

## BENEFIT DESCRIPTION

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### Network Blue

A managed care plan administered by  
Blue Cross and Blue Shield of Massachusetts, Inc.

# Traditional MIT Health Plan

*Network Blue*<sup>®</sup>

# Welcome to Traditional Health Plan

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

The MIT Traditional Health plan is a customized product administered by MIT Health Plan and Blue Cross and Blue Shield of Massachusetts. As a member of the MIT Traditional Health Plan you are expected to receive the majority of your care at MIT Medical. When appropriate you will be referred for medically necessary services within the HMO Blue Network as administered by Blue Cross and Blue Shield of Massachusetts.

Blue Cross and Blue Shield has been designated by your plan sponsor to provide administrative services to this health plan, such as claims processing, individual case management, utilization review, quality assurance programs, disease monitoring and management services as selected by the plan sponsor, claim review and other related services, and to arrange for a network of health care providers whose services are covered by this health plan. The MIT Health Plan Claims and Member Services and Blue Cross and Blue Shield customer service office can help you understand the terms of this health plan and what you need to do to get your maximum benefits.

Blue Cross and Blue Shield has entered into a contract with the plan sponsor to provide these administrative services to this health plan. This contract, including this benefit booklet and any applicable riders, will be governed by and construed according to the laws of the Commonwealth of Massachusetts, except as preempted by federal law.

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.

# Table of Contents

---

<b>Introduction</b> .....	<b>1</b>
<b>Schedule of Benefits</b> .....	<b>2</b>

## SECTION I – SERVICES WITHIN THE MIT MEDICAL DEPARTMENT OR ADMINISTERED BY MIT HEALTH PLANS

---

<b>Part 1 – Covered Services at MIT Medical</b> .....	<b>8</b>
<b>Part 2 – Prescription drugs obtained through MIT Pharmacy</b> .....	<b>13</b>
<b>Part 3 – Covered Services administered by MIT Health Plan</b> .....	<b>16</b>
<b>Part 4 – Grievance Review</b> .....	<b>18</b>
<b>Part 5 – Other Plan Provisions</b> .....	<b>22</b>
<b>Part 6 – Limitations and Exclusions</b> .....	<b>24</b>
<b>Part 7 – Filing a Claim for Benefits Administered by MIT Health Plan</b> .....	<b>27</b>

## SECTION II – SERVICES ADMINISTERED BY BLUE CROSS AND BLUE SHIELD OF MASSACHUSETTS

---

<b>Part 1 – Member Services</b> .....	<b>29</b>
Choosing a Primary Care Physician .....	29
Health Plan Identification Cards .....	29
Health Care Provider Network .....	29
Making an Inquiry and/or Resolving Claim Problems or Concerns .....	30
<b>Part 2 – Definitions</b> .....	<b>32</b>
<b>Part 3 – Emergency Medical Services</b> .....	<b>43</b>
Obtaining Emergency Medical Services .....	43
Post-Stabilization Care .....	43
Urgently-Needed Services Outside the Service Area .....	44
Filing a Claim for Emergency Medical (or Urgently Needed) Services .....	45

## Table of Contents

---

<b>Part 4 – Utilization Review Requirements</b> . . . . .	<b>46</b>
PCP Referral Requirements for Specialty Care . . . . .	46
Pre-Service Approval Requirements . . . . .	48
—Pre-Admission Review . . . . .	48
—Concurrent Review and Discharge Planning . . . . .	49
—Prior Approval for Certain Outpatient Services . . . . .	50
Individual Case Management . . . . .	52
<b>Part 5 – Covered Services</b> . . . . .	<b>53</b>
Admissions for Inpatient Medical and Surgical Care . . . . .	53
—General and Chronic Disease Hospital Admissions . . . . .	53
—Rehabilitation Hospital Admissions . . . . .	55
—Skilled Nursing Facility Admissions . . . . .	56
Ambulance Services . . . . .	56
Cardiac Rehabilitation . . . . .	56
Chiropractor Services . . . . .	57
Dialysis Services . . . . .	57
Durable Medical Equipment . . . . .	58
Early Intervention Services . . . . .	58
Emergency Medical Outpatient Services . . . . .	59
Home Health Care . . . . .	59
Hospice Services . . . . .	60
Infertility Services . . . . .	60
Lab Tests, X-Rays and Other Tests . . . . .	61
Maternity Services and Well Newborn Inpatient Care . . . . .	61
—Maternity Services . . . . .	61
—Well Newborn Inpatient Care . . . . .	62
Medical Care Outpatient Visits . . . . .	62
Medical Formulas . . . . .	63
Mental Health and Substance Abuse Treatment . . . . .	64
Oxygen and Respiratory Therapy . . . . .	65
Pharmacy Services and Supplies . . . . .	66
Podiatry Care . . . . .	69
Preventive Health Services . . . . .	69
—Routine Pediatric Care . . . . .	69
—Routine Adult Physical Exams and Tests . . . . .	70
—Routine Gynecological (GYN) Exams . . . . .	70
—Family Planning . . . . .	71
—Routine Hearing Exams and Tests . . . . .	71
—Routine Vision Exams . . . . .	71
—Wellness Benefits . . . . .	72
Prosthetic Devices . . . . .	73
Qualified Clinical Trials for Treatment of Cancer . . . . .	74

## Table of Contents

---

Radiation Therapy and Chemotherapy . . . . .	74
Second Opinions . . . . .	75
Short-Term Rehabilitation Therapy . . . . .	75
Speech, Hearing and Language Disorder Treatment . . . . .	74
Surgery as an Outpatient . . . . .	75
TMJ Disorder Treatment . . . . .	77
<b>Part 6 – Limitations and Exclusions . . . . .</b>	<b>78</b>
Admissions That Start Before Effective Date . . . . .	78
Benefits from Other Sources . . . . .	78
Blood and Related Fees . . . . .	78
Cosmetic Services and Procedures . . . . .	78
Custodial Care . . . . .	79
Dental Care . . . . .	79
Educational Testing and Evaluations . . . . .	79
Exams/Treatment Required by a Third Party . . . . .	79
Experimental Services and Procedures . . . . .	79
Eyewear . . . . .	80
Foot Care . . . . .	80
Medical Devices, Appliances, Materials and Supplies . . . . .	80
Missed Appointments . . . . .	80
Non-Covered Providers . . . . .	81
Non-Covered Services . . . . .	81
Overall Benefit Maximum . . . . .	82
Personal Comfort Items . . . . .	82
Private Room Charges . . . . .	82
Refractive Eye Surgery . . . . .	82
Reversal of Voluntary Sterilization . . . . .	83
Services and Supplies Furnished After Termination Date . . . . .	83
Services Furnished to Immediate Family . . . . .	83
Surrogate Pregnancy . . . . .	83
<b>Part 7 – Other Party Liability . . . . .</b>	<b>84</b>
Coordination of Benefits (COB) . . . . .	84
Medicare Program . . . . .	86
The Health Plan’s Rights to Recover Benefit Payments . . . . .	86
—Subrogation and Reimbursement of Benefit Payments . . . . .	86
—Member Cooperation . . . . .	87
Workers’ Compensation . . . . .	87
<b>Part 8 – Filing a Claim . . . . .</b>	<b>88</b>
When the Provider Files a Claim . . . . .	88
When the Member Files a Claim . . . . .	88
Timeliness of Claim Payments . . . . .	89

## Table of Contents

---

<b>Part 9 – Grievance Program</b> .....	<b>90</b>
Making an Inquiry and/or Resolving Claim Problems or Concerns .....	90
Internal Formal Grievance Review .....	90
External Review .....	92
Appeals Process for Rhode Island Residents or Services .....	93
<b>Part 10 – Other Health Plan Provisions</b> .....	<b>96</b>
Access to and Confidentiality of Medical Records .....	97
Acts of Providers .....	97
Assignment of Benefits .....	97
Authorized Representative .....	97
Changes to This Health Plan .....	97
Charges for Non-Medically Necessary Services .....	98
Disagreement with Recommended Treatment .....	98
Services Furnished by Non-Network Providers .....	98
Time Limit for Legal Action .....	99
<b>Part 11 – Eligibility for Coverage</b> .....	<b>100</b>
Who Is Eligible to Enroll .....	100
Enrollment Periods .....	102
—Initial Enrollment .....	102
—Special Enrollment .....	102
—Qualified Medical Child Support Order .....	103
—Open Enrollment Period .....	103
Making Other Membership Changes .....	104
<b>Part 12 – Termination of Coverage</b> .....	<b>105</b>
<b>Part 13 – Continuation of Coverage</b> .....	<b>107</b>
Family and Medical Leave Act .....	107
Consolidated Omnibus Budget Reconciliation Act .....	107
<b>Part 14 – Health Insurance Portability</b> .....	<b>110</b>
Pre-Existing Conditions .....	110
HIPAA Certificates .....	110

# Introduction

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You are covered under this health plan. This health plan is a non-insured, self-funded health benefits plan and is financed by contributions by your *group* and/or its enrolled employees. 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 health plan, such as claims processing, individual case management, *utilization review*, quality assurance programs, disease monitoring and management services as selected by the *plan sponsor*, claim review and other related services, and to arrange for a network of health care providers whose services are covered by this health plan. The name and address of this organization is: **Blue Cross and Blue Shield of Massachusetts, Inc., Landmark Center, 401 Park Drive, Boston, Massachusetts 02215-3326.**

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 health plan.

This benefit booklet provides you with a complete description of your benefits while you are enrolled in this health plan. It explains your benefits and the terms of your coverage under this health plan. You should read this benefit booklet to become familiar with the key points. Keep it handy so that you can refer to it. The words that are shown in italics have special meanings. (These words are defined in Section II, Part 2.) Your *group* or *Blue Cross and Blue Shield* may change the coverage described in this benefit booklet. If this is the case, the change is described in a *rider*. Your *group* will supply you with *riders* (if there are any) that apply to your coverage under this health plan. Please keep any *riders* with your benefit booklet so that you can refer to them.

As a Traditional Health Plan *member*, you must choose a PCP at MIT Medical who will furnish most of your health care. When you need to see a specialist, your PCP will refer you to a network specialist. You have also agreed that you will receive your health care from health care providers who are in the *Blue Cross and Blue Shield* HMO Blue health care network (“*network providers*”). But, if you need *emergency medical care*, this health plan will cover those services even when they are furnished by a health care provider who is not in the HMO Blue health care network (“*non-network provider*”). Except as described in this benefit booklet, this health plan will not cover services that are furnished by *non-network providers*. **Before using your coverage, you should make note of some key points. Be sure to read about the limits and exclusions on your coverage. They are described in Parts 3, 4, 5, 6 and 7 of Section II.**

<b>Important Note:</b>	In this benefit booklet, the term “you” refers to any <i>member</i> who has the right to the coverage provided by this health plan—the <i>subscriber</i> or the enrolled spouse or any other enrolled dependent.
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## Traditional Health Plan

# Schedule of Benefits

This is your Schedule of Benefits. This chart describes the costs that you must pay for *covered services*. It also shows the *benefit limit* that applies for a specific *covered service*. Do not rely on this chart alone. Be sure to read this benefit booklet to understand all of the requirements that you must follow to receive coverage. You should also read the descriptions of *covered services* and the limitations and exclusions that apply for this coverage. To receive all of your health plan benefits, you have chosen a MIT Medical physician as your PCP who will furnish your medical care and, when necessary, arrange or coordinate other health care services for you. If you and your PCP decide that you need to see a specialist for *outpatient* specialty care, you may need to first obtain an approved referral from your PCP. Or, certain services must be approved in advance by *Blue Cross and Blue Shield*. For example, you must have prior approval from *Blue Cross and Blue Shield* before you are admitted for an *inpatient* stay. (See Part 4 in Section II.) You should check with your PCP or your *network provider* to make sure that a PCP referral or prior approvals (if any are required) are obtained from *Blue Cross and Blue Shield* before you receive these services. Or, you may have to pay all costs.

Overall Member Cost-Share Provisions	
<b>Deductible</b>	None
<b>Out-of-Pocket Maximum</b>	None
<b>Overall Benefit Maximum</b>	None

Your Network Blue Benefits:		Your Cost is:
<b>Admissions for Inpatient Medical and Surgical Care</b>	In a network General Hospital	Nothing
	In a network Rehabilitation Hospital	Nothing
	In a network Chronic Disease Hospital or Skilled Nursing Facility ( <b>100-day benefit limit per member per calendar year</b> )	Nothing up to the benefit limit; then, you pay all costs
<b>Ambulance Services</b> ( <i>medically necessary</i> ground or air ambulance transport. There is a \$10,000 benefit limit for air ambulance)	Emergency ambulance (up to 1,000 miles per trip)	Nothing
	Other ambulance (up to 100 miles per trip)	
<b>Cardiac Rehabilitation</b>	<i>Outpatient</i> services	Nothing

Your Network Blue Benefits:		Your Cost is:
<b>Chiropractor Services</b> <i>(outpatient services for members age 16 or older)</i>	Labs and x-rays	Nothing
	Medical care services, including spinal manipulation ( <b>12-visit benefit limit per member per calendar year</b> )	\$10 <i>copayment</i> per visit up to the <i>benefit limit</i> ; then, you pay all costs
<b>Dialysis Services</b>	<i>Outpatient</i> and home dialysis	Nothing
<b>Durable Medical Equipment</b>	All medically necessary DME as indicated by your medical condition.	Nothing
	(This benefit limit does not apply when durable medical equipment is furnished as part of covered home dialysis, home health care or hospice services.)	
<b>Early Intervention Services</b>	\$5,200 <i>benefit limit</i> per eligible child per calendar year (\$15,600 lifetime)	Nothing
<b>Emergency Medical Outpatient Services</b>	Emergency room	\$50 copayment per visit
	(An emergency room copayment is waived if the visit results in your being held for an overnight observation stay or being admitted for inpatient care within 24 hours.)	
	Office, health center and hospital services	Nothing
<b>Home Health Care</b>	Medically necessary care	Nothing
<b>Hospice Services</b>	<i>Inpatient</i> or <i>outpatient</i> hospice services for terminally ill	Nothing
<b>Infertility Services</b> <i>(See page 59 for a description of these covered services.)</i>	<i>Inpatient</i> services and <i>outpatient</i> labs and x-rays	Nothing
	<i>Outpatient</i> surgical services	Nothing
	<i>Outpatient</i> medical care services	Nothing
<b>Lab Tests, X-Rays and Other Tests</b>	<i>Outpatient</i> diagnostic tests (includes preoperative tests)	Nothing
<b>Maternity Services and Well Newborn Inpatient Care</b>	Maternity services (includes delivery, prenatal care and postnatal care)	Nothing
	Well newborn care during enrolled mother's maternity admission	Nothing

Your Network Blue Benefits:		Your Cost is:
<b>Medical Care Outpatient Visits</b> (includes syringes and needles dispensed during a visit)	Office and health center services	Nothing
	Hospital services and home visits	Nothing
<b>Medical Formulas</b>	<b>\$2,500 benefit limit per member per calendar year for low protein foods</b>	Nothing (for low protein foods, all costs more than the benefit limit)
<b>Mental Health and Substance Abuse Treatment – Inpatient</b>	<i>Inpatient</i> admissions in a network General Hospital	Nothing
	<i>Inpatient</i> admissions in a network Mental hospital or Substance Abuse Facility	Nothing up to the <i>benefit limit</i> (if any); then, you pay all costs
	<b>Note:</b> This coverage is limited to: 60 <i>inpatient</i> days per member per calendar year in a network mental hospital or substance abuse facility plus 30 more days per calendar year for alcoholism; and 50 <i>outpatient</i> visits per member per calendar	
<b>Mental Health and Substance Abuse Treatment – Outpatient</b>	<i>Outpatient</i> services to a Network Provider	\$20 <i>copayment</i> per visit up to the <i>benefit limit</i> ; then, you pay all costs
	<i>Outpatient</i> services to a non-Network Provider	All charges above the maximum allowance of \$60 per visit for a non-network provider
	<b>Note:</b> This coverage is limited to a combined 50 visits per calendar year, for network and non-network providers	
<b>Oxygen and Respiratory Therapy</b>	Oxygen and equipment for its administration	Nothing
	<i>Outpatient</i> respiratory therapy	
<b>Pharmacy Services and Supplies</b> with Standard Drug Formulary (includes syringes and needles)	At MIT Pharmacy (up to 30-day formulary supply; some medications – up to a 90-day supply with 2 <i>copayments</i> )	Tier 1: \$8 <i>copayment</i> Tier 2: \$25 <i>copayment</i> Tier 3: \$40 <i>copayment</i>
	Retail Pharmacy Benefit (limited to a 30-day formulary supply per fill)	Tier 1: \$15 <i>copayment</i> Tier 2: \$40 <i>copayment</i> Tier 3: \$50 <i>copayment</i>
	(For insulin infusion pumps, the cost you would normally pay for covered drugs and supplies will not apply. For these items, you pay nothing.)	
<b>Podiatry Care</b> (routine care is not covered except when medically necessary due to certain circulatory conditions.)	<i>Outpatient</i> labs and x-rays	Nothing
	<i>Outpatient</i> surgical service	Nothing
	<i>Outpatient</i> medical care service	Nothing

Your Network Blue Benefits:		Your Cost is:
<b>Preventive Health Services</b> with \$150 Fitness Benefit (See pages 71-73 for a complete description of covered services.)	Routine Pediatric Care – at MIT Medical only, except limited pediatric services	Nothing
	This includes (but is not limited to) routine services determined suitable for the member by the PCP; immunizations; routine labs and x-rays; and blood tests to screen for lead poisoning.	
<b>Preventive Health Services</b> (continued) Most services covered only at MIT Medical.	Routine Adult Exams at MIT Medical only	Nothing
	This includes (but is not limited to) routine services determined suitable for the member by the PCP; immunizations; routine labs and x-rays; routine mammograms at least once between age 35 through 39 and once per calendar year for a member age 40 or older; and blood tests to screen for lead poisoning.	
	Routine GYN Exams ( <i>once per member per calendar year</i> )	Nothing
	This includes a routine Pap smear test once per member per calendar year.	
	Family Planning at MIT Medical only	Nothing
	Routine Hearing Exams and Tests at MIT Medical only	Nothing
	This includes newborn hearing screening tests.	
	Routine Vision Exams ( <i>once per member every 12 months</i> ) at MIT Medical	Nothing
<b>Prosthetic Devices</b>	Ostomy supplies	Nothing
	Artificial limb devices, including repairs	Nothing
	Other external prosthetic devices	Nothing
<b>Radiation Therapy and Chemotherapy</b>	<i>Outpatient</i> services	Nothing
<b>Short-Term Rehabilitation Therapy</b> ( <i>outpatient</i> physical and/or occupational therapy)	48-visit <i>benefit limit per member per calendar year</i>	Nothing up to the benefit limit; then, you pay all costs
<b>Speech, Hearing and Language Disorder Treatment</b> ( <i>outpatient</i> services)	Diagnostic tests	Nothing
	Speech therapy - 24-visit <i>benefit limit per member per calendar year</i>	Nothing up to the benefit limit; then, you pay all costs
	Medical care services	Nothing

Your Network Blue Benefits:		Your Cost is:
<b>Surgery as an Outpatient</b> (includes removal of impacted teeth when the teeth are fully or partially imbedded in the bone, through MIT Medical.)	Day surgery at a surgical day care unit, ambulatory surgical facility or hospital <i>outpatient</i> department	Nothing
	Office and health center services	Nothing
<b>TMJ Disorder Treatment</b>	<i>Outpatient</i> x-rays	Nothing
	<i>Outpatient</i> surgical service	Nothing
	<i>Outpatient</i> physical therapy (short-term rehabilitation therapy <i>benefit limit</i> applies)	Nothing up to benefit limit; then, you pay all costs
	<i>Outpatient</i> medical care service	

## SECTION I.

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Services within the MIT Medical Department  
or Administered by MIT Health Plan

# Traditional MIT Health Plan

## Part I

# Covered Services at MIT Medical

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The following services are covered under the Traditional MIT Health Plan **when rendered within The MIT Medical Department.**

### Acupuncture

Visits to an acupuncturist for pain management. Referral required.

**Note:** Benefit is limited to 18 visits per calendar year.

### Allergy

Visits to an allergist

**Note:** Allergy serum is covered at 100%.

### Audiology

Visits to an audiologist including hearing aid evaluations.

### Birth Control

This health plans benefit provides benefits for the following birth control devices under the yearly pharmacy benefit with the described limitations and cost sharing:

- Birth control pills are covered for an up to 30 day supply with a copayment based upon the tier in which the birth control pill used is assigned. Members may purchase an up to 90 day supply at one time (with the corresponding copayment calculated on a two month supply copayment).
- Diaphragm – The purchase of a diaphragm is covered with a copayment based upon the tier to which the diaphragm used is assigned. Over the counter gel used in conjunction with the diaphragm is not covered.
- Inter-uterine devices (IUD) – the purchase of an IUD is covered at 50% of the cost of the device. The IUD must be obtained through MIT Medical.
- Depo Provera injections are covered with a two month copayment per injection. One injection provides 3 months of birth control prevention.
- Transdermal patches for an up to 30 day supply with a copayment based upon the tier in which the transdermal patch used is assigned. Members may purchase an up to 90 day supply at one time (with the corresponding copayment calculated on a two month supply copayment).

- Intra-vaginal contraceptive medication devices for an up to 30 day supply with a copayment based upon the tier in which the transdermal patch used is assigned. Members may purchase an up to 90 day supply at one time (with the corresponding copayment calculated on a two month supply copayment).

**Note:** Over-the-counter birth control preparations (condoms, birth control foams, jellies, and sponges, etc.) are not covered.

## Cardiology

Visits to a cardiologist.

**Note:** Coverage includes the provision of any medically necessary stress tests.

## Co-pay Immunizations

This health plan provides coverage for a number of immunizations with a \$25 co-payment per immunization. Those immunizations identified as co-pay immunizations include:

- Cholera
- Hepatitis A
- Hepatitis B
- ISG
- Gardasil
- Japanese Encephalitis
- Meningococcal
- Rabies
- Typhoid (oral and injectible)
- Rotavirus
- Yellow Fever
- Zostervax

## Dermatology

Visits to a dermatologist for covered conditions.

**Note:** Cosmetic dermatology services not covered.

## Endocrinology

Visits to an endocrinologist.

## Ear, Nose & Throat

Visits to an otolaryngologist.

## Flu Shots & Public Health Immunizations

This health plan provides coverage for immunizations such as flu shots and other public health immunizations.

## Gastroenterology

Visits to a gastroenterologist.

## Gynecology

Visits to a gynecologist. Coverage includes routine pap smears, pregnancy testing and birth control counseling.

**Note:** Non-prescription birth control devices not covered.

## Infertility Consultations

Visits for infertility consultations.

## Inpatient Hospitalization

Inpatient hospitalization when hospitalized in the MIT Medical Department Inpatient Unit. This coverage includes general nursing care and medically necessary ancillaries.

**Note:** Non-medically necessary items and items supplied for patient convenience are not covered.

## Internal Medicine

Visits to an internist for routine care and most routine physicals.

**Note:** Form physicals are not covered. A form physical is generally defined as a physical necessary for pre-employment, pre-matriculation and certification or re-certification of a license.

## Laboratory and Other Diagnostic Testing

Lab tests and diagnostic testing.

**Note:** Some lab tests are not covered (i.e., genetic testing). Laboratory tests not covered by the plan will be billed directly to the patient.

## Mental Health

Visits to a mental health practitioner for short term problem focused treatment of mental conditions, stress management or for alcohol and substance abuse.

## Neurology

Visits to a neurologist.

## Nutrition

Visits to a nutritionist.

## **Ophthalmology**

Visits to an ophthalmologist or optometrist.

**Note:** Eyeglasses and contact lens are not covered. Discounts are offered for eye glasses purchased at MIT Optical.

## **Orthopedics**

Visits to an orthopedist.

**Note:** Orthotics are not covered.

## **Pediatrics**

Visits to a pediatrician.

**Note:** Includes well baby visits.

## **Pharmacy**

Covered with co-payment. See page 13 for a full description of the pharmacy benefit available through the MIT Medical Pharmacy.

**Note:** Over the counter items are not covered.

## **Pulmonary Medicine**

Visits to a pulmonologist.

## **Surgery**

Visits to a surgeon.

## **Urgent Care**

The Urgent Care unit is open seven days a week, 24 hours a day.

## **Urology**

Visits to an urologist.

## **X-Ray and Mammography**

X-rays and mammograms

## Temporomandibular Joint Syndrome

This health plan provides benefits for oral surgery consultations for the diagnosis of Temporomandibular Joint Syndrome (TMJ) only when performed in the MIT Medical Dental Service.

**Note:** Coverage is limited to the oral surgery consultation fee only. See Part II, Section I – Benefits Administered by *Blue Cross Blue Shield of Massachusetts* for coverage guidelines for treatment of TMJ. X-Rays taken during an oral surgery consultation are not covered.

**Note:** There is no coverage for TMJ oral surgery consultations when performed at offices other than the MIT Dental Service.

## Wisdom Teeth

This health plan provides benefits for the evaluation of wisdom teeth only when performed in the MIT Medical Dental Service.

**Note:** Coverage is limited to the oral surgery consultation fee only. See Part II, Section I – Benefits Administered by *Blue Cross Blue Shield of Massachusetts* for coverage guidelines for removal of wisdom teeth. X-Rays taken during an oral surgery consultation are not covered.

**Note:** There is no coverage for Wisdom Teeth consultations when performed at offices other than the MIT Medical Dental Service.

## Part 2

# Prescription Drugs when obtained through the MIT Pharmacy

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This health plan provides benefits for *covered prescription drugs* when filled at the MIT Medical Pharmacy. Benefits are under the following guidelines:

- Members are encouraged to fill prescriptions at the MIT Pharmacy for formulary drugs unless the prescription is for a newly diagnosed urgent condition and the MIT Pharmacy is closed. Any refills should be filled at the MIT Pharmacy. Obtaining your prescriptions through the MIT Pharmacy allows better clinical coordination and has a lower out of pocket expense for the member. (Please see Section II for information about pharmacy benefits administered by BCBSMA.)
- Coverage is for up to 30 day supply with a copayment based upon the tier in which the drug is classified.
- When medically indicated by the provider, up to a 90-day supply of most chronic medications may be dispensed at 3 month intervals for twice the 30-day copayment. New medications will be dispensed in a 30 day supply and are not eligible for a 90 day supply at the time of the initial fill.
- Refill prescriptions may be filled no sooner than 10 days before the next prescription refill date.
- The copayments for an up to 30 day supply are:
  - *Tier one* \$8
  - *Tier two* \$25
  - *Tier three* \$40
- In order to fill a prescription at the MIT Pharmacy, the prescription must be written by an MIT Medical provider or a provider to which a member has been referred by an MIT Medical provider.
- Non formulary drugs may be purchased through the MIT Pharmacy . The MIT Pharmacy will obtain the medication through an arrangement with Inman Pharmacy. The medication can generally be delivered the same day, or the next business day.

Note: Members will not be reimbursed for prescription drugs purchased at outside pharmacies. Please see Section II for information about pharmacy benefits administered by BCBSMA.

**Drug coverage limits** have been established for specific drugs or drug classifications. The following are included in these restrictions:

- Perishable drugs fills limited to one (1) up to 30 day supply in a 30 day period.

- Infertility drugs (Fertinex, Progesterone, Suppositories, Progesterone Injection, Human Chorionic Gonadotropin, Profasi, Follistim) fills limited up to one (1) up to 30 day supply in a 30 day period. Prior approval must be obtained before coverage.
- Dental Prophylaxis (Amoxicillin, Erythromycin, other antibiotics as outlined in dental guidelines) fills limited to a maximum of sixteen (16) capsule maximum per month.
- Viagra coverage limited to male members. Limit of up to four (4) tablets per 30 day period.  
**Note:** Effective March 1, 2009, members may obtain a three month supply (12 tablets) of Viagra, or similar medications, at one time, with the 3 month copay.
- Members filling prescriptions for Viagra at the MIT Medical Pharmacy may purchase an additional 10 tablets per month on a cash basis (not covered by health plan).
- Toradol fills limited to a maximum five (5) day supply
- Triptans (migrane medication- Imitrex, Amerge, Maxalt, Zomig) limited to up to 30 day supply per fill; one (1) fill per 30 day period. Imitrex is limited to nine (9) tablets per fill or six (6) injections (3 boxes with 2 shots per box) or one (1) box nasal spray (1 box contains six (6) doses). Amerge, Maxalt, Zomig are limited to nine (9) tablets per fill.
- Schedule II drugs fills limited to one (1) up to 30 day supply in a 30 day period.
- Schedule III drugs fills limited to one (1) up to 30 day supply in a 30 day period.
- Drugs for intermittent therapies (e.g. antibiotics) fills limited to one (1) up to 30 day supply in a 30 day period.
- Drugs not recommended for long term use. Prescriptions limited to current prescribing guidelines (see provider or pharmacist for prescribing guidelines).
- Drugs prescribed on “as needed” basis. Fills limited to one (1) up to 30 day supply in a 30 day period.
- Chantix, for the treatment of nicotine addiction, is covered for a maximum 24-week therapy, once per lifetime.

**Conditionally covered drugs** - This health plan may provide coverage for certain non covered prescription drugs on an individual consideration basis after review by the MIT Health Plans and MIT Medical providers:

- Diet Drugs (Meridia, Zenical, Phentermine, Ionamin, Adipex P) are not routinely covered. Coverage may be considered for patients meeting the clinical criteria established by MIT Medical for pharmaceutical weight loss treatment (BMI with corresponding obesity diagnosis; demonstrated continual weight loss). Patients approved for treatment are limited to an up to 30 day supply per fill; one (1) fill per 30 day period.
- Retin A for members over 25 years of age is covered for acne therapy only. A letter of medical necessity from the members physician must be submitted for coverage consideration.
- Renova for members over 25 years of age is covered for acne therapy only. A letter of medical necessity from the member’s physician must be submitted for coverage consideration.

- Onychomycosis (nail fungal infection – Lamasil, Diflucan, oral tablets ) are not routinely covered. Coverage may be considered for patients meeting the clinical criteria established by MIT Medical for nail fungal infection treatment (drug is documented as medically necessary; prescribed by a dermatologist in the presence of a positive KOH culture; multi-nail involvement; soft tissue involvement). Patients approved for treatment are limited to an up to 30 day supply per fill; one (1) fill per 30 day period.
- Emla Cream (topical anesthetic) when used in children prior to an injection.
- Dental prescriptions are covered only if prescribed as a result of a covered dental procedure.

**Note:** Insulin and basic diabetic supplies (test strips, lancets, etc), while classified as an over the counter medication, are covered under the pharmacy benefits subject to copayment amounts.

## Part 3

# Covered Services outside MIT Medical; administered by MIT Health Plan

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Under the Traditional MIT Health Plan, you have the right to the benefits described in this section, except as limited or excluded in other sections of this Benefit Description. (For a list of benefit limitations and exclusions for the Traditional MIT Health Plan see Section 2 – Benefits Administered by *Blue Cross and Blue Shield* of Massachusetts, page 81 and Section 1 – Benefits Administered by The MIT Health Plans, page 26).

## Important Facts to Remember About Your Benefits

The benefits described in this Benefits Description are provided **only** when:

- The treatment is furnished by a *covered* provider. (For more information, see Section 2, page 19 definitions)
- Your treatment is *medically necessary* for you.
- Your treatment conforms with *Blue Cross and Blue Shield* medical policy guidelines that are in effect at the time the services or supplies are furnished. If you have access to a FAX machine, you may request medical policy information by calling the Medical Policy on Demand toll-free service at 1-888-MED-POLI. Or, you may call the Blue Cross and Blue Shield customer service office to request a copy of the information; or your treatment been approved by The MIT Health Plans.
- Call MIT Health Plan Claims and Member Services at 617-253-5979 if you have any questions regarding your benefits.

## Air Ambulance

This health plan provides benefits for an air ambulance to transport you when your emergency medical condition requires the use of an air ambulance rather than ground ambulance transportation under the following conditions:

- Benefit limited to up to \$10,000 per episode of care
- The air ambulance must be medically necessary and approved and coordinated by an MIT Medical provider prior to service being rendered.
- Patient must be airlifted by air ambulance from one acute facility to another acute facility in our network of hospitals.

## Childbirth Classes

This plan provides coverage for childbirth class under the following guidelines:

- Class must be taken at either the MIT Medical Department or the Mount Auburn Hospital.
- Coverage is limited to one class per pregnancy.

**Note:** There is no coverage for childbirth class performed at locations other than the MIT Medical Department or Mount Auburn Hospital.

## Maternity Support Services

This health plan provides coverage for either (1) home health visit or one (1) home location visit postpartum under the following guidelines:

- Member must be under the care of an MIT Medical physician during pregnancy
- Delivery must occur at the Mount Auburn Hospital
- Visit must be performed by CareGroup Home Care
- Benefit limited to either (1) home care visit or (1) home lactation visit

## Part 4

# Grievance Review

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You have the right to a review when you disagree with a decision by The MIT Medical Department to bill you for a service, or if you have a complaint about the care or service you have received from The MIT Medical Department.

## Patient Advocate

Our goal is to provide excellent, easily accessible medical care to the entire MIT community. If you are dissatisfied with your care or with any aspect of our service, we encourage you to discuss the problem with the physician or other provider of service. If the problem involves a bill for services provided by MIT Medical, we ask you talk directly to our billing area, (617) 258-5336. For questions about claims for services outside MIT Medical or what is covered under the Traditional MIT Health Plan, call Claims and Member Services at (617) 253-5979.

If the outcome of this discussion is not satisfactory, or of you prefer to talk the problem over with someone else, we have a Patient Advocate on our staff who will try to resolve your concerns. You need not identify yourself when you contact the Patient Advocate. Any information you provide is confidential, and your privacy is confidential.

You can reach the Patient Advocate at (617) 253-4976 or by e-mail [advocate@MED.MIT.EDU](mailto:advocate@MED.MIT.EDU). You may contact the patient advocate by phone, by mail, or in person by making an appointment. The Patient Advocate will listen to your concerns and explore possible courses of action. She or he will work toward resolving the issue and try to achieve a common understanding. Identification of problems through the Patient Advocate is one way we continue to improve our service to patients.

## Making an Inquiry and/or Resolving Billing Problems or Concerns regarding services provided by MIT Medical

Most problems or concerns can be handled with just one phone call. For help resolving a problem or concern with services rendered by the MIT Medical Department, you should call the MIT Medical Billing office at (617) 258-5336. A customer service representative will work with you to help you resolve your problem or concern as quickly as possible.

When resolving a problem or concern, The MIT Medical Department will consider all aspects of the particular case, including the terms of your benefits as described in this Benefits Description, Section 1, policies and procedures that support the administration of these benefits, the provider's input, as well as your understanding and expectation of benefits. The MIT Medical Department 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. MIT Medical will follow its standard business practices guidelines when resolving your problem or concern.

You also have the right to a review when you disagree with a decision by the MIT Health Plans to deny payment for services.

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

Most problems or concerns can be handled with just one phone call. (See page 2 for more information about Member Services.) For help resolving a problem or concern, you should first call the MIT Health Plans Claims and Member Services Office at 617-253-5979. A customer service representative will work with you to help you understand your benefits or resolve your problem or concern as quickly as possible.

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

## Appeal to MIT Health Plans

After you have contacted a Claims and Member Services representative as described above and if the services remain denied, you have the right to submit a formal appeal to the MIT Health Plans.

## Formal Appeal to MIT Health Plans

**How to Submit an Appeal**—to request a formal review by the MIT Health Plans, you (or your authorized representative) may either:

Send your appeal in writing to:

Health Plans Clinical Review Board  
MIT Health Plans, E23-308  
77 Massachusetts Avenue  
Cambridge, MA 02139  
Fax: 1-617-253-6558

The MIT Health Plans will let you know that your request was received by sending you a written confirmation within 5 business days.

Or, you may send your appeal to the MIT Health Plans internet address [hplan@med.mit.edu](mailto:hplan@med.mit.edu). Please note "Appeal" in the subject header. The MIT Health Plans will let you know that your request was received by sending you a confirmation within 5 business days by e mail.

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

All appeals must be received by the MIT Health Plans 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 an Appeal Request**—Your request for a formal appeal should include: the name and health plan 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 appeal including any previous correspondence from the MIT Health Plans regarding the claims or services. The MIT Health Plans needs to review the medical records and treatment information that relate to your appeal.

**Authorized Representative**—you may choose to have another person act on your behalf during the appeal process. You must designate this person in writing to the MIT Health Plans by filling out and filing an *Authorization for Disclosure* form with the plan. Or, if you are not able to do this, a person such as a conservator, a person with power of attorney or a family member may be your authorized representative.

**Who Handles the Appeal Review**—appeals are reviewed by the Health Plans Clinical Review Board comprised of individuals, including clinicians, who are knowledgeable about the MIT Health Plans and the issues involved in the appeal.

**Response Time**—appeals to the MIT Health Plans will be completed within 30 calendar days, unless additional information is required. Every reasonable effort will be made to speed up the review of appeals that involve health care services that are soon to be obtained by the *member*.

**Note:** If your appeal began after an inquiry to the MIT Health Plan’s Claims and Member Services office, the 30-day response time will begin on the day your notification that you disagree with the MIT Health Plans answer and would like to initiate a formal appeal is received by the MIT Health Plans.

The MIT Health Plans may extend the time frame to complete the appeal review, with your permission, in cases when the MIT Health Plans and the *member* agree that additional time is required to fully investigate and respond to the appeal.

**Response**—once the review is completed, the MIT Health Plans will notify you in writing of the decision or the outcome of the appeal. If the MIT Health Plans continues to deny coverage for all or part of a health care service or supply, the MIT Health Plans response will explain the reasons for the continued denial.

**Appeal Records**—the MIT Health Plans will maintain a record of all formal appeals, including the response for each appeal review, for up to seven years.

**Expedited Review for Immediate or Urgently-Needed Services**—In place of the formal appeal described above, you have the right to request an “expedited” review right away when your appeal

concerns medical care or treatment for which waiting for a response under the appeal timeframes described above would seriously jeopardize your life or health or your ability to regain maximum function as determined by your MIT Medical clinician, 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 appeal. If you request an expedited review, the MIT Health Plans will review your appeal and notify you of the decision within 3 business days after your request is received.

## Part 5

# Other Plan Provisions

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## Confidentiality

The MIT Medical Department keeps a complete medical record for each patient so that all information relevant to your medical care is readily available to our health care providers. Keeping this information confidential is one of our primary concerns. The medical record is the property of the MIT Medical Department, and information in it can be released only with your signed consent. Your written authorization is valid for 30 days and must specify the information to be released and the recipient.

In addition, without specific instructions from you, information regarding sensitive issues such as sexually transmitted diseases, psychiatric problems or drug or alcohol abuse will not be released.

The only exception to this policy is the release of information in response to a court order or to an outside physician in a medical emergency.

Within the MIT Medical Department, your record is available only to attending medical providers and persons authorized by the Medical Director to review the record for administrative purposes, such as utilization review or claims payment. All The MIT Medical Department personnel must agree in writing to uphold the confidentiality policy. Violations may be grounds for disciplinary action, up to and including dismissal.

Although e-mail seems convenient, The MIT Medical Department policy is not to use e-mail for clinical patient-specific information outside of The MIT Medical Department, because privacy cannot be assured. Patients are encouraged to register on MIT Medical's PatientOnline which provides patients with a secure portal to communicate with MIT clinicians. PatientOnline is located on the MIT Medical website at <http://medweb.mit.edu>.

A May 1998 hospital accreditation newsletter spotlighted The MIT Medical Department's Policy on Confidentiality of Patient Information as a model policy for other health care organization. In addition The MIT Medical Department will comply with all Health Insurance Portability and Accountability Act (HIPAA) requirements. Every subscriber will receive a notice of our privacy policy, which will also be posted in our clinical areas and on our website. This notice will detail your specific privacy rights under HIPAA. If you would like a copy of the policy, send an e-mail to [HIPAA\\_Review@med.mit.edu](mailto:HIPAA_Review@med.mit.edu). MIT Medical received its most recent accreditation—the Joint Commission on Accreditation of Healthcare Organization's Gold Seal of Approval—in October 2005. This accreditation is for a three-year period ending in October 2008.

If you have any questions or concerns about your medical record or The MIT Medical Department's confidentiality policy, contact the Manager of Medical Records, telephone (617) 253- 4906, room E23-023 or the Privacy Officer at: [privacy@med.mit.edu](mailto:privacy@med.mit.edu).

## Changes you need to report to us

To keep your coverage current and valid, there are certain things we need to keep track of. These include your **name**, your **mailing address**, your **e-mail address**, your **phone number**, your **MIT ID number or employer identification number if not an MIT employee**, and the **personal physician** you selected. You may be asked to confirm this information when accessing services within the MIT Medical Department and if changes have occurred, with the exception of changes to your PCP, to report them to your employer's benefits office. PCP changes should be submitted directly to the MIT Health Plans office, E23-308, [hplan@med.mit.edu](mailto:hplan@med.mit.edu), 617-253-1322 or via the on-line PCP choice form at our website <http://medweb.mit.edu>.

Changes to dependents on your health plan including the adding or removing of dependents or corrections to dependent information must be made through your employer's benefits office.

## Part 6

# Limitations and Exclusions

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*In addition to those services listed as limited and excluded in Section 2, Benefits Administered by Blue Cross and Blue Shield, the benefits described in this part of the benefit description are limited or excluded as follows:*

### **Birth Control**

This health plan does not provide coverage for over-the-counter birth control preparations (birth control foams, jellies, sponges, etc.).

### **Durable Medical Equipment**

This health plan does not provide coverage for the durable medical equipment listed below. Benefits for covered Durable Medical Equipment are administered by BCBSMA. Please see section II for additional coverage information.

Durable medical equipment not specifically listed as either covered or not covered is presumed to be non-covered. Members requesting a coverage decision for durable medical equipment not specified on either the covered or non-covered list should submit their request to the health plan for individual consideration.

- Air Conditioners
- Air Purifiers
- Arch supports or orthotics
- Bed wedge (foam)
- Bed wetting devices or alarms
- Bras for breast prosthesis
- Breast pumps (manual or electric)
- Chair car services
- Chairs with electric seat lifts
- Communication or learning boards (electronic)
- Contact lens (see covered durable medical equipment for exception)
- Corrective shoes (see covered durable medical equipment for exception)
- Dehumidifiers
- Dental appliances/night guards (see covered durable medical equipment for exception)
- Disposables (gloves, masks, tape, swabs, gauze, pads, diapers, etc.)

- Elevators
- Ergonomically designed chairs
- Exercycles
- Eyeglasses (see covered durable medical equipment for exception)
- Grab bars
- Hearing aides
- Heating pads
- Humidifiers
- Jacuzzis
- Over the toilet chairs
- Ovulation kits
- Personal comfort items (telephone, radio, TV, personal care services, etc.)
- Pregnancy test kits
- Prone board
- Pulse monitors
- Urinary suspensary (male) appliances
- Whirlpools

## Pharmacy

This health plan does not provide coverage for certain drugs and pharmaceuticals including but not limited to the following:

- Clarinex
- Dental prescriptions when prescribed for a non covered procedure
- Drugs that are available in the same strength as an over the counter product
- Drugs not approved by the Federal Drug Administration (FDA)
- Drugs prescribed for cosmetic reason
- Diet Drugs Meridia, Xenical, Phentermine, Ionamin, Adipex P (see covered pharmacy benefit for exception guidelines)
- Hair Loss drugs Propecia, Minoxidil, Loniten, Proscar when prescribed for treatment of hair loss
- Non-sedating antihistamines
- Retin A for members over 25 years of age (see covered pharmacy benefit for exception guidelines)
- Renova for members over 25 years of age (see covered pharmacy benefit for exception guidelines)

- Onychomycosis drugs (Lamisil, Diflucan oral tablets) (see covered pharmacy benefit for exception guidelines)
- Over the counter medications
- Emla Cream (topical anesthetic) when used for cosmetic or non-covered procedures and services. (See covered pharmacy benefit for exception guidelines).
- Viagra for female members
- Vitamins (prescription or over the counter)

## Part 7

# Filing a Claim for Benefits Directly Administered by the MIT Health Plans

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### Services Administered by MIT Health Plans

You should file a claim to the Claims and Member Services office of the MIT Health Plans for covered services directly administered by the MIT Health Plans. For Acupuncture and Childbirth Classes, the MIT Health Plans will reimburse you, and it is up to you to pay your provider. For other covered services, providers may be paid by the MIT Health Plans after submission of the required supporting documentation. To file a claim for payment, you must:

- Fill out a claim form;
- Attach Itemized bill(s);
- Mail or drop off the claim form and attached bill to Claims and Member Services, MIT Health Plans, E23-191, 77 Massachusetts Avenue, Cambridge, MA 02139.
- You can get claim forms from the MIT Health Plans, Claims and Member Services office at E23-191 or via the MIT Health Plans web site at <http://medweb.mit.edu>. Forms are listed on the website under “About MIT Medical; Forms and Publications”.

Upon receipt of claim, you will be sent a check within 4 to 6 weeks to the extent of your benefits as described in this Benefit Description, Section I – Benefits Administered by the MIT Health Plans. Or, you will be sent a notice in writing as to why your claim is not being paid or what other information or records the MIT Health Plans needs to decide if your claim should be paid.

**You must file a claim within one year of the date you received the covered service.** The MIT Health Plans does not have to honor claims submitted after this one year period.

## SECTION II.

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Services Administered by Blue Cross  
and Blue Shield of Massachusetts

# Traditional MIT Health Plan

## Part I

# Member Services

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### Choosing a Primary Care Physician

**When You Enroll.** At the time you enroll in the Traditional Health Plan, you must choose a *primary care physician* (PCP) at MIT Medical. Usually, different *members* of your family have different health care needs. For this reason, each *member* of a family may choose a different PCP. Your choice is important. Your choice will determine who you will see for most of your health care and where you will receive it. As soon as you enroll and you choose your PCP, you should make an appointment with him or her. This will allow your PCP to get to know your medical history and to give you medical attention and treatment that is tailored to your needs.

Your primary care provider also coordinates your overall health care and provides referrals to other specialists at MIT Medical and, if necessary, outside specialists affiliated with the greater Blue Cross Blue Shield network of Massachusetts. In most cases, you must get a referral from your primary care provider before you can see specialists in order for services to be covered.

**Need Help to Choose a PCP?** Primary care providers at MIT Medical include both physicians and nurse practitioners. Specialists in internal medicine and family practice serve as primary care providers for adults; specialists in pediatrics serve as primary care providers for children; and specialists in adolescent medicine and family practice serve as primary care providers for young adults. For a complete listing of primary care providers, please see the MIT Medical Services Directory. If you have questions about an individual clinician or accessing services call *Claims and Member Services* office at 617-253-5979.

To choose or change your personal clinician, please complete the Primary Care Provider Choice form located on the MIT Medical website at <http://medweb.mit.edu/howdoi/choose.html> or call Patient Registration at 617-253-6286. The website provides information on PCP's specialty, which medical schools the PCP attended and if languages other than English are spoken in the PCP's office as well as other interesting details.

### Health Plan Identification Cards

After you enroll in this health plan, you will receive a BCBSMA identification (ID) card. Your health plan ID card will identify you as a person who has the right to the coverage described in this benefit booklet. The health plan ID card is for identification purposes only. While you are a *member*, you must show your health plan ID card to the health care provider before you receive *covered services*. If you lose your health plan ID card or it is stolen, you should contact the *Blue Cross and Blue Shield* customer service office. They will send you a new health plan ID card. Or, you may use the internet to ask for a new health plan ID card. To use the *Blue Cross and Blue Shield* online member self-service option, log on to [www.bluecrossma.com](http://www.bluecrossma.com).

## Health Care Provider Network outside of MIT Medical

To receive all of your health plan benefits, you must obtain your health care from health care providers who are enrolled in the HMO Blue health care network (“*network providers*”). Your *primary care physician* (PCP) will furnish most of your health care. If you and your PCP decide you need to see a specialist, your PCP will refer you to the network specialist that he or she determines is best for treating your specific condition. But, if you need *emergency medical care*, this health plan will cover those services even when they are furnished by a *non-network provider*. See Part 10 for a few other times when this health plan may cover services that are furnished by a *non-network provider*. **Except as described in this benefit booklet, this health plan will not cover any services furnished by non-network providers.**

**How to Find a Network Provider.** There are a few ways for you to find an HMO Blue *network provider*.

- Call the MIT Health Plan Claims and Member Services at 617-253-5979 or by email at [mservices@med.mit.edu](mailto:mservices@med.mit.edu)
- Call the Blue Cross and Blue Shield customer service office. The toll-free phone number is shown on the back of your health plan ID card. They will tell you if a health care provider is a network provider. Or, they can help you find a network provider who is in your local area.
- Call the *Blue Cross and Blue Shield* Physician Selection Service at 1-800-821-1388.
- Use the *Blue Cross and Blue Shield* online physician directory (Find a Doctor). To do this, log on to [www.bluecrossma.com](http://www.bluecrossma.com). This online provider directory will provide you with the most current list of HMO Blue *network providers*.

If you are traveling out of this health plan’s *service area* and you need *emergency medical care* (or *urgent care*), you can get help to find a health care provider. Just call 1-800-810-BLUE. You can call this phone number 24 hours a day for help to find a health care provider. When you call, you should have your health plan ID card ready. You must be sure to let the representative know that you are looking for health care providers that participate with the local Blue Cross and/or Blue Shield Plan. Or, you may also use the internet. To use the online “BlueCard® Doctor & Hospital Finder,” log on to [www.bcbs.com](http://www.bcbs.com).

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

**Member Service.** Call the MIT Health Plan Claims and Member Services at 617-253-5979 or by email at [mservices@med.mit.edu](mailto:mservices@med.mit.edu) regarding questions about your benefits under this Plan. *Blue Cross and Blue Shield* can also help you to understand the terms of your health plan. They can help you to resolve a problem or concern that you may have about your health care benefits. You can call or write to the *Blue Cross and Blue Shield* customer service office. **The *Blue Cross and Blue Shield* toll-free phone number is shown on the back of your health plan ID card.** (To use the Telecommunications Device for the Deaf, call 1-800-522-1254.) You can call Monday through Friday from 8:00 a.m. to 8:00 p.m. (Eastern Time). Or, you can write to: **Blue Cross Blue Shield of Massachusetts, Member Service, P.O. Box 9134, North Quincy, MA 02171-9134.** A *Blue Cross and Blue Shield* customer service representative will work with you to resolve your problem or

concern as quickly as possible. (For more about the *Blue Cross and Blue Shield* formal grievance review process, see Part 9.)

**Medical Policy Information.** To receive all of the benefits described in this benefit booklet, your health care must conform to *Blue Cross and Blue Shield* medical policy guidelines. The guidelines that apply are those that are in effect at the time you receive a health care service or supply. If you have access to a fax machine, you may ask for a fax of the *Blue Cross and Blue Shield* medical policy information. To do this, call the Medical Policy on Demand toll-free service at 1-888-MED-PO-LI. Or, you may call the *Blue Cross and Blue Shield* customer service office. You can ask them to mail this information to you.

**Need a Language Translator?** MIT Medical and the MIT Health Plan offices have access to a **language line which** arranges for foreign language or sign language interpreters at our Cambridge and Lexington medical centers. Some of our physicians and nurse practitioners speak other languages, and all have access to the Language Line telephone translation service. If either you or a friend needs language support, please tell us when you make an appointment. (This interpreter is not an employee of MIT or MIT Medical.)

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

## Part 2

# Definitions

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The following words are shown in italics in your benefit booklet. The meaning of these words will help you understand your health care benefits.

### Allowed Charge

This is the charge that *Blue Cross and Blue Shield* uses to calculate payment of your health care benefits. The *allowed charge* depends on the type of health care provider that furnishes a *covered service* to you.

- **Network Providers.** For health care providers (or groups of health care providers) that have an HMO Blue payment agreement with *Blue Cross and Blue Shield* to furnish *covered services to members*, the *allowed charge* is based on the provisions of that health care provider's (or that provider group's) HMO Blue payment agreement. In general, when you share in the cost for your *covered services* (such as a *deductible*, a *copayment* and/or *coinsurance*), the calculation for the amount that you pay is based on the initial full *allowed charge* for the *network provider*. This amount that you pay is generally not subject to future adjustments—up or down—even though the *network provider's* payment may be subject to future adjustments for such things as provider contractual settlements, risk-sharing settlements and fraud or other operations.
- **Health Care Providers Outside of Massachusetts with a Local Payment Agreement.** For health care providers outside of Massachusetts who have a payment agreement with the local Blue Cross and/or Blue Shield Plan, the *allowed charge* is the “negotiated price” that the local Blue Cross and/or Blue Shield Plan passes on to *Blue Cross and Blue Shield*. (Blue Cross and/or Blue Shield Plan means an independent corporation or affiliate operating under a license from the Blue Cross and Blue Shield Association.) In many cases, the negotiated price paid by *Blue Cross and Blue Shield* to the local Blue Cross and/or Blue Shield Plan is a discount from the provider's billed charges. However, a number of local Blue Cross and/or Blue Shield Plans can determine only an estimated price at the time your claim is paid. Any such estimated price is based on expected settlements, withholds, any other contingent payment arrangements and non-claims transactions, such as provider advances, with the provider (or with a specific group of providers) of the local Blue Cross and/or Blue Shield Plan in the area where services are received. In addition, some local Blue Cross and/or Blue Shield Plans' payment agreements with providers do not give a comparable discount for all claims. These local Blue Cross and/or Blue Shield Plans elect to smooth out the effect of their payment agreements with providers by applying an average discount to claims. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. Local Blue Cross and/or Blue Shield Plans that use these estimated or averaging methods to calculate the negotiated price may prospectively adjust their estimated or average prices to correct for overestimating or underestimating past prices. However, the amount you pay is considered

a final price. In most cases for *covered services* furnished by these health care providers, you pay only your *deductible, copayment and/or coinsurance*, whichever applies.

- **Other Health Care Providers.** For non-*network providers* in Massachusetts or health care providers outside of Massachusetts who do not have a payment agreement with the local Blue Cross and/or Blue Shield Plan, the health care provider's actual charge is used by *Blue Cross and Blue Shield* to calculate your benefits. For *covered services* furnished by these health care providers, you pay only your *copayment, deductible and/or coinsurance*, whichever applies.

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

## Benefit Limit

The day, visit or dollar benefit maximum that applies to your coverage under this health plan for certain health care services or supplies. **Your Schedule of Benefits and Part 5 of this benefit booklet describe the *benefit limits* for your coverage under this health plan.** (Also refer to *riders*—if there are any—that apply to your health plan.) Once the amount of the benefits that you have received reaches the *benefit limit* for a specific *covered service*, no more benefits will be provided by this health plan for those health care services or supplies. When this is the case, you must pay all costs that you incur that are more than the *benefit limit* for those health care services or supplies.

## 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 health plan, such as claims processing, individual case management, *utilization review*, quality assurance programs, disease monitoring and management services as selected by the *plan sponsor*, claim review and other related services, and to arrange for a network of health care providers whose services are covered by this health plan. This includes an employee or designee of *Blue Cross and Blue Shield* (including a Blue Cross and/or Blue Shield Plan) who is authorized to make decisions or take action called for as described in this benefit booklet.

## Coinsurance

The cost that you pay for a certain *covered service* that is calculated as a percentage. *Blue Cross and Blue Shield* will calculate your cost-share amount based on the health care provider's actual charge or the *Blue Cross and Blue Shield allowed charge*, whichever is less (unless otherwise required by law). **Your Schedule of Benefits shows those *covered services* for which you must pay a *coinsurance*.** It also shows the *coinsurance* percentage that *Blue Cross and Blue Shield* will use to calculate your cost of the *covered service*. (Also refer to *riders*—if there are any—that apply to your health plan.) See page 32 for information about the *allowed charge*. *Blue Cross and Blue Shield* applies the following rules when calculating your *coinsurance* amounts:

- **The Effect of Provider Withholds and Risk Sharing on Coinsurance.** In some situations, a small amount is withheld from this health plan's share of the *allowed charge* payment to the *network provider* in accordance with the provider's network payment agreement. The withheld amount is paid to the *network provider* only if the *network provider's* performance meets certain standards set by *Blue Cross and Blue Shield*. Even if the *network provider* ultimately does not earn the withheld amount, your *coinsurance* is still calculated based on the actual charge or the full *allowed charge*. Your *coinsurance* will not be adjusted for any withheld amount or a *network provider's* failure to earn a withhold.

In other situations, *Blue Cross and Blue Shield* may have arrangements with network providers in which the network providers share the risk of the cost of covered services. Under these arrangements, at the conclusion of a specific performance measuring period, and following the *network providers'* receipt of a fee-for-service payment (minus a withhold, if any), *Blue Cross and Blue Shield* may owe additional incentive fees to *network providers*, or the *network providers* may be required to pay back a portion of their fees. The calculation of your *coinsurance* will not be adjusted for the effects of these risk sharing arrangements.

- **The Effect of Capitation Payments on Coinsurance.** In some situations, you will be charged *coinsurance* for a *covered service* for which the *network provider* is compensated on a capitation basis rather than on a fee-for-service basis. This may happen, for example, when *members* self-refer to *network providers*. In these situations, *Blue Cross and Blue Shield* will calculate your *coinsurance* payment in the following manner. First, *Blue Cross and Blue Shield* will determine what the fee-for-service amount would have been had the service been performed by a *network provider* on a fee-for-service basis. Next, *Blue Cross and Blue Shield* will apply your applicable *coinsurance* percentage to this converted fee-for-service figure to determine your *coinsurance* amount. The periodic capitation payments that the *network providers* receive will not be the basis for the *coinsurance* calculation.

## Copayment

The cost that you must pay for a certain *covered service* which is a fixed dollar amount. In most cases, a *network provider* will collect the *copayment* from you at the time he or she furnishes the *covered service*. However, when the health care provider's actual charge at the time of providing the *covered service* is less than your *copayment*, you pay only that health care provider's actual charge or the *Blue Cross and Blue Shield allowed charge*, whichever is less. Any later charge adjustment—up or down—will not affect your *copayment* (or the amount you were charged at the time of the service if it was less than the *copayment*). **Your Schedule of Benefits shows the amount of your copayment. It also shows those covered services for which you must pay a copayment.** (Also refer to *riders*—if there are any—that apply to your health plan.) At certain times when you would normally pay a *copayment*, the *copayment* may be waived. A *copayment* will be waived when any one of the following occurs.

- An emergency room *copayment* will be waived when: your hospital emergency room visit results in your being held for an overnight observation stay; or you are admitted for *inpatient* care within 24 hours of your visit to the emergency room.

## Covered Services

Health care services and supplies for which this health plan provides coverage as described in this benefit booklet. Most *covered services* are furnished by your *primary care physician* (PCP). Except as described in this benefit booklet, all other *covered services* must be furnished for you by *network providers* when they are arranged or recommended by your PCP and, if it is required, when they are approved by *Blue Cross and Blue Shield*. See page 30 for help to find a *network provider*. (See Part 10 for the few times when this health plan may cover services and supplies that are furnished for you by a non-*network provider*.)

## Custodial Care

A type of care that is not covered by this health plan. *Custodial care* means **any of the following**:

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

## Deductible

The cost that you must pay before this health plan provides benefits for certain *covered services*. The amount that is put toward your *deductible* is calculated based on the health care provider's actual charge or the *Blue Cross and Blue Shield allowed charge*, whichever is less (unless otherwise required by law). **If your health plan includes a *deductible*, your Schedule of Benefits shows the amount of your *deductible*. It also shows those *covered services* for which you must pay the *deductible* before this health plan provides benefits for you.** (Also refer to *riders*—if there are any—that apply to your health plan.) When a *deductible* does apply, there are some costs that you pay that do not count toward the *deductible*. These costs that do not count include:

- Any *copayments* and *coinsurance* that you pay.
- The costs that you pay when your coverage is reduced or denied because you did not follow the requirements of the *Blue Cross and Blue Shield utilization review* program. (See Part 4.)
- The costs that you pay that are more than the *allowed charge*.
- The costs that you pay because this health plan has provided all of the benefits it allows for that *covered service* (for example, early intervention for an enrolled child).

## Diagnostic Lab Tests

The examination or analysis of tissues, liquids or wastes from the body. This also includes: the taking and interpretation of 12-lead electrocardiograms; all standard electroencephalograms; and glycosylated hemoglobin (HgbA1C) tests, urinary protein/microalbumin tests and lipid profiles to diagnose and treat diabetes.

## Diagnostic X-Ray and Other Imaging Tests

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

## Effective Date

The date on which your coverage in this health plan begins.

## Emergency Medical Care

Medical, surgical or psychiatric care that you need immediately due to the sudden onset of a condition that manifests itself by symptoms of sufficient severity, including severe pain, which are severe enough that the lack of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing your life or health or the health of another (including an unborn child) in serious jeopardy or serious impairment of bodily functions or serious dysfunction of any bodily organ or part or, as determined by a provider with knowledge of your condition, result in severe pain that cannot be managed without such care. Some examples of conditions that require *emergency medical care* are: suspected heart attacks; strokes; poisoning; loss of consciousness; convulsions; and suicide attempts.

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

### Important Note:

For purposes of filing a claim or the formal grievance review (see Parts 8 and 9), *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.

## 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 health benefits plan.

## Inpatient

A patient who is a registered bed patient in a facility. This also includes a patient who is receiving *Blue Cross and Blue Shield* approved intensive services such as: partial hospital programs; or covered residential care. (A patient who is kept overnight in a hospital solely for observation is **not** considered an *inpatient*. This is true even though the patient uses a bed. In this case, the patient is considered an *outpatient*. This is important for you to know since your cost and *benefit limits* may differ for *inpatient* and *outpatient* coverage.)

## Medical Technology Assessment Guidelines

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

## Medically Necessary

All *covered services* must be *medically necessary* and appropriate for your specific health care needs. (This is true for all *covered services* except: routine circumcision; voluntary termination of pregnancy; voluntary sterilization procedures; stem cell transplant donor suitability testing; and preventive health services.) This means that all *covered services* must be consistent with generally accepted principles of professional medical practice. *Blue Cross and Blue Shield* decides which health care services are *medically necessary* and appropriate for you by using the following guidelines. All health care services and supplies 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 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 health plan.
- As cost effective as any established alternatives and consistent with the level of skilled services that are furnished.
- Furnished in the least intensive type of medical care setting that is required by your medical condition.

It is not a service that: is furnished solely for your convenience or religious preference or 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.

## Member

You, the person who has the right to the coverage described in this benefit booklet. A *member* may be the *subscriber* or his or her enrolled spouse (or former spouse, if applicable) or any other enrolled dependent.

## Mental Conditions

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

## Network Mental Health Provider

A health care provider that has a written payment agreement with Blue Cross and Blue Shield to participate in the Managed Care Behavioral Health Network and who may furnish *covered services* for the treatment of a *mental condition*. These health care providers include any one of the following kinds of health care providers.

- Alcohol and drug treatment facilities.
- Clinical specialists in psychiatric and mental health nursing.

- Community health centers (that are a part of a general hospital).
- Day care centers.
- Detoxification facilities.
- General hospitals.
- Licensed independent clinical social workers.
- Licensed mental health counselors.
- Mental health centers.
- Mental hospitals.
- Physicians.
- Psychologists.
- Other mental health providers designated by *Blue Cross and Blue Shield*.

## Network Provider

A health care provider (or a group of health care providers) that has a written HMO Blue payment agreement with, or that has been designated by, *Blue Cross and Blue Shield* to furnish *covered services* to *members* of this health plan. These health care providers are part of *Blue Cross and Blue Shield's* HMO Blue network of health care providers. The kinds of health care providers that may furnish *covered services* to you include any of the ones listed below.

- **Hospital and Other Covered Facilities.** These kinds of health care providers include: alcohol and drug treatment facilities; ambulatory surgical facilities; chronic disease hospitals; community health centers; day care centers; detoxification facilities; free-standing diagnostic imaging facilities; free-standing dialysis facilities; free-standing radiation therapy and chemotherapy facilities; general hospitals; independent labs; mental health centers; mental hospitals; rehabilitation hospitals; and skilled nursing facilities.
- **Physician and Other Covered Professional Providers.** These kinds of health care providers include: certified registered nurse anesthetists; chiropractors; dentists; licensed audiologists; licensed dietitian nutritionists; licensed speech-language pathologists; nurse midwives; nurse practitioners; occupational therapists; optometrists; physical therapists; physicians; and podiatrists.
- **Other Covered Health Care Providers.** These kinds of health care providers include: ambulance services; appliance companies; cardiac rehabilitation centers; early intervention providers; home health agencies; home infusion therapy providers; hospice providers; mail service pharmacy; oxygen suppliers; retail pharmacies; and visiting nurse associations.

(See page 30 for more help to find a *network provider*.)

## Out-of-Pocket Maximum

The total amount that you pay for certain *covered services*. Your Schedule of Benefits will show if this provision applies to your coverage. If it does, it will show the amount of your *out-of-pocket maximum* and the time frame for which it applies. It will also show those costs that you pay that will count toward the *out-of-pocket maximum*. (Also refer to *riders*—if there are any—that apply to your health plan.) When your costs that count toward the *out-of-pocket maximum* add up to the *out-of-pocket maximum* amount, this health plan provides full benefits based on the *Blue Cross and Blue Shield allowed charge* for these *covered services* until the end of the time frame in which the *out-of-pocket maximum* provision applies. (For example, this time frame may mean: the calendar year; or your *plan year*.) When an *out-of-pocket-maximum* does apply, there are some costs that you pay that **do not** count toward the *out-of-pocket maximum*. These costs that do not count include:

- The costs that you pay when your coverage is reduced or denied because you did not follow the requirements of the *Blue Cross and Blue Shield utilization review* program. (See Part 4.)
- The costs that you pay that are more than the *allowed charge*.
- The costs that you pay because this health plan has provided all of the benefits it allows for that *covered service* (for example, early intervention for an enrolled child).

(See your Schedule of Benefits for any other costs that you may have to pay that do not count toward your *out-of-pocket maximum*.)

## Outpatient

A patient who is not a registered bed patient in a facility. For example, a patient who is at a network health center, at a *network provider's* office, at a network surgical day care unit or at a network ambulatory surgical facility is considered an *outpatient*. A patient who is kept overnight in a hospital solely for observation is also considered an *outpatient*. This is true even though the patient uses a bed. (This does not include a patient who is receiving *Blue Cross and Blue Shield* approved intensive services. This means services such as: a partial hospital program; or covered residential care. See the term “Inpatient.”)

## 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.

## Plan Year

The 12-month period of time that starts on the original *effective date* of your coverage under this health plan, and continues for 12 consecutive months. A new *plan year* begins each 12-month period thereafter. If you are not sure when your *plan year* begins, contact your *plan sponsor*. The plan year for the Traditional Health Plan is the calendar year.

## Primary Care Physician (PCP)

The MIT Medical primary care physician (PCP) that you choose to furnish your primary medical care and to arrange and coordinate all other *covered services*. The PCP that you have chosen for your health care is called your “PCP” in this benefit booklet. As a member of the Traditional Health Plan you must select a PCP at MIT Medical, at the Cambridge or Lexington location.

## Rider

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

## Room and Board

Your room, meals and general nursing services while you are an *inpatient* in a covered facility. This includes hospital services that are furnished in an intensive care or similar unit.

## Service Area

The geographic area in which *Blue Cross and Blue Shield* provides *covered services* for you. *Blue Cross and Blue Shield's service area* includes all cities and towns in the Commonwealth of Massachusetts. *Blue Cross and Blue Shield* does not provide coverage for health care services or supplies received outside of *Blue Cross and Blue Shield's service area*, except for: *emergency medical care*; and *urgent care*.

## Special Services

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

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

## Subscriber

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

## Urgent Care

Medical, surgical or psychiatric care (other than *emergency medical care*) that you need right away. This is care that you need to prevent serious deterioration of your health when an unforeseen illness or injury occurs. In most cases, *urgent care* will be brief diagnostic care and treatment to stabilize your condition. This health plan will cover *urgent care* that you receive from a non-*network provider only* when you are temporarily outside of the *service area*. In this case, you are not able to get the care you need from your PCP or from a *network provider*. (See Part 3, Section II.)

## Utilization Review

The approach that *Blue Cross and Blue Shield* uses to evaluate the necessity and appropriateness of health care services. This approach uses a set of formal techniques. These techniques are designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. They include: pre-admission review; concurrent review; discharge planning; pre-approval of some *outpatient* services; post-payment review; and individual case management. *Blue Cross and Blue Shield's* utilization management policies are designed to encourage appropriate care and services (not less care). *Blue Cross and Blue Shield* understands the need for concern about underutilization. *Blue Cross and Blue Shield* shares this concern with its *members* and health care providers. *Blue Cross and Blue Shield* does not compensate individuals who conduct *utilization review* activities based on denials. It also does not offer incentives to health care providers to encourage inappropriate denials of care and services.

*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 health 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 health plan.

## Part 3

# Emergency Medical Services

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## Obtaining Emergency Medical Services

You do not need a referral from your PCP or an approval from *Blue Cross and Blue Shield* before you obtain *emergency medical care*. This health plan provides world wide emergency coverage. This means that this health plan covers *emergency medical care* whether you are in or out of the health plan's *service area*. These emergency medical services may include *inpatient* or *outpatient* services by health care providers who are qualified to furnish *emergency medical care*. This includes care that is needed to evaluate or stabilize your emergency medical condition.

**At the onset of an emergency medical condition that in your judgment requires *emergency medical care*, you should go to the nearest emergency room. If you need help, dial 911. Or, call your local emergency medical service system phone number.** You will not be denied coverage as described in this benefit booklet for medical and transportation services that you incur as a result of your emergency medical condition. You usually need emergency medical services because of the sudden onset of a condition manifesting itself by symptoms of sufficient severity, including severe pain, which are severe enough that the lack of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing your life or health or the health of another (including an unborn child) in serious jeopardy or serious impairment of bodily functions or serious dysfunction of any bodily organ or part or, as determined by a provider with knowledge of your condition, result in severe pain that cannot be managed without such care. Some examples of conditions that require *emergency medical care* are: suspected heart attacks; strokes; poisoning; loss of consciousness; convulsions; and suicide attempts.

When you receive *emergency medical care* at a non-network hospital emergency room, this health plan will provide the same coverage that you would otherwise receive if a network hospital emergency room had furnished the services.

## 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. If the emergency room provider and your PCP do not agree as to the right medical treatment for you, this health plan will provide benefits for the *covered services* that are recommended by the emergency room provider. But, this health plan will provide benefits only for the care that is covered by the health plan.

- **Outpatient Follow-Up Care.** Your emergency room provider may recommend that you have *outpatient* follow-up care. If this happens, the emergency room provider must call your PCP as soon as you are stable to obtain a referral for your *outpatient* follow-up care. If your PCP is not available, the emergency room provider must call *Blue Cross and Blue Shield* to obtain this referral. *Blue Cross and Blue Shield* will provide an approved referral

for one follow-up visit for *covered services*. You must contact your PCP for a referral for any continued follow-up care that you may need. (When you receive *emergency medical care* outside of the *service area*, you will receive coverage for one follow-up visit, if you need it. This one follow-up visit does not need a prior approval from *Blue Cross and Blue Shield* or your PCP as long as you are still outside of the *service area*.)

- **Transfer to Another Inpatient Facility.** Your emergency room provider may recommend your transfer to another facility for *inpatient* care. If this happens, the emergency room provider must call your PCP. This is required so that your PCP can be involved in the coordination of your health care, and so that the transfer can be arranged as soon as your condition is stable.
- **Admission from the Emergency Room.** Your condition may require that you be admitted directly from the emergency room into that hospital for *inpatient emergency medical care*. If this happens, the emergency room provider is not required to notify your PCP before you are admitted. But, it is important that your PCP be notified of the admission. This is so that your PCP (or *Blue Cross and Blue Shield*) can be involved in the coordination of your health care.

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

## Urgently-Needed Services Outside the Service Area

This health plan covers *urgent care* when you are temporarily outside of the *service area*. You usually need *urgent care* because an unforeseen illness or injury occurs and based on your location, you are not able to obtain treatment from your PCP or from a *network provider*.

- **Urgently-Needed Medical Services.** When you are traveling outside of the *service area* and you need *urgent care* for a medical condition, you should try to call your PCP for advice. If you cannot call your PCP, you should go to the nearest appropriate health care facility. Then, after you receive care, you must call *Blue Cross and Blue Shield* customer service office. The *Blue Cross and Blue Shield* toll-free phone number to call is shown on the back of your health plan ID card. Your call must be made within 48 hours of receiving the *urgent care*. This health plan will provide coverage for one follow-up visit, if you need it. This one follow-up visit does not need a referral from your PCP or prior approval from *Blue Cross and Blue Shield* as long as you are still outside of the *service area*.
- **Urgently-Needed Mental Health and/or Substance Abuse Treatment.** When you are traveling outside of the *service area* and you need *urgent care* for a *mental condition*, you must call your mental health/substance abuse referral phone number. This toll-free phone number is shown on the back of your health plan ID card. You may call 24 hours a day, 7 days a week to obtain help and treatment.

## Filing a Claim for Emergency Medical (or Urgently-Needed) Services

In most cases, you do not have to file a claim. You do not have to file a claim when: you receive *covered services* from a *network provider*; or, you receive *covered services* from a *non-network provider* outside of Massachusetts who has a payment agreement with the local Blue Cross and/or Blue Shield Plan. The health care provider will file the claim for you. Just tell the health care provider that you are a *member* and show your health plan ID card. *Blue Cross and Blue Shield* will pay the health care provider directly for *covered services*.

You may have to file your claim when: you receive *covered services* from a *non-network provider* in Massachusetts; or you receive *covered services* from a *non-network provider* outside of Massachusetts who does not have a payment agreement with the local Blue Cross and/or Blue Shield Plan. The health care provider may ask you to pay the entire charge at the time of your visit or at a later time. It is up to you to pay the health care provider. *Blue Cross and Blue Shield* will repay you. *Blue Cross and Blue Shield* will deduct any *deductible* and/or *copayment* and/or *coinsurance*, whichever applies.

(See Part 8 for more help about filing a claim.)

## Part 4

# Utilization Review Requirements

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To receive all of your health plan benefits, you must receive *covered services* from your PCP or your *covered services* must be arranged or recommended by your PCP and furnished by a *network provider*. In most cases, before you obtain *covered services* from a *network provider*, you must obtain a referral from your PCP or a prior approval from *Blue Cross and Blue Shield*. This section describes how the referral and pre-service approval process works. You may check on the status or outcome of your request for a referral or prior approval for proposed health care services or supplies at any time. To check, you may call your *network provider*. Or, you may call the MIT Health Plan Claims and Member Services at 617-253-5979 or by email at [mervices@med.mit.edu](mailto:mervices@med.mit.edu)

## PCP Referral Requirements for Specialty Care

In most cases, your PCP will furnish your health care. But, if you and your PCP decide that you need to see a specialist for *covered services*, your PCP will refer you to a network specialist. The specialist will usually be one your PCP knows and is probably someone affiliated with your PCP's hospital or medical group. **You must have an approved referral from your PCP before you receive most specialty care in order for you to receive your health plan coverage.**

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

**Mental Health and Substance Abuse Treatment.** You may seek care for a *mental condition without prior authorization*. If you need assistance, you, your PCP, or a MIT Medical Mental Health clinician can call the *Blue Cross and Blue Shield* mental health and substance abuse referral toll-free phone number. This phone number is shown on the back of your health plan ID card.

**Specialty Care That Does Not Require a PCP Referral.** You must have a *Blue Cross and Blue Shield* approved referral from your PCP before you receive most *outpatient* specialty care from a network specialist. But, there are a few times when a referral is not required for specialty care. You do **not** need a *Blue Cross and Blue Shield* approved referral from your PCP (or prior approval from *Blue Cross and Blue Shield*) before you receive any of the health care services listed below. Your MIT Medical clinician may submit a request to the MIT Health Plan office for certain services for coordination of care.

- *Emergency medical care.*
- *Covered services* that are furnished by a network obstetrician, network gynecologist or network nurse midwife; or gynecological services and other women’s health services that are furnished by a network family practitioner. This includes: one routine annual gynecological (GYN) exam and any services that are required as a result of the exam; and evaluations and health care services that result from acute or emergency gynecological conditions. (But, prior *Blue Cross and Blue Shield* approval is required for non-emergency and non-maternity *inpatient* admissions; and for infertility treatment.) For these *covered services*, you will not have to pay any more to the *network provider* than you would normally pay if you had received a *Blue Cross and Blue Shield* approved referral from your PCP.
- Lab tests, x-rays and other covered tests that are furnished by a *network provider*.
- Maternity services, including prenatal and postnatal care, that are furnished by a *network provider*.
- Radiation therapy and chemotherapy that is furnished by a network facility.
- Covered routine vision exams that are furnished by a network ophthalmologist or network optometrist.
- Outpatient mental health services.
- *Urgent care* that is received outside of the *service area*.

<b>PCP Referral Requirements can change</b>	From time to time, <i>Blue Cross and Blue Shield</i> may change the list of <i>covered services</i> that require an approved referral from your PCP. At any time, your PCP or <i>network provider</i> (or <i>Blue Cross and Blue Shield</i> ) can tell you if your <i>covered service</i> needs a PCP referral
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**Specialty Care Furnished by Non-Network Providers.** If your condition requires *covered services* that cannot be furnished for you by a *network provider*, your PCP may refer you to a *non-network provider* for the *covered services*. In some cases, in addition to your PCP, *Blue Cross and Blue Shield* must approve the referral in writing before you receive the services. You should not obtain any services from a *non-network provider* until you check with your PCP. (See Part 10 for information about when this health plan may cover services that are furnished by *non-network providers*.)

## Pre-Service Approval Requirements

To receive all of the coverage described in this benefit booklet, you must obtain all your health care from health care providers who are enrolled in the *Blue Cross and Blue Shield* HMO Blue health care network (“*network providers*”). For many *covered services*, you do not need prior approval from *Blue Cross and Blue Shield*. **But, there are certain health care services or supplies that do require prior approval from *Blue Cross and Blue Shield* in order for you to receive coverage under this health plan. Your coverage may be denied if you do not follow these requirements.** For these health care services, your PCP must recommend or order the *covered service* for you. The *network provider* will request prior approval from *Blue Cross and Blue Shield* for you. Your health care provider will be considered your authorized representative for the prior approval process. *Blue Cross and Blue Shield* will tell your health care provider if a proposed service has been approved. Or, *Blue Cross and Blue Shield* may ask your health care provider for more information if it is needed to make a decision. To check on the status of a request or to check for the outcome of a *utilization review* decision, you may call your health care provider or the *Blue Cross and Blue Shield* customer service office. (The toll-free phone number is shown on the back of your health plan ID card.) **Remember, you should check with your health care provider before you receive services or supplies to make sure that your health care provider has obtained approval (when required) from *Blue Cross and Blue Shield*. Otherwise, you will have to pay all charges for those services and/or supplies.**

## Pre-Admission Review

Before you go into a hospital or other covered health care facility for *inpatient* care, your health care provider must obtain an approval from *Blue Cross and Blue Shield* in order for your care to be covered by this health plan. (This does not apply to your admission if it is for *emergency medical care* or for maternity care.) ***Blue Cross and Blue Shield* will determine if the health care setting is suitable to treat your condition. *Blue Cross and Blue Shield* will make this decision within two working days of the date that it receives all of the necessary information from your health care provider.**

**Missing Information.** In some cases, *Blue Cross and Blue Shield* will need more information or records to determine if the health care setting is suitable to treat your condition. (For example, *Blue Cross and Blue Shield* may ask for the results of a face-to-face clinical evaluation or of a second opinion.) If *Blue Cross and Blue Shield* does need more information, *Blue Cross and Blue Shield* will ask for this missing information or records within 15 calendar days of the date that it received your health care provider’s request for approval. The information or records that *Blue Cross and Blue Shield* asks for must be provided to *Blue Cross and Blue Shield* within 45 calendar days of *Blue Cross and Blue Shield*’s request. **If this information or these records are not provided to *Blue Cross and Blue Shield* within these 45 calendar days, your proposed coverage will be denied. If *Blue Cross and Blue Shield* receives this information or records within this time frame, *Blue Cross and Blue Shield* will make a decision within two working days of the date it is received.**

**Coverage Approval.** If *Blue Cross and Blue Shield* determines that the proposed setting for your health care is suitable, *Blue Cross and Blue Shield* will call the health care facility. *Blue Cross and Blue Shield* will make this phone call within 24 hours of the time the decision is made. This phone call will let the facility know of the coverage approval status of the pre-admission review. Then,

within two working days of that phone call, *Blue Cross and Blue Shield* will send a written (or electronic) notice to you and to the facility. This notice will let you know (and confirm) that your coverage was approved.

**Coverage Denial.** If *Blue Cross and Blue Shield* determines that the proposed setting is not *medically necessary* for your condition, *Blue Cross and Blue Shield* will call the health care facility. *Blue Cross and Blue Shield* will make this phone call within 24 hours of the time the decision is made. This phone call will let the facility know that the coverage was denied and to discuss alternative treatment. Then, within one working day of that phone call, *Blue Cross and Blue Shield* will send a written (or electronic) notice to you and to the facility. This notice will explain *Blue Cross and Blue Shield's* coverage decision. This notice will: describe the reasons for the denial and the applicable terms of your coverage as described in this benefit booklet; give the specific medical and scientific reasons for the denial; specify any alternative treatment, health care services and supplies that would be covered; refer to and include *Blue Cross and Blue Shield's* clinical guidelines that apply and were used and any review criteria; and describe the review process and your right to pursue legal action.

**Reconsideration of Adverse Determination.** Your health care provider may ask that *Blue Cross and Blue Shield* reconsider its decision when *Blue Cross and Blue Shield* has determined that *inpatient* coverage is not *medically necessary* for your condition. In this case, *Blue Cross and Blue Shield* will arrange for the decision to be reviewed by a clinical peer reviewer. This review will be held between your health care provider and the clinical peer reviewer. And, it will be held within one working day of the date that your health care provider asks for *Blue Cross and Blue Shield's* decision to be reconsidered. If the initial decision is not reversed, you (or the health care provider on your behalf) may ask for a formal review. The process to ask for a formal review is described in Part 9 of this benefit booklet. (You may request a formal review even if your health care provider has not asked that *Blue Cross and Blue Shield's* decision be reconsidered.)

## **Concurrent Review and Discharge Planning**

Concurrent Review means that while you are an *inpatient*, *Blue Cross and Blue Shield* will monitor and review the health care services you receive to make sure you still need *inpatient* coverage in that facility.

In some cases, *Blue Cross and Blue Shield* may determine upon review that you will need to continue *inpatient* coverage in that health care facility beyond the number of days first thought to be required for your condition. When *Blue Cross and Blue Shield* makes this decision, *Blue Cross and Blue Shield* will call the health care facility to let the facility know of the coverage approval status of the review. This phone call will be made within one working day of receiving all necessary information. *Blue Cross and Blue Shield* will also send a written (or electronic) notice to you and to the facility to explain the decision. This notice will be sent within one working day of that phone call. This notice will include: the number of additional days that are being approved for coverage (or the next review date); the new total number of approved days or services; and the date the approved services will begin.

In other cases, based on a *medical necessity* determination, *Blue Cross and Blue Shield* may determine that you no longer need *inpatient* coverage in that health care facility. Or, you may no

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

**You may choose to stay in the health care facility after you have been told by your health care provider or *Blue Cross and Blue Shield* that *inpatient* coverage is no longer *medically necessary*. If you do, this health plan will not provide any more coverage. You must pay all costs for the rest of that *inpatient* stay. This starts from the date the written notice is sent to you from *Blue Cross and Blue Shield*.**

**Reconsideration of Adverse Determination.** Your health care provider may ask that *Blue Cross and Blue Shield* reconsider its decision when *Blue Cross and Blue Shield* has determined that continued *inpatient* coverage is not *medically necessary* for your condition. In this case, *Blue Cross and Blue Shield* will arrange for the decision to be reviewed by a clinical peer reviewer. This review will be held between your health care provider and the clinical peer reviewer. And, it will be held within one working day of the date that your health care provider asks for *Blue Cross and Blue Shield's* decision to be reconsidered. If the initial decision is not reversed, you (or the health care provider on your behalf) may ask for a formal review. The process to ask for a formal review is described in Part 9 of this benefit booklet. (You may request a formal review even if your health care provider has not asked that *Blue Cross and Blue Shield's* decision be reconsidered.)

## **Prior Approval for Certain Outpatient Services**

To receive all of the coverage described in this benefit booklet, certain *outpatient* services or supplies must be approved in advance by *Blue Cross and Blue Shield*. For these services or supplies, your health care provider will request an approval for you from *Blue Cross and Blue Shield*. *Blue Cross and Blue Shield* will determine if the proposed health care services should be covered as *medically necessary* for your condition. *Blue Cross and Blue Shield* will make this decision within two working days of the date that it receives all of the necessary information from your health care provider. You must receive an approval from *Blue Cross and Blue Shield* for the *outpatient* health care services listed below.

- Ambulance services for non-emergency services.
- Cardiac rehabilitation.
- Certain pharmaceuticals supplied as part of covered hospice services.
- Certain prescription drugs.
- Home infusion therapy.

- Infertility treatment.
- Certain surgery performed at a health care facility.

<b>Pre-Approval Requirements can change</b>	From time to time, <i>Blue Cross and Blue Shield</i> may change this list of services and supplies that require a prior approval from <i>Blue Cross and Blue Shield</i> . At any time, your PCP or network provider (or <i>Blue Cross and Blue Shield</i> ) can tell you if your service needs an approval from <i>Blue Cross and Blue Shield</i> .
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**Missing Information.** In some cases, *Blue Cross and Blue Shield* will need more information or records to determine if the proposed services or supplies should be covered as *medically necessary* to treat your condition. (For example, *Blue Cross and Blue Shield* may ask for the results of a face-to-face clinical evaluation or of a second opinion.) If *Blue Cross and Blue Shield* does need more information, *Blue Cross and Blue Shield* will ask for this missing information or records within 15 calendar days of the date that it received your health care provider’s request for approval. The information or records that *Blue Cross and Blue Shield* asks for must be provided to *Blue Cross and Blue Shield* within 45 calendar days of *Blue Cross and Blue Shield*’s request. **If this information or these records are not provided to *Blue Cross and Blue Shield* within these 45 calendar days, your proposed coverage will be denied.** If *Blue Cross and Blue Shield* receives this information or records within this time frame, *Blue Cross and Blue Shield* will make a decision within two working days of the date it is received.

**Coverage Approval.** If *Blue Cross and Blue Shield* determines that the proposed course of treatment should be covered as *medically necessary* for your condition, *Blue Cross and Blue Shield* will call the health care provider. *Blue Cross and Blue Shield* will make this phone call within 24 hours of the time the decision is made. This phone call will let the health care provider know of the coverage approval status of the review. Then, within two working days of that phone call, *Blue Cross and Blue Shield* will send a written (or electronic) notice to you and to the health care provider. This notice will let you know (and confirm) that your coverage was approved.

**Coverage Denial.** If *Blue Cross and Blue Shield* determines that the proposed course of treatment should not be covered as *medically necessary* for your condition, *Blue Cross and Blue Shield* will call the health care provider. *Blue Cross and Blue Shield* will make this phone call within 24 hours of the time the decision is made. This phone call will let the health care provider know that the coverage was denied and to discuss alternative treatment. Then, within one working day of that phone call, *Blue Cross and Blue Shield* will send a written (or electronic) notice to you and to the health care provider. This notice will explain *Blue Cross and Blue Shield*’s coverage decision. This notice will: describe the reasons for *Blue Cross and Blue Shield*’s denial and the applicable terms of your coverage as described in this benefit booklet; give the specific medical and scientific reasons for *Blue Cross and Blue Shield*’s denial; specify any alternative treatment, health care services and supplies that would be covered; refer to and include *Blue Cross and Blue Shield*’s clinical guidelines that apply and were used and any review criteria; and describe the review process and your right to pursue legal action.

**Reconsideration of Adverse Determination.** Your health care provider may ask that *Blue Cross and Blue Shield* reconsider its decision when *Blue Cross and Blue Shield* has determined that the proposed course of treatment will not be *medically necessary* for your condition. In this case, *Blue Cross and Blue Shield* will arrange for the decision to be reviewed by a clinical peer reviewer. This

review will be held between your health care provider and the clinical peer reviewer. And, it will be held within one working day of the date that your health care provider asks for *Blue Cross and Blue Shield's* decision to be reconsidered. If the initial decision is not reversed, you (or the health care provider on your behalf) may ask for a formal review. The process to ask for a formal review is described in Part 9 of this benefit booklet. (You may request a formal review even if your health care provider has not asked that *Blue Cross and Blue Shield's* decision be reconsidered.)

## Individual Case Management

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

- Shorten an *inpatient* stay. This may occur by sending a *member* home or to a less intensive setting to continue treatment.
- Direct a *member* to a less costly setting when an *inpatient* stay has been proposed.
- Prevent future *inpatient* stays. This may occur by providing coverage for *outpatient* care instead.

*Blue Cross 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. This includes: the patient (or the guardian); the hospital; the attending physician; and the proposed health care provider. There must be a written agreement between the patient (or the patient's family or guardian) and *Blue Cross and Blue Shield*. There must also be an agreement between the health care provider and *Blue Cross and Blue Shield* to furnish the services that are approved through this alternative treatment plan.

## Part 5

# Covered Services

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You have the right to the coverage described in this section, except as limited or excluded in other sections of this benefit booklet. Also, be sure to read your Schedule of Benefits. It will describe the costs that you must pay for *covered services*. And, it shows the *benefit limit* that applies to a specific *covered service*. To receive all of your health plan benefits, you have chosen a network physician as your PCP who will furnish your medical care and, when necessary, arrange or coordinate other health care services for you. If you and your PCP decide that you need to see a specialist for *outpatient* specialty care, you may need to first obtain an approved referral from your PCP. And, when it is required by *Blue Cross and Blue Shield*, you must obtain prior approval from *Blue Cross and Blue Shield*. (See Part 4.) For all *covered services*, you must be sure to obtain your health care from a *network provider*. Of course if you need *emergency medical care*, this health plan will cover those services even when they are furnished by a *non-network provider*. (See Part 10 for a few other times when this health plan may cover your services even when they are furnished by a *non-network provider*.)

## Admissions for Inpatient Medical and Surgical Care

### General and Chronic Disease Hospital Admissions

Except for an admission for *emergency medical care* or maternity care, your *network provider* must receive approval from *Blue Cross and Blue Shield* before you enter a general or chronic disease hospital for *inpatient* care. *Blue Cross and Blue Shield* will let you know when your coverage is approved. (See Part 4.) When *inpatient* care is approved by *Blue Cross and Blue Shield*, this health plan provides coverage for as many days as are *medically necessary* for you. (This health plan also provides coverage when you are admitted to a non-network general hospital for *emergency medical care* and, in some cases, *urgent care*. See Part 3.) This coverage includes:

- Semiprivate *room and board* and *special services* that are furnished for you by the hospital.
- Surgery that is performed for you by a *network provider*. This includes a network physician; or a network podiatrist; or a network nurse practitioner; or a network dentist. This may also include the services of an assistant surgeon (network physician) when *Blue Cross and Blue Shield* decides that an assistant is needed. This coverage includes (but is not limited to):
  - **Reconstructive surgery.** This is non-dental surgery that is meant to improve or give you back bodily function or to correct a functional physical impairment that was caused by: a birth defect; a prior surgical procedure or disease; or an accidental injury. This also includes surgery that is done to correct a deformity or disfigurement that was caused by an accidental injury.
  - **Women's Health and Cancer Rights:** As required by federal law, this coverage includes breast reconstruction in connection with a mastectomy. This health plan provides coverage for: all stages of reconstruction of the breast on which the mastectomy was

**IMPORTANT:** Refer to your Schedule of Benefits for the cost that you must pay for *covered services* and for any *benefit limit* that may apply to a specific *covered service*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by this health plan for those services or supplies.

performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas. These services will be furnished in a manner determined in consultation with the attending physician and the patient.

- **Transplants.** This includes human organ and stem cell (“bone marrow”) transplants that are furnished according to *Blue Cross and Blue Shield’s* medical policy and *medical technology assessment guidelines*. This includes one or more stem cell transplants for a *member* who has been diagnosed with breast cancer that has spread. For covered transplants, these benefits also include: the harvesting of the donor’s organ or stem cells when the recipient is a *member*; and drug therapy that is furnished during the transplant procedure to prevent the transplanted organ/tissue or stem cells from being rejected. (“Harvesting” includes: the surgical removal of the donor’s organ or stem cells; and the related *medically necessary* services and/or tests that are required to perform the transplant itself. No benefits are provided for the harvesting of the donor’s organ or stem cells when the recipient is not a *member*.) See “Lab Tests, X-Rays and Other Tests” for your coverage for donor testing.
- **Oral surgery.** This includes: reduction of a dislocation or fracture of the jaw or facial bone; excision of a benign or malignant tumor of the jaw; and orthognathic surgery that you need to correct a significant functional impairment that cannot be adequately corrected with orthodontic services. In this case, you must have a serious medical condition that requires that you be admitted to a network hospital as an *inpatient* in order for the surgery to be safely performed. (Orthognathic surgery is not covered when it is performed mainly for cosmetic reasons. This surgery must be performed along with orthodontic services. If it is not, the network oral surgeon must send a letter to *Blue Cross and Blue Shield* asking for approval for the surgery. No benefits are provided for the orthodontic services.)

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

- Voluntary termination of pregnancy; and voluntary sterilization procedures.
- Anesthesia services that are related to covered surgery. This includes those services that are furnished for you by a network physician other than the attending physician; or by a network certified registered nurse anesthetist.
- Radiation and x-ray therapy that is furnished for you by a network physician. This includes: radiation therapy using isotopes, radium, radon or other ionizing radiation; and x-ray therapy for cancer or when used in place of surgery.
- Chemotherapy (drug therapy for cancer) that is furnished for you by a network physician.
- Interpretation of *diagnostic x-ray and other imaging tests*, *diagnostic lab tests* and diagnostic machine tests, when these tests are not furnished by a hospital-based radiologist

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**IMPORTANT:** Refer to your Schedule of Benefits for the cost that you must pay for *covered services* and for any *benefit limit* that may apply to a specific *covered service*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by this health plan for those services or supplies.

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or pathologist. This includes these services when they are furnished for you by a network physician; or by a network podiatrist.

- Medical care that is furnished for you by a network physician; or by a network nurse practitioner; or by a podiatrist. This includes medical care furnished by a network physician other than the attending physician to treat an uncommon aspect or complication of your illness or injury. This health plan will provide benefits for medical care furnished by two or more network physicians at the same time. But, this is the case only when *Blue Cross and Blue Shield* decides that the care is needed to treat a critically ill patient. The second physician must be an expert in a different medical sub-specialty than the attending physician. This health plan will provide benefits only for the attending network physician if the second physician is an expert in the same medical sub-specialty as the attending physician.
- Monitoring services that are related to dialysis, when they are furnished for you by a *network provider*.
- Consultations. These services must be furnished for you by a network physician other than the attending physician. The consultation must be needed to diagnose or treat the condition for which you were admitted. Or, it must be for a complication that develops after you are an *inpatient*. The attending physician must order the consultation. The network physician who furnishes it must send a written report to *Blue Cross and Blue Shield* if it asks for one. The network physician who furnishes this consultation for you must be an expert in a different medical sub-specialty than the attending physician. This health plan will provide benefits only for the attending network physician if the consultant is an expert in the same medical sub-specialty as the attending physician.
- Intensive care services. These services must be furnished for you by a network physician other than the attending physician; or by a network nurse practitioner. This means services that you need for only a limited number of hours to treat an uncommon aspect or complication of your illness or injury.
- Emergency admission services. These services must be furnished for you by a network physician; or by a network nurse practitioner. This means that a complete history and physical exam is performed before you are admitted as an *inpatient* for *emergency medical care* and your treatment is taken over immediately by another network physician.
- Pediatric specialty care. This is care that is furnished for you by a *network provider* who has a recognized expertise in specialty pediatrics.
- Second opinions. These services must be furnished for you by a network physician. This includes a third opinion when the second opinion differs from the first.

### Rehabilitation Hospital Admissions

Your *network provider* must receive approval from *Blue Cross and Blue Shield* before you enter a network rehabilitation hospital for *inpatient* care. *Blue Cross and Blue Shield* will let you know when your coverage is approved. (See Part 4.) When *inpatient* care is approved by *Blue Cross and Blue Shield*, this health plan provides coverage until you reach your *benefit limit*. Your Schedule of

**IMPORTANT:** Refer to your Schedule of Benefits for the cost that you must pay for *covered services* and for any *benefit limit* that may apply to a specific *covered service*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by this health plan for those services or supplies.

Benefits describes the *benefit limit* that applies for these *covered services*. (Also refer to *riders*—if there are any—that apply to your health plan.) Once you reach this *benefit limit*, no more benefits will be provided by this health plan for these services. (This is the case whether or not the care is *medically necessary*.) This coverage includes: semiprivate *room and board* and *special services* furnished for you by the network rehabilitation hospital; and medical care furnished for you by a network physician or by a network nurse practitioner.

### Skilled Nursing Facility Admissions

Your *network provider* must receive approval from *Blue Cross and Blue Shield* before you enter a network skilled nursing facility for *inpatient care*. *Blue Cross and Blue Shield* will let you know when your coverage is approved. (See Part 4.) When *inpatient care* is approved by *Blue Cross and Blue Shield*, this health plan provides coverage until you reach your *benefit limit*. Your Schedule of Benefits describes the *benefit limit* that applies for these *covered services*. (Also refer to *riders*—if there are any—that apply to your health plan.) Once you reach this *benefit limit*, no more benefits will be provided by this health plan for these services. (This is the case whether or not the care is *medically necessary*.) This coverage includes: semiprivate *room and board* and *special services* furnished for you by the network skilled nursing facility; and medical care furnished for you by a network physician or by a network nurse practitioner.

## Ambulance Services

This health plan covers ambulance transport. This coverage includes:

- **Emergency Ambulance.** This includes an ambulance that takes you to an emergency medical facility for *emergency medical care*. For example, this may be an ambulance that takes you from an accident scene to the hospital. Or, it may take you from your home to a hospital due to a heart attack. This also means an air ambulance that takes you to a hospital when your emergency medical condition requires that you use an air ambulance rather than a ground ambulance. **If you need help, call 911. Or, call your local emergency phone number.**
- **Other Ambulance.** This includes *medically necessary* transport by a network ambulance. For example, this may be an ambulance that is required to take you to or from the nearest hospital (or other covered facility) to receive care. This also includes an ambulance that is needed for a *mental condition*.

No benefits are provided: for taxi service; or to transport you to or from your medical appointments.

## Cardiac Rehabilitation

This health plan covers *outpatient* cardiac rehabilitation when it is furnished for you by a *network provider*. You will be covered for as many visits as are *medically necessary* for your condition. Your first visit must be within 26 weeks of the date that you were first diagnosed with cardiovascular disease. Or, you must start within 26 weeks after you have had a cardiac event. *Blue Cross and*

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**IMPORTANT:** Refer to your Schedule of Benefits for the cost that you must pay for *covered services* and for any *benefit limit* that may apply to a specific *covered service*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by this health plan for those services or supplies.

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*Blue Shield* must determine through medical documentation that you meet one of these conditions: you have cardiovascular disease or angina pectoris; or you have had a myocardial infarction, angioplasty or cardiovascular surgery. (This type of surgery includes: a heart transplant; or coronary bypass graft surgery; or valve repair or replacement.) For angina pectoris, this health plan covers only one course of cardiac rehabilitation for each *member*.

No benefits are provided for: club membership fees (except when it is covered by this health plan as a fitness benefit); counseling services that are not part of your cardiac rehabilitation program (for example, this may be educational, vocational or psychosocial counseling); medical or exercise equipment that you use in your home; services that are provided to your family; and additional services that you receive after you complete a cardiac rehabilitation program.

## Chiropractor Services

This health plan covers *outpatient* chiropractic services when they are furnished for you by a network chiropractor who is licensed to furnish the specific *covered service*. This coverage includes: *diagnostic lab tests* (such as blood tests); diagnostic x-rays, other than magnetic resonance imaging (MRI), computerized axial tomography (CT scans) and other imaging tests; and *outpatient* medical care services, including spinal manipulation. **Your Schedule of Benefits describes the *benefit limit*, if any, that applies to services by a chiropractor.** Once you reach the *benefit limit*, no more benefits will be provided by this health plan for these services.

## Dialysis Services

This health plan covers *outpatient* dialysis when it is furnished for you by a network hospital; or by a network community health center; or by a network free-standing dialysis facility; or by a network physician. Your coverage also includes home dialysis when it is furnished under the direction of a *network provider*. Your home dialysis coverage includes: non-durable medical supplies (such as dialysis membrane and solution, tubing and drugs that are needed during dialysis); the cost to install the dialysis equipment in your home; and the cost to maintain or fix the dialysis equipment. *Blue Cross and Blue Shield* will decide whether to rent or to buy the dialysis equipment. If the dialysis equipment is bought, this health plan keeps ownership rights to it. It does not become your property. No home dialysis benefits are provided for: costs to get or supply power, water or waste disposal systems; costs of a person to help with the dialysis procedure; and costs that are not needed to run the dialysis equipment.

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**IMPORTANT:** Refer to your Schedule of Benefits for the cost that you must pay for *covered services* and for any *benefit limit* that may apply to a specific *covered service*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by this health plan for those services or supplies.

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## Durable Medical Equipment

This health plan covers durable medical equipment that you buy or rent from a network appliance company or another provider who is designated by *Blue Cross and Blue Shield* to furnish the specific covered appliance. **Your Schedule of Benefits describes the *benefit limit* that applies for these *covered services*.** (Also refer to *riders*—if there are any—that apply to your health plan.) Once you reach the *benefit limit*, no more benefits will be provided by this health plan for these services. (The *benefit limit* does not apply when durable medical equipment is furnished as part of covered home dialysis, home health care or hospice services.)

This coverage is provided for equipment that: can stand repeated use; serves a medical purpose; is *medically necessary* for you; is not useful if you are not ill or injured; and can be used in the home. Some examples of covered durable medical equipment include (but are not limited to):

- Knee braces; and back braces.
- Orthopedic and corrective shoes that are part of a leg brace.
- Hospital beds; wheelchairs; crutches; and walkers.
- Glucometers. These are covered when the device is *medically necessary* for you due to your type of diabetic condition.
- Visual magnifying aids; and voice-synthesizers. These are covered only for a legally blind *member* who has insulin dependent, insulin using, gestational or non-insulin dependent diabetes.
- Insulin injection pens. (When your health plan includes pharmacy coverage, your benefits for these items when you buy them from a pharmacy are provided as a pharmacy benefit. See page 66.)

From time to time, the equipment that is covered by this health plan may change. This change will be based on *Blue Cross and Blue Shield's* periodic review of its medical policy and *medical technology assessment guidelines* to reflect new applications and technologies. You may call the *Blue Cross and Blue Shield* customer service office for help. (See Part 1.)

*Blue Cross and Blue Shield* will decide whether to rent or buy the durable medical equipment. If *Blue Cross and Blue Shield* decides to rent the equipment, your benefits will not be more than the amount that would have been covered if the equipment were bought. This health plan provides coverage for the least expensive equipment of its type that meets your needs. If *Blue Cross and Blue Shield* determines that you chose durable medical equipment that costs more than what you need for your medical condition, this health plan will provide coverage **only** for those costs that would have been paid for the least expensive equipment that meets your needs. In this case, you must pay all of the health care provider's charges that are more than the claim payment.

## Early Intervention Services

This health plan covers early intervention services when they are furnished by a network early intervention provider for an enrolled child from birth through age two. (This means until the child

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turns three years old.) This coverage includes *medically necessary*: physical, speech/language and occupational therapy; nursing care; and psychological counseling. **This health plan limits this coverage to \$5,200 for each eligible child in each calendar year. But, no more than \$15,600 will be paid by this health plan during the whole time that the child is eligible for these services.** Once an eligible child reaches the *benefit limit*, no more benefits will be provided by this health plan for these services.

## Emergency Medical Outpatient Services

This health plan covers *emergency medical care* and *urgent care* that you receive at an emergency room of a general hospital. (See Part 3.) **At the onset of an emergency medical condition that (in your judgment) requires *emergency medical care*, you should go to the nearest emergency room. If you need help, call 911. Or, call your local emergency phone number.** This health plan also covers *emergency medical care* and *urgent care* that you receive outside of the *service area* when your care is furnished for you by a hospital outpatient department; or by a community health center; or by a physician; or by a dentist; or by a nurse practitioner.

## Home Health Care

This health plan covers home health care when it is furnished (or arranged and billed) for you by a network home health care provider. This coverage is provided only when: you are expected to reach a defined medical goal that is set by your attending physician; and, for medical reasons, you are not reasonably able to travel to another treatment site where medically appropriate care can be furnished for your condition. This coverage includes:

- Part-time skilled nursing visits; physical, speech/language and occupational therapy; medical social work; nutrition counseling; home health aide services; medical supplies; durable medical equipment; enteral infusion therapy; and basic hydration therapy.
- Home infusion therapy that is furnished for you by a network home infusion therapy provider. This includes: the infusion solution; the preparation of the solution; the equipment for its administration; and necessary part-time nursing.

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

**No benefits** are provided for: meals, personal comfort items and housekeeping services; *custodial care*; treatment of *mental conditions*; and home infusion therapy, including the infusion solution, when it is furnished by a pharmacy or other health care provider that is not a home infusion therapy provider. (The only exception is for enteral infusion therapy and basic hydration therapy that is furnished by a home health care provider.)

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## Hospice Services

This health plan covers hospice services that are furnished by (or arranged and billed by) a network hospice provider. “Hospice services” means pain control and symptom relief and supportive and other care for a *member* who is terminally ill (the patient is expected to live six months or less). These services are furnished to meet the needs of the *member* and of his or her family during the illness and death of the *member*. These services may be furnished at home, in the community and in facilities. This hospice coverage includes:

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

## Infertility Services

This health plan covers services to diagnose and treat infertility. This coverage is provided for a healthy *member* who has not been able to conceive or produce conception during a period of one year. All of these services must be furnished according to *Blue Cross and Blue Shield* medical policy and *medical technology assessment guidelines*. This coverage includes:

- Artificial insemination.
- Sperm and egg and/or inseminated egg procurement and processing.
- Banking of sperm or inseminated eggs. (This health plan covers these charges only when they are not covered by the donor’s health care plan.)
- Infertility technologies. These include: in vitro fertilization; gamete intrafallopian transfer; zygote intrafallopian transfer; natural oocyte retrieval intravaginal fertilization; intracytoplasmic sperm injection; and assisted embryo hatching.

All services must be approved as *medically necessary* by *Blue Cross and Blue Shield*. And, they must be furnished by an infertility provider that has been approved by *Blue Cross and Blue Shield*. Otherwise, no benefits will be provided by this health plan.

No benefits are provided for: long term sperm or egg preservation or long term cryopreservation not associated with active infertility treatment; costs that are associated with achieving pregnancy through surrogacy (gestational carrier); and infertility treatment that is needed as a result of a prior sterilization or unsuccessful sterilization reversal procedure. (This health plan will provide coverage for *medically necessary* infertility treatment that is needed after a sterilization reversal procedure that is successful as determined by appropriate diagnostic tests.)

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## Lab Tests, X-Rays and Other Tests

This health plan covers *outpatient* diagnostic tests when they are furnished for you by a *network provider*. (This may include a network nurse practitioner.) This coverage includes:

- *Diagnostic lab tests*. These tests also include diagnostic machine tests such as pulmonary function tests and holter monitoring.
- *Diagnostic x-ray and other imaging tests*.
- Preoperative tests. These tests must be performed before a scheduled *inpatient* or surgical day care unit admission for surgery. And, they must not be repeated during the admission. These tests include: *diagnostic lab tests*; *diagnostic x-ray and other imaging tests*; and diagnostic machine tests (such as pulmonary function tests).
- Human leukocyte antigen testing or histocompatibility locus antigen testing that is furnished to a *member* by a *network provider*. These tests are necessary to establish stem cell (“bone marrow”) transplant donor suitability. They include testing for A, B or DR antigens or any combination.

## Maternity Services and Well Newborn Inpatient Care

### Maternity Services

This health plan covers all medical care that is related to pregnancy and childbirth (or miscarriage) when it is furnished for you by a covered health care provider. This coverage is provided for any female *member*. This coverage includes:

- Semiprivate *room and board* and *special services* when the enrolled mother is an *inpatient* in a network general hospital. Nursery charges for a well newborn are included with the benefits for the mother’s maternity admission. The mother’s (and newborn child’s) *inpatient* stay will be no less than 48 hours following a vaginal delivery or 96 hours following a Caesarian section unless the mother and her attending physician decide otherwise as provided by law. If the mother chooses to be discharged earlier, this health plan covers one home visit within 48 hours of discharge, when it is furnished by a network physician; or by a network registered nurse; or by a network nurse midwife; or by a network nurse practitioner. This visit may include: parent education; assistance and training in breast or bottle feeding; and appropriate tests. This health plan will provide coverage for more visits that are furnished by a *network provider* **only** if *Blue Cross and Blue Shield* determines they are clinically necessary.
- Delivery of one or more than one baby. This includes prenatal and postnatal medical care that is furnished by a network physician; or by a network nurse midwife. Your benefits for prenatal and postnatal medical care that is furnished by a network physician or by a network nurse midwife are included in the claim payment for the delivery. The benefits that this health plan provides for these services will be those that are in effect on the date of delivery. When a network physician or a network nurse midwife furnishes only prenatal and/or postnatal care, benefits for those services are based on the date the care is received.

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This health plan also covers prenatal and postnatal medical care exams and lab tests when they are furnished for you by a network general hospital; or by a network community health center. The benefits that this health plan provides for these services will be those that are in effect on the date the care is received.

- Standby attendance that is furnished by the pediatrician, when a known or suspected complication threatening the health of the mother or the child that requires a network pediatrician be present during the delivery.

All expectant mothers enrolled under this health plan may take part in a program that provides support and education for expectant mothers. Through this program, *members* receive outreach and education that add to the care the *member* gets from her network obstetrician or network nurse midwife. You may call the *Blue Cross and Blue Shield* customer service office for more information.

### Well Newborn Inpatient Care

This health plan covers well newborn care when it is furnished during the enrolled mother's *inpatient* maternity stay. This coverage includes:

- Pediatric care that is furnished for a well newborn by a network physician (who is a pediatrician); or by a network nurse practitioner. (These visits are counted toward any *benefit limit* that may apply for subsequent *outpatient* visits for routine pediatric care that is received during the child's first year of life.)
- Routine circumcision that is furnished by a network physician.
- Newborn hearing screening tests that are performed by a *network provider* before the newborn child (an infant under three months of age) is discharged from the hospital to the care of the parent or guardian.

(See "Admissions for Inpatient Medical and Surgical Care" for your coverage when an enrolled newborn child requires *medically necessary inpatient* care.)

### Medical Care Outpatient Visits

This health plan covers *outpatient* care to diagnose or treat your medical condition when your services are furnished by your MIT Medical PCP or, when arranged by your PCP, furnished for you by another *network provider*. (This may include: a network nurse practitioner; or a network nurse midwife; or a network optometrist; or a network licensed dietitian nutritionist.) This coverage includes:

- Medical care to diagnose or treat your illness or injury. This includes nutrition counseling.

**Women's Health and Cancer Rights:** As required by federal law, this coverage includes medical care services to treat physical complications at all stages of mastectomy, including lymphedemas and breast reconstruction in connection with a mastectomy. These services will be furnished in a manner determined in consultation with the attending physician and the patient.

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- Medical exams and contact lenses that are needed to treat keratoconus. (This includes the cost of the fitting of these contact lenses.)
- Hormone replacement therapy for peri- and post-menopausal women.
- Follow-up care that is related to an accidental injury or an emergency medical condition.
- Allergy testing. (This includes tests that you need such as PRIST, RAST and scratch tests.)
- Injections. (This includes injections that you need such as allergy shots.)
- Syringes and needles that are *medically necessary* for you. (Your benefits for these items when you buy them from a pharmacy are provided as a pharmacy benefit. See page 66.)
- Diabetes self-management training and education, including medical nutrition therapy, when it is provided by a certified diabetes health care professional who is a covered provider or who is affiliated with a covered health care provider.
- Pediatric specialty care that is furnished for you by a *network provider* who has a recognized expertise in specialty pediatrics.
- Non-dental services that are furnished for you by a network dentist. This coverage is provided only if the services would normally be covered when they are furnished for you by a physician. (See Part 6, “Dental Care.”)
- Monitoring and medication management for *members* taking psychiatric drugs. This also includes neuropsychological assessment services. (These services may also be furnished by a *network mental health provider*.) These visits are included in the annual *benefit limit* for mental health and substance abuse treatment.

## Medical Formulas

This health plan covers medical formulas and foods as described below:

- Special medical formulas that are *medically necessary* for you to treat one of the listed conditions: homocystinuria; maple syrup urine disease; phenylketonuria; propionic acidemia; methylmalonic acidemia; or tyrosinemia.
- Enteral formulas that you need to use at home. These must be *medically necessary* for you to treat malabsorption caused by one of the listed conditions: Crohn’s disease; chronic intestinal pseudo-obstruction; gastroesophageal reflux; gastrointestinal motility; ulcerative colitis; or inherited diseases of amino acids and organic acids.
- Food products that are modified to be low protein. These foods must be *medically necessary* for you to treat inherited diseases of amino acids and organic acids. (You may buy these food products directly from a distributor.) **This health plan limits this coverage to \$2,500 for each member in each calendar year.** Once you reach the *benefit limit*, no more benefits will be provided by this health plan for these services.

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## Mental Health and Substance Abuse Treatment

This health plan covers *medically necessary* services to diagnose and/or treat *mental conditions*. This includes drug addiction and alcoholism. This coverage is provided for:

- Biologically-based *mental conditions*. “Biologically-based mental conditions” means:
  - schizophrenia;
  - schizoaffective disorder;
  - major depressive disorder;
  - bipolar disorder;
  - paranoia and other psychotic disorders;
  - obsessive-compulsive disorder;
  - panic disorder;
  - delirium and dementia;
  - affective disorders; and
  - any biologically-based *mental conditions* that appear in the most recent edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders and are scientifically recognized and approved by the Commissioner of the Department of Mental Health in consultation with the Commissioner of the Division of Insurance.
- Rape-related mental or emotional disorders for victims of a rape or victims of an assault with intent to rape.
- All other non-biologically-based *mental conditions* not described above. (This includes drug addiction and alcoholism.)

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

## Inpatient Services

This health plan covers admissions in a network general or mental hospital or network substance abuse treatment facility. This coverage is limited to 60 days for each *member* in each calendar year when the admission is in a mental hospital or substance abuse treatment facility. (An additional 30 days each calendar year is available for treatment of alcoholism.) Once you reach the *benefit limit*, no more benefits will be provided by this health plan for these services. This coverage includes: semiprivate *room and board*; facility *special services*; and psychiatric care furnished by a network physician (who is a specialist in psychiatry) or by a network psychologist or by a network clinical specialist in psychiatric and mental health nursing.

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All services must be approved in advance by *Blue Cross and Blue Shield*. During the pre-approval process (see Part 4), *Blue Cross and Blue Shield* will assess the *member's* specific mental health needs. The least intensive type of setting that is required for the *member's* condition will be approved by *Blue Cross and Blue Shield*. There are times when a *member* will require *covered services* that are more intensive than the typical *outpatient* services. But, these services may not require that the *member* be admitted for 24-hour hospital care. These intermediate mental health care services that may be approved by *Blue Cross and Blue Shield* include (but are not limited to): acute residential treatment; partial hospital programs; or intensive outpatient programs. *Blue Cross and Blue Shield* will arrange for treatment with the appropriate *mental health provider*.

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

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

(Since *Blue Cross and Blue Shield* considers coverage for these intermediate mental health care services to be an *inpatient* benefit, any *benefit limits* or *member* cost sharing for *outpatient* mental health services will **not** apply.)

### Outpatient Services

This health plan covers *outpatient* services when they are furnished for you by a *network* or non-network *mental health provider*. For *mental conditions* including substance abuse, this coverage is limited to 50 visits for each *member* in each calendar year. These *benefit limits* do not apply to electric shock therapy. Once you reach the *benefit limit* (if it applies), no more benefits will be provided by this health plan for these services.

<p><b>Member responsibility for mental health services</b></p>	<p><i>Covered services</i> provided by <i>Network Mental Health Providers</i> are covered in full, less a \$20 <i>member copayment</i>, up to the combined <i>benefit limit</i>. <i>Covered services</i> provided by a non-Network provider are covered up to a maximum of \$60 per visit, up to the combined <i>benefit limit</i>. The <i>member</i> is responsible for the difference between the <i>Blue Cross and Blue Shield</i> payment and the provider's charge.</p>
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## Oxygen and Respiratory Therapy

This health plan covers:

- Oxygen and the equipment to administer it for use in the home. These items must be obtained from a network oxygen supplier. This includes oxygen concentrators.
- Respiratory therapy services. These services must be furnished for you by a network general, chronic disease or rehabilitation hospital; or by a network community health center. Some examples include postural drainage and chest percussion.

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## Pharmacy Services and Supplies

This health plan covers certain drugs and supplies that you buy from a network pharmacy. This coverage is provided **only** when all of the following criteria are met.

- The drug or supply that you buy is listed on the *Blue Cross and Blue Shield Drug Formulary* as a covered drug or supply.
- The drug or supply that you buy is prescribed for your use out of the hospital or another health care facility.
- The drug or supply that you buy is purchased from a network pharmacy that is approved by *Blue Cross and Blue Shield* for payment for the specific covered drug and/or supply. This means that for most covered drugs and supplies, you may buy your drug or supply from any network retail pharmacy. However, for a select number of covered drugs and supplies, you may need to buy your drug or supply from certain network pharmacies that specialize in treating specific diseases and that have been approved by *Blue Cross and Blue Shield* for payment for that specific covered drug or supply.

**Drug Formulary.** The *Blue Cross and Blue Shield Drug Formulary* is a list of *Blue Cross and Blue Shield* approved drugs and supplies. Under its agreement with the *plan sponsor*, *Blue Cross and Blue Shield* has the right to update its Drug Formulary from time to time. In this case, your coverage for certain drugs and supplies may change. For example, a drug may be added to or excluded from the Drug Formulary; or a drug may change from one *member* cost-share level to another *member* cost-share level. For the list of drugs that are not included on the *Blue Cross and Blue Shield Drug Formulary*, you may access this information on-line at <http://www.bluecrossma.com/pharmacy>. You may check for updates or obtain more information about the *Blue Cross and Blue Shield Drug Formulary*, including which drugs are not included on the formulary, by calling the *Blue Cross and Blue Shield* customer service office. The toll-free phone number is shown on the back of your health plan ID card. You may also go online and log on to the *Blue Cross and Blue Shield* internet website at [www.bluecrossma.com](http://www.bluecrossma.com).

**Drug Formulary Exception Process.** Prescriptions for non-formulary medications must be obtained through the MIT Pharmacy. The MIT Pharmacy will obtain the medication from another pharmacy. Medications obtained in this manner will be subject to the MIT Pharmacy *copayment* amount. *Blue Cross and Blue Shield* also includes a Drug Formulary Exception Process for medications obtained from a *network pharmacy*. This process allows your prescribing health care provider to ask for an exception from *Blue Cross and Blue Shield*. This exception is to ask for coverage for a drug (or supply) that is not on the *Blue Cross and Blue Shield Drug Formulary*. *Blue Cross and Blue Shield* will consider a Drug Formulary exception request if there is a medical basis for your not being able to take, for your condition, any of the covered drugs or an over-the-counter drug. If the Drug Formulary exception request is approved by *Blue Cross and Blue Shield*, you will receive coverage for the drug (or supply) that is not on the *Blue Cross and Blue Shield Drug Formulary*. For this drug (or supply), you will pay the highest *member* cost-share amount.

**Buying Covered Drugs and Supplies.** For questions regarding your pharmacy coverage contact Claims and Member Services at 617-253-5979. For help to obtain your pharmacy coverage at

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a Network pharmacy, you may call the *Blue Cross and Blue Shield* customer service office. The toll-free phone number is shown on the back of your health plan ID card. A *Blue Cross and Blue Shield* customer service representative can help you find a pharmacy where you may buy a specific drug or supply. They can also help you find out which *member* cost-share level you will pay for a specific covered drug or supply. Or, you may also go online and log on to the *Blue Cross and Blue Shield* internet website at [www.bluecrossma.com](http://www.bluecrossma.com).

		MIT Pharmacy copay and limitations	Express Scripts copay and limitations
<b>Pharmacy Benefits:</b> Members can choose to obtain their prescription medications through the MIT Pharmacy or from a network pharmacy. There are benefit differences and may be differences in the Formulary.	Tier 1 copay	\$8/ up to a 30-day supply	\$15/ up to a 30-day supply
	Tier 2 copay	\$25/ up to a 30-day supply	\$40/ up to a 30-day supply
	Tier 3 copay	\$40/ up to a 30-day supply	\$50/ up to a 30-day supply
	Supply limit	For many drugs, up to a 90-day supply for double the 30-day copayment	Limited to a 30-day supply per fill
	Prescribing physician	Prescription must be written by an MIT clinician or by a provider to whom member was referred by an MIT clinician	No restrictions
	Mental health prescriptions	Member must notify MIT Medical, so a referral can be entered before prescription can be filled	No restrictions
	Mail order	Available through MIT Pharmacy; request can be submitted through Patient Online.	Not available
	NOTE: Health Plan members must fill all prescriptions at the MIT Pharmacy or a participating Express Scripts pharmacy. There is no reimbursement for prescriptions filled at a non-participating pharmacy.		

(When you buy your drug or supply, the pharmacist will give you a generic equivalent of the prescribed drug whenever it is allowed.)

**Covered Drugs and Supplies.** This pharmacy coverage is provided for:

- Drugs that require a prescription by law and are furnished in accordance with *Blue Cross and Blue Shield medical technology assessment guidelines*. These include: birth control drugs; oral diabetes medication that influences blood sugar levels; hormone replacement therapy drugs for peri- and post-menopausal women; and certain drugs used on an off-label basis (such as: drugs used to treat cancer; and drugs used to treat HIV/AIDS).
- Injectable insulin and disposable syringes and needles needed for its administration,

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whether or not a prescription is required. (When a *copayment* applies to your pharmacy coverage, if insulin, syringes and needles are bought at the same time, you pay two *copayments*: one for the insulin; and one for the syringes and needles.)

- Materials to test for the presence of sugar when they are ordered for you by a physician for home use. These include: blood glucose monitoring strips; ketone strips; lancets; urine glucose testing strips; normal, low and high calibrator solution/chips; and dextrostik or glucose test strips. (See “Durable Medical Equipment” for your coverage for glucometers.)
- Insulin injection pens.
- Insulin infusion pumps and related pump supplies. (You will obtain the insulin infusion pump from an appliance company instead of a pharmacy. For the insulin infusion pump itself, the cost you would normally pay for covered drugs and supplies will be waived.)
- Syringes and needles that are *medically necessary* for you.
- Drugs that do not require a prescription by law (“over-the-counter” drugs), if any, that are listed on the *Blue Cross and Blue Shield* Drug Formulary as a covered drug. Your Pharmacy Program booklet will list the over-the-counter drugs that are covered, if there are any. Or, you may go online and log on to the *Blue Cross and Blue Shield* internet website at [www.bluecrossma.com](http://www.bluecrossma.com).
- Diaphragms and other prescription birth control devices that have been approved by the U.S. Food and Drug Administration (FDA). For these, you pay the cost of the lowest *member* cost-share level.
- Prescription prenatal vitamins and pediatric vitamins with fluoride.
- Nicotine gum or nicotine patches (or other smoking cessation aids that require a prescription by law) when they are prescribed by a physician. **This health plan limits this coverage to three 30-day supply for each *member* in each calendar year.**

**Non-Covered Drugs and Supplies.** No pharmacy benefits are provided for:

- Anorexiant.
- Pharmaceuticals that you can buy without a prescription, except as described above.
- Medical supplies such as dressings and antiseptics.
- The cost of delivering drugs to you.
- Combination vitamins that require a prescription, except for: prescription prenatal vitamins; and pediatric vitamins with fluoride.
- Dental topical fluoride, rinses and gels that require a prescription.
- Immunizing agents; toxoids; blood; and blood products.
- Drugs and supplies that you buy from a non-network retail pharmacy. The only exception is when you are traveling outside of the *service area* and a network retail pharmacy is not reasonably available to you. In this case, you may fill your prescription at any retail pharmacy. But, you must pay all charges at the time you buy your drug. Then, you should

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call the *Blue Cross and Blue Shield* customer service office for a claim form to file your claim. *Blue Cross and Blue Shield* will repay you, less the amount you would normally pay for covered drugs and supplies.

- Drugs and supplies that you buy from a non-designated mail service pharmacy.
- Drugs and supplies that you buy from a pharmacy that has not been approved by *Blue Cross and Blue Shield* for payment for the specific covered drug or supply.
- Non-sedating antihistamines.
- Drugs and supplies that are dispensed or administered by health care providers, when they are supplied by the provider during the visit. This includes health care providers such as: physician assistants; home health care providers; and visiting nurses.

## Podiatry Care

This health plan covers non-routine podiatry (foot) care when it is furnished for you by a network general hospital; or by a network surgical day care unit; or by a network ambulatory surgical facility; or by a network community health center; or by a network physician; or by a network podiatrist. This coverage includes:

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

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

## Preventive Health Services

### **Routine Pediatric Care – Covered at MIT Medical ONLY (except for children under the age of 6 who may be seen by any Network Provider)**

This health plan covers routine pediatric care that the PCP decides is suitable for a *member* from birth through age 18. This coverage is provided for at least: six visits during the first year of life (birth to age one, including *inpatient* visits for a well newborn); three visits during the second year of life (age one to age two); and one visit in each calendar year from age two through age five (until age 6). This coverage includes:

- Routine medical exams; history; measurements; sensory (vision and auditory) screening; and neuropsychiatric evaluation and development screening and assessment.

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**IMPORTANT:** Refer to your Schedule of Benefits for the cost that you must pay for *covered services* and for any *benefit limit* that may apply to a specific *covered service*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by this health plan for those services or supplies.

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- Hereditary and metabolic screening at birth.
- Appropriate immunizations. (This includes: flu shots; and travel immunizations.)
- Tuberculin tests; hematocrit, hemoglobin and other appropriate blood tests; urinalysis; and blood tests to screen for lead poisoning.
- Other related routine services that are furnished in line with *Blue Cross and Blue Shield* medical policy guidelines.

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

### **Routine Adult Physical Exams and Tests – Covered at MIT Medical ONLY**

This health plan covers routine physical exams (including related lab tests and x-rays) that your MIT Medical physician (or your nurse practitioner) decides are suitable for a *member* who is age 19 or older. This coverage includes:

- Routine medical exams and related routine lab tests and x-rays that are furnished in line with *Blue Cross and Blue Shield* medical policy guidelines.
- Routine mammograms. (This includes at least one baseline mammogram during the five-year period a *member* is age 35 through 39; and a routine mammogram once in each calendar year for a *member* who is age 40 or older.)
- Blood tests to screen for lead poisoning.
- Immunizations. (This includes: flu shots; and travel immunizations.)
- Routine prostate-specific antigen (PSA) blood tests (at least once in each calendar year for a *member* who is age 40 or older).
- Routine sigmoidoscopies and barium enemas (at least once every three calendar years for a *member* who is age 50 or older).
- Routine colonoscopies (at least once every ten calendar years for a *member* who is age 50 or older).

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

### **Routine Gynecological (GYN) Exams**

This health plan covers one routine GYN exam, including one routine Pap smear test, for each *member* in each calendar year. These services must be furnished for you by a network physician; or by a network nurse practitioner; or by a network nurse midwife. You do not need a referral from your PCP (or a prior approval from *Blue Cross and Blue Shield*) before you obtain these *covered services*, or gynecological services and other women's health services that you obtain from a network obstetrician or a network gynecologist or a network nurse midwife or a network family

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**IMPORTANT:** Refer to your Schedule of Benefits for the cost that you must pay for *covered services* and for any *benefit limit* that may apply to a specific *covered service*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by this health plan for those services or supplies.

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practitioner. This includes *medically necessary* services that are required as a result of your annual routine GYN exam and evaluations. It also includes health care services that result from acute or emergency gynecological conditions. But remember, prior approval is required for *inpatient* admissions.

### **Family Planning – Covered at MIT Medical ONLY**

This health plan covers family planning services when they are furnished for you by a *network provider*. (This may include: a network nurse practitioner; or a network nurse midwife.) This coverage includes: medical exams; and genetic counseling.

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

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

### **Routine Hearing Exams and Tests – Covered at MIT Medical ONLY**

This health plan covers:

- Routine hearing exams. This includes hearing tests that are part of the covered hearing exam. These services must be furnished for you by a *network provider*.
- Newborn hearing screening tests for a newborn child (an infant under three months of age) when they are furnished by a *network provider*. (See “Maternity Services and Well Newborn Inpatient Care” for your *inpatient* coverage.)

### **Routine Vision Exams – Covered at MIT Medical ONLY**

This health plan covers a routine vision exam when it is furnished for you by a network ophthalmologist; or by a network optometrist. **Your Schedule of Benefits describes the *benefit limit* that applies for routine vision exams.** (Also refer to *riders*—if there are any—that apply to your health plan.) Once you reach the *benefit limit*, no more benefits will be provided by this health plan for these services during the same time frame.

No benefits are provided for eyeglasses and contact lenses (except as otherwise described in this benefit booklet).

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**IMPORTANT:** Refer to your Schedule of Benefits for the cost that you must pay for *covered services* and for any *benefit limit* that may apply to a specific *covered service*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by this health plan for those services or supplies.

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### Wellness Benefits

While you are enrolled in this health plan, you may be reimbursed for some fees that you pay to participate in fitness programs and/or weight loss programs. (Any *deductible*, *copayment* and *out-of-pocket maximum* provisions do not apply to these wellness benefits.)

- **Fitness Benefit.** This health plan will provide up to a total of \$150 in each calendar year to reimburse you for fees paid for an approved health club membership or for fitness classes at an approved health club. You can claim this maximum fitness benefit of \$150 for any combination of fees incurred by the *subscriber*, the enrolled spouse (or former spouse, if it applies) and enrolled dependents. However, this \$150 benefit is the total fitness benefit that is reimbursed during a calendar year for all *members* enrolled under the same health plan membership. (For a health club membership, each *member* claiming all or part of the fitness benefit must have paid at least four months' health club fees for that calendar year.) You are eligible for the fitness benefit for fees paid to: privately-owned or privately-sponsored health clubs or fitness facilities, including individual health clubs and fitness centers; YMCAs; YWCAs; Jewish Community Centers; and municipal fitness centers.

No **fitness benefit** is provided for any fees or costs that you pay for: country clubs; social clubs (such as ski or hiking clubs); sports teams or leagues; spas; instructional dance studios; and martial arts schools.

- **Weight Loss Program Benefit.** For each health plan membership, this health plan will provide up to a total of \$150 in each calendar year to reimburse you for fees paid for hospital-based weight loss programs or for non-hospital-based weight loss programs designated by *Blue Cross and Blue Shield*. You can claim this maximum weight loss program benefit of \$150 for any combination of fees incurred by the *subscriber*, the enrolled spouse (or former spouse, if it applies) and enrolled dependents. However, this \$150 benefit is the total weight loss program benefit that is reimbursed during a calendar year for all *members* enrolled under the same health plan membership. To find out which weight loss program(s) are designated by *Blue Cross and Blue Shield*, you may log on to the *Blue Cross and Blue Shield* internet website at [www.bluecross.ma.com](http://www.bluecross.ma.com). Or, you may call the *Blue Cross and Blue Shield* customer service office. The toll-free phone number is shown on your health plan ID card.

No **weight loss program benefit** is provided for any fees or costs that you pay for: online weight loss programs; any non-hospital-based weight loss program not designated by *Blue Cross and Blue Shield*; individual nutrition counseling sessions (see "Medical Care Out-patient Visits" for your coverage for nutritional counseling); pre-packaged meals, books, videos, scales or other items or supplies bought by the member; and any other items not included as part of a weight loss class or weight loss course.

To receive your fitness benefit or your weight loss program benefit, you must file a claim no later than March 31st after the year for which you are claiming your benefit. The date on which you file a claim will be considered the "incurred date," unless your claim is for eligible expenses for the prior calendar year. In that case, the incurred date will be shown as December 31st of that

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**IMPORTANT:** Refer to your Schedule of Benefits for the cost that you must pay for *covered services* and for any *benefit limit* that may apply to a specific *covered service*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by this health plan for those services or supplies.

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prior year. This means that the incurred date reflects the calendar year for which you are claiming your benefit. To file a claim, you must: fill out a claim form; attach your original itemized paid receipt(s); and mail the claim to *Blue Cross and Blue Shield*. For a claim form or help to file a claim, you may call the *Blue Cross and Blue Shield* customer service office. Or, you may log on to the *Blue Cross and Blue Shield* internet website at [www.bluecrossma.com](http://www.bluecrossma.com) for help or to print a claim form.

## Prosthetic Devices

This health plan covers prosthetic devices that you get from a network appliance company, or from another provider who is designated by *Blue Cross and Blue Shield* to furnish the covered prosthetic device. This coverage is provided for devices that are: used to replace the function of a missing body part; made to be fitted to your body as an external substitute; and not useful when you are not ill or injured. Some examples of prosthetic devices include (but are not limited to):

- Artificial limb devices to replace (in whole or in part) an arm or a leg. This includes any repairs that are needed for the artificial leg or arm.
- Artificial eyes.
- Ostomy supplies; and urinary catheters.
- Breast prostheses. This includes mastectomy bras.
- Insulin infusion pumps and related pump supplies that are *medically necessary* for *members* with insulin dependent diabetes. (When your health plan includes pharmacy coverage, your benefits for these items are provided as a pharmacy benefit. See page 66.)
- Therapeutic/molded shoes and shoe inserts that are furnished for a *member* with severe diabetic foot disease.
- Scalp hair prostheses (wigs). This coverage is provided only when hair loss is due to: chemotherapy; radiation therapy; infections; burns; traumatic injury; congenital baldness; and medical conditions resulting in alopecia areata or alopecia totalis (capitus). No benefits are provided for wigs when hair loss is due to: male pattern baldness; female pattern baldness; or natural or premature aging.

This health plan provides this coverage for the most appropriate *medically necessary* model that meets your medical needs. This means that if *Blue Cross and Blue Shield* determines that you chose a model that costs more than what you need for your medical condition, this health plan will provide benefits **only** for those charges that would have been paid for the most appropriate *medically necessary* model that meets your medical needs. In this case, you must pay all of the provider's charges that are more than the claim payment.

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**IMPORTANT:** Refer to your Schedule of Benefits for the cost that you must pay for *covered services* and for any *benefit limit* that may apply to a specific *covered service*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by this health plan for those services or supplies.

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## Qualified Clinical Trials for Treatment of Cancer

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

No benefits are provided for:

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

## Radiation Therapy and Chemotherapy

This health plan covers *outpatient* radiation and x-ray therapy and chemotherapy when it is furnished for you by a *network provider*. (This may include: a network nurse practitioner; or a *network provider* who has a recognized expertise in specialty pediatrics.) This coverage includes:

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

## Second Opinions

This health plan covers an *outpatient* second opinion about your medical care when it is furnished for you by a network physician. This coverage includes a third opinion when the second opinion differs from the first. Remember, as with other medical visits, your PCP must refer you to a network physician for these services. (See “Lab Tests, X-Rays and Other Tests” for your coverage for related diagnostic tests.)

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**IMPORTANT:** Refer to your Schedule of Benefits for the cost that you must pay for *covered services* and for any *benefit limit* that may apply to a specific *covered service*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by this health plan for those services or supplies.

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## Short-Term Rehabilitation Therapy

This health plan covers *medically necessary outpatient* short-term rehabilitation therapy when it is furnished for you by a *network provider*. (This may include a *network provider* who has a recognized expertise in specialty pediatrics.) This coverage includes: physical therapy; speech/language therapy; occupational therapy; or an organized program of these combined services. **Your Schedule of Benefits describes the *benefit limit*, if any, that applies to short-term rehabilitation therapy.** (Also refer to *riders*—if there are any—that apply to your health plan.) Once you reach the *benefit limit*, no more benefits will be provided by this health plan for these services. (The *benefit limit* does not apply when these services are furnished as part of a covered home health care program; or to diagnose and treat speech, hearing and language disorders.)

## Speech, Hearing and Language Disorder Treatment

This health plan covers *medically necessary* services to diagnose and treat speech, hearing and language disorders when the services are furnished for you by a *network provider*. (This may include: a *network provider* who has a recognized expertise in specialty pediatrics.) This coverage includes: diagnostic tests, including hearing exams and tests; speech/language therapy; and medical care to diagnose or treat speech, hearing and language disorders.

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

## Surgery as an Outpatient

This health plan covers *outpatient* surgical services when they are furnished for you by a *network provider*. (This may include: a network nurse practitioner; or a *network provider* who has a recognized expertise in specialty pediatrics.) This coverage includes:

- Routine circumcision; voluntary termination of pregnancy; voluntary sterilization procedures.
- Endoscopic procedures.
- Surgical procedures, including emergency and scheduled surgery. This coverage includes (but is not 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.

**Women's Health and Cancer Rights:** As required by federal law, this coverage includes breast reconstruction in connection with a mastectomy. This health plan provides coverage for: all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas. These services will be furnished in a manner determined in consultation with the attending physician and the patient.

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**IMPORTANT:** Refer to your Schedule of Benefits for the cost that you must pay for *covered services* and for any *benefit limit* that may apply to a specific *covered service*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by this health plan for those services or supplies.

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- **Transplants.** This includes human organ and stem cell (“bone marrow”) transplants that are furnished according to *Blue Cross and Blue Shield* medical policy and *medical technology assessment guidelines*. This includes one or more stem cell transplants for a *member* who has been diagnosed with breast cancer that has spread. For covered transplants, this coverage also includes: the harvesting of the donor’s organ or stem cells when the recipient is a *member*; and drug therapy during the transplant procedure to prevent the transplanted organ/tissue or stem cells from being rejected. (“Harvesting” includes: the surgical removal of the donor’s organ or stem cells; and the related *medically necessary* services and/or tests that are required to perform the transplant itself. No benefits are provided for the harvesting of the donor’s organ or stem cells when the recipient is not a *member*.) See “Lab Tests, X-Rays and Other Tests” for your coverage for donor testing.
- **Oral surgery.** This includes: reduction of a dislocation or fracture of the jaw or facial bone; excision of a benign or malignant tumor of the jaw; and orthognathic surgery that you need to correct a significant functional impairment that cannot be adequately corrected with orthodontic services. This coverage is provided when the surgery is furnished at a network facility, provided that you have a serious medical condition that requires that you be admitted to a network surgical day care unit of a hospital or to a network ambulatory surgical facility in order for the surgery to be safely performed. This coverage is also provided when the surgery is furnished at a network oral surgeon’s office. (Orthognathic surgery is not covered when it is performed mainly for cosmetic reasons. This surgery must be performed along with orthodontic services. If it is not, the oral surgeon must send a letter to *Blue Cross and Blue Shield* asking for approval for the surgery. No benefits are provided for the orthodontic services.)

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

- Non-dental surgery and necessary postoperative care by a network dentist. (See Part 6, “Dental Care.”)
- Necessary postoperative care that you receive after covered *inpatient* or *outpatient* surgery.
- Anesthesia services that are related to covered surgery. This includes anesthesia administered by a network physician other than the attending physician; or by a network certified registered nurse anesthetist.

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**IMPORTANT:** Refer to your Schedule of Benefits for the cost that you must pay for *covered services* and for any *benefit limit* that may apply to a specific *covered service*. Once you reach your *benefit limit* for a specific *covered service*, no more benefits are provided by this health plan for those services or supplies.

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### TMJ Disorder Treatment

This health plan covers *outpatient* services that are furnished for you by a *network provider* to diagnose and/or treat temporomandibular joint (TMJ) disorders that are caused by or result in a specific medical condition (such as degenerative arthritis and jaw fractures or dislocations). The medical condition must be proven to exist by means of diagnostic x-ray tests or other generally accepted diagnostic procedures. This coverage includes:

- Diagnostic x-rays.
- Surgical repair or intervention.
- Non-dental medical care services to diagnose and treat a TMJ disorder.
- Splint therapy. (This also includes measuring, fabricating and adjusting the splint.)
- Physical therapy. (The *benefit limit* for short-term rehabilitation therapy applies for these services. See “Short-Term Rehabilitation Therapy.”)

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

## Part 6

# Limitations and Exclusions

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The coverage described in this benefit booklet is limited or excluded as described in this part. Other limits or restrictions and exclusions on your coverage may be found in Parts 3, 4, 5 and 7. You should be sure to read all of the provisions described in this benefit booklet.

### Admissions That Start Before Effective Date

The coverage that is described in this benefit booklet is provided only for those *covered services* that are furnished on or after your *effective date*. If you are already an *inpatient* in a hospital (or in another covered health care facility) on your *effective date*, you or your health care provider must call *Blue Cross and Blue Shield*. (See Part 4.) This health plan will provide coverage starting on your *effective date* **but only** if *Blue Cross and Blue Shield* is able to coordinate your care. This coverage is subject to all of the provisions described in this benefit booklet.

### Benefits from Other Sources

No benefits are provided for health care services and supplies to treat an illness or injury for which you have the right to benefits under government programs. These include the Veterans Administration for an illness or injury connected to military service. They also include programs set up by other local, state, federal or foreign laws or regulations that provide or pay for health care services and supplies or that require care or treatment to be furnished in a public facility. No benefits are provided by this health plan if you could have received governmental benefits by applying for them on time. This exclusion does not include Medicaid or Medicare. (See Part 7 if you are eligible for Medicare benefits.)

### Blood and Related Fees

No benefits are provided for: whole blood; packed red blood cells; blood donor fees; and blood storage fees.

### Cosmetic Services and Procedures

No benefits are provided for cosmetic services that are performed solely for the purpose of making you look better. This is the case whether or not these services are meant to make you feel better about yourself or to treat your *mental condition*. For example, no coverage is provided for: acne related services such as the removal of acne cysts, injections to raise acne scars, cosmetic surgery and dermabrasion or other procedures to plane the skin; electrolysis; hair removal or restoration (except as described in Part 5 for scalp hair prostheses); and liposuction. (See Part 5 for your coverage for reconstructive surgery.)

## Custodial Care

No benefits are provided for *custodial care*. This type of care may be furnished with or without routine nursing or other medical care and the supervision or care of a physician.

## Dental Care

Except as described otherwise in Part 5, no benefits are provided for treatment that *Blue Cross and Blue Shield* determines to be for dental care. This is the case even when the dental condition is related to or caused by a medical condition or medical treatment. There is one exception. This health plan does provide coverage for facility charges when you have a serious medical condition that requires that you be admitted to a hospital as an *inpatient* or to a surgical day care unit of a hospital or to an ambulatory surgical facility in order for your dental care to be safely performed. Some examples of serious medical conditions are: hemophilia; and heart disease.

## Educational Testing and Evaluations

No benefits are provided for exams, evaluations or services that are performed solely for educational or developmental purposes. The only exceptions are for: covered early intervention services (when these services are covered by your health plan); treatment of *mental conditions* for enrolled dependents who are under age 19; and *covered services* to diagnose and/or treat speech, hearing and language disorders. (See Part 5.)

## Exams/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: exams and tests that are required for recreational activities, employment, insurance and school; and court-ordered exams and services, except when they are *medically necessary* services. (But, certain exams may be covered when they are furnished as part of a covered routine physical exam. See Part 5.)

## Experimental Services and Procedures

The coverage that is described in this benefit booklet is provided only when the *covered services* are furnished according to *Blue Cross and Blue Shield 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 this health plan will provide coverage for it. There are two exceptions. This health plan does provide coverage for:

- One or more stem cell (“bone marrow”) transplants for a *member* who has been diagnosed with breast cancer that has spread.
- Certain drugs that are used on an off-label basis. Some examples of these drugs are: drugs used to treat cancer; and drugs used to treat HIV/AIDS.

## Eyewear

No benefits are provided for eyeglasses and contact lenses. There are two exceptions. This health plan does provide coverage for: contact lenses when they are needed to treat keratoconus (including the fitting of these contact lenses); and intraocular lenses that are implanted (or one pair of eyeglasses instead) after corneal transplant, cataract surgery or other covered eye surgery, when the natural eye lens is replaced.

## Foot Care

No benefits are provided for:

- Routine foot care services, except when your care is *medically necessary* for you due to a systemic circulatory disease (such as diabetes). This includes (but is not limited to): trimming of corns; trimming of nails; and other hygienic care.
- Certain non-routine foot care services and supplies. This includes (but is not limited to): foot orthotics; arch supports; shoe (foot) inserts; orthopedic and corrective shoes that are not part of a leg brace (except as described in Part 5 for “Prosthetic Devices”); and fittings, castings and other services related to devices for the feet.

## Medical Devices, Appliances, Materials and Supplies

No benefits are provided for medical devices, appliances, materials and supplies, except as described otherwise in Part 5. Some examples of non-covered items are:

- Devices such as: air conditioners; air purifiers; arch supports; bath seats; bed pans; bath tub grip bars; chair lifts; computers; computerized communication devices; computer software; 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.

Special clothing, except for: gradient pressure support aids for lymphedema or venous disease;

- clothing needed to wear a covered device (for example, mastectomy bras and stump socks); and therapeutic/molded shoes and shoe inserts for a *member* with severe diabetic foot disease.
- Self-monitoring devices, except for certain devices that *Blue Cross and Blue Shield* decides would give a *member* having particular symptoms the ability to detect or stop the onset of a sudden life-threatening condition.

## Missed Appointments

No benefits are provided for charges for appointments that you do not keep. Physicians and other health care providers may charge you if you do not keep your scheduled appointments. They may do so if you do not give them reasonable notice. You must pay for these costs. Appointments that you do not keep are not counted against any *benefit limits* for coverage that are described in your benefit booklet.

## Non-Covered Providers

No benefits are provided for any services and supplies that are furnished by the kinds of health care providers that **are not** covered under your health plan. For each *covered service*, this benefit booklet specifies the kinds of health care providers that are covered. (See Part 2. The definition of *network provider* describes the kinds of health care providers that are covered by this health plan. Also refer to *riders*—if there are any—that apply to your health plan.)

## Non-Covered Services

No benefits are provided for:

- A service or supply that is not described as a *covered service* under this health plan. An example of *non-covered services* is private duty nursing. There is one exception. As other services and supplies are approved by the U.S. Food and Drug Administration (FDA) for the diagnosis and treatment of insulin dependent, insulin using, gestational or non-insulin dependent diabetes, your coverage will be changed to include those services and supplies as long as they can be classified under a category of services or supplies that are already covered under your health plan and they conform with *Blue Cross and Blue Shield medical technology assessment guidelines*.
- Services and supplies that do not conform to *Blue Cross and Blue Shield* medical policy guidelines.
- Services and supplies that you received when you were not enrolled under this health plan. (This health plan will provide coverage for routine nursery charges and routine newborn exams that are furnished during an enrolled mother's maternity admission. But, to ensure coverage for all other *covered services* for the newborn child, you must enroll the newborn child under the *subscriber's* health plan membership within the time period required to make membership changes.)
- Any service or supply that is furnished along with a *non-covered service*.
- Any service or supply that is furnished by a health care provider who has not been approved by *Blue Cross and Blue Shield* for payment for the specific service or supply.
- Services and supplies that are obtained outside of the *service area*. This also applies even when a student is going to school outside of the *service area*. The only exceptions are for: *emergency medical care*; and *urgent care*.
- Services and supplies that are not considered by *Blue Cross and Blue Shield* to be *medically necessary* for you. The only exceptions are for: routine circumcision; voluntary termination of pregnancy; voluntary sterilization; stem cell ("bone marrow") transplant donor suitability testing; preventive health services; and birth control drugs used for contraceptive purposes and diaphragms.
- Services that are furnished to someone other than the patient, except as described in this benefit booklet for: hospice services; and the harvesting of a donor's organ or stem cells (which includes the surgical removal of the donor's organ or stem cells and the related *medically necessary* services and/or tests that are required to perform the transplant itself) when the recipient is a *member*.

- Services that are furnished to all patients due to a facility's routine admission requirements.
- Services and supplies that are related to sex change surgery or to the reversal of a sex change.
- A health care provider's charge for shipping and handling or taxes.
- A health care provider's charge to file a claim for you. Also, a health care provider's charge to transcribe or copy your medical records.
- A separate fee for services furnished by: interns; residents; fellows; or other physicians who are salaried employees of the hospital or other facility.
- Expenses that you have when you choose to stay in a hospital or another health care facility beyond the discharge time that is determined by *Blue Cross and Blue Shield*.

## Overall Benefit Maximum

When the benefits described in this benefit booklet are subject to an overall benefit maximum, no further benefits are provided by this health plan once this overall benefit maximum has been reached. **Your Schedule of Benefits will show if an overall benefit maximum applies to your coverage. If it does, it will show the amount of your overall benefit maximum.** (Also refer to *riders*—if there are any—that apply to your health plan.) There may also be *benefit limits* or restrictions that apply for certain *covered services*. See your Schedule of Benefits and Part 5 for information about *benefit limits* for specific services and supplies.

If you reach your overall benefit maximum, this amount may be restored. This is the case if *Blue Cross and Blue Shield* finds that your health condition and complications of that condition that caused the maximum to be reached are no longer present or no longer need care or treatment. *Blue Cross and Blue Shield* will review your request to restore your overall benefit maximum. When *Blue Cross and Blue Shield* does this, it will use medical data such as recent claims history. *Blue Cross and Blue Shield* will also ask for a statement from your physician.

## Personal Comfort Items

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

## Private Room Charges

While you are an *inpatient*, this health plan provides coverage for *room and board* based on the semiprivate room rate. At certain times, this health plan may provide coverage for a private room charge. This coverage is provided **only** when *Blue Cross and Blue Shield* determines that a private room is *medically necessary* for you. If a private room is used but not approved in advance by *Blue Cross and Blue Shield*, you must pay all costs that are more than the semiprivate room rate.

## 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.

## Services and Supplies Furnished After Termination Date

No benefits are provided for services and supplies that are furnished after your termination date under this health plan. There is one exception. This will occur if you are admitted as an *inpatient* in a hospital before your termination date and payment to the hospital is based on a “Diagnosis Related Grouping.” In this case, the hospital’s DRG payment that is approved by *Blue Cross and Blue Shield* will be paid to the hospital. This amount will be paid by *Blue Cross and Blue Shield* even when your coverage under this health plan ends during your admission. No benefits are provided by *Blue Cross and Blue Shield* for other services and/or supplies that are furnished during that same *inpatient* admission.

## Services Furnished to Immediate Family

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

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

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

## Surrogate Pregnancy

No benefits are provided for services that are related to achieving pregnancy through a surrogate (gestational carrier).

## Part 7

# Other Party Liability

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### Coordination of Benefits (COB)

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

You must include information on your enrollment forms about other health plans under which you are covered. Once you are enrolled in this health 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 health 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 plan 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 health 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 health 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 health plan will not pay benefits until PIP is exhausted.

This health plan will not provide any more benefits than those already described in this benefit booklet. This health plan will not provide duplicate benefits for *covered services*. If this health plan pays more than the amount that it should have under COB, then you must give that amount back to *Blue Cross and Blue Shield* on behalf of this health plan. This health plan has the right to get that amount back from you or any appropriate person, insurance company or other organization.

<b>Important Notice:</b>	If you fail to comply with the provisions of this COB section, payment of your claim may be denied.
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### 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 health 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.
- **Children of Parents Who Are Not Separated or Divorced (“Birthday Rule”).** When the person who is claiming benefits is covered under two or more plans as a dependent child of parents who are not separated or divorced, the plan of the parent whose birthday falls earlier in a year will determine benefits before the plan of the parent whose birthday falls later in the year. This is referred to as the “birthday rule.” This refers only to the month and day in a calendar year, not the year in which the parent was born. However, if both parents have the same birthday, the plan that has covered a parent the longest will determine benefits before the plan that has covered a parent for a shorter period of time. (If another plan does not include the “birthday rule” described in this section, but instead includes a rule based on the gender of the parent and as a result, if the plans do not agree on the order of benefits, the “birthday rule” will be used to determine the order of benefits.)
- **Children of Separated or Divorced Parents.** When the person who is claiming benefits is a covered child of parents who are separated or divorced, unless there is a court order that requires one parent to be responsible for health care coverage, the order used to determine benefits will be: (1) the plan of the parent who has custody of the child will determine benefits before the plan of the parent who does not have custody of the child; (2) the plan of the spouse of the parent who has custody will determine benefits before the plan of the parent who does not have custody of the child; and then (3) the plan of the parent who does not have custody of the child.

If there is a court decree that states that one of the parents is responsible for health care expenses of the child, the plan covering that parent will determine benefits first, provided that the plan has knowledge of the terms of the court decree. If a court decree grants joint custody but does not state that one parent is responsible for the child’s health care expenses, the “birthday rule” described above will be used to determine the order of benefits.

- **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 none of the previous COB rules determine 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.

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 health plan.

## Medicare Program

When you are eligible for the Medicare program and Medicare is allowed by federal law to be the primary payor, the coverage provided by this health plan will be reduced by the amount of benefits allowed under Medicare for the same *covered services*. This reduction will be made whether or not you actually receive the benefits from Medicare.

### Under Age 65 with End Stage Renal Disease (ESRD)

If you are under age 65 and eligible for Medicare only because of ESRD (permanent kidney failure), the coverage that is described in this benefit booklet will be provided before Medicare benefits. This is the case **only** during the first 30 months of your ESRD Medicare coverage. Then, the coverage described in this benefit booklet will be reduced by the amount that Medicare allows for the same *covered services*.

### Under Age 65 with Other Disability

If you are under age 65 and eligible for Medicare only because of a disability other than ESRD, the coverage that is described in this benefit booklet will be provided before Medicare benefits. This is the case **only** if you are the actively employed *subscriber* or the enrolled spouse or dependent of the actively employed *subscriber*. If you are an inactive employee or a retiree or the enrolled spouse or dependent of the inactive employee or retiree, the coverage described in this benefit booklet will be reduced by the amount that Medicare allows for the same *covered services*.

### Age 65 or Older

If you are age 65 or older and eligible for Medicare only because of age, the coverage that is described in this benefit booklet will be provided before Medicare benefits as long as you have chosen this health plan as your primary payor. This can be the case **only** if you are an actively employed *subscriber* or the enrolled spouse of the actively employed *subscriber*. (If you are actively employed at the time you reach age 65 and become eligible for Medicare, you must choose between Medicare and this health plan as the primary payor of your health care benefits. For more help, contact your *plan sponsor*.)

### Dual Medicare Eligibility

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

## The Health Plan's Rights to Recover Benefit Payments

### Subrogation and Reimbursement of Benefit Payments

If you are injured by any act or omission of another person, the benefits under this health plan will be subrogated. This means that this health plan and *Blue Cross and Blue Shield*, as this health plan's representative, may use your right to recover money from the person(s) who caused the inju-

ry or from any insurance company or other party. If you recover money, this health 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 health 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 health 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 health 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 health plan paid benefits. You must not do anything that might limit this health plan's right to full reimbursement.

### Workers' Compensation

No coverage is provided for health care services that are furnished to treat an illness or injury that *Blue Cross and Blue Shield* determines was work-related. This is the case even if you have an agreement with the workers' compensation carrier that releases them from paying for the claims. All employers provide their employees with workers' compensation or similar insurance. This is done to protect employees in case of a work-related illness or injury. All health care claims for a work-related illness or injury must be billed to the employer's workers' compensation carrier. It is up to you to use the workers' compensation insurance. If *Blue Cross and Blue Shield* pays for any work-related health care services, *Blue Cross and Blue Shield*, on behalf of this health plan, has the right to get paid back from the party that legally must pay for the health care claims. *Blue Cross and Blue Shield*, on behalf of this health plan, also has the right, where possible, to reverse payments made to providers.

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

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

If *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 8

# Filing a Claim

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### When the Provider Files a Claim

Your health care provider will file a claim for you when you receive a *covered service* from a *network provider*. Or, for *covered services* you receive outside of Massachusetts, a health care provider will file a claim for you when he or she has a payment agreement with the local Blue Cross and/or Blue Shield Plan. Just tell the health care provider that you are a *member* and show the health care provider your health plan ID card. Also, be sure to give the health care provider any other information that is needed to file your claim. You must properly inform your health care provider within 30 days after you receive the *covered service*. If you do not, coverage will not have to be provided. *Blue Cross and Blue Shield* will pay the health care provider directly for *covered services*.

### When the Member Files a Claim

You may have to file your claim when you receive a *covered service* from a non-*network provider* in Massachusetts or a non-*network provider* outside of Massachusetts who does not have a payment agreement with the local Blue Cross and/or Blue Shield Plan. The health care provider may ask you to pay the entire charge at the time of the visit or at a later time. It is up to you to pay your health care provider. To file a claim to *Blue Cross and Blue Shield* 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.

You can get claim forms from the *Blue Cross and Blue Shield* customer service office. (See Part 1.) *Blue Cross and Blue Shield* will mail to you all forms that you will need within 15 days after receiving notice that you obtained some service or supply for which you may be paid.

When you receive *covered services* outside the United States, you must file your claim to the BlueCard Worldwide Service Center. (The BlueCard Worldwide International Claim Form you receive from *Blue Cross and Blue Shield* will include the address to mail your claim.) The service center will prepare your claim. This includes: converting your bill to U.S. currency; and sending it to *Blue Cross and Blue Shield* for repayment to you.

You must file a claim within one year of the date you received the *covered service*. This health plan will not have to provide coverage for services and/or supplies for which a claim is submitted after this one-year period.

## Timeliness of Claim Payments

Within 30 calendar days after *Blue Cross and Blue Shield* receives a completed request for coverage or payment, *Blue Cross and Blue Shield* will make a decision. When appropriate, *Blue Cross and Blue Shield* will make a payment to the health care provider (or to you if you sent in the claim) for your claim to the extent of your coverage as described in this benefit booklet. Or, *Blue Cross and Blue Shield* will send you and/or the health care provider a notice in writing of why your claim is not being paid in full or in part.

### Missing Information

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

- **Missing Information Received within 45 Days.** If the additional information is provided to *Blue Cross and Blue Shield* within 45 calendar days of *Blue Cross and Blue Shield*'s request, *Blue Cross and Blue Shield* will make a decision within the time remaining in the original 30-day claim determination period. Or, *Blue Cross and Blue Shield* will make the decision within 15 calendar days of the date that the additional information is received by *Blue Cross and Blue Shield*, whichever is later.
- **Missing Information Not Received within 45 Days.** If the additional information is not provided to *Blue Cross and Blue Shield* within 45 calendar days of *Blue Cross and Blue Shield*'s request, the claim for coverage or payment will be denied by *Blue Cross and Blue Shield*. If the additional information is submitted to *Blue Cross and Blue Shield* after these 45 days, then it may be viewed by *Blue Cross and Blue Shield* as a new claim for coverage or payment. In this case, *Blue Cross and Blue Shield* will make a decision within 30 days as described previously in this section.

## Part 9

# Grievance Program

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You have the right to a review: when you disagree with a decision that is made by *Blue Cross and Blue Shield* to deny payment for services; or if you have a complaint about the care or service you received from *Blue Cross and Blue Shield* or from a *network provider*.

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

Most problems or concerns can be handled with just one phone call. (See page 27 for more information.) For help to resolve a problem or concern, you should first call the *Blue Cross and Blue Shield* customer service office. The toll-free phone number is shown on your health plan ID card. A customer service representative will work with you to help you understand your coverage or to resolve your problem or concern as quickly as possible.

When resolving a problem or concern, *Blue Cross and Blue Shield* will consider all aspects of the particular case. This includes looking at: the terms of your health plan; the policies and procedures that support your health plan; the health care provider's input; and your understanding and expectation of coverage. *Blue Cross and Blue Shield* will use every opportunity to be reasonable in finding a solution that makes sense for all parties. *Blue Cross and Blue Shield* 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 it is resolving your problem or concern.

You may request a review through *Blue Cross and Blue Shield's* internal formal grievance program if you disagree with a decision that is given to you by the *Blue Cross and Blue Shield* customer service representative. *Blue Cross and Blue Shield's* formal grievance review process as described below will be followed when your request for a review is because *Blue Cross and Blue Shield* has determined that a service or supply is not *medically necessary* for your condition.

## Internal Formal Grievance Review

**How to Request a Grievance Review.** To request a formal review from the *Blue Cross and Blue Shield* internal Grievance Program, you (or your authorized representative) have three options.

- **Write or Fax.** The preferred option is for you to send your grievance in writing to: **Grievance Program, Blue Cross Blue Shield of Massachusetts, Landmark Center, 401 Park Drive, Boston, Massachusetts 02215-3326** (Fax: 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.
- **E-mail.** Or, you may send your grievance to the *Blue Cross and Blue Shield* Grievance Program internet address **[grievances@bcbsma.com](mailto: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.

- **Telephone Call.** Or, you may call the *Blue Cross and Blue Shield* Grievance Program at 1-800-472-2689 to request a formal grievance review.

Once your request is received, *Blue Cross and Blue Shield* will research the case in detail. They will ask for more information if it is needed. *Blue Cross and Blue Shield* will let you know in writing of the decision or the outcome of the review. 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 health plan ID number of the *member* asking for the review; a description of the problem; all relevant dates; names of health care providers or administrative staff involved; and details of the attempt that has been made to resolve the problem. If *Blue Cross and Blue Shield* needs to review the medical records and treatment information that relate to your grievance, *Blue Cross and Blue Shield* will promptly send you an authorization form to sign if needed. You must return this signed form to *Blue Cross and Blue Shield*. It will allow for the release of your medical records. You also have the right to look at and get copies (free of charge) of records and criteria that *Blue Cross and Blue Shield* has and that are relevant to your grievance, including the identity of any experts who were consulted.

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

**Who Handles the Grievance Review.** All grievances are reviewed by professionals who are knowledgeable about *Blue Cross and Blue Shield* and the issues involved in the grievance. The professionals who will review your grievance will 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 or 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* internal formal 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*. With your permission, *Blue Cross and Blue Shield* may extend the 30 calendar day time frame to complete a grievance review. This will happen in those cases when *Blue Cross and Blue Shield* and the *member* agree that additional time is required to fully investigate and respond to the grievance.

*Blue Cross and Blue Shield* may also extend the 30 calendar day time frame when the grievance review requires a review of your medical records and *Blue Cross and Blue Shield* requires your authorization to get these records. The 30-day response time will not include the days from when

*Blue Cross and Blue Shield* sends you the authorization form to sign until it receives your signed authorization form (if needed). If *Blue Cross and Blue Shield* does not receive your authorization within 30 working days after your grievance is received, *Blue Cross and Blue Shield* may make a final decision about your grievance without that medical information. In any case, for a grievance review involving services that have not yet been obtained by you, *Blue Cross and Blue Shield* will ask for your permission to extend the 30-day time frame if it cannot complete the review within 30 calendar days of receipt of your grievance.

**Important 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.

**Written Response.** Once the grievance review is completed, *Blue Cross and Blue Shield* will let you know in writing of the decision or the outcome of the review. If *Blue Cross and Blue Shield* continues to deny coverage for all or part of a health care service or supply, *Blue Cross and Blue Shield* will send an explanation to you. It will: describe the reasons for the denial and the applicable terms of your benefits as described in this benefit booklet; give the specific medical and scientific reasons for the denial; specify any alternative treatment, health care services and supplies that would be covered; and explain how to request 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 internal formal 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 phone number that is 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

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

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

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

**Reconsideration.** A reconsideration is the first step in this process. If you receive a letter from *Blue Cross and Blue Shield* that denies payment for your health care services, you may ask that *Blue Cross and Blue Shield* reconsider its decision. You must do this by writing to: Grievance Program, Blue Cross Blue Shield of Massachusetts, Landmark Center, 401 Park Drive, Boston, Massachusetts 02215-3326. You must send your request within 180 days of *Blue Cross and Blue Shield's* adverse decision. Along with your letter, you should include any information that will support your request. *Blue Cross and Blue Shield* will review your request. *Blue Cross and Blue Shield* will let you know the outcome of your request within 15 calendar days after it has received all information needed for the review.

**Appeal.** An appeal is the second step in this process. If *Blue Cross and Blue Shield* continues to deny coverage for all or part of the original service, you may request an appeal. You must do this within 60 days of the date that you receive the reconsideration denial letter from *Blue Cross and Blue Shield*. Your appeal request should include any information that supports your appeal. You may also inspect and add information to your case file to prepare your appeal. In accordance with Rhode Island state law, if you wish to review the information in your case file, you must make your request in writing and you must include the name of a physician who may review your case file on your behalf. Your physician may review, interpret and disclose any or all of that information to you. Once received by *Blue Cross and Blue Shield*, your appeal will be reviewed by a health care 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 after it has received all information needed for the appeal.

**External Appeal.** If your appeal is denied, you have the right to present your case to an appeals agency that is designated by Rhode Island and not affiliated with *Blue Cross and Blue Shield*. If you request this voluntary external appeal, Rhode Island requires that you pay for half of the cost of the appeal. Your *group* will pay for the remaining half. To file an external appeal, you must make your request in writing to: Grievance Program, Blue Cross Blue Shield of Massachusetts, Landmark Center, 401 Park Drive, Boston, Massachusetts 02215-3326. 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 payable to one of the following external appeals agencies: MassPRO (your fee is \$147.50) or the MAXIMUS Center for Health Dispute Resolution (your fee is \$144.20). If your service denial is for treatment of a *mental condition*, your fee is: \$237.50 for MassPRO; and \$144.20 for the MAXIMUS Center for Health Dispute Resolution.

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

**Expedited Appeal.** If your situation is an emergency, you have the right to an "expedited" appeal at all three levels of appeal as stated above. An emergency is defined as the sudden onset of a medical or *mental condition* that in the absence of immediate medical attention could reasonably be expected to result in placing your health or your ability to regain maximum function in serious jeopardy or, in your physician's opinion, would result in severe pain. You may request an expedited reconsideration or appeal by calling *Blue Cross and Blue Shield* at the phone number that is shown in your letter. *Blue Cross and Blue Shield* will notify you of the result of your expedited appeal within two working days or 72 hours, whichever is sooner, of its receipt. To request an expedited external appeal, you must send your request in writing to: Grievance Program, Blue Cross Blue Shield of Massachusetts, Landmark Center, 401 Park Drive, Boston, Massachusetts 02215-3326. Your request should state your reason(s) for your disagreement with the decision and include signed documentation from your provider that describes the emergency nature of your treatment. In addition, you must also enclose a check payable to one of the following external appeals agencies: MassPRO (your fee is \$172.50) or the MAXIMUS Center for Health Dispute Resolution (your fee is \$144.20). If your service denial is for treatment of a *mental condition*, your fee is: \$237.50 for MassPRO and \$144.20 for the MAXIMUS Center for Health Dispute Resolution.

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 case file. The external appeals agency will notify you in writing of the decision within 72 hours, whichever is sooner, of receiving your request for a review.

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

## Part 10

# Other Health Plan Provisions

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### Access to and Confidentiality of Medical Records

*Blue Cross and Blue Shield* and health care providers may, in accordance with applicable law, have access to all of your medical records and related information that is needed by *Blue Cross and Blue Shield* or health care providers. *Blue Cross and Blue Shield* may collect information from health care providers or from other insurance companies or from the *plan sponsor*. *Blue Cross and Blue Shield* will use this information to help them administer the coverage described in this benefit booklet and to get facts on the quality of care that is provided under this and other health care contracts. In accordance with law, *Blue Cross and Blue Shield* and health care providers may use this information, and may disclose it to necessary persons and entities as follows:

- For administering coverage (including coordination of benefits with other insurance plans); 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 U.S. 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 the *subscriber's group* or its auditors.
- For the purpose of processing a claim, medical information may be released to your *group's* reinsurance carrier.

<b>Commitment to Confidentiality:</b>	To get a copy of <i>Blue Cross and Blue Shield's</i> Commitment to Confidentiality statement, call the <i>Blue Cross and Blue Shield</i> customer service office. (See page 30.)
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*Blue Cross and Blue Shield* will not share information about you with the Medical Information Bureau (MIB). Except as described in this section, *Blue Cross and Blue Shield* will keep all of your information confidential. *Blue Cross and Blue Shield* will 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 of this information that you believe is not correct. *Blue Cross and Blue Shield* may charge you a reasonable fee for copying your records, unless your request is because *Blue Cross and Blue Shield* is declining or terminating your coverage under this health plan.

## 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 *network provider* or other 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 *network providers* or other health care providers.

## Assignment of Benefits

You cannot assign any benefit or monies due under this health plan to any person, corporation or other organization without *Blue Cross and Blue Shield's* written consent. Any assignment by you will be void. Assignment means the transfer of your rights to the benefits provided under this health plan to another person or organization. There is one exception. If Medicaid has already paid the health care provider, you can assign your benefits to Medicaid.

## Authorized Representative

You may choose to have another person act on your behalf concerning your health care coverage under this health 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 some cases, *Blue Cross and Blue Shield* may consider your health care facility or your physician to be your authorized representative. For example, *Blue Cross and Blue Shield* may tell your hospital that a proposed *inpatient* admission has been approved. Or, *Blue Cross and Blue Shield* may ask your physician for more information if more is needed for *Blue Cross and Blue Shield* to make a decision. *Blue Cross and Blue Shield* will consider the health care provider to be your authorized representative for *emergency medical care*. *Blue Cross and Blue Shield* will continue to send benefit payments and written communications regarding your health care coverage according to *Blue Cross and Blue Shield's* standard practices, unless you specifically ask *Blue Cross and Blue Shield* to do otherwise. (You can get a form to designate an authorized representative from the *Blue Cross and Blue Shield* customer service office. See Part 1.)

## Changes to This Health Plan

The *plan sponsor* or *Blue Cross and Blue Shield* may change the benefits described in this benefit booklet. For example, a change may be made to the cost that you must pay for certain *covered 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 health care coverage, 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.

## Charges for Non-Medically Necessary Services

You may receive health care services that are otherwise covered under this health plan. However, these services may not be determined by *Blue Cross and Blue Shield* to be *medically necessary* for you. This health plan does **not** provide coverage for health care services or supplies that are not *medically necessary* for you. If you receive care that is not *medically necessary* for you, you might be charged for the care by the health care provider. In some cases, *Blue Cross and Blue Shield* will defend you from a claim for payment for this care. *Blue Cross and Blue Shield* will defend you when this care is furnished by a health care provider who has a payment agreement with *Blue Cross and Blue Shield* not to charge for services that are not *medically necessary*. This does not apply if you were told, knew or reasonably should have known before you received this treatment that it was not *medically necessary*. To obtain *Blue Cross and Blue Shield's* defense in this situation, you must notify *Blue Cross and Blue Shield*. You must do this within 10 days of the date the lawsuit to collect for the service has been started. And, you must cooperate in the defense. If it is determined in the action that the *covered services* were *medically necessary*, this health plan will provide coverage for them.

## Disagreement with Recommended Treatment

When you enroll for coverage under this health plan, you agree that it is up to your PCP or other *network providers* to decide the right treatment for your care. You may (for personal or religious reasons) refuse to accept the procedures or treatments that are advised by your *network provider*. Or, you may ask for treatment that a *network provider* judges does not meet generally accepted professional standards of medical care. You have the right to refuse the treatment advice of the *network provider*. Or, you have the right to seek other care at your own expense. (If you want a second surgical opinion about your care, you have the right to coverage for second and third opinions. See Part 5.)

## Services Furnished by Non-Network Providers

By enrolling under this health plan, you have agreed to receive all of your health care from *network providers* (with the exception of outpatient mental health services). However, this health plan will provide coverage for *covered services* that you receive from a non-*network provider* in the following situations:

- You receive ambulance transport to an emergency medical facility for *emergency medical care*.
- You receive *emergency medical care*.
- You receive *urgent care* outside of *the service area*.
- Your condition requires covered services that cannot be furnished by a *network provider* and your PCP approves a referral to a non-*network provider* for the *covered services*. In some cases, *Blue Cross and Blue Shield* must also approve the services in writing before you receive them.

## Time Limit for Legal Action

Before you pursue a legal action against *Blue Cross and Blue Shield* for any claim under this health plan, you must complete an internal formal grievance review. (See Part 9.) You may, but you do not need to, complete an external review before you pursue a legal action. If, after you complete the grievance review, you choose to bring a legal action against *Blue Cross and Blue Shield*, you must bring this action within two years after the cause of the action arises. For example, if you are filing a legal action because you were denied a service or you were denied a claim for coverage under this health 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. If you go through the internal formal grievance process, it 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 from them are not counted toward the two-year limit.

## Part II

# Eligibility for Coverage

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## Who Is Eligible to Enroll

### Eligible Employee

An employee is eligible to enroll as a *subscriber* under this health plan as long as he or she:

- Meets the rules on length of service, active employment and number of hours worked that the *plan sponsor* has set to determine eligibility for *group* health care benefits. For details, contact your *plan sponsor*.
- Resides in the *service area* (or lives and/or works within a reasonable distance from the *service area*). See page 41 for a definition of service area.

### Eligible Spouse

The *subscriber* may enroll an eligible spouse for coverage under his or her health plan membership as long as the spouse resides in the *service area*. An “eligible spouse” includes the *subscriber’s* legal spouse or domestic partner.

A domestic partner is defined as a person of the same sex or opposite sex with whom the employee has entered into an exclusive relationship. Both the employee and the domestic partner must be at least 18 years of age and not married to anyone, share a mutually-exclusive enduring relationship, have shared a common residence and intend to do so indefinitely, consider themselves life partners, share joint responsibility for their common welfare and be financially interdependent, and otherwise meet all the eligibility requirements of the Traditional Health Plan.

In the event of divorce or legal separation, the person who was the spouse of the *subscriber* prior to the divorce or legal separation will remain eligible for coverage under the *subscriber’s* health plan membership, whether or not the judgment was entered prior to the *effective date* of this health plan. This coverage is provided with no additional premium. The former spouse will remain eligible for this coverage **only** until the *subscriber* is no longer required by the judgment to provide health insurance for the former spouse or the *subscriber* or former spouse remarries, whichever comes first. (In these situations, *Blue Cross and Blue Shield* must be notified within 30 days of a change to the former spouse’s address. Otherwise, *Blue Cross and Blue Shield* will not be liable for any acts or omissions due to having the former spouse’s incorrect address on file.)

If the *subscriber* remarries, the former spouse may continue coverage under a separate health plan membership with the *subscriber’s group*, provided the divorce judgment requires that the *subscriber* provide health insurance for the former spouse. This is true even if the *subscriber’s* new spouse is not enrolled under the *subscriber’s* health plan membership.

**Eligible Dependents**

The *subscriber* may enroll eligible dependents for coverage under his or her health plan membership. The *subscriber's* “eligible dependents” include:

- An unmarried dependent child who is under age 25. These include the *subscriber's* or legal spouse's dependent children who: live with the *subscriber* or the spouse on a regular basis; or qualify as dependents for federal tax purposes; or are the subjects of a court order that requires the *subscriber* to provide health insurance for the children.

These may include:

- A newborn child. The *effective date* of coverage for a newborn child will be the child's date of birth provided that the *subscriber* formally notifies the *plan sponsor* within 30 days of the date of birth. (A claim for the enrolled mother's maternity admission may be considered by *Blue Cross and Blue Shield* to be this notice when the *subscriber's* coverage is a family plan.) This health plan provides coverage for newborn infants for injury and sickness. This includes the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities and premature birth. The coverage for these services is subject to all of the provisions that are described in this benefit booklet.
- An adopted child. The *effective date* of coverage for an adopted child will be the date of placement with the *subscriber* for the purpose of adoption. The *effective date* of coverage for an adoptive child who has been living with the *subscriber* and for whom the *subscriber* has been getting foster care payments will be the date the petition to adopt is filed.

If the *subscriber* is enrolled under a family plan as of the date he or she assumes custody of a child for the purpose of adoption, the child's health care services for injury or sickness will be covered from the date of custody. (This coverage is provided without a waiting period or pre-existing condition restriction.) This includes the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities and premature birth. The coverage for these services is subject to all of the provisions that are described in this benefit booklet.

- A child who is recognized under a Qualified Medical Child Support Order as having the right to enroll for health care coverage.
- An unmarried full-time student dependent child who is under age 25. In this case, the *subscriber* must give *Blue Cross and Blue Shield* verification that the child is a full-time student at an accredited educational institution. This coverage ends when the student turns age 25 or marries, whichever comes first. (Enrolled full-time student dependents must follow all requirements of this health plan even if they attend school outside the *service area*. This means that no benefits are provided for services and/or supplies obtained without a PCP referral or an approval from *Blue Cross and Blue Shield*, except for *emergency medical care* and *urgent care*.)
- An unmarried disabled dependent child. A disabled dependent child may maintain coverage under the *subscriber's* health plan membership. But, the child must be either mentally or physically handicapped so as not to be able to earn his or her own living on the date he or she would normally lose eligibility under the *subscriber's* health plan membership. In this

case, the *subscriber* must make arrangements with *Blue Cross and Blue Shield* not more than 30 days after the date the child would normally lose eligibility. Also, *Blue Cross and Blue Shield* must be given any medical or other information that it may need to determine if the child can maintain coverage under the *subscriber's* health plan membership. From time to time, *Blue Cross and Blue Shield* may conduct reviews that will require a statement from the attending physician. This is to confirm that the child is still an eligible disabled dependent child.

- A newborn infant of an enrolled dependent immediately from the moment of birth and continuing after, until the enrolled dependent is no longer eligible as a dependent.

<b>Important Reminder:</b>	The eligibility provisions described in this section may differ from the federal tax laws that define who may qualify as a dependent.
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## Enrollment Periods

### Initial Enrollment

You may enroll under this health plan on your initial eligibility date as determined by your *group*. The *plan sponsor* is responsible for providing you with details about how and when you may enroll under this health plan. To enroll for coverage under this health plan, you must complete the enrollment form provided by your *plan sponsor* no later than 30 days after your eligibility date. (For more information, contact your *plan sponsor*.) If you choose not to enroll for coverage under this health 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 an eligible employee or an eligible dependent (including the employee's spouse) chooses not to enroll for coverage under this health plan on his or her initial eligibility date, federal law may allow the eligible employee and/or his or her eligible dependents to enroll under this health plan when:

- The employee and/or his or her eligible dependents have a loss of other coverage (see "Loss of Other Coverage" below for more information); or
- The employee gains a new eligible dependent (see "New Dependents" below for more information).

These rights are known as your "special enrollment rights."

**Loss of Other Coverage.** An eligible employee may choose not to enroll himself or herself or an eligible dependent (including a spouse) for coverage under this health plan on the initial eligibility date because he or she or the eligible dependent has other group health plan coverage. In this case, the employee and the eligible dependent may enroll under this health plan if the employee or the eligible dependent at a later date loses that other group health plan coverage because:

- The employee or the eligible dependents cease to be eligible for the other group health plan or the employer that is sponsoring the other group health plan ceases to make employer contributions for the other group health plan coverage; or

- The employee or the eligible dependents exhaust COBRA coverage under the other group health plan.

You will not have this special enrollment right if the loss of other coverage is a result of the eligible employee or the eligible dependent's failure to pay the applicable premiums.

**New Dependents.** If an eligible employee gains a new spouse or other new eligible dependent(s) due to marriage, adoption, placement for adoption or birth, the employee and the spouse and/or the new dependent(s) may enroll for coverage under this health plan. (If the new dependent is gained by birth, adoption or placement for adoption, enrollment under this health plan will be retroactive to the date of birth or the date of adoption or the date of placement for adoption, provided that the enrollment time requirements described below are met.)

**Special Enrollment Time Requirement.** To exercise your special enrollment rights, you must notify your *plan sponsor* no later than 30 days after the date on which the loss of other coverage occurs or the date which the *subscriber* gains a new dependent, whichever is applicable. For example, if your coverage under another group health plan is terminated, you must request enrollment under this health plan within 30 days after your other group 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.

#### **Qualified Medical Child Support Order**

If the *subscriber* chooses not to enroll an eligible dependent for coverage under this health plan on the initial eligibility date, the *subscriber* may be required by law to enroll the dependent if the *subscriber* is subject to a Qualified Medical Child Support Order (QMCSO). This QMCSO order is a state court or administrative agency order that requires an employer's group health plan to provide coverage to the child of an employee who is covered, or eligible to enroll for coverage, under the group health plan.

#### **Open Enrollment Period**

If you choose not to enroll for coverage under this health 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 for coverage under this health 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 Other Membership Changes

Generally, the *subscriber* may make membership changes (for example, change from an individual plan to a family plan) only if the *subscriber* has a change in family status. This includes a change such as: marriage or divorce; birth, adoption or change in custody of a child; death of an enrolled spouse or dependent; or the loss of an enrolled dependent's eligibility under the *subscriber's* health plan membership. **If you want to ask for a change or you need to change your name or mailing address, you should call or write to your *plan sponsor*.** The *plan sponsor* will send you any special forms you may need. You must request the change within the time period required by the *subscriber's group* to make a change. If you do not make the change within the required time period, you will have to wait until the *group's* next open enrollment period to make the change. All changes are allowed only when they comply with the eligibility and enrollment rules set by the *plan sponsor* for your *group* health benefits plan. They must also comply with the conditions outlined in this benefit booklet.

## Part 12

# Termination of Coverage

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## Loss of Eligibility for Coverage

You will lose coverage under this health plan when any one of the following occurs.

- **Group Eligibility Ends.** You are no longer eligible for *group* coverage when the *subscriber* loses eligibility for health care coverage with the *group*. This means: the *subscriber's* hours are reduced; or the *subscriber* leaves the job; or the *subscriber* no longer meets the rules that are set by the *group* for coverage under this health plan. (You will also lose eligibility for *group* coverage if you are an enrolled dependent when the *subscriber* dies.)
- **Move Out of the Service Area.** You are no longer eligible for coverage when you move permanently outside of the Network Blue *service area*. In this case, if you are still eligible for *group* coverage, you may be eligible to transfer your coverage to another health care plan that is offered by your *group*. (Contact your *plan* sponsor for help.)
- **At Age 65 and Eligible for Medicare.** You are no longer eligible for *group* coverage when you reach age 65 and become eligible for Medicare (Part A and Part B). However, as allowed by federal law, the *subscriber* (and the spouse and/or dependents) may have the option of continuing coverage under this health plan when the *subscriber* remains as an actively working employee after reaching age 65. You should review all options available to you with the *plan sponsor*. (Medicare eligible *subscribers* who retire and/or their spouses are not eligible to continue coverage under this health plan once they reach age 65.)
- **Loss of Dependent Status.** You are no longer eligible for *group* coverage when you lose eligibility as a dependent under the *subscriber's* health plan membership. When a dependent loses eligibility for coverage, the termination date of coverage under this health plan will be the date on which eligibility is lost. (See Part 11.)
- **Group Does Not Renew this Health Plan.** You are no longer eligible for *group* coverage when the *subscriber's group* does not renew this health plan.
- **Group Cancels this Health Plan.** You are no longer eligible for coverage when this group health plan is terminated by the *plan sponsor*.

When any one of these situations occurs, your coverage under this health plan will be terminated as of the date you lose your eligibility.

## Termination of Coverage:

Your coverage under this health plan will be cancelled when:

- The *subscriber* chooses to cancel his or her health plan membership as permitted by the *plan sponsor*.
- You have committed misrepresentation or fraud to *Blue Cross and Blue Shield*. For

example, you gave false or misleading information on your enrollment form. Or, you misused the health plan ID card by letting another person who was not enrolled under your health plan membership to attempt to get coverage. In this case, the termination of your coverage will go back to your *effective date*. Or, it may go back to the date of the misrepresentation or fraud. The termination date will be determined by *Blue Cross and Blue Shield*.

- You commit acts of physical or verbal abuse that pose a threat to health care providers or to other members and these acts are not related to your physical condition or *mental condition*.

## Part 13

# Continuation of Coverage

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### Family and Medical Leave Act

An employee may continue coverage under this health plan as provided by the Family and Medical Leave Act. (The Family and Medical Leave Act applies to you if your *group* has 50 or more employees.) An employee who has been employed at least one year and worked at least 1,250 hours within the previous 12 months is eligible to choose to continue coverage for up to 12 weeks of unpaid leave for the following reasons:

- The birth of the employee's child.
- The placement of a child with the employee for the purpose of adoption or foster care.
- To care for a seriously ill spouse, child or parent.
- A serious health condition rendering the employee unable to perform his or her job.

If the employee chooses to continue coverage during the leave, the employee will be given the same health care benefits that would have been provided if the employee were working, with the same premium contribution ratio. If the employee's premium for continued coverage under this health plan is more than 30 days late, the *plan sponsor* will send written notice to the employee. It will tell the employee that his or her coverage will be terminated. It will also give the date of the termination if payment is not received by that date. This notice will be mailed at least 15 days before the termination date.

If coverage under this health plan is discontinued due to non-payment of premium, the employee's coverage will be restored when he or she returns to work to the same level of benefits as those the employee would have had if the leave had not been taken and the premium payment(s) had not been missed. This includes coverage for eligible dependents. The employee will not be required to meet any qualification requirements imposed by *Blue Cross and Blue Shield* when he or she returns to work. This includes: new or additional waiting periods; waiting for an open enrollment period; or passing a medical exam to reinstate coverage.

### Consolidated Omnibus Budget Reconciliation Act

When you are no longer eligible for coverage in this health plan, you may be eligible to continue this coverage as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA). To continue this coverage, you will pay 102% of the premium cost to your *plan sponsor*. This law applies to you if you lose eligibility for coverage due to one of the following reasons:

- Termination of employment (for reasons other than gross misconduct).
- Reduction of work hours.
- Divorce or legal separation.

In the event of divorce or legal separation, a spouse is eligible to keep coverage under the employee's membership. This is the case only until the employee is no longer required by the divorce judgment to provide health insurance for the former spouse or the employee or former spouse remarries, whichever comes first. The former spouse's eligibility for continued COBRA coverage will start on the date of divorce even if he or she continues coverage under the employee's membership. While the former spouse continues coverage under the employee's membership, there is no additional premium. After remarriage, under federal law, the former spouse may be eligible to continue coverage under an individual membership for additional premium.

- Death of the employee.
- Employee's entitlement to Medicare benefits.
- Loss of status as an eligible dependent.

The period of this continued COBRA coverage begins with the date of your qualifying event. And, the length of this continued COBRA coverage will be up to 36 months from that qualifying event. This is true except for termination of employment or reduction of work hours, in which cases continued COBRA coverage is available for only 18 months or, if you are qualified for disability under Title II or Title XVI of the Social Security Act, up to 29 months. (See below for more information about continued coverage for disabled employees or disabled dependents.)

**Continuation of Coverage for Same-Sex Spouses.** When a *subscriber's* legal same-sex spouse is no longer eligible for coverage under this health plan, that spouse (or if applicable, civil union spouse) and his or her dependent children may continue coverage in the subscriber's *group* to the same extent that a legal opposite-sex spouse (and his or her dependent children) could continue coverage upon loss of eligibility for coverage under this health plan.

### **Additional COBRA Coverage for Disabled Employees**

Within 60 days of the employee's termination of employment or reduction in hours, if an employee or an eligible dependent is determined to be disabled under Title II or Title XVI of the Social Security Act, COBRA coverage will continue for the employee and eligible dependents for up to 29 months from the date of the qualifying event. The premium cost for the additional 11 months may be up to 150% of the premium rate. If during the 11 additional months, eligibility for disability is lost, COBRA coverage may terminate before the 29 months is completed. You should contact your *plan sponsor* for more information about COBRA coverage.

### **Special Rules for Retired Employees**

A retired employee, the spouse and/or eligible dependent children of a retired employee or a surviving spouse of a retired deceased employee who loses eligibility for coverage in this health plan as a result of a bankruptcy proceeding (Title 11 of the United States Code) is also eligible for continued COBRA coverage. A retired employee and/or the surviving spouse of a deceased retired employee may enroll for lifetime COBRA coverage as of the date of the bankruptcy proceeding, provided that the loss of *group* eligibility occurs within one year before the date on which the bankruptcy proceeding begins. Or, if *group* eligibility is lost within one year after the date on which the bankruptcy proceeding begins, they may enroll for lifetime COBRA coverage as of the date *group* eligibility is lost. Spouses and/or eligible dependent children of these retired employees may enroll

for continued COBRA coverage until the retired employee dies. Once the retired employee dies, his or her surviving spouse and/or eligible dependent children may enroll for up to an additional 36 months of continued COBRA coverage beyond the date of the retired employee's death.

Lifetime COBRA coverage for retired employees will end if this health plan is terminated by the *plan sponsor* or for any of the other reasons described below. (See "Termination of COBRA Coverage.")

### **Enrollment for COBRA Coverage**

In order to enroll for continued coverage in this health plan, you must complete a COBRA Election Form. The completed election form must be returned to the office at the address on the form. The form must be returned within 60 days from your date of termination of coverage or your notification of COBRA eligibility, whichever is later. If you do not return the completed form, it will be considered a waiver. And, you will not be allowed to continue coverage in this health plan. (The 60 days will be counted from the date of the COBRA eligibility notice to the postmarked date of the mailed election form.)

### **Termination of COBRA Coverage**

Your COBRA coverage will end when:

- The length of time allowed for continued COBRA coverage is reached (for example, 18 months or 29 months or 36 months from the qualifying event).
- You fail to make timely payment of your COBRA premiums.
- You enroll in another employer sponsored health care plan and that plan does not include pre-existing conditions limitations or waiting periods.
- You become entitled to Medicare benefits.

(The longer time allowed for continued coverage for disabled *members* will end when the *member* is no longer disabled.)

Your continued coverage under this health plan will also end when the *group* terminates its agreement with *Blue Cross and Blue Shield* to provide the coverage described in this benefit booklet. In this case, coverage may continue under another health care plan. Contact your *plan sponsor* for more information.

## Part 14

# Health Insurance Portability

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### Pre-Existing Conditions

Federal law may affect your health care coverage if you are enrolled or become eligible to enroll in a health benefit plan that excludes coverage for pre-existing conditions. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which benefits may be excluded for medical conditions that are present before you enroll in a health benefit plan. A pre-existing condition exclusion may not be imposed for more than 12 months—18 months for a late enrollee—from the effective date of your coverage in a health benefit plan. In addition, pregnancy will not be considered a pre-existing condition. A pre-existing condition exclusion period is reduced by the time you were enrolled in a prior health benefit plan as long as that prior plan was terminated within 63 days of your effective date in the new health benefit plan. You are entitled to a certificate that will show evidence of your prior health care coverage. A certificate of prior coverage may help you obtain coverage without a pre-existing condition exclusion even if you buy health insurance other than through an employer group health plan.

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

### HIPAA Certificates

All *members* have the right to receive a certificate of group health plan coverage when:

- The *member* ceases coverage under the *group's* health benefit plan or coverage would have been lost had the *member* not elected to continue coverage under COBRA.
- The *member's* continued coverage under COBRA ends.
- The *member* requests a certificate of group health plan coverage within 24 months of his or her loss of health care coverage.
- The *member's* claim is denied because he or she has reached a lifetime limit on all benefits (if any).

When a *member's* coverage under this health plan ends and that *member* is eligible for a certificate of group health plan coverage, the *plan sponsor* and/or *Blue Cross and Blue Shield* will provide this certificate to the *member*.