



Harvard University
Student Health Program
(HUSHP) Handbook
AY2017

HUSHP Member Services

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Appendix 1: The Student Health Insurance Plan: Blue Cross Blue Shield Hospital/Specialty Benefit Description

Appendix 2: The Student Health Insurance Plan: Optum Rx Prescription Drug Benefit

Massachusetts Insurance Requirements and HUSHP

Massachusetts law requires that any full-time student enrolled in an institution of higher learning in Massachusetts participate in a student health insurance program or in a health plan of comparable coverage. The Division of Health Care Finance and Policy's (Division) regulation, 114.6 CMR 3.00: Student Health Insurance, implements the student health requirement and sets forth the minimum benefit levels and required services for a Student Health Program (SHP). The regulation also establishes the criteria by which a school may waive a student's participation in SHP upon demonstration of comparable insurance coverage.

Because of the Massachusetts SHP regulations, all Harvard students are automatically enrolled in the Harvard University Student Health Program (HUSHP) and the cost of the program is applied to their term bill. HUSHP is a comprehensive health program comprised of two parts:

Student Health Fee

All students are charged this health fee as part of enrollment. The Student Health Fee covers most services at Harvard University Health Services (HUHS), including primary care, medical and surgical specialty care, mental health/counseling services, radiology, physical therapy, and urgent care. *Note: Some services that are provided at HUHS (e.g., Quest Laboratory services and Obstetrics/Gynecology) will be billed to the Student Health Insurance Plan or a student's outside insurance plan.*

HUSHP Student Health Insurance Plan: Blue Cross Blue Shield (BCBS) Hospital/ Specialty and Optum Rx Prescription Drug Coverage

This insurance plan provides hospital/specialty care through Blue Cross Blue Shield (BCBS) of Massachusetts and prescription drug coverage through Optum Rx. Coverage includes emergency room visits, hospitalizations, diagnostic lab/radiology services, ambulatory surgery, specialty care outside of HUHS (limited), and prescription drug coverage. *Note: Students with comparable insurance coverage may be eligible to waive the Student Health Insurance Plan (see page 8 for more information).*

HUSHP Eligibility

STUDENTS

All full-time and part-time registered Harvard students are eligible for and automatically enrolled in the Harvard University Student Health Program (HUSHP). Charges are applied to the student's term bill. Students with other insurance are eligible to "waive" coverage in the Student Health Insurance Plan. Students who are half-time or less are eligible to waive enrollment in both the Student Health Fee and the Student Health Insurance Plan. Eligibility for coverage is affected by a leave of absence or withdrawal.

Extension School Students: Students enrolled at the Extension School are eligible for HUSHP if registered for an active degree, certificate, or diploma and are registered three-quarter time (12 credits) or more per term.

Graduating Students: Coverage ends on the last day of the HUSHP coverage period in which the student graduates (either 7/31 or 1/31). *November & March degree candidates: please see page 11.*

Pre-Matriculating Students: Students attending formal pre-matriculation programs are eligible to purchase one or two months of HUSHP coverage (Student Health Fee and the Student Health Insurance Plan). Students must contact their program administrator to confirm eligibility.

STUDENT DEPENDENTS

Dependents are eligible for enrollment in HUSHP when the student is participating in both the Student Health Fee and the Student Health Insurance Plan. If for any reason the student's coverage is terminated, the dependents' coverage will be terminated as well.

Students will be required to supply appropriate documentation for each family member enrolled in their plan. Extension School students must contact the Extension School registrar to enroll dependents.

Student dependents and required documentation include:

- Spouse: valid marriage certificate or I20 form for international students
- Dependent children (up to age 26): birth certificate, legal documentation of adoption or guardianship, or DS-2019 form for international students

POST-DOCTORAL AFFILIATES

Post-Doctoral Affiliates (also known as post-doctoral fellows): Eligible to enroll in HUSHP as long as they have a current appointment and are not eligible for employer-sponsored health insurance. When an affiliate's appointment is terminated, HUSHP coverage will be terminated at the end of the term of coverage (either 1/31 or 7/31).

Affiliate Dependents: Dependents of eligible post-doctoral affiliates are eligible for enrollment in HUSHP when the affiliate is enrolled. If for any reason the affiliate's coverage is terminated, the dependents' coverage will also be terminated.

Appropriate documentation is required for each family member enrolled in an affiliate's plan. Affiliate dependents and documentation include:

- Spouse: valid marriage certificate or I20 form for international students
- Dependent children (up to age 26): birth certificate, legal documentation of adoption or guardianship, or DS-2019 form for international students

HUSHP Eligibility for Renewal

STUDENTS

HUSHP coverage is automatically renewed each plan year for all full-time and part-time registered Harvard students. Charges are applied to the student bill.

Extension School Students: Students enrolled at the Extension School are eligible for HUSHP if registered for an active degree, certificate, or diploma and are registered three-quarter time (12 credits) or more per term. Extension school students should check with their school regarding the renewal process.

STUDENT DEPENDENTS

Dependents are eligible for renewal in HUSHP when the student is participating in both the Student Health Fee and the Student Health Insurance Plan. If for any reason the student's coverage is terminated, the dependents' coverage will be terminated as well. Dependent renewal is not automatic.

POST-DOCTORAL AFFILIATES

Post-Doctoral Affiliates (also known as post-doctoral fellows): Eligible for renewal in HUSHP as long as they have a current appointment and are not eligible for employer-sponsored health insurance. When an affiliate's appointment is terminated, HUSHP coverage will be terminated at the end of the term of coverage (either 1/31 or 7/31).

Affiliate Dependents: Dependents of eligible post-doctoral affiliates are eligible for renewal in HUSHP when the affiliate is enrolled. If for any reason the affiliate's coverage is terminated, the dependents' coverage will also be terminated.

Renewal for post-doctoral affiliates and their eligible dependents is not automatic.

The Harvard University Student Health Program does not impose pre-existing condition limitations nor exclusions. Eligible students, student dependents, and post-doctoral affiliates/dependents shall not be discriminated against due to health status.

HUSHP Enrollment Periods & Terms of Cancellation

Open Enrollment Periods Student Dependents Post-Doctoral Affiliates/Dependents	
Fall 2016 June 1, 2016—August 31, 2016	Spring 2017 December 1, 2016—February 28, 2017

ENROLLMENT DUE TO LIFE CHANGING EVENTS

STUDENT DEPENDENTS

Student dependents may be added to your plan within 45 days of a life changing event during the year (or late fees and other restrictions apply); the coverage and cost are pro-rated to the day of the event. You must submit documentation confirming one of these events to Member Services:

- A dependent's entry into the country
- Loss of other health insurance coverage
- Marriage
- Birth of a child, legal adoption, or legal guardianship

POST-DOCTORAL AFFILIATES & AFFILIATE DEPENDENTS

Post-Doctoral Affiliates and their dependents may be enrolled on HUSHP outside of the open enrollment periods within 45 days of a life changing event (or late fees and other restrictions apply); the coverage and cost are pro-rated to the first day of the month of the event. You must submit documentation confirming one of these events to Member Services:

- Entry into the country
- Loss of other health insurance coverage
- Marriage
- Birth of a child, legal adoption, or legal guardianship

CANCELLATION

Student dependents & Post-doctoral affiliates/affiliate dependents may request enrollment cancellations through Member Services. Refunds are given for future terms of health insurance only; refunds are not available after a term of coverage has begun (Fall term: August 1; Spring term: February 1).

Coverage Dates and Rates

Coverage Dates:

Fall Term	August 1, 2016—January 31, 2017
Spring Term	February 1, 2017—July 31, 2017

Rates for 2016-2017

Students	One Term (Fall or Spring)	Two Terms (Full Plan Year)
Student Health Fee	\$544	\$1,088
Student Health Insurance Plan	\$1,315	\$2,630
Total	\$1,859	\$3,718

Student Dependents	One Term (Fall or Spring)	Two Terms (Full Plan Year)
Spouse	\$2,981	\$5,962
Child	\$1,563	\$3,126
Second Child*	\$787	\$1,574

*There are no additional charges for more than two children.

Post-Doctoral Affiliates	One Term (Fall or Spring)	Two Terms (Full Plan Year)
Affiliate	\$4,537	\$9,074
Dependent 1 Only	\$5,693	\$11,386
Dependent 2 Only*	\$4,550	\$9,100

*There are no additional charges for more than two dependents.

Benefit Summary

STUDENT HEALTH FEE

Harvard University Health Services (HUHS) is a multi-specialty group practice. There are four campus locations: Harvard Square (Smith Campus Center), Harvard Business School (Cumnock Hall), Harvard Law School (Pound Hall), and Longwood Medical Area (Vanderbilt Hall). The following HUHS services are covered under the Student Health Fee when medically necessary as determined by your provider, with no copayment required:

- Primary Care
- Mental Health
- Urgent Care

Services at HUHS are not subject to pre-determined visit limits.

On Site Specialty Services:

- Allergy & Asthma
- Dermatology
- Ear, Nose, & Throat
- Endocrinology
- Gastroenterology
- Mammography
- Neurology
- Nutrition
- Ophthalmology
- Orthopedics
- Physical Therapy
- Podiatry
- Rheumatology
- Surgery
- Urology
- X-Ray

Covered Immunizations*:

- Preventive immunizations as recommended and supported by the Advisory Committee on Immunization Practices, by the U.S. Preventive Services Task Force, and by the U.S. Department of Health and Human Services.

*Covered at HUHS only; Must be enrolled in Student Health Fee and Student Health Insurance Plan.

Additional non-covered services available at HUHS on a fee-for-service basis:

- Contact Lens Services
- Dental Services
- Durable Medical Equipment*
- Gynecology/Obstetrics*
- Immunizations required for travel
- Pharmacy*
- Quest Diagnostics*
- Wellness Programs

*Covered under the Student Health Insurance Plan

Benefit Summary

STUDENT HEALTH INSURANCE PLAN

The Student Health Insurance Plan consists of hospital/specialty care coverage administered by Blue Cross Blue Shield of Massachusetts (BCBS) and prescription drug coverage administered by Optum Rx.

Blue Cross Blue Shield coverage includes, but is not limited to, the following services:

Type of Care	Coverage under the Student Health Insurance Plan
Ambulatory surgery	Covered when medically necessary; \$75 co-payment with in-network providers; subject to deductible and co-insurance for out-of-network providers
Diagnostic labs/radiology services	Covered in full with in-network providers; subject to deductible and co-insurance for out-of-network providers
High-tech imaging services	Covered when medically necessary; \$50 co-payment with in-network providers; subject to deductible and co-insurance for out-of-network providers
Emergency room visits	Covered when medically necessary; \$100 co-payment with in-network and out-of-network hospitals
Specialty care outside of HUHS	Covered when medically necessary; limited to 6 visits per plan year; \$35 co-payment with in-network providers; subject to deductible and co-insurance for out-of-network providers
Inpatient Admission to a General Hospital, Psychiatric Hospital, or Substance Abuse Facility	Covered when medically necessary; \$100 co-payment with in-network providers; subject to deductible and co-insurance for out-of-network providers

PRESCRIPTION DRUG COVERAGE

Optum Rx administers coverage for the prescription drug portion of the Student Health Insurance Plan. Prescription drugs may be obtained on campus at the HUHS Pharmacy or at most retail pharmacies.

For complete details on coverage under Blue Cross Blue Shield, please review APPENDIX I: BCBS Benefit Description.

For complete details on prescription drug coverage, please review APPENDIX II: Optum Rx Prescription Drug Coverage.

Benefits Summary

MENTAL HEALTH BENEFITS

The Harvard University Student Health Program offers a wide range of services for mental health care.

THE STUDENT HEALTH FEE

The Student Health Fee covers mental/behavioral health visits and psychopharmacology visits at Harvard University Health Services (HUHS). There is no visit limit at HUHS; the number of visits is based on medical necessity as determined by the provider.

THE STUDENT HEALTH INSURANCE PLAN

The Student Health Insurance Plan covers mental health inpatient and outpatient services outside of HUHS.

Students who waive the Student Health Insurance Plan are eligible to be seen at HUHS under the Student Health Fee, but will be responsible for the cost of mental health care received outside of HUHS.

Services	Coverage under the Student Health Fee for services at HUHS	Coverage under the Student Health Insurance Plan
Outpatient mental health	Covered in full	40 visits per plan year (combined in and out-of-network)
Psychopharmacology Visits Pediatric (through age 17)	Covered in full	10 visits per plan year (subject to clinic and physicians' office visit limit)
Psychopharmacology Visits Adult (18 and older)	Covered in full	6 visits per plan year (Subject to clinic and physicians' office visit limit)
Inpatient Admission to a General Hospital, Psychiatric Hospital, or Substance Abuse Facility	N/A	\$100 co-payment with in-network providers; subject to deductible and co-insurance for out-of-network providers

ANCILLARY SERVICES

Ancillary services are covered nationwide by the Student Health Insurance Plan.

Ancillary providers include Independent Clinical Laboratory and Durable/Home Medical Equipment providers.

In most cases, you receive the highest level of benefits when you choose a preferred provider in the **Blue Care Elect/PPO network**.

In order for an ancillary service to process as part of your **in-network** level of benefits, **all** of the following criteria must be met:

- The ordering physician must be a Blue Cross Blue Shield PPO provider
- The rendering provider (lab or DME) processing the order must be a Blue Cross Blue Shield PPO provider
- For labs: the ordering physician and the rendering lab must be located in the **same state**
- For DME providers: the ordering physician and the rendering DME vendor must be in the **same state** where the DME is shipped to

If all of the above criteria are not met, the claim will process against your out-of-network level of benefits (\$250 deductible and 30% coinsurance will apply).

Waiving HUSHP

WAIVER ELIGIBILITY AND RULES

Students with comparable health insurance may be eligible to waive enrollment in the Student Health Insurance Plan. In limited cases, the Student Health Fee may also be waived.

Term	Waiver Deadline
August 1 – January 31 (Fall)	July 31*
February 1 – July 31 (Spring)	January 31*

By waiving, coverage is terminated to the first day of the plan term for which a waiver was completed (e.g., either August 1 or February 1).

*Charges will remain on your term bill if you do not waive by the required deadlines.

STUDENT HEALTH INSURANCE PLAN

To waive the Student Health Insurance Plan, a student must present evidence of comparable coverage. Coverage under a Health Benefit Plan is comparable if:

1. The health benefit plan provides to the student, throughout the school year, reasonably comprehensive coverage of health services, including preventive and primary care, emergency services, surgical services, hospitalization benefits, ambulatory patient services, and mental health services, and prescription drugs; and
2. The services covered under the Health Benefit Plan, including all services listed in 956 CMR 8.05 (2)(a)(1), are reasonably accessible to the Student in the area where the Student attends School.

Note: Foreign-based health insurance will not be accepted as comparable coverage.

STUDENT HEALTH FEE

To waive the Student Health Fee, a student must fit into one of the categories below:

1. Traveling scholars/study abroad students studying outside the country
2. Enrolled half-time or less (must also waive the Student Health Insurance Plan)
3. A non-resident student who resides outside of Massachusetts, with no activities on campus for the entire term. *Note: Students who live out of state but attend class on campus do not qualify to waive.*
4. Enrolled in the Harvard University Group Health Plan (HUGHP)
5. Active military who are prohibited from receiving health care from any facility other than Hanscom Air Force Base (requires an attestation form to be completed)

After submitting a waiver application, students will receive a confirmation email. Print this email and keep it for your records. Member Services will not review any disputed fees without a copy of a waiver application confirmation email.

Eligible students must complete separate waivers for the Student Health Insurance Plan and the Student Health Fee. Eligible students must complete waivers for each term of study.

WAIVER RESCIND POLICY

Students who have previously waived the Student Health Insurance Plan may be eligible to re-enroll based on certain criteria.

1. If a student rescinds his/her Student Health Insurance Plan waiver within 60 days of a loss of alternative insurance coverage, the student will be enrolled in the Student Health Insurance Plan from the first day of the month in which the other coverage ended.
 - a. The cost of the Student Health Insurance Plan will be prorated to the first day of the month in which the other coverage ended.
 - b. Documentation of your loss of coverage must be submitted with the rescind application.
2. If a student rescinds his/her Student Health Insurance Plan waiver 61 days or more after the loss of alternative insurance coverage, the student will be enrolled in the Student Health Insurance Plan from the first day of the month in which the other coverage ended.
 - a. The cost of the Student Health Insurance Plan will be prorated to the first day of the month in which the other coverage ended.
 - b. The student will be assessed a penalty of \$150 for each calendar month beyond the allowed 60 days.
 - c. Documentation of your loss of coverage must be submitted with the rescind application.
 - d. Coverage cannot be reinstated more than 102 days from the date that HUSHP Member Services receives a completed application or the beginning of the term of coverage, whichever is sooner.
3. If a student rescinds his/her Student Health Insurance Plan waiver without a loss of insurance coverage, but by the waiver deadline:
 - a. The cost of the plan will not be prorated.
 - b. The student will be enrolled to the start date of the term he/she is rescinding.
 - c. The student will be charged a \$50 processing fee.
4. If a student applies to rescind his/her Student Health Insurance Plan waiver without a loss of insurance coverage, but after the waiver deadline, the student will not be allowed to enroll in the Student Health Insurance Plan until the following term.

Students may not submit false information to HUSHP Member Services in connection with obtaining or waiving the Student Health Insurance Plan. If Member Services learns of facts that may indicate false information has been provided, such as that a student has submitted a waiver based on having alternative insurance coverage but no such alternative coverage exists, Member Services will report this to the appropriate Dean of Students for disciplinary action.

HUSHP Policies

LEAVE OF ABSENCE/WITHDRAWAL POLICY

Students expecting to take a leave of absence or withdraw from the University should contact HUSHP Member Services at 617.495.2008 or mervices@huhs.harvard.edu as early as possible so that information regarding insurance options can be reviewed with the student in a timely manner.

1. When a student takes a leave of absence or withdraws from Harvard, the applicable student coverage will end the last day of the month of the official last date of attendance as recorded by the registrar's office. *Students with a last date of attendance between 12/1 and 1/31 for the fall term and between 5/1 and 7/31 for the spring term will retain coverage through the end of the health insurance period for that term (see chart below).*
2. Students are eligible to purchase **four** months of additional coverage, effective from the first day without coverage. To initiate enrollment, the student must submit an enrollment application to HUSHP Member Services within 30 days of the date of loss of coverage (or, in the case of students going on leave before a new term starts, by 9/15 or 3/15). Payment is by check only and should be made payable to Harvard University.
3. Students can only purchase the coverage they were currently enrolled in at the time of leave (i.e., Student Health Fee only or Student Health Fee and the Student Health Insurance Plan).
4. Students are eligible to enroll dependents under the continuation of coverage option only if those dependents were enrolled at the time of leave.
5. All health care costs incurred after the HUSHP termination date will be the responsibility of the student.
6. In very limited cases, appeals for additional coverage past the four months may be granted.
7. This policy does not apply to Extension School students or post-doctoral affiliates.

If the student's official last date of attendance is in:	Coverage will end:	The charge that will remain on the term bill (based on what the student is enrolled in):
Fall Term 2016		
August	August 31	1 month
September	September 30	2 months
October	October 31	3 months
November	November 30	4 months
December through January	January 31	Full term cost
Spring Term 2017		
February	February 28	1 month
March	March 31	2 months
April	April 30	3 months
May through July	July 31	Full term cost

Example: If a student takes a leave of absence in the fall and the student's official last date of attendance is November 15, his/her "registered" student coverage would end on November 30. The cost for four months of coverage would remain on his/her term bill. The student would then have 30 days from the loss of coverage date to enroll in the 4 month leave of absence extension.

HUSHP Policies

APPEALS FOR ADDITIONAL LEAVE OF ABSENCE COVERAGE

Students who purchase leave of absence coverage from the University may file an appeal to extend coverage beyond the allotted four months of coverage.

To qualify for the appeal, the student must show proof that he/she was unable to secure other insurance coverage. The student must show that they were denied enrollment by at least two health insurance carriers.

Appeals must be submitted to Member Services at least one month prior to the student's last date of coverage under the leave of absence coverage.

HUSHP Policies

NOVEMBER GRADUATES

A student's eligibility for HUSHP coverage depends upon the date by which the student's degree requirements are completed:

- November degree candidates who complete their degree requirements **on or before September 8** will have the HUSHP coverage retroactively cancelled back to the last day of the prior term of coverage (July 31) and students will be charged for any services incurred through the health program during this period.
- Students who register for the fall term and complete their degree requirements **on or after September 9** will be charged for HUSHP for the fall term and will have coverage from August through January.

SAMPLE SCENARIO 1 (student is not eligible for HUSHP)

5/30 Student misses May degree deadline and is presumed to be November degree candidate

7/01 Student is billed for HUSHP

8/25 Student registers for fall term

9/08 Student completes degree requirements and is no longer a registered student for the fall term

9/09 HUSHP is cancelled retroactively to the last day of the prior term of coverage (July 31)

SAMPLE SCENARIO 2 (student is eligible for HUSHP)

5/30 Student misses May degree deadline and is presumed to be November degree candidate

7/01 Student is billed for HUSHP

8/25 Student registers for fall term

9/20 Student completes degree requirements

9/21 HUSHP remains on student's term bill and the student is covered from August 1 through January 31

MARCH GRADUATES

HUSHP coverage will end on January 31 for all March degree graduates.

Filing a Grievance

You have the right to file a grievance if you disagree with a decision to deny payment for services, or if you have a complaint about the care or service you received from a health care provider.

Contact **HUSHP Member Services** for help resolving a problem or concern; Member Services may refer your concern to the HUHS Patient Advocate, or to Blue Cross Blue Shield (BCBS), depending on the nature of your concern.

HUHS PATIENT ADVOCATE

The Patient Advocate is available to discuss and assist with any Harvard University Health Services related problems, concerns, or questions, including:

- Navigating the health care system
- Available choices regarding medical care
- Patients who feel they have encountered a problem
- Special-needs arrangements

All requests, including positive comments and recommendations for improvement, are welcome and confidential.

Financial support may be available through the HUHS Medical Hardship Fund only for students (including those on leave of absence), dependents and affiliates (and their dependents) who are active members in both components of HUSHP (Student Health Fee and the Student Health Insurance Plan), and who incur significant out-of-pocket expenses and need financial assistance. Financial hardship must be indicated. Contact the Patient Advocate at patadvoc@huhs.harvard.edu for more information.

FILING A FORMAL GRIEVANCE REVIEW WITH BLUE CROSS BLUE SHIELD

For students with the Student Health Insurance Plan, a formal review may be requested from the BCBS internal grievance program. You (or your authorized representative) have three options:

1. **Write or Fax** The preferred option is for you to send your grievance in writing to: **Member Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126**. Or, you may fax your grievance to **617.246.3616**. BCBS will let you know that your request was received by sending you a written confirmation within 15 calendar days.
2. **Email** You may email your grievance to the BCBS Member Grievance Program at **grievances@bcbsma.com**. BCBS will let you know that your request was received by sending you an immediate confirmation by email.
3. **Telephone** You may call the BCBS Member Grievance Program at **800.472.2689**.

When resolving a problem or concern, BCBS will consider all aspects of the particular case, including all provisions of this health plan, the policies and procedures that support this health plan, the health care provider's medical opinion, and your understanding and expectation of coverage by this health plan. BCBS will use every opportunity to be reasonable in finding a solution that makes sense for all parties. BCBS may use an individual consideration approach when it is judged to be appropriate. BCBS will follow its standard guidelines when it resolves your problem or concern.

Optional Dental Plan Enrollment

ELIGIBILITY

Students and their dependents may enroll in an optional Blue Cross Blue Shield of Massachusetts.

Coverage Periods	Enrollment Periods
AY1617: August 1, 2016 through July 31, 2017	June 1, 2016 through September 30, 2016
Spring 17*: February 1, 2017 through July 31, 2017	December 1, 2016 through February 28, 2017

*Spring term dental coverage is for new incoming Spring term students and student returning from a Fall term leave of absence only.

PLAN YEAR RATES

Student only	\$469
Student plus one dependent	\$905
Student plus two or more dependents	\$1,398

ENROLLMENT & RENEWAL

Enrollment/Renewal is voluntary and is not automatic. Enrollment applications are available online at hushp.harvard.edu. Applications must be submitted to Member Services by the enrollment deadlines.

ENROLLMENT DUE TO LIFE CHANGING EVENT

Students can enroll in the dental plan after the open enrollment deadline(s) with a life changing event. If students have another dental plan that ended, they have 30 days from the end date of their alternative dental plan to enroll. The coverage and cost are pro-rated to the first day of the month of the event. Documentation that confirms the loss of coverage must be submitted with the enrollment application.

Glossary of Terms

You are responsible for your health care, so it helps to be informed. Below are commonly used health insurance terms; familiarize yourself with the definitions as they may guide you to better understand your coverage.

DEFINITIONS/HEALTH INSURANCE TERMINOLOGY

Coinsurance - The portion of eligible expenses that plan members are responsible for paying, most often after a deductible is met. An example of coinsurance could be that your health plan covers 70% of covered medical charges and you are responsible for the remaining 30%.

Copayment - The amount that you must pay for (certain) covered services. Your copayment is usually a fixed dollar amount.

Covered Services - Services or supplies for which your health plan will pay (or “cover”) all or a portion of the cost. Most health plans do not cover all services and supplies, and it is important to be aware of any limitations and restrictions that apply to your covered services.

Deductible - The amount that you must pay before benefits are provided for (certain) covered services.

Exclusions - Specific conditions or circumstances for which a health plan will not provide benefits.

Medically Necessary Services - Services or supplies which are appropriate and necessary for the symptoms, diagnosis, or treatment of a medical condition, and which meet additional guidelines pertaining to necessary provision of medical or mental health care. Services must be medically necessary in order to be covered.

In-Network - A group of physicians, hospitals, and other health care providers who participate in a specific managed care plan. When you receive care from an in-network provider, you pay only a copayment for covered services.

Out-of-Network - Physicians, hospitals, and other health care providers who do not participate in your plan’s network. Services obtained from an out-of-network provider are subject to deductibles and coinsurance.

Out-of-Pocket Maximum - When the deductible and coinsurance amounts you have paid in a plan year add up to the out-of-pocket maximum, the health plan will begin covering 100% of eligible charges for the remainder of the year.

Plan Year - The time period your health plan provides coverage. The HUSHP plan year runs from August 1 – July 31.

Preferred Provider Organization (PPO) - A type of insurance product that combines in-network and out-of-network coverage. When you use in-network (or “participating”) doctors and hospitals, you pay only a copayment for covered services. You also have the flexibility to see out-of-network (“non-participating”) providers, but you will be responsible for a deductible and coinsurance for inpatient and outpatient covered services. The Harvard Student BCBS Plan is a PPO plan.

Pre-Existing Condition - A pre-existing condition is a health condition that existed prior to your application for a health insurance policy or enrollment in a new health plan. Examples of pre-existing conditions include pregnancy, heart disease, high blood pressure, cancer, diabetes, or asthma. HUSHP does not impose pre-existing condition limitations.

Usual & Customary Fee/Allowed Amount - The common cost of a specific medical service; this fee can be lower than what a physician charges and is based on a variety of criteria including provider type and service region.

Important Phone Numbers

URGENT AND EMERGENCY

Life threatening Emergencies Dial 911
Urgent Care (after hours) 617.495.5711

INSURANCE INQUIRIES

HUSHP Member Services 617.495.2008 HUHS Smith Campus Ctr—1st Floor
BCBS Member Services 800.257.8141
BCBS Worldwide 800.810.2583 or 804.673.1686 (collect if outside the U.S.)
Optum Rx Customer Service 844.265.1223

HEALTH SERVICES

Patient Advocate 617.495.7583 HUHS Smith Campus Ctr—1st Floor
Care Coordination 617.495.3271
General Inquiries & Information 617.495.5711
HUHS Pharmacy 617.495.6661

Primary Care

Internal Medicine 3-North 617.495.8414
Internal Medicine 3-East 617.495.2001
Business School Clinic 617.495.6455
Law School Clinic 617.495.4414
Medical Area Clinic 617.432.1370
Pediatrics 617.495.4171

Specialty Care

Allergy 617.495.5182
Dermatology 617.495.5182
Ear, Nose, & Throat 617.495.2068
Endocrinology 617.495.2068
Gastroenterology 617.495.2068
General Surgery 617.495.2068
Gynecology/Obstetrics 617.495.2333
Hematology 617.495.2001
Laboratory 617.495.9258
Neurology 617.495.2068
Nutrition 617.495.2068
Ophthalmology/Optomety 617.495.2068
Orthopedics 617.495.5717
Physical Therapy 617.496.0699
Podiatry 617.495.5717
Radiology 617.496.0699
Rheumatology 617.495.2068
Urology 617.495.2068

Counseling Services

Mental Health Services 617.495.2042
Alcohol & Other Drugs 617.496.0133
Sexual Assault Prevention & Response 617.495.9100
Bureau of Study Counsel 617.495.2581

**Appendix I:
Student Health Insurance Plan
Blue Cross Blue Shield Hospital/Specialty
Benefit Description**

Schedule of Benefits

Blue Care[®] Elect

Harvard University Student Health Plan

This is the *Schedule of Benefits* that is a part of your Benefit Description. This chart describes the cost share amounts that you will have to pay for *covered services*. It also shows the *benefit limits* that apply for *covered services*. Do not rely on this chart alone. **Be sure to read all parts of your Benefit Description to understand the requirements you must follow to receive all of your coverage. You should also read the descriptions of *covered services* and the limitations and exclusions that apply for this coverage.** All words that show in italics are explained in Part 2. **To receive the highest level of coverage, you must obtain your health care services and supplies from *covered providers* who participate in your health plan's provider network.** Also, for some health care services, you may have to have an approved referral from your *primary care provider* or approval from your health plan in order for you to receive coverage from your health plan. These requirements are fully outlined in Part 4. If a referral or an approval is required, you should make sure that you have it before you receive your health care service. Otherwise, you may have to pay all costs for the health care service.

Your health plan's provider network is the **PPO** provider network. See Part 1 for information about how to find a provider in your health care network.

The following definitions will help you understand your cost share amounts and how they are calculated.

- A ***deductible*** is the cost you may have to pay for certain *covered services* you receive during your annual coverage period before benefits are paid by the health plan. This chart shows the dollar amount of your *deductible* and the *covered services* for which you must first pay the *deductible*.
- A ***copayment*** is the fixed dollar amount you may have to pay for a *covered service*, usually when you receive the *covered service*. This chart shows the times when you will have to pay a *copayment*.
- A ***coinsurance*** is the percentage (for example, 20%) you may have to pay for a *covered service*. This chart shows the times, if there are any, when you will have to pay *coinsurance*.

Your cost share will be calculated based on the *allowed charge* or the provider's actual charge if it is less than the *allowed charge*. You will not have to pay charges that are more than the *allowed charge* when you use a *covered provider* who participates in your health care network to furnish *covered services*. **But, when you use an out-of-network provider, you may also have to pay all charges that are in excess of the *allowed charge* for *covered services*. This is called "*balance billing*." These balance billed charges are in addition to the cost share you have to pay for *covered services*. (Exceptions to this paragraph are explained in Part 2.)**

IMPORTANT NOTE: The provisions described in this *Schedule of Benefits* may change. If this happens, the change is described in a *rider*. Be sure to read each *rider* (if there are any) that applies to your coverage in this health plan to see if it changes this *Schedule of Benefits*.

The explanation of any special provisions as noted by an asterisk can be found after this chart.

Overall Member Cost Share Provisions		In-Network Benefits	Out-of-Network Benefits
<p>Deductible</p> <p>Your <i>deductible</i> per plan year is:</p> <p>This <i>deductible</i> applies to all out-of-network benefits <u>except</u> certain <i>covered services</i> as noted in this chart.</p>		<p>The <i>deductible</i> is the cost you have to pay for certain <i>covered services</i> during your annual coverage period before benefits will be paid for those <i>covered services</i>.</p>	
		<p>\$0 per member</p> <p>\$0 per family</p>	<p>\$250 per member</p> <p>\$500 per family</p>
		<p>Any costs you pay for in-network benefits will <u>not</u> be applied toward the out-of-network <i>deductible</i>.</p>	
		<p>The family <i>deductible</i> can be met by eligible costs incurred by any combination of <i>members</i> enrolled under the same family plan. But, no one <i>member</i> will have to pay more than the per member <i>deductible</i>.</p>	
<p>Out-of-Pocket Maximum</p> <p>Your <i>out-of-pocket maximum</i> per plan year is:</p> <p>This <i>out-of-pocket maximum</i> is a total of the <i>deductible</i>, <i>copayments</i>, and <i>coinsurance</i> you pay for <i>covered services</i>.</p> <p>This <i>out-of-pocket maximum</i> does <u>not</u> apply to drug benefits administered by your <i>group's</i> pharmacy benefits manager.</p>		<p>The <i>out-of-pocket maximum</i> is the most you could pay during your annual coverage period for your share of the costs for <i>covered services</i>.</p>	
		<p>\$1,700 per member</p> <p>\$3,400 per family</p>	<p>\$7,500 per member</p> <p>\$15,000 per family</p>
		<p>The cost share amounts applied toward the in-network <i>out-of-pocket maximum</i> will not be applied toward the out-of-network <i>out-of-pocket maximum</i> and the cost share amounts applied toward the out-of-network <i>out-of-pocket maximum</i> will not be applied toward the in-network <i>out-of-pocket maximum</i>.</p>	
		<p>The family <i>out-of-pocket maximum</i> can be met by eligible costs incurred by any combination of <i>members</i> enrolled under the same family plan. But, no one <i>member</i> will have to pay more than the per member <i>out-of-pocket maximum</i>.</p>	
Overall Benefit Maximum		None	
Covered Services		In-Network Benefits Your Cost Is:	Out-of-Network Benefits Your Cost Is:
Admissions for Inpatient Medical and Surgical Care	<ul style="list-style-type: none"> In a General Hospital <p><u>Hospital services</u></p>	\$100 <i>copayment</i> per admission	30% after <i>deductible</i>
	<p><u>Physician and other covered professional provider services</u></p>	No charge	30% after <i>deductible</i>
	<ul style="list-style-type: none"> In a Chronic Disease Hospital 	(same as admissions in a General Hospital)	(same as admissions in a General Hospital)
	<ul style="list-style-type: none"> In a Rehabilitation Hospital <p><u>Hospital services</u></p>	No charge	30% after <i>deductible</i>
	<p><u>Physician and other covered professional provider services</u></p>	No charge	30% after <i>deductible</i>

This chart shows your cost share for *covered services*. You must pay all charges in excess of a *benefit limit*.

Covered Services		In-Network Benefits Your Cost Is:	Out-of-Network Benefits Your Cost Is:
Admissions for Inpatient Medical and Surgical Care (continued)	• In a Skilled Nursing Facility <u>Facility services</u>	No charge	30% after <i>deductible</i>
	<u>Physician and other covered professional provider services</u>	No charge	30% after <i>deductible</i>
Ambulance Services (ground or air ambulance transport)	• Emergency ambulance	No charge	same as in-network benefits
	• Other ambulance	No charge	No charge (<i>deductible</i> does not apply)
Cardiac Rehabilitation	<i>Outpatient</i> services	\$35 <i>copayment</i> per visit	30% after <i>deductible</i>
Chiropractor Services (for <i>members</i> of any age)	• <i>Outpatient</i> lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	• <i>Outpatient</i> medical care services, including spinal manipulation (12-visit <i>benefit limit</i> per <i>member</i> per <i>plan year</i>)	\$35 <i>copayment</i> per visit	30% after <i>deductible</i>
Dialysis Services	<i>Outpatient</i> services and home dialysis	No charge	30% after <i>deductible</i>
Durable Medical Equipment	• Covered medical equipment rented or purchased for home use	No charge	30% after <i>deductible</i>
	• One breast pump per birth (rented or purchased)	No charge No coverage is provided for hospital-grade breast pumps.	30% after <i>deductible</i>
Early Intervention Services	<i>Outpatient</i> intervention services for eligible child from birth through age two	\$35 <i>copayment</i> per visit	30% after <i>deductible</i>
Emergency Medical Outpatient Services	• Emergency room services	\$100 <i>copayment</i> per visit; <i>copayment</i> waived if held for observation or admitted within 24 hours	same as in-network benefits
	• Hospital outpatient department services	\$35 <i>copayment</i> per visit	30% after <i>deductible</i>
	• Office, health center, and home services	\$35 <i>copayment</i> per visit	30% after <i>deductible</i>
Home Health Care	Home care program	No charge	30% after <i>deductible</i>
Hospice Services	<i>Inpatient</i> or <i>outpatient</i> hospice services for terminally ill	No charge	30% after <i>deductible</i>

This chart shows your cost share for *covered services*. You must pay all charges in excess of a *benefit limit*.

Covered Services		In-Network Benefits Your Cost Is:	Out-of-Network Benefits Your Cost Is:
Infertility Services	• <i>Inpatient</i> services	See Admissions for Inpatient Medical and Surgical Care	See Admissions for Inpatient Medical and Surgical Care
	• <i>Outpatient</i> surgical services	See Surgery as an Outpatient	See Surgery as an Outpatient
	• <i>Outpatient</i> lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	• <i>Outpatient</i> medical care services	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits
Lab Tests, X-Rays, and Other Tests (diagnostic services)	• <i>Outpatient</i> lab tests	No charge	30% after <i>deductible</i>
	• <i>Outpatient</i> x-rays	No charge	30% after <i>deductible</i>
	• <i>Outpatient</i> advanced imaging tests (CT scans, MRIs, PET scans, nuclear cardiac imaging)	\$50 <i>copayment</i> per category of test per service date	30% after <i>deductible</i>
	• Other <i>outpatient</i> tests and preoperative tests	No charge	30% after <i>deductible</i>
Maternity Services and Well Newborn Inpatient Care (includes \$90/\$45 for childbirth classes; <i>deductible</i> does not apply)	• Maternity services		
	<u>Facility services</u>	\$100 <i>copayment</i> per admission for <i>inpatient</i> services, otherwise no charge	30% after <i>deductible</i>
	<u>Physician and other covered professional provider services</u> (includes delivery and postnatal care)	No charge	30% after <i>deductible</i>
	• Prenatal care	No charge	30% after <i>deductible</i>
	• Well newborn care during enrolled mother's maternity admission	No charge	30% after <i>deductible</i>

This chart shows your cost share for *covered services*. You must pay all charges in excess of a *benefit limit*.

Covered Services		In-Network Benefits Your Cost Is:	Out-of-Network Benefits Your Cost Is:
Medical Care Outpatient Visits (includes syringes and needles dispensed during a visit)	<ul style="list-style-type: none"> Office and home medical services (10-visit <i>benefit limit</i> per <i>plan year</i> for <i>member</i> age 17 or younger, except no <i>benefit limit</i> when furnished by a Harvard Vanguard provider; or 6-visit <i>benefit limit</i> per <i>plan year</i> for <i>member</i> age 18 or older; except no <i>benefit limit</i> when furnished by a Harvard Vanguard OB/GYN physician or Harvard Vanguard OB/GYN nurse practitioner) 	\$35 <i>copayment</i> per visit*	30% after <i>deductible</i>
	<ul style="list-style-type: none"> Health center and hospital outpatient medical services 	\$35 <i>copayment</i> per visit	30% after <i>deductible</i>
Medical Formulas	Certain medical formulas and low protein foods	No charge	30% after <i>deductible</i>
Mental Health and Substance Abuse Treatment	<ul style="list-style-type: none"> <i>Inpatient</i> admissions in a General Hospital <u>Hospital services</u> 	\$100 <i>copayment</i> per admission	30% after <i>deductible</i>
	<ul style="list-style-type: none"> <u>Physician and other covered professional provider services</u> 	No charge	30% after <i>deductible</i>
	<ul style="list-style-type: none"> <i>Inpatient</i> admissions in a Mental Hospital or Substance Abuse Facility <u>Facility services</u> 	\$100 <i>copayment</i> per admission	30% after <i>deductible</i>
	<ul style="list-style-type: none"> <u>Physician and other covered professional provider services</u> 	No charge	30% after <i>deductible</i>
	<ul style="list-style-type: none"> <i>Outpatient</i> services for up to 40 visits per <i>member</i> per <i>plan year</i> 	No charge for first 8 visits and \$35 <i>copayment</i> per visit for remaining covered visits per <i>plan year</i>	30% after <i>deductible</i>
Oxygen and Respiratory Therapy	<ul style="list-style-type: none"> Oxygen and equipment for its administration 	No charge	30% after <i>deductible</i>
	<ul style="list-style-type: none"> <i>Outpatient</i> respiratory therapy 	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits

This chart shows your cost share for *covered services*. You must pay all charges in excess of a *benefit limit*.

Covered Services		In-Network Benefits Your Cost Is:	Out-of-Network Benefits Your Cost Is:
Podiatry Care	• <i>Outpatient</i> lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	• <i>Outpatient</i> surgical services	See Surgery as an Outpatient	See Surgery as an Outpatient
	• <i>Outpatient</i> medical care services	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits
Prescription Drugs and Supplies	• Retail Pharmacy	Not covered under this part of your <i>group</i> health plan	Not covered under this part of your <i>group</i> health plan
	• Mail Service Pharmacy	Not covered under this part of your <i>group</i> health plan	Not covered under this part of your <i>group</i> health plan
Preventive Health Services	• Routine pediatric care <u>Routine medical exams and immunizations</u>	No charge	30% after <i>deductible</i> (out-of-network benefits limited to nine visits first year of life, three visits second year of life, two visits age 2, and one visit per <i>plan year</i> age 3 through 17)
	<u>Routine tests</u>	No charge	30% after <i>deductible</i>
	These <i>covered services</i> include (but are not limited to): routine exams; immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning.		
	• Preventive dental care	For pediatric essential dental benefits for <i>members</i> under age 19, see your pediatric essential dental benefits booklet	Not covered; you pay all charges
	• Routine adult care <u>Routine medical exams and immunizations</u> <u>Routine tests</u>	Not covered under this part of your <i>group</i> health plan	Not covered under this part of your <i>group</i> health plan
		No charge	30% after <i>deductible</i>
		These <i>covered services</i> are limited to: routine lab tests; one routine mammogram between age 35 through 39 and one per <i>plan year</i> for ages 40 and older; and routine sigmoidoscopies, barium enemas, and colonoscopies. Contact your <i>group</i> for student health plan coverage for other preventive health services.	
	• Routine GYN care <u>Routine GYN exams</u>	\$35 <i>copayment</i> per visit, except no charge for Harvard Vanguard OB/GYN physician or nurse practitioner visits*	30% after <i>deductible</i>
		<u>Routine Pap smear tests</u>	No charge
	• Family planning	No charge	30% after <i>deductible</i>

This chart shows your cost share for *covered services*. You must pay all charges in excess of a *benefit limit*.

Covered Services		In-Network Benefits Your Cost Is:	Out-of-Network Benefits Your Cost Is:
Preventive Health Services (continued)	<ul style="list-style-type: none"> Routine hearing care 	No charge	30% after <i>deductible</i>
	<u>Routine hearing exams/tests</u>	No charge	30% after <i>deductible</i>
	<u>Newborn hearing screening tests</u>	No charge	30% after <i>deductible</i>
	<u>Hearing aids/related services</u>	Not covered; you pay all charges	Not covered; you pay all charges
	<ul style="list-style-type: none"> Routine vision care 	\$35 <i>copayment</i> per visit	30% after <i>deductible</i>
	<ul style="list-style-type: none"> <u>Routine vision exams</u> (one exam per <i>member</i> per <i>plan year</i>) <u>Vision supplies</u> 	Not covered; you pay all charges	Not covered; you pay all charges
Prosthetic Devices	<ul style="list-style-type: none"> Ostomy supplies 	No charge	30% after <i>deductible</i>
	<ul style="list-style-type: none"> Artificial limb devices (includes repairs) and other external prosthetic devices 	No charge	30% after <i>deductible</i>
Radiation Therapy and Chemotherapy	<ul style="list-style-type: none"> Hospital and free-standing radiation and chemotherapy facility <i>outpatient</i> services 	No charge	30% after <i>deductible</i>
	<ul style="list-style-type: none"> Office and health center services 	\$35 <i>copayment</i> per visit	30% after <i>deductible</i>
Second Opinions	<i>Outpatient</i> second and third opinions	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits
Short-Term Rehabilitation Therapy (physical, occupational, and speech therapy)	<i>Outpatient</i> services (60-visit <i>benefit limit</i> per <i>member</i> per <i>plan year</i> only for physical and occupational therapy, except for autism; a <i>benefit limit</i> does not apply for speech therapy)	\$35 <i>copayment</i> per visit	30% after <i>deductible</i>
Speech, Hearing, and Language Disorder Treatment	<ul style="list-style-type: none"> <i>Outpatient</i> diagnostic tests 	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	<ul style="list-style-type: none"> <i>Outpatient</i> speech therapy 	See Short-Term Rehabilitation Therapy	See Short-Term Rehabilitation Therapy
	<ul style="list-style-type: none"> <i>Outpatient</i> medical care services 	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits

This chart shows your cost share for *covered services*. You must pay all charges in excess of a *benefit limit*.

Covered Services		In-Network Benefits Your Cost Is:	Out-of-Network Benefits Your Cost Is:
Surgery as an Outpatient (includes removal of impacted teeth that are fully or partially imbedded in the bone)	<ul style="list-style-type: none"> • <i>Outpatient</i> day surgery 		
	<ul style="list-style-type: none"> • <u>Hospital surgical day care unit or outpatient department services</u> 	\$75 <i>copayment</i> per admission	30% after <i>deductible</i>
	<ul style="list-style-type: none"> • <u>Ambulatory surgical facility services</u> 	\$75 <i>copayment</i> per admission	30% after <i>deductible</i>
	<ul style="list-style-type: none"> • <u>Physician and other covered professional provider services</u> 	No charge	30% after <i>deductible</i>
	<ul style="list-style-type: none"> • Sterilization procedure for a female <i>member</i> when performed as the primary procedure for family planning reasons 	No charge	30% after <i>deductible</i>
	<ul style="list-style-type: none"> • Office and health center surgical services 	\$35 <i>copayment</i> per visit*	30% after <i>deductible</i>
TMJ Disorder Treatment	<ul style="list-style-type: none"> • <i>Outpatient</i> x-rays 	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	<ul style="list-style-type: none"> • <i>Outpatient</i> surgical services 	See Surgery as an Outpatient	See Surgery as an Outpatient
	<ul style="list-style-type: none"> • <i>Outpatient</i> physical therapy 	See Short-Term Rehabilitation Therapy	See Short-Term Rehabilitation Therapy
	<ul style="list-style-type: none"> • <i>Outpatient</i> medical care services 	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits

Note: Your health plan includes in-network benefits for Christian Science services. The cost share amount you pay for *covered services* you receive from a Christian Science sanatorium or practitioner is the same that applies for similar *covered services* when they are furnished by a preferred hospital or preferred physician for in-network benefits.

*Your cost share will be waived when you receive any routine and non-routine medical and surgical *covered services* and immunizations from a Harvard Vanguard OB/GYN physician or Harvard Vanguard OB/GYN nurse practitioner; or for *members* age 17 or younger, from any Harvard Vanguard provider.

This chart shows your cost share for *covered services*. You must pay all charges in excess of a *benefit limit*.

Student Health Plan

A PPO Health Plan administered by
Blue Cross and Blue Shield of Massachusetts, Inc.

Harvard University *Benefit Description*

Welcome!

This benefit booklet provides you with a description of your benefits while you are enrolled under this health plan. You should read this booklet to familiarize yourself with this health 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 health plan, such as claims processing, individual case management, *utilization review*, quality assurance programs, disease monitoring and management services as selected by the *plan sponsor*, claim review and other related services, and to arrange for a network of health care providers whose services are covered by this health plan. The *Blue Cross and Blue Shield* customer service office can help you understand the terms of this health plan and what you need to do to get your maximum benefits.

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

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

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Introduction

You are covered under the **Harvard University Student Health Plan**. This health plan is a non-insured, self-funded health benefits plan and is financed by contributions by the *group*. An organization has been designated by your *plan sponsor* to provide administrative services to this health plan, such as claims processing, individual case management, *utilization review*, quality assurance programs, disease monitoring and management services as selected by the *plan sponsor*, claim review and other related services, and to arrange for a network of health care providers whose services are covered by this health plan. The name and address of this organization is: Blue Cross and Blue Shield of Massachusetts, Inc., 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 health plan.

This benefit booklet explains your health care coverage while you are enrolled in this health plan. This benefit booklet also has a *Schedule of Benefits* which describes the cost share amounts that you must pay for *covered services* (such as a *deductible*, or a *coinsurance*, or a *copayment*). You should read this benefit booklet and your *Schedule of Benefits* to become familiar with the key points of your health plan. You should keep them handy so that you can refer to them. The words that are shown in italics have special meanings. These words are explained in Part 2 of this benefit booklet. *Blue Cross and Blue Shield* and/or your *group* may change the health care coverage described in this benefit booklet or your *Schedule of Benefits*. If this is the case, the change is described in a *rider*. Please keep any *riders* with your benefit booklet and *Schedule of Benefits* so that you can refer to them.

This health plan is a preferred provider health plan. This means that you determine the costs that you will pay each time you choose a health care provider to furnish *covered services*. You will receive the highest level of benefits when you use health care providers who participate in your PPO health care network. These are called your “in-network benefits.” If you choose to use covered health care providers who do not participate in your PPO health care network, you will usually receive a lower level of benefits. In this case, your out-of-pocket costs will be more. These are called your “out-of-network benefits.”

Before using your health care coverage, you should make note of the limits and exclusions. These limits and exclusions are described in this benefit booklet in Parts 3, 4, 5, 6, 7, and 8.

Important Note:

The term “you” refers to any *member* who has the right to the coverage provided by this health plan—the *subscriber* or the enrolled spouse or any other enrolled dependent.

Part 1

Member Services

Your Primary Care Provider

As a *member* of this health plan, you are not required to choose a *primary care provider* to coordinate the health care benefits described in this benefit booklet. However, your PPO health care network includes physicians who are family or general practitioners, internists, pediatricians, geriatric specialists, nurse practitioners, and physician assistants that you may choose to furnish your primary medical care. **You may choose any covered provider to furnish your health care services and supplies. But, your choice is important because it may impact the costs that you pay for some health care services.**

How to Determine a Preferred Physician's Specialty

To determine a preferred physician's specialty, you can look in your PPO provider directory or use the online "Find a Doctor" physician directory. Some preferred physicians may have more than one specialty. When your health plan has a cost share that differs based on the preferred physician's specialty type, *Blue Cross and Blue Shield* will use the primary specialty type as shown in the PPO provider directory to determine your cost share amount. For example, a preferred physician may be primarily a dermatologist but may also be a family practitioner. In this case, your cost share amount is determined based on the "dermatologist" specialty type since it is the preferred physician's primary specialty as shown in the *Blue Cross and Blue Shield* PPO provider directory. A preferred physician may change his or her specialty at any time. However, *Blue Cross and Blue Shield* will change a preferred physician's specialty only once every two years.

Some preferred physicians and other professional provider types are part of a multi-specialty provider group. When your health plan has a cost share that differs based on the preferred physician's specialty type, *Blue Cross and Blue Shield* will apply the lower cost share amount for primary care provider specialty types to the multi-specialty provider groups, unless a different cost share amount is described for multi-specialty provider groups in your *Schedule of Benefits* and/or *riders*.

In other states, the local Blue Cross and/or Blue Shield Plan may have established provider specialty types that are not recognized by *Blue Cross and Blue Shield*. In those cases when a preferred physician's specialty type or professional provider type is not recognized, *Blue Cross and Blue Shield* will apply the higher cost share amount for specialists and other non-primary care provider specialty types.

Refer to the *Schedule of Benefits* for your plan option to see if your cost share amount is based on a preferred physician's specialty type or other provider type.

Your Health Care Network

This health plan consists of two benefit levels: one for in-network benefits; and one for out-of-network benefits. The costs that you pay for *covered services* will differ based on the benefit level. To receive the highest benefit level (your in-network benefits), you must obtain your health care services and supplies from providers who participate in your PPO health care network. These health care providers are referred to as "*preferred providers*." (See "*covered providers*" in Part 2.) If you choose to obtain your health care services and supplies from a *covered provider* who does not participate in this PPO health care network,

WORDS IN ITALICS ARE EXPLAINED IN PART 2.

you will usually receive the lowest benefit level (your out-of-network benefits). See Part 8 in this benefit booklet for the times when in-network benefits will be provided if you receive *covered services* from a *covered provider* who is not a *preferred provider*.

When You Need Help to Find a Health Care Provider

There are a few ways for you to find a health care provider who participates in your health care network. At the time you enroll in this health plan, a directory of health care providers for your health plan will be made available to you at no additional cost. To find out if a health care provider participates in your health care network, you can look in this provider directory. Or, you can also use any one of the following ways to find a provider who participates in your health care network. You can:

- Call the *Blue Cross and Blue Shield* customer service office. The toll free phone number to call is shown on your ID card. They will tell you if a provider is in your health care network. Or, they can help you find a *covered provider* who is in your local area.
- Call the *Blue Cross and Blue Shield* Physician Selection Service at **1-800-821-1388**.
- Use the *Blue Cross and Blue Shield* online physician directory (Find a Doctor). To do this, log on to **www.bluecrossma.com**. This online provider directory will provide you with the most current list of health care providers who participate in your health care network.

If you or your physician cannot find a provider in your health care network who can furnish a *medically necessary covered service* for you, you can ask *Blue Cross and Blue Shield* for help. To ask for this help, you can call the *Blue Cross and Blue Shield* customer service office. They will help you find providers in your health care network who can furnish the *covered service*.

When You Are Living or Traveling Outside of Massachusetts

If you live or are traveling outside of Massachusetts, you can get help to find a health care provider. Just call **1-800-810-BLUE**. You can call this phone number 24 hours a day for help to find a health care provider. When you call, you should have your ID card ready. You must be sure to let the representative know that you are looking for health care providers that participate with the BlueCard PPO program. Or, you can also use the internet. To use the online “Blue National Doctor & Hospital Finder,” log on to **www.bcbs.com**. (For some types of *covered providers*, a local Blue Cross and/or Blue Shield Plan may not have, in the opinion of *Blue Cross and Blue Shield*, established an adequate PPO health care network. If this is the case and you obtain *covered services* from this type of *covered provider*, the in-network benefit level will be provided for these *covered services*. See Part 8 in this benefit booklet.) If you are outside the United States, Puerto Rico, and the U.S. Virgin Islands, there are no local Blue Cross and/or Blue Shield Plans. But, you can still call 1-800-810-BLUE. (Or, you can call collect at 1-804-673-1177.) In this case, the BlueCard Worldwide® Service Center can help you to access a health care provider. Then, if you are admitted as an *inpatient*, you should call the service center and the hospital should submit the claim for you. (See Part 9.)

Your Identification Card

After you enroll in this health plan, you will receive an identification (ID) card. The ID card will identify you as a person who has the right to coverage in this health plan. The ID card is for identification purposes only. While you are a *member*, you must show your ID card to your health care provider before you receive *covered services*. If you lose your ID card or it is stolen, you should contact the *Blue Cross and Blue Shield* customer service office. They will send you a new card. Or, you can use the *Blue Cross and Blue Shield* Web site to ask for a new ID card. To use the *Blue Cross and Blue Shield* online member self service option, you must log on to **www.bluecrossma.com**. Just follow the steps to ask for a new ID card.

WORDS IN ITALICS ARE EXPLAINED IN PART 2.

Your Inquiries and/or Claim Problems or Concerns

Blue Cross and Blue Shield can help you to understand the terms of your coverage in this health plan. They can also help you to resolve a problem or concern that you may have about your health care benefits. You can call or write to the *Blue Cross and Blue Shield* customer service office. You can call Monday through Friday from 8:00 a.m. to 8:00 p.m. (Eastern Time). The toll free phone number to call is shown on your ID card. For the Telecommunications Relay Service, call 711 using a text telephone (TTY) or other assistive text device. Or, you can write to: Blue Cross Blue Shield of Massachusetts, Member Service, P.O. Box 9134, North Quincy, MA 02171-9134. A *Blue Cross and Blue Shield* customer service representative will work with you to resolve your problem or concern as quickly as possible.

When You Need a Language Translator

A language translator service is available when you call Member Services at the toll-free telephone number shown on your health plan ID card. If you need these translation services, just tell the customer service representative when you call. Then during your call, an interpreter will assist in answering your questions or helping you to understand health plan procedures.

Part 2

Explanation of Terms

The following words are shown in italics in this benefit booklet, the *Schedule of Benefits*, and any *riders* that apply to your coverage in this health plan. The meaning of these words will help you understand your benefits.

Allowed Charge (Allowed Amount)

Blue Cross and Blue Shield calculates payment of your benefits based on the *allowed charge* (sometimes referred to as the *allowed amount*). This is the maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance,” or “negotiated rate.” The *allowed charge* that *Blue Cross and Blue Shield* uses depends on the type of health care provider that furnishes the *covered service* to you. If your health care provider charges you more than the *allowed amount*, you may have to pay the difference (see below).

- **For Preferred Providers in Massachusetts.** For health care providers who have a preferred provider arrangement (a “PPO payment agreement”) with *Blue Cross and Blue Shield*, the *allowed charge* is based on the provisions of that health care provider’s PPO payment agreement. **For covered services furnished by these health care providers, you pay only your deductible and/or your copayment and/or your coinsurance, whichever applies.** In general, when you share in the cost for your *covered services* (such as a *deductible*, and/or a *copayment* and/or a *coinsurance*), the calculation for the amount that you pay is based on the initial full *allowed charge* for that health care provider (or the actual charge if it is less). This amount that you pay for a *covered service* is generally not subject to future adjustments—up or down—even though the health care provider’s payment may be subject to future adjustments for such things as provider contractual settlements, risk-sharing settlements, and fraud or other operations.

A *preferred provider’s* payment agreement may provide for an *allowed charge* that is more than the provider’s actual charge. For example, a hospital’s *allowed charge* for an *inpatient* admission may be based on a “Diagnosis Related Grouping” (DRG). In this case, the *allowed charge* may be more than the hospital’s actual charge. If this is the case, *Blue Cross and Blue Shield* will calculate your cost share amount based on the lesser amount—this means the *preferred provider’s* actual charge instead of the *allowed charge* will be used to calculate your cost share. The claim payment made to the *preferred provider* will be the full amount of the *allowed charge* less your cost share amount.

- **For Health Care Providers Outside of Massachusetts with a Local Payment Agreement.** For health care providers outside of Massachusetts who have a payment agreement with the local Blue Cross and/or Blue Shield Plan, the *allowed charge* is the “negotiated price” that the local Blue Cross and/or Blue Shield Plan passes on to *Blue Cross and Blue Shield*. (Blue Cross and/or Blue Shield Plan means an independent corporation or affiliate operating under a license from the Blue Cross and Blue Shield Association.) In many cases, the negotiated price paid by *Blue Cross and Blue Shield* to the local Blue Cross and/or Blue Shield Plan is a discount from the provider’s billed charges. However, a number of local Blue Cross and/or Blue Shield Plans can determine only an estimated price at the time your claim is paid. Any such estimated price is based on expected settlements, withholdings, any

other contingent payment arrangements and non-claims transactions, such as interest on provider advances, with the provider (or with a specific group of providers) of the local Blue Cross and/or Blue Shield Plan in the area where services are received. In addition, some local Blue Cross and/or Blue Shield Plans' payment agreements with providers do not give a comparable discount for all claims. These local Blue Cross and/or Blue Shield Plans elect to smooth out the effect of their payment agreements with providers by applying an average discount to claims. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. Local Blue Cross and/or Blue Shield Plans that use these estimated or averaging methods to calculate the negotiated price may prospectively adjust their estimated or average prices to correct for overestimating or underestimating past prices. However, the amount you pay is considered a final price. **In most cases for covered services furnished by these health care providers, you pay only your deductible and/or your copayment and/or your coinsurance, whichever applies.**

Value-Based Provider Arrangements: A provider's payment agreement with a local Blue Cross and/or Blue Shield Plan may include: a payment arrangement based on health outcomes; and/or coordination of care features. Under these payment agreements, the providers will be assessed against cost and quality standards. Payments to these providers may include provider incentives, risk sharing, and/or care coordination fees. If you receive *covered services* from such a provider, you will not have to pay any cost share for these fees, except when a local Blue Cross and/or Blue Shield Plan passes these fees to *Blue Cross and Blue Shield* through average pricing or fee schedule adjustments for claims for *covered services*. When this happens, you pay only your *deductible* and/or your *copayment* and/or your *coinsurance*, whichever applies.

- **For Other Health Care Providers.** For physician and other covered professional providers in Massachusetts who do not have a PPO payment agreement with *Blue Cross and Blue Shield*, the *allowed charge* is based on the standard allowance that *Blue Cross and Blue Shield* has established for its indemnity product for participating providers. The *allowed charge* may sometimes be less than the health care provider's actual charge. **If this is the case, you will be responsible for the amount of the covered provider's actual charge that is in excess of the allowed charge ("balance billing"). This is in addition to your deductible and/or your copayment and/or your coinsurance, whichever applies.** For this reason, you may wish to discuss charges with your health care provider before you receive *covered services*. There are a few exceptions. This provision does not apply to: *emergency medical care* such as care you receive at an emergency room of a general hospital or by hospital-based emergency medicine physicians, or as an *inpatient*; ambulance transport for *emergency medical care*; *covered services* furnished by hospital-based anesthesiologists, pathologists, or radiologists; or *covered services* for which there is no established *allowed charge* (such as services received outside the United States). For these *covered services*, the full amount of the health care provider's actual charge is used to calculate your claim payment. For *covered services* furnished by any other type of *covered providers* in Massachusetts or outside of Massachusetts, your claim payment will be calculated based on the health care provider's actual charge.

Exception: For health care providers who do not have a payment agreement with *Blue Cross and Blue Shield* or, for health care providers outside of Massachusetts, with the local Blue Cross and/or Blue Shield Plan, there may be times when *Blue Cross and Blue Shield* is able to negotiate a fee with the provider that is less than the *allowed charge* that would have been used to calculate your claim payment (as described in the above paragraph). When this happens, the "negotiated fee" will be used as the *allowed charge* to calculate your claim payment and you will not have to pay the amount of the provider's charge that is in excess of the negotiated fee. You will only have to pay your *deductible* and/or your *copayment* and/or your *coinsurance*, whichever applies. *Blue Cross and Blue Shield* will

Part 2 – Explanation of Terms (continued)

send you a written notice about your claim that will tell you how your claim was calculated, including the *allowed charge*, the amount paid to the provider, and the amount you must pay to the provider.

Pharmacy Providers

Blue Cross and Blue Shield may have payment arrangements with pharmacy providers or pharmacy benefit managers that may, in some cases, result in an *allowed charge* for a covered drug or supply that is higher than the price *Blue Cross and Blue Shield* negotiated with the pharmacy provider or pharmacy benefit manager, or that result in rebates on covered drugs and supplies. Any difference between the *allowed charge* and the negotiated price is used to administer the health plan's pharmacy program. The cost that you pay for a covered drug or supply is determined based on the *allowed charge* at the time you buy the drug or supply. If you are charged a cost share amount (such as a *deductible*, or *copayment*, or *coinsurance*), your payment will be determined based on the *allowed charge*, not the price *Blue Cross and Blue Shield* pays. The cost that you pay will not be adjusted for any later rebates, settlements, or other monies paid to *Blue Cross and Blue Shield* from pharmacy providers or pharmacy benefit managers.

Appeal

An *appeal* is something you do if you disagree with a *Blue Cross and Blue Shield* decision to deny a request for coverage of health care services or drugs, or payment, in part or in full, for services or drugs you already received. You may also make an *appeal* if you disagree with a *Blue Cross and Blue Shield* decision to stop coverage for services that you are receiving. For example, you may ask for an *appeal* if *Blue Cross and Blue Shield* doesn't pay for a service, item, or drug that you think you should be able to receive. Part 10 explains what you have to do to make an *appeal*. It also explains the review process.

Balance Billing

There may be certain times when a health care provider will bill you for the difference between the provider's charge and the *allowed charge*. This is called *balance billing*. A *preferred provider* cannot *balance bill* you for *covered services*. See "*allowed charge*" above for information about the *allowed charge* and the times when a health care provider may *balance bill* you.

Benefit Limit

For certain health care services or supplies, there may be day, visit, or dollar benefit maximums that apply to your coverage in this health plan. Your *Schedule of Benefits* and Part 5 of this benefit booklet describe the benefit limits that apply to your coverage. Once the amount of the benefits that you have received reaches the *benefit limit* for a specific *covered service*, no more benefits will be provided by this health plan for those health care services or supplies. When this happens, you must pay the full amount of the provider's charges that you incur for those health care services or supplies that are more than the *benefit limit*. An overall lifetime benefit limit will not apply for coverage in this health plan.

Blue Cross and Blue Shield

This term refers to Blue Cross and Blue Shield of Massachusetts, Inc., the organization that has been designated by your *plan sponsor* to provide administrative services to this health plan, such as claims processing, individual case management, *utilization review*, quality assurance programs, disease monitoring and management services as selected by the *plan sponsor*, claim review and other related services, and to arrange for a network of health care providers whose services are covered by this health plan. This includes an employee or designee of *Blue Cross and Blue Shield* (including another Blue Cross and/or Blue Shield Plan) who is authorized to make decisions or take action called for by this health plan.

WORDS IN ITALICS ARE EXPLAINED IN PART 2.

Blue Cross and Blue Shield has full discretionary authority to interpret this benefit booklet. This includes determining the amount, form, and timing of benefits, conducting *medical necessity* reviews, and resolving any other matters regarding your right to benefits for *covered services* as described in this benefit booklet. All determinations by *Blue Cross and Blue Shield* with respect to benefits under this health plan will be conclusive and binding unless it can be shown that the interpretation or determination was arbitrary and capricious.

Coinsurance

For some *covered services*, you may have to pay a *coinsurance*. This means the cost that you pay for these *covered services* (your “cost share amount”) will be calculated as a percentage. When a *coinsurance* applies to a specific *covered service*, *Blue Cross and Blue Shield* will calculate your cost share amount based on the health care provider’s actual charge or the *Blue Cross and Blue Shield allowed charge*, whichever is less (unless otherwise required by law). Your *Schedule of Benefits* shows the *covered services* for which you must pay a *coinsurance* (if there are any). If a *coinsurance* applies, your *Schedule of Benefits* also shows the percentage that *Blue Cross and Blue Shield* will use to calculate your cost share amount.

Copayment

For some *covered services*, you may have to pay a *copayment*. This means the cost that you pay for these *covered services* (your “cost share amount”) is a fixed dollar amount. In most cases, a *covered provider* will collect the *copayment* from you at the time he or she furnishes the *covered service*. However, when the health care provider’s actual charge at the time of providing the *covered service* is less than your *copayment*, you pay only that health care provider’s actual charge or the *Blue Cross and Blue Shield allowed charge*, whichever is less (unless otherwise required by law). Any later charge adjustment—up or down—will not affect your *copayment* (or the cost you were charged at the time of the service if it was less than the *copayment*). Your *Schedule of Benefits* shows the amount of your *copayment*. It also shows those *covered services* for which you must pay a *copayment*.

Covered Providers

To receive the highest benefit level under this health plan (your in-network benefits), you must obtain your health care services and supplies from *covered providers* who participate in your PPO health care network. These health care providers are referred to as “*preferred providers*.” A *preferred provider* is a health care provider who has a written preferred provider arrangement (a “PPO payment agreement”) with, or that has been designated by, *Blue Cross and Blue Shield* or with a local Blue Cross and/or Blue Shield Plan to provide access to *covered services* to *members*. You also have the option to seek *covered services* from a *covered provider* who is not a *preferred provider*. (These health care providers are often called “*non-preferred providers*.”) In this case, you will receive the lowest benefit level under this health plan (your out-of-network benefits). To find out if a health care provider participates in your PPO health care network, you can look in the provider directory that is provided for your health plan. The kinds of health care providers that are *covered providers* are those that are listed below in this section.

- **Hospital and Other Covered Facilities.** These kinds of health care providers are: alcohol and drug treatment facilities; ambulatory surgical facilities; Christian Science sanatoriums; chronic disease hospitals (sometimes referred to as a chronic care or long term care hospital for *medically necessary covered services*); community health centers; day care centers; detoxification facilities; free-standing diagnostic imaging facilities; free-standing dialysis facilities; free-standing radiation therapy and

Part 2 – Explanation of Terms (continued)

chemotherapy facilities; general hospitals; independent labs; limited services clinics; mental health centers; mental hospitals; rehabilitation hospitals; and skilled nursing facilities.

- **Physician and Other Covered Professional Providers.** These kinds of health care providers are: certified registered nurse anesthetists; chiropractors; Christian Science practitioners; clinical specialists in psychiatric and mental health nursing; dentists; licensed alcohol and drug counselor I providers; licensed applied behavioral analysts for services furnished on or after October 1, 2016; licensed audiologists; licensed dietitian nutritionists (or a dietitian or a nutritionist or a dietitian nutritionist who is licensed or certified by the state in which the provider practices); licensed independent clinical social workers; licensed marriage and family therapists; licensed mental health counselors; licensed speech-language pathologists; nurse midwives; nurse practitioners; occupational therapists; optometrists; physical therapists; physicians; physician assistants; podiatrists; psychiatric nurse practitioners; psychologists; and urgent care centers.
- **Other Covered Health Care Providers.** These kinds of health care providers are: ambulance services; appliance companies; cardiac rehabilitation centers; early intervention providers; home health agencies; home infusion therapy providers; hospice providers; oxygen suppliers; and visiting nurse associations.

A *covered provider* may include other health care providers that are designated for you by *Blue Cross and Blue Shield*.

Covered Services

This benefit booklet and your *Schedule of Benefits* describe the health care services and supplies for which *Blue Cross and Blue Shield* will provide coverage for you while you are enrolled in this health plan. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.) These health care services and supplies are referred to as “*covered services*.” Except as described otherwise in this benefit booklet and your *Schedule of Benefits*, all *covered services* must be *medically necessary* for you, furnished by *covered providers* and, when it is required, approved by *Blue Cross and Blue Shield*.

Custodial Care

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

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

Deductible

For some *covered services*, you may have to pay a *deductible* before you will receive benefits from this health plan. When your health plan includes a *deductible*, the amount that is put toward your *deductible* is

WORDS IN ITALICS ARE EXPLAINED IN PART 2.

calculated based on the health care provider's actual charge or the *Blue Cross and Blue Shield allowed charge*, whichever is less (unless otherwise required by law). Your *Schedule of Benefits* shows the amount of your *deductible* (if there is one). Your *Schedule of Benefits* also shows those *covered services* for which you must pay the *deductible* before you receive benefits. When a *deductible* applies, there are some costs that you pay that do not count toward the *deductible*. These costs that do **not** count toward the *deductible* are:

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

Diagnostic Lab Tests

This health plan provides coverage for *diagnostic lab tests*. These *covered services* include the examination or analysis of tissues, liquids, or wastes from the body. These covered tests also include (but are not limited to): the taking and interpretation of 12-lead electrocardiograms; all standard electroencephalograms; and glycosylated hemoglobin (HgbA1C) tests, urinary protein/microalbumin tests, and lipid profiles to diagnose and treat diabetes.

Diagnostic X-Ray and Other Imaging Tests

This health plan provides coverage for *diagnostic x-rays and other imaging tests*. These *covered services* include: 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 are: magnetic resonance imaging (MRI); and computerized axial tomography (CT scans). These types of tests also include diagnostic tests that require the use of radioactive drugs.

Effective Date

This term is used to mean the date on which your coverage in this health plan starts. Or, it means the date on which a change to your coverage in this health plan takes effect.

Emergency Medical Care

As a *member* of this health plan, you have worldwide coverage for *emergency medical care*. This is the type of care you need immediately due to the sudden onset of an emergency medical condition. An “emergency medical condition” is a medical condition, whether physical, behavioral, related to substance abuse, or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that, in the absence of prompt care, could reasonably be expected by a prudent layperson who has an average knowledge of health and medicine to result in:

- placing your life or health or the health of another (including an unborn child) in serious jeopardy; or
- serious impairment of bodily functions; or
- serious dysfunction of any bodily organ or part; or,
- as determined by a provider with knowledge of your condition, severe pain that cannot be managed without such care.

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

Grievance

A *grievance* is a type of oral or written complaint you make about care or service you received from *Blue Cross and Blue Shield* or from a provider who participates in your health care network. This type of complaint concerns the service you receive or the quality of your care. It does not involve a dispute with a coverage or payment decision. Part 10 explains what you have to do to file a *grievance*. It also explains the review process.

Group

The term “*group*” refers to the institution (or institute) of higher education that has entered into an agreement (a “contract”) under which *Blue Cross and Blue Shield* provides administrative services for the *group’s* self-insured student health plan.

Inpatient

The term “inpatient” refers to your status as a hospital patient, or as a patient in a health care facility, when you are admitted as a registered bed patient. Even if you stay in the hospital or health care facility overnight, you might still be considered an “outpatient.” Your status is important because it affects how much you will pay for *covered services*, like x-rays, drugs, lab tests, and physician services. You are an *inpatient* starting the day you are formally admitted with a doctor’s order as a registered bed patient in a hospital or other health care facility. Note: You are an *outpatient* when you are kept overnight in a hospital or health care facility solely for observation, even though you use a bed or spend the night. Observation services are to help the doctor decide if a patient needs to be admitted for care or can be discharged. These services may be given in the emergency room or another area of the hospital.

Medical Policy

To receive your health plan coverage, your health care services and supplies must meet the criteria for coverage that are defined in each *Blue Cross and Blue Shield medical policy* that applies. Each health care service or supply must also meet the *Blue Cross and Blue Shield medical technology assessment criteria*. (See below.) The policies and criteria that will apply are those that are in effect at the time you receive the health care service or supply. These policies are based upon *Blue Cross and Blue Shield’s* assessment of the quality of the scientific and clinical evidence that is published in peer reviewed journals. *Blue Cross and Blue Shield* may also consider other clinical sources that are generally accepted and credible. (These sources may include specialty society guidelines, textbooks, and expert opinion.) These *medical policies* explain *Blue Cross and Blue Shield’s* criteria for when a health care service or supply is *medically necessary*, or is not *medically necessary*, or is investigational. These policies form the basis of coverage decisions. A policy may not exist for each health care service or supply. If this is the case for a certain health care service or supply, *Blue Cross and Blue Shield* may apply its *medical technology assessment criteria* and its *medical necessity* criteria to determine if the health care service or supply is *medically*

necessary or if it is not *medically necessary* or if it is investigational. To check for a *Blue Cross and Blue Shield medical policy*, you can go online and log on to the *Blue Cross and Blue Shield Web site* at **www.bluecrossma.com**. (Your health care provider can also access a policy by using the *Blue Cross and Blue Shield provider Web site*.) Or, you can call the *Blue Cross and Blue Shield customer service office*. You can ask them to mail a copy to you.

Medical Technology Assessment Criteria

To receive your health plan coverage, all of your health care services and supplies must conform to *Blue Cross and Blue Shield medical technology assessment criteria*. These criteria assess whether a technology improves health outcomes such as length of life or ability to function when performing everyday tasks. The *medical technology assessment criteria* that apply are those that are in effect at the time you receive a health care service or supply. These criteria are:

- 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 U.S. Food and Drug Administration (FDA). Any approval granted as an interim step in the FDA regulatory process is not sufficient. (The FDA Humanitarian Device Exemption is one example of an interim step.) Except as required by law, this health plan may limit coverage for drugs, biological products, and devices to those specific indications, conditions, and methods of use approved by the FDA.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed English-language journals. The qualities of the body of studies and the consistency of the results are considered in evaluating the evidence. The evidence should demonstrate that the technology can measurably alter the physiological changes related to a disease, injury, illness, or condition. In addition, there should be evidence or a convincing argument based on established medical facts that the measured alterations affect health outcomes. Opinions and evaluations by national medical associations, consensus panels, and other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence upon which they are based.
- The technology must improve the net health outcome. The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
- The technology must be as beneficial as any established alternatives. The technology should improve the net outcome as much as or more than established alternatives. The technology must be as cost effective as any established alternative that achieves a similar health outcome.
- The improvement must be attainable outside the investigational setting. When used under the usual conditions of medical practice, the technology should be reasonably expected to improve health outcomes to a degree comparable to that published in the medical literature.

Medically Necessary (Medical Necessity)

To receive your health plan coverage, all of your health care services and supplies must be *medically necessary* and appropriate for your health care needs. (The only exceptions are for certain routine and preventive health care services that are covered by this health plan.) *Blue Cross and Blue Shield* has the discretion to determine which health care services and supplies that you receive (or you are planning to receive) are *medically necessary* and appropriate for coverage. It will do this by referring to the guidelines described below.

Part 2 – Explanation of Terms (continued)

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

- Furnished in accordance with generally accepted standards of professional medical practice (as recognized by the relevant medical community);
- Clinically appropriate, in terms of type, frequency, extent, site, and duration; and they must be considered effective for your illness, injury, or disease;
- Consistent with the diagnosis and treatment of your condition and in accordance with *Blue Cross and Blue Shield medical policies* and *medical technology assessment criteria*;
- Essential to improve your net health outcome and as beneficial as any established alternatives that are covered by *Blue Cross and Blue Shield*;
- 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.

Member

The term “you” refers to any *member* who has the right to the coverage provided by this health plan. A *member* may be the *subscriber* or his or her enrolled eligible spouse (or former spouse, if applicable) or any other enrolled eligible dependent.

Mental Conditions

This health plan provides coverage for treatment of psychiatric illnesses or diseases. These include drug addiction and alcoholism. The illnesses or diseases that qualify as *mental conditions* are listed in the latest edition, at the time you receive treatment, of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders.

Mental Health Providers

This health plan provides coverage for treatment of a *mental condition* when these *covered services* are furnished by a *covered provider* who is a *mental health provider*. These *covered providers* include any one or more of the following kinds of health care providers: alcohol and drug treatment facilities; clinical specialists in psychiatric and mental health nursing; community health centers (that are a part of a general hospital); day care centers; detoxification facilities; general hospitals; licensed alcohol and drug counselor I providers; licensed independent clinical social workers; licensed marriage and family therapists; licensed mental health counselors; mental health centers; mental hospitals; physicians; psychiatric nurse practitioners; psychologists; and other *mental health providers* that are designated for you by *Blue Cross and Blue Shield*.

Out-of-Pocket Maximum (Out-of-Pocket Limit)

Under this health plan, there is a maximum cost share amount that you will have to pay for certain *covered services*. This is referred to as an “*out-of-pocket maximum*.” The *Schedule of Benefits* will show the amount of your *out-of-pocket maximum* and the time frame for which it applies. It will also describe the cost share amounts you pay that will count toward the *out-of-pocket maximum*. Once the cost share amounts you have paid that count toward the *out-of-pocket maximum* add up to the *out-of-pocket maximum* amount, you will receive full benefits based on the *Blue Cross and Blue Shield allowed charge* for more of these *covered services* during the rest of the time frame in which the *out-of-pocket maximum* provision applies. There are some costs that you pay that do not count toward the *out-of-pocket maximum*. These costs that do **not** count toward the *out-of-pocket maximum* are:

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

Outpatient

The term “outpatient” refers to your status as a patient. Your status is important because it affects how much you will pay for *covered services*. You are an *outpatient* if you are getting emergency room services, observation services, outpatient day surgery, or other hospital services such as lab tests or x-rays and the doctor has not written an order to admit you to the hospital or health care facility as an *inpatient*. In these cases, you are an *outpatient* even if you spend the night at the hospital or health care facility. You are also an *outpatient* if you are getting *covered services* at a health center, at a provider’s office, or in other covered outpatient settings, or at home. Note: You are an *outpatient* when you are kept overnight in a hospital or health care facility solely for observation, even though you use a bed or spend the night. Observation services are to help the doctor decide if a patient needs to be admitted for care or can be discharged. These services may be given in the emergency room or another area of the hospital.

Plan Sponsor

The *plan sponsor* is Harvard University, the institution (or institute) of higher education that has entered into an agreement (a “contract”) under which *Blue Cross and Blue Shield* provides administrative services for the *group’s* self-insured student health plan.

Plan Year

Under this health plan, the *deductible*, *out-of-pocket maximum*, and *benefit limits* will be calculated based on a *plan year* basis. Your *plan year* starts on August 1 of each year and continues until the following July 31. A new *plan year* begins each 12-month period thereafter.

Primary Care Provider

Your PPO health care network includes physicians (who are internists, family practitioners, or pediatricians), nurse practitioners, and physician assistants that you may choose to furnish your primary medical care. These health care providers are generally called *primary care providers*. As a *member* of this health plan, you are not required to choose a *primary care provider* in order for you to receive your health plan coverage. **You may choose any covered provider to furnish your health care services and**

supplies. But, your choice is important because it will impact the costs that you pay for your health care services and supplies. Your costs will be less when you use health care providers who participate in your PPO health care network to furnish your *covered services*.

Rider

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

Room and Board

For an approved *inpatient* admission, *covered services* include *room and board*. This means your room, meals, and general nursing services while you are an *inpatient*. This includes hospital services that are furnished in an intensive care or similar unit.

Schedule of Benefits

This benefit booklet includes a *Schedule of Benefits*. It describes the cost share amount that you must pay for each *covered service* (such as a *deductible*, *copayment*, or *coinsurance*). And, it includes important information about your *deductible* and *out-of-pocket maximum*. It also describes *benefit limits* that apply for certain *covered services*. Be sure to read all parts of this benefit booklet and your *Schedule of Benefits* to understand all of your health care benefits. You should read the *Schedule of Benefits* along with the descriptions of *covered services* and the limits and exclusions that are described in this benefit booklet.

Important Note:

A *rider* may change the information that is shown in your *Schedule of Benefits*. Be sure to read each *rider* (if there is any).

Service Area

The *service area* is the geographic area in which you may receive all of your health care services and supplies. Your *service area* includes all counties in the Commonwealth of Massachusetts. In addition, for those *members* who are living or traveling outside of Massachusetts (but within the United States) this health plan provides access to the local Blue Cross and/or Blue Shield Plan's PPO health care networks.

Special Services (Hospital and Facility Ancillary Services)

When you receive health care services from a hospital or other covered health care facility, *covered services* include certain services and supplies that the health care facility normally furnishes to its patients for diagnosis or treatment while the patient is in the facility. These *special services* include (but are not limited to) 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.

Part 2 – Explanation of Terms (continued)

- Drugs, medications, solutions, biological preparations, and medical and surgical supplies that are used while you are in the facility.
- Administration of infusions and transfusions and blood processing fees. These do not include the cost of: whole blood; packed red blood cells; blood donor fees; or blood storage fees.
- Internal prostheses (artificial replacements of parts of the body) that are part of an operation. These include things such as: hip joints; skull plates; intraocular lenses that are implanted after corneal transplant, cataract surgery, or other covered eye surgery, when the natural eye lens is replaced; and pacemakers. They do not include things such as: ostomy bags; artificial limbs or eyes; hearing aids; or airplane splints.

Subscriber

The *subscriber* is the eligible student who signs the enrollment form at the time of enrollment in this health plan.

Urgent Care

This health plan provides coverage for *urgent care*. This is medical, surgical, or psychiatric care, other than *emergency medical care*, that you need right away. This is care that you need to prevent serious deterioration of your health when an unforeseen illness or injury occurs. In most cases, *urgent care* will be brief diagnostic care and treatment to stabilize your condition.

Utilization Review

This term refers to the programs that *Blue Cross and Blue Shield* uses to evaluate the necessity and appropriateness of your health care services and supplies. *Blue Cross and Blue Shield* uses a set of formal techniques that are designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings, and drugs. These programs are designed to encourage appropriate care and services (not less care). *Blue Cross and Blue Shield* understands the need for concern about underutilization. *Blue Cross and Blue Shield* shares this concern with its *members* and health care providers. *Blue Cross and Blue Shield* does not compensate individuals who conduct *utilization review* activities based on denials. *Blue Cross and Blue Shield* also does not offer incentives to health care providers to encourage inappropriate denials of care and services. These programs may include any or all of the following.

- Pre-admission review, concurrent review, and discharge planning.
- Pre-approval of some *outpatient* services, including drugs (whether the drugs are furnished to you by a health care provider along with a *covered service*).
- Drug formulary management (compliance with the *Blue Cross and Blue Shield* Drug Formulary). This also includes quality care dosing which helps to monitor the quantity and dose of the drug that you receive, based on Food and Drug Administration (FDA) recommendations and clinical information.
- Step therapy to help your health care provider furnish you with the appropriate drug treatment. (With step therapy, before coverage is approved for certain “second step” drugs, it is required that you first try an effective “first step” drug.)
- Post-payment review.
- Individual case management.

Part 3

Emergency Services

You do not need a referral from your health care provider or an approval from *Blue Cross and Blue Shield* before you obtain *emergency medical care*. As a *member* of this health plan, you will receive worldwide emergency coverage. These emergency medical services may include *inpatient* or *outpatient* services by health care providers who are qualified to furnish *emergency medical care*. This includes care that is needed to evaluate or stabilize your emergency medical condition. **At the onset of an emergency medical condition that in your judgment requires *emergency medical care*, you should go to the nearest emergency room. If you need help, dial 911. Or, call your local emergency medical service system phone number.** You will not be denied coverage for medical and transportation services that you incur as a result of your emergency medical condition. You usually need emergency medical services because of the sudden onset of an emergency medical condition. An “emergency medical condition” is a medical condition, whether physical, behavioral, related to substance abuse, or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that, in the absence of prompt care, could reasonably be expected by a prudent layperson who has an average knowledge of health and medicine to result in: placing your life or health or the health of another (including an unborn child) in serious jeopardy; or serious impairment of bodily functions; or serious dysfunction of any bodily organ or part; or, as determined by a provider with knowledge of your condition, severe pain that cannot be managed without such care. Some examples of conditions that require *emergency medical care* are: suspected heart attacks; strokes; poisoning; loss of consciousness; convulsions; and suicide attempts.

Inpatient Emergency Admissions

Your condition may require that you be admitted into a hospital for *inpatient emergency medical care*. If this happens, you or the admitting facility (or someone on your behalf) must call *Blue Cross and Blue Shield* within 48 hours of your admission. (A health care facility that participates in your health care network should call *Blue Cross and Blue Shield* for you.) This call must include: your name; your ID number; the name of the health care facility; the date of admission; and the condition for which you are receiving treatment. This information is required so that *Blue Cross and Blue Shield* can evaluate and monitor the appropriateness of your *inpatient* health care services.

Outpatient Emergency Services

When you have an emergency medical condition, you should receive care at the nearest emergency room. If you receive *emergency medical care* at an emergency room of a hospital that does not participate in your health care network, your health plan will provide the same coverage that you would otherwise receive if you had gone to a hospital that does participate in your health care network.

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. But, benefits will be provided only for the health care services and supplies that are covered by your health plan.

- **Admissions from the Emergency Room.** Your condition may require that you be admitted directly from the emergency room into that hospital for *inpatient emergency medical care*. If this happens, you or the admitting facility (or someone on your behalf) must call *Blue Cross and Blue Shield*. (A health care facility that participates in your health care network should call *Blue Cross and Blue Shield* for you.) This call must be made within 48 hours of your admission. This call must include: your name; your ID number; the name of the health care facility; the date of admission; and the condition for which you are receiving treatment. This is required so that *Blue Cross and Blue Shield* can evaluate and monitor the appropriateness of your *inpatient* health care services.
- **Transfers to Other Inpatient Facilities.** Your emergency room provider may recommend your transfer to another facility for *inpatient* care. If this happens, you or the admitting facility (or someone on your behalf) must call *Blue Cross and Blue Shield*. (A health care facility that participates in your health care network should call *Blue Cross and Blue Shield* for you.) This call must be made within 48 hours of your admission. This is required so that *Blue Cross and Blue Shield* can evaluate the appropriateness of the *inpatient* health care services.
- **Outpatient Follow Up Care.** Your emergency room provider may recommend that you have *outpatient* follow up care. If this happens, the emergency room provider must call *Blue Cross and Blue Shield* to obtain an approval when the type of care that you need requires an approval from *Blue Cross and Blue Shield*. (See Part 4.) If you need to have more follow up care and an approval is required, you or your health care provider must obtain the approval from *Blue Cross and Blue Shield*.

Part 4

Utilization Review Requirements

To receive all of the coverage provided by your health plan, you must follow all of the requirements described in this section. **Your coverage may be denied if you do not follow these requirements.**

Pre-Service Approval Requirements

There are certain health care services or supplies that must be approved for you by *Blue Cross and Blue Shield*. A health care provider who participates in your health care network should request a pre-service approval on your behalf. (You must request this review if the health care provider does not start the process for you.) For the pre-service review, *Blue Cross and Blue Shield* will consider your health care provider to be your authorized representative. ***Blue Cross and Blue Shield* will tell you and your health care provider if coverage for a proposed service has been approved or if coverage has been denied.** To check on the status of a request or to check for the outcome of a *utilization review* decision, you can call your health care provider or the *Blue Cross and Blue Shield* customer service office. The toll free phone number to call is shown on your ID card. Remember, you should check with your health care provider before you receive services or supplies to make sure that your health care provider has received approval from *Blue Cross and Blue Shield* when a pre-service approval is required. Otherwise, you will have to pay all charges for those health care services and/or supplies.

(The requirements described below in this part do not apply to your *covered services* when Medicare is the primary coverage.)

Referrals for Specialty Care

You do not need a referral from your *primary care provider* or your attending physician in order for you to receive your health plan coverage. But, there are certain health care services and supplies that must be approved by *Blue Cross and Blue Shield* before you receive them. (See below.)

Pre-Service Review for Outpatient Services

To receive all of your coverage for certain *outpatient* health services and supplies, you must obtain a pre-service approval from *Blue Cross and Blue Shield*. A provider who participates in your health care network will request this approval on your behalf. During the pre-service review, *Blue Cross and Blue Shield* will determine if your proposed health care services or supplies should be covered as *medically necessary* for your condition. *Blue Cross* and *Blue Shield* will make this decision within two working days of the date that it receives all of the needed information from your health care provider.

You must receive a pre-service approval from *Blue Cross and Blue Shield* for:

- Certain *outpatient* specialty care, procedures, services, and supplies. Some examples of services that may require prior approval include: some types of surgery; non-emergency ambulance; and certain *outpatient* treatment plans that require a review due to factors such as (but not limited to) the variability in length of treatment, the difficulty in predicting a standard length of treatment, the risk factors and provider discretion in determining treatment intensity compared to symptoms, the difficulty in measuring outcomes, or the variability in cost and quality. **To find out if a treatment, service, or supply needs a pre-service review, you can check with your health care provider.**

You can also find out by calling the *Blue Cross and Blue Shield* customer service office or using the online *Blue Cross and Blue Shield* member self service option. To check online, log on to the *Blue Cross and Blue Shield* Web site at www.bluecrossma.com. Just follow the steps to check your benefits.

- Infertility treatment.
- Certain prescription drugs that are administered to you by a non-pharmacy health care provider during a covered visit. For example, you receive an injection or an infusion of a drug in a physician's office or in a hospital outpatient setting. A key part of this pre-service approval process is the step therapy program. It helps your health care provider provide you with the appropriate drug treatment. To find out if your prescription drug requires a prior approval from *Blue Cross and Blue Shield*, you can call the *Blue Cross and Blue Shield* customer service office.

Pre-Approval Requirements Can Change:

From time to time, *Blue Cross and Blue Shield* may change the list of health care services and supplies that require a prior approval. To check these requirements, you can use the online *Blue Cross and Blue Shield* member self service option. To do this, log on to the *Blue Cross and Blue Shield* Web site at www.bluecrossma.com. When a material change is made to these requirements, *Blue Cross and Blue Shield* will let the *subscriber's group* on your behalf know about the change at least 60 days before the change becomes effective.

Missing Information

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

Coverage Approval

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

Coverage Denial

If through the pre-service review *Blue Cross and Blue Shield* determines that your proposed health care service, supply, or course of treatment should **not** be covered as *medically necessary* for your condition, *Blue Cross and Blue Shield* will call the health care provider. *Blue Cross and Blue Shield* will make this phone call within 24 hours of the time the decision is made to let the health care provider know that the coverage was denied and to discuss alternative treatment. Then, within one working day of that phone call, *Blue Cross and Blue Shield* will send a written (or electronic) notice to you and to the health care provider. This notice will explain *Blue Cross and Blue Shield's* coverage decision. This notice will include: information related to the details about your coverage denial; the reasons that *Blue Cross and Blue Shield* has denied the request and the applicable terms of your coverage in this health plan; the specific medical and scientific reasons for which *Blue Cross and Blue Shield* has denied the request; any alternative treatment or health care services and supplies that would be covered; *Blue Cross and Blue Shield* clinical guidelines that apply and were used and any review criteria; and the review process and your right to pursue legal action.

Reconsideration of Adverse Determination

Your health care provider may ask that *Blue Cross and Blue Shield* reconsider its decision when *Blue Cross and Blue Shield* has determined that your proposed health care service, supply, or course of treatment is not *medically necessary* for your condition. In this case, *Blue Cross and Blue Shield* will arrange for the decision to be reviewed by a clinical peer reviewer. This review will be held between your health care provider and the clinical peer reviewer. And, it will be held within one working day of the date that your health care provider asks for *Blue Cross and Blue Shield's* decision to be reconsidered. If the initial decision is not reversed, you (or the health care provider on your behalf) may ask for a formal review. The process to ask for a formal review is described in Part 10 of this benefit booklet. You may request a formal review even if your health care provider has not asked that the *Blue Cross and Blue Shield* decision be reconsidered.

Pre-Admission Review

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

Exception: If your admission is for substance abuse treatment in a hospital or other covered health care facility that is certified or licensed by the Massachusetts Department of Public Health, prior approval from *Blue Cross and Blue Shield* will **not** be required. For an admission in one of these health care facilities, coverage will be provided for *medically necessary* acute treatment services and clinical stabilization services for up to a total of 14 days without prior approval, as long as the health care facility notifies *Blue Cross and Blue Shield* and provides the initial treatment plan within 48 hours of your admission. Concurrent Review (see page 22) will start on or after day seven of your admission. For all other admissions (except as described in the paragraph above), you must have prior approval from *Blue Cross and Blue Shield* in order for your *inpatient* care to be covered by this health plan.

Missing Information

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

Coverage Approval

If *Blue Cross and Blue Shield* determines that the proposed setting for your health care is suitable, *Blue Cross and Blue Shield* will call the health care facility. *Blue Cross and Blue Shield* will make this phone call within 24 hours of the time the decision is made to let the facility know of the coverage approval status of the pre-admission review. Then, within two working days of that phone call, *Blue Cross and Blue Shield* will send a written (or electronic) notice to you and to the facility. This notice will let you know (and confirm) that your coverage was approved.

Coverage Denial

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

Reconsideration of Adverse Determination

Your health care provider may ask that *Blue Cross and Blue Shield* reconsider its decision when *Blue Cross and Blue Shield* has determined that *inpatient* coverage is not *medically necessary* for your condition. In this case, *Blue Cross and Blue Shield* will arrange for the decision to be reviewed by a clinical peer reviewer. This review will be held between your health care provider and the clinical peer reviewer. And, it will be held within one working day of the date that your health care provider asks for the *Blue Cross and Blue Shield* decision to be reconsidered. If the initial decision is not reversed, you (or the health care provider on your behalf) may ask for a formal review. The process to ask for a formal review is described in Part 10 of this benefit booklet. You may request a formal review even if your health care provider has not asked that the *Blue Cross and Blue Shield* decision be reconsidered.

Concurrent Review and Discharge Planning

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

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

In other cases, based on a *medical necessity* determination, *Blue Cross and Blue Shield* may determine that you no longer need *inpatient* coverage in that health care facility. Or, you may no longer need *inpatient* coverage at all. *Blue Cross and Blue Shield* will make this decision within one working day of receiving all necessary information. *Blue Cross and Blue Shield* will call the health care facility to let them know of this decision. *Blue Cross and Blue Shield* will discuss plans for continued coverage in a health care setting that better meets your needs. This phone call will be made within 24 hours of the *Blue Cross and Blue Shield* coverage decision. For example, your condition may no longer require *inpatient* coverage in a hospital, but it still may require skilled nursing coverage. If this is the case, your physician may decide to transfer you to a skilled nursing facility. Any proposed plans will be discussed with you by your physician. All arrangements for discharge planning will be confirmed in writing with you. *Blue Cross and Blue Shield* will send this written (or electronic) notice to you and to the facility within one working day of that phone call to the facility. You may choose to stay in the health care facility after you have been told by your health care provider or *Blue Cross and Blue Shield* that *inpatient* coverage is no longer *medically necessary*. But, if you do, this health plan will not provide any more coverage. You must pay all costs for the rest of that *inpatient* stay. This starts from the date the written notice is sent to you from *Blue Cross and Blue Shield*.

Reconsideration of Adverse Determination

Your health care provider may ask that *Blue Cross and Blue Shield* reconsider its decision when *Blue Cross and Blue Shield* has determined that continued *inpatient* coverage is not *medically necessary* for your condition. In this case, *Blue Cross and Blue Shield* will arrange for the decision to be reviewed by a clinical peer reviewer. This review will be held between your health care provider and the clinical peer reviewer. And, it will be held within one working day of the date that your health care provider asks for the *Blue Cross and Blue Shield* decision to be reconsidered. If the initial decision is not reversed, you (or the health care provider on your behalf) may ask for a formal review. The process to ask for a formal review is described in Part 10 of this benefit booklet. You may request a formal review even if your health care provider has not asked that the *Blue Cross and Blue Shield* decision be reconsidered.

Individual Case Management

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

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

WORDS IN ITALICS ARE EXPLAINED IN PART 2.

Part 4 – Utilization Review Requirements (continued)

Blue Cross and Blue Shield may, in some situations, present a specific alternative treatment plan to you and your attending physician. This treatment plan will be one that is *medically necessary* for you. *Blue Cross and Blue Shield* will need the full cooperation of everyone involved. This includes: the patient (or the guardian); the hospital; the attending physician; and the proposed health care provider. *Blue Cross and Blue Shield* may require that there be a written agreement between the patient (or the patient's family or guardian) and *Blue Cross and Blue Shield*. *Blue Cross and Blue Shield* may also require that there be an agreement between the health care provider and *Blue Cross and Blue Shield* to furnish the services that are approved through this alternative treatment plan.

Part 5

Covered Services

You have the right to the coverage described in this part, except as limited or excluded in other parts of this benefit booklet. Also, be sure to read your *Schedule of Benefits*. It describes the cost share amounts that you must pay for *covered services*. And, it shows the *benefit limits* that apply to specific *covered services*. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.) **Your coverage in this health plan consists of two benefit levels: one for in-network benefits; and one for out-of-network benefits.** This means that your cost share amount differs based on the benefit level of the *covered services* that you receive. The highest benefit level is provided when you receive *covered services* from a *covered provider* who participates in your PPO health care network. This is your in-network benefit level. The lowest benefit level is usually provided when you receive *covered services* from a *covered provider* who does not participate in your PPO health care network. This is your out-of-network benefit level. Your *Schedule of Benefits* shows the cost share amounts that you will pay for in-network benefits and for out-of-network benefits.

Admissions for Inpatient Medical and Surgical Care

General and Chronic Disease Hospital Admissions

Except for an admission for *emergency medical care* or for maternity care, you and your health care provider must receive approval from *Blue Cross and Blue Shield* as outlined in this benefit booklet before you enter a general or chronic disease hospital for *inpatient* care. *Blue Cross and Blue Shield* will let you and your health care provider know when your coverage is approved. (See Part 4.) When *inpatient* care is approved by *Blue Cross and Blue Shield* or it is for *inpatient emergency medical care*, this health plan provides coverage for as many days as are *medically necessary* for you. These *inpatient* benefits are also available for *inpatient* care you receive in a Christian Science sanatorium. (For maternity care, see page 35.) This coverage includes:

- Semiprivate *room and board*; and *special services* that are furnished for you by the hospital.
- Surgery that is performed for you by a physician; or a nurse practitioner; or a dentist. This may also include the services of an assistant surgeon (physician) when *Blue Cross and Blue Shield* decides that an assistant is needed. These *covered services* include (but are not limited to):
 - **Reconstructive surgery.** This means non-dental surgery that is meant to improve or give you back bodily function or to correct a functional physical impairment that was caused by: a birth defect; a prior surgical procedure or disease; or an accidental injury. It also includes surgery that is done to correct a deformity or disfigurement that was caused by an accidental injury.

Women's Health and Cancer Rights

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

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

- **Transplants.** This means human organ (or tissue) and stem cell (“bone marrow”) transplants that are furnished according to *Blue Cross and Blue Shield medical policy* and *medical technology assessment criteria*. It also includes one or more stem cell transplants for a *member* who has been diagnosed with breast cancer that has spread. For covered transplants, coverage also includes: the harvesting of the donor’s organ (or tissue) or stem cells when the recipient is a *member*; and drug therapy that is furnished during the transplant procedure to prevent the transplanted organ (or tissue) or stem cells from being rejected. “Harvesting” includes: the surgical removal of the donor’s organ (or tissue) or stem cells; and the related *medically necessary* services and/or tests that are required to perform the transplant itself. No benefits are provided for the harvesting of the donor’s organ (or tissue) or stem cells when the recipient is not a *member*. (See “Lab Tests, X-Rays, and Other Tests” for your coverage for donor testing.)

- **Oral surgery.** This means: reduction of a dislocation or fracture of the jaw or facial bone; excision of a benign or malignant tumor of the jaw; and orthognathic surgery that you need to correct a significant functional impairment that cannot be adequately corrected with orthodontic services. You must have a serious medical condition that requires that you be admitted to a hospital as an *inpatient* in order for the surgery to be safely performed. (Orthognathic surgery is not covered when it is performed mainly for cosmetic reasons. This surgery must be performed along with orthodontic services. If it is not, the oral surgeon must send a letter to *Blue Cross and Blue Shield* asking for approval for the surgery. No benefits are provided for the orthodontic services.)

Covered oral surgery also includes the removal of impacted teeth (includes wisdom teeth), when the teeth are fully or partially imbedded in the bone.

- **Gender reassignment surgery.** This means gender reassignment surgery for gender identity disorders. No benefits are provided for services and procedures that are considered to be cosmetic services that may be used to make a person look more feminine or more masculine. For example, no benefits are provided for procedures such as (but not limited to): plastic surgery of the nose, face lift, lip enhancement, facial bone reduction, plastic surgery of the eyelids, liposuction of the waist, reduction of the thyroid cartilage, hair removal, hair transplants, surgery of the larynx including shortening of the vocal cords, chin implants, nose implants, and lip reduction.

- **Voluntary termination of pregnancy (abortion).**

- **Voluntary sterilization procedures.** To provide coverage for the women’s preventive health services as recommended by the U.S. Department of Health and Human Services, any in-network *deductible, copayment, and/or coinsurance* will be waived for a sterilization procedure furnished for a female *member* when it is performed as the primary procedure for family planning reasons. This provision does not apply for hospital services. For all situations except as described in this paragraph, the cost share amount for elective surgery will still apply.

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

- Anesthesia services that are related to covered surgery. This includes those services that are furnished for you by a physician other than the attending physician; or by a certified registered nurse anesthetist.
- Radiation and x-ray therapy that is furnished for you by a physician. This includes: radiation therapy using isotopes, radium, radon, or other ionizing radiation; and x-ray therapy for cancer or when used in place of surgery.
- Chemotherapy (drug therapy for cancer) that is furnished for you by a physician.
- Interpretation of *diagnostic x-ray and other imaging tests, diagnostic lab tests*, and diagnostic machine tests, when these tests are furnished by a physician or by a podiatrist instead of by a hospital-based radiologist or pathologist who is an employee of the hospital. (When these services are furnished by a radiologist or pathologist who is an employee of the hospital, coverage is provided as a *special service* of the hospital.)
- Medical care that is furnished for you by a physician; or by a nurse practitioner; or by a by a Christian Science practitioner. This includes medical care furnished for you by a physician other than the attending physician to treat an uncommon aspect or complication of your illness or injury. This health plan will cover medical care furnished for you by two or more physicians at the same time. But, this is the case only when *Blue Cross and Blue Shield* decides that the care is needed to treat a critically ill patient. The second physician must be an expert in a different medical sub-specialty than the attending physician. This health plan will cover only the attending physician if the second physician is an expert in the same medical sub-specialty as the attending physician.

No benefits are provided for services that are furnished by a podiatrist while you are an *inpatient*.

- Monitoring services that are related to dialysis, when they are furnished for you by a *covered provider*.
- Consultations. These services must be furnished for you by a physician other than the attending physician. The consultation must be needed to diagnose or treat the condition for which you were admitted. Or, it must be for a complication that develops after you are an *inpatient*. The attending physician must order the consultation. The physician who furnishes it must send a written report to *Blue Cross and Blue Shield* if they ask for one. The physician who furnishes this consultation for you must be an expert in a different medical sub-specialty than the attending physician. This health plan will cover only the attending physician if the consultant is an expert in the same medical sub-specialty as the attending physician.
- Intensive care services. These services must be furnished for you by a physician other than the attending physician; or by a nurse practitioner. This means services that you need for only a limited number of hours to treat an uncommon aspect or complication of your illness or injury.
- Emergency admission services. These services must be furnished for you by a physician; or by a nurse practitioner. This means that a complete history and physical exam is performed before you are admitted as an *inpatient* for *emergency medical care* and your treatment is taken over immediately by another physician.

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

- Pediatric specialty care. This is care that is furnished for you by a *covered provider* who has a recognized expertise in specialty pediatrics.
- Second surgical opinions. These services must be furnished for you by a physician. This includes a third opinion when the second opinion differs from the first.

Rehabilitation Hospital Admissions

You and your health care provider must receive approval from *Blue Cross and Blue Shield* as outlined in this benefit booklet before you enter a rehabilitation hospital for *inpatient* care. *Blue Cross and Blue Shield* will let you and your health care provider know when your coverage is approved. (See Part 4.) When *inpatient* care is approved by *Blue Cross and Blue Shield*, this health plan provides coverage for as many days as are *medically necessary* for you. (Coverage is provided only for those services that are determined by *Blue Cross and Blue Shield* to be *medically necessary* for you.) This coverage includes: semiprivate *room and board* and *special services* furnished for you by the hospital; and medical care furnished for you by a physician or by a nurse practitioner.

Skilled Nursing Facility Admissions

You and your health care provider must receive approval from *Blue Cross and Blue Shield* as outlined in this benefit booklet before you enter a skilled nursing facility for *inpatient* care. *Blue Cross and Blue Shield* will let you and your health care provider know when your coverage is approved. (See Part 4.) When *inpatient* care is approved by *Blue Cross and Blue Shield*, this health plan provides coverage for as many days as are *medically necessary* for you. (Coverage is provided only for those services that are determined by *Blue Cross and Blue Shield* to be *medically necessary* for you.) This coverage includes: semiprivate *room and board* and *special services* furnished for you by the facility; and medical care furnished for you by a physician or by a nurse practitioner.

Ambulance Services

This health plan covers ambulance transport. This coverage includes:

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

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

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

Autism Spectrum Disorders Services

This health plan covers *medically necessary* services to diagnose and treat autism spectrum disorders when the *covered services* are furnished by a *covered provider*. This may include (but is not limited to): a physician; a psychologist; or a *covered provider* who is an autism services provider (such as a board certified behavior analyst who is employed by a covered facility or agency or a board certified behavior analyst who has been designated for you and approved for coverage by *Blue Cross and Blue Shield*). For *covered services* furnished on or after October 1, 2016, this may include (but is not limited to): a physician; a psychologist; or a licensed applied behavioral analyst. This coverage includes:

- Assessments, evaluations (including neuropsychological evaluations), genetic testing, and/or other tests to determine if a *member* has an autism spectrum disorder.
- Habilitative and rehabilitative care. This is care to develop, maintain, and restore, to the maximum extent practicable, the functioning of the *member*. This care includes, but is not limited to, applied behavior analysis that is supervised by a board certified behavior analyst. For *covered services* furnished on or after October 1, 2016, this care includes, but is not limited to, applied behavior analysis that is furnished by or supervised by: a psychologist; or a licensed applied behavioral analyst.
- Psychiatric and psychological care that is furnished by a *covered provider* such as: a physician who is a psychiatrist; or a psychologist.
- Therapeutic care that is furnished by a *covered provider*. This may include (but is not limited to): a speech, occupational, or physical therapist; or a licensed independent clinical social worker.

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

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

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

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

Cardiac Rehabilitation

This health plan covers *outpatient* cardiac rehabilitation when it is furnished for you by a cardiac rehabilitation provider. You will be covered for as many visits as are *medically necessary* for your condition. Your first visit must be within 26 weeks of the date that you were first diagnosed with cardiovascular disease. Or, you must start within 26 weeks after you have had a cardiac event. *Blue Cross and Blue Shield* must determine through medical documentation that you meet one of these conditions: you have cardiovascular disease or angina pectoris; or you have had a myocardial infarction, angioplasty, or cardiovascular surgery. (This type of surgery includes: a heart transplant; or coronary bypass graft surgery; or valve repair or replacement.) For angina pectoris, this health plan covers only one course of cardiac rehabilitation for each *member*.

No benefits are provided for: club membership fees; counseling services that are not part of your cardiac rehabilitation program (for example, these *non-covered services* may be educational, vocational, or psychosocial counseling); medical or exercise equipment that you use in your home; services that are provided to your family; and additional services that you receive after you complete a cardiac rehabilitation program.

Chiropractor Services

This health plan covers *outpatient* chiropractic services when they are furnished for you by a chiropractor who is licensed to furnish the specific *covered service* only until you reach your *benefit limit*. This coverage includes: *diagnostic lab tests* (such as blood tests); diagnostic x-rays other than magnetic resonance imaging (MRI), computerized axial tomography (CT scans), and other imaging tests; and *outpatient* medical care services, including spinal manipulation. Your *Schedule of Benefits* describes the *benefit limit* that applies for these *covered services*. Once you reach the *benefit limit*, no more benefits will be provided for these services. Whether or not there is a *benefit limit* for these services, coverage is provided only for those services that are determined by *Blue Cross and Blue Shield* to be *medically necessary* for you.

Cleft Lip and Cleft Palate Treatment

This health plan covers services to treat conditions of cleft lip and cleft palate for a *member* who is under age 18 (from birth through age 17). To receive coverage, these services must be furnished by a *covered provider* such as: a physician; a dentist; a nurse practitioner; a physician assistant; a licensed speech-language pathologist; a licensed audiologist; a licensed dietitian nutritionist; or a *covered provider* who has a recognized expertise in specialty pediatrics. These services may be furnished in the provider's office or at a hospital or other covered facility. This coverage includes:

- Medical, dental, oral, and facial surgery.
- Surgical management and follow-up care by oral and plastic surgeons.
- Speech therapy, audiology services, and nutrition services.

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

Your coverage for these *covered services* is provided to the same extent as coverage is provided for similar *covered services* to treat other physical conditions.

No **benefits** are provided for: preventive and restorative dental care; prosthetic management therapy; orthodontic treatment; or other dental services.

Dialysis Services

This health plan covers *outpatient* dialysis when it is furnished for you by a hospital; or by a community health center; or by a free-standing dialysis facility; or by a physician. This coverage also includes home dialysis when it is furnished under the direction of a *covered provider*. Your home dialysis coverage includes: non-durable medical supplies (such as dialysis membrane and solution, tubing, and drugs that are needed during dialysis); the cost to install the dialysis equipment in your home up to \$300; and the cost to maintain or to fix the dialysis equipment. *Blue Cross and Blue Shield* will decide whether to rent or to buy the dialysis equipment. If the dialysis equipment is bought, *Blue Cross and Blue Shield* keeps ownership rights to it. It does not become your property. No home dialysis benefits are provided for: costs to get or supply power, water, or waste disposal systems; costs of a person to help with the dialysis procedure; and costs that are not needed to run the dialysis equipment.

Durable Medical Equipment

This health plan covers durable medical equipment or covered supplies that you buy or rent from a *covered provider* that is an appliance company or from another provider who is designated by *Blue Cross and Blue Shield* to furnish the specific covered equipment or supply. This coverage is provided for equipment or supplies that in most cases: can stand repeated use; serves a medical purpose; is *medically necessary* for you; is not useful if you are not ill or injured; and can be used in the home.

Some examples of covered durable medical equipment include (but are not limited to):

- Knee braces; and back braces.
- Orthopedic and corrective shoes that are part of a leg brace.
- Hospital beds; wheelchairs; crutches; and walkers.
- Glucometers. These are covered when the device is *medically necessary* for you due to your type of diabetic condition.
- Visual magnifying aids; and voice-synthesizers. These are covered only for a legally blind *member* who has insulin dependent, insulin using, gestational, or non-insulin dependent diabetes.
- Insulin injection pens.

These *covered services* include one breast pump for each birth (other than a hospital grade breast pump) that you buy or rent from an appliance company or from a provider who is designated by *Blue Cross and Blue Shield* to furnish breast pumps. However, your coverage will not be more than the full *allowed charge* for the purchase price of a breast pump. If an in-network *deductible* and/or *coinsurance* would

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

normally apply to these *covered services*, both the *deductible* and *coinsurance* will be waived for your in-network benefits for a covered breast pump. No benefits are provided for a hospital grade breast pump.

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

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

Early Intervention Services

This health plan covers early intervention services when they are furnished by an early intervention provider for an enrolled child from birth through age two. (This means until the child turns three years old.) This coverage includes *medically necessary*: physical, speech/language, and occupational therapy; nursing care; and psychological counseling.

Emergency Medical Outpatient Services

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

For emergency room visits, you may have to pay a *copayment* for *covered services*. If a *copayment* does apply to your emergency room visit, it is waived if the visit results in your being held for an overnight observation stay or being admitted for *inpatient* care within 24 hours. (Your *Schedule of Benefits* describes your cost share amount.)

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

Home Health Care

This health plan covers home health care when it is furnished (or arranged and billed) for you by a home health care provider. This coverage is provided only when: you are expected to reach a defined medical goal that is set by your attending physician; the “home” health care is furnished at a place where you live (unless it is a hospital or other health care facility that furnishes skilled nursing or rehabilitation services); and, for medical reasons, you are not reasonably able to travel to another treatment site where medically appropriate care can be furnished for your condition. This coverage includes:

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

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

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

Hospice Services

This health plan covers hospice services when they are furnished (or arranged and billed) for you by a hospice provider. “Hospice services” means pain control and symptom relief and supportive and other care for a *member* who is terminally ill and expected to live 12 months or less. These services are furnished to meet the needs of the *member* and of his or her family during the illness and death of the *member*. They may be furnished at home, in the community, and in facilities. This coverage includes:

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

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

Infertility Services

This health plan covers services to diagnose and treat infertility for a *member* who has not been able to conceive or produce conception during a period of one year. *Blue Cross and Blue Shield* may approve coverage for infertility services in two other situations: when the *member* has been diagnosed with cancer and, after treatment, the *member* is expected to become infertile; or when a *member* is age 35 or older and has not been able to conceive or produce conception during a period of six months. To receive coverage for infertility services, they must be *medically necessary* for you, furnished by a *covered provider*, and approved by *Blue Cross and Blue Shield* as outlined in this benefit booklet and in the *Blue Cross and Blue Shield medical policy*. You and your health care provider must receive approval from *Blue Cross and Blue Shield* before you obtain infertility services. *Blue Cross and Blue Shield* will let you and your health care provider know when your coverage is approved. (See Part 4.) **In all cases, covered services must conform with *Blue Cross and Blue Shield medical policy* and meet *Blue Cross and Blue Shield medical technology assessment criteria*.** (See page 11 for help for how to access or obtain a copy of the *medical policy*.) This coverage may include (but is not limited to):

- Artificial insemination.
- Sperm and egg and/or inseminated egg procurement and processing.
- Banking of sperm or inseminated eggs (only when they are not covered by the donor's health plan); and other services as outlined in *Blue Cross and Blue Shield medical policy*.
- Infertility technologies, such as: in vitro fertilization and embryo placement; gamete intrafallopian transfer; zygote intrafallopian transfer; natural oocyte retrieval intravaginal fertilization; and intracytoplasmic sperm injection.

If *covered services* are furnished outside of Massachusetts and the health care provider does not have a payment agreement with the local Blue Cross and/or Blue Shield Plan, this health plan will provide these benefits only when the provider is board certified and meets the appropriate American Society of Reproductive Medicine standards for an infertility provider. Otherwise, no benefits will be provided for the services furnished by those providers.

Coverage for Prescription Drugs

The drugs that are used for infertility treatment are **not** covered under this part of the *group's* student health plan, even if a non-pharmacy health care provider administers the drug for you during a covered visit. You must contact the *group* for information about your prescription drug coverage. **No benefits are provided under this part of the *group's* student health plan for the cost of these drugs when the drug is furnished by a non-pharmacy health care provider.**

No benefits are provided for: long term sperm or egg preservation or long term cryopreservation not associated with active infertility treatment; costs that are associated with achieving pregnancy through surrogacy (gestational carrier); infertility treatment that is needed as a result of a prior sterilization or unsuccessful sterilization reversal procedure (except for *medically necessary* infertility treatment that is needed after a sterilization reversal procedure that is successful as determined by appropriate diagnostic tests); and in vitro fertilization furnished for a fertile woman to select the genetic traits of the embryo

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

(coverage may be available for the genetic testing alone when the testing conforms with *Blue Cross and Blue Shield medical policy*).

Lab Tests, X-Rays, and Other Tests

This health plan covers *outpatient* diagnostic tests when they are furnished for you by a *covered provider*. This coverage includes:

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

If a *copayment* normally applies to these *covered services*, the *copayment* will **not** apply to the interpretation costs that are billed in conjunction with any one of the tests; and it will be waived when the tests are furnished during an emergency room visit or during a day surgery admission, or at a hospital and the results of lab test(s) are required right away so the hospital can furnish treatment to you. You can call the *Blue Cross and Blue Shield* customer service office for information about the times when your *copayment* may be waived. The toll free phone number to call is shown on your ID card. Your *Schedule of Benefits* describes your cost share amount.

Maternity Services and Well Newborn Inpatient Care

Maternity Services

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

- Semiprivate *room and board* and *special services* when the enrolled mother is an *inpatient* in a general hospital. This includes nursery charges for a well newborn. These charges are included with the benefits for the mother’s maternity admission. The mother’s (and newborn child’s) *inpatient* stay will be no less than 48 hours following a vaginal delivery or 96 hours following a Caesarian section unless the mother and her attending physician decide otherwise as provided by law. If the mother chooses to be discharged earlier, this health plan covers one home visit within 48 hours of discharge, when it is furnished by a physician; or by a registered nurse; or by a nurse midwife; or by a nurse practitioner. This visit may include: parent education; assistance and training in breast or bottle

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feeding; and appropriate tests. This health plan will cover more visits that are furnished by a *covered provider* only if *Blue Cross and Blue Shield* determines the visits are clinically necessary.

- Delivery of one or more than one baby. This includes prenatal and postnatal medical care that is furnished for you by a physician; or by a nurse midwife. Your benefits for prenatal and postnatal medical care that is furnished by a physician or by a nurse midwife are included in *Blue Cross and Blue Shield's* payment for the delivery. The benefits that are provided for these services will be those that are in effect on the date of delivery. When a physician or a nurse midwife furnishes only prenatal and/or postnatal care, benefits for those services are based on the date the care is received. This health plan also covers prenatal and postnatal medical care exams and lab tests when they are furnished for you by a general hospital; or by a community health center. Your benefits for these services are based on the date the care is received.
- Standby attendance that is furnished for you by a physician (who is a pediatrician), when a known or suspected complication threatening the health of the mother or the child requires that a pediatrician be present during the delivery.
- Childbirth classes for up to \$90 for one childbirth course for each covered expectant mother and up to \$45 for each refresher childbirth course. The expectant mother is encouraged to attend the childbirth course that is recommended by her physician or by her health care facility or by her nurse midwife. You must pay the full cost of the childbirth course. After you complete the course, call the *Blue Cross and Blue Shield* customer service office for a claim form to file your claim. You will not be reimbursed for this amount unless you complete the course, except when your delivery occurs before the course ends.

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

**Coverage for
Childbirth
Classes:**

You must contact your *group* for information about your student health plan coverage for childbirth classes and refresher childbirth classes.

No benefits are provided for a home birth, unless: the home birth is due to an emergency or unplanned delivery that occurs at home prior to being admitted to a hospital; or the home birth occurs outside of Massachusetts.

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Well Newborn Inpatient Care

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

- Pediatric care that is furnished for a well newborn by a physician (who is a pediatrician); or by a nurse practitioner.
- Routine circumcision that is furnished by a physician.
- Newborn hearing screening tests that are performed by a *covered provider* before the newborn child (an infant under three months of age) is discharged from the hospital to the care of the parent or guardian.

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

Medical Care Outpatient Visits

This health plan covers *outpatient* care to diagnose or treat your medical condition when the services or supplies are furnished for you by a *covered provider*. This may include (but is not limited to): a physician; or a nurse practitioner; or an optometrist; or a licensed dietitian nutritionist; or a Christian Science sanatorium or practitioner. These services may be furnished in the provider's office or at a covered facility or, as determined appropriate by *Blue Cross and Blue Shield*, at home.

Important Note:

Refer to your *Schedule of Benefits* for a description of annual visit limits that may apply for these *covered services*. Any *benefit limit* does not apply for phototherapy treatment (including PUVA) and, when a visit is for respiratory therapy, for separate charges for the therapy procedure.

This coverage includes:

- Medical care services to diagnose or treat your illness, condition, or injury. These medical services also include (but are not limited to) nutrition counseling.

Women's Health and Cancer Rights

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

- Certain medical care services you receive from a limited services clinic. A limited services clinic can provide on-the-spot, non-emergency care for symptoms such as a sore throat, cough, earache, fatigue, poison ivy, flu, body aches, or infection. You do not need an appointment to receive this care. If you want to find out if a specific service is covered at a limited services clinic, you can call the limited

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

services clinic or you can call the *Blue Cross and Blue Shield* customer service office. Generally, the cost share amount you pay for these *covered services* is the same cost share amount that you would pay for similar services furnished by a physician. Refer to the *Schedule of Benefits* for your plan option for your cost share amount when you receive *covered services* at a limited services clinic.

- Medical exams and contact lenses that are needed to treat keratoconus. This includes the cost of the fitting of these contact lenses.
- Hormone replacement therapy for peri- and post-menopausal women.
- *Urgent care* services.
- Follow up care that is related to an accidental injury or an emergency medical condition.
- Allergy testing. (This includes tests that you need such as PRIST, RAST, and scratch tests.)
- Injections. This includes the administration of injections that you need such as allergy shots or other *medically necessary* injections. And, except for certain self injectable drugs as described below in this section, this coverage also includes the vaccine, serum, or other covered drug that is furnished during your covered visit. (This section does not include injections that are covered as a surgical service such as a nerve block injection or an injection of anesthetic agents. See “Surgery as an Outpatient.”)

Coverage for Self Injectable and Certain Other Drugs

There are self injectable and certain other prescription drugs used for treating your medical condition that are **not** covered under this part of the *group’s* student health plan, even if a non-pharmacy health care provider administers the drug for you during a covered visit. You must contact the *group* for information about your prescription drug coverage. **No benefits are provided under this part of the *group’s* student health plan for the cost of these drugs when the drug is furnished by a non-pharmacy health care provider.** For a list of these drugs, you can call the *Blue Cross and Blue Shield* customer service office. Or, you can log on to the *Blue Cross and Blue Shield* Web site at www.bluecrossma.com.

- Syringes and needles when they are *medically necessary* for you. If a *copayment* would normally apply to your visit, it is waived if the visit is only to obtain these items.)
- Diabetes self-management training and education, including medical nutrition therapy, when it is furnished for you by a certified diabetes health care professional who is a *covered provider* or who is affiliated with a *covered provider*.
- Pediatric specialty care that is furnished for you by a *covered provider* who has a recognized expertise in specialty pediatrics.
- Non-dental services that are furnished for you by a dentist who is licensed to furnish the specific *covered service*. This coverage is provided only if the services are covered when they are furnished for you by a physician.
- Monitoring and medication management for *members* taking psychiatric drugs; and/or neuropsychological assessment services. These services may also be furnished by a *mental health provider*.

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

Medical Formulas

This health plan covers medical formulas and low protein foods to treat certain conditions. This coverage includes:

- Special medical formulas that are *medically necessary* for you to treat one of the listed conditions: homocystinuria; maple syrup urine disease; phenylketonuria; propionic acidemia; methylmalonic acidemia; or tyrosinemia.
- Enteral formulas that you need to use at home and are *medically necessary* for you to treat malabsorption caused by one of the listed conditions: Crohn’s disease; chronic intestinal pseudo-obstruction; gastroesophageal reflux; gastrointestinal motility; ulcerative colitis; or inherited diseases of amino acids and organic acids.
- Food products that are modified to be low protein and are *medically necessary* for you to treat inherited diseases of amino acids and organic acids. (You may buy these food products directly from a distributor.)

Mental Health and Substance Abuse Treatment

This health plan covers *medically necessary* services to diagnose and/or treat *mental conditions*. This coverage includes:

- Biologically-based *mental conditions*. “Biologically-based mental conditions” means: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder; delirium and dementia; affective disorders; eating disorders; post-traumatic stress disorders; autism; substance abuse disorders (drug addiction and alcoholism); and any biologically-based *mental conditions* that appear in the most recent edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders that are scientifically recognized and approved by the Commissioner of the Department of Mental Health.
- Rape-related mental or emotional disorders for victims of a rape or victims of an assault with intent to rape.
- Non-biologically-based mental, behavior, or emotional disorders of enrolled dependent children who are under age 19. This coverage includes pediatric specialty mental health care that is furnished by a *mental health provider* who has a recognized expertise in specialty pediatrics.
- All other non-biologically-based *mental conditions* not described above.

No benefits are provided for: psychiatric services for a condition that is not a *mental condition*; residential or other care that is *custodial care*; and services and/or programs that are not *medically necessary* to treat your *mental condition*. Some examples of services and programs that are not covered by this health plan are: services that are performed in educational, vocational, or recreational settings; and “outward bound-type,” “wilderness,” “camp,” or “ranch” programs. These types of non-covered programs may be in residential or nonresidential settings. They may include therapeutic elements and/or clinical staff services as well as vocational, educational, problem solving, and/or recreational activities. These programs may have educational accreditation. The staff may include some licensed mental health providers who may provide some therapy. No benefits are provided for any services furnished along with

WORDS IN ITALICS ARE EXPLAINED IN PART 2.

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

one of these non-covered programs. For example, no benefits are provided for therapy and/or psychotherapy furnished along with one of these non-covered programs.

Inpatient Services

Usually, to receive coverage for *inpatient* services, you and your *mental health provider* must receive approval from *Blue Cross and Blue Shield* as outlined in this benefit booklet before you enter a hospital or other covered facility. (See Part 4 for these requirements.) *Blue Cross and Blue Shield* will let you and your *mental health provider* know when your coverage is approved. When *inpatient* care is approved by *Blue Cross and Blue Shield*, this health plan provides coverage for as many days as are *medically necessary* for you. This coverage includes: *semiprivate room and board* and *special services*; and psychiatric care that is furnished for you by a physician (who is a specialist in psychiatry), or by a psychologist, or by a clinical specialist in psychiatric and mental health nursing, or by another *mental health provider*.

Intermediate Treatments

There may be times when you will need *medically necessary* care that is more intensive than typical *outpatient* care. But, you do not need 24-hour *inpatient* hospital care. This “intermediate” care may include (but is not limited to):

- Acute residential treatment. Your coverage for this treatment is considered to be an *inpatient* benefit. During the *inpatient* pre-service review process (see Part 4), *Blue Cross and Blue Shield* will assess your specific health care needs. The least intensive type of setting that is required for your *mental condition* will be approved by *Blue Cross and Blue Shield*.
- Partial hospital programs or intensive outpatient programs. Your coverage for these programs is considered to be an *outpatient* benefit.

If you would normally pay a *copayment* for *inpatient* or *outpatient* benefits, the *copayment* will be waived when you get covered intermediate care. But, you must still pay your *deductible* and/or *coinsurance*, whichever applies.

Outpatient Services

This health plan covers *outpatient covered services* to diagnose and/or treat *mental conditions* when the services are furnished for you by a *mental health provider*. **You must contact the group for a complete description of your coverage for outpatient services to diagnose and/or treat mental conditions.**

Oxygen and Respiratory Therapy

This health plan covers:

- Oxygen and the equipment to administer it for use in the home. These items must be obtained from an oxygen supplier. This includes oxygen concentrators.
- Respiratory therapy services. These services must be furnished for you by a *covered provider*. Some examples are: postural drainage; and chest percussion.

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

Podiatry Care

This health plan covers non-routine podiatry (foot) care when it is furnished for you by a *covered provider*. This may include (but is not limited to): a physician; or a podiatrist. This coverage includes: *diagnostic lab tests*; diagnostic x-rays; surgery and necessary postoperative care; and other *medically necessary* foot care such as treatment for hammertoe and osteoarthritis.

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

Preventive Health Services

In this benefit booklet, the term “preventive health services” refers to *covered services* that are performed to prevent diseases (or injuries) rather than to diagnose or treat a symptom or complaint, or to treat or cure a disease after it is present. This health plan provides coverage for preventive health services in accordance with applicable federal laws and regulations.

Routine Pediatric Care

This health plan covers routine pediatric care for a *member* from birth through age 17 that is furnished by a *covered provider* and is in line with applicable *Blue Cross and Blue Shield medical policies*. This coverage is limited to an age-based schedule and a maximum number of visits. Your *Schedule of Benefits* describes the age-based schedule and the visit limits that apply for these *covered services*. This coverage includes:

- Routine medical exams; history; measurements; sensory (vision and auditory) screening; and neuropsychiatric evaluation and development screening; and assessment.
- Hereditary and metabolic screening at birth.
- Appropriate immunizations as recommended by the Advisory Committee on Immunization Practices. This includes (but is not limited to): flu shots; and travel immunizations.
- Tuberculin tests; hematocrit, hemoglobin, and other appropriate blood tests; urinalysis; and blood tests to screen for lead poisoning.
- Preventive care and screenings supported by the Health Resources and Services Administration.
- Other preventive health services as required by applicable federal laws and regulations. This includes (but is not limited to) preventive health services as recommended by the U.S. Preventive Services Task Force.
- Other related routine services that are furnished in line with *Blue Cross and Blue Shield medical policies*.

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

For an enrolled child who receives coverage for vaccines from a federal or state agency, this health plan provides coverage only to administer the vaccine. Otherwise, this health plan also provides coverage for a covered vaccine along with the services to administer the vaccine.

Important Note about Your Coverage for Preventive Health Services:	You have the right to full in-network coverage for the preventive health services that are recommended and supported by the Advisory Committee on Immunization Practices, by the U.S. Preventive Services Task Force, and by the U.S. Department of Health and Human Services. You must contact the <i>group</i> for a complete description of your coverage for these preventive health services.
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No benefits are provided for exams that are needed: to take part in school, camp, and sports activities; or by third parties. The only exception to this is when these exams are furnished as a covered routine exam.

Preventive Dental Care for Members under Age 19

For a description of pediatric essential dental benefits for *members* under age 19, refer to the pediatric essential dental benefit booklet that is part of the *group's* student health plan.

Routine Adult Physical Exams and Tests

This part of the *group's* student health plan covers the following routine tests, when the test is furnished by a *covered provider*:

- Routine lab tests.
- A routine mammogram during the five-year period a *member* who is age 35 through 39 and once each *plan year* for a *member* who is age 40 or older.
- Routine sigmoidoscopies and barium enemas.
- Routine colonoscopies.

Important Note about Your Coverage for Preventive Health Services:	You have the right to full in-network coverage for the preventive health services that are recommended and supported by the Advisory Committee on Immunization Practices, by the U.S. Preventive Services Task Force, and by the U.S. Department of Health and Human Services. You must contact the <i>group</i> for a complete description of your coverage for these preventive health services.
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No benefits are provided for exams that are needed: to take part in school, camp, and sports activities; or by employers or third parties. The only exception to this is when these exams are furnished as a covered routine exam.

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

Routine Gynecological (GYN) Exams

This health plan covers routine GYN exams and related tests (including Pap smear tests) when the services are furnished by a *covered provider*. This may include (but is not limited to): a physician; or a nurse practitioner; or a nurse midwife.

Important Note about Your Coverage for Women’s Preventive Health Services:

All female *members* have the right to full in-network coverage coverage for women’s preventive health services as recommended by the U.S. Department of Health and Human Services. These types of preventive health services include: yearly well-woman visits; domestic violence screening; human papillomavirus (HPV) DNA testing; screening for human immunodeficiency virus (HIV) infection; birth control methods and counseling; screening for gestational diabetes; and breastfeeding support and breast pumps.

Family Planning

This health plan covers family planning services when they are furnished for you by a *covered provider*. This may include (but is not limited to): a physician; or a nurse practitioner; or a nurse midwife. This coverage includes:

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

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

Routine Hearing Care Services

This health plan covers routine hearing exams and tests. This includes: routine hearing exams and tests furnished for you by a *covered provider*; and newborn hearing screening tests for a newborn child (an infant under three months of age). See “Well Newborn Inpatient Care” for your *inpatient* coverage for newborn hearing screening tests.

No benefits are provided for hearing aids.

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Routine Vision Exams

This health plan covers a periodic routine vision exam when it is furnished for you by an ophthalmologist or by an optometrist. Your *Schedule of Benefits* describes the *benefit limit* that applies for routine vision exams—this is the time period during which a routine vision exam will be covered by your health plan. Once you have received this coverage, no more benefits will be provided for another exam during the same time period. **You must contact the group for a complete description of your coverage for routine vision exams.**

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

Wellness Rewards

While you are enrolled in this health plan, you may be eligible to receive wellness rewards for some fees that you pay to participate in qualified fitness programs and/or weight loss programs.

- **Fitness Benefit.** Your health plan will reimburse you for your costs for monthly membership fees for three consecutive months of one family or individual health club membership or, as an alternative, for up to 10 fitness classes taken by any combination of *subscriber*, spouse, and/or dependent children enrolled under the same student health plan membership, at a qualified health club during a calendar year. You can claim this fitness benefit once each calendar year. For information about what you need to do to be eligible for this fitness benefit and how to claim your fitness benefit, refer to your fitness program benefit materials. This fitness benefit applies for fees paid to: privately-owned or privately-sponsored health clubs or fitness facilities, including individual health clubs and fitness centers; YMCAs; YWCAs; Jewish Community Centers; and municipal fitness centers. No fitness benefit is provided for any health club initiation fees or fees or costs that you pay for: personal training sessions; country clubs; social clubs (such as ski or hiking clubs); sports teams or leagues; spas; instructional dance studios; and martial arts schools.
- **Weight Loss Program Benefit.** Your health plan will reimburse you for your costs for up to three months for participation in qualified weight loss program(s) each calendar year. A qualified weight loss program is a hospital-based weight loss program or a non-hospital-based weight loss program designated by *Blue Cross and Blue Shield*. You can claim this three-month weight loss program benefit once each calendar year for any combination of *members* (such as the *subscriber*, spouse, and/or dependent children) enrolled under the same student health plan membership. To find out which weight loss program(s) are designated by *Blue Cross and Blue Shield*, you can log on to the *Blue Cross and Blue Shield* Web site at www.bluecrossma.com. Or, you can call the *Blue Cross and Blue Shield* customer service office. The toll free phone number to call is shown on your ID card. No weight loss program benefit is provided for any fees or costs that you pay for: online weight loss programs; any non-hospital-based weight loss program not designated by *Blue Cross and Blue Shield*; individual nutrition counseling sessions (see “Medical Care Outpatient Visits” for your coverage for

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nutritional counseling); pre-packaged meals, books, videos, scales, or other items or supplies bought by the *member*; and any other items not included as part of a weight loss class or weight loss course.

To receive your fitness benefit and/or your weight loss program benefit, you must file a claim no later than March 31st after the year for which you are claiming your benefit. If you file your claim during the calendar year for which you are claiming your benefit, the date on which you file the claim will be considered the incurred date. But, if you file your claim after the year for which you are claiming your benefit, the incurred date will be shown as December 31st of the prior year. This means that the incurred date reflects the calendar year for which you are claiming your benefit. To file a claim, you must: fill out a claim form; attach your original itemized paid receipt(s); and mail the claim to *Blue Cross and Blue Shield*. For a claim form or help to file a claim, you can call the *Blue Cross and Blue Shield* customer service office. Or, you can log on to the *Blue Cross and Blue Shield* Web site at www.bluecrossma.com to print a claim form.

Prosthetic Devices

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

- Artificial limb devices to replace (in whole or in part) an arm or a leg. This includes any repairs that are needed for the artificial leg or arm.
- Artificial eyes.
- Ostomy supplies; and urinary catheters.
- Breast prostheses. This includes mastectomy bras.
- Therapeutic/molded shoes and shoe inserts that are furnished for a *member* with severe diabetic foot disease.
- Insulin infusion pumps and related pump supplies.
- One wig (scalp hair prosthesis) in each calendar year (but no less than \$350 in coverage each calendar year) for a *member* whose hair loss is due to: chemotherapy; radiation therapy; infections; burns; traumatic injury; congenital baldness; and medical conditions resulting in alopecia areata or alopecia totalis (capitus). No benefits are provided for wigs when hair loss is due to: male pattern baldness; female pattern baldness; or natural or premature aging.
- Augmentative communication devices. An “augmentative communication device” is one that assists in restoring speech. It is needed when a *member* is unable to communicate due to an accident, illness, or disease such as amyotrophic lateral sclerosis (ALS).

This health plan covers the most appropriate *medically necessary* model that meets your medical needs. This means that if *Blue Cross and Blue Shield* determines that you chose a model that costs more than what you need for your medical condition, benefits will be provided only for those charges that would

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

have been paid for the most appropriate *medically necessary* model that meets your medical needs. In this case, you must pay all of the provider's charges that are more than the *Blue Cross and Blue Shield* claim payment.

Qualified Clinical Trials for Treatment of Cancer

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

No benefits are provided for:

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

Other Approved Clinical Trials

In addition to clinical trials for cancer, this health plan covers a *member* who participates in an approved clinical trial for a life-threatening disease or condition, as required by federal law. This means a disease or condition from which death is likely unless the course of the disease is interrupted. This coverage is provided for *covered services* that are consistent with the study protocol and with the standard of care for a person with the *member's* condition; and, as long as the services would be covered if the *member* did not participate in the trial. But, no benefits are provided for an investigational drug or device, whether or not it has been approved for use in the trial.

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

Radiation Therapy and Chemotherapy

This health plan covers *outpatient* radiation and x-ray therapy and chemotherapy when it is furnished for you by a *covered provider*. This may include (but is not limited to): a physician; or a nurse practitioner; or a free-standing radiation therapy and chemotherapy facility; or a hospital; or a *covered provider* who has a recognized expertise in specialty pediatrics. This coverage includes:

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

Coverage for Self Injectable and Certain Other Drugs

There are self injectable and certain other prescription drugs used for cancer treatment or treatment of cancer symptoms due to cancer treatment that are **not** covered under this part of the *group's* student health plan, even if a non-pharmacy health care provider administers the drug for you during a covered visit. You must contact the *group* for information about your prescription drug coverage. **No benefits are provided under this part of the *group's* student health plan for the cost of these drugs when the drug is furnished by a non-pharmacy health care provider.** For a list of these drugs, you can call the *Blue Cross and Blue Shield* customer service office. Or, you can log on to the *Blue Cross and Blue Shield* Web site at www.bluecrossma.com.

Second Opinions

This health plan covers an *outpatient* second surgical opinion when it is furnished for you by a physician. This coverage includes a third opinion when the second opinion differs from the first. (See “Lab Tests, X-Rays, and Other Tests” for your coverage for related diagnostic tests.)

Short-Term Rehabilitation Therapy

This health plan covers *medically necessary outpatient* short-term rehabilitation therapy when it is furnished for you by a *covered provider*. This may include (but is not limited to): a physical therapist; or an occupational therapist; or a licensed speech-language pathologist; or a *covered provider* who has a recognized expertise in specialty pediatrics. This coverage includes: physical therapy; speech/language therapy; occupational therapy; or an organized program of these combined services. This health plan provides coverage only until you reach your *benefit limit*. Your *Schedule of Benefits* describes the *benefit limit* that applies for these *covered services*. Once you reach the *benefit limit*, no more benefits will be provided for these services. The *benefit limit* does not apply: to speech therapy; when any of these services are furnished as part of a covered home health care program; or when any of these services are furnished to treat autism spectrum disorders. Whether or not there is a *benefit limit* for these services, coverage is provided only for those services that are determined by *Blue Cross and Blue Shield* to be *medically necessary* for you.

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

Speech, Hearing, and Language Disorder Treatment

This health plan covers *medically necessary* services to diagnose and treat speech, hearing, and language disorders when the services are furnished for you by a *covered provider*. This may include (but is not limited to): a licensed audiologist; or a licensed speech-language pathologist; or a *covered provider* who has a recognized expertise in specialty pediatrics. This coverage includes: diagnostic tests, including hearing exams and tests; speech/language therapy; and medical care to diagnose or treat speech, hearing, and language disorders. (The *benefit limit* that applies for short-term rehabilitation therapy does not apply for speech therapy.)

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

Surgery as an Outpatient

This health plan covers *outpatient* surgical services when they are furnished for you by a *covered provider*. This may include (but is not limited to): a surgical day care unit of a hospital; or an ambulatory surgical facility; or a physician; or a nurse practitioner; or a *covered provider* who has a recognized expertise in specialty pediatrics. This coverage includes:

- Routine circumcision.
- Voluntary termination of pregnancy (abortion).
- Voluntary sterilization procedures. To provide coverage for the women’s preventive health services as recommended by the U.S. Department of Health and Human Services, any in-network *deductible*, *copayment*, and/or *coinsurance* will be waived for a sterilization procedure furnished for a female *member* when it is performed as the primary procedure for family planning reasons. For all situations except as described in this paragraph, the cost share amount for elective surgery will still apply.
- Endoscopic procedures.
- Surgical procedures. This includes emergency and scheduled surgery. This coverage includes (but is not limited to):
 - **Reconstructive surgery.** This means non-dental surgery that 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. It also includes surgery to correct a deformity or disfigurement that was caused by an accidental injury.

Women’s Health and Cancer Rights

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

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

- **Transplants.** This means human organ (or tissue) and stem cell (“bone marrow”) transplants that are furnished according to *Blue Cross and Blue Shield medical policy* and *medical technology assessment criteria*. This includes one or more stem cell transplants for a *member* who has been diagnosed with breast cancer that has spread. For covered transplants, this coverage also includes: the harvesting of the donor’s organ (or tissue) or stem cells when the recipient is a *member*; and drug therapy during the transplant procedure to prevent the transplanted organ (or tissue) or stem cells from being rejected. “Harvesting” includes: the surgical removal of the donor’s organ (or tissue) or stem cells; and the related *medically necessary* services and/or tests that are required to perform the transplant itself. No benefits are provided for the harvesting of the donor’s organ (or tissue) or stem cells when the recipient is not a *member*. (See “Lab Tests, X-Rays, and Other Tests” for your coverage for donor testing.)

- **Oral surgery.** This means: reduction of a dislocation or fracture of the jaw or facial bone; excision of a benign or malignant tumor of the jaw; and orthognathic surgery that you need to correct a significant functional impairment that cannot be adequately corrected with orthodontic services. This coverage is provided when the surgery is furnished at a facility, provided that you have a serious medical condition that requires that you be admitted to a surgical day care unit of a hospital or to an ambulatory surgical facility in order for the surgery to be safely performed. This coverage is also provided when the surgery is furnished at an oral surgeon’s office. (Orthognathic surgery is not covered when it is performed mainly for cosmetic reasons. This surgery must be performed along with orthodontic services. If it is not, the oral surgeon must send a letter to *Blue Cross and Blue Shield* asking for approval for the surgery. No benefits are provided for the orthodontic services.)

Covered oral surgery also includes the removal of impacted teeth (includes wisdom teeth), when the teeth are fully or partially imbedded in the bone.

- **Gender reassignment surgery.** This means gender reassignment surgery for gender identity disorders. No benefits are provided for services and procedures that are considered to be cosmetic services that may be used to make a person look more feminine or more masculine. For example, no benefits are provided for procedures such as (but not limited to): plastic surgery of the nose, face lift, lip enhancement, facial bone reduction, plastic surgery of the eyelids, liposuction of the waist, reduction of the thyroid cartilage, hair removal, hair transplants, surgery of the larynx including shortening of the vocal cords, chin implants, nose implants, and lip reduction.

- Internal prostheses (artificial replacements of parts of the body) that are furnished by the health care facility as part of a covered surgery such as intraocular lenses that are implanted after corneal transplant, cataract surgery, or other covered eye surgery, when the natural eye lens is replaced.

- Non-dental surgery and necessary postoperative care that is furnished for you by a dentist who is licensed to furnish the specific *covered service*. (See Part 6, “Dental Care.”)

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

- Necessary postoperative care that you receive after covered *inpatient* or *outpatient* surgery.
- Anesthesia services that are related to covered surgery. This includes anesthesia that is administered by a physician other than the attending physician; or by a certified registered nurse anesthetist.

Coverage for Self Injectable and Certain Other Drugs Furnished in an Office or Health Center

There are self injectable and certain other prescription drugs used for treating your medical condition that are **not** covered under this part of the *group's* student health plan, even if a non-pharmacy health care provider administers the drug for you during a covered visit. You must contact the *group* for information about your prescription drug coverage. **No benefits are provided under this part of the *group's* student health plan for the cost of these drugs when the drug is furnished by a non-pharmacy health care provider.** For a list of these drugs, you can call the *Blue Cross and Blue Shield* customer service office. Or, you can log on to the *Blue Cross and Blue Shield* Web site at www.bluecrossma.com. (This exclusion does not apply when these covered drugs are furnished to you during a covered day surgical admission at a surgical day care unit of a hospital, ambulatory surgical facility, or hospital outpatient department.)

TMJ Disorder Treatment

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

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

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

Part 6

Limitations and Exclusions

Your coverage in this health plan is limited or excluded as described in this part. Other limits or restrictions and exclusions on your coverage may be found in Parts 3, 4, 5, 7, and 8 of this benefit booklet. You should be sure to read all of the provisions that are described in this benefit booklet, your *Schedule of Benefits*, and any *riders* that apply to your coverage in this health plan.

Admissions That Start Before Effective Date

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

Benefits from Other Sources

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

Cosmetic Services and Procedures

No benefits are provided for cosmetic services that are performed solely for the purpose of making you look better. This is the case whether or not these services are meant to make you feel better about yourself or to treat your *mental condition*. For example, no 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 (except as described in Part 5 for scalp hair prostheses); and liposuction. (See Part 5 for your coverage for reconstructive surgery.)

Custodial Care

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

Dental Care

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

Educational Testing and Evaluations

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

Exams or Treatment Required by a Third Party

No benefits are provided for physical, psychiatric, and psychological exams or treatments and related services that are required by third parties. Some examples of *non-covered services* are: exams and tests that are required for recreational activities, employment, insurance, and school; and court-ordered exams and services, except when they are *medically necessary* services. (But, certain exams may be covered when they are furnished as part of a covered routine physical exam. See Part 5.)

Experimental Services and Procedures

This health plan provides coverage only for *covered services* that are furnished according to *Blue Cross and Blue Shield medical technology assessment criteria*. No benefits are provided for health care charges that are received for or related to care that *Blue Cross and Blue Shield* considers experimental services or procedures. The fact that a treatment is offered as a last resort does not mean that this health plan will cover it. There are two exceptions. As required by law, this health plan will cover:

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

Eyewear

Except as described otherwise in this benefit booklet, no benefits are provided for eyeglasses and contact lenses.

Medical Devices, Appliances, Materials, and Supplies

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

- Devices such as: air conditioners; air purifiers; arch supports; bath seats; bed pans; bath tub grip bars; chair lifts; computerized communication devices (except for those that are described in Part 5); computers; computer software; dehumidifiers; dentures; elevators; foot orthotics; hearing aids;

heating pads; hot water bottles; humidifiers; orthopedic and corrective shoes that are not part of a leg brace; raised toilet seats; and shoe (foot) inserts.

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

Missed Appointments

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

Non-Covered Providers

No benefits are provided for any services and supplies that are furnished by the kinds of health care providers that are not covered by this health plan. This benefit booklet describes the kinds of health care providers that are covered by the health plan. (See “*covered providers*” in Part 2 of this benefit booklet.)

Non-Covered Services

No benefits are provided for:

- A service or supply that is not described as a *covered service*. Some examples of *non-covered services* are: acupuncture; private duty nursing; and reversal of sterilization.
- A service or supply that is furnished along with a *non-covered service*.
- A service or supply that does not conform to *Blue Cross and Blue Shield medical policies*.
- A service or supply that does not conform to *Blue Cross and Blue Shield medical technology assessment criteria*.
- A service or supply that is not considered by *Blue Cross and Blue Shield* to be *medically necessary* for you. The only exceptions are for: covered routine or other covered voluntary health care services or supplies; preventive health care services and supplies; and donor suitability for bone marrow transplant.
- A service or supply that is furnished by a health care provider who has not been approved by *Blue Cross and Blue Shield* for payment for the specific service or supply.
- A service or supply that is furnished to someone other than the patient, except as described in this benefit booklet for: hospice services; and the harvesting of a donor’s organ (or tissue) or stem cells when the recipient is a *member*. This coverage includes the surgical removal of the donor’s organ (or tissue) or stem cells and the related *medically necessary* services and tests that are required to perform the transplant itself.
- A service or supply that you received when you were not enrolled in this health plan. (The only exception is for routine nursery charges that are furnished during an enrolled mother’s maternity admission and certain other newborn services.)
- A service or supply that is furnished to all patients due to a facility’s routine admission requirements.
- A service or supply that is related to achieving pregnancy through a surrogate (gestational carrier).

- A service or supply that is related to sex change surgery or to the reversal of a sex change, except as described in Part 5 for gender reassignment surgery.
- Refractive eye surgery for conditions that can be corrected by means other than surgery. This type of surgery includes radial keratotomy.
- Whole blood; packed red blood cells; blood donor fees; and blood storage fees.
- A health care provider's charge for shipping and handling or taxes.
- A health care provider's charge to file a claim for you. Also, a health care provider's charge to transcribe or copy your medical records.
- A separate fee for services furnished by: interns; residents; fellows; or other physicians who are salaried employees of the hospital or other facility.
- Expenses that you have when you choose to stay in a hospital or another health care facility beyond the discharge time that is determined by *Blue Cross and Blue Shield*.

Personal Comfort Items

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

Private Room Charges

While you are an *inpatient*, this health plan covers *room and board* based on the semiprivate room rate. If a private room is used, you must pay all costs that are more than the semiprivate room rate.

Services and Supplies Furnished After Termination Date

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

Services Furnished to Immediate Family

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

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

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

WORDS IN ITALICS ARE EXPLAINED IN PART 2.

Part 7

Other Party Liability

Other Health Coverage

Blue Cross and Blue Shield will coordinate payment of *covered services* with hospital, medical, dental, health, or other plans under which you are covered. *Blue Cross and Blue Shield* will do this to make sure that the cost of your health care services is not paid more than once. Other plans include: personal injury insurance; automobile insurance, including medical payments coverage; homeowner's insurance; and other plans that cover hospital or medical expenses. You must include information on your enrollment forms about other health plans under which you are covered. Once you are enrolled for coverage under this health plan, you must notify *Blue Cross and Blue Shield* if you add or change health plan coverage. Upon *Blue Cross and Blue Shield's* 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). This health plan is the secondary payor when another hospital, medical, dental, health or other plan provides benefits for health care services. This means that no benefits will be provided by this health plan until after the primary payor determines its share, if any, of the liability.

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

Important Notice: If you fail to comply with the provisions of this COB section, payment of your claim may be denied.

Medicare Program

Generally, the benefits that are available under the *group's* student health plan are secondary to or in excess of the benefits provided by Medicare. This means that when you are eligible for Medicare and Medicare is allowed by federal law to be the primary payor, the coverage provided by the *group's* student health plan will be reduced by the amount of benefits allowed under Medicare for the same *covered services*. This reduction will be made whether or not you actually receive the benefits from Medicare.

The Health Plan's Rights to Recover Benefit Payments

Subrogation and Reimbursement of Benefit Payments

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

Member Cooperation

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

Workers' Compensation

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

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

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

Part 8

Other Health Plan Provisions

Access to and Confidentiality of Medical Records

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

- For administering coverage (including coordination of benefits with other insurance plans); managing care; quality assurance; utilization management; the prescription drug history program; *appeal* and claims review activities; or other specific business, professional, or insurance functions for *Blue Cross and Blue Shield*.
- For bona fide medical research according to the regulations of the U.S. Department of Health and Human Services and the U.S. Food and Drug Administration for the protection of human subjects.
- As required by law or valid court order.
- As required by government or regulatory agencies.
- As necessary for the operations of Blue Cross and Blue Shield of Massachusetts, Inc.
- As required by the *subscriber's group* or by its auditors to make sure that *Blue Cross and Blue Shield* is administering your coverage in this health plan properly.
- For the purpose of processing a claim, medical information may be released to your *group's* reinsurance carrier.

Commitment to Confidentiality:

To get a copy of *Blue Cross and Blue Shield's* Commitment to Confidentiality statement, call the *Blue Cross and Blue Shield* customer service office. (See Part 1.)

Blue Cross and Blue Shield will not share information about you with the Medical Information Bureau (MIB). *Blue Cross and Blue Shield* respects your right to privacy. *Blue Cross and Blue Shield* will not use or disclose personally identifiable information about you without your permission, unless the use or disclosure is permitted or required by law and is done in accordance with the law. You have the right to get the information *Blue Cross and Blue Shield* collects about you. You may also ask *Blue Cross and Blue Shield* to correct any of this information that you believe is not correct. *Blue Cross and Blue Shield* may charge you a reasonable fee for copying your records, unless your request is because *Blue Cross and Blue Shield* is declining or terminating your coverage in this health plan.

Acts of Providers

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

Blue Cross and Blue Shield will not interfere with the relationship between health care providers and their patients. You are free to select or discharge any health care provider. *Blue Cross and Blue Shield* is not responsible if a provider refuses to furnish services to you. *Blue Cross and Blue Shield* does not guarantee that you will be admitted to any facility or that you will get a special type of room or service. If you are admitted to a facility, you will be subject to all of its requirements. This includes its requirements on admission, discharge, and the availability of services.

Assignment of Benefits

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

Authorized Representative

You may choose to have another person act on your behalf concerning your health care coverage in this health plan. You must designate this person in writing to *Blue Cross and Blue Shield*. Or, if you are not able to do this, a person such as a conservator, a person with power of attorney, or a family member may be your authorized representative. In some cases, *Blue Cross and Blue Shield* may consider your health care facility or your physician or other health care provider to be your authorized representative. For example, *Blue Cross and Blue Shield* may tell your hospital that a proposed *inpatient* admission has been approved. Or, *Blue Cross and Blue Shield* may ask your physician for more information if more is needed for *Blue Cross and Blue Shield* to make a decision. *Blue Cross and Blue Shield* will consider the health care provider to be your authorized representative for *emergency medical care*. *Blue Cross and Blue Shield* will continue to send benefit payments and written communications regarding your health care coverage according to *Blue Cross and Blue Shield's* standard practices, unless you specifically ask *Blue Cross and Blue Shield* to do otherwise. You can get a form to designate an authorized representative from the *Blue Cross and Blue Shield* customer service office. (See Part 1.)

Changes to Health Plan Coverage

Blue Cross and Blue Shield and/or the *plan sponsor* may change the provisions of your coverage in this health plan. For example, a change may be made to the cost share amount that you must pay for certain *covered services* such as your *copayment* or your *deductible* or your *coinsurance*. The *plan sponsor* is responsible for sending you a notice of any change. The notice will describe the change being made. It will also give the *effective date* of the change. When a change is made to your health care coverage, you can get the actual language of the change from your *plan sponsor*. The change will apply to all benefits for services you receive on or after its *effective date*.

Charges for Non-Medically Necessary Services

You may receive health care services that would otherwise be covered by this health plan, except that these services are not determined to be *medically necessary* for you by *Blue Cross and Blue Shield*. This health plan does not cover health care services or supplies that are not *medically necessary* for you. If you receive care that is not *medically necessary* for you, you might be charged for the care by the health care provider. A provider who has a payment agreement with *Blue Cross and Blue Shield* has agreed not to charge you for services that are not *medically necessary*, unless you were told, knew, or reasonably should have known before you received this treatment that it was not *medically necessary*.

Clinical Guidelines and Utilization Review Criteria

Blue Cross and Blue Shield applies *medical technology assessment criteria* and *medical necessity* guidelines when it develops its clinical guidelines, *utilization review* criteria, and *medical policies*. *Blue Cross and Blue Shield* reviews its clinical guidelines, *utilization review* criteria, and *medical policies* from time to time. *Blue Cross and Blue Shield* does this to reflect new treatments, applications, and technologies. For example, when a new drug is approved by the U.S. Food and Drug Administration (FDA), *Blue Cross and Blue Shield* reviews its safety, effectiveness, and overall value on an ongoing basis. While a new treatment, technology, or drug is being reviewed, it will not be covered by this health plan. Another example is when services and supplies are approved by the U.S. Food and Drug Administration (FDA) for the diagnosis and treatment of insulin dependent, insulin using, gestational, or non-insulin dependent diabetes. In this case, coverage will be provided for those services or supplies as long as they can be classified under a category of *covered services*.

Disagreement with Recommended Treatment

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

Member Cooperation

You agree to provide *Blue Cross and Blue Shield* with information it needs to comply with federal and/or state law and regulation. If you do not do so in a timely manner, your claims may be denied and/or your coverage in this health plan may be affected.

Pre-Existing Conditions

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

Quality Assurance Programs

Blue Cross and Blue Shield uses quality assurance programs. These programs affect different aspects of health care. This may include, for example, health promotion. From time to time, *Blue Cross and Blue Shield* may add or change the programs that it uses. *Blue Cross and Blue Shield* will do this to ensure that it continues to provide you and your family with access to high-quality health care and services. For more information, you can call the *Blue Cross and Blue Shield* customer service office. The toll free phone number to call is shown on your ID card. Some of the clinical programs that *Blue Cross and Blue Shield* uses are:

- A breast cancer screening program. It encourages female *members* who are over 50 to have mammograms.
- A cervical cancer screening program. It helps to get more female *members* who are age 18 and older to have a Pap smear test.
- A program that furnishes outreach and education to an expectant mother. It adds to the care that the *member* gets from her obstetrician or nurse midwife.
- A program that promotes timely postnatal checkups for new mothers.
- Diabetes management and education. This helps diabetic *members* to self-manage their diabetes. It also helps to identify high-risk *members* and helps to assess their ongoing needs.
- Congestive heart failure disease management, education, and monitoring.

Services Furnished by Non-Preferred Providers

As a *member* of this health plan, you will usually receive the highest benefit level (your in-network benefits) only when you obtain *covered services* from a *covered provider* who participates in your PPO health care network. There are a few times when this health plan will provide in-network benefits for *covered services* you receive from a *covered provider* who does not participate in your PPO network. These few situations are described below in this section. If you receive *covered services* from a *covered provider* who does not participate in your PPO health care network, you will receive in-network benefits **only when:**

- You receive *emergency medical care*.
- You receive *covered services* that are not reasonably available from a *preferred provider* (see “*covered provider*” in Part 2 of this benefit booklet) and you had prior approval from *Blue Cross and Blue Shield* to obtain these *covered services*. Or, you receive *covered services* from a *covered provider* before a preferred network is established for that type of provider.
- You are living or traveling outside of Massachusetts and you receive *covered services* from a type of *covered provider* for which the local Blue Cross and/or Blue Shield Plan has not, in the opinion of *Blue Cross and Blue Shield*, established an adequate PPO health care network.
- You receive *covered services* from a non-preferred hospital-based anesthetist, pathologist, or radiologist while you are at a preferred hospital.

This health plan will also provide in-network benefits in the event Medicare is your primary payor (as allowed by federal law) and you receive *covered services* from a non-*preferred provider* outside of Massachusetts and that provider accepts Medicare assignment, whether or not the provider participates with the local Blue Cross and/or Blue Shield Plan. (Medicare assignment is an agreement by the provider to accept the Medicare-approved amount as payment in full for services furnished.)

Services in a Disaster

Blue Cross and Blue Shield is not liable if events beyond its control—such as war, riot, public health emergency, or natural disaster—cause delay or failure of *Blue Cross and Blue Shield* to arrange for or coordinate access to health care services and coverage for *members*. *Blue Cross and Blue Shield* will make a good faith effort to arrange for or to coordinate health care services to be furnished in these situations.

Time Limit for Legal Action

Before you pursue a legal action against *Blue Cross and Blue Shield* for any claim under this health plan, you must complete the *Blue Cross and Blue Shield* internal formal review. (See Part 10.) You may, but you do not need to, complete an external review before you pursue a legal action. If, after you complete the formal review, you choose to bring a legal action against *Blue Cross and Blue Shield*, you must bring this action within two years after the cause of the action arises. For example, if you are filing a legal action because you were denied a service or you were denied a claim for coverage from this health plan, you will lose your right to bring a legal action against *Blue Cross and Blue Shield* unless you file your action within two years after the date of the decision of the final internal *appeal* of the service or claim denial.

Part 9

Filing a Claim

When the Provider Files a Claim

The health care provider will file a claim for you when you receive a *covered service* from a *covered provider* who has a payment agreement with *Blue Cross and Blue Shield*. Or, for *covered services* you receive outside of Massachusetts, a health care provider will file a claim for you when he or she has a payment agreement with the local Blue Cross and/or Blue Shield Plan. Just tell the health care provider that you are a *member* and show the health care provider your ID card. Also, be sure to give the health care provider any other information that is needed to file your claim. You must properly inform your health care provider within 30 days after you receive the *covered service*. If you do not, coverage will not have to be provided. *Blue Cross and Blue Shield* will pay the health care provider directly for *covered services* when the provider has a payment agreement with *Blue Cross and Blue Shield* or with the local Blue Cross and/or Blue Shield Plan. (When you are outside the United States, Puerto Rico, and the U.S. Virgin Islands and the BlueCard Worldwide Service Center has arranged your *inpatient* admission, the hospital should file the claim for you. In this case, the hospital will usually bill you only for your *deductible* and/or your *copayment* and/or your *coinsurance*, whichever applies. But, if you paid the hospital's actual charge in full at the time of the service, you must submit a claim as described in the section below.)

When the Member Files a Claim

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

- Fill out a claim form;
- Attach your original itemized bills; and
- Mail the claim to the *Blue Cross and Blue Shield* customer service office.

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

When you receive *covered services* outside the United States, Puerto Rico, and the U.S. Virgin Islands, you must file your claim to the BlueCard Worldwide Service Center. (The BlueCard Worldwide International Claim Form you receive from *Blue Cross and Blue Shield* will include the address to mail your claim.) You can get help with filing your claim by calling the service center at **1-800-810-BLUE**.

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

Timeliness of Claim Payments

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

Missing Information

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

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

Part 10

Appeal and Grievance Program

You have the right to a full and fair review when you disagree with a decision that is made by *Blue Cross and Blue Shield* to deny a request for coverage or payment for services; or you disagree with how your claim was paid; or you are denied coverage in this health plan; or your coverage is canceled or discontinued by *Blue Cross and Blue Shield* for reasons other than nonpayment of your cost for coverage in this *group* health plan. You also have the right to a full and fair review when you have a complaint about the care or service you received from *Blue Cross and Blue Shield* or from a provider who participates in your health care network. Part 10 explains the process for handling these types of problems and concerns.

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

Inquiries and/or Claim Problems or Concerns

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

Blue Cross and Blue Shield will consider all aspects of the particular case when resolving a problem or concern. This includes looking at: all of the provisions of this health plan; the policies and procedures that support this health plan; the health care provider's input; and your understanding of coverage by this health plan. *Blue Cross and Blue Shield* may use an individual consideration approach when *Blue Cross and Blue Shield* judges it to be appropriate. *Blue Cross and Blue Shield* will follow its standard guidelines when it resolves your problem or concern.

If after speaking with a *Blue Cross and Blue Shield* customer service representative, you still disagree with a decision that is given to you, you may request a formal review through the *Blue Cross and Blue Shield* Member Appeal and Grievance Program.

Appeal and Grievance Review Process

Internal Formal Review

How to Request an Internal Formal Appeal or Grievance Review

To request an internal formal *appeal* or *grievance* review, you (or your authorized representative) have three options.

- **Write or Fax.** The preferred option is for you to send your request for an *appeal* or a *grievance* review in writing to: **Member Appeal and Grievance Program, Blue Cross Blue Shield of**

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Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Or, you may fax your request to **1-617-246-3616**. *Blue Cross and Blue Shield* will let you know that your request was received by sending you a written confirmation within 15 calendar days. When you send your request, you should be sure to include any documentation that will help the review.

- **E-mail.** Or, you may send your request for an *appeal* or a *grievance* review to the *Blue Cross and Blue Shield* Member Appeal and Grievance Program e-mail 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. When you send your request, you should be sure to include any documentation that will help the review.
- **Telephone Call.** Or, you may call the *Blue Cross and Blue Shield* Member Appeal and Grievance Program at **1-800-472-2689**.

Important Note:

Before you make an *appeal* or file a *grievance*, you should read “What to Include in an Appeal or Grievance Review Request” that shows later in this section.

Once your *appeal* or *grievance* request is received, *Blue Cross and Blue Shield* will research the case in detail. *Blue Cross and Blue Shield* will ask for more information if it is needed and let you know in writing of the review decision or the outcome of the review. If your request for a review is about termination of your coverage for concurrent services that were previously approved by *Blue Cross and Blue Shield*, the disputed coverage will continue until this review process is completed. This continuation of your coverage does not apply to services: that are limited by a day, dollar, or visit *benefit limit* and that exceed the *benefit limit*; that are *non-covered services*; or that were received prior to the time you requested the formal review. It also does not apply if your request for a review was not received on a timely basis, based on the course of the treatment.

All requests for an *appeal* or a *grievance* review must be received by *Blue Cross and Blue Shield* within 180 calendar days of the date of treatment, event, or circumstance which is the cause of your dispute or complaint, such as the date you were told of the service denial or claim denial.

What to Include in an Appeal or Grievance Review Request

Your request for an internal formal *appeal* or *grievance* review should include: the name, ID number, and daytime phone number of the *member* asking for the review; a description of the problem; all relevant dates; names of health care providers or administrative staff involved; and details of the attempt that has been made to resolve the problem.

- **Appealing a Coverage Decision.** A “coverage decision” is a decision that *Blue Cross and Blue Shield* makes about your coverage or about the amount your *group* health plan will pay for your health care services or drugs. For example, your doctor may have to contact *Blue Cross and Blue Shield* and ask for a coverage decision before you receive proposed services. Or, a coverage decision is made when *Blue Cross and Blue Shield* decides what is covered and how much you will pay for services you have already received. In some cases, *Blue Cross and Blue Shield* might decide a service or drug is not covered or is no longer covered for you. You can make an *appeal* if you disagree with a coverage decision made by *Blue Cross and Blue Shield*.

When you make an *appeal* about a *medical necessity* coverage decision, *Blue Cross and Blue Shield* will review your health plan contract and the policies and procedures that are in effect for your *appeal* along with medical treatment information that will help in the review. Some examples of the medical information that will help *Blue Cross and Blue Shield* review your *appeal* may include: medical records related to your *appeal*, provider consultation and office notes, and related lab or other test results. If *Blue Cross and Blue Shield* needs to review your medical records and you have not provided your consent, *Blue Cross and Blue Shield* will promptly send you an authorization form to sign. You must return this signed form to *Blue Cross and Blue Shield*. It will allow for the release of your medical records. You 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 *appeal*, including the identity of any experts who were consulted.

If you disagree with how your claim was paid or you are denied coverage for a specific health care service or drug, you can make an *appeal* about the coverage decision. *Blue Cross and Blue Shield* will review the health plan contract that is in effect for your *appeal* to see if all of the rules were properly followed and to see if the service or drug is specifically excluded or limited by your health plan. The *appeal* decision will be based on the terms of your health plan contract. For example, if a service is excluded or limited by your health plan contract, no benefits can be provided even if the services are *medically necessary* for you. For this reason, you should be sure to review all parts of your health plan contract for any coverage limits and exclusions. These parts include this benefit booklet, your *Schedule of Benefits*, and *riders* (if there are any) that apply for your health plan contract.

- **Filing a Grievance.** You can file a *grievance* when you have a complaint about the care or service you received from *Blue Cross and Blue Shield* or from a health care provider who participates in your health care network. Some examples of these types of problems are: you are unhappy with the quality of the care you have received; you are having trouble getting an appointment or waiting too long to get care; or you are unhappy with how the customer service representative has treated you. If you submit a formal *grievance* about the quality of care you received from a *Blue Cross and Blue Shield* provider, *Blue Cross and Blue Shield* will contact you to obtain your permission to contact the provider (if your permission is not included in your formal *grievance*). For this type of *grievance*, *Blue Cross and Blue Shield* will investigate the *grievance* with your permission, but the results of any provider peer review are confidential. For this reason, you will not receive the results of this type of investigation.

Choosing an Authorized Representative

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

Who Handles the Appeal or Grievance Review

All *appeals* and *grievances* are reviewed by professionals who are knowledgeable about *Blue Cross and Blue Shield* and the issues involved in the *appeal* or *grievance*. The professionals who will review your *appeal* or *grievance* will be different from those who participated in *Blue Cross and Blue Shield's* prior decisions regarding the subject of your review, nor will they work for anyone who did. When a review is related to a *medical necessity* denial, at least one reviewer will be an individual who is an actively practicing health care professional in the same or similar specialty who usually treats the medical condition or performs the procedure or provides treatment that is the subject of your review.

Response Time for an Appeal or Grievance Review

The review and response for an internal formal *appeal* or *grievance* review will be completed within 30 calendar days. Every reasonable effort will be made to speed up the review for requests that involve health care services that are soon to be obtained by the *member*.

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

Important Note:

If your *appeal* or *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 an internal formal review.

Written Response for an Appeal or Grievance Review

Once the review is completed, *Blue Cross and Blue Shield* will let you know in writing of the decision or the outcome of the review. If *Blue Cross and Blue Shield* continues to deny coverage for all or part of a health care service or supply, *Blue Cross and Blue Shield* will send an explanation to you. This notice will include: information related to the details of your *appeal* or *grievance*; the reasons that *Blue Cross and Blue Shield* has denied the request and the applicable terms of your coverage in this health plan; the specific medical and scientific reasons for which *Blue Cross and Blue Shield* has denied the request; any alternative treatment or health care services and supplies that would be covered; *Blue Cross and Blue Shield* clinical guidelines that apply and were used and any review criteria; and how to request an external review.

Appeal and Grievance Review Records

You have the right to look at and get copies of records and criteria that *Blue Cross and Blue Shield* has and that are relevant to your *appeal* or *grievance*. These copies will be free of charge. *Blue Cross and Blue Shield* will maintain a record of all formal *appeals* and *grievances*, including the response for each review, for up to seven years.

Expedited Review for Immediate or Urgently-Needed Services

In place of the internal formal review as described above in this section, you have the right to request an “expedited” review right away when your situation is for immediate or urgently-needed services and waiting for a response under the review time frames 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 review. If you request an expedited review, *Blue Cross and Blue Shield* will review your request and notify you of the decision within 72 hours after your request is received, or such shorter time period as required by federal law.

External Review

You must first go through the *Blue Cross and Blue Shield* internal formal *appeal* and *grievance* review process as described above. The *Blue Cross and Blue Shield* review decision may be to continue to deny all or part of your coverage in this health plan. In this case, you may be entitled to a voluntary external review. You are not required to pursue an external review. Your decision whether to pursue an external review will not affect your other coverage. If you receive a denial letter from *Blue Cross and Blue Shield* in response to your internal *appeal* or *grievance* review, the letter will tell you what steps you can take to file a request for an external review. **If you decide to request an external review, you must file your request within the four months after you receive the denial letter from *Blue Cross and Blue Shield*.** *Blue Cross and Blue Shield* will work closely with you to guide you through the external review process.

You (or your authorized representative) have the right to file an “expedited” external review at the same time that you file a request for an internal expedited review. This right applies to a *member* who is in an urgent care situation or to a *member* receiving an ongoing course of treatment. See below for more information about requesting an expedited external review.

How to Request an External Review

To request an external review, you must complete the external review request form that is provided with the denial letter you receive from *Blue Cross and Blue Shield*. Once your external review request form is completed, you must send it to *Blue Cross and Blue Shield* as shown on the form.

You (or your authorized representative) have the right to request an expedited review when your situation is for immediate or urgently-needed services as follows:

- When your request concerns medical care or treatment for which waiting for a response under the standard (non-expedited) external review time frames would seriously jeopardize your life or health or your ability to regain maximum function; or
- When your request concerns an internal formal review final adverse benefit determination for an admission, availability of care, continued stay, or health care services for which you received emergency services, while you are an *inpatient*.

External Review Process

When *Blue Cross and Blue Shield* receives your request for an external review, your case will be referred to an external review agency to complete your external review. You (or your authorized representative) will be notified by the external review agency of your eligibility and acceptance for an external review. In some cases, the review agency may need more information about your situation. If this is the case, they will request it from *Blue Cross and Blue Shield*, you, or your authorized representative.

The review agency will consider all aspects of the case and send a written response of the outcome. They will send the response to you (or your authorized representative) and to *Blue Cross and Blue Shield*.

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within 45 days of receiving the request. If the agency determines additional time is needed to fully and fairly evaluate the request, the agency will notify you and *Blue Cross and Blue Shield* of the extended review period. In the case of an expedited review, you will be notified of their decision within 72 hours. This 72-hour period starts when the external review agency receives your case.

If the review agency overturns *Blue Cross and Blue Shield's* decision in whole or in part, *Blue Cross and Blue Shield* will send you (or your authorized representative) a notice of the review decision made by the agency. This notice will confirm the decision of the review agency. It will also tell you (a) what steps or procedures you must take (if any) to obtain the requested coverage or services; (b) the date by which *Blue Cross and Blue Shield* will pay for or authorize the requested services; and (c) the name and phone number of the person at *Blue Cross and Blue Shield* who will make sure your *appeal* or *grievance* is resolved.

The decision made by way of the external review process will be accepted as final.

You have the right to look at and get copies of records and criteria that *Blue Cross and Blue Shield* has and that are relevant to your *appeal* or *grievance*. These copies will be free of charge.

Appeals Process for Rhode Island Residents or Services

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

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

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

Reconsideration

A reconsideration is the first step in this process. If you receive a letter from *Blue Cross and Blue Shield* that denies payment for your health care services, you may ask that *Blue Cross and Blue Shield* reconsider its decision. You must do this by writing to: Member Appeal and Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. You must send your request within 180 days of *Blue Cross and Blue Shield's* adverse decision. Along with your letter, you should include any information that will support your request. *Blue Cross and Blue Shield* will review your request. *Blue Cross and Blue Shield* will let you know the outcome of your request within 15 calendar days after it has received all information needed for the review.

Appeal

An *appeal* is the second step in this process. If *Blue Cross and Blue Shield* continues to deny coverage for all or part of the original service, you may request an *appeal*. You must do this within 60 days of the date that you receive the reconsideration denial letter from *Blue Cross and Blue Shield*. Your *appeal* request should include any information that supports your *appeal*. You may also inspect and add information to your *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 you must include the name of a physician who may review your case file on your behalf. Your physician may review, interpret, and disclose any or all of that information to you. Once received by *Blue Cross and Blue Shield*, your *appeal* will be reviewed by a health care provider in the same specialty as your attending provider. *Blue Cross and Blue Shield* will notify you of the outcome of your *appeal* within 15 calendar days after it has received all information needed for the *appeal*.

External Appeal

If your *appeal* is denied, you have the right to present your case to an appeals agency that is designated by Rhode Island and not affiliated with *Blue Cross and Blue Shield*. If you request this voluntary external *appeal*, Rhode Island requires that you pay for half of the cost of the *appeal*. *Blue Cross and Blue Shield* will pay 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 Appeal and Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Along with your request, you must: state your reason(s) for your disagreement with *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 *Blue Cross and Blue Shield* receives your written request and payment for the *appeal*, *Blue Cross and Blue Shield* will forward your request to the external appeals agency. *Blue Cross and Blue Shield* will also send its 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 condition* that in the absence of immediate medical attention could reasonably be expected to result in placing your health or your ability to regain maximum function in serious jeopardy or, in your physician’s opinion, would result in severe pain. You may request an expedited reconsideration or *appeal* by calling *Blue Cross and Blue Shield* at the phone number shown in your letter. *Blue Cross and Blue Shield* will notify you of the result of your expedited *appeal* within two working days or 72 hours of its receipt, whichever is sooner, or such shorter time period as required by federal law. 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 Appeal and Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Your request should state your reason(s) for your disagreement with the decision and include signed documentation from your provider that describes the emergency nature of your treatment. In addition, you must also enclose a check made payable to the designated appeals agency for your share of the cost for the expedited external *appeal*.

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

WORDS IN ITALICS ARE EXPLAINED IN PART 2.

External Appeal Final Decision

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

Part 11

Eligibility for Coverage

Eligibility for Student Health Plan Coverage

Eligible Student

You are eligible for coverage under the *group's* student health plan as long as you are a full-time or part-time student enrolled at Harvard University. For more details, contact the *plan sponsor*.

Eligible Spouse

An eligible student who is enrolled in the *group's* student health plan may enroll an eligible spouse for coverage under his or her student health plan membership. An “eligible spouse” includes the enrolled student’s legal spouse. (A legal civil union spouse, where applicable, is eligible to enroll under the student’s membership in this health plan to the extent that a legal civil union spouse is determined eligible by the *plan sponsor*. For more details, contact your *plan sponsor*.)

Former Spouse

In the event of a divorce or a legal separation, the person who was the spouse of the enrolled student prior to the divorce or legal separation will remain eligible for coverage under the enrolled student’s membership, whether or not the judgment was entered prior to the *effective date* of the enrolled student’s membership. This coverage is provided with no additional cost other than the normal cost of covering a current spouse. The former spouse will remain eligible for this coverage **only** until the enrolled student is no longer required by the judgment to provide health insurance for the former spouse or the enrolled student or former spouse remarries, whichever comes first. In these situations, *Blue Cross and Blue Shield* must be notified within 30 days of a change to the former spouse’s address. Otherwise, *Blue Cross and Blue Shield* will not be liable for any acts or omissions due to having the former spouse’s incorrect address on file. If the enrolled student remarries, the former spouse may continue coverage under a separate student health plan membership with the *group*, provided the divorce judgment requires that the enrolled student provide health insurance for the former spouse. This is true even if the enrolled student’s new spouse is not enrolled under the enrolled student’s membership.

Eligible Dependents

An eligible student who is enrolled in the *group's* student health plan may enroll eligible dependents under his or her student health plan membership. “Eligible dependents” include the enrolled student’s (or his or her spouse’s) children until the end of the calendar month in which the child turns age 26. To be an eligible dependent, a child under age 26 is not required to live with the enrolled student or the enrolled student’s spouse, be a dependent on the enrolled student’s or spouse’s tax return, or be a full-time student. These eligible dependents may include:

- A newborn child. The *effective date* of coverage for a newborn child will be the child’s date of birth provided the enrolled student formally notifies the *plan sponsor* within the time period required to make family status changes. (A claim for the enrolled mother’s maternity admission may be considered to be this notice when the enrolled student’s coverage is a family plan.) This health plan provides coverage for newborn infants for injury and sickness. This includes the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth. The coverage for these services is subject to all of the provisions of this health plan.

- An adopted child. The *effective date* of coverage for an adopted child will be the date of placement with the enrolled student for the purpose of adoption. The *effective date* of coverage for an adoptive child who has been living with the enrolled student and for whom the enrolled student has been getting foster care payments will be the date the petition to adopt is filed. If the student is enrolled under a family plan as of the date he or she assumes custody of a child for the purpose of adoption, the child's health care services for injury or sickness will be covered from the date of custody. This coverage is provided without a waiting period or pre-existing condition restriction. This includes the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities and premature birth. The coverage for these services is subject to all of the provisions of this health plan.

If an eligible dependent child is married, the dependent child and his or her children can enroll for coverage under the enrolled student's membership. The dependent child's spouse is **not** eligible to enroll as a dependent for coverage under the enrolled student's membership.

An eligible dependent may also include:

- A person under age 26 who is not the enrolled student's (or spouse's) child but who qualifies as a dependent under the Internal Revenue Code.
- A newborn infant of an enrolled dependent child immediately from the moment of birth and continuing after, until the enrolled dependent child is no longer eligible as a dependent.
- A child recognized under a Qualified Medical Child Support Order as having the right to enroll for health care coverage.
- A disabled dependent child age 26 or older. A dependent child who is mentally or physically incapable of earning his or her own living and who is enrolled under the student's membership will continue to be covered after he or she would otherwise lose dependent eligibility for coverage under the enrolled student's membership, so long as the child continues to be mentally or physically incapable of earning his or her own living. In this case, the enrolled student must make arrangements with *Blue Cross and Blue Shield* through the *plan sponsor* within the time period required to make family status changes. Also, *Blue Cross and Blue Shield* must be given any medical or other information that it may need to determine if the child can maintain coverage in the *group's* student health plan under the enrolled student's membership. From time to time, *Blue Cross and Blue Shield* may conduct reviews that will require a statement from the attending physician. This is to confirm that the child is still an eligible disabled dependent child.

**Important
Reminder:**

The eligibility provisions for dependents that are described in this section may differ from the federal tax laws that define who may qualify as a dependent.

Membership Changes

Generally, an enrolled student may make membership changes (for example, change from a student-only plan to a family plan) only if he or she has a change in family status. This includes a change such as: marriage or divorce; birth, adoption, or change in custody of a child; death of an enrolled spouse or dependent; or the loss of an enrolled dependent's eligibility under the enrolled student's student health plan membership. **If you want to ask for a membership change or you need to change your name or mailing address, you should call or write to your *plan sponsor*.** The *plan sponsor* will send you any special forms that you may need. You must request the change within the time period required by the *group* to make a change. All changes are allowed only when they comply with the eligibility and

Part 11 – Eligibility for Coverage (continued)

enrollment rules set by the *plan sponsor* for the *group's* student health plan and they must comply with the conditions outlined in this benefit booklet.

Part 12

Termination of Coverage

When your eligibility for the *group's* student health plan ends, your coverage in this health plan will be terminated as of the date you lose eligibility. Your eligibility ends when:

- You are no longer an “eligible student” as determined by the *group*. In the event that a spouse and/or dependents are enrolled under the student’s membership, their coverage will also be terminated as of the date the student loses eligibility for coverage in the *group's* student health plan. The coverage for the student’s enrolled spouse and/or dependents will also be terminated in the event the enrolled student dies.
- You are enrolled as a dependent and you lose your status as an eligible dependent under the enrolled student’s student health plan membership.

Whether you are the enrolled student or you are the student’s enrolled spouse or other enrolled dependent child, your coverage in this health plan will end when:

- The *group's* contract with *Blue Cross and Blue Shield* is terminated (or is not renewed).
- Your coverage in this health plan will be canceled, or in some cases *Blue Cross and Blue Shield* may limit your benefits, if you have committed misrepresentation or fraud. For example, you gave false or misleading information on the enrollment form. Or, you misused your ID card by letting another person who was not enrolled in the *group's* student health plan attempt to get coverage. Your coverage in this health plan may be terminated when the fraud or misrepresentation is discovered or, as permitted by law, back to your *effective date* or the date of the misrepresentation or fraud. Your coverage in this health plan may be terminated retroactive to a date in the past (rather than on a current or future date) only if you committed fraud or made an intentional misrepresentation of a material fact. The termination date will be determined by *Blue Cross and Blue Shield*.
- You commit acts of physical or verbal abuse that pose a threat to, or a threat to the health of, health care providers or other *members* or employees of *Blue Cross and Blue Shield* or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc., and these acts are not related to your physical condition or *mental condition*.
- You fail to comply in material way with any provisions of this health plan. For example, if you fail to provide information that *Blue Cross and Blue Shield* requests related to your coverage in this health plan, *Blue Cross and Blue Shield* may terminate your coverage.

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Appendix 2: Student Health Insurance Plan Optum Rx Prescription Drug Benefit

OPTUM RX PRESCRIPTION DRUG BENEFIT

Prescription drug coverage is included in the Student Health Insurance Plan and is administered by Optum Rx.

YOUR COST FOR UP TO A 30 DAY SUPPLY:

Tier 1 \$17

Tier 2 \$40

Tier 3 \$55

Other: \$0 copayment for prescription contraceptive products that are generic or brand name without a generic equivalent; 50% coinsurance for Malarone & Mefloquine

Rx Co-payment out-of-pocket maximum: \$1,300 per individual per plan year; \$2,600 per family per plan year

FILLING PRESCRIPTIONS

You can fill prescriptions at the HUHS Pharmacy or any Optum Rx participating retail pharmacy. In order to fill prescriptions at the HUHS Pharmacy, the prescription must be written by an HUHS clinician.

Benefits of using the HUHS Pharmacy:

- Convenient location in the Smith Campus Center
- Free delivery to HUHS satellite clinics
- You can fill up to 3 months at a time
- All purchases can be applied to your student bill
- 24/7 refill line: 617.495.8468

Specialty medications

Specialty medications must be filled at the HUHS Pharmacy (617-495-6661) or through Briova Specialty Pharmacy (855-427-4682). Members will be able to fill specialty medications twice at other retail pharmacies before being required to use the HUHS Pharmacy and/or Briova Specialty Pharmacy.

Prescription Drug Benefit Appeals Process

Members may file complaints through Optum Rx Member Services by phone, fax, or via the web portal. Once the complaint is received, it is forwarded to a Grievance Specialist.

- Phone: 844-265-1223
- Fax: 866-235-3171
- Web portal: <https://www.mycatamaranrx.com/PortalCentral/>

Appendix 2: Student Health Insurance Plan Optum Rx Prescription Drug Benefit Continued

Filling prescriptions outside of Massachusetts

Prescriptions can be filled at any Optum Rx participating pharmacy in the United States. Your copayment(s) and drug benefits will not change. To locate participating pharmacies, contact Optum Rx Member Services at 844.265.1223.

Prescription needs when outside of the United States

If you take a prescriptions drug, contact your doctor and have your prescription written for the number of months you need filled while traveling abroad. Contact HUSHP Member Services (617.495.2008) to request a travel override. You will need to submit a copy of your travel itinerary to HUSHP Member Services for review; this must be done at least 72 hours before you need to pick up your prescription.

If you purchase prescriptions while out of the country, you can file for reimbursement through Optum Rx. As long as the prescription is a covered medication, you will be reimbursed at 100% minus a second tier copayment. You will need an itemized receipt to file for reimbursement. Visit hushp.harvard.edu for a claim form or call Optum Rx at 844.265.1223.

