Date: 01/20/2016

To: MIT CAMPUS

Documents Provided: Subscriber Certificate(s) and Riders as of 01/01/2016

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 01/01/2016.

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.
Managed Blue for Seniors

Subscriber Certificate

A Blue Cross and Blue Shield of Massachusetts
HMO Blue, Inc. plan
Welcome to HMO Blue

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

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

Sèvis Tradiksyon ak Entèpretasyon
Genyen yon sèvis tradiksyon ki disponib lè w rele biwo sèvis kliyan Blue Cross and Blue Shield nan nimewo telefon gratis ki sou kat didanifikasyon plan asirans ou an. Sèvis sa a ba w aksè a entèpret ki ka tradwi plis ke 140 lang diferan. Si w ta bezwenn utilize sèvis tradiksyon sa yo, sempleman di reprazantan sèvis kliyan an sa lè w rele. Epi lè w rele a, Blue Cross and Blue Shield pral itilize yon liy sèvis pou lang pou gen aksè a yon entèpret ki pral ede w jwenn repons a ekksyony ou genyen oswa ede w konprann pwosèdi Blue Cross and Blue Shield yo. (Entèpret sa a pa anplwaye ni li pa mandate pa Plan an oubyen pa Blue Cross and Blue Shield.)

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

翻譯服務
當您以健康計劃識別卡上的免付費電話號碼致電 Blue Cross and Blue Shield 客戶服務辦公室之時，您就能獲得語言翻譯服務。這項服務能為您提供 140 多種不同語言的翻譯服務。若您
需要翻譯服務，在致電時告訴客戶服務代表即可。隨後 Blue Cross and Blue Shield 會利用語言
服務專線找一個翻譯員，為您解答或協助您了解 Blue Cross and Blue Shield 程序。（此翻譯員
並非 Plan 或 Blue Cross and Blue Shield 的僱員或所指派的人員。）
Услуги по письменным и устным переводам
Позвонив в отдел обслуживания клиентов компании Blue Cross and Blue Shield по бесплатному телефону, указанному в Вашем удостоверении клиента медицинского плана, Вы можете воспользоваться услугами переводчика. В распоряжении наших клиентов имеются переводчики, работающие более чем со 140 языками. Если Вы нуждаетесь в переводе, сообщите об этом ответственому на Ваш позвонок сотруднику отдела обслуживания клиентов компании. В этом случае – прямо во время Вашего звонка – компания Blue Cross and Blue Shield свяжется с переводчиком службы переводов, который переводит для Вас ответы на Ваши вопросы и помогает Вам понять правила, действующие в компании Blue Cross and Blue Shield. (Такой переводчик не является сотрудником или назначенным лицом медицинского плана Plan или компаниии Blue Cross and Blue Shield.)

خدمات الترجمة الحرارية والشفوية
عندما تتصل بقسم خدمة العمل لدى Blue Cross and Blue Shield، فعلى الرقم المجاني الذي تجد مطروحًا على بطاقة تأمينكم الصحي، تستطيع الاستفادة من خدمة الترجمة. توفر لك هذه الخدمة إمكانية الاتصال بترجمينًا لأكثر من 140 لغة. إذا كنت في حاجة إلى الترجمة، عليك فقط بإخبار موظف خدمة العمل عندما تصل، وأندا اتصال، سنستخدم خدمات ترجمة على الهدف للاتصال بالترجمين الذي سيساعد في الإجابة على أسئلتكم أو ساعدك على فهم إجراءات (Blue Cross and Blue Shield أو Plan). (Blue Cross and Blue Shield أو Plan.)

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

Serviço de Tradução e Interpretação
O serviço de apoio da Blue Cross and Blue Shield tem disponível um serviço de tradução, quando telefona para o número gratuito indicado no seu cartão de identificação do plano de saúde. Este serviço dá acesso a intérpretes em mais de 140 idiomas diferentes. Se necessitar deste serviço de tradução, comunique-o ao representante do serviço de clientes que o atender via telefone. Então, durante a sua chamada a Blue Cross and Blue Shield utilizará um intérprete de um serviço de interpretação por telefone, que o ajudará a obter respostas às suas questões ou a entender os procedimentos da Blue Cross and Blue Shield. (Este intérprete não é um funcionário nem uma pessoa designada pelo Plan ou pela Blue Cross and Blue Shield.)
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Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. certifies that you have the right to coverage according to the terms of this Managed Blue for Seniors contract. This contract is a prepaid (“insured”) group health maintenance contract between the member’s group and Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. (the Plan) to provide health care services and benefits to participants of the group health plan sponsored by the member’s group. Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. will provide the coverage that is described in this Managed Blue for Seniors contract as long as you are enrolled under this contract when you receive covered services, the premium that your group owes for this coverage has been paid to Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. and you follow all the requirements of the Plan.

This Managed Blue for Seniors Subscriber Certificate is part of the contract between your group and Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc., located at 101 Huntington Avenue, Suite 1300, Boston, Massachusetts 02199-7611, to provide Managed Blue for Seniors coverage to you (the member). It explains your coverage and the terms of your membership under this contract. It also describes your responsibilities as well as the Plan’s responsibilities to you. You should read this 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.

Your group or the Plan may change the coverage described in this contract (see Part 11). If this is the case, the change is described in a rider. Your plan sponsor or the Plan can supply you with any riders that apply to your coverage under this contract. Please keep any riders with your Managed Blue for Seniors contract for easy reference.

Managed Blue for Seniors is a supplemental insurance plan that provides additional coverage to your Medicare Hospital Insurance (Part A) and to your Medicare Medical Insurance (Part B). Medicare is the primary insurer. Your Managed Blue for Seniors coverage supplements your Medicare insurance by paying part or all of the Part A and Part B deductibles and coinsurance when those same services and/or supplies are eligible for coverage under this Managed Blue for Seniors contract. Your Medicare handbook explains your Medicare coverage in detail as well as the restrictions that apply to this coverage and also explains how you can get other booklets that deal with specific topics related to your Medicare coverage.

As a Managed Blue for Seniors member, you must choose a primary care physician (PCP) who will furnish most of your health care. If you and your PCP decide you need to see a specialist, your PCP will refer you to the HMO Blue network specialist that he or she determines is best for treating your specific condition. It will usually be a specialist your PCP knows, probably someone affiliated with your PCP’s hospital or medical group. And, by enrolling in Managed Blue for Seniors, you have agreed to receive all your health care from HMO Blue.
network providers. To find out if a health care provider is a network provider, you may look in the directory of HMO Blue network providers. Of course if you need emergency medical care, the Plan will cover those services even when they are furnished by non-network providers. (See Part 11 for a few other situations when the Plan may cover services furnished by non-network providers.) Unless otherwise described in this Managed Blue for Seniors contract, the Plan will not cover any other services by non-network providers.

Before using your coverage, you should remember there are limitations or exclusions. Be sure to read the limitations and exclusions on your coverage that are described in Parts 3, 4, 5, 6 and 7.
Member Services

Choosing a Primary Care Physician

When You Enroll. At the time you enroll in Managed Blue for Seniors, you must choose a PCP from the HMO Blue network of internal medicine or family practice physicians. Your choice of a PCP is important. Because PCPs will generally refer their patients to network specialists affiliated with the PCP’s network hospital or medical group, your choice will determine who you will see and where you will receive most of your health care. You should make an appointment with your PCP as soon as you enroll in Managed Blue for Seniors. This will allow your PCP to get to know your medical history and to give you medical attention and treatment that is tailored to your needs.

If your PCP leaves the HMO Blue network, the Plan will send you a written notice at least 30 days before your PCP’s disenrollment date. The notice will tell you how to choose a new PCP. In most cases, the Plan will continue to provide Managed Blue for Seniors coverage for covered services you receive from your PCP for up to an additional 30 days. (See Part 11 for more information.)

Need Help Choosing a PCP? If you need help in choosing a PCP, you may call the Plan’s customer service office. The toll-free telephone number is shown on your Managed Blue for Seniors identification card. Or, you may call the Physician Selection Service at 1-800-821-1388. A representative will be able to tell you a physician’s specialty, the medical schools he or she attended and if languages other than English are spoken in the physician’s office.

Changing Your PCP. You may change your PCP at any time. All you have to do is call or write the Plan’s customer service office. Or, you may request this change online by using the Plan’s member self-service option located on the internet website at www.bluecrossma.com. Usually, the change will be made on the date the Plan gets your request or on a future date of your choice.

Network of Health Care Providers

HMO Blue Provider Network. Under this Managed Blue for Seniors contract, you will receive all your health care from health care providers who are enrolled as network providers. Your primary care physician (PCP) will furnish most of your health care. If you and your PCP decide you need to see a specialist, your PCP will refer you to the network specialist that he or she determines is best for treating your specific condition. (For more information about when a referral is not required from your PCP, see Part 4.) Of course if you need emergency medical care, the Plan will cover those services even when they are furnished by non-network providers. (See Part 11 for a few other situations when the Plan may cover services furnished by non-network providers.) Except as described in this contract, the Plan will not cover any
services furnished by non-network providers. This is true even if the services are eligible for coverage under Medicare.

Finding a Network Provider. At the time you enroll in Managed Blue for Seniors, your group will make available to you a directory of HMO Blue network providers. This provider directory is available to you at no additional charge. To find out if a health care provider is a network provider, you may look in this directory. Or, you may also use any of the following options to find out if a health care provider is a network provider. You may:

- Call the Plan’s customer service office. This toll-free telephone number is shown on your Managed Blue for Seniors identification card.
- Call the Physician Selection Service at 1-800-821-1388.
- Access the Plan’s online Physician Directory (Find a Doctor) at www.bluecrossma.com. The list of network providers is subject to change. The Plan’s online physician directory will provide you with the most current list of network providers.

Massachusetts Board of Registration: 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.

Identification Cards

After you enroll in Managed Blue for Seniors, you will receive a Managed Blue for Seniors identification card. This card is for identification purposes only. While you are a member, you must show your identification card to the network provider before you receive covered services.

Lost Your ID Card? If your Managed Blue for Seniors identification card is lost or stolen, you should contact the Plan’s customer service office. They will send you a new Managed Blue for Seniors 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 Claim Problems or Concerns

Calling Member Service. For help to understand the terms of your Managed Blue for Seniors contract or to resolve a problem or concern, you may call the Plan’s customer service office. A customer service representative will work with you to help you understand your coverage or resolve your problem or concern as quickly as possible. You can call the Plan’s customer service office Monday through Friday from 8:00 a.m. to 6:00 p.m. (Eastern Time). The Plan’s toll-free telephone number is shown on your Managed Blue for Seniors identification card. (To use the Telecommunications Device for the Deaf, call 1-800-522-1254.)
Or, you can write to: Blue Cross Blue Shield of Massachusetts  
Member Service  
P.O. Box 9201  
North Quincy, MA 02171-9201

The Plan 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.

More Information: For information about the Plan’s inquiry process and the formal grievance review process, see Part 9.

Requesting Medical Policy Information. To receive all the coverage described in this contract, your treatment must conform to the Plan’s medical policy guidelines that are in effect at the time the services or supplies are furnished. To check for a medical policy, you can go online and log on to www.bluecrossma.com. Or, you may call the Plan’s customer service office to request a copy of the information.

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

- A health plan report card 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.
Do not rely on this chart alone. It merely highlights your Managed Blue for Seniors coverage. Be sure to read Part 4 for the requirements you must follow to receive coverage, the explanations in Part 5 and the limitations and exclusions in Part 6, as well as all provisions of this contract.

Note: Your group or the Plan may change this coverage. If this is the case, the change is described in a rider. Your plan sponsor or the Plan can supply you with any riders that apply to your coverage under this Managed Blue for Seniors contract. Please keep any riders with your Managed Blue for Seniors contract for easy reference.

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<td>Nothing</td>
</tr>
<tr>
<td>• Network chronic disease or rehabilitation hospital services (365-day lifetime limit after Medicare days end)</td>
<td>Nothing (after Medicare days end, you pay nothing up to lifetime day limit; then, you pay all costs)</td>
</tr>
<tr>
<td>• Network physician or other covered professional provider services</td>
<td>Nothing</td>
</tr>
<tr>
<td>• Medicare-certified skilled nursing facility services (100 days per benefit period)</td>
<td>Nothing up to day limit per benefit period; then, you pay all costs</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>$40 copayment per one-way trip (waived for emergency medical care transport)</td>
</tr>
<tr>
<td>• Emergency ambulance transport</td>
<td>$40 copayment per one-way trip (waived for emergency medical care transport)</td>
</tr>
<tr>
<td>• Other medically necessary network ambulance transport</td>
<td>$40 copayment per one-way trip (waived for emergency medical care transport)</td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
<td>$10 copayment per visit</td>
</tr>
<tr>
<td>Outpatient services</td>
<td>$10 copayment per visit</td>
</tr>
<tr>
<td>Chiropractor Services</td>
<td>$10 copayment per visit</td>
</tr>
<tr>
<td>(limited to spinal manipulation)</td>
<td>$10 copayment per visit</td>
</tr>
<tr>
<td>Diabetic Testing Materials, Drugs, Medical Formulas and Food Products</td>
<td>Nothing (or, for food products, nothing up to coverage limit; then, you pay all costs)</td>
</tr>
<tr>
<td>(coverage for food products limited to $2,500 per calendar year)</td>
<td>Nothing (or, for food products, nothing up to coverage limit; then, you pay all costs)</td>
</tr>
<tr>
<td>Dialysis Services</td>
<td>Nothing</td>
</tr>
<tr>
<td>Outpatient and home services</td>
<td>Nothing</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>$10 copayment for each covered item</td>
</tr>
<tr>
<td>Rented or purchased for home use from an approved network provider</td>
<td>$10 copayment for each covered item</td>
</tr>
</tbody>
</table>

WORDS IN ITALICS ARE DEFINED IN PART 2.
### Your Managed Blue for Seniors Coverage:

<table>
<thead>
<tr>
<th>Emergency Medical Outpatient Services</th>
<th>Your Cost is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Emergency room visits</td>
<td>$50 copayment per visit</td>
</tr>
<tr>
<td>Note: The emergency room copayment will be waived if you are admitted as an inpatient or you are held for an overnight observation stay.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Health Care</th>
<th>Nothing</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Office, health center and hospital outpatient department</td>
<td>$10 copayment per visit (nothing for hospital services)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lab Tests, X-Rays and Other Tests</th>
<th>Nothing</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Office and health center services</td>
<td>$10 copayment per visit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospice Services</th>
<th>Nothing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice for terminally ill</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maternity Services</th>
<th>$10 copayment for first visit; then, you pay nothing</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Office and health center services</td>
<td>$10 copayment per visit</td>
</tr>
<tr>
<td>• Hospital outpatient department</td>
<td>Nothing*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Care Outpatient Visits</th>
<th>Nothing*</th>
</tr>
</thead>
<tbody>
<tr>
<td>(“sick” visits) includes syringes and needles dispensed during a visit (see Note below)</td>
<td></td>
</tr>
<tr>
<td>*If the network provider’s office is located at, or professional services are billed by, the hospital, you must pay the amount that you would normally pay for an office visit.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Health and Substance Abuse Treatment</th>
<th>Nothing</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Network general hospital inpatient services</td>
<td></td>
</tr>
<tr>
<td>• Network mental hospital or substance abuse facility inpatient services</td>
<td>Nothing**</td>
</tr>
</tbody>
</table>

**For non-biologically-based mental conditions (other than rape-related mental or emotional conditions), after Medicare days end, your coverage is limited to 60 days per calendar year plus 30 more days per calendar year for alcoholism treatment.**

<table>
<thead>
<tr>
<th>Oxygen</th>
<th>Nothing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxygen and equipment from a network provider</td>
<td></td>
</tr>
</tbody>
</table>

Note: Your coverage for these supplies is provided only when they are furnished on and after July 13, 2006.

**Words in italics are defined in Part 2.**
## Your Managed Blue for Seniors Coverage:  

<table>
<thead>
<tr>
<th>Service</th>
<th>Your Cost is:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Podiatry Care</strong></td>
<td></td>
</tr>
<tr>
<td>• Office and health center services</td>
<td>$10 <em>copayment</em> per visit</td>
</tr>
<tr>
<td>• Hospital outpatient department</td>
<td>Nothing*</td>
</tr>
<tr>
<td><em>If the network provider’s office is located at, or professional services are billed by, the hospital, you must pay the amount that you would normally pay for an office visit.</em></td>
<td></td>
</tr>
<tr>
<td><strong>Preventive Health Services</strong></td>
<td></td>
</tr>
<tr>
<td>• Routine physical exams</td>
<td>$10 <em>copayment</em> per visit</td>
</tr>
<tr>
<td>- Routine mammograms (at least once between age 35-39 and once per calendar year for age 40 and older)</td>
<td>Nothing</td>
</tr>
<tr>
<td>• Routine GYN exams (once per calendar year)</td>
<td>$10 <em>copayment</em> per visit</td>
</tr>
<tr>
<td>- Routine Pap smear tests (once per calendar year)</td>
<td>Nothing</td>
</tr>
<tr>
<td>• Family planning</td>
<td>$10 <em>copayment</em> per visit</td>
</tr>
<tr>
<td>• Routine vision exams (once per calendar year)</td>
<td>$10 <em>copayment</em> per visit</td>
</tr>
<tr>
<td><strong>Prosthetic Devices</strong></td>
<td>Purchased for home use from an approved network provider</td>
</tr>
<tr>
<td><strong>Radiation Therapy and Chemotherapy</strong></td>
<td><em>Outpatient services</em></td>
</tr>
<tr>
<td><strong>Second Opinions</strong></td>
<td><em>Outpatient services</em></td>
</tr>
<tr>
<td><strong>Short-Term Rehabilitation Therapy</strong></td>
<td><em>Outpatient physical, speech and/or occupational therapy</em></td>
</tr>
<tr>
<td><strong>Surgery as an Outpatient</strong></td>
<td></td>
</tr>
<tr>
<td>(includes related anesthesia)</td>
<td>• Office and health center services</td>
</tr>
<tr>
<td></td>
<td>• Network surgical day care unit, ambulatory surgical facility and hospital outpatient department*</td>
</tr>
<tr>
<td></td>
<td><em>If the network provider’s office is located at, or professional services are billed by, the hospital, you must pay the amount that you would normally pay for an office visit.</em></td>
</tr>
<tr>
<td><strong>TMJ Disorder Treatment</strong></td>
<td><em>Outpatient services</em></td>
</tr>
<tr>
<td></td>
<td><em>Unless the network provider’s office is located at, or professional services are billed by, the hospital, you pay nothing for medical care or surgery furnished by a network hospital.</em></td>
</tr>
</tbody>
</table>

*WORDS IN ITALICS ARE DEFINED IN PART 2.*
Part 2

Definitions

The following terms are shown in italics in this contract. These terms will give you a better understanding of your Managed Blue for Seniors coverage.

Allowed Charge

The charge that is used to calculate payment of your coverage. The allowed charge depends on whether the service is covered by both Medicare and the Plan or solely by the Plan. For a service covered by both Medicare and the Plan, the allowed charge is set by Medicare. (Your Medicare handbook explains how Medicare calculates the allowed charge for Medicare coverage.) When coverage is provided solely by the Plan, the allowed charge depends on the type of health care provider that furnishes a covered service to you as described below:

- **Network Providers.** For network providers, the allowed charge is based on the provisions of that provider’s HMO Blue network payment agreement with the Plan. In general, when you share in the cost for covered services (such as a copayment), the calculation for the amount that you pay is based on the initial full allowed charge for the network provider. This amount that you pay is generally not subject to future adjustments—up or down—even though the network provider’s payment may be subject to future adjustments for such things as provider contractual settlements, risk-sharing settlements and fraud or other operations.

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

- **Non-Network Providers Without a Local Payment Agreement.** For non-network
  providers in Massachusetts and non-network providers outside of Massachusetts that
do not have a payment agreement with the local Blue Cross and/or Blue Shield Plan
(or, if there is a local payment agreement and that agreement does not apply for
services received by members enrolled in Managed Blue for Seniors), the provider’s
actual charges are used to calculate your coverage.

**Pharmacy Providers.** The Plan may have payment arrangements with pharmacy providers that
may result in rebates on covered drugs and supplies. When this contract includes pharmacy
coverage, the amount that you pay for a covered drug or supply is determined at the time you
buy the drug or supply. The amount that you pay will not be adjusted for any later rebates,
settlements or other monies paid to the Plan from pharmacy providers or vendors.

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

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

**Coinsurance**
The amount that you must pay for a certain covered service that is calculated as a percentage.
The coinsurance calculation depends on whether the service is covered by both Medicare and the
Plan or solely by the Plan.

- **Coverage Provided Solely by the Plan.** For covered services that are covered solely
  by the Plan, coinsurance (if any) is calculated as a percentage of the provider’s actual
  charge or the allowed charge, whichever is less (unless otherwise required by law).

WORDS IN ITALICS ARE DEFINED IN PART 2.
• **Coverage Provided by Both Medicare and the Plan.** For covered services that are covered by both Medicare and the Plan, coinsurance is calculated as a percentage of the Medicare allowed amount and it is the portion that Medicare does not pay each time you receive a Medicare-approved service. There are two types of Medicare coinsurance, Part A and Part B. Your Managed Blue for Seniors coverage supplements your Medicare insurance by paying part or all of the Part A and Part B coinsurance when those same services and/or supplies are eligible for coverage under this Managed Blue for Seniors contract.

**Medicare Part A Coinsurance.** The Part A coinsurance is divided into three types:

− The inpatient hospital daily coinsurance from the 61st through the 90th day during a benefit period for which you receive Medicare coverage as an inpatient in a hospital. This is set at one quarter of the Part A deductible.

− The inpatient hospital daily coinsurance for each of your 60 hospital inpatient reserve days. This is set at one half of the Part A deductible.

− The extended care services daily coinsurance from the 21st through the 100th day during a benefit period for which you receive Medicare coverage as an inpatient in a skilled nursing facility. This is set at 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 change in calendar year.

**Medicare Part B Coinsurance.** For most Medicare Part B covered services, the Part B coinsurance is set at 20% of the Medicare allowed amount.

**Contract**

This contract, including your Managed Blue for Seniors Subscriber Certificate, any riders or other changes to this contract, your enrollment form and the agreement that the Plan has with your group to provide Managed Blue for Seniors coverage to you. This 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 HMO Blue, Inc. (the Plan), which is a corporation independent of and operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the “Association”) permitting the Plan to use the Blue Cross and Blue Shield Service Marks in the Commonwealth of Massachusetts, and that the Plan 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 the Plan and that no person, entity or organization other than the Plan will be held accountable or liable to you or your group for any of the Plan’s obligations to you created under this contract. This paragraph will not create any additional obligations whatsoever on the part of the Plan other than those obligations created under other provisions of this contract.

WORDS IN ITALICS ARE DEFINED IN PART 2.
Part 2 – Definitions (continued)

Copayment
The amount that you must pay for a certain covered service which is a fixed dollar amount. In most cases, a network provider will collect the copayment from you at the time he or she furnishes the covered service. However, when the provider’s actual charge at the time of providing the covered service is less than your copayment, you pay only that provider’s actual charge or the allowed charge, whichever is less. Any later charge adjustment—up or down—will not affect your copayment (or the amount you were charged at the time of the service if it was less than the copayment). Part 1 shows the amount of your copayment and which covered services are subject to a copayment. At certain times when a copayment would normally apply, your copayment may be waived. Your copayment will be waived when:

- Your hospital emergency room visit results in your being held for an overnight observation stay or your being admitted for inpatient care within 24 hours. In this case, the emergency room copayment will be waived.
- You are transported by ambulance to an emergency medical facility for emergency medical care. In this case, the ambulance copayment will be waived.
- Your visit is only for: lab tests and/or x-rays; and immunizations or certain injections such as allergy shots. In this case, any outpatient visit copayment will be waived. (This does not apply to injections that are covered as a surgical service such as nerve block injections or injections of anesthetic agents.)
- You receive certain approved “intermediate” mental health care services such as day treatment program services in lieu of an inpatient admission (see page 38 for more information). In this case, an inpatient copayment, if there is any, will be waived.

Covered Services
Health care services or supplies for which the Plan provides coverage as described in this contract, including any riders to this Managed Blue for Seniors contract. Most covered services are furnished by your primary care physician (PCP). Other covered services may be furnished by other network providers when arranged or recommended by your PCP and, when required, approved in advance by the Plan. (See Part 11 for those situations when the Plan may cover services furnished by non-network providers.)

Custodial Care
A type of care that is not covered by the Plan. 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

WORDS IN ITALICS ARE DEFINED IN PART 2.
Part 2 – **Definitions** (continued)

- 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.)

**Important Note:** For covered services eligible for coverage under both *Medicare* and Managed Blue for Seniors, the *Plan* uses *Medicare’s* guidelines to determine if a type of care is considered to be *custodial care*.

**Deductible**
The amounts set by *Medicare* as the Part A *deductible* and Part B *deductible*. These amounts may change. Your *Medicare* handbook will tell you the amount of the *deductibles*. The *Medicare* Part A *deductible* applies for each *benefit period*. The *Medicare* Part B *deductible* applies once each calendar year. Your Managed Blue for Seniors coverage supplements your *Medicare* insurance by paying part or all of the Part A and Part B *deductibles* when those same services and/or supplies are eligible for coverage under this Managed Blue for Seniors *contract*.

The *Medicare* program also includes a “blood *deductible*.” This is 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.) Under your Managed Blue for Seniors *contract*, the *Plan* provides coverage for the *Medicare* blood *deductible*.

**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; 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.

**Effective Date**
The date, as shown on the *Plan’s* records, on which your membership under this Managed Blue for Seniors *contract* starts. Or, the date on which a change to this Managed Blue for Seniors *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 conditions when: you are admitted as an inpatient as required under Massachusetts General Laws, Chapter 123, Section 12; you seem very likely to endanger yourself as shown by a serious suicide attempt, a plan to commit suicide or behavior that shows that you are not able to care for yourself; or you seem very likely to endanger others as shown by an action against another person that could cause serious physical injury or death or by a plan to harm another person.

Important Note:
For purposes of filing a claim or the formal grievance review (see Parts 8 and 9), the Plan considers “emergency medical care” to constitute “urgent care” as defined under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Group
Any corporation, partnership, individual proprietorship or other organization that has an agreement with the Plan to provide health care coverage for a group of members. The group will send payment to the Plan for coverage provided by the Plan for covered members and will also deliver to the members all notices from the Plan. The group is the subscriber’s agent and is not the agent of the Plan.

Inpatient
A patient who is a registered bed patient in a facility. This also includes a patient who is receiving approved intensive services such as partial hospital programs or covered residential care. (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. This is important for you to know since your cost of covered services and coverage limits may differ for inpatient and outpatient coverage.)
Medical Technology Assessment Guidelines

For covered services not eligible for coverage under Medicare, the guidelines that the Plan uses to assess whether a technology improves health outcomes such as length of life or ability to function. The Plan’s 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, the Plan may limit coverage for drugs, biological products and devices to those specific indications, conditions and methods of use approved by the FDA.

- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed English-language journals. The qualities of the body of studies and the consistency of the results are considered in evaluating the evidence. The evidence should demonstrate that the technology can measurably alter the physiological changes related to a disease, injury, illness or condition. In addition, there should be evidence or a convincing argument based on established medical facts that the measured alterations affect health outcomes. Opinions and evaluations by national medical associations, consensus panels and other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence upon which they are based.

- The technology must improve the net health outcome. The technology’s beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.

- The technology must be as beneficial as any established alternatives. The technology should improve the net outcome as much as or more than established alternatives. The technology must be as cost-effective as any established alternative that achieves a similar health outcome.

- The improvement must be attainable outside the investigational setting. When used under the usual conditions of medical practice, the technology should be reasonably expected to improve health outcomes to a degree comparable to that published in the medical literature.

**Important Note:** For covered services eligible for coverage under both Medicare and Managed Blue for Seniors, the Plan uses Medicare’s guidelines to make this assessment.
Medically Necessary

All covered services, except voluntary termination of pregnancy, voluntary sterilization, and 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 not eligible for coverage under Medicare, the Plan decides which health care services are medically necessary and appropriate for you by using the following guidelines. All health care services must be required to diagnose or treat your illness, injury, symptom, complaint or condition. They must also be:

- Consistent with the diagnosis and treatment of your condition and in accordance with the Plan’s medical policy and medical technology assessment guidelines.
- Essential to improve your net health outcome and as beneficial as any established alternatives covered by this Managed Blue for Seniors contract.
- 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 network 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.

| Important Note: | For covered services eligible for coverage under both Medicare and Managed Blue for Seniors, the Plan determines which services are medically necessary by using Medicare’s “reasonable and necessary” guidelines. |

Medicare

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

Member

You, the person who has the right to the coverage described in this contract.

Mental Conditions

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

A network provider that may furnish covered services for the treatment of mental conditions. These network providers include:

- Alcohol and drug treatment facilities.
- Clinical specialists in psychiatric and mental health nursing.
- Community health centers (that are a part of a general hospital).
- Detoxification facilities.
- General hospitals.
- Licensed independent clinical social workers.
- Licensed mental health counselors.
- Mental health centers.
- Mental hospitals.
- Physicians.
- Psychologists.
- Any other mental health provider designated by the Plan.

Network Provider

A health care provider that has a written HMO Blue payment agreement with (or that has been designated by) the Plan to furnish covered services to Plan members. These providers are part of the HMO Blue network of health care providers. The kinds of health care providers that may furnish covered services to you include:

- **Hospital and Other Covered Facilities.** Alcohol and drug treatment facilities; ambulatory surgical facilities; chronic disease hospitals; community health centers; detoxification facilities; free-standing diagnostic imaging facilities; free-standing dialysis facilities; free-standing radiation therapy and chemotherapy facilities; general hospitals; independent labs; mental health centers; mental hospitals; rehabilitation hospitals; and skilled nursing facilities.

- **Physician and Other Covered Professional Providers.** 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; nurses; occupational therapists; optometrists; paraprofessionals; physical therapists; physicians; podiatrists; and psychologists.

- **Other Covered Health Care Providers.** Ambulance services; appliance companies; cardiac rehabilitation centers; home health agencies; home infusion therapy providers; hospice providers; oxygen suppliers; and visiting nurse associations.

**Note:** To find out if a health care provider is a network provider, you may look in the directory of HMO Blue network providers. Or, you may call the Plan’s customer service office at the toll-free telephone number shown on your Managed Blue for Seniors identification.
card (or the Physician Selection Service at 1-800-821-1388). You may also access the Plan’s online Physician Directory on the internet website at www.bluecrossma.com.

**Outpatient**

A patient who is not a registered bed patient in a facility. For example, a patient at a network health center, network provider’s office, network surgical day care unit or network 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. (This does not include a patient who is receiving approved intensive services such as partial hospital programs or covered residential care—see the definition of “Inpatient.”)

**Plan**

Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc., the not-for-profit managed care subsidiary of Blue Cross and Blue Shield. The Plan is licensed by the Commonwealth of Massachusetts as a health maintenance organization (HMO) to arrange for the coordinated delivery of health care services to its members. “Plan” also means an employee or designee of Blue Cross and Blue Shield who is authorized to make decisions or take action called for under this Managed Blue for Seniors contract.

**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 coverage under this contract. The premium amount is part of the agreement between the Plan and the group. The Plan may change your premium amount. Each time the Plan changes the premium, the Plan 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 to the Plan for your coverage under this contract to the Plan. The Plan is not responsible for providing coverage for a group member if the group fails to make premium payments. In this case, the Plan must provide notification to the group’s member.

**Primary Care Physician (PCP)**

The network physician that you choose to furnish medical care and to arrange and coordinate all other covered services. Your primary care physician also makes necessary referrals to other network providers for specialty care. A primary care physician may be an internist or a family practitioner. The HMO Blue Directory of Providers lists the Plan’s primary care physicians. Your primary care physician is called your “PCP” in this contract.
Rider
An amendment that changes the terms described in this Managed Blue for Seniors contract. The Plan or your group may change the terms of your contract. For example, a rider may change the amount you must pay for certain services such as the amount of your copayment or it may add or limit the coverage provided by the Plan under this Managed Blue for Seniors contract. A rider describes the material change that is made to your contract. The Plan will supply you with any riders that apply to your coverage under this Managed Blue for Seniors contract. You should keep any riders with your 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.

Service Area
The geographic area in which the Plan provides covered services. The only exceptions are for emergency medical care and urgent care. The Managed Blue for Seniors service area includes all cities and towns in the Commonwealth of Massachusetts.

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.
- Administration of infusions and transfusions. These do not include the cost of: whole blood; packed red blood cells; blood donor fees; or blood storage fees that are not eligible for coverage 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; intraocular lenses; and pacemakers. They do not include things such as: ostomy bags; artificial limbs or eyes; hearing aids; or airplane splints.
**Urgent Care**
Medical, surgical or psychiatric care other than *emergency medical care* that you need to prevent serious deterioration of your health when an unforeseen illness or injury occurs while you are temporarily outside the Managed Blue for Seniors *service area*. In most circumstances, *urgent care* will consist of brief diagnostic and treatment services to stabilize your condition so that you can return to the Managed Blue for Seniors *service area* for more treatment.

**Important Note:** For purposes of filing a claim or the formal grievance review (see Parts 8 and 9), the Plan considers “*emergency medical care*” to constitute “*urgent care*” as defined under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. As used in this *contract*, this *urgent care* term is not the same as the “*urgent care*” term defined under ERISA.

**Utilization Review**
The approach that the *Plan* uses to evaluate the necessity and appropriateness of many different services. (In most cases, these services are not eligible for coverage under *Medicare*, but are covered by the *Plan*.) 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 pre-admission review, concurrent review, discharge planning, pre-authorization of selected *outpatient* services, post-payment review and individual case management. The *Plan’s* utilization management policies are designed to encourage appropriate care and services (not less care). The *Plan* understands the need for special concern about underutilization, and shares this concern with its *members* and providers. The *Plan* does not compensate individuals who conduct *utilization review* activities based on denials. It also does not offer incentives to providers to encourage inappropriate denials of care and services. (See Part 11, “Process to Develop Clinical Guidelines and *Utilization Review* Criteria” for more information.)
Part 3

Emergency Medical Services

Obtaining Emergency Medical Services
You do not need a referral from your PCP or approval from the Plan before you obtain emergency medical care. The Plan provides world wide emergency coverage. This means that the Plan covers emergency medical services whether you are in or out of the Managed Blue for Seniors service area. 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.

Call 911. At the onset of an emergency medical condition that in your judgment requires emergency medical care, you should go to the nearest emergency room. For assistance, call your local emergency medical service system by dialing the emergency telephone access number 911, or the local emergency telephone number. You will not be denied coverage for medical and transportation services described in this 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. The Plan will consider post-stabilization covered services to be authorized if the referral or authorization is not provided within 30 minutes of the emergency room provider’s call. If the emergency room provider and your PCP do not agree as to the right medical treatment for you, the Plan will provide coverage for the covered services that are recommended by the emergency room provider. But, the Plan provides coverage only for treatment that is covered by this contract.

- Outpatient Follow-up Care. Your emergency room provider may recommend outpatient follow-up care. If this is the case, the emergency room provider must call your PCP as soon as you are stable to obtain a referral for your outpatient follow-up
care. If your PCP is not available, the emergency room provider must call the Plan to obtain this referral. The Plan will provide an approved referral for one follow-up visit for covered services. You must contact your PCP for a referral for any continued follow-up care that you may need. (When you receive emergency medical care outside the service area, coverage will be provided for one Medicare-approved visit, if you need it, without prior authorization from the Plan or your PCP while you are still outside the service area.)

- **Transfer to another Inpatient Facility.** Your emergency room provider may recommend transfer for inpatient care to another facility. If this is the case, the emergency room provider must call your PCP so that your PCP can be involved in the coordination of your health care and transfer can be arranged as soon as your condition is stable.

- **Admission from the Emergency Room.** 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, the emergency room provider is not required to notify your PCP before you are admitted. But, it is important that your PCP be notified of the admission so that your PCP (or the Plan) can be involved in the coordination of your health care.

**Notification Requirements**

**Call Within 48 Hours.** It is important to notify your PCP of any emergency medical condition. This is so that your PCP (or the Plan) can be involved in the coordination of your health care and so that follow-up care can be arranged, if needed. You, the facility or someone on your behalf must call your PCP within 48 hours of receiving emergency medical care, including emergency room visits or emergency admissions.

**Urgently-Needed Services Out of the Service Area**

The Plan also covers urgent care when you are temporarily out of the service area. You usually need urgent care because an unforeseen illness, injury or condition occurs and it is not reasonable, given the circumstances, to obtain treatment through your PCP or from a network provider. When you are traveling outside the service area and need urgent care for a medical condition, you should try to call your PCP for guidance. If you cannot call your PCP, you should seek treatment at the nearest appropriate health care facility.

**Medical Services.** If you receive urgent care for a medical condition while you are out of the service area, you must call your PCP or the Plan’s customer service office at the toll-free telephone number shown on your Managed Blue for Seniors identification card within 48 hours of receiving the care. The Plan will provide coverage for one Medicare-approved visit (if you need it) without a referral from your PCP while you are still outside the service area.

**Mental Health and Substance Abuse Treatment.** If you need urgent care for a mental condition, you must call your mental health/substance abuse referral toll-free telephone number shown on the back of your Managed Blue for Seniors identification card before you seek help. Words in italics are defined in Part 2.
treatment. You may call this referral telephone number 24 hours a day, seven days a week to obtain help and treatment.

**Filing a Claim for Emergency or Urgently-Needed Services**

You do not have to file a claim when you receive *covered services* from a *network provider*. The provider will file the claim for you. Just tell the provider that you are a *member* and show him or her your Managed Blue for Seniors identification card. The *Plan* will pay the provider directly for *covered services*. But, you may have to file your claim when you receive *covered services* from a non-*network provider*. 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 your provider. The *Plan* will repay you, less any applicable *copayment*.

**More Information:**

See Part 8 for more information about filing a claim for repayment.
Part 4
Utilization Review Requirements

PCP Referrals for Specialty Care

In most cases, your PCP will furnish needed health care. But, if you and your PCP decide that you need to see a specialist (such as an allergist or a cardiologist) for covered services, your PCP will refer you to an appropriate network specialist. The specialist will usually be one your PCP knows, probably someone affiliated with your PCP’s hospital or medical group.

You must obtain an approved referral from your PCP before you receive most outpatient specialty care from a network specialist in order for you to receive coverage from the Plan.

Your PCP will obtain approval of your referral to a network specialist from the Plan when required. Your referral approval may be time limited. Or, in some cases, your PCP may authorize a “standing” referral for specialty care with a network specialist when your PCP determines the referrals are appropriate and the network specialist agrees to the treatment plan. The network specialist will provide your PCP with necessary clinical and administrative information on a regular basis. Referrals authorize specific services and may authorize a specific number of visits that will be needed to diagnose, evaluate or treat your condition. It is up to you to comply with any limits set out in the Plan’s referral approval. It is up to your network physician or other network provider to get additional referrals or approvals from the Plan for related services.

Mental Health and Substance Abuse Treatment. You will usually call your PCP before you seek health care from other network medical providers. But, before you seek care for a mental condition, you or your PCP must call the mental health/substance abuse referral toll-free telephone number. This number is shown on the back of your Managed Blue for Seniors identification card. If the Plan determines that you require treatment for a mental condition, you will be referred to a network mental health provider.

Specialty Care Not Requiring a PCP Referral. You must obtain an approved referral from your PCP before you receive most outpatient specialty care from a network specialist in order for you to receive coverage from the Plan. However, there are a few times when a referral is not required for specialty care. You do not need an approved referral from your PCP (or prior approval from the Plan) before you receive:

- Emergency medical care.
- Covered services by a network obstetrician, network gynecologist or network nurse midwife or gynecological services and other women’s health services by a network family practitioner. This includes: one routine annual gynecological (GYN) exam and any services required as a result of the exam; and evaluations and health care services that result from acute or emergency gynecological conditions. (But, prior Plan approval is required for non-emergency and non-maternity inpatient admissions that...
Part 4 – **Utilization Review Requirements** (continued)

are not eligible for coverage under *Medicare.*) For these *covered services,* you will not have to pay any more to the *network provider* than you would normally pay if you had received an approved referral from your PCP.

- *Covered services* from a network chiropractor.
- Lab tests, x-rays and other covered tests from a *network provider*.
- Maternity services, including prenatal and postnatal care, from a *network provider*.
- Radiation therapy and chemotherapy from a network facility.
- Routine vision exams from a network ophthalmologist or network optometrist.
- *Urgent care* received outside the *service area.*

**PCP Referral Requirements Can Change:** From time to time, the Plan may change this list of services that require a referral from your PCP. At any time, your PCP or *network provider* (or the Plan) can tell you if your service needs a referral. When a change is made to your Managed Blue for Seniors contract, the Plan will send you a *rider* that describes the change.

**Specialty Care by Non-Network Providers.** If your condition requires *covered services* that cannot be furnished by a *network provider,* your PCP may approve a referral to a non-*network provider* for the *covered services.* In some cases, in addition to your PCP, the Plan must approve the referral in writing before you receive the services. You should not obtain any services from a non-*network provider* until you check with your PCP. (See Part 11 for more information about when the Plan may cover services furnished by non-*network providers.*)

**Plan Authorization Requirements**

There are certain *covered services* (as described later in this section) that require prior approval from the Plan instead of a referral from your PCP in order for you to receive the coverage described in this contract. In these cases, your PCP must recommend or order the *covered service.* The *network provider* will obtain prior approval from the Plan for you. You should check with your *network provider* to make sure that he or she has obtained approval (when required) for the health care services or supplies before they are furnished to you. Otherwise, only Medicare coverage will be provided. You must pay the Medicare *deductibles* and *coinsurance* and any other amount that Medicare does not cover.

**Mental Health and Substance Abuse Treatment.** All treatment of *mental conditions* must be authorized in advance by the Plan. Before you seek treatment for a *mental condition,* you or your PCP must first call the mental health/substance abuse referral toll-free telephone number. The Plan will assess your specific mental health needs and arrange for treatment with a *network mental health provider.* Otherwise, only Medicare coverage will be provided. You must pay the Medicare *deductibles* and *coinsurance* and any other amount that Medicare does not cover.

WORDS IN ITALICS ARE DEFINED IN PART 2.
Referral Telephone Number: The mental health/substance abuse referral toll-free telephone number to call to arrange for treatment with a network mental health provider is shown on the back of your Managed Blue for Seniors identification card.

Your Authorized Representative. Your provider will be considered your authorized representative for the prior approval process. The Plan will tell the provider if a proposed service has been approved or may ask your provider for more information if it is needed to make a decision. (See Part 11 for more information about authorized representatives.)

Checking Status of Pre-Approval Request. To check on the status or outcome of a utilization review decision, you may call your network provider or the Plan’s customer service office at the toll-free telephone number shown on your Managed Blue for Seniors identification card.

Pre-Admission Review
Before you enter a facility for inpatient non-emergency medical care and non-maternity care that is not eligible for coverage under Medicare, your network provider must obtain approval from the Plan in order for the care to be covered by the Plan. Within two working days of receiving all necessary information, the Plan will determine if the health care setting is suitable to treat your condition.

Missing Information. If necessary information is missing or more information is needed (such as results of a face-to-face clinical evaluation or a second opinion), the Plan will request the necessary information or records within 15 calendar days of receiving the pre-approval request. The requested information or records must be provided within 45 calendar days of the Plan’s request. If the requested information or records are not provided to the Plan within 45 calendar days of the request, the proposed coverage will be denied. Within two working days of receiving all necessary information, the Plan will determine if the health care setting is suitable to treat your condition.

Coverage Approval. If the Plan determines that the proposed setting for your care is suitable, the Plan will call the network facility within 24 hours of the determination to let the facility know the coverage approval status of the pre-admission review. The Plan will also send a written (or electronic) confirmation of the coverage approval to you and the facility within two working days of the phone call to the network facility.

Coverage Denial. If the Plan determines that the proposed setting is not medically necessary for your condition, the Plan will call the network facility within 24 hours of the determination to let the facility know of the denial of coverage and to recommend alternative treatment. The Plan will also send a written (or electronic) explanation of the coverage decision to you and the facility within one working day of the phone call to the network facility. (This explanation will: describe the reasons for the denial and the applicable terms of your coverage as described in this contract; give the specific medical and scientific reasons for the denial; specify any alternative treatment, health care services and supplies that would be covered; reference and include...
applicable Plan clinical guidelines used and review criteria; and describe the review process and your right to pursue legal action.)

Reconsideration of Adverse Determination. When the Plan determines that inpatient coverage is not medically necessary for your condition, your network provider may ask the Plan to arrange a reconsideration of that decision from a clinical peer reviewer. This reconsideration will be conducted between your network provider and the clinical peer reviewer within one working day of the request for a reconsideration. If the initial determination is not reversed, you (or the network provider on your behalf) may request a formal review as described in Part 9 of this contract. (You may request a formal review even though your network provider has not followed this reconsideration process.)

Concurrent Review and Discharge Planning
Concurrent Review means that while you are an inpatient, if your stay is not eligible for coverage under Medicare, the Plan will monitor and evaluate the clinical necessity and appropriateness of the health care services you are receiving and to make sure you still need inpatient coverage in that network facility.

In some cases, the Plan may determine that you will need continued inpatient coverage in that network facility beyond the number of days initially thought to be required for your condition. The Plan will make this determination within one working day of receiving all necessary information. When this is the case, the Plan will call the network facility within one working day of the coverage determination to let the facility know the approval status of the review. The Plan will also send a written (or electronic) explanation of the decision to you and the facility within one working day of the phone call to the network facility. This written (or electronic) explanation will include the number of additional days that are being approved for coverage (or the next review date), the new total number of approved days or services and the date the approved services will begin.

In other cases, based on medical necessity determination, the Plan may determine that you no longer need inpatient coverage in that network facility. Or, you may no longer need inpatient coverage at all. The Plan will make this coverage determination within one working day of receiving all necessary information. When this is the case, the Plan will call the network facility within 24 hours of the coverage determination to let the facility know of the decision and to discuss plans for continued coverage in a health care setting that better meets your needs. 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 network physician may decide to transfer you to an appropriate network skilled nursing facility. Any proposed plans will be discussed with you by your network physician. All arrangements for discharge planning will be confirmed in writing with you. The Plan will send this written (or electronic) confirmation to you and the facility within one working day of the phone call to the network facility.

If you choose to stay in the facility after you have been notified by your network provider or the Plan that inpatient coverage is no longer medically necessary, no further coverage will be provided (except as otherwise required during the formal grievance process). You must
pay all charges for the rest of that inpatient stay, starting from the date the written notification is sent to you.

**Reconsideration of Adverse Determination.** When the Plan determines that continued inpatient coverage is not medically necessary for your condition, your network provider may ask the Plan to arrange a reconsideration of that decision from a clinical peer reviewer. This reconsideration will be conducted between your network provider and the clinical peer reviewer within one working day of the request for a reconsideration. If the initial determination is not reversed, you (or the network provider on your behalf) may request a formal review as described in Part 9 of this contract. (You may request a formal review even though your network provider has not followed this reconsideration process.)

**Pre-Approval for Certain Outpatient Services**

Before you receive certain outpatient covered services, your network provider must obtain approval from the Plan in order for you to receive coverage from the Plan. Within two working days of receiving all necessary information from the network provider, the Plan will determine if the proposed services should be covered as medically necessary for your condition. The outpatient services that must be pre-approved by the Plan include:

- Ambulance services for non-emergency services.
- Cardiac rehabilitation.
- Certain pharmaceuticals supplied as part of covered hospice services.
- Certain prescription drugs.
- Home infusion therapy.
- Certain surgical procedures performed at a network facility.
- Mental health and substance abuse treatment.

**Pre-Approval Requirements Can Change:**

From time to time, the Plan may change this list of services requiring prior Plan approval. At any time, your network provider can tell you if a service requires prior approval from the Plan. (You may also call the Plan’s customer service office at the toll-free telephone number shown on your Managed Blue for Seniors identification card.) When a change is made to your contract, the Plan will send you a rider that describes the change.

**Missing Information.** If necessary information is missing or more information is needed (such as results of a face-to-face clinical evaluation or a second opinion), the Plan will request the necessary information or records within 15 calendar days of receiving the pre-approval request. The requested information or records must be provided within 45 calendar days of the Plan’s request. If the requested information or records are not provided to the Plan within 45 calendar days of the request, the proposed coverage will be denied. Within two working days of receiving all necessary information, the Plan will determine if the proposed services should be covered as medically necessary for your condition.
Coverage Approval. If the Plan determines that the proposed course of treatment should be covered as medically necessary for your condition, the Plan will call the network provider within 24 hours of the determination to let the provider know the approval status of the review. The Plan will also send a written (or electronic) confirmation of the approval to you and the provider within two working days of the phone call to the network provider.

Coverage Denial. If the Plan determines that the proposed course of treatment should not be covered as medically necessary for your condition, the Plan will call the network provider within 24 hours of the determination to let the provider know of the denial of coverage and to discuss alternative treatments. The Plan will also send a written (or electronic) explanation of the coverage decision to you and the provider within one working day of the phone call to the network provider. (This explanation will: describe the reasons for the denial and the applicable terms of your coverage as described in this contract; give the specific medical and scientific reasons for the denial; specify any alternative treatment, health care services and supplies that would be covered; reference and include applicable Plan clinical guidelines used and review criteria; and describe the review process and your right to pursue legal action.)

Reconsideration of Adverse Determination. When the Plan determines that the proposed course of treatment will not be covered as medically necessary for your condition, your network provider may ask the Plan to arrange a reconsideration of that decision from a clinical peer reviewer. This reconsideration will be conducted between your network provider and the clinical peer reviewer within one working day of the request for a reconsideration. If the initial determination is not reversed, you (or the network provider on your behalf) may request a formal review as described in Part 9 of this contract. (You may request a formal review even though your network provider has not followed this reconsideration process.)
**Individual Case Management**

Individual Case Management is a flexible program for managing your care in some situations. Through this program, the *Plan* works with your network 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 *contract* may be approved to:

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

The *Plan* 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. The *Plan* 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 the *Plan*, and between the provider and the *Plan* to furnish the services approved through this alternative treatment plan.
Part 5
Covered Services

You have the right to the coverage described in this section, except as limited or excluded in other sections of this contract. Be sure to read your Managed Blue for Seniors Schedule of Benefits for a description of the amounts that you must pay for covered services. Under this Managed Blue for Seniors contract, you have chosen a network physician as your PCP who will furnish covered treatment or to arrange and coordinate covered treatment with a network specialist. To receive all the coverage described in this contract, if you and your PCP decide that you need to see a specialist for outpatient specialty care, you must first obtain an approved referral from your PCP. For certain other health care services or supplies furnished by a network provider, your PCP or network provider may have to obtain prior approval from the Plan. (See Part 4 for more information.) You should check with your PCP or your network provider to make sure that any required referrals or prior approvals are obtained before the services and/or supplies are furnished. Otherwise, only Medicare coverage will be provided for those services and/or supplies. You will have to pay the Medicare deductibles and coinsurance and any other amount that Medicare does not cover.

Admissions for Inpatient Medical and Surgical Care

Hospital Admissions

For Medicare-Approved Services. When you are an inpatient in a network hospital, the Plan provides coverage for the Medicare Part A deductible and Part A coinsurance through the 90th day in each benefit period (plus the Part A coinsurance for any hospital inpatient reserve days that you use in a benefit period).

After Medicare Coverage Ends. After you have used all of your Medicare days in a benefit period, the Plan provides full coverage for semiprivate room and board and special services for:

- As many days as are medically necessary for your condition when you are an inpatient in a network general hospital.
- Up to a lifetime total of 365 days when you are an inpatient in a network chronic disease or network rehabilitation hospital. (Any days you use in a network general hospital after Medicare coverage has ended will count toward this 365-day lifetime limit.)

Note: If you have a right to Medicare hospital inpatient reserve days, you must use them before the Plan provides coverage after the 90th day in a benefit period.
Skilled Nursing Facility Admissions
When you are an inpatient in a network skilled nursing facility, the Plan provides coverage for the Medicare Part A coinsurance through the 100th day in each benefit period. Medicare and the Plan will provide coverage for these services only if your stay meets all of Medicare’s rules and regulations for a covered stay in a Medicare-certified skilled nursing facility. For example, Medicare requires that you must have been in the hospital at least three days in a row before being admitted to a Medicare certified skilled nursing facility. You will find these rules described in your Medicare handbook.

No coverage is provided for inpatient skilled nursing facility services that are not eligible for coverage under Medicare.

Physician and Other Professional Provider Services
The Plan provides coverage for the Medicare Part B deductible and Part B coinsurance for all inpatient services covered by Medicare when they are furnished by a network physician or another covered network professional provider, including a network nurse practitioner. The Plan provides this coverage for as many days as are medically necessary. Medicare has restrictions on certain types of services. These restrictions are described in your Medicare handbook.

Women’s Health and Cancer Rights
The Plan provides coverage for the Medicare Part B deductibles and Part B coinsurance for breast reconstruction in connection with a mastectomy. The Plan provides coverage for: all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas. These services will be furnished in a manner determined in consultation with the attending physician and the patient.

Human Organ and Stem Cell (“Bone Marrow”) Transplants
For Medicare-Approved Services. The Plan provides coverage for the Medicare Part A and Part B deductibles and coinsurance for human organ and stem cell transplants only when they are eligible for coverage under Medicare.

For Services Not Covered by Medicare. The Plan provides full coverage 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. (Remember: These stem cell transplants are not eligible for coverage under Medicare.) For covered transplants, coverage includes: room and board and special services in a network hospital; network physician services; network hospital and network 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.

WORDS IN ITALICS ARE DEFINED IN PART 2.
No coverage is provided for: transplants that are not covered by Medicare, except as described in this section; and the harvesting of the donor’s organ or stem cells when the recipient is not a member.

Ambulance Services
The Plan provides coverage for the Medicare Part B deductible and Part B coinsurance for:

- Medicare-approved ambulance transport to an emergency medical facility for emergency medical care. For example, covered ambulance services include transport from an accident scene or to a hospital due to symptoms of a heart attack. (You do not have to pay the ambulance copayment for this transport for emergency medical care.) If you need assistance at the onset of an emergency medical condition that in your judgment requires emergency medical care, call your local emergency medical service system by dialing the emergency telephone access number 911, or the local emergency telephone number.

- Other Medicare-approved medically necessary ambulance transport by a network ambulance service to take you to or from the nearest hospital (or another covered facility). You must pay an ambulance copayment for this transport for non-emergency medical care.

Cardiac Rehabilitation
After you pay your copayment, the Plan provides coverage for the Medicare Part B deductible and Part B coinsurance for outpatient cardiac rehabilitation furnished by a network provider. You must meet certain conditions in order to qualify for cardiac rehabilitation services under Medicare. The conditions you must meet are described in your Medicare handbook. This coverage complies with the regulations of the Massachusetts Department of Public Health.

No coverage is provided for services that do not qualify for coverage under Medicare.

Chiropractor Services
After you pay your copayment, the Plan provides coverage for the Medicare Part B deductible and Part B coinsurance for chiropractic services furnished by a network chiropractor. This coverage is limited to manual manipulation of the spine to correct a subluxation that can be shown by x-ray.

No coverage is provided for x-rays or other services furnished by a network chiropractor.
Diabetic Testing Materials, Drugs, Medical Formulas and Food Products

**Medicare-Approved Services.** The Plan provides coverage for the Medicare Part B deductible and Part B coinsurance for the following covered services when approved for coverage under Medicare. This includes:

- Drugs covered by Medicare Part B. This includes: drugs that must be given to you by a network provider; antigens; clotting factors for a person 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.
- Materials to test for the presence of blood sugar when ordered by a network physician for home use.
- Special medical formulas that are medically necessary to treat: homocystinuria; maple syrup urine disease; phenylketonuria; propionic acidemia; methylmalonic acidemia; and tyrosinemia.
- 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.

**For Services Not Covered by Medicare.** The Plan provides full coverage for:

- Materials to test for the presence of urine sugar.
- Special medical formulas approved by the Massachusetts Department of Public Health and medically necessary to treat: homocystinuria; maple syrup urine disease; phenylketonuria; propionic acidemia; methylmalonic acidemia; and tyrosinemia.
- 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.
- Food products modified to be low protein that are medically necessary to treat inherited diseases of amino acids and organic acids. This coverage is provided for up to $2,500 in each calendar year. You must pay all chargers that are more than this $2,500 benefit limit in each calendar year. You may buy these food products directly from the distributor.

**Dialysis Services**

The Plan provides coverage for the Medicare Part B deductible and Part B coinsurance for outpatient dialysis furnished by a network hospital, network free-standing dialysis facility or network physician and for home dialysis services.
Durable Medical Equipment
After you pay your copayment for each item, the Plan provides coverage for the Medicare Part B deductible and Part B coinsurance for Medicare-approved durable medical equipment that you buy or rent from a network appliance company (or another Medicare-covered provider that is designated by the Plan to provide the specific covered appliance). “Durable medical equipment” is defined as equipment that:

- Can stand repeated use; and
- Serves a medical purpose; and
- Is medically necessary for you; and
- Is not useful if you are not ill or injured; and
- Can be used in the home.

The restrictions that apply to buying or renting durable medical equipment are described in your Medicare handbook.

Examples of covered items include: knee and back braces; hospital beds; wheelchairs; crutches; walkers; equipment to administer oxygen for use in the home such as an oxygen concentrator; orthopedic and corrective shoes that are part of a leg brace; insulin injection pens; and glucometers that are medically necessary due to the patient’s type of diabetic condition.

Note: Although items such as artificial arms, legs and eyes meet Medicare’s definition of durable medical equipment, they are covered by Medicare as “prosthetic devices.” (See your Medicare handbook for more information.)

Emergency Medical Outpatient Services
After you pay your copayment, the Plan provides coverage for the Medicare Part B deductible and Part B coinsurance for outpatient emergency medical services and urgent care you receive at an emergency room of a general hospital. This coverage also includes emergency medical care and urgent care received outside the service area when the services are furnished by a Medicare-covered provider, including a nurse practitioner. (See Part 3 for more information.)

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

Home Health Care
Medicare provides full coverage for Medicare-approved home health care. You must meet certain conditions in order to qualify for home health care services under Medicare. The conditions you must meet are described in your Medicare handbook. It also lists in detail the services covered by Medicare as well as the services that are not covered.
Hospice Services

Medicare-Approved Services. Medicare provides coverage for hospice services only when you qualify for those hospice services. When Medicare does not provide full coverage for hospice services, the Plan provides coverage for the difference between the amount Medicare pays and the amount it allows for hospice services. You must meet certain conditions in order to qualify for hospice services under Medicare. The conditions you must meet are described in your Medicare handbook.

For Services Not Covered by Medicare. When Medicare does not provide any coverage for hospice services, the Plan provides full coverage for these services as required by state law when these services are furnished by (or arranged and billed by) a network 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.

This hospice coverage includes:

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

Lab Tests, X-Rays and Other Tests

The Plan provides coverage for the Medicare Part B deductible and Part B coinsurance for outpatient diagnostic x-rays and other imaging tests, diagnostic lab tests and other diagnostic tests furnished by a network provider, including a network nurse practitioner.

Maternity Services

After you pay your copayment for the first visit for prenatal care, the Plan provides coverage for the Medicare Part B deductible and Part B coinsurance for medical care (including care by a network nurse midwife) related to pregnancy and childbirth (or miscarriage). This coverage includes prenatal and postnatal care and exams and lab tests. The Plan provides coverage for inpatient care as described in this contract for “Admissions for Inpatient Medical and Surgical Care.” The inpatient stay will be no less than 48 hours following a vaginal delivery or 96 hours following a Caesarian section unless the mother and her attending physician decide otherwise as provided by law. If the mother chooses to be discharged earlier, the Plan provides coverage for one home visit by a network physician, network registered nurse, network nurse midwife or network nurse practitioner within 48 hours of discharge. This visit may include: parent
education; assistance and training in breast or bottle feeding; and appropriate tests. The Plan will provide coverage for more visits furnished by a network provider only if the Plan determines they are clinically necessary.

**Medical Care Outpatient Visits**

When you need outpatient care to treat a medical condition, after you pay your copayment, the Plan provides coverage for the Medicare Part B deductible and Part B coinsurance for medical care furnished by your PCP or, when arranged by your PCP, by another network provider, including a network nurse practitioner or network optometrist. This coverage also includes:

- Nutrition counseling, medical nutrition therapy and health education services if covered by Medicare.
- Hormone replacement therapy for peri- and post-menopausal women.
- Monitoring and medication management for members taking psychiatric drugs. This also includes neuropsychological assessment services. (These services may also be furnished by a network mental health provider.)
- Contact lenses that are needed to treat keratoconus, including the fitting of these contact lenses. (Your copayment does not apply for these covered services.)

This coverage also includes syringes and needles that are furnished on and after July 13, 2006, provided that they are medically necessary for you and they are supplied by a covered health care provider during your visit or when you buy them from a licensed pharmacy. For these covered supplies, the copayment that you would normally pay for your visit will be waived when the visit is only to obtain the syringes and needles. The only exception is when you buy these syringes and needles from a pharmacy and your contract includes pharmacy coverage. (In this case, this coverage will be provided under your Managed Blue for Seniors pharmacy program.)

**Mental Health and Substance Abuse Treatment**

The Plan provides coverage for medically necessary services to diagnose and/or treat mental conditions. This includes drug addiction and alcoholism. This coverage is provided for:

- Biologically-based mental conditions. “Biologically-based mental conditions” means:
  - schizophrenia;
  - schizoaffective disorder;
  - major depressive disorder;
  - bipolar disorder;
  - paranoia and other psychotic disorders;
  - obsessive-compulsive disorder;
  - panic disorder;
  - delirium and dementia;
  - affective disorders; and
  - any biologically-based mental conditions that appear in the most recent edition of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* that are scientifically recognized and approved by the
Commissioner of the Department of Mental Health 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.
- All other non-biologically-based mental conditions (including drug addiction and alcoholism) not described above.

No coverage is provided for: psychiatric services for a condition that is not a mental condition; residential or other care that is custodial care; or services and/or programs that are not medically necessary to treat your mental 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.

**Inpatient Services**

**Hospital Services.** When you are an inpatient in a network general hospital or network mental hospital, the Plan provides coverage for the Medicare Part A deductible and Part A daily coinsurance for all available Medicare days as described in this contract for “Admissions for Inpatient Medical and Surgical Care.” After you have used all of your Medicare days in a benefit period (or all of your 190 lifetime days in a mental hospital), the Plan provides full coverage for semiprivate room and board and special services for as many days as are medically necessary for your mental condition when you are an inpatient in a network general hospital or network mental hospital, except as may be limited for certain non-biologically-based mental conditions. For mental conditions other than biologically-based mental conditions and treatment of rape-related conditions, after you have used all of your Medicare days in a benefit period (or all of your 190 lifetime days in a mental hospital), your coverage under this Managed Blue for Seniors contract is limited to 60 days in each calendar year when the admission is in a mental hospital or substance abuse treatment facility. (An additional 30 days in each calendar year are available for alcoholism treatment.) In certain situations, using these days will count toward the 365 day lifetime limit in a network chronic disease or network rehabilitation hospital.

**Network Physician and Other Covered Professional Provider Services.** The Plan provides coverage for the Medicare Part B deductible and Part B coinsurance for inpatient psychiatric care that is covered by Medicare and full coverage for psychiatric care that is not covered by Medicare. The Plan provides this coverage for as many days as are medically necessary for your mental condition when the care is furnished by a network physician (who is a specialist in psychiatry) or a network psychologist or network clinical specialist in psychiatric and mental health nursing. (Remember: Medicare does not provide any coverage for psychiatric care by a clinical specialist in psychiatric and mental health nursing.)

All services must be approved in advance by the Plan. During the pre-approval process (see Part 4), the Plan will assess your specific mental health needs. The least intensive type of setting that is required for your condition will be approved by the Plan. 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. These “intermediate” mental health care services that may be approved by the Plan include (but are not limited to):

WORDS IN ITALICS ARE DEFINED IN PART 2.
acute residential treatment; partial hospital programs; or intensive outpatient programs. The Plan will arrange for treatment with the appropriate network mental health provider.

If an inpatient day-limit applies for the mental condition (see description above), these treatments will be counted as part of the day limit as follows:

- One acute residential treatment day will count as one day of your inpatient day limit.
- Two partial hospital treatment days will count as one day of your inpatient day limit.
- Two intensive outpatient treatment days will count as one day of your inpatient day limit.

(Note: Since the Plan considers coverage for these intermediate mental health care services to be an inpatient benefit, any coverage limits or member costs for outpatient mental health services will not apply.)

**Outpatient Services**

After you pay your copayment, the Plan provides coverage for outpatient psychiatric care furnished by a network physician (who is a specialist in psychiatry) or another network mental health provider for as many visits as are medically necessary for your mental condition, except as may be limited for certain non-biologically-based mental conditions. (When the care is covered by Medicare, the Plan pays the Medicare Part B deductible and Part B coinsurance, less your copayment.) For mental conditions other than biologically-based mental conditions and treatment of rape-related conditions, your coverage is limited to 24 visits in each calendar year. (An additional 8 visits in each calendar year are available for alcoholism treatment. As required by state law, the value of these 8 visits for alcoholism treatment will be at least $500 in each calendar year.) You must pay all charges that are more than these limits in each calendar year.

Remember: Medicare does not provide any coverage for psychiatric care by a clinical specialist in psychiatric and mental health nursing or a licensed mental health counselor.

**Note:** Any limits that would normally apply to alcoholism or drug addiction treatment will not apply when this treatment is furnished in conjunction with covered treatment of another mental condition. This provision applies to the mental health coverage described in this entire section.

**Oxygen**

The Plan provides coverage for the Medicare Part B deductible and Part B coinsurance for oxygen obtained from a network oxygen supplier. (See “Durable Medical Equipment” for your coverage for equipment to administer oxygen such as oxygen concentrators.)
Podiatry Care
After you pay your copayment, the Plan provides coverage for the Medicare Part B deductible and Part B coinsurance for non-routine podiatry (foot) care furnished by a network provider, including a network podiatrist. This coverage includes:

- Diagnostic lab tests.
- Diagnostic x-rays.
- Surgery and necessary postoperative care.
- Other medically necessary foot care such as treatment for hammertoe and osteoarthritis.

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

Preventive Health Services
Routine Physical Exams and Tests
After you pay your copayment, the Plan provides coverage for routine physical exams that your PCP decides are suitable for you. This coverage includes: routine medical exams and related routine services furnished in accordance with the Plan’s medical policy guidelines; lab tests; x-rays; mammograms (at least one baseline during the five-year period a member is age 35 through 39 and one in each calendar year for a member age 40 or older); blood tests to screen for lead poisoning (as required by state law); hepatitis shots for a member at risk for getting the disease; and immunizations, including travel immunizations. (Remember: Medicare provides full coverage for pneumococcal shots and flu shots.)

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

Note: When routine mammograms are covered by Medicare, the Plan provides coverage for the Medicare Part B coinsurance for these mammograms. (Remember: The Medicare Part B deductible does not apply to routine mammograms.)

Routine Gynecological (GYN) Exams
After you pay your copayment, the Plan provides coverage for one routine GYN exam, including a routine Pap smear test, in each calendar year when the services are furnished by a network physician, network nurse practitioner or network nurse midwife. (Note: When routine GYN exams and routine Pap smear tests are covered by Medicare, the Plan provides coverage for the Medicare Part B coinsurance, less your copayment. The Medicare Part B deductible does not apply to these services. The Medicare limitations that apply to these services are described in WORDS IN ITALICS ARE DEFINED IN PART 2.)
Part 5 – **Covered Services** (continued)

your *Medicare* handbook.) You do not need a referral from your PCP (or prior *Plan* approval) to obtain *covered services* from a network obstetrician, network gynecologist or network nurse midwife or gynecological services and other women’s health services by a network family practitioner. This includes *medically necessary* services required as a result of the annual routine GYN exam and evaluations and health care services that result from acute or emergency gynecological conditions. (But remember, prior *Plan* approval is required for *inpatient* admissions that are not eligible for coverage under *Medicare.*)

**Family Planning**

After you pay your *copayment*, the *Plan* provides coverage for family planning services furnished by a *network provider*, including a network nurse practitioner or network nurse midwife. (Remember: Family planning is not covered by *Medicare.*) This coverage includes:

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

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

**Routine Vision Exams**

After you pay your *copayment*, the *Plan* provides coverage for one routine vision exam in each calendar year when the exam is furnished by a network ophthalmologist or network optometrist. This coverage is limited to the Titmus Vision Test and other diagnostic eye screening tests that the *Plan* decides are needed. These services do not need a referral from your PCP. But, you do need a referral for any follow up care that you might need for your condition.

*No coverage* is provided for eyeglasses and contact lenses, except as described in this *contract* for contact lenses to treat keratoconus and intraocular lenses that are implanted (or one pair of eyeglasses instead) after corneal transplant, cataract surgery or other covered eye surgery when the natural eye lens is replaced.

**Wellness Benefits**

While you are enrolled in the *Plan*, you may be reimbursed for some fees that you pay to participate in fitness programs and/or weight loss programs.

*WORDS IN ITALICS ARE DEFINED IN PART 2.*
Fitness Benefit. The Plan will provide up to a total of $150 in each calendar year to reimburse you for fees paid for a health club membership or for fitness classes at a health club. You can claim this maximum fitness benefit of $150 for any combination of fees that you incurred during a calendar year. (For a health club membership, you must have paid at least four months’ health club fees for that calendar year.) You are eligible for the fitness benefit for fees paid to privately-owned or privately-sponsored health clubs or fitness facilities, including individual health clubs and fitness centers, YMCAs, YWCAs, Jewish Community Centers and municipal fitness centers.

No fitness benefit is provided for any fees or costs that you pay for:

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

Weight Loss Program Benefit. The Plan will provide up to a total of $150 in each calendar year to reimburse you for fees paid for hospital-based weight loss programs or for non-hospital-based weight loss programs designated by the Plan. You can claim this maximum weight loss program benefit of $150 for any combination of fees that you incurred during a calendar year. To find out which weight loss program(s) are designated by the Plan, you may use the internet website at www.bluecrossma.com. Or, you may call the Plan customer service office at the toll-free telephone number shown on your Managed Blue for Seniors identification card.

No weight loss program benefit is provided for any fees or costs that you pay for:

- On-line weight loss programs.
- Any non-hospital-based weight loss program not designated by the Plan.
- Individual nutrition counseling sessions. (For your coverage for nutritional counseling services, see “Medical Care Outpatient Visits.”)
- Pre-packaged meals; books; videos; scales; or other items or supplies that you buy.
- Any other items not included as part of a weight loss class or weight loss course.

Filing a Claim for the Fitness Benefit or Weight Loss Program Benefit. To receive your fitness benefit or your weight loss program benefit, you must file a claim no later than March 31st after the year for which you are claiming your benefit. The date on which you file a claim will be considered the “incurred date,” unless your claim is for eligible expenses for the prior calendar year. In that case, the incurred date will be shown as December 31st of that prior year. This means that the incurred date reflects the calendar year for which you are claiming your benefit. To file a claim, you must: fill out a claim form; attach your original itemized paid receipt(s); and mail the claim to the Plan. For a claim form or help to file a claim, you may call
the Plan customer service office. Or, you may use the internet website at www.bluecrossma.com for help or to print a claim form.

Prosthetic Devices
After you pay your copayment for each item, the Plan provides coverage for the Medicare Part B deductible and Part B coinsurance for Medicare-approved prosthetic devices that you obtain from a network appliance company (or another Medicare-covered provider that is designated by the Plan to furnish the covered prosthetic device). This coverage includes devices that are: used to replace the function of a missing body part; made to be fitted to your body as an external substitute; and not useful when you are not ill or injured. Examples of prosthetic devices covered by the Plan include:

- Artificial arms, legs and eyes.
- Ostomy supplies.
- Insulin infusion pumps and related pump supplies that are covered by Medicare Part B.
- Urinary catheters
- Breast prostheses, including mastectomy bras.
- Therapeutic/molded shoes and shoe inserts for a member with severe diabetic foot disease.
- Scalp hair prostheses (wigs) when hair loss is due to: chemotherapy; radiation therapy; infections; burns; traumatic injury; congenital baldness; and medical conditions resulting in alopecia areata or alopecia totalis (capitus). (Remember: Scalp hair prostheses are not covered under Medicare.) This coverage is limited to $500 in each calendar year. No coverage is provided for wigs when hair loss is due to: male pattern baldness; female pattern baldness; or natural or premature aging.

Radiation Therapy and Chemotherapy
The Plan provides coverage for the Medicare Part B deductible and Part B coinsurance for radiation and x-ray therapy and chemotherapy furnished by a network provider, including a network nurse practitioner.

Second Opinions
After you pay your copayment, the Plan provides coverage for the Medicare Part B deductible and Part B coinsurance for an outpatient second opinion about your medical care when furnished by a network physician. This coverage includes a third opinion when the second opinion differs from the first. Remember, as with other medical visits, your PCP must refer you to a network physician for these services. (See “Lab Tests, X-Rays and Other Tests” for your coverage for related diagnostic tests.)
Short-Term Rehabilitation Therapy
After you pay your copayment, the Plan provides coverage for the Medicare Part B deductible and Part B coinsurance for short-term rehabilitation therapy furnished by a type of network provider approved by Medicare. This coverage includes:

- Physical therapy.
- Speech/language therapy.
- Occupational therapy.
- An organized program of these combined services.

Remember: Medicare coverage is limited for these services. The Medicare limitations are described in your Medicare handbook.

Surgery as an Outpatient
After you pay your copayment, the Plan provides coverage for the Medicare Part B deductible and Part B coinsurance for outpatient surgical services furnished by a network provider, including a network nurse practitioner. (The Plan also provides this coverage for voluntary termination of pregnancy and voluntary sterilization.)

Women’s Health and Cancer Rights
The Plan provides coverage for the Medicare Part B deductibles and Part B coinsurance for breast reconstruction in connection with a mastectomy. The Plan provides coverage for: all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas. These services will be furnished in a manner determined in consultation with the attending physician and the patient.

Human Organ and Stem Cell (“Bone Marrow”) Transplants
For Medicare-Approved Services. The Plan provides coverage for the Medicare Part B deductibles and Part B coinsurance for human organ and stem cell transplants only when they are eligible for coverage under Medicare.

For Services Not Covered by Medicare. The Plan provides full coverage 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. (Remember: These stem cell transplants are not eligible for coverage under Medicare.) For covered transplants, coverage includes: network hospital special services; network physician services; network hospital and network 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.
No coverage is provided for: transplants that are not covered by Medicare, except as described in this section; and the harvesting of the donor’s organ or stem cells when the recipient is not a member.

**Oral Surgery**
The Plan limits coverage for oral surgery 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. The Plan provides coverage (with a PCP referral) when the surgery is furnished at a network hospital only if you have a serious medical condition that requires that you be admitted to a network hospital as an inpatient or to the surgical day care unit of a network hospital or to a network ambulatory surgical facility in order for the surgery to be safely performed. The Plan also provides this coverage without a referral from your PCP when the surgery is furnished at a network oral surgeon’s office.

**Anesthesia**
The Plan provides coverage for the Medicare Part B deductible and Part B coinsurance for anesthesia services furnished by a network physician other than the attending physician or by a network certified registered nurse anesthetist, when the anesthesia is related to covered surgery.

**TMJ Disorder Treatment**
After you pay your copayment, the Plan provides coverage for the Medicare Part B deductible and Part B coinsurance for temporomandibular joint (TMJ) disorder treatment furnished by a network provider. The Plan limits coverage for TMJ disorders to disorders that are caused by or result in a specific medical condition such as degenerative arthritis and jaw fractures or dislocations. The medical condition must be proven to exist by means of diagnostic x-ray tests or other generally accepted diagnostic procedures. This coverage includes:

- Non-dental medical care services to diagnose and treat a TMJ disorder.
- Diagnostic x-rays.
- Splint therapy (measuring, fabricating and adjusting the splint).
- Physical therapy.
- Surgical repair or intervention.

No coverage is provided for: appliances, other than a mandibular orthopedic repositioning appliance (MORA); and services, supplies or procedures to change the height of teeth or otherwise restore occlusion (such as bridges, crowns or braces).
Part 6

Limitations and Exclusions

The coverage described in this contract is limited or excluded as follows:

**Admissions before Effective Date**
The coverage described in this contract is provided only for covered services furnished on or after your effective date. But, if you are already an inpatient in a hospital (or another covered health care facility) on your effective date, the Plan will provide coverage starting on your effective date only if the Plan is notified of the admission and the Plan is given the opportunity to coordinate your care. This coverage is subject to all the provisions described in this contract.

**Benefits from Other Sources**
No coverage is provided for health care services and supplies to treat an illness or injury for which you have the right to benefits under government programs. These include the Veterans Administration for an illness or injury connected to military service. They also include programs set up by other local, state, federal or foreign laws or regulations that provide or pay for health care services and supplies or that require care or treatment to be furnished in a public facility. No coverage is provided if you could have received governmental benefits by applying for them on time. (The Plan does provide supplemental coverage for covered services that are eligible for coverage under Medicare.)

**Blood and Related Fees**
No coverage is provided for blood donor fees. (The Plan does provide coverage for whole blood and blood components and blood storage fees that are eligible for coverage under Medicare. This coverage includes the non-replacement fee for the first three pints or units of blood that you use in each calendar year—the blood deductible.)

**Cosmetic Services and Procedures**
No coverage is provided for cosmetic services and supplies (including prescription drugs) that are not eligible for coverage under Medicare. These include 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 your mental condition. For example, no coverage is 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.

**Note:** Coverage for cosmetic services is 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.

**Custodial Care**
No coverage is 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 coverage is provided for dental care that is not eligible for coverage under *Medicare*.

**Exams/Treatment Required by a Third Party**
No coverage is provided for physical, psychiatric and psychological exams, treatments and related services that are required by third parties. Some examples of non-covered services are: exams and tests required for recreational activities, employment, insurance and school; and court-ordered exams and services, except for *medically necessary* services. (But, certain exams may be covered when they are furnished as part of a covered routine physical exam.)

**Experimental Services and Procedures**
The coverage described in this *contract* is provided only when *covered services* are furnished in accordance with *medical technology assessment guidelines*. No coverage is provided for health care charges that are received for or related to care that the *Plan* considers to be experimental services or procedures. The fact that a treatment is offered as a last resort does not mean that coverage will be provided for it. There are two exceptions to this exclusion. As required by law, the *Plan* does provide coverage for:

- One or more stem cell (“bone marrow”) transplants for a *member* who has been diagnosed with breast cancer that has spread. The *member* must meet the eligibility standards that have been set by the Massachusetts Department of Public Health.
- Certain drugs used on an off-label basis. Some examples are: drugs used to treat cancer; and drugs used to treat HIV/AIDS.

**Foot Care**
No coverage is provided for:

- Routine foot care services such as trimming of corns, trimming of nails and other hygienic care, except when your care is *medically necessary* due to systemic circulatory diseases (such as diabetes).
- Certain non-routine foot care services and supplies such as: foot orthotics, arch supports, shoe (foot) inserts and orthopedic and corrective shoes that are not part of a leg brace (except as described in Part 5 for “Prosthetic Devices”); and fittings, castings and other services related to devices for the feet.
Hearing Aids
No coverage is provided for hearing aids or exams to prescribe, fit or change them.

Medical Devices, Appliances, Materials and Supplies
No coverage is provided for medical devices, appliances, materials and supplies, except as otherwise described in Part 5. 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; eyeglasses and contact lenses (except as otherwise described as a covered service); foot orthotics; hearing aids; heating pads; hot water bottles; humidifiers; orthopedic and corrective shoes that are not part of a leg brace; raised toilet seats; and in most cases, shoe (foot) inserts. But, coverage is provided for therapeutic/molded shoes and shoe inserts for a member with severe diabetic foot disease.

Missed Appointments
No coverage is 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 limits for coverage described in this contract.

Non-Covered Providers
No coverage is provided for any services and supplies furnished by the kinds of providers that are not covered under this Managed Blue for Seniors contract. For each covered service, this contract specifies the kinds of providers that are covered. (See Part 11 for those situations when the Plan may cover services furnished by non-network providers.)

Non-Covered Services
No coverage is provided for:

- Any service or supply that is not approved by Medicare, except as otherwise described in Part 5.
- A service or supply that is not described as a covered service in this contract. Some examples of non-covered services are: acupuncture; private duty nursing; and prescription drugs, except when they are covered by Medicare Part B or when they are administered to a member while an inpatient or outpatient in a health care facility covered under this contract. (If your Managed Blue for Seniors contract includes prescription drug coverage, this coverage is described in a rider. Refer to any riders that apply to your Managed Blue for Seniors contract for information about your prescription drug coverage.)
- Services that do not conform with the Plan’s medical policy guidelines.
- Services or supplies that you received when you were not enrolled under this contract.
- Any service or supply furnished along with a non-covered service

WORDS IN ITALICS ARE DEFINED IN PART 2.
Any service or supply that is furnished by a provider who has not been approved by the Plan for payment for the specific service or supply.

Services and supplies that are obtained outside the service area. The only exceptions are for emergency medical care and urgent care.

Services and supplies that are not considered medically necessary by the Plan. The only exceptions are for: voluntary termination of pregnancy; voluntary sterilization; birth control drugs used for contraceptive purposes; and preventive health services as described in Part 5.

Services that are furnished to someone other than the patient, except as described in this contract for: hospice services; and the harvesting of a donor’s organ or stem cells when the recipient is a member.

Services that are furnished to all patients due to a facility’s routine admission requirements.

A provider’s charge for shipping and handling or taxes.

A provider’s charge to file a claim. Also, a provider’s charge to transcribe or copy your medical records.

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 the Plan.

**Personal Comfort Items**

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

**Private Room Charges**

For covered room and board, the coverage described in this Managed Blue for Seniors contract is provided based on the semiprivate room rate. But, coverage may be provided for private room charges when the Plan determines that a private room is medically necessary for you. If a private room is used when not approved in advance by the Plan, you must pay any charges that are more than the semiprivate room rate.

**Refractive Eye Surgery**

No coverage is 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 coverage is provided for the reversal of sterilization.
Services and Supplies after Termination Date

No coverage is provided for services and supplies furnished after your termination date under this contract. (If a member is admitted as an inpatient in a hospital before his or her termination date and payment to the hospital is based on a “Diagnosis Related Grouping,” the hospital’s DRG payment that is approved by the Plan will be paid to the hospital even when the member is terminated from membership under this Managed Blue for Seniors contract during the admission. However, no other coverage is provided for other services and/or supplies furnished during that inpatient admission.)

Services Furnished to Immediate Family

No coverage is provided for a covered service furnished by a provider to himself or herself or to a member of his or her immediate family. The only exception is for drugs for which the Plan provides coverage when used by a physician, dentist or podiatrist while furnishing a covered service. “Immediate family” means any of the following members of a provider’s family:

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

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).

Surrogate Pregnancy

No coverage is provided for services related to achieving pregnancy through a surrogate (gestational carrier).
Part 7

Other Party Liability

Coordination of Benefits (COB)

The Plan will coordinate payment of covered services with hospital, medical, dental, health or other plans (except for Medicare) under which you are covered. The Plan 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 contract, you must notify the Plan if you add or change health plan coverage. Upon request, you must also supply the Plan 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 Managed Blue for Seniors contract is secondary, no benefits will be provided until after the primary payor determines its share, if any, of the liability. The Plan decides which is the primary and secondary payor. To do this, the Plan relies on Massachusetts law, including the COB regulations issued by the Massachusetts Division of Insurance. A copy of these rules is available from the Plan upon request. Unless otherwise required by law, coverage under this contract will be secondary when another plan provides you with coverage for health care services.

The Plan will not provide any more benefits than those already described in this contract. The Plan will not provide duplicate benefits for covered services. If the Plan pays more than the amount that it should have under COB, then you must give that amount back to the Plan. The Plan 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.
The Plan’s 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 Managed Blue for Seniors contract will be subrogated. This means that the Plan 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, the Plan 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 the Plan will not be reduced by any attorney’s fees or expenses you incur.

Member Cooperation
You must give the Plan information and help. This means you must complete and sign all necessary documents to help the Plan get this money back. This also means that you must give the Plan 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 the Plan paid benefits. You must not do anything that might limit the Plan’s right to full reimbursement.

Workers’ Compensation
No coverage is provided for health care services that are furnished to treat an illness or injury that the Plan 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 the Plan pays for any work-related health care services, the Plan has the right to get paid back from the party that legally must pay for the health care claims. The Plan 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), the Plan 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 the Plan is billed in error for these services, you must promptly call or write the Plan’s customer service office.
Part 8
Filing a Claim

When the Provider Files a Claim
Your provider will file a claim for you when you receive a covered service from a network provider. Just tell the provider that you are a member and show him or her your Managed Blue for Seniors 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, coverage will not have to be provided. The Plan will pay the provider directly for covered services.

When the Member Files a Claim
You may have to file your claim when you receive a covered service from a non-network provider. (However, in most instances when a service is eligible for coverage under Medicare, the provider will file a Medicare claim for you. Once Medicare processes the claim, the claim will be sent to the Plan for further processing.) 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 your provider. To file a claim for repayment, you must:

- Fill out a claim form;
- Attach your original itemized bills; and
- Mail the claim to the Plan’s customer service office.

You can get claim forms from the Plan’s customer service office. The Plan will mail to you all applicable forms within 15 days after receiving notice that you obtained some service or supply for which you may be paid.

You must file a claim for services covered under this Managed Blue for Seniors contract within one year of the date you received the covered service. The Plan does not have to provide coverage for services and/or supplies for which a claim is submitted after this one-year period. (There are different time limits for filing Medicare claims. Refer to your Medicare handbook for information about filing Medicare claims.)
**Timeliness of Claim Payments**

Within 30 calendar days after the Plan receives a completed request for coverage 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 coverage described in this 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.

**Missing Information.** If the request for coverage or payment is not complete or if more information is needed to make a final determination for the claim, the Plan will ask for the information or records it needs within 30 calendar days of receiving the request for coverage or payment. This additional information must be provided to the Plan within 45 calendar days of this request.

**Missing Information Received Within 45 Days.** If the additional information is provided to the Plan 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.

**Missing Information Not Received Within 45 Days.** If the additional information is not provided to the Plan within 45 calendar days of the request, the claim for coverage 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 coverage or payment. In this case, a decision will be made within 30 days as described previously in this section.
Part 9

Grievance Program

You have the right to a review when you disagree with a decision by the Plan to deny payment for services, or if you have a complaint about the care or service you received from the Plan or a network provider.

Making an Inquiry and/or Resolving Claim Problems or Concerns

Most problems or concerns can be handled with just one phone call. (See page 4 for more information about Member Services.) For help resolving a problem or concern, you should first call the Plan’s customer service office at the toll-free telephone number shown on your Managed Blue for Seniors identification card. A customer service representative will work with you to help you understand your coverage or resolve your problem or concern as quickly as possible.

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.

When resolving a problem or concern, the Plan will consider all aspects of the particular case, including the terms of your contract, the policies and procedures that support this contract, the provider’s input, as well as your understanding and expectation of coverage. The Plan 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. The Plan 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 the Plan has not responded within three working days of receiving your inquiry, you may request a review through the Plan’s formal internal grievance program. If this is the case, the Plan 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 the Plan has determined that a service or supply is not medically necessary for your condition.
Formal Grievance Review

Internal Formal Grievance Review

How to Request a Grievance Review. To request a formal review from the Plan’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  
  Fax: 1-617-246-3616  
  
  The Plan 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 the Plan’s Member Grievance Program internet address grievances@bcbsma.com. The Plan will let you know that your request was received by sending you a confirmation immediately by e-mail.

- Or, you may call the Plan’s Member Grievance Program at 1-800-472-2689. When your request is made by telephone, the Plan will send you a written account of the grievance within 48 hours of your phone call.

Once your request is received, the Plan 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 the Plan, 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 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 assist 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 the *Plan* needs to review the medical records and treatment information that relate to your grievance, the *Plan* will promptly send you an authorization form to sign if needed. You must return this signed form to the *Plan*. 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 the *Plan* 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 the *Plan*. 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 the *Plan* and the issues involved in the grievance. The individuals who will review your grievance will be those who did not participate in any of the *Plan*’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 the *Plan*’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*. The 30 calendar day time frame to complete a grievance review may be extended, with your permission, in cases when the *Plan* and the *member* agree that additional time is required to fully investigate and respond to the grievance.

The 30 calendar day time frame may also be extended when the grievance review requires a review of your medical records and requires your authorization to get these records. The 30-day response time will not include the days from when the *Plan* sends you the authorization form to sign until it receives your signed authorization form if needed. If the *Plan* does not receive your authorization within 30 working days after your grievance is received, the *Plan* may make a final decision about your grievance without that medical information. In any case, for a grievance review involving services that have not yet been obtained by you, the *Plan* will ask for your permission to extend the 30-day time frame if it cannot complete the review within 30 calendar days of receipt of your grievance.

A grievance that is not acted upon within the specified time frames will be considered resolved in favor of the *member*.  

**WORDS IN ITALICS ARE DEFINED IN PART 2.**
Note: If your grievance review began after an inquiry, the 30-day response time will begin on the day you tell the Plan that you disagree with the Plan’s answer and would like a formal grievance review.

Written Response. Once the grievance review is completed, the Plan will let you know in writing of the decision or the outcome of the review. If the Plan continues to deny coverage for all or part of a health care service or supply, the Plan will send an explanation to you. It will: describe the reasons for the denial and the applicable terms of your benefits as described in this Managed Blue for Seniors contract; give the specific medical and scientific reasons for the denial; specify any alternative treatment, health care services and supplies that would be covered; reference and include applicable Plan clinical guidelines used and review criteria; and explain how to request an external review.

Grievance Records. The Plan 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. The Plan 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 the Plan 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, the Plan 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, the Plan 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, including durable medical equipment, 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. The member’s physician can also request reversal of a denial for durable medical equipment earlier than 48 hours by providing more specific information about the immediate and severe harm to the member.
- 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, the Plan will send a letter to the member within five working days. It will: describe the reasons for the denial and the applicable terms of your benefits as described in this Managed Blue for Seniors contract; give the specific medical and scientific reasons for the denial; specify any
alternative treatment, health care services and supplies that would be covered; reference and include applicable Plan clinical guidelines used and review criteria; and explain how to request 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 the Plan’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 the Plan's formal internal grievance process as described above, unless the Plan 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. The Plan’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 the Plan 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 the Plan 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 the Plan. In addition, you must send the required $25 fee to pay for your portion of the cost of the review. The Plan 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 the Plan.**

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 the Plan, 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 the Plan.

**WORDS IN ITALICS ARE DEFINED IN PART 2.**
the *Plan*. 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 the *Plan* 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 the *Plan*, 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 the *Plan* 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 the *Plan* 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 the *Plan’s* decision in whole or in part, the *Plan* 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 the *Plan* will pay for or authorize the requested services; and (c) the name and telephone number of the person at the *Plan* who will make sure your grievance is resolved.

**WORDS IN ITALICS ARE DEFINED IN PART 2.**
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 the Plan 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 contract.

The following provisions apply only to:

- A member who lives in Rhode Island and is planning to obtain services that the Plan has determined are not medically necessary.
- A member who lives outside Rhode Island and is planning to obtain services in Rhode Island that the Plan has determined are not medically necessary.

The Plan decides which covered services are medically necessary by using its medical necessity guidelines. Some of the covered services that are described in this Managed Blue for Seniors contract may not be medically necessary for you. If the Plan 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 the Plan reconsider its decision by writing to: Member Grievance Program, Blue Cross Blue Shield of Massachusetts, 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. The Plan 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 the Plan 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 Plan case file to prepare your appeal. In accordance with Rhode Island state law, if you wish to review the information in your Plan 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 the Plan, your appeal will be reviewed by a provider in the same specialty as your attending provider. The Plan 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 the Plan. If you request this voluntary external appeal, Rhode Island requires you be responsible for half of the cost of the appeal and the Plan will be responsible for the remaining half. The notice you receive from the Plan about your appeal will advise you of: the name of the appeals agency that is designated by Rhode Island; and your share of the cost for an external appeal. To file an external appeal, you must make your request in writing to: Member Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Along with your request, you must state your reason(s) for your disagreement with the Plan’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, the Plan will forward your request to the external appeals agency along with the Plan’s portion of the fee and your entire Plan case file. The external appeals agency will notify you in writing of the decision within ten working days of receiving all necessary information.

**Expedited Appeals.** If your situation is an emergency, you have the right to an “expedited” appeal at all three levels of appeal as stated above. An emergency is defined as the sudden onset of a medical or mental condition that in the absence of immediate medical attention could reasonably be expected to result in placing your health or your ability to regain maximum function in serious jeopardy or, in your physician’s opinion, would result in severe pain. You may request an expedited reconsideration or appeal by contacting the Plan at the telephone number shown in your letter. The Plan 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 the Plan about your appeal will advise you of: the name of the appeals agency that is designated by Rhode Island; and the amount that Rhode Island requires you pay for your share of the cost for an expedited external appeal. To request an expedited external appeal, you must send your request in writing to: Member Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Your request should state your reason(s) for 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 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, the Plan will forward your request to the external appeals agency along with the Plan’s portion of the fee and your entire Plan 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 the Plan, this completes the appeals process for your case. But, if the external appeals agency reverses the Plan’s decision, the claim in dispute will be reprocessed by the Plan upon receipt of the notice of the final appeal decision. In addition, the Plan 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 10

Quality Assurance Programs

The Plan uses quality assurance programs that are designed to improve the quality of health care and services provided to Plan members. These quality assurance programs affect different aspects of health care such as disease treatment, health promotion and service. From time to time, the Plan may add or change the quality assurance programs that it uses to ensure that the Plan continues to provide you and your family with high-quality health care and services.

Note: For more information about these programs, you may call the Plan's customer service office at the toll-free telephone number shown on your Managed Blue for Seniors identification card.

Clinical Programs
The Plan uses clinical programs that are designed to improve the health care you receive. Some of these programs include:

- Breast cancer screening, a program that encourages female members over 50 to have mammograms.
- Cervical cancer screening, a program that helps get more female members ages 18 and older to have a Pap smear test.
- A program that promotes timely postnatal checkups for new mothers.
- Diabetes case management and general education to assist diabetic members with the self-management of diabetes and to identify high-risk members and to assess their ongoing care management needs. Ongoing interventions are targeted to members and physicians based on risk levels. The goal is to help the member stay as healthy and active as possible.
- Congestive heart failure disease management, education and ongoing monitoring to assist the patient and his or her physician, cardiologist and family to develop, coordinate and monitor a comprehensive treatment plan in an effort to lead to the best health outcome for the member.

Service Program
The Plan uses a service program that is directed to improving a member’s access to care. Through this program, the Plan works to improve the availability and accessibility of primary care physicians and high-volume specialists to members. To do this, the Plan measures and monitors wait times (the time from the member’s call to a doctor until the time of an appointment) to help shorten the time you have to wait to see a physician. The Plan also monitors the adequacy of the provider network to ensure that the Plan has enough primary and specialty care providers in the HMO Blue network.

WORDS IN ITALICS ARE DEFINED IN PART 2.
Part 11
Other Contract Provisions

Access to and Confidentiality of Medical Records
The Plan and network providers may, in accordance with applicable law, have access to all medical records and related information needed by the Plan or network providers. The Plan may collect information from health care providers, other insurance companies or the plan sponsor to help the Plan administer the coverage described in this contract and to get facts on the quality of care provided under this and other health care contracts. In accordance with law, the Plan and network providers may use this information, and may disclose it to necessary persons and entities as follows:

- For administering coverage (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 the Plan.
- 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 the Plan is administering your coverage properly.

Note: To obtain a copy of the Plan’s Commitment to Confidentiality statement, call the Plan’s customer service office at the toll-free telephone number shown on your Managed Blue for Seniors identification card.

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

You have the right to get the information the Plan collects about you. You may also ask the Plan to correct any information that you believe is not correct. The Plan may charge a reasonable fee for copying records, unless your request is because the Plan is declining or terminating your coverage under this Managed Blue for Seniors contract.
Part 11 – Other Contract Provisions (continued)

Acts of Providers
The Plan is not liable for the acts or omissions by any individuals or institutions that furnish care or services to you. In addition, a network provider or other health care provider does not act as an agent on behalf of or for the Plan. And, the Plan does not act as an agent for network providers or other health care providers.

Assignment of Benefits
You cannot assign any benefit or monies due under this Managed Blue for Seniors contract to any person, corporation or other organization without the Plan’s written consent. Any assignment by you will be void. Assignment means the transfer of your rights to the benefits provided under this Managed Blue for Seniors contract to another person or organization.

Authorized Representative
You may choose to have another person act on your behalf concerning your coverage under this Managed Blue for Seniors contract. You must designate this person in writing to the Plan. 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, the Plan may consider your health care facility or your physician to be your authorized representative. For example, the Plan 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, the Plan will consider the provider to be your authorized representative for emergency medical care services. The Plan will continue to send benefit payments and written communications regarding health care coverage in accordance with the Plan’s standard practices, unless specifically requested to do otherwise.

Note: You can get a form to designate an authorized representative from the Plan’s customer service office.

Changes to This Contract
The plan sponsor or the Plan may change a part of this Managed Blue for Seniors contract. For example, a change may be made to the amount you must pay for certain services (your copayment). When the Plan makes a change to your 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 contract, the Plan will send you a rider that describes the change.

Disagreement with Recommended Treatment
When you enroll in the Plan, you agree that it is up to your PCP and other network providers to determine the right treatment for your care. You may (for personal or religious reasons) refuse to accept the procedures or treatments advised by your network provider. Or, you may ask for treatment that a network provider judges does not meet generally accepted professional standards of medical care. You have the right to refuse the treatment advice of the network provider. Or, you have the right to seek other care at your own expense. If you want a second opinion about
your treatment, you have the right to coverage for second and third opinions as described in Part 5.

Pre-Existing Conditions

Your coverage in the Plan is not limited based on medical conditions that are present on or before your effective date. This means that your health care services will be covered from the effective date of your membership in the Plan without a pre-existing condition restriction. But, coverage for these services is subject to all the provisions described in this contract.

Process to Develop Clinical Guidelines and Utilization Review Criteria

The Plan applies medical technology assessment guidelines to develop its clinical guidelines and utilization review criteria. In developing these, the Plan 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 the Plan; 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.

The Plan 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), the Plan reviews their safety, effectiveness and overall value on an ongoing basis. While a new drug is being reviewed, it will not be covered by the Plan.

Services Furnished by Non-Network Providers

By enrolling in the Plan, you have agreed to receive all your health care from network providers. But, the Plan will provide coverage for covered services you receive from non-network providers in the following situations:

- You receive emergency medical care.
- You receive urgent care outside the service area.
- Your condition requires covered services that cannot be furnished by a network provider and your PCP approves a referral to the non-network provider for the covered services. In some cases, in addition to your PCP, the Plan must approve the referral in writing before you receive the services.
- You are a newly enrolled member who is receiving an ongoing course of treatment by a non-network physician, or whose primary care physician is a non-network

WORDS IN ITALICS ARE DEFINED IN PART 2.
physician, and your group only offers its employees a choice of health insurance plans in which your physician does not participate as a covered provider. In this case, the Plan will provide coverage for up to 30 days from your effective date or, for a member who is in her second or third trimester of pregnancy, until the first postnatal visit or, for a member with a terminal illness, until the member’s death. (For a member with a terminal illness, this coverage is provided when the member is expected to live six months or less as determined by a physician.)

• Your primary care physician disenrolls from the Plan’s provider network (for other than quality-related reasons or fraud). In this case, the Plan will provide coverage for covered services you continue to receive from that PCP for up to 30 days after the physician’s disenrollment from the Plan’s provider network.

• The network provider of a member who is in her second or third trimester of pregnancy is involuntarily disenrolled from the Plan’s provider network (for other than quality-related reasons or fraud). In this case, the Plan will continue to provide coverage for covered services in connection with the pregnancy until the first postnatal visit.

• The network provider of a member with a terminal illness is involuntarily disenrolled from the Plan’s provider network (for other than quality-related reasons or fraud). In this case, the Plan will continue to provide coverage for covered services in connection with the terminal illness until the member’s death. (This coverage is provided when the terminally ill member is expected to live six months or less as determined by a physician.)

Services in a Disaster
The Plan is not liable if events beyond its control, such as war, riot, public health emergency or natural disaster, cause delay or failure of the Plan to furnish covered services to its members. The Plan will make a good faith effort to furnish health care or arrange for health care to be furnished in these situations.

Time Limit for Legal Action
Before pursuing a legal action against the Plan for any claim under this Managed Blue for Seniors contract, you must complete the Plan’s formal internal grievance review (see Part 9). 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 the Plan, 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 coverage under this contract, you will lose your right to bring a legal action against the Plan 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 12

Eligibility for Coverage

Who Is Eligible to Enroll
You are eligible to enroll as a member in Managed Blue for Seniors only if you meet all of the following requirements:

- You are an eligible group member. This means you must meet the written eligibility requirements that your group imposes as long as they do not conflict with the Plan’s eligibility requirements. For details, contact your plan sponsor.
- You reside in the service area (or live and/or work within a reasonable distance from the service area).
- You are eligible for Medicare Part A and Medicare Part B and enrolled in Medicare Part B.
- 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 not receiving care in a Medicare-certified hospice.
- You are allowed by federal law to enroll in group health care coverage under which Medicare is the primary payer.

Enrollment Periods
You may enroll in Managed Blue for Seniors on your initial eligibility date (such as your Medicare effective date). To enroll in Managed Blue for Seniors, you must complete the enrollment form provided in your enrollment packet and return it to the address specified in the enrollment packet no later than 30 days after your eligibility date.

If you choose not to enroll in Managed Blue for Seniors within 30 days of your initial eligibility date, you may enroll only 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 in Managed Blue for Seniors for the next year. The open enrollment period is announced to all eligible employees. To enroll in Managed Blue for Seniors during this enrollment period, you must complete the enrollment form provided in your enrollment packet and return it no later than the date specified in the enrollment packet.

Note: See Part 13 for information about enrolling in a nongroup plan when you lose eligibility for membership in Managed Blue for Seniors.
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 contract and in Blue Cross and Blue Shield’s Manual of Underwriting Guidelines for Group Business.
Part 13

Termination of Coverage

Loss of Eligibility for Coverage in Managed Blue for Seniors
You are no longer eligible for membership in Managed Blue for Seniors 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 in Managed Blue for Seniors.
- 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.) Or, if you are not eligible for group coverage, you may be eligible to enroll in a nongroup plan. (The Plan’s customer service office can help you in this situation.)
- You move permanently outside of the service area. 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.) Or, if you are not eligible for group coverage, you may transfer your coverage to another Blue Cross and/or Blue Shield Plan’s HMO plan, if available. (The Plan’s customer service office can help you if you decide to transfer your coverage.
- The plan sponsor fails to pay your premium for your coverage under this contract to the Plan within 30 days of the due date. In this case, the Plan 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 coverage offered by the Plan or Blue Cross and Blue Shield.
- Your group terminates (or does not renew) this Managed Blue for Seniors contract.

In any of these situations, your membership in the Plan 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
Part 13 – Termination of Coverage (continued)

...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 Managed Blue for Seniors 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, the Plan must be notified within 30 days of a change to the former spouse’s address. Otherwise, the Plan will not be liable for any acts or omissions due to having the former spouse’s incorrect address on file.)

Note: 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 in the Plan ends when you choose to cancel your Managed Blue for Seniors contract as permitted by the plan sponsor. The Plan must receive the termination request not more than 30 days after your termination date.

Termination by the Plan
You do not have to worry that the Plan will cancel you because you are using your coverage or because you will need more covered services in the future. The Plan will cancel your membership in the Plan only when:

- You committed misrepresentation or fraud to the Plan. For example, you gave false or misleading information on the enrollment application form. Or, you misused the Managed Blue for Seniors identification card by letting another person not enrolled under this Managed Blue for Seniors contract attempt to get coverage. Termination will go back to your effective date. Or, it will go back to the date of the misrepresentation or fraud, as determined by the Plan.
- You commit acts of physical or verbal abuse that pose a threat to, or a threat to the health of, network providers or other members or employees of the Plan or Blue Cross and Blue Shield of Massachusetts, Inc. and that are not related to your physical...
condition or mental condition. This termination will follow procedures approved by the Massachusetts Commissioner of Insurance.

- The Plan cancels this Managed Blue for Seniors 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 coverage under this contract is terminated, you may be eligible to enroll in a nongroup plan offered by the Plan or Blue Cross and Blue Shield. The benefits and premium charges for these nongroup plans may differ from your coverage provided under this contract. At the time you lose eligibility for membership under this Managed Blue for Seniors contract, the Plan 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 nongroup plan offered by the Plan or Blue Cross and Blue Shield and how you may apply for enrollment in one of these nongroup plans.
This rider modifies the terms of your health plan. Please keep this rider with your Subscriber Certificate for easy reference.

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

1. A prior approval from Blue Cross Blue Shield HMO Blue (the “Plan”) will not be required for substance abuse treatment furnished by a network provider that is certified or licensed by the Massachusetts Department of Public Health. For an admission in a hospital or other covered health care facility, coverage will be provided for medically necessary acute treatment services and clinical stabilization services for up to a total of 14 days without prior approval, as long as the health care facility notifies Blue Cross Blue Shield HMO Blue and provides the initial treatment plan within 48 hours of your admission. Concurrent Review will start on or after day seven of your admission. For all other admissions (except as described in your Subscriber Certificate), you must have prior approval from Blue Cross Blue Shield HMO Blue in order for your inpatient care to be covered by Managed Blue for Seniors.

2. The benefits described in your Subscriber Certificate include care you get from a Blue Cross Blue Shield HMO Blue network 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 Blue Shield HMO Blue provides full coverage. (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 Blue Shield HMO Blue.

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

The *Plan* provides coverage for services to treat conditions of cleft lip and cleft palate for a *member* who is under age 18 (from birth through age 17). After *Medicare* provides benefits, the *Plan* provides coverage 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 services are not covered by *Medicare*, the *Plan* provides full coverage, as long as services are furnished by a *network provider*.

These services include:
- Medical, dental, oral, and facial surgery.
- Surgical management and follow-up care by oral and plastic surgeons.
- Speech therapy, audiology services, and nutrition services.
- Orthodontic treatment.
- Preventive and restorative dental care to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy.

All other provisions remain as described in your Subscriber Certificate.
This rider modifies the terms of your Subscriber Certificate. Please keep this rider with your Subscriber Certificate for easy reference.

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

**Medically Necessary (Medical Necessity)**

To receive coverage under this 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: voluntary termination of pregnancy; voluntary sterilization procedures; and preventive and routine health care services.) For covered services not eligible for coverage under Medicare, the Plan decides which health care services that you receive (or you are planning to receive) are medically necessary and appropriate for coverage. It will do this by using all of the guidelines described below.

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

- furnished in accordance with generally accepted standards of professional medical practice (as recognized by the relevant medical community);
- clinically appropriate, in terms of type, frequency, extent, site and duration; and they must be considered effective for your illness, injury or disease;
- consistent with the diagnosis and treatment of your condition and in accordance with the Plan’s 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 the Plan;
- 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 Subscriber Certificate.
This *rider* modifies the terms of your health plan. Please keep this *rider* with your Subscriber Certificate for easy reference.

The coverage described in your Subscriber Certificate has been changed.

This health plan covers *medically necessary* services to diagnose and treat autism spectrum disorders when the *covered services* are furnished by a *covered provider*. This may include (but is not limited to): a physician; a psychologist; or a *covered provider* who is an autism services provider. This coverage includes:

- Assessments, evaluations (including neuropsychological evaluations), genetic testing, and/or other tests to determine if a *member* has an autism spectrum disorder.
- Habilitative and rehabilitative care. This is care to develop, maintain, and restore, to the maximum extent practicable, the functioning of the *member*. This care includes, but is not limited to, applied behavior analysis that is supervised by a board certified behavior analyst.
- Psychiatric and psychological care that is furnished by a *covered provider* such as: a physician who is a psychiatrist; or a psychologist.
- Therapeutic care that is furnished by a *covered provider*. This may include (but is not limited to): a speech, occupational, or physical therapist; or a licensed independent clinical social worker.

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

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

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

This coverage for autism spectrum disorders does not affect an obligation to provide services to an individual under an individualized family service plan, an individualized education program, or an individualized service plan. This means that, for services related to autism spectrum disorders, no benefits are provided by this health plan for: services that are furnished by school personnel under an individualized education program; or services that are furnished, or that are required by law to be furnished, by a school or in a school-based setting.

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

All other provisions remain as described in your Subscriber Certificate.
This rider modifies the terms of your Subscriber Certificate. Please keep this rider with your Subscriber Certificate for easy reference.

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

All other provisions remain as described in your Subscriber Certificate.