Date: 04/28/2023

To: MMHG/PEMBROKE/MX

Documents Provided: Benefit Description and Riders as of 01/01/2023

Attached are the Blue Cross Blue Shield of Massachusetts Benefit Description and associated riders for your health plan. While the Benefit Description 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".

Blue Cross and Blue Shield of Massachusetts, Inc. administers your health plan benefits in accordance with the terms contained in this Benefit Description and associated riders. In the event of a dispute between any description prepared by you and the Benefit Description and associated riders, this Benefit Description and associated riders will govern.

The Benefit Description and associated riders are accurate as of 01/01/2023.

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.

Medex®′ 2

A Medicare supplement plan administered by
Blue Cross and Blue Shield of Massachusetts, Inc.

Benefit Description

Welcome to Medex!

This booklet provides you with a description of your benefits while you are enrolled under the Medex health care plan offered by your *plan sponsor*. You should read this booklet to familiarize yourself with this Medex plan's main provisions and keep it handy for reference.

Blue Cross and Blue Shield has been designated by your *plan sponsor* to provide administrative services to this Medex plan, such as claims processing, case management and other services, and to arrange for a network of health care providers whose services are covered by this Medex plan. The *Blue Cross and Blue Shield* customer service office can help you understand the terms of this Medex plan and what you need to do to get your maximum benefits.

Blue Cross and Blue Shield of Massachusetts, Inc. (*Blue Cross and Blue Shield*) is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting *Blue Cross and Blue Shield* to use the Blue Cross and Blue Shield Service Marks in the Commonwealth of Massachusetts. *Blue Cross and Blue Shield* has entered into a contract with the *plan sponsor* on its own behalf and not as the agent of the Association.

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

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

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

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

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

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

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

Arabic/ةيبر:

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

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

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

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

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

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

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

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

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

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

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

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

Persian/پارسیان:

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

Lao/ພາສາລາວ: ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: **711**).

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

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Introduction

You are covered under this Medex health care plan ("Medex"). This Medex plan is a non-insured self-funded benefits plan and is financed by contributions by your *group* and its participants. For details concerning your *group's* contributions, contact your *plan sponsor*.

An organization has been designated by your *plan sponsor* to provide administrative services to this Medex plan, such as claims processing, case management and other services, and to arrange for a network of health care providers whose services are covered by this Medex plan. The name and address of this organization is: Blue Cross and Blue Shield of Massachusetts, Inc., 101 Huntington Avenue, Suite 1300, Boston, Massachusetts 02199-7611.

These benefits are provided by your *group* on a self-funded basis. *Blue Cross and Blue Shield* is not an underwriter or insurer of the benefits provided by this Medex plan.

This booklet provides you with a description of your benefits while you are enrolled in this Medex plan. You should read this booklet 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* may change the terms of this Medex plan. If this is the case, the change is described in a *rider*. Your *plan sponsor* can supply you with any *riders* that apply to your benefits.

Also, since this Medex plan provides benefits to supplement your *Medicare* insurance for certain services covered by *Medicare* Part A and/or Part B, you should read the most current edition of your *Medicare* handbook (Medicare & You) to fully understand your benefits. This is a book put out by *Medicare* that describes the benefits you get under that program as well as the restrictions that apply to your *Medicare* benefits. Your *Medicare* handbook also explains how you can get other booklets that deal with specific topics about your *Medicare* benefits.

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

Member Services

Identification Cards

When you enroll in this Medex plan, you will receive a Medex identification card. This card is for identification purposes only. While you are a *member*, you must show your identification card to the provider before you receive *covered services*. If your identification card is lost or stolen, you should contact the *Blue Cross and Blue Shield* customer service office. They will send you a new Medex identification card. To use the *Blue Cross and Blue Shield* online member self-service option, log on to **www.bluecrossma.org**.

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

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

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

See Part 8 for more information about the formal grievance review process.

Note: For general information about your *Medicare* benefits, you should call the toll-free help line at **1-800-633-4227** (1-800-MEDICARE). Or, to use the Telecommunications Device for the Deaf, call 1-877-486-2048. However, if you have a problem or concern about a *Medicare* claim, you should call the telephone number that appears on your Medicare Summary Notice for help in resolving your claim problem.

Requesting Medical Policy Information

To receive all the benefits described in this Medex Benefit Description for *covered services* that are not eligible for benefits under *Medicare*, your treatment must conform to *Blue Cross and Blue Shield's* medical policy guidelines that are in effect at the time the services or supplies are furnished. To check for a *Blue Cross and Blue Shield* medical policy, you can go online and log on to **www.bluecrossma.org**. Or, you may call the *Blue Cross and Blue Shield* customer service office to request a copy of the information.

Discrimination Is Against the Law

Blue Cross and Blue Shield complies with applicable federal civil rights laws and does not discriminate on the basis of race; color; national origin; age; disability; sex; sexual orientation; or

gender identity. *Blue Cross and Blue Shield* does not exclude people or treat them differently because of race; color; national origin; age; disability; sex; sexual orientation; or gender identity.

Blue Cross and Blue Shield provides:

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

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

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

Part 1

Schedule of Benefits

Do not rely on this chart alone. It merely highlights some of the benefits available to a *member* enrolled under *Medicare* Hospital Insurance (Part A), *Medicare* Medical Insurance (Part B) and this Medex plan. Be sure to read the most current edition of your *Medicare* handbook, the explanations in Part 4 and the limitations and exclusions in Part 5, as well as all provisions of this Benefit Description.

Note: Your *group* or *Blue Cross and Blue Shield* may change these benefits. If this is the case, the change is described in a *rider*. Your *plan sponsor* can supply you with any *riders* that apply to your benefits. Please keep any *riders* with this booklet for easy reference.

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

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

Medicare Provides	Medex Provides	Your Cost*	Page
Admissions for Inpatient Medical and Surgical Care (continued)			
***Physician* and other covered professional provider services**: Full benefits less the Part B *deductible* and Part B *coinsurance* for as many days as are *medically necessary*	***Physician* and other covered professional provider services**: The Part B *deductible* and Part B *coinsurance* (full benefits when covered by Medex only) for as many days as are *medically necessary*	***Physician* and other covered professional provider services**: Nothing for as many days as are *medically necessary*	**21**
Chiropractor Services			
Full benefits less the Part B *deductible* and Part B *coinsurance*	The Part B *deductible* and Part B *coinsurance*	Nothing	**22**
Continued Active Care within 100 days after *hospital* discharge to treat a condition for which you were an *inpatient* in a *hospital* for at least three days in a row			
Full benefits less the Part B *deductible* and Part B *coinsurance* (includes: cardiac rehabilitation; drugs covered by *Medicare* Part B; medical care services; and *Medicare* approved short-term rehabilitation therapy)	The Part B *deductible* and Part B *coinsurance* (includes: cardiac rehabilitation; drugs covered by *Medicare* Part B; medical care services; and *Medicare* approved short-term rehabilitation therapy)	Nothing	**22**
Diabetic Testing Materials, Enteral Formulas and Food Products			
When covered by *Medicare*, full benefits less the Part B *deductible* and Part B *coinsurance*	**When covered by *Medicare*,** the Part B *deductible* and Part B *coinsurance*	**When covered by *Medicare*,** nothing	**23**
When not covered by *Medicare*, nothing	**When not covered by *Medicare*,** full benefits for: diabetic testing materials; certain enteral formulas; and low protein food products for up to $2,500 per calendar year	**When not covered by *Medicare*,** nothing for diabetic testing materials and certain enteral formulas: and all charges after Medex has provided benefits for $2,500 per calendar year for low protein food products	**23**

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

Medicare Provides	Medex Provides	Your Cost*	Page
Dialysis Services			
Full benefits less the Part B *deductible* and Part B *coinsurance*	The Part B *deductible* and Part B *coinsurance*	Nothing	**23**
Emergency Medical Outpatient Services			
Full benefits less the Part B *deductible* and Part B *coinsurance*	The Part B *deductible* and Part B *coinsurance*	Nothing	**23**
Home Health Care			
For home health care visits, full benefits	**For home health care visits,** nothing	**For home health care visits,** nothing**	**23**
For *durable medical equipment* covered by *Medicare*, full benefits less the Part B *deductible* (when applicable) and Part B *coinsurance*	**For *durable medical equipment* covered by *Medicare*,** nothing	**For *durable medical equipment* covered by *Medicare*,** the Part B *deductible* (when applicable) and Part B *coinsurance*	**23**
Hospice Services			
When covered by *Medicare*, full benefits for most services	**When *Medicare* does not provide full benefits,** the difference between the amount *Medicare* pays and the *allowed charge*	**When covered by *Medicare*,** nothing	**24**
When not covered by *Medicare*, nothing	**When not covered by *Medicare*,** full benefits	**When not covered by *Medicare*,** nothing	**24**
Lab Tests, X-Rays and Other Tests			
Full benefits less the Part B *deductible* and Part B *coinsurance*	The Part B *deductible* and Part B *coinsurance*	Nothing	**24**

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

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

Medicare Provides	Medex Provides	Your Cost*	Page
Mental Health Treatment for Biologically-Based Mental or Nervous Conditions***			
***Inpatient* admissions in a general or mental *hospital*:** Full semiprivate benefits less the Part A *deductible* for day 1-60 and Part A *coinsurance* for day 61-90 per *benefit period*; and full semiprivate benefits less the Part A *coinsurance* for 60 *Medicare* lifetime reserve days (Benefits in a mental *hospital* are limited to 190 days per lifetime)	***Inpatient* admissions in a general or mental *hospital*:** The Part A *deductible* for day 1-60 and Part A *coinsurance* for day 61-90 per *benefit period*; the Part A *coinsurance* for any *Medicare* lifetime reserve days used; then after *Medicare* days are used up, full semiprivate benefits through the 365th day per *benefit period*	***Inpatient* admissions in a general or mental *hospital*:** Nothing through the 365th day per *benefit period*; then all charges	**25**
***Inpatient physician* and other covered professional mental health provider services**: Full benefits less the Part B *deductible* and Part B *coinsurance* for as many days as are *medically necessary*	***Inpatient physician* and other covered professional mental health provider services**: The Part B *deductible* and Part B *coinsurance* (full benefits when covered by Medex only) for as many days as are *medically necessary*	***Inpatient Physician* and other covered professional mental health provider services**: Nothing for as many days as are *medically necessary*	**25**
***Outpatient* treatment:** Full benefits less the Part B *deductible* and Part B *coinsurance* (Nothing for services not covered by *Medicare*)	***Outpatient* treatment:** The Part B *deductible* and Part B *coinsurance* (full benefits when covered by Medex only) for as many visits as are *medically necessary*	***Outpatient* treatment:** Nothing for as many visits as are *medically necessary*	**25**

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

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

Medicare Provides	Medex Provides	Your Cost*	Page
Mental Health Treatment for Non-Biologically-Based Mental or Nervous Conditions not included in above section (includes drug addiction and alcoholism)			
***Inpatient* admissions in a general or mental *hospital*:** Full semiprivate benefits less the Part A *deductible* for day 1-60 and Part A *coinsurance* for day 61-90 per *benefit period*; and full semiprivate benefits less the Part A *coinsurance* for 60 *Medicare* lifetime reserve days (Benefits in a mental *hospital* are limited to 190 days per lifetime)	***Inpatient* admissions in a general or mental *hospital*:** The Part A *deductible* for day 1-60 and Part A *coinsurance* for day 61-90 per *benefit period*; the Part A *coinsurance* for any *Medicare* lifetime reserve days; then after *Medicare* days are used up, full semiprivate benefits through the 365th day per *benefit period* in a general *hospital* (up to 120 days per *benefit period* but up to at least 60 days per calendar year in a mental *hospital*), less any days in a *hospital* already covered by *Medicare* in that *benefit period* (or calendar year)	***Inpatient* admissions in a general or mental *hospital*:** Nothing through the 365th day per *benefit period* in a general *hospital*; and nothing for up to 120 days per *benefit period* (but up to at least 60 days per calendar year) in a mental *hospital*; then all charges	**25**
***Inpatient physician* and other covered professional mental health provider services**: Full benefits less the Part B *deductible* and Part B *coinsurance* for as many days as are *medically necessary*	***Inpatient physician* and other covered professional mental health provider services**: The Part B *deductible* and Part B *coinsurance* for *Medicare* and Medex *covered services* for as many days as are *medically necessary* in a general or mental *hospital*; full benefits for as many days as are *medically necessary* in a general *hospital* and for up to 120 days per *benefit period* (but up to at least 60 days per calendar year) in a mental *hospital* when covered by Medex only	***Inpatient Physician* and other covered professional mental health provider services**: Nothing for *Medicare* and Medex *covered services* for as many days as are *medically necessary* in a general or mental *hospital*; nothing for as many days as are *medically necessary* in a general *hospital* and for up to 120 days per *benefit period*, (but up to at least 60 days per calendar year) in a mental *hospital* when covered by Medex only; then all charges	**26**

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

Medicare Provides	Medex Provides	Your Cost*	Page
Mental Health Treatment for Non-Biologically-Based Mental or Nervous Conditions (continued)			
***Outpatient* treatment:** Full benefits less the Part B *deductible* and Part B *coinsurance* (Nothing for services not covered by *Medicare*)	***Outpatient* treatment:** The Part B *deductible* and Part B *coinsurance* for as many visits as are *medically necessary* for *Medicare* and Medex *covered services*; and full benefits when covered by Medex only for up to 24 visits per calendar year	***Outpatient* treatment:** Nothing for *Medicare* and Medex *covered services* for as many visits as are *medically necessary*; and nothing for up to 24 visits per calendar year for services covered by Medex only; then all charges	**26**
Physical Therapist Services			
Full benefits less the Part B *deductible* and Part B *coinsurance* for *Medicare* approved physical therapy	The Part B *deductible* and Part B *coinsurance* for *Medicare* approved physical therapy	Nothing for *Medicare* approved physical therapy	**26**
Podiatry Care			
Full benefits less the Part B *deductible* and Part B *coinsurance*	The Part B *deductible* and Part B *coinsurance*	Nothing	**26**
Radiation and X-Ray Therapy			
Full benefits less the Part B *deductible* and Part B *coinsurance*	The Part B *deductible* and Part B *coinsurance*	Nothing	**27**
Routine Tests			
For routine mammograms: Full benefits less the Part B *coinsurance* (the Part B *deductible* does not apply) for one baseline mammogram between age 35 through 39 and one routine mammogram per year for a *member* age 40 or older	**For routine mammograms:** The Part B *coinsurance* (the Part B *deductible* does not apply) for one baseline mammogram between age 35 through 39 and one routine mammogram per year for a *member* age 40 or older	**For routine mammograms:** Nothing for one baseline mammogram between age 35 through 39; and one routine mammogram per year for a *member* age 40 or older	**27**

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

Medicare Provides	Medex Provides	Your Cost*	Page
Routine Tests (continued)			
For routine Pap smear tests covered by *Medicare*: Full benefits less the Part B *coinsurance* (the Part B *deductible* does not apply) for one routine Pap smear test per two years (one per year for a *member* at high risk for cervical or vaginal cancer)	**For routine Pap smear tests covered by *Medicare*:** The Part B *coinsurance* (the Part B *deductible* does not apply) for one routine Pap smear test per two years (one per year for a *member* at high risk for cervical or vaginal cancer)	**For routine Pap smear tests covered by *Medicare*:** Nothing for one routine Pap smear test per two years (one per year for a *member* at high risk for cervical or vaginal cancer)	**27**
For routine Pap smear tests not covered by *Medicare*: Nothing	**For routine Pap smear tests not covered by *Medicare*:** Full benefits for one routine Pap smear test per calendar year	**For routine Pap smear tests not covered by *Medicare*:** Nothing for one routine Pap smear test per calendar year	**27**
Surgery as an Outpatient			
Full benefits less the Part B *deductible* and Part B *coinsurance*	The Part B *deductible* and Part B *coinsurance*	Nothing	**28**

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

Part 2
Definitions

The following terms are shown in italics in this Benefit Description and in any *riders* that apply to your benefits under this Medex plan. These terms will give you a better understanding of your benefits.

Accident

Any bodily injury that you sustain as the direct result of an *accident*. This does not include any injury that is the result of a disease, bodily infirmity or any other cause. Medex provides benefits as described in this Benefit Description for treatment of *accidents*.

Allowed Charge

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

- For a service eligible for benefits under *Medicare*, the term *allowed charge* has the same meaning as fee schedule amount, payment rate or reasonable charge does under *Medicare*. *Medicare* sets the *allowed charge* for a service according to a special formula. (See your *Medicare* handbook for details.) You may have to pay the amount of the actual charge that is more than the *allowed charge*. (See Part 9.)

- For a service eligible for benefits under Medex only, for *covered providers* that have a payment agreement with *Blue Cross and Blue Shield*, the *allowed charge* is based on the provisions of that provider's payment agreement. In most cases, you do not have to pay the amount of the actual charge that is more than the *allowed charge*. But, you must pay this excess amount when *covered services* are furnished by professional providers and you could have received benefits or services from someone else without charge or you have received or will receive payment from another person or insurance company. Once these payments from the other person or insurance company have been applied to your provider balances and used up, you do not have to pay the excess charge.

  For *covered providers* that do not have a payment agreement with *Blue Cross and Blue Shield*, the *allowed charge* is set by *Blue Cross and Blue Shield*. It is the amount that *Blue Cross and Blue Shield* determines to be in the range of fees most often made by similar providers for the same service or supply. This amount is usually less than the provider's actual charge. **In this case, you must pay the amount that is more than the *allowed charge*.**

Benefit Period

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

Blood Deductible

The non-replacement fee for the first three pints or units of blood or packed red blood cells that you use each calendar year. A *hospital* or *skilled nursing facility* cannot charge you for any of the first three pints of blood that you personally replace or arrange to have replaced by another person or organization. This Medex plan **does not** provide benefits for the *blood deductible*.

Blue Cross and Blue Shield

Blue Cross and Blue Shield of Massachusetts, Inc., the organization that has been designated by your *plan sponsor* to provide administrative services to this Medex plan, such as claims processing, case management and other services, and to arrange for a network of health care providers whose services are covered by this Medex plan. This includes an employee or designee of *Blue Cross and Blue Shield* who is authorized to make decisions or take action called for as described in this Benefit Description. *Blue Cross and Blue Shield* has full discretionary authority to interpret this Benefit Description. This includes determining the amount, form, and timing of benefits, conducting *medical necessity* reviews, and resolving any other matters regarding your right to benefits for *covered services* as described in this Benefit Description. All determinations by *Blue Cross and Blue Shield* with respect to benefits under this Medex plan will be conclusive and binding unless it can be shown that the interpretation or determination was arbitrary and capricious.

Coinsurance

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

Medicare Part A Coinsurance

There are three types of Part A *coinsurance*:

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

The Part A *coinsurance* is determined by the dates you receive covered *inpatient* care. If a *benefit period* continues over more than one calendar year, the Part A *coinsurance* may change with the new calendar year. Medex provides benefits as described in this Benefit Description for the Part A *coinsurance*.

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

Medex provides benefits as described in this Benefit Description for the Part B *coinsurance* (usually 20% of the *Medicare* allowed amount or a fixed copayment amount) for each *covered service*.

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

Covered Provider

A health care provider for which Medex provides benefits as described in this Benefit Description when *covered services* are furnished to you. This Benefit Description specifies the kinds of providers that are covered. (See Part 9.) Except as stated otherwise, the health care provider must: be eligible to provide services covered by *Medicare*; and have a payment agreement with *Blue Cross and Blue Shield*. Health care providers that may furnish *covered services* to you include: ambulatory surgical facilities; cardiac rehabilitation centers; certified registered nurse anesthetists; chiropractors; Christian Science sanatoriums; chronic disease *hospitals*; clinical specialists in psychiatric and mental health nursing; community health centers; dentists; detoxification facilities; diagnostic imaging facilities; dialysis facilities; general *hospitals*; home infusion therapy providers; hospice providers; licensed independent clinical social workers; licensed mental health counselors; mental health centers; mental *hospitals*; nurse midwives; nurse practitioners; physical therapists; *physicians*; podiatrists; psychologists; rehabilitation *hospitals*; and *skilled nursing facilities*.

Covered Services

The health care services or supplies for which Medex provides benefits as described in this Benefit Description. These health care services or supplies must be furnished by *covered providers* in order for you to receive the benefits provided by this Medex plan.

Deductible

The amount of the *Medicare allowed charge* that must be paid before *Medicare* benefits start. There are two types of *deductibles*, Part A and Part B. *Medicare* sets the amounts of the Part A and Part B *deductibles*. They may change. (Your *Medicare* handbook tells you the amount of the *deductibles*.) The Part A *deductible* must be paid once each *benefit period*. The Part B *deductible* must be paid once each calendar year. Medex provides benefits as described in this Benefit Description for the Part A and Part B *deductibles*.

Diagnostic Lab Tests

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

Diagnostic X-Ray and Other Imaging Tests

Fluoroscopic tests and their interpretation; and the taking and interpretation of roentgenograms and other imaging studies that are recorded as a permanent picture, such as film. Some examples of imaging tests include magnetic resonance imaging (MRI) and computerized axial tomography (CT scans). These types of tests also include diagnostic tests that require the use of radioactive drugs.

Durable Medical Equipment

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

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

Effective Date

The date on which your membership in this Medex plan starts.

Emergency Medical Care

Medical, surgical or psychiatric care that you need immediately due to the sudden onset of a condition manifesting itself by acute symptoms, 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, serious impairment of bodily functions or serious dysfunction of any bodily organ or part. Some examples of conditions that require *emergency medical care* are: suspected heart attacks; strokes; poisoning; loss of consciousness; convulsions; and suicide attempts.

This also includes treatment of *mental or nervous conditions* when: you are admitted as an *inpatient* as required under Massachusetts General Laws, Chapter 123, Section 12; you seem very likely to endanger yourself as shown by a serious suicide attempt, a plan to commit suicide or behavior that shows that you are not able to care for yourself; or you seem very likely to endanger others as shown by an action against another person that could cause serious physical injury or death or a plan to harm another person.

Note: For purposes of filing a claim for *covered services* eligible for benefits under Medex but not under *Medicare* or the formal grievance review (see Parts 8 and 9), *Blue Cross and Blue Shield*

considers "*emergency medical care*" to constitute "urgent care" as defined under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. However, for *covered services* eligible for benefits under *Medicare*, *Blue Cross and Blue Shield* uses *Medicare's* guidelines or decisions to determine whether your condition requires *emergency medical care*.

Group

The corporation, partnership, individual proprietorship or other organization that has entered into an agreement under which *Blue Cross and Blue Shield* provides administrative services for the *group's* self-insured Medex plan.

Hospital

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

Medex provides benefits as described in this Benefit Description for *hospital* services that are covered by Medex only. This means that *Medicare* does not make any payment for these services.

Inpatient

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

Medical Technology Assessment Guidelines

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

- The technology must have final approval from the appropriate government regulatory bodies. This criterion applies to drugs, biological products, devices (such as *durable medical equipment*) and diagnostic services. A drug, biological product or device must have final approval from the Food and Drug Administration (FDA). Any approval granted as an interim step in the FDA regulatory process is not sufficient. Except as required by law, Medex may limit benefits for drugs, biological products and devices to those specific indications, conditions and methods of use approved by the FDA.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed English-language journals. The qualities of the body of studies and the consistency of the results are considered in evaluating the evidence. The evidence should demonstrate that the technology can measurably alter the physiological changes related to a disease, injury, illness or condition. In addition, there should be evidence or a convincing argument based on established medical facts that the measured alterations

affect health outcomes. Opinions and evaluations by national medical associations, consensus panels and other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence upon which they are based.

- The technology must improve the net health outcome. The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
- The technology must be as beneficial as any established alternatives. The technology should improve the net outcome as much as or more than established alternatives. The technology must be as cost effective as any established alternatives that achieve a similar health outcome.
- The improvement must be attainable outside the investigational setting. When used under the usual conditions of medical practice, the technology should be reasonably expected to improve health outcomes to a degree comparable to that published in the medical literature.

Medically Necessary

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

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

It is not a service that: is furnished solely for your convenience or religious preference or the convenience of your family or health care provider; promotes athletic achievements or a desired lifestyle; improves your appearance or how you feel about your appearance; or increases or enhances your environmental or personal comfort.

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

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

Member
You, the person who has the right to the benefits described in this Benefit Description. A *member* is enrolled as the *subscriber* in this Medex plan.

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

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

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

Medex provides benefits as described in this Benefit Description for *physician* services that are covered by Medex only. This means that *Medicare* does not make any payment for these services.

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

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.

Rider

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

Sickness

An illness or disease of a *member* for which expenses are incurred on or after your *effective date* and while this Medex plan is in force.

Skilled Nursing Facility

A *skilled nursing facility* as defined by *Medicare*. The term "*skilled nursing facility*" does not include a convalescent nursing home, rest facility or facility for the aged that primarily furnishes custodial care, including training in activities of daily living.

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

Special Services

The services and supplies that a facility normally furnishes to its patients for diagnosis or treatment while the patient is in the facility. *Special services* include such things as:

- The use of special rooms. These include: operating rooms; and treatment rooms.
- Tests and exams.
- The use of special equipment in the facility. Also, the services of the people hired by the facility to run the equipment.
- Drugs, medications, solutions, biological preparations and medical and surgical supplies used while you are in the facility.
- Whole blood, packed red blood cells and the administration of infusions and transfusions. These do not include the cost of: blood donor fees; or blood storage fees not eligible for benefits under *Medicare*.
- Internal prostheses (artificial replacements of parts of the body) that are part of an operation. These include things such as: hip joints; skull plates; prosthetic lenses, including intraocular lenses; and pacemakers. They do not include things such as: ostomy bags; artificial limbs or eyes; hearing aids; or airplane splints.

Subscriber

You, the eligible person who signs the enrollment form at the time of enrollment in this Medex plan.

Part 3

Emergency Medical Services

Obtaining Emergency Medical Services

Both *Medicare* and Medex provide benefits for emergency medical services as described in this Benefit Description. These emergency medical services may include *inpatient* or *outpatient* services by providers qualified to furnish *emergency medical care* and that are needed to evaluate or stabilize your emergency medical condition.

At the onset of an emergency medical condition that in your judgment requires *emergency medical care*, you should go to the nearest emergency room. If you need help, call 911. Or, call your local emergency phone number. You will not be denied benefits for medical and transportation services described in this Benefit Description 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 with acute symptoms, 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, serious impairment of bodily functions or serious dysfunction of any bodily organ or part. Some examples of conditions that require *emergency medical care* are: suspected heart attacks; strokes; poisoning; loss of consciousness; convulsions; and suicide attempts.

Post-Stabilization Care

After your emergency medical condition has been evaluated and stabilized in the *hospital* emergency room, you may be ready to go home or you may require further care. For example, your condition may require that you be admitted directly from the emergency room for *inpatient emergency medical care* in that *hospital.* If this is the case, you do not have to obtain approval from *Blue Cross and Blue Shield* before you are admitted. Or, your emergency room provider may recommend transfer for *inpatient* care in another facility or *outpatient* follow up care instead. In any case, both *Medicare* and Medex provide benefits for post-stabilization care as described in this Benefit Description.

Part 4

Covered Services

You have the right to the benefits described in this section, except as limited or excluded in other sections of this Benefit Description. (See Part 5 for a description of your benefits for services received outside the United States, Puerto Rico, or the U.S. Virgin Islands.) Also, be sure to read the most current edition of your *Medicare* handbook since in most cases, Medex provides benefits only for services eligible for benefits under *Medicare* Part A and/or Part B. Your *Medicare* handbook explains the benefits you get under the *Medicare* program as well as the restrictions that apply to your *Medicare* benefits.

Admissions for Inpatient Medical and Surgical Care

Hospital Services

After *Medicare* provides benefits, Medex provides benefits based on the *allowed charge* for all available *Medicare* days in a *benefit period*) when you are an *inpatient* in a *hospital* other than a mental *hospital*. After you have used all of your *Medicare* days in a *benefit period*, Medex provides full benefits based on the *allowed charge* for semiprivate *room and board* and *special services*. (If you have a right to *Medicare hospital inpatient* reserve days, you must use them before Medex provides benefits after the 90th day in a *benefit period*.) Medex provides these benefits through the 365th day of each *benefit period* when you are an *inpatient* in a general, chronic disease or rehabilitation *hospital*.

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

Skilled Nursing Facility Services

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

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

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

Christian Science Sanatorium Services

When you are an *inpatient* in a Christian Science sanatorium that is operated, or listed and certified, by the First Church of Christ, Scientist, in Boston, Massachusetts, Medex provides benefits for one of the following choices:

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

Physician and Other Covered Professional Provider Services

After *Medicare* provides benefits, Medex provides benefits based on the *allowed charge* for all *inpatient* services covered by *Medicare* when furnished by a *physician* or another *Medicare* covered professional provider including a podiatrist, certified registered nurse anesthetist, nurse midwife or nurse practitioner. Medex provides these benefits for as many days as are *medically necessary* for your condition.

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

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

Women's Health and Cancer Rights

After *Medicare* provides benefits, Medex provides benefits based on the *allowed charge* for breast reconstruction in connection with a mastectomy. Medex provides these benefits for: all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and medical care services to treat physical complications at all stages of mastectomy, including lymphedemas. These services will be furnished in a manner determined in consultation with the attending *physician* and the patient.

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

After *Medicare* provides benefits, Medex provides benefits based on the *allowed charge* for human organ and stem cell transplants **only** when they are eligible for benefits under *Medicare*. There is one exception. Medex provides full benefits based on the *allowed charge* for one or more stem

cell transplants for a *member* who has been diagnosed with breast cancer that has spread when these stem cell transplants are furnished in accordance with *Blue Cross and Blue Shield* medical policy and *medical technology assessment guidelines*. (These stem cell transplants are not eligible for benefits under *Medicare*.) For covered transplants, benefits include: *room and board* and *special services*; *physician* services; *hospital* and *physician* services for the harvesting of the donor's organ or stem cells when the recipient is a *member* ("harvesting" includes the surgical removal of the donor's organ or stem cells and related *medically necessary* services and/or tests that are required to perform the transplant itself); and drug therapy during the transplant procedure to prevent rejection of the transplanted organ/tissue or stem cells.

Chiropractor Services

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

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

Continued Active Care After Hospital Discharge

After *Medicare* provides benefits, Medex provides benefits based on the *allowed charge* for *outpatient* services needed to continue active treatment of a condition for which you were an *inpatient* in a *hospital* for at least three days in a row. You must receive these services within 100 days after you are discharged. These services may include:

- Cardiac rehabilitation furnished by a *Medicare* covered *provider*.
- Drugs covered by *Medicare* Part B. These include: drugs that must be given to you by a *Medicare covered provider* (including a home infusion therapy provider); antigens; clotting factors for a *member* with hemophilia; erythropoietin; drugs for immunosuppressive therapy; injectable drugs for osteoporosis for homebound menopausal women; and chemotherapy and anti-emetic drugs you can take by yourself.
- Medical care furnished by a *Medicare covered provider* including a nurse practitioner. This includes: clinic, office and home visits; follow up medical care related to an accidental injury or medical emergency; and non-dental services by a dentist only if the services would normally be covered when furnished by a *physician*. (See Part 5, "Dental Care.") This also includes: monitoring and medication management for *members* taking psychiatric drugs; and neuropsychological assessment services. (These services may also be furnished by a *Medicare* covered mental health provider.)
- Short-term rehabilitation therapy when approved by *Medicare* and furnished by a *Medicare covered provider*. This includes: physical therapy; speech/language therapy; occupational therapy; or an organized program of these combined services. *Medicare* has restrictions on certain types of short-term rehabilitation therapy services. These restrictions are described in your *Medicare* handbook.

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

Diabetic Testing Materials, Enteral Formulas and Food Products

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

- Materials to test for the presence of blood sugar when ordered by a *physician* and glucometers.

  Note: Medex provides full benefits based on the *allowed charge* for materials to test for the presence of urine sugar. These diabetic testing materials are not covered by *Medicare* Part B.

- Enteral formulas for home use that are *medically necessary* to treat malabsorption caused by: Crohn's disease; chronic intestinal pseudo-obstruction; gastroesophageal reflux; gastrointestinal motility; ulcerative colitis; and inherited diseases of amino acids and organic acids. Medex provides full benefits based on the *allowed charge* for these formulas when they are not covered by *Medicare* Part B.
- Food products modified to be low protein that are *medically necessary* to treat inherited diseases of amino acids and organic acids. These food products are not covered by *Medicare*. Medex provides these benefits for up to $2,500 in each calendar year. You must pay all charges that are more than this $2,500 limit in each calendar year. You may buy these food products directly from a distributor.

Dialysis Services

After *Medicare* provides benefits, Medex provides benefits based on the *allowed charge* for *outpatient* dialysis treatment and self-dialysis training services by a *Medicare covered provider* and for home dialysis services.

Emergency Medical Outpatient Services

After *Medicare* provides benefits, Medex provides benefits based on the *allowed charge* for the following services by a *Medicare covered provider* including a nurse practitioner:

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

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

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

Home Health Care

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

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

Hospice Services

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

When *Medicare* does not provide any benefits for hospice services, Medex provides full benefits based on the *allowed charge* for these services. These benefits include:

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

Medex provides these benefits only when: the patient has a terminal illness and is expected to live six months or less, as certified by a *physician*; the patient and attending *physician* have agreed to a plan of care that stresses pain control and symptom relief rather than curative treatment; an adult is the primary care person in the home; and the patient lives in the service area of the hospice provider.

Lab Tests, X-Rays and Other Tests

After *Medicare* provides benefits, Medex provides benefits based on the *allowed charge* for *outpatient diagnostic lab tests*, *diagnostic x-ray and other imaging tests* and other diagnostic tests by a *Medicare covered provider* including a nurse practitioner.

Mental Health and Substance Abuse Treatment

Medex provides benefits for:

- Services to diagnose and/or treat a biologically-based *mental or nervous condition*. "Biologically-based *mental or nervous conditions*" means: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder; delirium and dementia; affective disorders; and any biologically-based *mental or nervous conditions* appearing in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders that are scientifically recognized and approved by the Commissioner of the Department of Mental Health in consultation with the Commissioner of the Division of Insurance.
- Treatment of rape-related mental or emotional disorders for victims of a rape or victims of an assault with intent to rape.

Medex provides these benefits as follows:

- After *Medicare* provides benefits, Medex provides benefits based on the *allowed charge* for all available *Medicare* days in a *benefit period* when you are an *inpatient* in a general or mental *hospital*. After you have used all of your *Medicare* days in a *benefit period* (or all of your 190 *Medicare* lifetime days in a mental *hospital*), Medex provides full benefits based on the *allowed charge* for semiprivate *room and board* and *special services*. (If you have a right to *Medicare hospital inpatient* reserve days, you must use them before Medex provides benefits after the 90th day in a *benefit period*.) Medex provides these benefits through the 365th day of each *benefit period* when you are an *inpatient* in a general or mental *hospital*.

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

- After *Medicare* provides benefits, Medex provides benefits based on the *allowed charge* for *inpatient* services by a *physician* (who is a specialist in psychiatry) or psychologist. When the services are not covered by *Medicare*, Medex provides full benefits based on the *allowed charge* for services by a *physician* (who is a specialist in psychiatry), psychologist or clinical specialist in psychiatric and mental health nursing. (*Medicare* does not provide any benefits for services by a clinical specialist in psychiatric and mental health nursing.) Medex provides these benefits for as many days as are *medically necessary* for your condition.

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

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

- After *Medicare* provides benefits, Medex provides benefits based on the *allowed charge* for all available *Medicare* days in a *benefit period* when you are an *inpatient* in a general or mental *hospital*. After you have used all of your *Medicare* days in a *benefit period* (or all of your 190 *Medicare* lifetime days in a mental *hospital*), Medex provides full benefits based on the *allowed charge* for semiprivate *room and board* and *special services*. (If you have a right to *Medicare hospital inpatient* reserve days, you must use them before Medex provides benefits after the 90th day in a *benefit period*.) Medex provides these benefits: through the 365th day of each *benefit period* when you are an *inpatient* in a general *hospital*; and up to 120 days in each *benefit period* (but up to at least 60 days in each calendar year) when you

are an *inpatient* in a mental *hospital*, less any days in a general or mental *hospital* already covered by *Medicare* in the same *benefit period* (or calendar year).

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

- After *Medicare* provides benefits, Medex provides benefits based on the *allowed charge* for *inpatient* services by a *physician* (who is a specialist in psychiatry) or psychologist. When the services are not covered by *Medicare*, Medex provides full benefits based on the *allowed charge* for services by a *physician* (who is a specialist in psychiatry), psychologist or clinical specialist in psychiatric and mental health nursing. (*Medicare* does not provide any benefits for services by a clinical specialist in psychiatric and mental health nursing.) Medex provides these benefits for: as many days as are *medically necessary* for your condition when you are an *inpatient* in a general or mental *hospital* when services are covered by both *Medicare* and Medex; and up to 120 days in each *benefit period*, (but up to at least 60 days in each calendar year) for services covered by Medex only when you are an *inpatient* in a mental *hospital*.
- After *Medicare* provides benefits, Medex provides benefits based on the *allowed charge* for *outpatient* services by a *Medicare* covered mental health provider. When the services are not covered by *Medicare*, Medex provides full benefits based on the *allowed charge* for services by a *physician* (who is a specialist in psychiatry), psychologist, licensed independent clinical social worker, clinical specialist in psychiatric and mental health nursing or licensed mental health counselor. (*Medicare* does not provide any benefits for services by a clinical specialist in psychiatric and mental health nursing or a licensed mental health counselor.) Medex provides these benefits for up to 24 visits in each calendar year.

No benefits are provided for psychiatric services for a condition that is not a *mental or nervous condition*.

Physical Therapist Services

After *Medicare* provides benefits, Medex provides benefits based on the *allowed charge* for physical therapy by an independent registered physical therapist when approved by *Medicare*.

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

Podiatry Care

After *Medicare* provides benefits, Medex provides benefits based on the *allowed charge* for non-routine podiatry (foot) care by a *physician* or podiatrist. These benefits may include:

- *Diagnostic lab tests*.
- Diagnostic x-rays.
- Surgery that is an integral part of the treatment of foot injury.

- Other *medically necessary* foot care such as treatment for hammertoe and osteoarthritis.

No benefits are provided for: routine foot care services such as trimming of corns, trimming of nails and other hygienic care except when they are covered by *Medicare* and *medically necessary* because you have systemic circulatory disease (such as diabetes). Also, no benefits are provided for certain non-routine foot care services and supplies such as: treatment of flat feet or partial dislocations in the feet; foot orthotics, arch supports, shoe (foot) inserts, orthopedic and corrective shoes; and fittings, castings and other services related to devices for the feet.

Radiation and X-Ray Therapy

After *Medicare* provides benefits, Medex provides benefits based on the *allowed charge* for radiation and x-ray therapy by a *Medicare covered provider* including a nurse practitioner.

Routine Tests

Routine Mammograms

After *Medicare* provides benefits, Medex provides benefits based on the *allowed charge* for routine mammograms when furnished by a *physician* or another *Medicare covered provider* including a nurse midwife. These benefits are limited to:

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

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

Note: Medex provides benefits for diagnostic mammograms as described earlier in Part 4 for x-rays.

Routine Pap Smear Tests

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

Medex provides full benefits based on the *allowed charge* for one routine Pap smear test in each calendar year when *Medicare* does not provide benefits for these tests.

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

Note: Medex provides benefits for diagnostic Pap smear tests as described earlier in Part 4 for lab tests.

Surgery as an Outpatient

After *Medicare* provides benefits, Medex provides benefits based on the *allowed charge* for *outpatient* surgery approved by *Medicare* when furnished by a *physician* or another *Medicare covered provider*, including a nurse practitioner.

Women's Health and Cancer Rights

After *Medicare* provides benefits, Medex provides benefits based on the *allowed charge* for breast reconstruction in connection with a mastectomy. Medex provides these benefits for: all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and medical care services to treat physical complications at all stages of mastectomy, including lymphedemas. These services will be furnished in a manner determined in consultation with the attending *physician* and the patient.

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

After *Medicare* provides benefits, Medex provides benefits based on the *allowed charge* for human organ and stem cell ("bone marrow") transplants **only** when they are eligible for benefits under *Medicare*. There is one exception. Medex provides full benefits based on the *allowed charge* for one or more stem cell transplants for a *member* who has been diagnosed with breast cancer that has spread when these stem cell transplants are furnished in accordance with *Blue Cross and Blue Shield* medical policy and *medical technology assessment guidelines*. (These stem cell transplants are not eligible for benefits under *Medicare*.) For covered transplants, benefits include: *hospital* and *physician* services for the harvesting of the donor's organ or stem cells when the recipient is a *member* ("harvesting" includes the surgical removal of the donor's organ or stem cells and related *medically necessary* services and/or tests that are required to perform the transplant itself); and drug therapy during the transplant procedure to prevent rejection of the transplanted organ/tissue or stem cells.

Oral Surgery

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

Anesthesia

After *Medicare* provides benefits, Medex provides benefits based on the *allowed charge* for anesthesia services related to covered surgery. This includes anesthesia administered by a *physician* other than the attending *physician* or by a certified registered nurse anesthetist.

Part 5
Limitations and Exclusions

The *covered services* described in this Benefit Description are limited or excluded as follows:

Admissions Before a Member's Effective Date
The benefits described in this Benefit Description are provided only for *covered services* furnished on or after your *effective date*. If you are already an *inpatient* in a *hospital* (or another covered health care facility) on your *effective date*, Medex will provide benefits starting on your *effective date.* This is the case only if from the start of that *inpatient* stay until your *effective date* you were covered the whole time under a contract with a Blue Cross and/or Blue Shield Plan. But, these benefits are subject to all the provisions described in this Benefit Description.

Ambulance Services
No benefits are provided for ambulance services. (See your *Medicare* handbook for information about the benefits *Medicare* provides for these services.)

Benefits From Other Sources
No benefits are provided for health care services and supplies to treat an illness or injury for which you have the right to benefits under government programs. These include the Veterans Administration for an illness or injury connected to military service. They also include programs set up by other local, state, federal or foreign laws or regulations that provide or pay for health care services and supplies or that require care or treatment to be furnished in a public facility. Medex does not provide supplemental benefits for *covered services* not eligible for benefits under *Medicare*. Also, no benefits are provided if you could have received governmental benefits by applying for them on time.

Birth Control
No benefits are provided for: birth control drugs; birth control devices (for example, IUDs, diaphragms and levonorgestrel implant systems); and over-the-counter birth control preparations (for example, condoms, birth control foams, jellies and sponges).

Blood and Related Fees
No benefits are provided for: whole blood; packed red blood cells; blood donor fees; and blood storage fees not eligible for benefits under *Medicare*. (See your *Medicare* handbook for details about the benefits *Medicare* provides.)

Consultations

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

Cosmetic Services and Procedures

Benefits for cosmetic services are limited to reconstructive surgery. This non-dental surgery is meant to improve or give back bodily function or correct a functional physical impairment that was caused by: a birth defect; a prior surgical procedure or disease; or an accidental injury. This also includes surgery to correct a deformity or disfigurement that was caused by an accidental injury.

No benefits are provided for cosmetic services as described above if these services are not eligible for benefits under *Medicare*. Also, no benefits are provided for cosmetic services that are performed solely for the purpose of making you look better, whether or not these services are meant to make you feel better about yourself or treat a *mental or nervous condition*. For example, no benefits are provided for: acne related services such as the removal of acne cysts, injections to raise acne scars, cosmetic surgery and dermabrasion or other procedures to plane the skin; electrolysis; hair removal or restoration; and liposuction.

Custodial Care

No benefits are provided for custodial care. This is care that is furnished mainly to help a person in the activities of daily living. It does not require day-to-day attention by medically-trained persons. It may consist, for example, of: *room and board*; routine nursing; services to help in personal hygiene and self-care for a *member* who is mentally and/or physically disabled but who does not require the regular attention of medically-licensed staff; or services to a *member* whose condition is not likely to improve, even if the *member* receives the regular attention of medically-licensed staff. Also, no benefits are provided for services to observe or reassure a *member*.

Dental Care

No benefits are provided for dental care not eligible for benefits under *Medicare*. This includes routine dental care, unless *Medicare* determines that a medical condition or the severity of a dental procedure requires that you be admitted to a *hospital* as an *inpatient* when you receive these services. Routine dental care includes filling, removal or replacement of teeth or structures that directly support the teeth.

Educational Testing and Evaluations

No benefits are provided for exams, evaluations or services that are performed solely for educational or developmental purposes.

Exams/Treatment Required by a Third Party

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

Experimental Services and Procedures

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

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

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

Eye Exams/Eyewear

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

Foot Care

No benefits are provided for:

- Routine foot care services such as trimming of corns, trimming of nails and other hygienic care except when they are covered by *Medicare* and *medically necessary* because you have systemic circulatory disease (such as diabetes).
- Certain non-routine foot care services and supplies such as: treatment of flat feet or partial dislocations in the feet; foot orthotics, arch supports, shoe (foot) inserts, orthopedic and corrective shoes; and fittings, castings and other services related to devices for the feet.

Hearing Aids

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

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

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

Immunizations and Shots

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

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

Medical Care Outpatient Visits

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

Medical Devices, Appliances, Materials and Supplies

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

Also, no benefits are provided for *durable medical equipment* and prosthetic devices such as artificial arms, legs and eyes. There are a few exceptions to this exclusion. Benefits are provided as described in Part 4 for: diabetic testing materials, including glucometers (which are classified under the same category as *durable medical equipment* when covered by *Medicare*); and *durable medical equipment* supplied as part of approved home dialysis or hospice services.

Missed Appointments

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

Non-Covered Providers

Unless otherwise specified, this Medex plan provides benefits only for *covered services* furnished by providers: eligible to provide services covered by *Medicare*; that have a payment agreement with *Blue Cross and Blue Shield*; and that have been approved by *Blue Cross and Blue Shield* for payment for the specific *covered service*. No benefits are provided for any services and supplies furnished by the kinds of providers that **are not** covered by this Medex plan. This Benefit Description specifies the kinds of providers that are covered. (See Part 9, "Providers.")

Non-Covered Services

No benefits are provided for:

- Any service or supply that is not described as a *covered service* in this Benefit Description. Some examples of non-*covered services* are: acupuncture (except when *Medicare* provides benefits for these services as long as *Medicare* conditions are met); prescription drugs (except when covered by *Medicare* as described in Part 4 or administered to an *inpatient* or *outpatient* in a health care facility covered by this Medex plan); and voluntary sterilization.
- Any service or supply that is not eligible for benefits under *Medicare* Part A and/or Part B, except as described in Part 4.
- Services that would normally be eligible for benefits under Medex only, but do not conform with *Blue Cross and Blue Shield's* medical policy and *medical technology assessment guidelines*.
- Services or supplies that you received when you were not enrolled in this Medex plan.
- Any service or supply furnished along with a non-*covered service*.
- Services and supplies that are not considered *medically necessary*. The only exceptions are for the routine mammograms and routine Pap smear tests described in Part 4.
- Services furnished to someone other than the patient, except as described in Part 4 for: hospice services; and the harvesting of a donor's organ or stem cells when the recipient is a *member*.
- Services furnished to all patients due to a facility's routine admission requirements.
- A service made necessary by an act of war that takes place after your *effective date*.
- The travel time and related expenses of a provider.
- A service for which you are not required to pay or for which you would not be required to pay if you did not have this Medex plan.
- A provider's charge to file a claim. Also, a provider's charge to transcribe or copy your medical records.
- A provider's charge for: shipping and handling; taxes; or interest (finance charges).
- A separate fee for services by: interns, residents; fellows; or other *physicians* who are salaried employees of the *hospital* or other facility.
- Expenses that you have when you choose to stay in a *hospital* or another health care facility beyond the discharge time determined by *Blue Cross and Blue Shield*.

Personal Comfort Items

No benefits are provided for items or services that are furnished for your personal care or convenience or for the convenience of your family. Some other examples of non-covered items or services are: telephone; radio; television; and personal care services.

Private Duty Nursing

No benefits are provided for private duty nursing services.

Private Room Charges

For covered *room and board*, Medex provides benefits based on the semiprivate room rate. If a private room is used, you must pay any charges that are more than the semiprivate room rate. This

is the case unless *Medicare* provides benefits for private room charges when *Medicare* determines that a private room is *medically necessary* for you.

Refractive Eye Surgery

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

Reversal of Voluntary Sterilization

No benefits are provided for the reversal of sterilization.

Routine Physical Exams and Tests

No benefits are provided for routine physical exams and tests, except for the routine mammograms and routine Pap smear tests described in Part 4.

Services and Supplies After a Member's Termination Date

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

Services Furnished by Immediate Family or Members of Your Household

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

- Spouse or spousal equivalent.
- Parent, child, brother or sister (by birth or adoption).
- Stepparent, stepchild, stepbrother or stepsister.
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law or sister-in-law. (For purposes of providing *covered services*, an in-law relationship does not exist between the provider and the spouse of his or her wife's (or husband's) brother or sister.)
- Grandparent or grandchild.
- Those persons sharing a common abode with you as part of a single family unit (members of your household). They include domestic employees and others who live together as a single family unit. A roomer or boarder is not included.

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

Services Received Outside the United States

Medicare usually does not provide benefits for services received outside of the United States, Puerto Rico, or the U.S. Virgin Islands. (See your Medicare handbook for details.) When it does, Blue Cross and Blue Shield provides only the Medex benefits for covered services as described in this Medex contract. When it does not, Blue Cross and Blue Shield provides both the Medex benefits and the benefits normally paid by Medicare for covered services as described in this Medex contract. But, if you set up a residence outside the United States, Puerto Rico, or the U.S. Virgin Islands, Blue Cross and Blue Shield will not provide any benefits.

If you are traveling outside the United States, Puerto Rico, or the U.S. Virgin Islands and you need *emergency medical care* (or urgent care), you can get help to find a health care provider. There are no providers that have a payment agreement with *Blue Cross and Blue Shield*, but you can call **1-800-810-BLUE**. (Or, you can call collect at 1-804-673-1177.) In this case, the Blue Cross Blue Shield Global Core Service Center can help you to access a health care provider. (See Part 7 for information on filing a claim.)

Part 6

Other Party Liability

Coordination of Benefits (COB)

Blue Cross and Blue Shield will coordinate payment of *covered services* with hospital, medical, dental, health or other plans (except for *Medicare*) under which you are covered. *Blue Cross and Blue Shield* will do this to make sure that the cost of your health care services is not paid more than once. Other plans include: personal injury insurance; automobile insurance, including medical payments coverage; homeowner's insurance; and other plans that cover hospital or medical expenses.

You must include information on your enrollment forms about other health plans under which you are covered. Once you are enrolled in this Medex plan, you must notify *Blue Cross and Blue Shield* if you add or change health plan coverage. Upon request, you must also supply *Blue Cross and Blue Shield* with information about other plans that may provide you with coverage for health care services.

Under COB, the plan that provides benefits first is known as the primary payor. And the plan(s) that provide benefits next are known as the secondary payor(s). When coverage under this Medex plan is secondary, no benefits will be provided until after the primary payor determines its share, if any, of the liability. *Blue Cross and Blue Shield* decides which is the primary and secondary payor. To do this, *Blue Cross and Blue Shield* relies on the COB regulations issued by the Massachusetts Division of Insurance (see the COB rules described below). To the extent state law does not govern this Medex plan, however, state law will not limit *Blue Cross and Blue Shield's* discretion to determine which is the primary and secondary payor. For example, this Medex plan is not subject to Massachusetts requirements concerning coordination between no-fault automobile personal injury protection (PIP) and health insurance, and if PIP is available, this Medex plan will not pay benefits until PIP is exhausted.

This Medex plan will not provide any more benefits than those already described in this Benefit Description. This Medex plan will not provide duplicate benefits for *covered services*. If this Medex plan pays more than the amount that it should have under COB, then you must give that amount back to this Medex plan. This Medex plan has the right to get that amount back from you or any appropriate person, insurance company or other organization.

COB Rules to Determine the Order of Benefits

When other plan(s) under which you are covered include COB rules consistent with the COB rules described in this section, *Blue Cross and Blue Shield* will decide which plan is the primary payor and the secondary payor based on these COB rules. However, if another plan under which you are covered does not include COB rules consistent with the COB rules described below, that plan will determine benefits before this Medex plan.

- **Employee/Dependent Rule.** The plan that covers the person who is claiming benefits as an employee (the *subscriber*) will determine benefits before a plan under which that person is covered as a dependent.

- **Active/Inactive Employee Status.** The plan that covers the person who is claiming benefits as an active employee (or as a dependent of that employee) will determine benefits before a plan under which that person is covered as a laid-off or retired employee (or as a dependent of that employee). If another plan does not include this COB rule and if, as a result the plans do not agree on the order of benefits, this COB rule will not be used to determine the order of benefits.

- **Plans With the Earlier Effective Date.** If neither of the previous COB rules determines the order of benefits, the plan that has covered the person who is claiming benefits longer will be determined before the plan that has covered the person who is claiming benefits for a shorter period of time.

Note: If other plan(s) under which you are covered do not include COB rules consistent with the COB rules described in this section, that plan will determine benefits before this Medex plan.

Plan Rights to Recover Benefit Payments

Subrogation and Reimbursement of Benefit Payments

If you are injured by any act or omission of another person, the benefits under this Medex plan will be subrogated. This means that this Medex plan and *Blue Cross and Blue Shield*, as this Medex plan's representative, 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, this Medex 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 this Medex plan will not be reduced by any attorney's fees or expenses you incur.

Member Cooperation

You must give *Blue Cross and Blue Shield*, as this Medex plan's representative, information and help. This means you must complete and sign all necessary documents to help *Blue Cross and Blue Shield* get this money back on behalf of this Medex plan. This also means that you must give *Blue Cross and Blue Shield* timely notice of all significant steps during the 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 this Medex plan paid benefits. You must not do anything that might limit this Medex plan's right to full reimbursement.

Workers' Compensation

No benefits are provided for health care services and supplies to treat an illness or injury for which you have the right to benefits under any workers' compensation act or equivalent employer liability or indemnification law. All employers provide their employees with workers' compensation insurance. This is done to protect employees in case of work related illness or injury. All medical claims related to the illness or injury must be billed to the employer's workers' compensation carrier. It is up to you to use workers' compensation insurance. If this Medex plan provides or pays for *covered services* that are covered by workers' compensation, *Blue Cross and Blue Shield* on behalf of this Medex plan has the right to get paid back from the party that legally must pay for the health care services.

If you have recovered the value of services from workers' compensation or another employer liability program, you will have to pay the amount recovered for medical services that were paid by this Medex plan. If *Blue Cross and Blue Shield* is billed in error for these services, you must promptly call or write the *Blue Cross and Blue Shield* customer service office.

Part 7
Filing a Claim

When the Provider Files a Claim

For *Medicare* Part A covered services, *hospitals*, *skilled nursing facilities* and other *covered providers* must submit claims to *Medicare* for you. You do not have to file claims for these services. (For services received outside the United States, Puerto Rico, or the U.S. Virgin Islands and when the Blue Cross Blue Shield Global Core Service Center has arranged your *inpatient* admission, the *hospital* may file the claim for you. In the event the *hospital* does not file the claim for you, you must submit a claim as described in the section below.)

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

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

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

When the Member Files a Claim

There are times when you will have to file a claim for *Medicare* and/or Medex benefits. Some examples are described below. The provider may ask you to pay the entire charge at the time of the visit or at a later time. It is up to you to pay the provider.

You should not have to file a claim for *Medicare* Part A benefits unless you receive *hospital* or other health care facility services outside the United States, Puerto Rico, or the U.S. Virgin Islands that are covered by *Medicare*. When you have to file a claim for *Medicare* Part A benefits, you will receive a Medicare Summary Notice when your claim has been processed.

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

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

- Your *physician* or another provider refuses to file a claim for you for *covered services* eligible for benefits under *Medicare*, even though it is required by law.
- You receive services outside the United States, Puerto Rico, or the U.S. Virgin Islands that are covered by *Medicare*.

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

You have to file a Medex claim when:

- You receive *covered services* that are eligible for benefits under *Medicare* and *Blue Cross and Blue Shield* does not get the claim from *Medicare*.
- You receive *skilled nursing facility* services covered by Medex only and the *skilled nursing facility* does not file a claim to *Blue Cross and Blue Shield* for you. In this case, you must have the *skilled nursing facility* fill out a Level of Care Form for each month of your stay. This Level of Care Form must be attached to your Medex claim form along with your original itemized bills.
- You get materials to test for the presence of urine sugar, enteral formulas covered by Medex only or low protein food products. (Since materials to test for the presence of blood sugar, including glucometers, and in some cases enteral formulas are covered by both *Medicare* Part B and Medex, if the provider does not file a claim for you, you will have to file a claim for your *Medicare* benefits before you file a claim for your Medex benefits for these items.)
- You receive a service covered by Medex only from a provider that does not have an agreement with *Blue Cross and Blue Shield*.
- You receive services outside the United States, Puerto Rico, or the U.S. Virgin Islands that are covered by Medex. In this case, in addition to itemized bills with the date you received the services, you must get the medical notes for these services. If the *covered services* are also eligible for benefits under Medicare, you must first send the claim to Medicare. When your claim has been processed, Medicare will send you a notice. Then, you will have to file a claim for your Medex benefits. (You must file your claim to the Blue Cross Blue Shield Global Core Service Center. The Blue Cross Blue Shield Global Core Claim Form you receive from *Blue Cross and Blue Shield* will include the address to mail your claim. You can get help with filing your claim by calling the service center at **1-800-810-BLUE**.)

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

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

You can get Medex claim forms from the *Blue Cross and Blue Shield* customer service office. *Blue Cross and Blue Shield* will mail to you all applicable forms within 15 days after receiving notice that you obtained some service or supply for which you may be paid.

Time Limit for Filing a Claim

When you have to file a *Medicare* claim, you must do so within the time periods specified in your *Medicare* handbook. When you have to file a Medex claim, you must do so within two years of the date you received the *covered service*. *Blue Cross and Blue Shield* does not have to honor claims submitted after this two year period.

Timeliness of Claim Payments

Within 30 calendar days after *Blue Cross and Blue Shield* receives a completed request for Medex benefits or payment, a decision will be made and, where appropriate, payment will be made to the provider (or to you if you sent in the claim) for your claim to the extent of your Medex benefits described in this Benefit Description. Or, you and/or the provider will be sent a notice in writing of why your claim is not being paid in full or in part.

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

If the additional information is provided to *Blue Cross and Blue Shield* within 45 calendar days of the request, a decision will be made within the time remaining in the original 30-day claim determination period or within 15 calendar days of the date the additional information is received, whichever is later.

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

Part 8

Grievance Program

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

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

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

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

When resolving a problem or concern, *Blue Cross and Blue Shield* will consider all aspects of the particular case, including the terms of your *group* benefits as described in this Benefit Description, *Blue Cross and Blue Shield* policies and procedures that support the administration of these benefits, the provider's input, as well as your understanding and expectation of benefits. *Blue Cross and Blue Shield* will use every opportunity to be reasonable in finding a solution that makes sense for all parties and may use an individual case management approach when it is judged to be appropriate. *Blue Cross and Blue Shield* will follow its standard business practices guidelines when resolving your problem or concern.

If you disagree with the decision given to you by the customer service representative, you may request a review through the formal internal grievance program as described below.

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

Formal Grievance Review

Internal Formal Grievance Review

How to Request a Grievance Review—To request a formal review from the internal Member Grievance Program, you (or your authorized representative) have three options.

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

- Or, you may send your grievance to the Member Grievance Program internet address **grievances@bcbsma.com**. *Blue Cross and Blue Shield* will let you know that your request was received by sending you a confirmation immediately by e-mail.

- Or, you may call the Member Grievance Program at **1-800-472-2689.**

Once your request is received, *Blue Cross and Blue Shield* will research the case in detail and ask for more information as needed. When the review is completed, *Blue Cross and Blue Shield* will let you know in writing of the decision or the outcome of the review.

All grievances must be received by *Blue Cross and Blue Shield* within one year of the date of treatment, event or circumstance, such as the date you were told of the service denial or claim denial.

What to Include in a Grievance Review Request
Your request for a formal grievance review should include: the name and Medex 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; details of the attempt that has been made to resolve the problem; and any comments, documents, records and other information to support your grievance. If *Blue Cross and Blue Shield* needs to review the medical records and treatment information that relate to your grievance, *Blue Cross and Blue Shield* will promptly send you an authorization form to sign if needed. You must return this signed form to *Blue Cross and Blue Shield*. It will allow for the release of your medical records. You also have the right to look at and get copies (free of charge) of records and criteria that *Blue Cross and Blue Shield* has and that are relevant to your grievance, including the identity of any experts who may have been consulted.

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

Who Handles the Grievance Review
All grievances are reviewed by individuals who are knowledgeable about *Blue Cross and Blue Shield* and the issues involved in the grievance. The individuals who will review your grievance will be those who did not participate in any of *Blue Cross and Blue Shield's* prior decisions regarding the subject of your grievance, nor do they work for anyone who did. When a grievance is related to a *medical necessity* denial, at least one grievance reviewer is an individual who is an actively practicing health care professional in the same or similar specialty that usually treats the medical condition, performs the procedure or provides treatment that is the subject of your grievance.

Response Time
The review and response for *Blue Cross and Blue Shield's* formal internal grievance review will be completed within 30 calendar days. Every reasonable effort will be made to speed up the review of grievances that involve health care services that are soon to be obtained by the *member*. (When the grievance review is for services you have already obtained and it requires a review of your medical records, the 30-day response time will not include the days from when *Blue Cross and Blue Shield* sends you the authorization form to sign until it receives your signed authorization form if needed. If *Blue Cross and Blue Shield* does not receive your authorization within 30 calendar days after you are asked for it, *Blue Cross and Blue Shield* may make a final decision about your grievance without that medical information.)

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

Blue Cross and Blue Shield may extend the time frame to complete a grievance review, with your permission, in cases when *Blue Cross and Blue Shield* and the *member* agree that additional time is required to fully investigate and respond to the grievance.

Response
Once the grievance review is completed, *Blue Cross and Blue Shield* will let you know of the decision or the outcome of the review. If *Blue Cross and Blue Shield* continues to deny coverage for all or part of a health care service or supply, *Blue Cross and Blue Shield's* response will explain the reasons. It will give you the specific medical and scientific reasons for the denial and a description of alternative treatment, health care services and supplies that would be covered and information about requesting an external review.

Grievance Records
Blue Cross and Blue Shield will maintain a record of all formal grievances, including the response for each grievance review, for up to seven years.

Expedited Review for Immediate or Urgently-Needed Services
In place of the formal grievance review described above, you have the right to request an "expedited" review right away when your grievance review concerns medical care or treatment for which waiting for a response under the grievance review timeframes described above would seriously jeopardize your life or health or your ability to regain maximum function as determined by *Blue Cross and Blue Shield* or your *physician*, or if your *physician* says that you will have

severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance review. If you request an expedited review, *Blue Cross and Blue Shield* will review your grievance and notify you of the decision within 72 hours after your request is received.

External Review

For all grievances, you must first go through the formal internal grievance process as described above. In some cases, you are then entitled to a voluntary external review. *Blue Cross and Blue Shield's* grievance review may deny coverage for all or part of a health care service or supply. When the denial is because *Blue Cross and Blue Shield* has determined that the service or supply is not *medically necessary*, you have the right to an external review. You are not required to pursue an external review and your decision whether to pursue it will not affect your other benefits. If you receive a denial letter from *Blue Cross and Blue Shield* for this reason, the letter will tell you what steps you should take to file a request for an external review. A decision will be provided within ten days of the date the external reviewer receives your request for a review.

You also have the right to an expedited external review. You may request an expedited external review by contacting *Blue Cross and Blue Shield* at the telephone number shown in your denial letter. A final decision will be provided within 72 hours after the external reviewer receives your request for a review.

You must file your request for an external review or expedited external review within 30 days of receiving the denial letter sent to you by *Blue Cross and Blue Shield* following the formal internal grievance process. *Blue Cross and Blue Shield* will work closely with you to guide you through the external review or expedited external review process.

Appeals Process for Rhode Island Residents or Services

The following provisions apply only to:

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

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

Reconsideration

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

let you know the outcome of your reconsideration request within 15 calendar days after receipt of all necessary information.

Appeal

An appeal is the second step in this process. If *Blue Cross and Blue Shield* continues to deny benefits for all or part of the original service, you may request an appeal within 60 days of receiving the reconsideration denial letter. Your appeal request should include any information that supports your appeal. You may also inspect and add information to your *Blue Cross and Blue Shield* case file to prepare your appeal. In accordance with Rhode Island state law, if you wish to review the information in your *Blue Cross and Blue Shield* case file, you must make your request in writing and include the name of a *physician* who may review your file on your behalf. Your *physician* may review, interpret and disclose any or all of that information to you. Once received by *Blue Cross and Blue Shield*, your appeal will be reviewed by a provider in the same specialty as your attending provider. *Blue Cross and Blue Shield* will notify you of the outcome of your appeal within 15 calendar days of receiving all necessary information.

External Appeal

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

Within five working days after the receipt of your written request and payment for the appeal, *Blue Cross and Blue Shield* will forward your request to the external appeals agency along with your *group's* portion of the fee and your entire *Blue Cross and Blue Shield* case file. The external appeals agency will notify you in writing of the decision within ten working days of receiving all necessary information.

Expedited Appeal

If your situation is an emergency, you have the right to an expedited appeal at all three levels of appeal as stated above. An emergency is defined as the sudden onset of a medical or *mental or nervous condition* that in the absence of immediate medical attention could reasonably be expected to result in placing your health or your ability to regain maximum function in serious jeopardy or, in your *physician*'s opinion, would result in severe pain. You may request an expedited reconsideration or appeal by contacting *Blue Cross and Blue Shield* at the telephone number shown in your letter. *Blue Cross and Blue Shield* will notify you of the result of your expedited appeal within 72 hours of its receipt. If your appeal is denied, you have the right to request an expedited external appeal. The notice you receive from *Blue Cross and Blue Shield* about your appeal will advise you of: the name of the appeals agency that is designated by Rhode Island; and the amount that Rhode Island requires you pay for your share of the cost for an expedited external appeal. To

request an expedited external appeal, you must send your request in writing to: Member Grievance Program, Blue Cross and Blue Shield of Massachusetts, Inc., One Enterprise Drive, Quincy, MA 02171-2126. Your request should state your reason(s) for your disagreement with the decision and include signed documentation from your provider that describes the emergency nature of your treatment. In addition, you must also enclose a check made payable to the designated appeals agency for your share of the cost for the expedited external appeal.

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

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

Medicare Appeals and Grievances

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

Part 9
Other Plan Provisions

Payment of Claims for Medicare Part B Covered Services and Supplies
Claims for *Medicare* Part B covered services and supplies are paid under the assignment method or the non-assignment method.

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

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

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

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

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

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

You will not have to pay the amount that is more than the *allowed charge* set by *Medicare* when you receive *covered services* eligible for benefits under *Medicare* from a Massachusetts *physician* (whether or not the *physician* has an agreement with *Blue Cross and Blue Shield*) or from another professional provider that does have an agreement with *Blue Cross and Blue Shield*. This is the case even when the *physician* or other professional provider does not agree to accept assignment on the claim for these services. But, Medex will not provide benefits in excess of any limits stated in this Benefit Description.

Access to and Confidentiality of Your Medical Records
Blue Cross and Blue Shield and health care providers may, in accordance with applicable law, have access to all medical records and related information needed by *Blue Cross and Blue Shield* or health care providers. *Blue Cross and Blue Shield* may collect information from health care

providers, other insurance companies or the *plan sponsor* to help *Blue Cross and Blue Shield* administer the benefits described in this Benefit Description and to get facts on the quality of care provided under this and other health care contracts. In accordance with law, *Blue Cross and Blue Shield* and health care providers may use this information, and may disclose it to necessary persons and entities as follows:

- For administering benefits (including coordination of benefits with other insurance plans); disease management programs; managing care; quality assurance; utilization management; the prescription drug history program; grievance and claims review activities; or other specific business, professional or insurance functions for *Blue Cross and Blue Shield*.
- 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.
- For the purpose of processing a claim, medical information may be released to your *group's* reinsurance carrier.

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

You have the right to get the information *Blue Cross and Blue Shield* collects about you. You may also ask *Blue Cross and Blue Shield* to correct any information that you believe is not correct. *Blue Cross and Blue Shield* may charge a reasonable fee for copying records.

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

Acts of Providers

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

Blue Cross and Blue Shield will not interfere with the relationship between providers and their patients. You are free to select or discharge any provider. It is not up to *Blue Cross and Blue Shield* to find a provider for you. *Blue Cross and Blue Shield* is not responsible if a provider refuses to furnish services to you.

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

Assignment of Benefits

You cannot assign any benefit or monies due under this Medex plan to any person, corporation or other organization without the *plan sponsor's* and *Blue Cross and Blue Shield's* written consent. Any assignment by you will be void. Assignment means the transfer of your rights to the benefits provided by this Medex plan to another person or organization.

Authorized Representative

You may choose to have another person act on your behalf concerning your benefits under this Medex plan. You must designate this person in writing to *Blue Cross and Blue Shield*. Or, if you are not able to do this, a person such as a conservator, a person with power of attorney or a family member may be your authorized representative. In certain situations, *Blue Cross and Blue Shield* may consider your health care facility or your *physician* to be your authorized representative. For example, *Blue Cross and Blue Shield* may tell your *hospital* that a proposed *inpatient* admission has been approved or may ask your *physician* for more information if more is needed to make a decision. Or, *Blue Cross and Blue Shield* will consider the provider to be your authorized representative for *emergency medical care* services. (You can get a form to designate an authorized representative from the *Blue Cross and Blue Shield* customer service office.) *Blue Cross and Blue Shield* will continue to send benefit payments and written communications regarding Medex coverage in accordance with *Blue Cross and Blue Shield's* standard practices, unless specifically requested to do otherwise.

Benefits for Pre-Existing Conditions

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

Changes to This Medex Plan

The *plan sponsor* or *Blue Cross and Blue Shield* may change the benefits described in this Benefit Description. For example, a change may be made to the amount you must pay for certain services. The *plan sponsor* is responsible for sending you a notice of any change. The notice will describe the change being made. It will also give the effective date of the change. When a change is made to your benefits, you can get the actual language of the change from your *plan sponsor*. The change will apply to all benefits for services you receive on or after its effective date.

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

Charges for Services That Are Not Medically Necessary

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

Counting Inpatient Days

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

Providers

This Benefit Description specifies the kinds of providers that are covered. **The kinds of providers covered by this Medex plan are:**

- ***Hospitals* and other facilities.** These include: ambulatory surgical facilities; cardiac rehabilitation centers; Christian Science sanatoriums; chronic disease *hospitals*; community health centers; day care centers; detoxification facilities; free-standing diagnostic imaging facilities; free-standing dialysis facilities; general *hospitals*; *Medicare* certified independent labs; mental health centers; mental *hospitals*; rehabilitation *hospitals*; and *skilled nursing facilities*.

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

  Medex provides benefits for *covered services* (including equipment and supplies for home dialysis) that you receive at a *hospital* or dialysis facility that does not participate with *Medicare* as long as the *hospital* or dialysis facility: has an agreement with *Blue Cross and Blue Shield*; or is not in Massachusetts and has an agreement with the local Blue Cross and/or Blue Shield Plan. In either case, *Blue Cross and Blue Shield* provides the same benefits to which you would have been entitled from Medex had you been in a *hospital* or dialysis facility that participates with *Medicare*.

- **Professional providers.** These include: certified registered nurse anesthetists; chiropractors; clinical specialists in psychiatric and mental health nursing; dentists; licensed independent clinical social workers; licensed mental health counselors; nurse midwives; nurse practitioners; physical therapists; *physicians*; podiatrists; and psychologists.

- **Other health care providers.** These include: home infusion therapy providers; retail hospice providers.

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

Covered Services in Massachusetts

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

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

- In *Blue Cross and Blue Shield's* judgment you receive services that are furnished in an emergency and a provider having an agreement with *Blue Cross and Blue Shield* is not reasonably available.
- You receive *covered services* eligible for benefits under *Medicare* when furnished by a *hospital, skilled nursing facility* or dialysis facility.
- You receive *covered services* eligible for benefits under *Medicare* when furnished by a Christian Science sanatorium.
- You receive *covered services* eligible for benefits under *Medicare* from a *physician*.
- You get materials to test for the presence of urine sugar, enteral formulas covered by Medex only or low protein food products from a licensed provider or supplier.

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

Covered Services Outside Massachusetts

Medex provides the benefits described in this Benefit Description only when *covered services* are furnished by a provider eligible to provide services covered by *Medicare* (unless stated otherwise). In addition, the benefits described in this Benefit Description for *covered services* by providers that have an agreement with *Blue Cross and Blue Shield* are also provided for *covered services* by

providers that **do not** have an agreement with *Blue Cross and Blue Shield*. But, there are some exceptions to this rule:
- Benefits for services covered by Medex only by general, chronic disease, rehabilitation and mental *hospitals* are provided only when the facility has a payment agreement with the local Blue Cross and/or Blue Shield Plan.
- Benefits for services by a detoxification facility, licensed independent clinical social worker or nurse midwife are provided only when the *covered services* are eligible for benefits under *Medicare*.
- Benefits for *covered services* are provided only when the *provider* is licensed in a jurisdiction having licensing requirements substantially similar to those in Massachusetts and the provider meets the educational and clinical standards *Blue Cross and Blue Shield* requires for providers that have a payment agreement with *Blue Cross and Blue Shield*.

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

Utilization Review Program

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

For *covered services* that are eligible for benefits under Medex only, utilization review is the approach that *Blue Cross and Blue Shield* uses to evaluate the necessity and appropriateness of many different services. This approach employs a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. These techniques include: post payment review; and individual case management as described below.

Note: For more information about the utilization review program, you may call the *Blue Cross and Blue Shield* customer service office at **1-800-258-2226**. Or, if a different telephone number appears on your Medex identification card, you may call that number.

Blue Cross and Blue Shield applies *medical technology assessment guidelines* to develop its clinical guidelines and utilization review criteria. In developing these, *Blue Cross and Blue Shield* carefully assesses a treatment to determine that it is:
- Consistent with generally accepted principals of professional medical practice; and
- Required to diagnose or treat your illness, injury, symptom, complaint or condition; and
- Essential to improve your net health outcome and as beneficial as any established alternatives covered by this Medex 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.

Blue Cross and Blue Shield reviews clinical guidelines and utilization review criteria periodically to reflect new treatments, applications and technologies.

As new drugs are approved by the Food and Drug Administration (FDA), *Blue Cross and Blue Shield* reviews their safety, effectiveness and overall value on an ongoing basis. While a new drug is being reviewed, it will not be covered by this Medex plan.

Individual Case Management

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

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

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

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

Time Limit for Legal Action

Before pursuing a legal action against *Blue Cross and Blue Shield* for any claim under this Medex plan, you must complete a formal internal grievance review as described in Part 8 of this Benefit Description. You may, but do not need to, pursue an external review prior to pursuing a legal action.

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

Part 10

Enrollment and Termination

Eligibility for Coverage

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

- You are an eligible *group member*. This means you must meet the written requirements that your *plan sponsor* has set to determine eligibility for *group* health care benefits. For details, contact your *plan sponsor*.
- You are eligible for *Medicare* Part A and *Medicare* Part B and enrolled in *Medicare* Part B.

  Note: If you drop Part A or Part B of *Medicare*, Medex **will not** provide that portion of the benefits normally paid by *Medicare*. But, Medex will still provide the Medex benefits available for *covered services* as described in this Benefit Description.

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

Enrollment Periods

Initial Enrollment

You may enroll in this Medex plan on your initial eligibility date (such as your *Medicare* effective date). The *plan sponsor* is responsible for providing you with details about how and when you may enroll in this Medex plan. To enroll, 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. (For more information, contact your *plan sponsor*.) If you choose not to enroll in this Medex plan on your initial eligibility date, you may enroll only during an open enrollment period or within 30 days of a special enrollment event as provided by federal law.

Special Enrollment

If you choose not to enroll in this Medex plan on your initial eligibility date, you may be able to enroll at a future time when a special enrollment event occurs. As provided by federal law, a special enrollment is available when:

- The *subscriber* loses eligibility for other health care coverage and that was the reason the *subscriber* chose not to enroll in this Medex plan.
- The employer contributions toward health care coverage are terminated.

To enroll, you must notify your *plan sponsor* no later than 30 days after the special enrollment event. For example, if your coverage under another health plan is terminated, you must request enrollment in this Medex plan within 30 days after your other health care coverage ends. The *plan*

sponsor will send you any special forms you may need. If you do not request enrollment within 30 days, you will have to wait until the *group's* next open enrollment period to enroll.

Open Enrollment Period
If you choose not to enroll in this Medex plan within 30 days of your initial eligibility date, you may enroll during an open enrollment period. The open enrollment period is the time each year during which eligible persons may enroll for or change coverage for the next year. The open enrollment period is announced to all eligible employees. To enroll in this Medex plan 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.

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 are allowed only when they comply with the eligibility and enrollment rules set by the *plan sponsor* for your *group* health care benefits and the conditions outlined in this Benefit Description.

Loss of Eligibility for Coverage in This Medex Plan

You do not have to worry that your membership in this Medex plan will be canceled because you are using your benefits or because you will need more *covered services* in the future. Your membership in this Medex plan will be canceled **only when**:

- You choose to cancel your membership in this Medex plan as permitted by the *plan sponsor*. You may do so at any time for any reason by sending a written notice to the *plan sponsor*. *Blue Cross and Blue Shield* must receive the termination request from the *plan sponsor* not more than 30 days after your termination date.
- 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 this Medex plan.
- You lose your *Medicare* coverage. In this case, if you are still eligible for *group* coverage, you may be eligible to transfer your coverage to another health care plan that is offered by your *group*. (Contact your *plan sponsor* for help in this situation.) Or, if you are not eligible for *group* coverage, you may be eligible to enroll in a nongroup plan. (The *Blue Cross and Blue Shield* customer service office can help you in this situation.) In any case, *Blue Cross and Blue Shield* must receive the termination request not more than 30 days after your termination date.
- You committed misrepresentation or fraud. For example, you gave false or misleading information on the enrollment application form. Or, you misused the Medex identification card by letting another person not enrolled in this Medex plan attempt to get benefits. Termination will go back to your *effective date*. Or, it will go back to the date of the misrepresentation or fraud as determined by *Blue Cross and Blue Shield*.
- You commit acts of physical or verbal abuse that pose a threat to, or a threat to the health of, *Blue Cross and Blue Shield* participating providers or other *members* or employees of *Blue*

Cross and Blue Shield or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. and that are not related to your physical condition or *mental or nervous condition*.
- This Medex plan is terminated by the *plan sponsor*.

Enrollment in a Nongroup Plan

When your membership in this Medex plan is terminated, you may be eligible to enroll in a nongroup plan offered by the local Blue Cross and/or Blue Shield Plan. The benefits and premium charges for these nongroup plans may differ from your coverage provided by this Medex plan.

At the time you lose eligibility for membership in this Medex plan, *Blue Cross and Blue Shield* will send you a letter explaining your health care options. This letter will include a toll-free telephone number that you may call to find out about the nongroup plans that may be available to you in the state where you live.

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Rider

Acupuncture Services

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

The *outpatient* benefits described in your Benefit Description have been changed by adding coverage for acupuncture services.

Medex provides benefits for acupuncture services (whether or not they are *medically necessary*) furnished by any licensed acupuncturist for up to 12 visits for each *member* in each calendar year. For these *covered services,* your cost share is the same amount that you would normally pay for other office visits for medical care services.

For *covered services* furnished on or after May 1, 2019 by a licensed acupuncturist that has a payment agreement with *Blue Cross and Blue Shield* for your health plan; or, for *covered services* by a licensed acupuncturist outside of Massachusetts who has a payment agreement with the local Blue Cross and/or Blue Shield Plan for your health plan, the *allowed charge* is based on the provisions of that health care provider's payment agreement. Otherwise, the *allowed charge* used to calculate your claim payment for these *covered services* is based on the full amount of the licensed acupuncturist's actual charge.

At the time of your visit (or at a later time), the provider may ask you to pay all billed charges. In this case, since these services are not covered by *Medicare*, you will have to file a Medex claim to *Blue Cross and Blue Shield* for reimbursement of these *covered services*. To file a claim for reimbursement, you must: fill out a claim form; attach your original itemized bills; and mail the claim to the *Blue Cross and Blue Shield* customer service office. You can obtain claim forms from the *Blue Cross and Blue Shield* customer service office.

All other provisions remain as described in your Benefit Description.

Rider 02-369

Shingles Vaccinations

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

The *outpatient* benefits described in your Benefit Description have been changed.

Medex provides full benefits based on the *allowed charge* for shingles vaccine and its administration when these services are furnished by a *covered provider* during the same visit. (Medex provides benefits for the *Medicare* Part B *deductible* and Part B *coinsurance* for these services, if any, when they are covered by *Medicare* Part B.)

All other provisions remain as described in your Benefit Description.

Rider 03-805

Family Planning

This rider modifies the terms of your health plan. Please keep this rider with your Benefit Description for easy reference.

The *outpatient* benefits described in your Benefit Description have been changed by adding family planning services.

Medex provides full benefits based on the *allowed charge* for family planning services furnished by a general hospital, community health center, *physician*, nurse practitioner or nurse midwife. (These services are not eligible for benefits under *Medicare*.) For these *covered services*, you pay nothing. These benefits include:

- Consultations, exams, procedures and medical services related to the use of all contraceptive methods to prevent pregnancy that have been approved by the United States Food and Drug Administration (FDA).
- Injection of birth control drugs, including the prescription drug when it is supplied by the 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 United States Food and Drug Administration, when the items are supplied by the provider during the visit.
- Genetic counseling.

In addition, when your Medex plan includes prescription drug benefits, your benefits also include birth control prescription drugs and devices listed on the *Blue Cross and Blue Shield* formulary. These include diaphragms and other prescription birth control devices that have been approved by the United States Food and Drug Administration. The benefits for these *covered services* are provided to the same extent that benefits are provided for other covered prescription drugs and supplies.

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

All other provisions remain as described in your Benefit Description.

Rider

Mental Health and Substance Use Treatment

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

The benefits described in your Benefit Description have been changed for covered mental health and substance use treatment services.

The following intermediate mental health care services have been added for *members* who are under age 19:

- Community-Based Acute Treatment (CBAT) programs that provide mental health care in a staff-secure setting on a 24-hour basis, with sufficient clinical staffing to ensure the *member's* safety, while providing intensive therapeutic services including (but not limited to): daily medication monitoring; psychiatric assessment; nursing availability; specialing (as needed); individual, group, and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing, as needed. Or, you may require services of higher intensity than those provided by a CBAT program, including more frequent psychiatric and psychopharmacological evaluation and treatment and more intensive staffing and service delivery. This may be delivered through an Intensive Community-Based Acute Treatment (ICBAT) program. ICBAT programs may admit *members* with more acute symptoms than those admitted to CBAT. ICBAT programs are able to treat *members* with clinical symptoms that are similar to those which would be treated under *inpatient* mental health care but who are able to be cared for safely in an unlocked setting. Your coverage for these CBAT and ICBAT programs is considered to be an *inpatient* benefit. (These CBAT and ICBAT programs are substantially similar to acute residential treatment programs.)
- In-home behavioral services that provide a combination of *medically necessary* behavior management therapy and behavior management monitoring. These services may be furnished where the *member* resides, including in the *member's* home, a foster home, a therapeutic foster home, or another community setting. Behavior management monitoring is the monitoring of behavior, the implementation of a behavior plan, and reinforcing the implementation of a behavior plan by the *member's* parent or other caregiver. Behavior management therapy addresses challenging behaviors that interfere with a *member's* successful functioning. Behavior management therapy includes: a functional behavioral assessment and observation of the *member* in the home and/or community setting; development of a behavior plan; and supervision and coordination of interventions to address specific behavioral goals

or performance, including the development of a crisis-response strategy. Behavior management therapy may also include short-term counseling and assistance. Your coverage for these services is considered to be an *outpatient* benefit.

- In-Home Therapy services that provide *medically necessary* therapeutic clinical intervention or ongoing therapeutic training and support. These services are furnished where the *member* resides, including in the *member's* home, a foster home, a therapeutic foster home, or another community setting. Therapeutic clinical intervention includes: a structured and consistent therapeutic relationship between a licensed clinician and a *member* and their family to treat the *member's* mental health needs, including improvement of the family's ability to provide effective support for the *member* and promotion of health functioning of the *member* within the family; the development of a treatment plan; and the use of established psychotherapeutic techniques, working with the family or a subset of the family to enhance problem solving, limit setting, communication, emotional support or other family or individual functions. Ongoing therapeutic training and support services support the implementation of a treatment plan following therapeutic clinical intervention. These services include (but are not limited to): teaching the *member* to understand, direct, interpret, manage, and control feelings and emotional responses to situations; and assisting the family in supporting the *member* and addressing the *member's* emotional and mental health needs. Your coverage for these services is considered to be an *outpatient* benefit.
- Family support and training services that provide *medically necessary* assistance to the *member's* parent or caregiver to increase their ability to reduce or resolve the *member's* emotional or mental health needs. These services are furnished where the *member* resides, including in the *member's* home, a foster home, a therapeutic foster home, or another community setting. Family support and training services support one or more goals on the *member's* treatment plan. These services include (but are not limited to): educating the *member's* parent or caregiver about the *member's* mental health needs and resiliency factors; teaching the *member's* parent or caregiver how to access and use available services on behalf of the *member*; and how to identify formal and informal services and support in their communities, including parent support and self-help groups. Your coverage for these services is considered to be an *outpatient* benefit.
- Therapeutic mentoring services that provide *medically necessary* support to assist a *member* with age appropriate social functioning or to reduce or resolve deficits in the *member's* age-appropriate social functioning as a result of a diagnosis listed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. These services are furnished where the *member* resides, including in the *member's* home, a foster home, a therapeutic foster home, or another community setting. Therapeutic mentoring is a skill building service that supports one or more goals on the *member's* treatment plan. These services include (but are not limited to):

supporting, coaching, and training the *member* in age appropriate behaviors; interpersonal communication; problem solving; conflict resolution; and relating appropriately to other children, adolescents, and adults. Your coverage for these services is considered to be an *outpatient* benefit.
- Intensive care coordination services that provide targeted case management services to eligible *members* with serious emotional disturbance(s) in order to meet the comprehensive medical, mental health, and psychosocial needs of a *member* and the *member's* family. These services include: an assessment; the development of an individualized care plan; referrals to appropriate levels of care; monitoring of goals; and coordinating with other services and social supports and with state agencies, as indicated. These services include both face-to-face and telephone meetings. These services may be furnished in the provider's office or in the *member's* home or in other settings, as clinically appropriate. Your coverage for these services is considered to be an *outpatient* benefit.
- Mobile crisis intervention services that are available 24 hours a day, seven days a week to provide short-term, mobile, on-site, face-to-face therapeutic responses to a *member* experiencing a behavioral health crisis. Mobile crisis intervention is used: to identify, assess, treat, and stabilize a situation; to reduce the immediate risk of danger to the *member* or others; and to make referrals and linkages to all *medically necessary* behavioral health services and supports and the appropriate level of care. Mobile crisis intervention includes a crisis assessment and crisis planning, which may result in the development or update of a crisis safety plan. Your coverage for these services is considered to be an *outpatient* benefit.

When these intermediate mental health care services are not covered by *Medicare*, Medex provides full benefits based on the *allowed charge* for these services.

All other provisions remain as described in your Benefit Description.

Rider 05-811

Mental Health and Substance Abuse Treatment

This rider modifies the terms of your health plan. Please keep this rider with your Benefit Description for easy reference.

The Medex benefits described in your Benefit Description have been changed for services to diagnose and treat *mental or nervous conditions* (including drug addiction and alcoholism) as described in this rider. All other provisions remain as described in your Benefit Description.

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

- **Biologically-based *mental or nervous conditions*.** "Biologically-based *mental or nervous conditions*" means: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder; delirium and dementia; affective disorders; and any biologically-based *mental or nervous conditions* appearing in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders that are scientifically recognized and approved by the commissioner of the department of mental health in consultation with the commissioner of the Division of Insurance.
- **Rape-related mental or emotional disorders** for victims of a rape or victims of an assault with intent to rape.

Medex provides benefits for the *Medicare* Part A *deductible* and Part A daily *coinsurance* for all available *Medicare* days as described in your Benefit Description when you are an *inpatient* in a general or mental *hospital*. After you have used all of your *Medicare* days in a *benefit period* (or all of your 190 lifetime days in a mental *hospital*), Medex provides full benefits based on the *allowed charge* for semiprivate *room and board* and *special services* for up to a lifetime total of 365 days when you are an *inpatient* in a general or mental *hospital*.

Also, Medex provides benefits for the *Medicare* Part B *deductible* and Part B *coinsurance* for *inpatient* services by a *physician* (who is a specialist in psychiatry) or psychologist. When the services are not covered by *Medicare*, Medex provides full benefits based on the *allowed charge* for services by a *physician* (who is a specialist in psychiatry), psychologist or clinical specialist in psychiatric and mental health nursing. Medex provides these benefits for as many days as are *medically necessary* for your condition.

Medex provides benefits for the *Medicare* Part B *deductible* and Part B *coinsurance* for *outpatient* services by a *Medicare* covered mental health provider. When the services are not covered by *Medicare*, Medex provides full benefits based on the *allowed charge* for services by a *physician* (who is a specialist in psychiatry), psychologist, licensed independent clinical social worker, clinical specialist in psychiatric and mental health nursing or licensed mental health counselor. Medex provides these benefits for as many visits as are *medically necessary* for your condition.

Mental Health and Substance Abuse Treatment

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

Medex provides benefits for the *Medicare* Part A *deductible* and Part A daily *coinsurance* for all available *Medicare* days as described in your Benefit Description when you are an *inpatient* in a general or mental *hospital*. After you have used all of your *Medicare* days in a *benefit period* (or all of your 190 lifetime days in a mental *hospital*), Medex provides full benefits based on the *allowed charge* for semiprivate *room and board* and *special services*. Medex provides these benefits for:

- Up to 120 days in each *benefit period* (but up to at least 60 days in each calendar year) when you are an *inpatient* in a mental *hospital*, less any days in a mental *hospital* already covered by *Medicare* or Medex in the same *benefit period* (or calendar year). In certain cases, using these days will reduce the Medex lifetime days available in a mental *hospital*. (See below.)
- Up to a lifetime total of 365 days when you are an *inpatient* in a general or, in certain cases, a mental *hospital*.

Also, Medex provides benefits for the *Medicare* Part B *deductible* and Part B *coinsurance* for *inpatient* services by a *physician* (who is a specialist in psychiatry) or psychologist. When the services are not covered by *Medicare*, Medex provides full benefits based on the *allowed charge* for services by a *physician* (who is a specialist in psychiatry), psychologist or clinical specialist in psychiatric and mental health nursing. Medex provides these benefits for: as many days as are *medically necessary* for your condition when you are an *inpatient* in a general hospital; and up to 120 days in each *benefit period*, (but up to at least 60 days in each calendar year) when you are an *inpatient* in a mental *hospital*.

Medex provides benefits for the *Medicare* Part B *deductible* and Part B *coinsurance* for *outpatient* services by a *Medicare* covered mental health provider. When the services are not covered by *Medicare*, Medex provides full benefits based on the *allowed charge* for services by a *physician* (who is a specialist in psychiatry), psychologist, licensed independent clinical social worker, clinical specialist in psychiatric and mental health nursing or licensed mental health counselor for up to 24 visits in each calendar year.

Note: Any lifetime days that you use in a general or mental *hospital* for treatment of any *mental or nervous condition* will reduce the number of lifetime days available in a general, chronic disease or rehabilitation *hospital* for medical and/or surgical care.

Rider 05-812

Mental Health and Substance Abuse Care

This rider modifies the terms of your health plan. Please keep this rider with your Benefit Description for easy reference.

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

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

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

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

All other provisions remain as described in your Benefit Description.

Rider 08-3804
Lyme Disease and HIV Associated Lipodystrophy

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

The benefits described in your Benefit Description have been changed.

Long-Term Antibiotic Therapy Treatment for Lyme Disease

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

HIV Associated Lipodystrophy Syndrome

1. For services furnished on or after November 8, 2016, the benefits for *inpatient* admissions and *outpatient* surgery as described in your Benefit Description include benefits for surgery to correct or repair disturbances of body composition caused by HIV associated lipodystrophy syndrome, when the *covered provider* has determined that this treatment is necessary to correct, repair, or lessen the effects of HIV associated lipodystrophy syndrome. These services include, but are not limited to: reconstructive surgery, such as suction-assisted lipectomy; other restorative procedures; and dermal injections or fillers for reversal of facial lipoatrophy syndrome. *Blue Cross and Blue Shield* provides benefits for these *covered services* to the same extent as benefits are provided for similar *covered services* to treat other conditions. In the event that these services are not covered by *Medicare*, *Blue Cross and Blue Shield* provides full benefits based on the *allowed charge*, as long as the services are furnished by a health care provider who has a payment agreement with *Blue Cross and Blue Shield*.
2. When your prescription drug benefits are provided under this health plan, covered drugs include prescription drugs to treat HIV associated lipodystrophy syndrome. When prescription drug benefits are not provided under this health plan, *Blue Cross and Blue*

Rider 08-3804

Lyme Disease and HIV Associated Lipodystrophy

Shield provides full benefits based on the *allowed charge* for prescription drugs obtained on or after November 8, 2016 to treat HIV associated lipodystrophy syndrome.

All other provisions remain as described in your Benefit Description.

Rider

Benefit Changes

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

The benefits described in your Benefit Description have been changed for services furnished on or after May 20, 2018.

1. The benefits for *inpatient* admissions and *outpatient* surgery as described in your Benefit Description include benefits for a sterilization procedure furnished for a female *member* when it is performed as the primary procedure for family planning reasons. (These services are not covered by *Medicare*.) Medex provides full benefits based on the *allowed charge* for these voluntary sterilization procedures when these services are furnished by (or arranged and billed by) a *covered provider*. This provision does not apply for *hospital* services. Benefits for *hospital* services remain as described in your Benefit Description.

2. When your prescription drug benefits are provided under this health plan, covered drugs include prescription birth control drugs and contraceptive methods (such as diaphragms) that have been approved by the U.S. Food and Drug Administration (FDA). This coverage is provided for up to a 3-month supply for the first fill of the covered drug or other method and up to a 12-month supply for additional fills of the same prescription. (The 12-month supply may be issued all at once or over the course of the 12-month period.) Your cost share will be waived for generic birth control drugs and methods (or for a brand-name drug or method when a generic is not available or not medically appropriate for you). If you choose to use a brand-name birth control drug or method when a generic is available or appropriate for you, you will have to pay your cost share.

All other provisions remain as described in your Benefit Description.

Rider

Reproductive Health Care Services

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

The benefits described in your Benefit Description have been changed.

The below new section for "Reproductive Health Care Services" has been added to Part 4, "Covered Services" as follows:

Reproductive Health Care Services

Under this Medex plan, you have the right to access reproductive health care services when they are furnished for you by a *covered provider* in a location where it is legal to perform such services. This includes: supplies, care and services of a medical, behavioral health, mental health, surgical, psychiatric, therapeutic, diagnostic, preventive, rehabilitative or supportive nature relating to pregnancy; contraception; assisted reproduction; miscarriage management; or termination of pregnancy (abortion).

Except as described below for abortion and abortion-related care, your benefits for covered reproductive health care services are provided to the same extent as benefits are provided for similar *covered services* to treat other physical conditions.

Abortion and Abortion-Related Care

Medicare provides benefits for abortion and abortion-related care only in limited circumstances. (See the most current edition of your *Medicare* handbook for more information.) When abortion and abortion-related care is provided by *Medicare*, Medex provides benefits for any *Medicare* Part A or Part B *deductibles* and/or *coinsurance* when the services are furnished for you by a *covered provider* in a location where it is legal to perform such services.

When these *covered services* are not covered by *Medicare*, Medex provides full benefits based on the *allowed charge* for abortion and abortion-related care when the services are furnished for you by a *covered provider* in a location where it is legal to perform such services.

Benefits for an abortion include: surgical services and certain prescription drugs related to a medication abortion (when your prescription drug coverage is provided under this Medex plan); and abortion-related care as defined by Massachusetts Division of Insurance guidance. *Covered services* for abortion-related care include (but are not limited to): pre- and post-abortion medical services and diagnostic tests.

All other provisions remain as described in your Benefit Description.

Rider

Overall Plan Changes

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

The definition of “medically necessary” as described in Part 2 of your Benefit Description 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: covered preventive and routine health care services.) For *covered services* eligible for benefits under *Medicare*, *Blue Cross and Blue Shield* has the discretion to determine which health care services that you receive (or you are planning to receive) are *medically necessary* and appropriate for coverage. *Blue Cross and Blue Shield* does this by referring to *Medicare’s* “reasonable and necessary” guidelines. For *covered services* eligible for benefits under Medex but not under *Medicare*, *Blue Cross and Blue Shield* has the discretion to determine which health care services that you receive (or you are planning to receive) are *medically necessary* and appropriate for coverage. *Blue Cross and Blue Shield* does this by referring to the guidelines described below.

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

- Furnished in accordance with generally accepted standards of professional medical practice (as recognized by the relevant medical community);
- Clinically appropriate, in terms of type, frequency, extent, site and duration; and they must be considered effective for your illness, injury or disease;
- Consistent with the diagnosis and treatment of your condition and for services covered by Medex only, furnished in accordance with *Blue Cross and Blue Shield* medical policy and *medical technology assessment guidelines*;
- Essential to improve your net health outcome and as beneficial as any established alternatives that are covered by this Medex *contract*;
- Consistent with the level of skilled services that are furnished and furnished in the least intensive type of medical care setting that is required by your medical condition; and
- Not more costly than an alternative service or sequence of services at least as likely to produce the same therapeutic or diagnostic results to diagnose or treat your illness, injury or disease.

This does **not** include a service that: is primarily for your convenience or for the convenience of your family or the health care provider; is furnished solely for your religious preference;

promotes athletic achievements or a desired lifestyle; improves your appearance or how you feel about your appearance; or increases or enhances your environmental or personal comfort.

All other provisions remain as described in your Benefit Description.

Rider 08-833 Rev.

Autism Spectrum Disorders

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

The benefits described in your Benefit Description have been changed.

This Medex plan provides benefits for *medically necessary* services to diagnose and treat autism spectrum disorders when the *covered services* are furnished by a *covered provider.* This may include (but is not limited to): a physician; a psychologist; or a licensed applied behavioral analyst. This coverage includes:

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

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

This Medex plan provides benefits for these *covered services* to the same extent as benefits are provided for similar *covered services* to diagnose and treat a physical condition.

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

This coverage for autism spectrum disorders does not affect an obligation to provide services to an individual under an individualized family service plan, an individualized education program, or an individualized service plan. This means that, for services related to autism spectrum disorders, no benefits are provided for: services that are furnished by school personnel under an 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 Benefit Description has been changed to also include licensed applied behavioral analysts.

All other provisions remain as described in your Benefit Description.

Rider 09-001
Inpatient Dental Services

This rider modifies the terms of your health plan. Please keep this rider with your Benefit Description for easy reference.

The *inpatient* benefits described in your Benefit Description for *hospital* services and dentist's services have been changed.

Dentist's Services for Which Benefits Are Provided

In addition to the *inpatient* benefits described in your Benefit Description, Medex provides full benefits based on the *allowed charge* for the following services by a dentist. These benefits are provided only when *Blue Cross and Blue Shield* determines that you have a serious medical or dental condition that requires that you be admitted as an *inpatient* to a *hospital* in order to receive the dentist's services. Some examples of serious medical conditions are: hemophilia; and heart disease.

- Surgical removal of unerupted teeth or impacted teeth only when imbedded in bone.
- Extraction of seven or more permanent teeth.

Inpatient Hospital Services

When *Medicare* does not provide benefits for *inpatient hospital* charges, Medex provides full benefits based on the *allowed charge* for semiprivate *room and board* and *special services* for the number of days described in your Benefit Description when you receive the *inpatient* dentist's services listed above.

All other provisions remain as described in your Benefit Description.

Rider
Benefit Changes

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

The benefits described in your Benefit Description have been changed.

1. The definition of "Outpatient" as described in Part 2, Definitions has been changed as follows:

   ### Outpatient
   A patient who is not a registered bed patient in a facility. For example, a patient at a health center, provider's office, surgical day care unit or ambulatory surgical facility is considered an *outpatient*. A patient who is kept overnight in a *hospital* solely for observation is also considered an *outpatient*. This is true even though the patient uses a bed. You are also an *outpatient* if you are getting *covered services* at a health center, at a provider's office (this can be either in-person or via telehealth), or in other covered outpatient settings, or at home.

2. The following new sections have been added to Part 4, Covered Services:

   ### COVID-19 Testing and Treatment
   Blue Cross and Blue Shield provides full benefits based on the *allowed charge* for services to diagnose or treat the 2019 novel coronavirus disease (COVID-19) when the services are furnished by a *covered provider* whether or not the provider has an agreement with *Blue Cross and Blue Shield*. This coverage includes *inpatient* or *outpatient* services such as:
   - *Emergency medical care,* including emergency ambulance transport.
   - Hospital or other covered health care facility services.
   - Cognitive rehabilitation services.
   - Professional, diagnostic, and laboratory services.
   - *Medically necessary* COVID-19 testing, including testing for asymptomatic *members* according to guidelines set by the Commonwealth of Massachusetts Secretary of the Executive Office of Health and Human Services.

   In the event that these services are not covered by *Medicare*, *Blue Cross and Blue Shield* provides full benefits based on the *allowed charge* for these services.

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

   If a benefit limit would normally apply to any of the *covered services* listed above, a benefit limit will not apply for *covered services* to diagnose or treat COVID-19.

Telehealth Services

After *Medicare* provides benefits, *Blue Cross and Blue Shield* provides benefits based on the *allowed charge* for telehealth services when the same in-person service would be covered by the health plan and the use of telehealth is appropriate. Your health care provider will work with you to determine if a telehealth visit is medically appropriate for your health care needs or if an in-person visit is required. For covered telehealth services, you will not have to pay any more than you would normally pay for an in-person office visit for the same *covered services* furnished by your covered health care provider.

All other provisions remain as described in your Benefit Description.

Rider 11-001

Private Duty Nursing

This rider modifies the terms of your health plan. Please keep this rider with your Benefit Description for easy reference.

The *inpatient* benefits described in your Benefit Description have been changed by adding private duty nursing.

After you pay the first $50 and 20% of the *allowed charge* in each *benefit period*, Medex provides benefits for the balance of the *allowed charge* for private duty nursing furnished by a registered nurse (RN) or licensed practical nurse (LPN) for up to a total of $1,000 in each *benefit period* when you are an *inpatient* in a *hospital*. You must pay all charges that are more than this $1,000 limit in each *benefit period*.

These benefits are provided only when: you are hospitalized as an *inpatient* for the treatment of a medical condition; the health care facility's regular nursing staff cannot perform skilled nursing care due to the frequency and complexity of the services; and *Blue Cross and Blue Shield* determines that the services are *medically necessary* for you.

Benefits are provided for the services of a private duty nurse who is a member of your immediate family or your household only when you prove to *Blue Cross and Blue Shield* that he or she could otherwise have been gainfully employed to perform these services.

All other provisions remain as described in your Benefit Description.

Rider 13-828

Low Protein Foods

This *rider* modifies the terms of your health plan. Please keep this *rider* with your Benefit Description 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 Benefit Description 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 Benefit Description.

Rider

Wellness Benefits

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

Wellness Benefits

While you are enrolled in this Medex *contract*, you may be reimbursed for some fees that you pay to participate in qualified fitness programs. For information about what you need to do to be eligible for these programs and how to claim these benefits, refer to your fitness reimbursement materials.

- **Fitness Benefit:** *Blue Cross and Blue Shield* will reimburse you up to $150 each calendar year for costs you pay to participate in a qualified fitness program. A qualified fitness program includes services, activities, and products that provide cardiovascular and strength-training benefits. Reimbursement is provided for: full service health clubs where you use a variety of cardiovascular and strength-training equipment for fitness; or, fitness studios where you take instructor-led group classes for cardiovascular and strength-training such as yoga, pilates, zumba, kickboxing, cross-fit, and indoor cycling/spinning; or, virtual/online memberships, subscriptions, programs, or classes for fitness using a digital platform; or, cardiovascular and strength-training equipment for fitness that is purchased for use in the home. Effective January 1, 2023, a qualified fitness program also includes pool-only facilities, membership and other fees to facilities with pools, water aerobics and other classes at facilities with pools, and aqua therapy at facilities with pools.

  This reimbursement is not provided for items that are considered to be recreational equipment and/or sports equipment (such as kayaks, inline skates, ice skates, trampolines, and fitness clothing). No fitness benefit is provided for any initiation fees or fees or costs you pay for: personal training sessions; country clubs; social clubs (such as ski, tennis, or hiking clubs); sports camps, leagues, or teams; spas; instructional dance studios; pool-only facilities (prior to January 1, 2023); ski passes; and martial arts schools.

To receive your fitness benefit, you must file a claim no later than March 31st after the year for which you are claiming your benefit. If you file your claim during the calendar year for which you are claiming your benefit, the date on which you file the claim will be considered the incurred date. But, if you file your claim after the year for which you are claiming your benefit, the incurred date will be shown as December 31st of the prior year. This means that the incurred date reflects the calendar year for which you are claiming your benefit. To file a claim, you must: fill out a claim form and follow the instructions to submit it to *Blue Cross and Blue Shield*. To get a claim form, log on to the *Blue Cross and Blue Shield* Web site at **www.bluecrossma.org**. If you need help to get a claim form or help to file a claim you can call the *Blue Cross and Blue*

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

All other provisions remain as described in your Benefit Description.

Rider 14-670

Routine Vision Supplies

This rider modifies the terms of your health plan. Please keep this rider with your Benefit Description for easy reference.

The *outpatient* benefits described in your Benefit Description have been changed.

This health plan provides benefits for up to $150 every 24 months for one set of prescription lenses and/or frames or contact lenses (including measurement, fitting, and adjustments). After you have received your maximum benefit in a 24-month period for these *covered services,* you must pay the full amount of the provider's charges that are in excess of the maximum benefit.

At the time of your visit to purchase vision supplies (or at a later time), the provider may ask you to pay all billed charges. In this case, you will have to file a claim to *Blue Cross and Blue Shield* for repayment of these *covered services*. To file a claim for repayment, you must: fill out a claim form; attach your original itemized bills; and mail the claim to the *Blue Cross and Blue Shield* customer service office. For a claim form or help to file a claim, you may call the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number that is on your Medex identification card.

Note: Your Medex benefits for services to treat eye disease or eye injury, including eyeglasses and/or lenses, have not been changed by this rider. See your Benefit Description for your benefits for these *covered services*.

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

All other provisions remain as described in your Benefit Description.

Rider 14-685

Hearing Aids and Related Services

This rider modifies the terms of your health plan. Please keep this rider with your Benefit Description for easy reference.

The *outpatient* benefits described in your Benefit Description have been changed by adding coverage for hearing aids and related services.

Medex provides benefits for hearing aids and *covered services* related to a covered hearing aid when the *covered services* are furnished by a *covered provider*, such as a licensed audiologist or licensed hearing instrument specialist. These *covered services* include: the initial hearing aid evaluation; one hearing aid for each hearing-impaired ear; fitting and adjustments of the hearing aid; and supplies such as (but not limited to) ear molds. **Your coverage for the hearing aid device itself is limited to $2,000 for one hearing aid for each hearing-impaired ear every 36 months.** If you choose a hearing aid device that costs more than this benefit maximum, you will have to pay the balance of the cost of the device that is in excess of the benefit maximum. No benefits are provided for replacement hearing aid batteries.

For these *covered services*, your cost share amount (*deductible*, copayment, and *coinsurance*, whichever applies) is waived.

No benefits are provided for hearing aid(s) delivered more than 60 days after your termination date under this Medex plan (even if they were prescribed while you were covered under this Medex plan); replacement parts for and repairs of the hearing aid(s); and charges to replace lost or broken hearing aid(s) unless at the time you replace the hearing aid(s) you have gone more than two calendar years without receiving this hearing aid benefit.

All other provisions remain as described in your Benefit Description.

Rider 15-806

Syringes and Needles

This rider modifies the terms of your health plan. Please keep this rider with your Benefit Description for easy reference.

The *outpatient* benefits described in your Benefit Description have been changed.

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

At the time of your visit to purchase *medically necessary* syringes and needles (or at a later time), the provider may ask you to pay all billed charges. If this happens, you will have to send a claim to *Blue Cross and Blue Shield* for repayment of these *covered services*. You must fill out a claim form and send it with your original itemized bill(s). To get a claim form or to get help to send your claim, you can call the *Blue Cross and Blue Shield* customer service office. The toll-free phone number to call is on your Medex card.

All other provisions remain as described in your Benefit Description.

Rider 17-001

Skilled Nursing Facility Services

This rider modifies the terms of your health plan. Please keep this rider with your Benefit Description for easy reference.

The *inpatient* benefits described in your Benefit Description for *skilled nursing facility* services have been changed.

1. When you are in a *skilled nursing facility* that participates with *Medicare*, Medex provides benefits for $16 a day from the 101st through the 365th day in each *benefit period*. You must pay the amount in excess of $16 a day from the 101st through the 365th day in each *benefit period*.
2. When you are in a *skilled nursing facility* that does not participate with *Medicare*, Medex provides benefits for $16 a day for up to 365 days in each *benefit period*. You must pay the amount in excess of $16 a day for up to 365 days in each *benefit period*.

Note: Benefits for covered *inpatient* care in all *skilled nursing facilities* are available for up to 365 days in each *benefit period* and are subject to the conditions described in your Benefit Description.

All other provisions remain as described in your Benefit Description.

Rider

Chiropractor Services

This rider modifies the terms of your health plan. Please keep this rider with your Benefit Description for easy reference.

The benefits described in your Benefit Description for chiropractic services have been changed.

1. Medex provides benefits for the *Medicare* Part B *deductible* and Part B *coinsurance* for chiropractic services furnished by a chiropractor when these services are covered by *Medicare*. These benefits are limited to manual manipulation of the spine to correct a subluxation that can be shown by x-ray. No benefits are provided for x-rays furnished by a chiropractor.
2. After you pay 80% of the *allowed charge*, Medex provides benefits for the balance of the *allowed charge* for chiropractic services furnished by a chiropractor when these services are not covered by *Medicare*.

All other provisions remain as described in your Benefit Description.

Rider 18-807

Optometrist Services

This rider modifies the terms of your health plan. Please keep this rider with your Benefit Description for easy reference.

The benefits described in your Benefit Description for *outpatient* medical care services have been changed for *covered services* furnished on and after January 1, 2004.

Medex provides benefits for *Medicare* approved *outpatient* medical care services furnished by an optometrist to diagnose or treat your illness or injury. These benefits are provided to the same extent that benefits are provided for *Medicare* approved *outpatient* medical care services furnished by a *physician*.

All other provisions remain as described in your Benefit Description.

Rider 18-808

Covered Health Care Providers

This rider modifies the terms of your health plan. Please keep this rider with your Benefit Description for easy reference.

The list of health care providers that may furnish *covered services* to you as described in your Benefit Description has been changed to include:

- **Licensed dietitian nutritionists** for *Medicare* approved *outpatient* nutrition counseling and medical nutrition therapy services that are furnished on and after August 1, 2003. The benefits for these *covered services* are the same as those benefits that are provided for *Medicare* approved *outpatient* medical care services furnished by a *physician*.
- **Occupational therapists** for *Medicare* approved *outpatient* short-term rehabilitation therapy that is furnished on and after January 1, 2004. The Benefits for these *covered services* are the same as those benefits that are provided for *Medicare* approved *outpatient* short-term rehabilitation therapy furnished by other covered professional providers.

All other provisions remain as described in your Benefit Description.

Rider 99-002

OBRA 90 Provisions

This rider modifies the terms of your health plan. Please keep this rider with your Benefit Description for easy reference.

The *inpatient* and *outpatient* benefits described in your Benefit Description have been changed as follows. All other provisions remain as described in your Benefit Description.

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

Medicare Part B Covered Services and Supplies

The benefits described in your Benefit Description have been changed to include all *Medicare* Part B covered services and supplies. These benefits are provided subject to the limitations and exclusions described in your *Medicare* handbook. These benefits include, but are not limited to: *physician's* office visits (without the *inpatient hospital* stay requirement); ambulance services; purchase or rental of *durable medical equipment*; *durable medical equipment* supplied as part of *Medicare* approved home health care services (*Medicare* provides full benefits based on the *allowed charge* for the home health care itself); bone mass density testing, diabetes self-management training services, routine colorectal cancer screening, routine GYN exams, routine prostate cancer screening and other preventive health services that are covered by *Medicare*; and treatment of all *mental or nervous conditions* (including drug addiction and alcoholism) when furnished by a *Medicare* covered mental health provider.

Note: Ambulance services are considered *covered providers* under this Medex plan. You will not have to pay the amount that is more than the *allowed charge* set by *Medicare* when you receive ambulance services from a Massachusetts ambulance service. This is the case even when the ambulance service does not agree to accept assignment on the claim for these services.

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

Payment to Providers for Services That Are Covered by Medex Only

Unless stated otherwise, Medex provides the benefits described in your Benefit Description for services covered by Medex only whether or not the provider has an agreement with *Blue Cross and Blue Shield*. For *covered providers* that do not have a payment agreement with *Blue Cross and Blue Shield*, the *allowed charge* is the provider's actual charge.

Rider 99-002

OBRA 90 Provisions

Providers

The following provisions apply:

1. *Medicare* does not provide any benefits for services and supplies furnished by a *hospital* or another health care facility that does not participate with *Medicare*. There is one exception to this exclusion. *Medicare* provides benefits for *emergency medical care* that you receive in a *hospital* or dialysis facility that does not participate with *Medicare*, but **only when** *Medicare* determines that a *Medicare* participating *hospital* or dialysis facility is not reasonably available. However, Medex provides benefits for *covered services* (including equipment and supplies for home dialysis) that you receive at a *hospital* or dialysis facility that does not participate with *Medicare.* Medex provides the same benefits to which you would have been entitled from Medex had you been in a *hospital* or dialysis facility that participates with *Medicare*. If you have used all of your regular *Medicare* days in a *benefit period* and all of your *Medicare hospital inpatient* reserve days, Medex provides full benefits based on the *allowed charge* for semiprivate *room and board* and *special services* for *emergency medical care* in a *hospital* that does not participate with *Medicare*. Medex provides these benefits under your 365 lifetime days. (See "*Inpatient Hospital* Services" below.)
2. Benefits for services furnished outside Massachusetts by a psychologist or licensed independent clinical social worker are provided only when the *covered services* are eligible for benefits under *Medicare*. No benefits are provided for services by the following providers when furnished outside Massachusetts: clinical specialists in psychiatric and mental health nursing; licensed independent clinical social workers (when services are covered by Medex only); licensed mental health counselors; and psychologists (when services are covered by Medex only).

Inpatient Hospital Services

Medex provides benefits as described in your Benefit Description for all available *Medicare* days when you are an *inpatient* in a *hospital*. After you have used all of your *Medicare* days in a *benefit period* (or all of your 190 lifetime days in a mental *hospital*), Medex provides full benefits based on the *allowed charge* for semiprivate *room and board* and *special services*. (If you have a right to *Medicare hospital inpatient* reserve days, you must use them before Medex provides benefits after the 90th day in a *benefit period*.) Medex provides these benefits for up to a lifetime total of 365 days when you are an *inpatient* in a general, chronic disease or rehabilitation *hospital* or, in certain cases, a mental *hospital*.

Note: Your Medex benefits in a mental *hospital* are provided as described in your Benefit Description or in a separate rider.

OBRA 90 Provisions

Private Room Charges

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

Coverage for Blood

Medex provides benefits for the *Medicare* Part A *blood deductible* (if it has not already been met) when you are an *inpatient* in a *hospital* or *skilled nursing facility*. Medex also provides benefits for the *Medicare* Part B *blood deductible* (if it has not already been met) when you are an *outpatient* in a *hospital*. You have to meet only one Part A or Part B *blood deductible* in each calendar year. (See your *Medicare* handbook for details.)

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

Admissions Before Your *Effective Date*

Medex provides benefits as described in your Benefit Description only for *covered services* furnished on or after your *effective date*. This means that if you are already in a *hospital* (or another covered health care facility) on your *effective date*, Medex will provide benefits beginning on your *effective date* for *covered services* furnished in connection with that *inpatient* stay, even if from the start of that stay until your *effective date* you were not covered the whole time under a contract with a Blue Cross and Blue Shield Plan.

Services and Supplies After Your Termination Date

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