Attached are the Blue Cross Blue Shield of Massachusetts Benefit Description and associated riders for your health plan. While the Benefit Description and riders provide complete and detailed benefit information, they may not include information that you, as the sponsor of a group health plan, may need to comply with your statutory or regulatory notice obligations under ERISA or other applicable law. For example, these documents may not include all the information required under ERISA to be in a "summary plan description".

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

The Benefit Description and associated riders are accurate as of 01/01/2016.

As you use this information, please keep in mind that Blue Cross and Blue Shield of Massachusetts, Inc. has a copyright on these documents. In addition, the use of these documents is for your plan administration purposes only. Please do not pass these documents on to any other person or entity for any other purpose unless authorized by Blue Cross and Blue Shield of Massachusetts, Inc.
Medex®′ 2

Benefit Description

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

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

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

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

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

An organization has been designated by your plan sponsor to provide administrative services to this Medex plan, such as claims processing, case management and other services, and to arrange for a network of health care providers whose services are covered by this Medex plan. The name and address of this organization is:

Blue Cross and Blue Shield of Massachusetts, Inc.
101 Huntington Avenue, Suite 1300
Boston, Massachusetts 02199-7611

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

This booklet provides you with a description of your benefits while you are enrolled in this Medex plan. You should read this booklet to familiarize yourself with the main provisions and keep it handy for reference. The words in italics have special meanings and are described in Part 2. Your group may change the terms of this Medex plan. If this is the case, the change is described in a rider. Your plan sponsor can supply you with any riders that apply to your benefits.

Also, since this Medex plan provides benefits to supplement your Medicare insurance for certain services covered by Medicare, you should read the most current edition of your Medicare handbook (Medicare & You) to fully understand your benefits. This is a book put out by Medicare that describes the benefits you get under that program as well as the restrictions that apply to your Medicare benefits. Your Medicare handbook also explains how you can get other booklets that deal with specific topics such as payment for certain outpatient hospital services, dialysis services, home health care, hospice care and mental health benefits.

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

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

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

For help to understand your benefits or to resolve a Medex problem or concern, you may call the Blue Cross and Blue Shield customer service office at 1-800-258-2226. Or, if a different telephone number appears on your Medex identification card, you may call that number. (To use the Telecommunications Device for the Deaf, call 1-800-522-1254.) A customer service representative will work with you to help you understand your Medex benefits or resolve your problem or concern as quickly as possible.

You can call the Blue Cross and Blue Shield customer service office Monday through Friday from 8:00 a.m. to 6:00 p.m. (Eastern Time). Or, you can write to:

Blue Cross and Blue Shield of Massachusetts, Inc.
Member Services
P.O. Box 9130
North Quincy, Massachusetts 02171-9130

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

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

Need a Language Translator? A language translator service is available when you call the Blue Cross and Blue Shield customer service office at 1-800-258-2226. (Or, if a different telephone number appears on your Medex identification card, you may call that number.) 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 1
Schedule of Benefits**

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

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

<table>
<thead>
<tr>
<th>Medicare Provides</th>
<th>Medex Provides</th>
<th>Your Cost¹</th>
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<tbody>
<tr>
<td><strong>Admissions for Inpatient Medical and Surgical Care</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>In a general hospital:</strong> Full semiprivate benefits less the Part A deductible for day 1-60 and Part A coinsurance for day 61-90 per benefit period; and full semiprivate benefits less the Part A coinsurance for 60 <em>Medicare</em> lifetime reserve days</td>
<td><strong>In a general hospital:</strong> The Part A deductible for day 1-60 and Part A coinsurance for day 61-90 per benefit period; the Part A coinsurance for any <em>Medicare</em> lifetime reserve days used; then after <em>Medicare</em> days are used up, full semiprivate benefits through the 365th day per benefit period</td>
<td><strong>In a general hospital:</strong> Nothing through the 365th day per benefit period; then all charges</td>
<td>21</td>
</tr>
</tbody>
</table>

| **In a skilled nursing facility that participates with Medicare:** Full semiprivate benefits for day 1-20 per benefit period; and full semiprivate benefits less the *Medicare* Part A coinsurance for day 21-100 per benefit period | **In a skilled nursing facility that participates with Medicare:** The Part A coinsurance for day 21-100 per benefit period; and $10 per day from day 101-365 per benefit period | **In a skilled nursing facility that participates with Medicare:** Nothing for day 1-100 per benefit period; and the charge over $10 per day from day 101-365 per benefit period; then all charges | 22 |

| **In a skilled nursing facility that does not participate with Medicare:** Nothing | **In a skilled nursing facility that does not participate with Medicare:** $8 per day for day 1-365 per benefit period | **In a skilled nursing facility that does not participate with Medicare:** The charge over $8 per day for day 1-365 per benefit period; then all charges | 22 |

¹Benefits for *covered services* are provided based on the *allowed charge*. You may have to pay any amount over the *allowed charge*. (See Parts 2 and 9.)
## Part 1
### Schedule of Benefits

<table>
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<th>Medicare Provides</th>
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<tr>
<td><strong>Admissions for Inpatient Medical and Surgical Care</strong> (continued)</td>
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<tr>
<td><strong>Physician and other covered professional provider services:</strong> Full benefits less the Part B deductible and Part B coinsurance for as many days as are medically necessary</td>
<td><strong>Physician and other covered professional provider services:</strong> The Part B deductible and Part B coinsurance (full benefits when covered by Medex only) for as many days as are medically necessary</td>
<td><strong>Physician and other covered professional provider services:</strong> Nothing for as many days as are medically necessary</td>
<td>22</td>
</tr>
<tr>
<td><strong>Chiropractor Services</strong></td>
<td>The Part B deductible and Part B coinsurance</td>
<td>Nothing</td>
<td>23</td>
</tr>
<tr>
<td>Full benefits less the Part B deductible and Part B coinsurance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Continued Active Care</strong> within 100 days after hospital discharge to treat a condition for which you were an inpatient in a hospital for at least three days in a row</td>
<td>The Part B deductible and Part B coinsurance (includes: cardiac rehabilitation; drugs covered by Medicare; medical care services; and Medicare approved short-term rehabilitation therapy)</td>
<td>Nothing</td>
<td>23</td>
</tr>
<tr>
<td>Full benefits less the Part B deductible and Part B coinsurance (includes: cardiac rehabilitation; drugs covered by Medicare; medical care services; and Medicare approved short-term rehabilitation therapy)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diabetic Testing Materials, Enteral Formulas and Food Products</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When covered by Medicare, full benefits less the Part B deductible and Part B coinsurance</td>
<td>When covered by Medicare, the Part B deductible and Part B coinsurance</td>
<td>When covered by Medicare, nothing</td>
<td>25</td>
</tr>
<tr>
<td>When not covered by Medicare, nothing</td>
<td>When not covered by Medicare, full benefits for: diabetic testing materials; certain enteral formulas; and low protein food products for up to $2,500 per calendar year</td>
<td>When not covered by Medicare, nothing for diabetic testing materials and certain enteral formulas: and all charges after Medex has provided benefits for $2,500 per calendar year for low protein food products</td>
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\(^1\)Benefits for **covered services** are provided based on the *allowed charge*. You may have to pay any amount over the *allowed charge*. (See Parts 2 and 9.)
# Part 1

## Schedule of Benefits

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<td><strong>Dialysis Services</strong>&lt;br&gt;Full benefits less the Part B deductible and Part B coinsurance</td>
<td>The Part B deductible and Part B coinsurance</td>
<td>Nothing</td>
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<td><strong>Emergency Medical Outpatient Services</strong>&lt;br&gt;Full benefits less the Part B deductible and Part B coinsurance</td>
<td>The Part B deductible and Part B coinsurance</td>
<td>Nothing</td>
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<td><strong>Home Health Care</strong>&lt;br&gt;For home health care visits, full benefits</td>
<td>For home health care visits, nothing</td>
<td>For home health care visits, nothing²</td>
<td>26</td>
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<td>For durable medical equipment covered by Medicare, full benefits less the Part B deductible (when applicable) and Part B coinsurance</td>
<td>For durable medical equipment covered by Medicare, nothing</td>
<td>For durable medical equipment covered by Medicare, the Part B deductible (when applicable) and Part B coinsurance</td>
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<td><strong>Hospice Services</strong>&lt;br&gt;When covered by Medicare, full benefits for most services</td>
<td>When Medicare does not provide full benefits, the difference between the amount Medicare pays and the allowed charge</td>
<td>When covered by Medicare, nothing</td>
<td>26</td>
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<tr>
<td>When not covered by Medicare, nothing</td>
<td>When not covered by Medicare, full benefits</td>
<td>When not covered by Medicare, nothing</td>
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<tr>
<td><strong>Lab Tests, X-Rays and Other Tests</strong>&lt;br&gt;Full benefits less the Part B deductible and Part B coinsurance</td>
<td>The Part B deductible and Part B coinsurance</td>
<td>Nothing</td>
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¹Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge. (See Parts 2 and 9.)

²These services are covered in full by Medicare as long as Medicare conditions are met.
## Part 1

### Schedule of Benefits

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<td><strong>Mental Health Treatment for Biologically-Based Mental or Nervous Conditions</strong>(^3)</td>
<td><strong>Inpatient admissions in a general or mental hospital:</strong> Full semiprivate benefits less the Part A deductible for day 1-60 and Part A coinsurance for day 61-90 per benefit period; and full semiprivate benefits less the Part A coinsurance for 60 Medicare lifetime reserve days (Benefits in a mental hospital are limited to 190 days per lifetime)</td>
<td><strong>Inpatient admissions in a general or mental hospital:</strong> The Part A deductible for day 1-60 and Part A coinsurance for day 61-90 per benefit period; the Part A coinsurance for any Medicare lifetime reserve days used; then after Medicare days are used up, full semiprivate benefits through the 365(^{th}) day per benefit period</td>
<td><strong>Inpatient admissions in a general or mental hospital:</strong> Nothing through the 365(^{th}) day per benefit period; then all charges</td>
</tr>
<tr>
<td><strong>Inpatient physician and other covered professional mental health provider services:</strong> Full benefits less the Part B deductible and Part B coinsurance for as many days as are medically necessary</td>
<td><strong>Inpatient physician and other covered professional mental health provider services:</strong> The Part B deductible and Part B coinsurance (full benefits when covered by Medex only) for as many days as are medically necessary</td>
<td><strong>Inpatient Physician and other covered professional mental health provider services:</strong> Nothing for as many days as are medically necessary</td>
<td>28</td>
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<tr>
<td><strong>Outpatient treatment:</strong> Full benefits less the Part B deductible and Part B coinsurance (Nothing for services not covered by Medicare)</td>
<td><strong>Outpatient treatment:</strong> The Part B deductible and Part B coinsurance (full benefits when covered by Medex only) for as many visits as are medically necessary</td>
<td><strong>Outpatient treatment:</strong> Nothing for as many visits as are medically necessary</td>
<td>28</td>
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\(^1\)Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge. (See Parts 2 and 9.)

\(^3\)Treatment for rape-related mental or emotional conditions is covered to the same extent as biologically-based conditions.
**Part 1**  
**Schedule of Benefits**

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<tr>
<td>Mental Health Treatment for Non-Biologically-Based Mental or Nervous Conditions not included in above section (includes drug addiction and alcoholism)</td>
<td>Inpatient admissions in a general or mental hospital: Full semiprivate benefits less the Part A deductible for day 1-60 and Part A coinsurance for day 61-90 per benefit period; and full semiprivate benefits less the Part A coinsurance for 60 Medicare lifetime reserve days (Benefits in a mental hospital are limited to 190 days per lifetime)</td>
<td>Inpatient admissions in a general or mental hospital: The Part A deductible for day 1-60 and Part A coinsurance for day 61-90 per benefit period; the Part A coinsurance for any Medicare lifetime reserve days; then after Medicare days are used up, full semiprivate benefits through the 365th day per benefit period in a general hospital (up to 120 days per benefit period but up to at least 60 days per calendar year in a mental hospital), less any days in a hospital already covered by Medicare in that benefit period (or calendar year)</td>
<td>28</td>
</tr>
<tr>
<td>Inpatient physician and other covered professional mental health provider services: Full benefits less the Part B deductible and Part B coinsurance for as many days as are medically necessary</td>
<td>Inpatient physician and other covered professional mental health provider services: The Part B deductible and Part B coinsurance for Medicare and Medex covered services for as many days as are medically necessary in a general or mental hospital; full benefits for as many days as are medically necessary in a general hospital and for up to 120 days per benefit period (but up to at least 60 days per calendar year) in a mental hospital when covered by Medex only</td>
<td>Inpatient Physician and other covered professional mental health provider services: Nothing for Medicare and Medex covered services for as many days as are medically necessary in a general or mental hospital; nothing for as many days as are medically necessary in a general hospital and for up to 120 days per benefit period, (but up to at least 60 days per calendar year) in a mental hospital when covered by Medex only; then all charges</td>
<td>29</td>
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¹Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge. (See Parts 2 and 9.)

WORDS IN ITALICS ARE DEFINED IN PART 2.
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**Schedule of Benefits**

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<td></td>
</tr>
<tr>
<td><em>Outpatient treatment:</em> Full benefits less the Part B deductible and Part B coinsurance (Nothing for services not covered by Medicare)</td>
<td><em>Outpatient treatment:</em> The Part B deductible and Part B coinsurance for as many visits as are medically necessary for Medicare and Medex covered services; and full benefits when covered by Medex only for up to 24 visits per calendar year</td>
<td><em>Outpatient treatment:</em> Nothing for Medicare and Medex covered services for as many visits as are medically necessary; and nothing for up to 24 visits per calendar year for services covered by Medex only; then all charges</td>
<td>29</td>
</tr>
<tr>
<td><strong>Physical Therapist Services</strong></td>
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<td>29</td>
</tr>
<tr>
<td>Full benefits less the Part B deductible and Part B coinsurance for Medicare approved physical therapy</td>
<td>The Part B deductible and Part B coinsurance for Medicare approved physical therapy</td>
<td>Nothing for Medicare approved physical therapy</td>
<td></td>
</tr>
<tr>
<td><strong>Podiatry Care</strong></td>
<td></td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>Full benefits less the Part B deductible and Part B coinsurance</td>
<td>The Part B deductible and Part B coinsurance</td>
<td>Nothing</td>
<td></td>
</tr>
<tr>
<td><strong>Radiation and X-Ray Therapy</strong></td>
<td></td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>Full benefits less the Part B deductible and Part B coinsurance</td>
<td>The Part B deductible and Part B coinsurance</td>
<td>Nothing</td>
<td></td>
</tr>
<tr>
<td><strong>Routine Tests</strong></td>
<td></td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>For routine mammograms: Full benefits less the Part B coinsurance (the Part B deductible does not apply) for one baseline mammogram between age 35 through 39 and one routine mammogram per year for a member age 40 or older</td>
<td>For routine mammograms: The Part B deductible and Part B coinsurance (the Part B deductible does not apply) for one baseline mammogram between age 35 through 39 and one routine mammogram per year for a member age 40 or older</td>
<td>For routine mammograms: Nothing for one baseline mammogram between age 35 through 39; and one routine mammogram per year for a member age 40 or older</td>
<td></td>
</tr>
</tbody>
</table>

\(^1\)Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge. (See Parts 2 and 9.)
**Part 1**  
**Schedule of Benefits**

<table>
<thead>
<tr>
<th>Medicare Provides</th>
<th>Medex Provides</th>
<th>Your Cost(^1)</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine Tests</strong> (continued)</td>
<td>For routine Pap smear tests covered by Medicare: Full benefits less the Part B coinsurance (the Part B deductible does not apply) for one routine Pap smear test per two years (one per year for a member at high risk for cervical or vaginal cancer)</td>
<td>For routine Pap smear tests covered by Medicare: The Part B coinsurance (the Part B deductible does not apply) for one routine Pap smear test per two years (one per year for a member at high risk for cervical or vaginal cancer)</td>
<td>For routine Pap smear tests covered by Medicare: Nothing for one routine Pap smear test per two years (one per year for a member at high risk for cervical or vaginal cancer)</td>
</tr>
<tr>
<td>For routine Pap smear tests not covered by Medicare: Nothing</td>
<td>For routine Pap smear tests not covered by Medicare: Full benefits for one routine Pap smear test per calendar year</td>
<td>For routine Pap smear tests not covered by Medicare: Nothing for one routine Pap smear test per calendar year</td>
<td>31</td>
</tr>
<tr>
<td><strong>Surgery as an Outpatient</strong></td>
<td>The Part B deductible and Part B coinsurance</td>
<td>Nothing</td>
<td>31</td>
</tr>
</tbody>
</table>

\(^1\)Benefits for covered services are provided based on the allowed charge. You may have to pay any amount over the allowed charge. (See Parts 2 and 9.)
Part 2
Definitions

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

**Accident**

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

**Allowed Charge**

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

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

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

For *covered providers* that do not have a payment agreement with *Blue Cross and Blue Shield*, the *allowed charge* is set by *Blue Cross and Blue Shield*. It is the amount that *Blue Cross and Blue Shield* determines to be in the range of fees most often made by similar providers for the same service or supply. This amount is usually less than the provider’s actual charge. **In this case, you must pay the amount that is more than the allowed charge.**
Part 2
Definitions

**Benefit Period**

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

**Blood Deductible**

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

**Blue Cross and Blue Shield**

Blue Cross and Blue Shield of Massachusetts, Inc., the organization that has been designated by your *plan sponsor* to provide administrative services to this Medex plan, such as claims processing, case management and other services, and to arrange for a network of health care providers whose services are covered by this Medex plan. This includes an employee or designee of *Blue Cross and Blue Shield* who is authorized to make decisions or take action called for as described in this Benefit Description.

**Coinsurance**

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

*Medicare Part A Coinsurance*

There are three types of Part A *coinsurance*:

- The *inpatient hospital daily coinsurance* from the 61st through the 90th day in each *benefit period*. This is equal to one fourth of the Part A *deductible*.

- The *inpatient hospital daily coinsurance* for each of your 60 *hospital inpatient reserve days*. This is equal to one half of the Part A *deductible*.

- The extended care services daily *coinsurance* for *inpatient skilled nursing facility* services from the 21st through the 100th day in each *benefit period* when these services are covered by *Medicare*. This is equal to one eighth of the Part A *deductible*. 
Part 2
Definitions

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

**Medicare Part B Coinsurance**

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

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

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

**Covered Provider**

A health care provider for which Medex provides benefits as described in this Benefit Description when covered services are furnished to you. This Benefit Description specifies the kinds of providers that are covered. (See Part 9.) Except as stated otherwise, the health care provider must: be eligible to provide services covered by Medicare; and have a payment agreement with Blue Cross and Blue Shield. Health care providers that may furnish covered services to you include: ambulatory surgical facilities; cardiac rehabilitation centers; certified registered nurse anesthetists; chiropractors; Christian Science sanatoriums; chronic disease hospitals; clinical specialists in psychiatric and mental health nursing; community health centers; dentists; detoxification facilities; diagnostic imaging facilities; dialysis facilities; general hospitals; home infusion therapy providers; hospice providers; licensed independent clinical social workers; licensed mental health counselors; mental health centers; mental hospitals; nurse midwives; nurse practitioners; physical therapists; physicians; podiatrists; psychologists; rehabilitation hospitals; and skilled nursing facilities.
Part 2
Definitions

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

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

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

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

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

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

Effective Date
The date on which your membership in this Medex plan starts.
Part 2
Definitions

Emergency Medical Care

Medical, surgical or psychiatric care that you need immediately due to the sudden onset of a condition manifesting itself by acute symptoms, including severe pain, which are severe enough that the lack of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing your health or the health of another (including an unborn child) in serious jeopardy, serious impairment of bodily functions or serious dysfunction of any bodily organ or part. Some examples of conditions that require emergency medical care are: suspected heart attacks; strokes; poisoning; loss of consciousness; convulsions; and suicide attempts.

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

Note: For covered services eligible for benefits under Medex but not under Medicare, Blue Cross and Blue Shield considers “emergency medical care” the same as “urgent care” as defined under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. However, for covered services eligible for benefits under Medicare, Blue Cross and Blue Shield uses Medicare’s guidelines or decisions to determine whether your condition requires emergency medical care.

Group

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

Hospital

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

Medex provides benefits as described in this Benefit Description for hospital services that are covered by Medex only. This means that Medicare does not make any payment for these services.
Part 2
Definitions

Inpatient

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

Medical Technology Assessment Guidelines

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

- The technology must have final approval from the appropriate government regulatory bodies. This criterion applies to drugs, biological products, devices (such as durable medical equipment) and diagnostic services. A drug, biological product or device must have final approval from the Food and Drug Administration (FDA). Any approval granted as an interim step in the FDA regulatory process is not sufficient. Except as required by law, Medex may limit benefits for drugs, biological products and devices to those specific indications, conditions and methods of use approved by the FDA.

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

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

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

Medically Necessary

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

• Consistent with the diagnosis and treatment of your condition and for services covered by Medex only, furnished in accordance with Blue Cross and Blue Shield medical policy and medical technology assessment guidelines.

• Essential to improve your net health outcome and as beneficial as any established alternatives covered by this Medex plan. This means that for services covered by Medex only, if Blue Cross and Blue Shield determines that your treatment is more costly than an alternative treatment, benefits are provided for the amount that would have been provided for the least expensive alternative treatment that meets your needs. In this case, you pay the difference between the claim payment and the actual charge.

• As cost effective as any established alternatives and consistent with the level of skilled services that are furnished.

• Furnished in the least intensive type of medical care setting required by your medical condition.

It is not a service that: is furnished solely for your convenience or religious preference or the convenience of your family or health care provider; promotes athletic achievements or a desired lifestyle; improves your appearance or how you feel about your appearance; or increases or enhances your environmental or personal comfort.
Part 2
Definitions

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

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

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

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

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

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

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

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

Room and Board
Your room, meals and general nursing services while you are an inpatient. This includes hospital services furnished in an intensive care or similar unit.
Part 2
Definitions

**Sickness**

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

**Skilled Nursing Facility**

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

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

**Special Services**

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

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

**Subscriber**

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

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

At the onset of an emergency medical condition that in your judgment requires emergency medical care, you should go to the nearest emergency room. For assistance, call your local emergency medical service system by dialing the emergency telephone access number 911, or the local emergency telephone number. You will not be denied benefits for medical and transportation services described in this Benefit Description that you incur as a result of your emergency medical condition.

You usually need emergency medical services because of the sudden onset of a condition with acute symptoms, including severe pain, which are severe enough that the lack of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing your health or the health of another (including an unborn child) in serious jeopardy, serious impairment of bodily functions or serious dysfunction of any bodily organ or part. Some examples of conditions that require emergency medical care are: suspected heart attacks; strokes; poisoning; loss of consciousness; convulsions; and suicide attempts.

Post-Stabilization Care

After your emergency medical condition has been evaluated and stabilized in the hospital emergency room, you may be ready to go home or you may require further care. For example, your condition may require that you be admitted directly from the emergency room for inpatient emergency medical care in that hospital. If this is the case, you do not have to obtain approval from Blue Cross and Blue Shield before you are admitted. Or, your emergency room provider may recommend transfer for inpatient care in another facility or outpatient follow up care instead. In any case, both Medicare and Medex provide benefits for post-stabilization care as described in this Benefit Description.
You have the right to the benefits described in this section, except as limited or excluded in other sections of this Benefit Description. (See Part 5 for a description of your benefits for services received outside the United States.) Also, be sure to read the most current edition of your *Medicare* handbook since in most cases, Medex provides benefits only for services eligible for benefits under *Medicare*. Your *Medicare* handbook explains the benefits you get under the *Medicare* program as well as the restrictions that apply to your *Medicare* benefits.

**Important Facts to Remember About Your Benefits**

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

- Your treatment is furnished by a *covered provider*. (For more information, see Part 9.)
- Your treatment is *medically necessary* for you.
- For *covered services* not eligible for benefits under *Medicare*, but eligible for benefits under Medex, 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. To check for a *Blue Cross and Blue Shield* medical policy, you can go online and log on to [www.bluecrossma.com](http://www.bluecrossma.com). Or, you may call the *Blue Cross and Blue Shield* customer service office to request a copy of the information.

**Admissions for Inpatient Medical and Surgical Care**

**Hospital Services**

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

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

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

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

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

Christian Science Sanatorium Services

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

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

Physician and Other Covered Professional Provider Services

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

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

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

**Women’s Health and Cancer Rights**

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

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

After Medicare provides benefits, Medex provides benefits based on the allowed charge for human organ and stem cell transplants only when they are: eligible for benefits under Medicare; and furnished in accordance with medical technology assessment guidelines. Medex also provides full benefits based on the allowed charge for one or more stem cell transplants for a member who has been diagnosed with breast cancer that has spread when these stem cell transplants are furnished in accordance with Blue Cross and Blue Shield medical policy and medical technology assessment guidelines. (These stem cell transplants are not eligible for benefits under Medicare.) For covered transplants, benefits also include: room and board and special services; physician services; hospital and physician services for the harvesting of the donor’s organ or stem cells when the recipient is a member; and drug therapy during the transplant procedure to prevent rejection of the transplanted organ/tissue or stem cells.

**Chiropractor Services**

After Medicare provides benefits, Medex provides benefits based on the allowed charge for chiropractic services furnished by a chiropractor. These benefits are limited to manual manipulation of the spine to correct a subluxation that can be shown by x-ray.
No benefits are provided for x-rays furnished by a chiropractor.

**Covered Services**

**Continued Active Care After Hospital Discharge**

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

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

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


## Covered Services

### Diabetic Testing Materials, Enteral Formulas and Food Products

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

- **Materials to test for the presence of blood sugar** when ordered by a *physician* and glucometers.
  
  **Note:** Medex provides full benefits based on the allowed charge for materials to test for the presence of urine sugar. These diabetic testing materials are not covered by *Medicare*.

- **Enteral formulas for home use** that are *medically necessary* to treat malabsorption caused by: Crohn's disease; chronic intestinal pseudo-obstruction; gastroesophageal reflux; gastrointestinal motility; ulcerative colitis; and inherited diseases of amino acids and organic acids. Medex provides full benefits based on the *allowed charge* for these formulas when they are not covered by *Medicare*.

- **Food products modified to be low protein** that are *medically necessary* to treat inherited diseases of amino acids and organic acids. These food products are not covered by *Medicare*. Medex provides these benefits for up to $2,500 in each calendar year. You must pay all charges that are more than this $2,500 limit in each calendar year. You may buy these food products directly from a distributor.

### Dialysis Services

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

### Emergency Medical Outpatient Services

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

- **Emergency medical care**.

- **Accident** treatment.

These benefits are also provided for first non-dental *accident* treatment (such as first aid and reduction of swelling) furnished by a dentist. (See Part 5, “Dental Care.”)
Note: At the onset of an emergency medical condition that in your judgment requires emergency medical care, you should go to the nearest emergency room. For assistance, call your local emergency medical service system by dialing the emergency telephone access number 911, or the local emergency telephone number.

Home Health Care

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

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

Hospice Services

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

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

- Services arranged by the hospice provider such as: home health aide visits; drugs; *durable medical equipment*; and skilled nursing visits.

- Respite care. This care is furnished to the hospice patient in order to relieve the family or primary care person from caregiving functions.

- Bereavement services. These services are provided to the family or primary care person after the death of the hospice patient. They can include: contacts; counseling; communication; and correspondence.

Medex provides these benefits only when: the patient has a terminal illness and is expected to live six months or less, as certified by a *physician*; the patient and attending *physician* have agreed to a plan of care that stresses pain control and symptom relief rather than curative treatment; an adult is the primary care person in the home; and the patient lives in the service area of the hospice provider.
Part 4
Covered Services

Lab Tests, X-Rays and Other Tests

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

Mental Health and Substance Abuse Treatment

Medex provides benefits for:

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

- Treatment of rape-related mental or emotional disorders for victims of a rape or victims of an assault with intent to rape.

Medex provides these benefits as follows:

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

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

Covered Services

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

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

Other Mental or Nervous Conditions (Including Drug Addiction and Alcoholism)

Medex provides benefits as described below for treatment of all other mental or nervous conditions (including drug addiction and alcoholism) not described in the prior section,

Medex provides these benefits as follows:

- After Medicare provides benefits, Medex provides benefits based on the allowed charge for all available Medicare days in a benefit period when you are an inpatient in a general or mental hospital. After you have used all of your Medicare days in a benefit period (or all of your 190 Medicare lifetime days in a mental hospital), Medex provides full benefits based on the allowed charge for semiprivate room and board and special services. (If you have a right to Medicare hospital inpatient reserve days, you must use them before Medex provides benefits after the 90th day in a benefit period.) Medex provides these benefits: through the 365th day of each benefit period when you are an inpatient in a general hospital; and up to 120 days in each benefit period (but up to at least 60 days in each calendar year) when you are an inpatient in a mental hospital, less any days in a general or mental hospital already covered by Medicare in the same benefit period (or calendar year).
Note: Any days that you use in a benefit period in a general or mental hospital for treatment of any mental or nervous condition will reduce the number of days available in that same benefit period in a general, chronic disease or rehabilitation hospital for medical and/or surgical care. (See “Admissions for Inpatient Medical and Surgical care” earlier in Part 4.)

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

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

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

Physical Therapist Services

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

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

Covered Services

Podiatry Care

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

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

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

Radiation and X-Ray Therapy

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

Routine Tests

Routine Mammograms

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

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

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

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

Covered Services

**Routine Pap Smear Tests**

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

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

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

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

**Surgery as an Outpatient**

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

**Women’s Health and Cancer Rights**

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

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

After *Medicare* provides benefits, Medex provides benefits based on the *allowed charge* for human organ and stem cell (“bone marrow”) transplants *only* when they are: eligible for benefits under *Medicare*; and furnished in accordance with *medical technology assessment guidelines*. Medex also provides full benefits based on the *allowed charge* for one or more stem cell transplants for a *member* who has been diagnosed with breast cancer that has spread when these stem cell transplants are furnished in accordance with *Blue Cross and Blue Shield* medical policy and *medical technology assessment guidelines*. (These stem cell transplants...
are not eligible for benefits under Medicare.) For covered transplants, benefits also include: hospital and physician services for 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 rejection of the transplanted organ/tissue or stem cells.

**Oral Surgery**

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

**Anesthesia**

After Medicare provides benefits, Medex provides benefits based on the allowed charge for anesthesia services related to covered surgery. This includes anesthesia administered by a physician other than the attending physician or by a certified registered nurse anesthetist.
Part 5
Limitations and Exclusions

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

**Admissions Before a Member’s Effective Date**

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

**Ambulance Services**

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

**Benefits From Other Sources**

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

**Birth Control**

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

**Blood and Related Fees**

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

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

Cosmetic Services and Procedures

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

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

Custodial Care

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

Dental Care

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

Educational Testing and Evaluations

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

Exams/Treatment Required by a Third Party

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

Experimental Services and Procedures

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

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

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

Eye Exams/Eyewear

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

Foot Care

No benefits are provided for:

- Routine foot care services such as trimming of corns, trimming of nails and other hygienic care except when they are covered by Medicare and medically necessary because you have systemic circulatory disease (such as diabetes).
**Limitations and Exclusions**

- Certain non-routine foot care services and supplies such as: treatment of flat feet or partial dislocations in the feet; foot orthotics, arch supports, shoe (foot) inserts, orthopedic and corrective shoes; and fittings, castings and other services related to devices for the feet.

**Hearing Aids**

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

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

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

**Immunizations and Shots**

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

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

**Medical Care Outpatient Visits**

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

**Medical Devices, Appliances, Materials and Supplies**

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

Also, no benefits are provided for *durable medical equipment* and prosthetic devices such as artificial arms, legs and eyes. There are a few exceptions to this exclusion. Benefits are provided as described in Part 4 for: diabetic testing materials, including glucometers (which are classified under the same category as *durable medical equipment* when covered by *Medicare*); and *durable medical equipment* supplied as part of approved home dialysis or hospice services.
Part 5
Limitations and Exclusions

Missed Appointments

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

Non-Covered Providers

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

Non-Covered Services

No benefits are provided for:

- Any service or supply that is not described as a covered service in this Benefit Description. Some example of non-covered service are: acupuncture; prescription drugs (except when covered by Medicare as described in Part 4 or administered to an inpatient or outpatient in a health care facility covered by this Medex plan); and voluntary sterilization.

- Any service or supply that is not eligible for benefits under Medicare, except as described in Part 4.

- Services that would normally be eligible for benefits under Medex only, but do not conform with Blue Cross and Blue Shield’s medical policy and medical technology assessment guidelines.

- Services or supplies that you received when you were not enrolled in this Medex plan.

- Any service or supply furnished along with a non-covered service.

- Services and supplies that are not considered medically necessary. The only exceptions are for the routine mammograms and routine Pap smear tests described in Part 4.
Part 5
Limitations and Exclusions

- Services furnished to someone other than the patient, except as described in Part 4 for: hospice services; and the harvesting of a donor’s organ or stem cells when the recipient is a member.
- Services furnished to all patients due to a facility's routine admission requirements.
- A service made necessary by an act of war that takes place after your effective date.
- The travel time and related expenses of a provider.
- A service for which you are not required to pay or for which you would not be required to pay if you did not have this Medex plan.
- A provider's charge to file a claim. Also, a provider's charge to transcribe or copy your medical records.
- A provider's charge for: shipping and handling; taxes; or interest (finance charges).
- A separate fee for services by: interns, residents; fellows; or other physicians who are salaried employees of the hospital or other facility.
- Expenses that you have when you choose to stay in a hospital or another health care facility beyond the discharge time determined by Blue Cross and Blue Shield.

Personal Comfort Items

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

Private Duty Nursing

No benefits are provided for private duty nursing services.

Private Room Charges

For covered room and board, Medex provides benefits based on the semiprivate room rate. If a private room is used, you must pay any charges that are more than the semiprivate room rate. This is the case unless Medicare provides benefits for private room charges when Medicare determines that a private room is medically necessary for you.
Part 5
Limitations and Exclusions

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

Reversal of Voluntary Sterilization
No benefits are provided for the reversal of sterilization.

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

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

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

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

WORDS IN ITALICS ARE DEFINED IN PART 2.
Part 5
Limitations and Exclusions

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

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

Services Received Outside the United States

*Medicare* usually does not provide benefits for services received outside the United States or its territories. (See your *Medicare* handbook for details.) When it does, Medex provides only the Medex benefits for *covered services* as described in this Benefit Description. When it does not, Medex provides both the Medex benefits and the benefits normally paid by *Medicare* for *covered services* as described in this Benefit Description. But, if you set up a residence outside the United States or its territories, Medex will not provide any benefits.
Coordination of Benefits (COB)

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

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

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

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

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

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

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

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

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

**Plan Rights to Recover Benefit Payments**

**Subrogation and Reimbursement of Benefit Payments**

If you are injured by any act or omission of another person, the benefits under this Medex plan will be subrogated. This means that this Medex plan and *Blue Cross and Blue Shield*, as this Medex plan’s representative, may use your right to recover money from the person(s) who caused the injury or from any insurance company or other party. If you recover money, this Medex plan is entitled to recover up to the amount of the benefit payments that it has made. This is true no matter where or by whom the recovered money is held or how it is designated and even if you do not recover the total amount of your claim against the other person(s). This is also true if the payment you receive is described as payment for other than health care expenses. The amount you must reimburse this Medex plan will not be reduced by any attorney’s fees or expenses you incur.
**Part 6**

**Other Party Liability**

*Member Cooperation*

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

*Workers’ Compensation*

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

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

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

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

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

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

When the Member Files a Claim

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

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

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

- You want a formal Part B coverage determination for services and/or supplies not covered by Medicare.
- Your physician or another provider refuses to file a claim for you for covered services eligible for benefits under Medicare, even though it is required by law.
Part 7
Filing a Claim

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

You have to file a Medex claim when:
- You receive covered services that are eligible for benefits under Medicare and Blue Cross and Blue Shield does not get the claim from Medicare.
- You receive skilled nursing facility services covered by Medex only and the skilled nursing facility does not file a claim to Blue Cross and Blue Shield for you. In this case, you must have the skilled nursing facility fill out a Level of Care Form for each month of your stay. This Level of Care Form must be attached to your Medex claim form along with your original itemized bills.
- You get materials to test for the presence of urine sugar, enteral formulas covered by Medex only or low protein food products. (Since materials to test for the presence of blood sugar, including glucometers, and in some cases enteral formulas are covered by both Medicare and Medex, if the provider does not file a claim for you, you will have to file a claim for your Medicare benefits before you file a claim for your Medex benefits for these items.)
- You receive a service covered by Medex only from a provider that does not have an agreement with Blue Cross and Blue Shield.
- You receive services outside the United States that are covered by Medex. In this case, in addition to itemized bills with the date you received the services, you must get the medical notes for these services. If the covered services are also eligible for benefits under Medicare, you must first send the claim to Medicare. When your claim has been processed, Medicare will send you a notice. Then, you will have to file a claim for your Medex benefits.

When you have to file a claim for your Medex benefits, you must:
- Fill out a Medex claim form; and attach original itemized bills that show the date you received the services;
- Attach the notice you receive from Medicare to the Medex claim form if the covered services are also eligible for benefits under Medicare; and
- Mail the claim to the Blue Cross and Blue Shield customer service office. Blue Cross and Blue Shield will then process your claim for Medex benefits.
You can get Medex claim forms from the *Blue Cross and Blue Shield* customer service office. *Blue Cross and Blue Shield* will mail to you all applicable forms within 15 days after receiving notice that you obtained some service or supply for which you may be paid.

**Time Limit for Filing a Claim**

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

**Timeliness of Claim Payments**

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

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

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

If the additional information is not provided to *Blue Cross and Blue Shield* within 45 calendar days of the request, the claim for Medex benefits or payment will be denied. If the additional information is submitted after this 45 days, then it may be viewed as a new claim for Medex benefits or payment. In this case, a decision will be made within 30 days as described previously in this section.
Part 8
Grievance Program

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

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

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

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

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

Formal Grievance Review

Internal Formal Grievance Review

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

- The preferred option is for you to send your grievance in writing to:
  Member Grievance Program
  Blue Cross and Blue Shield of Massachusetts, Inc.
  One Enterprise Drive
  Quincy, MA 02171-2126
  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.

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

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

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

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

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

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

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

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

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

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

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

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

**Expedited Review for Immediate or Urgently-Needed Services**—In place of the formal grievance review described above, you have the right to request an “expedited” review right away when your grievance review concerns medical care or treatment for which waiting for a response under the grievance review timeframes described above would seriously jeopardize your life or health or your ability to regain maximum function as determined by *Blue Cross and Blue Shield* or your physician, or if your physician says that you will have severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance review. If you request an expedited review, *Blue Cross and Blue Shield* will review your grievance and notify you of the decision within 72 hours after your request is received.

**External Review**

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

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

You must file your request for an external review or expedited external review within 30 days of receiving the denial letter sent to you by *Blue Cross and Blue Shield* following the formal internal grievance process. *Blue Cross and Blue Shield* will work closely with you to guide you through the external review or expedited external review process.
Part 8
Grievance Program

Appeals Process for Rhode Island Residents or Services

The following provisions apply only to:

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

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

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

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

External Appeal—If your appeal is denied, you have the right to present your case to an appeals agency that is designated by Rhode Island and not affiliated with Blue Cross and Blue Shield. If you request this voluntary external appeal, Rhode Island requires you be responsible for half of the cost of the appeal.
**Part 8**

**Grievance Program**

_group_ will be responsible for the remaining half. The notice you receive from _Blue Cross and Blue Shield_ about your appeal will advise you of: the name of the appeals agency that is designated by Rhode Island; and your share of the cost for an external appeal. To file an external appeal, you must make your request in writing to: Member Grievance Program, Blue Cross and Blue Shield of Massachusetts, Inc., One Enterprise Drive, Quincy, MA 02171-2126. Along with your request, you must state your reason(s) for your disagreement with _Blue Cross and Blue Shield_’s decision and enclose a check made payable to the designated appeals agency for your share of the cost for the external appeal.

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

**Expedited Appeal**—If your situation is an emergency, you have the right to an expedited appeal at all three levels of appeal as stated above. An emergency is defined as the sudden onset of a medical or _mental or nervous condition_ that in the absence of immediate medical attention could reasonably be expected to result in placing your health or your ability to regain maximum function in serious jeopardy or, in your _physician_’s opinion, would result in severe pain. You may request an expedited reconsideration or appeal by contacting _Blue Cross and Blue Shield_ at the telephone number shown in your letter. _Blue Cross and Blue Shield_ will notify you of the result of your expedited appeal within 72 hours of its receipt. If your appeal is denied, you have the right to request an expedited external appeal. The notice you receive from _Blue Cross and Blue Shield_ about your appeal will advise you of: the name of the appeals agency that is designated by Rhode Island; and the amount that Rhode Island requires you pay for your share of the cost for an expedited external appeal. To request an expedited external appeal, you must send your request in writing to: Member Grievance Program, Blue Cross and Blue Shield of Massachusetts, Inc., One Enterprise Drive, Quincy, MA 02171-2126. Your request should state your reason(s) for your disagreement with the decision and include signed documentation from your provider that describes the emergency nature of your treatment. In addition, you must also enclose a check made payable to the designated appeals agency for your share of the cost for the expedited external appeal.

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

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

Medicare Appeals and Grievances

If you do not agree with a decision by Medicare on the amount that Medicare has paid on a claim or whether the services you received are covered by Medicare, you have the right to appeal the decision. The steps you should take to appeal the decision are explained in your Medicare handbook. You may also call the toll-free help line at 1-800-633-4227 (1-800-MEDICARE) to ask for a copy of Medicare Appeals and Grievances (Complaints) for more detailed information about the Medicare appeals process.
Part 9
Other Plan Provisions

Payment of Claims for Medicare Part B Covered Services and Supplies

Claims for Medicare Part B covered services and supplies are paid under the assignment method or the non-assignment method.

**The Assignment Method**

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

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

**The Non-Assignment Method**

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

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

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

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

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

Access to and Confidentiality of Your Medical Records

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

- For administering benefits (including coordination of benefits with other insurance plans); disease management programs; managing care; quality assurance; utilization management; the prescription drug history program; grievance and claims review activities; or other specific business, professional or insurance functions for Blue Cross and Blue Shield.

- For bona fide medical research according to the regulations of the U.S. Department of Health and Human Services and the Food and Drug Administration for the protection of human subjects.

- As required by law or valid court order.

- As required by government or regulatory agencies.

- As required by your group or its auditors.

- For the purpose of processing a claim, medical information may be released to your group’s reinsurance carrier.

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

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

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

**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.

Blue Cross and Blue Shield will not interfere with the relationship between providers and their patients. You are free to select or discharge any provider. It is not up to Blue Cross and Blue Shield to find a provider for you. Blue Cross and Blue Shield is not responsible if a provider refuses to furnish services to you.
**Part 9**

**Other Plan Provisions**

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

**Assignment of Benefits**

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

**Authorized Representative**

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

**Benefits for Pre-Existing Conditions**

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

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

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

Charges for Services That Are Not Medically Necessary

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

Counting Inpatient Days

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

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

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

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

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

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

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

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

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

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

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

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

Covered Services Outside Massachusetts

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

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

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

Utilization Review Program

Utilization review refers to the approach that Blue Cross and Blue Shield uses to evaluate the necessity and appropriateness of many different services. This approach employs a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. These techniques include; post payment review; and individual case management as described below.

Note: For more information about the utilization review program, you may call the Blue Cross and Blue Shield customer service office at 1-800-258-2226. Or, if a different telephone number appears on your Medex identification card, you may call that number. (To use the Telecommunications Device for the Deaf, call 1-800-522-1254.)
Process to Develop Clinical Guidelines and Utilization Review Criteria

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

- Consistent with generally accepted principals of professional medical practice; and
- Required to diagnose or treat your illness, injury, symptom, complaint or condition; and
- Essential to improve your net health outcome and as beneficial as any established alternatives covered by this Medex plan; and
- As cost effective as any established alternatives and consistent with the level of skilled services that are furnished; and
- Furnished in the least intensive type of medical care setting required by your medical condition.

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

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

Individual Case Management

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

- Shorten an inpatient stay by sending you home or to a less intensive setting to continue treatment;
- Direct you to a less costly setting when an inpatient admission has been proposed; or
- Prevent future inpatient stays by providing outpatient benefits instead.
Blue Cross and Blue Shield may, in some situations, present a specific alternative treatment plan to you and your attending physician. This treatment plan will be one that is medically necessary for you. Blue Cross and Blue Shield will need the full cooperation of everyone involved: the patient (or guardian); the hospital; the attending physician; and the proposed setting or health care provider. Also, there must be a written agreement between the patient (or family or guardian) and Blue Cross and Blue Shield, and between the provider and Blue Cross and Blue Shield to furnish the services approved through this alternative treatment plan. The agreement will specify the maximum amount of benefits available under Individual Case Management. This maximum amount is equal to the total cost that your Medex benefits would have been had you stayed in the hospital.

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

**Time Limit for Legal Action**

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

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

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

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

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

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

Enrollment Periods

Initial Enrollment

You may enroll in this Medex plan on your initial eligibility date (such as your Medicare effective date). The plan sponsor is responsible for providing you with details about how and when you may enroll in this Medex plan. To enroll, you must complete the enrollment form provided in your enrollment packet and return it to the address specified in the enrollment packet no later than 30 days after your eligibility date. (For more information, contact your plan sponsor.) If you choose not to enroll in this Medex plan on your initial eligibility date, you may enroll only during an open enrollment period or within 30 days of a special enrollment event as provided by federal law.

Special Enrollment

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

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

WORDS IN ITALICS ARE DEFINED IN PART 2.
To enroll, you must notify your plan sponsor no later than 30 days after the special enrollment event. For example, if your coverage under another health plan is terminated, you must request enrollment in this Medex plan within 30 days after your other health care coverage ends. The plan sponsor will send you any special forms you may need. If you do not request enrollment within 30 days, you will have to wait until the group’s next open enrollment period to enroll.

**Open Enrollment Period**

If you choose not to enroll in this Medex plan within 30 days of your initial eligibility date, you may enroll during an open enrollment period. The open enrollment period is the time each year during which eligible persons may enroll for or change coverage for the next year. The open enrollment period is announced to all eligible employees. To enroll in this Medex plan during this enrollment period, you must complete the enrollment form provided in your enrollment packet and return it no later than the date specified in the enrollment packet.

**Making Membership Changes**

If you want to ask for a membership change or you need to change your name or mailing address, you should call or write your plan sponsor. The plan sponsor will send you any special forms you may need. You must request the membership change within 30 days of the reason for the change. If you do not make the change within 30 days, you will have to wait until the group’s next open enrollment period to make the change. All membership changes are allowed only when they comply with the eligibility and enrollment rules set by the plan sponsor for your group health care benefits and the conditions outlined in this Benefit Description.

**Loss of Eligibility for Coverage in This Medex Plan**

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

- You choose to cancel your membership in this Medex plan as permitted by the plan sponsor. You may do so at any time for any reason by sending a written notice to the plan sponsor. Blue Cross and Blue Shield must receive the termination request from the plan sponsor not more than 30 days after your termination date.
- You lose eligibility for health care coverage with the group. This means you no longer meet the rules set by the group for eligibility in this Medex plan.
- You lose your Medicare coverage. In this case, if you are still eligible for group coverage, you may be eligible to transfer your coverage to another
Part 10

Enrollment and Termination

health care plan that is offered by your group. (Contact your plan sponsor for help in this situation.) Or, if you are not eligible for group coverage, you may be eligible to enroll in a nongroup plan. (The Blue Cross and Blue Shield customer service office can help you in this situation.) In any case, Blue Cross and Blue Shield must receive the termination request not more than 30 days after your termination date.

- You committed misrepresentation or fraud. For example, you gave false or misleading information on the enrollment application form. Or, you misused the Medex identification card by letting another person not enrolled in this Medex plan attempt to get benefits. Termination will go back to your effective date. Or, it will go back to the date of the misrepresentation or fraud as determined by Blue Cross and Blue Shield.

- You commit acts of physical or verbal abuse that pose a threat to, or a threat to the health of, Blue Cross and Blue Shield participating providers or other members or employees of Blue Cross and Blue Shield or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. and that are not related to your physical condition or mental or nervous condition.

- This Medex plan is terminated by the plan sponsor.

Enrollment in a Nongroup Plan

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

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

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

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

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

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

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

All other provisions remain as described in your Benefit Description.
This rider modifies the terms of your health plan. Please keep this rider with your Benefit Description for easy reference.

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

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

   • **Biologically-based mental or nervous conditions.** “Biologically-based mental or nervous conditions” means: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder; delirium and dementia; affective disorders; and any biologically-based mental or nervous conditions appearing in the most recent edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders that are scientifically recognized and approved by the commissioner of the department of mental health in consultation with the commissioner of the Division of Insurance.

   • **Rape-related mental or emotional disorders** for victims of a rape or victims of an assault with intent to rape.

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

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

Medex provides benefits for the Medicare Part B deductible and Part B coinsurance for outpatient services by a Medicare covered mental health provider. When the services are not covered by Medicare, Medex provides full benefits based on the allowed charge for services by a physician (who is a specialist in psychiatry), psychologist, licensed independent clinical social worker, clinical specialist in psychiatric and mental health nursing or licensed mental health counselor. Medex provides these benefits for as many visits as are medically necessary for your condition.
2. The inpatient and outpatient benefits provided by this Medex plan for services to diagnose and treat those mental or nervous conditions (including drug addiction and alcoholism) not identified in section 1 have been changed as follows:

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

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

- Up to a lifetime total of 365 days when you are an inpatient in a general or, in certain cases, a mental hospital.

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

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

Note: Any lifetime days that you use in a general or mental hospital for treatment of any mental or nervous condition will reduce the number of lifetime days available in a general, chronic disease or rehabilitation hospital for medical and/or surgical care.
This rider modifies the terms of your health plan. Please keep this rider with your Benefit Description for easy reference.

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

**Medically Necessary (Medical Necessity)**

To receive coverage under this contract, all of your health care services must be medically necessary and appropriate for your health care needs. (The only exceptions to this are for: covered preventive and routine health care services.) For covered services eligible for benefits under Medicare, Blue Cross and Blue Shield decides which health care services that you receive (or you are planning to receive) are medically necessary and appropriate for coverage by using Medicare’s “reasonable and necessary” guidelines. For covered services eligible for benefits under Medex but not under Medicare, Blue Cross and Blue Shield decides which health care services that you receive (or you are planning to receive) are medically necessary and appropriate for coverage. It will do this by using all of the guidelines described below.

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

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

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

All other provisions remain as described in your Benefit Description.
This rider modifies the terms of your health plan. Please keep this rider with your Benefit Description for easy reference.

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

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

All other provisions remain as described in your Benefit Description.
This rider modifies the terms of your health plan. Please keep this rider with your Benefit Description for easy reference.

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

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

All other provisions remain as described in your Benefit Description.
This rider modifies the terms of your health plan. Please keep this rider with your Benefit Description for easy reference.

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

- **Licensed dietitian nutritionists** for Medicare approved outpatient nutrition counseling and medical nutrition therapy services that are furnished on and after August 1, 2003. The benefits for these covered services are the same as those benefits that are provided for Medicare approved outpatient medical care services furnished by a physician.

- **Occupational therapists** for Medicare approved outpatient short-term rehabilitation therapy that is furnished on and after January 1, 2004. The Benefits for these covered services are the same as those benefits that are provided for Medicare approved outpatient short-term rehabilitation therapy furnished by other covered professional providers.

All other provisions remain as described in your Benefit Description.
This rider modifies the terms of your health plan. Please keep this rider with your Benefit Description for easy reference.

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

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

**Medicare Part B Covered Services and Supplies**

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

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

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

**Payment to Providers for Services That Are Covered by Medex Only**

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

The following provisions apply:

1. Medicare does not provide any benefits for services and supplies furnished by a hospital or another health care facility that does not participate with Medicare. There is one exception to this exclusion. Medicare provides benefits for emergency medical care that you receive in a hospital or dialysis facility that does not participate with Medicare, but only when Medicare determines that a Medicare participating hospital or dialysis facility is not reasonably available. However, Medex provides benefits for covered services (including equipment and supplies for home dialysis) that you receive at a hospital or dialysis facility that does not participate with Medicare. Medex provides the same benefits to which you would have been entitled from Medex had you been in a hospital or dialysis facility that participates with Medicare. If you have used all of your regular Medicare days in a benefit period and all of your Medicare hospital inpatient reserve days, Medex provides full benefits based on the allowed charge for semiprivate room and board and special services for emergency medical care in a hospital that does not participate with Medicare. Medex provides these benefits under your 365 lifetime days. (See “Inpatient Hospital Services” below.)

2. Benefits for services furnished outside Massachusetts by a psychologist or licensed independent clinical social worker are provided only when the covered services are eligible for benefits under Medicare. No benefits are provided for services by the following providers when furnished outside Massachusetts: clinical specialists in psychiatric and mental health nursing; licensed independent clinical social workers (when services are covered by Medex only); licensed mental health counselors; and psychologists (when services are covered by Medex only).

Inpatient Hospital Services

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

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

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

**Coverage for Blood**

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

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

**Admissions Before Your Effective Date**

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

**Services and Supplies After Your Termination Date**

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