician* has an agreement with *Blue Cross and Blue Shield*) or 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 Shield* will not provide benefits in excess of any limits stated in this Medex *contract*.

- You receive services from a Massachusetts *physician* that are covered by *Medicare* only. In this case, you will still have to pay the *Medicare* Part B *deductible* (if it has not already been met) and Part B *coinsurance* for these services.

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 needed by *Blue Cross and Blue Shield* or health care providers. *Blue Cross and Blue Shield* may collect information from health care providers, other insurance companies or the *plan sponsor* to help *Blue Cross and Blue Shield* administer the benefits described in this Medex *contract* and to get facts on the quality of care provided under this and other health care contracts. In accordance with law, *Blue Cross and Blue Shield* and health care providers may use this information, and may disclose it to necessary persons and entities as 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.
- As required by your *group* or its auditors to ensure that *Blue Cross and Blue Shield* is administering your benefits properly.

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 *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 unless your request is because *Blue Cross and Blue Shield* is declining or terminating your benefits under this Medex *contract*.

Note: To obtain a copy of *Blue Cross and Blue Shield's* Commitment to Confidentiality statement, call the *Blue Cross and Blue Shield* customer service office at **1-800-258-2226**.

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 due under this 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 provided under this 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 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 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 Medex coverage in accordance with *Blue Cross and Blue Shield's* standard practices, unless specifically requested to do otherwise.

Note: You can get a form to designate an authorized representative from the *Blue Cross and Blue Shield* customer service office.

Benefits for Pre-Existing Conditions

Your benefits under this Medex *contract* are not limited based on medical conditions that are present on or before your *effective date*. But, these benefits are subject to all the provisions described in this Medex *contract*. This means that your health care services will be covered from the *effective date* of your membership under this Medex *contract* without a pre-existing condition restriction. But, there is one exception. 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* only if from the start of that *inpatient* stay until your *effective date* you were covered the whole time under a contract with a Blue Cross and/or Blue Shield Plan. (See Part 5, "Admissions Before a *Member's Effective Date*.")

Changes to This Contract

The *plan sponsor* or *Blue Cross and Blue Shield* may change a part of this Medex *contract*. For example, a change may be made to the amount you must pay for certain services. When *Blue Cross and Blue Shield* makes a change to this Medex *contract*, the *plan sponsor* will be notified at least 60 days before the *effective date* of the change. The notice will describe the change being made. It will also give the *effective date* of the change. When a material change is made to this Medex *contract*, *Blue Cross and Blue Shield* will send you a *rider* that describes the change.

Note: If you are 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.

Charges for Services That Are Not Medically Necessary

You may receive treatment that is otherwise covered as a Medex benefit as described in this 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 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 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.

Mandated Benefits for Services Outside Massachusetts

In addition to the *covered services* described in this Medex *contract*, when you live in a state other than Massachusetts, you may be entitled to receive benefits for other services and supplies as required by that state's law. You should call the *Blue Cross and Blue Shield* customer service office for more information.

Providers

This Medex *contract* specifies the kinds of providers that are covered. **The kinds of providers covered under this Medex *contract* are:**

- **Hospitals and other facilities.** These include: ambulatory surgical facilities; cardiac rehabilitation centers; Christian Science sanatoriums; chronic disease *hospitals*; community health centers; 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*; and *skilled nursing facilities*.

Note: *Medicare* does not provide any benefits for services and supplies furnished by a *hospital* or another health care facility that does not participate with *Medicare*. There is one exception to this exclusion. *Medicare* provides benefits for *emergency medical care* services that you receive in a *hospital* or dialysis facility that does not participate with *Medicare*, but **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* as long as the *hospital* or dialysis facility: has an agreement with *Blue Cross and Blue Shield*; or is not in Massachusetts and has an agreement with the local Blue Cross and/or Blue Shield Plan. In either case, *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*.

- **Professional providers.** These include: 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; *physicians*; podiatrists; and psychologists.

- **Other health care providers.** These include: ambulance services; home infusion therapy providers; and hospice providers.

  Note: *Medicare* does not provide any benefits for services and supplies furnished by a home infusion therapy provider or hospice provider that does not participate with *Medicare*.

Covered Services in Massachusetts

Blue Cross and Blue Shield provides the benefits described in this Medex *contract* only when *covered services* are furnished by a provider: eligible to provide services covered by *Medicare* (unless stated otherwise); that has a payment agreement with *Blue Cross and Blue Shield*; and has been approved by *Blue Cross and Blue Shield* for payment for the specific *covered service*.

There are some exceptions to this rule. The benefits described in this Medex *contract* for *covered services* by providers that have an agreement with *Blue Cross and Blue Shield* are also provided for *covered services* by providers that **do not** have an agreement with *Blue Cross and Blue Shield*, **but only when:**

- You are a newly enrolled *member* who is receiving an ongoing course of treatment by a non-participating *physician* and your *group* only offers its employees a choice of health insurance plans in which your *physician* does not participate. In this case, *Blue Cross and Blue Shield* will provide benefits for up to 30 days from your *effective date* or, for a *member* with a terminal illness, until the *member's* death. (For a *member* with a terminal illness, these benefits are provided when the *member* is expected to live six months or less as determined by a *physician*.)

- You receive services that are furnished in an emergency and a provider having an agreement with *Blue Cross and Blue Shield* is not reasonably available.
- You receive *covered services* eligible for benefits under *Medicare* when furnished by a *hospital, skilled nursing facility* or dialysis facility.
- You receive *covered services* eligible for benefits under *Medicare* when furnished by a Christian Science sanatorium.
- You receive *covered services* eligible for benefits under *Medicare* from a *physician*.
- You get materials to test for the presence of urine sugar, enteral formulas covered by Medex only or low protein food products from a licensed provider or supplier.
- The participating provider of a *member* with a terminal illness is involuntarily disenrolled (for other than quality related reasons or fraud). In this case, *Blue Cross and Blue Shield* will continue to provide benefits for *covered services* in connection with the terminal illness until the *member's* death. (These benefits are provided when the terminally ill *member* is expected to live six months or less, as determined by a *physician*.)

No benefits are provided for services by the following providers when they do not have an agreement with *Blue Cross and Blue Shield*: clinical specialists in psychiatric and mental health nursing; chronic disease *hospitals* (when services are covered by Medex only); detoxification facilities; free-standing diagnostic imaging facilities; general *hospitals* (when services are covered by Medex only); home infusion therapy providers (when services are covered by Medex only); licensed independent clinical social workers; licensed mental health counselors; mental *hospitals* (when services are covered by Medex only); rehabilitation *hospitals* (when services are covered by Medex only); and *skilled nursing facilities* (when services are covered by Medex only and the facility does not participate with *Medicare*).

Covered Services Outside Massachusetts

Blue Cross and Blue Shield provides the benefits described in this Medex *contract* only when *covered services* are furnished by a provider eligible to provide services covered by *Medicare* (unless stated otherwise). In addition, the benefits described in this Medex *contract* for *covered services* by providers that have an agreement with *Blue Cross and Blue Shield* are also provided for *covered services* by providers that **do not** have an agreement with *Blue Cross and Blue Shield*. But, there are some exceptions to this rule.

- Benefits for services covered by Medex only by general, chronic disease, rehabilitation and mental *hospitals* are provided only when the facility has a payment agreement with the local Blue Cross and/or Blue Shield Plan.
- Benefits for services by a detoxification facility, licensed independent clinical social worker or nurse midwife are provided only when the *covered services* are eligible for benefits under *Medicare*.
- Benefits for *covered services* are provided only when the *provider* is licensed in a jurisdiction having licensing requirements substantially similar to those in Massachusetts and the provider meets the educational and clinical standards *Blue Cross and Blue Shield* requires for providers that have a payment agreement with *Blue Cross and Blue Shield*.

No benefits are provided for services by the following providers when furnished outside Massachusetts: clinical specialists in psychiatric and mental health nursing; detoxification facilities (when services are covered by Medex only); independent labs not certified by *Medicare*;

licensed independent clinical social workers (when services are covered by Medex only); licensed mental health counselors; and nurse midwives (when services are covered by Medex only).

Quality Assurance Programs

Blue Cross and Blue Shield uses quality assurance programs that are designed to improve the quality of health care and services 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 to ensure that you continue to receive high-quality health care and services.

Note: For more information about these programs, you may call the *Blue Cross and Blue Shield* customer service office 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 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; concurrent review and discharge planning; and individual case management.

Note: For more information about the utilization review program, you may call the *Blue Cross and Blue Shield* customer service office 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 to determine that it is:

- Consistent with generally accepted principals of professional medical practice; and
- Required to diagnose or treat your illness, injury, symptom, complaint or condition; and
- Essential to improve your net health outcome and as beneficial as any established alternatives covered by this 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 required by your medical condition.

Blue Cross and Blue Shield reviews clinical guidelines and utilization review criteria 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 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 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.)

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.

Individual Case Management

Individual Case Management is a flexible program for managing your benefits in some situations. Through this program, *Blue Cross and Blue Shield* works with your providers to make sure that you get *medically necessary* services in the least intensive setting that meets your needs. Individual Case Management is for a *member* whose condition may otherwise require *inpatient hospital* care. Under Individual Case Management, coverage for services in addition to those described in this Medex *contract* may be approved to:

- Shorten an *inpatient* stay by sending you home or to a less intensive setting to continue treatment;
- Direct you to a less costly setting when an *inpatient* admission has been proposed; or
- Prevent future *inpatient* stays by providing *outpatient* benefits instead.

Blue Cross and Blue Shield may, in some situations, present a specific alternative treatment plan to you and your attending *physician*. This treatment plan will be one that is *medically necessary* for you. *Blue Cross and Blue Shield* will need the full cooperation of everyone involved: the patient (or guardian); the *hospital*; the attending *physician*; and the proposed setting or health care provider. Also, there must be a written agreement between the patient (or family or guardian) and *Blue Cross and Blue Shield*, and between the provider and *Blue Cross and Blue Shield* to furnish the services approved through this alternative treatment plan. The agreement will specify the maximum amount of benefits available under Individual Case Management. This maximum amount is equal to the total cost that your Medex benefits would have been had you stayed in the *hospital*.

At any time, you can decide to no longer take part in this program. If you do, you have the right to go back to the Medex *inpatient* benefits described in this Medex *contract*. If you have not yet begun a new *benefit period*, the number of *inpatient* days covered by Medex is reduced by the cost of the benefits that were provided under Individual Case Management. If you begin a new *benefit period*, you have the right to benefits for the full number of *inpatient* days described in this Medex *contract*.

Time Limit for Legal Action

Before pursuing a legal action against *Blue Cross and Blue Shield* for any claim under this 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 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 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 your request is received by the external reviewer until the date you receive the response are not counted toward the two-year limit.

Part 10

Enrollment and Termination

Eligibility for Coverage

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

- You are an eligible *group member*. This means you must meet the written requirements that your *plan sponsor* has set to determine eligibility for *group* health care benefits. For details, contact your *plan sponsor*.
- You are eligible for *Medicare* Part A and *Medicare* Part B and 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 normally paid by *Medicare*. But, *Blue Cross and Blue Shield* will still provide the Medex benefits available for *covered services* as described in this Medex *contract*.

- You are not covered by Medicaid.
- If you are under age 65, the disability that qualifies you for *Medicare* is not permanent kidney failure.
- You are allowed by federal law to enroll in a group health care plan under which *Medicare* is the primary payer.

Enrollment Periods

You may enroll under this Medex *contract* on your initial eligibility date (such as your *Medicare* effective date). To enroll, you must complete the enrollment form provided in your enrollment packet and return it no later than the date specified in the enrollment packet.

If you choose not to enroll under this Medex *contract* within 30 days of your initial eligibility date, you may enroll during an annual open enrollment period. The open enrollment period is the time each year during which eligible persons may enroll for or change coverage for the next year. The open enrollment period is announced by the *plan sponsor* to all eligible employees.

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 your *plan sponsor*. The *plan sponsor* will send you any special forms you may need.

You must request the membership change within 30 days of the reason for the change. If you do not make the change within 30 days, you will have to wait until the *group's* next open enrollment period to make the change.

All membership changes or any additions are allowed only when they comply with the conditions outlined in this Medex *contract* and in *Blue Cross and Blue Shield's* Manual of Underwriting Guidelines for Group Business.

Loss of Eligibility for Coverage Under This Contract

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

- You lose eligibility for health care coverage with the *group*. This means you no longer meet the rules set by the *group* for eligibility under this Medex *contract*.
- You lose your *Medicare* coverage. In this case, if you are still eligible for *group* coverage, you may be eligible to transfer your coverage to another health care plan that is offered by your *group*. (Contact your *plan sponsor* for help in this situation.) Or, if you are not eligible for *group* coverage, you may be eligible to enroll in a nongroup plan. (The *Blue Cross and Blue Shield* customer service office can help you in this situation.) In any case, *Blue Cross and Blue Shield* must receive the termination request not more than 30 days after your termination date.
- The *plan sponsor* fails to pay your *premium* to *Blue Cross and Blue Shield* within 30 days of the due date. In this case, *Blue Cross and Blue Shield* will notify you in writing of the termination of your membership in accordance with the Code of Massachusetts Regulations. This notice will give you information about the termination of your membership and your options, if any, to continue *Blue Cross and Blue Shield* coverage.
- Your *group* terminates (or does not renew) this Medex *contract*.

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

Continuation of Group Coverage Under State Law

When you lose eligibility for membership, you may be eligible to continue coverage as provided by state law. These state laws may apply to you if you lose eligibility for coverage due to one of the following reasons:

- Lay off or death of the employee. If this situation applies to you, coverage may be continued for up to 39 weeks from the date of the qualifying event. To continue coverage, the *member* will pay 100% of the *premium* cost.
- Plant closing or a partial plant closing in Massachusetts. If this situation applies to you, you and your *group* will each pay your share of the *premium* cost for up to 90 days after the plant closing. Then, to continue coverage for up to an additional 39 weeks, you will pay 100% of the *premium* cost.

  Note: If you become eligible for coverage under another employer sponsored health care plan at any time before the extension period ends, continued coverage under the above provisions also ends.

- Divorce or legal separation. In the event of divorce or legal separation, the person who was the spouse of the employee prior to the divorce or legal separation will remain eligible for coverage, whether or not the judgment was entered prior to the *effective date* of this Medex *contract*. This coverage is provided with no additional *premium*. The former spouse will

remain eligible for his or her coverage **only** until the employee is no longer required by the judgment to provide health insurance for the former spouse or the employee or former spouse remarries, whichever comes first. (In these situations, *Blue Cross and Blue Shield* must be notified within 30 days of a change to the former spouse's address. Otherwise, *Blue Cross and Blue Shield* will not be liable for any acts or omissions due to having the former spouse's incorrect address on file.) In the event that the employee remarries, the former spouse may continue his or her coverage with the employee's *group*, provided the divorce judgment requires that the employee provide health insurance for the former spouse. This is true even if the employee's new spouse is not enrolled for coverage with the employee's *group*.

Termination by the Member

Your membership under this Medex *contract* ends when you choose to cancel your Medex *contract* as permitted by the *plan sponsor*. You may do so at any time for any reason by sending a written notice to the *plan sponsor*. *Blue Cross and Blue Shield* must receive the termination request not more than 30 days after your termination date.

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 Medex *contract* **only when**:

- You committed misrepresentation or fraud. For example, you gave false or misleading information on the enrollment application form. Or, you misused the Medex identification card by letting another person not enrolled under this Medex *contract* attempt to get benefits. Termination will go back to your *effective date*. Or, it will go back to the date of the misrepresentation or fraud as determined by *Blue Cross and Blue Shield*.
- You commit acts of physical or verbal abuse that pose a threat to, or a threat to the health of, *Blue Cross and Blue Shield* participating providers or other *members* or employees of *Blue Cross and Blue Shield* or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. and that are not related to your physical condition or *mental or nervous condition*. This termination will follow procedures approved by the Massachusetts Commissioner of Insurance.
- *Blue Cross and Blue Shield* cancels this Medex *contract* for any reason as of a date approved by the Massachusetts Commissioner of Insurance (without prior notice) or cancels all contracts of this type as of any date.

Enrollment in a Nongroup Plan

When your membership under this Medex *contract* is terminated, you may be eligible to enroll in a nongroup plan offered by *Blue Cross and Blue Shield* or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. The benefits and premium charges for these nongroup plans may differ from your benefits provided under this Medex *contract*. At the time you lose eligibility for membership under this Medex *contract*, *Blue Cross and Blue Shield* will send you a letter explaining your health care options. This letter will include a toll-free telephone number that you may call to find out about if you are eligible for a *Blue Cross and Blue Shield* nongroup plan and how you may apply for enrollment in one of these nongroup plans.

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Rider 05-811

Mental Health and Substance Abuse Treatment

This rider modifies the terms of your Medex®′ Certificate for Group Subscribers. Please keep this rider with your Medex certificate for easy reference.

The Medex benefits described in your Medex certificate have been enhanced for services to diagnose and treat *mental or nervous conditions* (including drug addiction and alcoholism) as described in this rider.

1. *Blue Cross and Blue Shield* provides *inpatient* and *outpatient* Medex benefits as described below for services to diagnose and treat the following *mental or nervous conditions* when the services are furnished by a covered mental health provider:

- **Biologically-based *mental or nervous conditions***. "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.
- **Rape-related mental or emotional disorders** for victims of a rape or victims of an assault with intent to rape.

Blue Cross and Blue Shield provides benefits for the *Medicare* Part A *deductible* and Part A daily *coinsurance* for all available *Medicare* days as described in your Medex certificate 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 lifetime days in a mental *hospital*), *Blue Cross and Blue Shield* provides full benefits for semiprivate *room and board* and *special services* for up to a lifetime total of 365 days when you are an *inpatient* in a general or mental *hospital*.

Also, *Blue Cross and Blue Shield* provides benefits for the *Medicare* Part B *deductible* and Part B *coinsurance* for *inpatient* services 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 by a *physician* (who is a specialist in psychiatry), psychologist or clinical specialist in psychiatric and mental health

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R05-811 (1-1-01 Rev.) to be attached to the following Medex Certificate for Group Subscribers: ME-ABDED.

nursing. *Blue Cross and Blue Shield* provides these benefits for as many days as are *medically necessary* for your condition.

Blue Cross and Blue Shield provides benefits for the *Medicare* Part B *deductible* and Part B *coinsurance* for *outpatient* services 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. *Blue Cross and Blue Shield* provides these benefits for as many visits as are *medically necessary* for your condition.

2. The *outpatient* benefits provided under this *contract* for services to diagnose and treat **those *mental or nervous conditions* (including drug addiction and alcoholism) not identified in section 1** have been changed as follows:

Blue Cross and Blue Shield provides benefits for the *Medicare* Part B *deductible* and Part B *coinsurance* for *outpatient* services 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 for up to 24 visits in each calendar year.

Note: *Inpatient* Medex benefits for services to diagnose and treat those *mental or nervous conditions* (including drug addiction and alcoholism) not identified in section 1 are provided as described in your Medex certificate. (See "Admissions for *Inpatient* Care.")

All other provisions remain as described in your Medex certificate.

Rider 05-812

Mental Health and Substance Abuse Care

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

Effective October 1, 2015, the benefits described in your Medex certificate for mental health and substance abuse care have been changed.

1. The benefits described in your Medex certificate include care you get from a *Blue Cross and Blue Shield* participating licensed alcohol and drug counselor I. These benefits are provided only when the care is within the scope of practice for a licensed alcohol and drug counselor I. For these *covered services*, *Blue Cross and Blue Shield* provides full benefits based on the *allowed charge*. (Note: *Medicare* does not provide benefits for this type of provider.)

   Note: No benefits are provided for a licensed alcohol and drug counselor that does not have an agreement with *Blue Cross and Blue Shield*.

2. Medex benefits for abuse-deterrent opioid drug products are provided on a basis not less favorable than other non-abuse deterrent opioid drug products.

All other provisions remain as described in your Medex certificate.

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R05-812 (10-1-15) to be attached to Group and Direct-Billed Medex Certificates [ME-OBRARX, ME-RXABDED, ME-RXADED, ME-RXNODED, ME-ABDED, ME-CORE, ME 3 DB, ME 12 DB, MXLO DB, ME 4 DB, ME 2 DB, ME 11 DB]

Rider 08-3804
Lyme Disease and HIV Associated Lipodystrophy

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.

Long-Term Antibiotic Therapy Treatment for Lyme Disease

1. For services furnished on or after July 1, 2016, the benefits for home health care as described in your Medex *contract* include benefits for long-term antibiotic therapy treatment for a *member* who has been diagnosed with Lyme disease. These benefits are provided only when the treatment is determined by a licensed physician to be *medically necessary* and is ordered after a complete evaluation of the *member's*: symptoms; results of *diagnostic lab tests*; or response to treatment. When these services are covered by *Medicare*, *Medicare* provides full benefits based on the *allowed charge*. When these services are not covered by *Medicare*, *Blue Cross and Blue Shield* provides full benefits based on the *allowed charge* for long-term antibiotic therapy treatment of Lyme disease, as long as the services are furnished by a health care provider who has a payment agreement with *Blue Cross and Blue Shield*.
2. The exception as noted in "Experimental Services and Procedures" for certain drugs that are used on an off-label basis also includes, for services furnished on or after July 1, 2016, long-term antibiotic therapy drugs for the treatment of Lyme disease, if the drug has been approved for an indication by the U.S. Food and Drug Administration (FDA). (See home health care benefits above for your coverage for long-term antibiotic therapy treatment of Lyme disease.)

HIV Associated Lipodystrophy Syndrome

1. For services furnished on or after November 8, 2016, the benefits for *inpatient* admissions and *outpatient* surgery as described in your Medex *contract* include benefits for surgery to correct or repair disturbances of body composition caused by HIV associated lipodystrophy syndrome, when the *covered provider* has determined that this treatment is necessary to correct, repair, or lessen the effects of HIV associated lipodystrophy syndrome. These services include, but are not limited to: reconstructive surgery, such as suction-assisted lipectomy; other restorative procedures; and dermal injections or fillers for reversal of facial lipoatrophy syndrome. *Blue Cross and Blue Shield* provides benefits for these *covered services* to the same extent as benefits are provided for similar *covered services* to treat other conditions. In the event that these services are not covered by *Medicare*, *Blue Cross and*

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Blue Shield provides full benefits based on the *allowed charge*, as long as the services are furnished by a health care provider who has a payment agreement with *Blue Cross and Blue Shield*.

2. When your prescription drug benefits are provided under this Medex *contract*, covered drugs include prescription drugs to treat HIV associated lipodystrophy syndrome. When prescription drug benefits are not provided under this Medex *contract*, *Blue Cross and Blue Shield* provides full benefits based on the *allowed charge* for prescription drugs obtained on or after November 8, 2016 to treat HIV associated lipodystrophy syndrome.

All other provisions remain as described in your Medex certificate.

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Rider

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* has the discretion to determine which health care services that you receive (or you are planning to receive) are *medically necessary* and appropriate for coverage. *Blue Cross and Blue Shield* does this by referring to *Medicare's* "reasonable and necessary" guidelines. For *covered services* eligible for benefits under Medex but not under *Medicare*, *Blue Cross and Blue Shield* has the discretion to determine which *covered services* are *medically necessary* and appropriate for you. *Blue Cross and Blue Shield* does this by referring to the guidelines described below.

All health care services must be required services that a health care provider, using prudent clinical judgment, would provide to a patient in order to prevent or to evaluate or to diagnose or to treat an illness, injury, disease or its symptoms. And, these health care services must also be:

- Furnished in accordance with generally accepted standards of professional medical practice (as recognized by the relevant medical community);
- Clinically appropriate, in terms of type, frequency, extent, site and duration; and they must be considered effective for your illness, injury or disease;
- Consistent with the diagnosis and treatment of your condition and 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 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.

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 08-833 Rev.

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 licensed applied behavioral analyst. This coverage includes:

- Assessments, evaluations (including neuropsychological evaluations), genetic testing, and/or other tests to determine if a *member* has an autism spectrum disorder.
- Habilitative and rehabilitative care. This is care to develop, maintain, and restore, to the maximum extent practicable, the functioning of the *member*. This care includes, but is not limited to, applied behavior analysis that is furnished by or supervised by: a psychologist; or a licensed applied behavioral 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*.

(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 disorders, no benefits are provided for: services that are furnished by school personnel under an

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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 licensed applied behavioral analysts.

All other provisions remain as described in your Medex certificate.

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.

This change goes into effect on October 28, 2008.

All other provisions remain as described in your Medex certificate.

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R13-828 (10-9-08) to be attached to: Group and Direct-Billed Medex.

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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R15-806 (7-20-07) to be attached to: Group and Direct-Billed Medex.

Rider 99-002
OBRA 90 Provisions

This rider modifies the terms of your Medex®′ Certificate for Group Subscribers. Please keep this rider with your Medex certificate for easy reference.

Except for certain services covered by Medex only, the benefits described in your Medex certificate are provided only for *covered services* eligible for benefits under *Medicare* and furnished by *Medicare covered providers*.

Medicare Part B Covered Services and Supplies

The benefits described in your Medex certificate have been enhanced to include all *Medicare* Part B covered services and supplies. These benefits are provided subject to the limitations and exclusions described in your *Medicare* handbook. These benefits include, but are not limited to: *physician's* office visits (without the *inpatient hospital* stay requirement); ambulance services; purchase or rental of *durable medical equipment*; *durable medical equipment* supplied as part of *Medicare* approved home health care services (*Medicare* provides full benefits for the home health care itself); and treatment of *mental or nervous conditions* (including drug addiction and alcoholism) when furnished by a *Medicare* covered mental health provider.

Even though *physicians* and other professional providers are not required to participate with *Medicare* in order to be eligible to provide *Medicare* covered services and supplies, *hospitals* and other health care facilities must participate with *Medicare* in order for their services to be covered by *Medicare*. (See "*Covered Providers*" below for the exceptions to this rule.)

Payment to Providers for Services That Are Covered by Medex Only

The charge that is used to calculate payment of your benefits for services covered by Medex only by providers that do not have a payment agreement with *Blue Cross and Blue Shield* has been changed.

Unless stated otherwise, *Blue Cross and Blue Shield* provides the benefits described in your Medex certificate for services covered by Medex only whether or not the provider has an agreement with *Blue Cross and Blue Shield*. 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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R99-002 (1-1-01 Rev) to be attached to the following Medex Certificates for Group Subscribers: ME-ABDED; ME-RXADED; and ME-RXNODED.

Covered Providers

The following provisions apply:

- *Medicare* does not provide any benefits for services and supplies furnished by a *hospital* or another health care facility that does not participate with *Medicare*. There is one exception to this rule. *Medicare* provides benefits for *emergency medical care* that you receive in a *hospital* or dialysis facility that does not participate with *Medicare*, but **only when** *Medicare* determines that a *Medicare* participating *hospital* or dialysis facility is not reasonably available. However, *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 for *emergency medical care* in a *hospital* that does not participate with *Medicare* under your 365 lifetime days. (See "*Inpatient Hospital* Services" below.)
- Benefits for services furnished outside Massachusetts by a psychologist or licensed independent clinical social worker are provided only when the *covered services* are eligible for benefits under *Medicare*. No benefits are provided for services by the following providers when furnished outside Massachusetts: clinical specialists in psychiatric and mental health nursing; licensed independent clinical social workers (when services are covered by Medex only); licensed mental health counselors; and psychologists (when services are covered by Medex only).

Inpatient Hospital Services

The *inpatient* benefits described in your Medex certificate for *hospital* services have been changed.

Blue Cross and Blue Shield provides benefits as described in your Medex certificate for all available *Medicare* days when you are an *inpatient* in a *hospital*. After you have used all of your *Medicare* days in a *benefit period* (or all of your 190 lifetime days in a mental *hospital*), *Blue Cross and Blue Shield* provides full benefits for semiprivate *room and board* and *special services*. (If you have a right to *Medicare hospital inpatient* reserve days, you must use them before *Blue Cross and Blue Shield* provides benefits after the 90th day in a *benefit period*.) *Blue Cross and Blue Shield* provides these benefits as follows:

- Up to 120 days in each *benefit period* (but up to at least 60 days in each calendar year) when you are an *inpatient* in a mental *hospital*, less any days in a mental *hospital* already covered by *Medicare* or Medex in the same *benefit period* (or calendar year). In certain cases, using these days will reduce the Medex lifetime days available in a mental *hospital*. (See below.) No benefits are provided for a condition that is not a *mental or nervous condition.*
- Up to a lifetime total of 365 days when you are an *inpatient* in a general, chronic disease or rehabilitation *hospital* or, in certain cases, a mental *hospital*.

Note: The benefits described above for *inpatient* mental health and substance abuse treatment do not apply if you have another rider that provides these benefits. In this case, your benefits for *inpatient* mental health and substance abuse treatment are provided as described in that rider.

Private Room Charges

The *inpatient* benefits described in your Medex certificate for *hospital* services have been enhanced by adding private room benefits.

For covered *room and board*, you do not have to pay any charges that are more than the semiprivate room rate. This is the case when: *Medicare* provides benefits for private room charges when *Medicare* determines that a private room is *medically necessary* for you; or for services eligible for benefits under Medex only, *Blue Cross and Blue Shield* provides benefits for private room charges when *Blue Cross and Blue Shield* determines that a private room is *medically necessary* for you.

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

The *inpatient* benefits described in your Medex certificate have been enhanced by adding coverage for blood.

Blue Cross and Blue Shield provides benefits for the *Medicare* Part A *blood deductible* (if it has not already been met) 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 below.) 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 arrange to have replaced by another person or organization.

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

The *outpatient* benefits described in your Medex certificate have been enhanced by adding coverage for blood.

Blue Cross and Blue Shield provides benefits for the *Medicare* Part B *blood deductible* (if it has not already been met) when you are an *outpatient* in a *hospital*.

Blue Cross and Blue Shield also provides benefits for the *Medicare* Part A *blood deductible*. (See above.) 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 arrange to have replaced by another person or organization.

Mental Health and Substance Abuse *Outpatient* treatment

The benefits described in your Medex certificate for mental health and substance abuse *outpatient* treatment that is not covered by *Medicare* have been changed.

When not covered by *Medicare*, *Blue Cross and Blue Shield* provides full benefits based on the *allowed charge* for *outpatient* care to treat *mental or nervous conditions* (including drug addiction and alcoholism) up to the benefit limit described in your Medex certificate in each calendar year, less any *Blue Cross and Blue Shield* payments already made for *outpatient* treatment of *mental or nervous conditions* (including drug addiction and alcoholism) in that same calendar year, when 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 by a clinical specialist in psychiatric and mental health nursing or a licensed mental health counselor.) These benefits may include: services to evaluate, diagnose and treat your *mental or nervous*

condition; and psychological tests that are needed to decide the right treatment for your *mental or nervous condition*.

Note: The benefits described above for *outpatient* mental health and substance abuse treatment do not apply if you have another rider that provides these benefits. In this case, your benefits for *outpatient* mental health and substance abuse treatment are provided as described in that rider.

Admissions Before Your *Effective Date*

The provision on when *Blue Cross and Blue Shield* will begin to provide benefits when you are an *inpatient* on your *effective date* has been changed.

Blue Cross and Blue Shield provides benefits as described in your Medex certificate only for *covered services* furnished on or after your *effective date*.

This means that the provision that if you are already in a *hospital* (or another covered health care facility) on your *effective date*, *Blue Cross and Blue Shield* will not provide benefits in connection with that *inpatient* stay unless from the start of that stay until your *effective date* you were covered the whole time under a contract with a Blue Cross and Blue Shield Plan has been eliminated.

Services and Supplies After Your Termination Date

The provision on when *Blue Cross and Blue Shield* will continue to provide benefits after your termination date under this *contract* has been changed.

No benefits are provided for services and supplies furnished after your termination date under this *contract*. There is one exception. The Medex benefits described in this Medex certificate will continue to be provided for *inpatient* services, but **only if** you are receiving covered *inpatient* care on your termination date. In this case, Medex benefits will continue to be provided until all the Medex benefits allowed under this *contract* have been used up or the date of discharge, whichever comes first.

Other Provisions

All other provisions remain as described in your Medex certificate.