attached to and made part of
Point-of-Service Plan Benefit Description
ASC-POS (1-1-2022)

Schedule of Benefits

Blue Choice® New England Plan 2

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 **HMO Blue New England**. The *service area* where your *covered services* will be furnished includes all counties in Massachusetts, Connecticut, Maine, New Hampshire, Rhode Island, and Vermont. 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	PCP/Plan Approved Benefits	Self-Referred Benefits
Deductible Your *deductible* per calendar year is: This *deductible* applies to all self-referred benefits <u>except</u> certain *covered services* as noted in this chart.	The *deductible* is the cost you have to pay for certain *covered services* during your annual coverage period before benefits will be paid for those *covered services*.	
	\$0 per *member* \$0 per family	\$250 per *member* \$500 per family
	Any costs you pay for PCP/plan approved benefits will <u>not</u> be applied toward the self-referred benefits *deductible*.	
	The family *deductible* can be met by eligible costs incurred by any combination of *members* enrolled under the same family plan. But, no one *member* will have to pay more than the per *member deductible*.	
Out-of-Pocket Maximum Your *out-of-pocket maximum* per calendar year is: This *out-of-pocket maximum* is a total of the *deductible*, *copayments*, and *coinsurance* you pay for *covered services*.	The *out-of-pocket maximum* is the most you could pay during your annual coverage period for your share of the costs for *covered services*.	
	\$5,450 per *member* \$10,900 per family The amounts shown above exclude cost share you pay for your prescription drug benefits.	
	And a separate *out-of-pocket maximum* for prescription drug benefits: \$1,000 per *member* \$2,000 per family	
	The family *out-of-pocket maximum* can be met by eligible costs incurred by any combination of *members* enrolled under the same family plan. But, no one *member* will have to pay more than the per *member out-of-pocket maximum*.	
Overall Benefit Maximum	None	

Covered Services		PCP/Plan Approved Benefits **Your Cost Is:**	Self-Referred Benefits **Your Cost Is:**
Admissions for Inpatient Medical and Surgical Care	• In a General Hospital		
	<u>Hospital services</u>	No charge	20% after *deductible*
	<u>Physician and other covered professional provider services</u>	No charge	20% after *deductible*
	• In a Chronic Disease Hospital	(same as admissions in a General Hospital)	(same as admissions in a General Hospital)

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

Covered Services		PCP/Plan Approved Benefits Your Cost Is:	Self-Referred Benefits Your Cost Is:
Admissions for Inpatient Medical and Surgical Care (continued)	• In a Rehabilitation Hospital (60-day *benefit limit* per *member* per calendar year)		
	Hospital services	No charge	20% after *deductible*
	Physician and other covered professional provider services	No charge	20% after *deductible*
	• In a Skilled Nursing Facility (100-day *benefit limit* per *member* per calendar year)		
	Facility services	No charge	20% after *deductible*
	Physician and other covered professional provider services	No charge	20% after *deductible*
Ambulance Services (ground or air ambulance transport)	• Emergency ambulance	No charge	same as PCP/plan approved benefits
	• Other ambulance	No charge	20% after *deductible*
Cardiac Rehabilitation	*Outpatient* services	$10 *copayment* per visit	20% after *deductible*
Chiropractor Services (for *members* of any age)	• *Outpatient* lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	• *Outpatient* medical care services, including spinal manipulation (a *benefit limit* does not apply)	$10 *copayment* per visit	20% after *deductible*
Dialysis Services	*Outpatient* services and home dialysis	No charge	20% after *deductible*
Durable Medical Equipment	• Covered medical equipment rented or purchased for home use	20%	20% after *deductible*
	• One breast pump per birth (rented or purchased)	No charge	20% after *deductible*
		No coverage is provided for hospital-grade breast pumps.	
Early Intervention Services	*Outpatient* intervention services for eligible child from birth through age two	No charge	No charge (*deductible* does not apply)
Emergency Medical Outpatient Services	• Emergency room services	$100 *copayment* per visit; *copayment* waived if held for observation or admitted within 24 hours	same as PCP/plan approved benefits
	• Hospital outpatient department services	No charge	20% after *deductible*

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

Covered Services		PCP/Plan Approved Benefits Your Cost Is:	Self-Referred Benefits Your Cost Is:
Emergency Medical Outpatient Services (continued)	• Office, health center, and home services by your *primary care provider*; or by an OB/GYN physician or nurse midwife; or by a physician assistant or nurse practitioner designated by the health plan as primary care	$10 *copayment* per visit	20% after *deductible*
	by a network specialist or other *covered provider* (non-hospital), including a physician assistant or nurse practitioner designated by the health plan as specialty care	$10 *copayment* per visit	20% after *deductible*
Home Health Care	Home care program	No charge	20% after *deductible*
Hospice Services	*Inpatient* or *outpatient* hospice services for terminally ill	No charge	20% after *deductible*
Infertility Services	• *Inpatient* services	See Admissions for Inpatient Medical and Surgical Care	See Admissions for Inpatient Medical and Surgical Care
	• *Outpatient* surgical services	See Surgery as an Outpatient	See Surgery as an Outpatient
	• *Outpatient* lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	• *Outpatient* medical care services	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits
Lab Tests, X-Rays, and Other Tests (diagnostic services)	• *Outpatient* lab tests by a general hospital	No charge	20% after *deductible*
	by other *covered providers*	No charge	20% after *deductible*
	• *Outpatient* x-rays and other imaging tests (other than advanced imaging tests) by a general hospital	No charge	20% after *deductible*
	by other *covered providers*	No charge	20% after *deductible*

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

Covered Services		PCP/Plan Approved Benefits Your Cost Is:	Self-Referred Benefits Your Cost Is:
Lab Tests, X-Rays, and Other Tests (continued)	• *Outpatient* advanced imaging tests (CT scans, MRIs, PET scans, nuclear cardiac imaging)		
	by a general hospital	$25 *copayment* per category of test per service date	20% after *deductible*
	by other *covered providers*	$25 *copayment* per category of test per service date	20% after *deductible*
	• Other *outpatient* tests and preoperative tests		
	by a general hospital	No charge	20% after *deductible*
	by other *covered providers*	No charge	20% after *deductible*
Maternity Services and Well Newborn Care (includes $90/$45 for childbirth classes; *deductible* does not apply)	• Maternity services		
	Facility services (*inpatient* and *outpatient covered services*)	No charge	20% after *deductible*
	Physician and other covered professional provider services (includes delivery and postnatal care)	No charge	20% after *deductible*
	• Prenatal care	No charge	20% after *deductible*
	• Well newborn care during covered maternity admission	No charge	20% (*deductible* does not apply)
Medical Care Outpatient Visits (includes syringes and needles dispensed during a visit)	• Office, health center, and home medical services		
	by your *primary care provider*; or by an OB/GYN physician, nurse midwife, or limited services clinic; or by a physician assistant or nurse practitioner designated by the health plan as primary care	$10 *copayment* per visit	20% after *deductible*

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

Covered Services		PCP/Plan Approved Benefits Your Cost Is:	Self-Referred Benefits Your Cost Is:
Medical Care Outpatient Visits (continued)	• Office, health center, and home medical services by a network specialist or other *covered provider* (non-hospital), including a physician assistant or nurse practitioner designated by the health plan as specialty care	$10 *copayment* per visit	20% after *deductible*
	• Hospital outpatient medical services	No charge	20% after *deductible*
	• Acupuncture services (12-visit *benefit limit* per *member* per calendar year)	$10 *copayment* per visit	20% after *deductible*
Medical Formulas	Certain medical formulas and low protein foods	No charge	20% after *deductible*
Mental Health and Substance Use Treatment	• *Inpatient* admissions in a General Hospital Hospital services	No charge	20% after *deductible*
	Physician and other covered professional provider services	No charge	20% after *deductible*
	• *Inpatient* admissions in a Mental Hospital or Substance Use Facility Facility services	No charge	20% after *deductible*
	Physician and other covered professional provider services	No charge	20% after *deductible*
	• *Outpatient* services	$10 *copayment* per visit, except no charge for hospital services	20% after *deductible*
Oxygen and Respiratory Therapy	• Oxygen and equipment for its administration	No charge	20% after *deductible*
	• *Outpatient* respiratory therapy	No charge	20% after *deductible*
Podiatry Care	• *Outpatient* lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	• *Outpatient* surgical services	See Surgery as an Outpatient	See Surgery as an Outpatient
	• *Outpatient* 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		PCP/Plan Approved Benefits Your Cost Is:	Self-Referred Benefits Your Cost Is:
Prescription Drugs and Supplies Drug Formulary (includes syringes and needles)	• Retail Pharmacy (30-day supply) Tier 1 (generic): Tier 2 (preferred brand): Tier 3 (non-preferred):	\$10 *copayment* \$25 *copayment* \$45 *copayment*	Not covered; you pay all charges
		This cost share is waived for Tier 1 birth control drugs and devices; certain preventive drugs as required by federal law; insulin infusion pumps; and certain orally-administered anticancer drugs.	
	• Mail Order Pharmacy (90-day supply) Tier 1 (generic): Tier 2 (preferred brand): Tier 3 (non-preferred):	\$20 *copayment* \$50 *copayment* \$90 *copayment*	Not covered; you pay all charges
		This cost share is waived for Tier 1 birth control drugs and devices; certain preventive drugs as required by federal law; and certain orally-administered anticancer drugs.	
Preventive Health Services	• Routine pediatric care Routine medical exams and immunizations	No charge	20% after *deductible*
	Routine tests	No charge	20% after *deductible*
		These *covered services* 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 *members* under age 18 for treatment of cleft lip/cleft palate	No charge	20% after *deductible*
	• Routine adult care Routine medical exams and immunizations	No charge	20% after *deductible*
	Routine tests	No charge	20% after *deductible*
		These *covered services* include (but are not limited to): routine exams; immunizations; routine lab tests and x-rays; routine mammograms (may be subject to age and frequency requirements); blood tests to screen for lead poisoning; and routine colonoscopies.	
	• Routine GYN care Routine GYN exams (one exam per *member* per calendar year)	No charge	20% after *deductible*
	Routine Pap smear tests (one test per *member* per calendar year)	No charge	20% after *deductible*
	• Family planning	No charge	20% after *deductible*

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

Covered Services		PCP/Plan Approved Benefits Your Cost Is:	Self-Referred Benefits Your Cost Is:
Preventive Health Services (continued)	• Routine hearing care Routine hearing exams/tests	No charge	20% after *deductible*
	Newborn hearing screening tests	No charge	20% after *deductible*
	Hearing aids/related services	Not covered; you pay all charges	Not covered; you pay all charges
	• Routine vision care Routine vision exams (one exam per *member* every 24 months)	No charge	20% after *deductible*
	Vision supplies/related services	Not covered; you pay all charges	Not covered; you pay all charges
Prosthetic Devices	• Ostomy supplies	No charge	20% after *deductible*
	• Artificial limb devices (includes repairs) and other external prosthetic devices	20%	20% after *deductible*
Radiation Therapy and Chemotherapy	*Outpatient* services	No charge	20% after *deductible*
Second Opinions	*Outpatient* second and third opinions	See Medical Care Outpatient Visits	See Medical Care Outpatient Visits
Short-Term Rehabilitation Therapy (physical, occupational, and speech therapy) Includes habilitation services	*Outpatient* services (60-visit *benefit limit* per *member* per calendar year for physical and occupational therapy, except for autism; a *benefit limit* does not apply for speech therapy)	$10 *copayment* per visit	20% after *deductible*
Speech, Hearing, and Language Disorder Treatment	• *Outpatient* diagnostic tests	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	• *Outpatient* speech therapy	See Short-Term Rehabilitation Therapy	See Short-Term Rehabilitation Therapy
	• *Outpatient* 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		PCP/Plan Approved Benefits Your Cost Is:	Self-Referred Benefits Your Cost Is:
Surgery as an Outpatient (excludes removal of impacted teeth whether or not the teeth are imbedded in the bone)	• *Outpatient* day surgery Hospital surgical day care unit or outpatient department services	No charge	20% after *deductible*
	Ambulatory surgical facility services	No charge	20% after *deductible*
	Physician and other covered professional provider services	No charge	20% after *deductible*
	• Sterilization procedure for a female *member* when performed as the primary procedure for family planning reasons	No charge	20% after *deductible*
	• Office and health center surgical services by your *primary care provider*; or by an OB/GYN physician or nurse midwife; or by a physician assistant or nurse practitioner designated by the health plan as primary care	$10 *copayment* per visit	20% after *deductible*
	by a network specialist or other *covered provider* (non-hospital), including a physician assistant or nurse practitioner designated by the health plan as specialty care	$10 *copayment* per visit	20% after *deductible*
TMJ Disorder Treatment	• *Outpatient* x-rays	See Lab Tests, X-Rays, and Other Tests	See Lab Tests, X-Rays, and Other Tests
	• *Outpatient* surgical services	See Surgery as an Outpatient	See Surgery as an Outpatient
	• *Outpatient* physical therapy	See Short-Term Rehabilitation Therapy	See Short-Term Rehabilitation Therapy
	• *Outpatient* 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*.

Rider 02-360
Office Surgery

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

The *outpatient* benefits described in your Benefit Description for office or health center surgery have been changed.

Any *deductible, copayment*, and/or *coinsurance* that you would normally pay for covered surgical services furnished in a *network provider's* office or in a network health center no longer applies. For these *covered services*, you pay nothing.

All other provisions remain as described in your Benefit Description.

Rider 03-304

Infertility Services

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

The *inpatient* and *outpatient* benefits described in your Benefit Description for infertility services have been changed.

No self-referred benefits are provided for services to diagnose or treat infertility. When you chose to self-refer for these services, you must pay all charges.

All other provisions remain as described in your Benefit Description.

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Your Health Plan Benefit Description

Rider
Advanced Imaging Tests

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

The cost share amount you pay for *outpatient* advanced imaging tests as shown in your *Schedule of Benefits* has been changed as follows:

The *copayment* that you would normally pay for *outpatient* advanced imaging tests has been eliminated.

All other provisions remain as described in your Benefit Description.

Rider 05-545

Mental Health and Substance Abuse Treatment

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

The *outpatient* benefits described in your Benefit Description for mental health and substance abuse treatment have been changed.

The *copayment* amount that you would normally pay for *outpatient* mental health and substance abuse visits no longer applies. For these *covered services*, you pay nothing.

All other provisions remain as described in your Benefit Description.

Rider 06-001

Short-Term Rehabilitation Therapy

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

The *outpatient* self-referred benefits described in your Benefit Description for short-term rehabilitation therapy have been changed.

This health plan provides self-referred benefits for short-term rehabilitation therapy for as many visits as are *medically necessary* for your illness or injury.

Note: Your PCP/plan approved benefits for short-term rehabilitation therapy have not been changed by this rider.

All other provisions remain as described in your Benefit Description.

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Rider
Oral Surgery

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

The *inpatient* and *outpatient* benefits described in your Benefit Description for oral surgery have been changed.

Your benefits for oral surgery also include the removal of impacted teeth that are fully or partially imbedded in the bone.

All other provisions remain as described in your Benefit Description

Rider 10-2131
Copayments

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

The *copayment* amount for certain *outpatient covered services* has been changed from the amount described in your Benefit Description to:

(1) $15 *copayment* for each visit for the following *covered services*:
- cardiac rehabilitation services;
- medical care services to diagnose or treat your illness, condition, or injury, when the *covered service* is furnished by your *primary care provider* or by a network obstetrician, network gynecologist, network nurse practitioner, network nurse midwife, or network physician assistant;
- medical care services for treatment of infertility;
- mental health and/or substance abuse treatment; and
- speech/language therapy.

(2) $20 *copayment* for each visit for the following *covered services*:
- medical care services to diagnose or treat your illness, condition, or injury, when the *covered service* is furnished by a network specialist, including (but not limited to) a network chiropractor or a network podiatrist; and
- physical and occupational therapy.

Refer to your *Schedule of Benefits* for a description of the *covered services* for which the lower and higher *copayments* apply.

Note: This *rider* does not change the amount you must pay for: emergency room visits; diagnostic tests (such as lab tests and imaging tests); prescription drugs; and *outpatient* day surgery.

All other provisions remain as described in your Benefit Description.

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Rider
Deductible

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

The *deductible* amount as shown in your *Schedule of Benefits* has been changed as follows:

Your *deductible* per calendar year is: $300 per *member*
$600 per family

Refer to your *Schedule of Benefits* (and, if applicable, other *riders* that are part of your health plan) for a description of *covered services* for which the *deductible* applies.

All other provisions remain as described in your Benefit Description.

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Rider
Out-of-Pocket Maximum

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

The *out-of-pocket maximum* as shown in your *Schedule of Benefits* has been changed as follows:

Overall Member Cost Share Provisions	PCP/Plan Approved Benefits	Self-Referred Benefits
Out-of-Pocket Maximum	The *out-of-pocket maximum* is the most you could pay during your annual coverage period for your share of the costs for *covered services*.	
Your *out-of-pocket maximum* per calendar year is: This *out-of-pocket maximum* is a total of the *deductible*, *copayments*, and *coinsurance* you pay for *covered services*.	$2,000 per *member* $4,000 per family (excluding cost share amounts for prescription drugs)	
	and a separate *out-of-pocket maximum* for prescription drug benefits: $1,000 per *member* $2,000 per family	
	The family *out-of-pocket maximum* can be met by eligible costs incurred by any combination of *members* enrolled under the same family plan. But, no one *member* will have to pay more than the per *member out-of-pocket maximum*.	

All other provisions remain as described in your Benefit Description.

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Rider
Prescription Drugs

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

Your cost share amount for covered drugs and supplies you buy from a covered pharmacy is:

- **Retail Pharmacy** (30-day supply):
  Tier 1 (generic): $10 *copayment*
  Tier 2 (preferred brand): $15 *copayment*, except $10 *copayment* for generic
  Tier 3 (non-preferred): $35 *copayment*

- **Mail Service Pharmacy** (90-day supply):
  Tier 1 (generic): $10 *copayment*
  Tier 2 (preferred brand): $15 *copayment*, except $10 *copayment* for generic
  Tier 3 (non-preferred): $35 *copayment*

Note: Refer to your Benefit Description for the times when your cost share for covered drugs and supplies may be waived.

All other provisions remain as described in your Benefit Description.

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Rider
Routine Vision Exams

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

The benefits described in your Benefit Description for routine vision exams have been changed.

No benefits are provided for routine vision exams. For these services, you must pay all charges.

Important Note: Your benefits for medical care services and contact lenses needed to treat keratoconus and intraocular lenses implanted (or one pair of eyeglasses instead) after covered eye surgery when the natural eye lens is replaced have not been changed.

All other provisions remain as described in your Benefit Description.

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Rider
Hearing Aids and Related Services

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

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

This health plan covers hearing aids and related services for a *member* of any age, when the hearing aid and related services are furnished by a *covered provider,* such as a licensed audiologist or licensed hearing instrument specialist. This coverage includes:

- For a *member* who is age 21 or younger: One hearing aid for each hearing-impaired ear every 36 months and the following related services: initial hearing aid evaluation; fitting and adjustments of the hearing aid; hearing aid batteries; repair of broken hearing aids, and supplies such as (but not limited to) ear molds. **Your benefits for the hearing aid device itself are limited to $3,000 for each covered hearing aid.** If you choose a hearing aid device that costs more than this *benefit limit*, you will have to pay the balance of the cost of the device that is in excess of the *benefit limit*. This *benefit limit* does not apply to services related to a covered hearing aid.
- For a *member* who is age 22 or older: One hearing aid for each hearing-impaired ear or one set of binaural hearing aids per *member* every 36 months and the following related services: initial hearing aid evaluation; fitting and adjustments of the hearing aid; hearing aid batteries; repair of broken hearing aids, and supplies such as (but not limited to) ear molds. **Your benefits for the hearing aid device and related *covered services* are limited to a total of $5,000 per *member* every 36 months.** You will have to pay the balance of the cost that is in excess of the *benefit limit*.

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

No benefits are provided for hearing aids delivered more than 60 days after your termination date in this health plan, even if the hearing aid was prescribed while you were covered by the health plan.

All other provisions remain as described in your Benefit Description.

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Rider
Durable Medical Equipment

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

The cost share amount you pay for durable medical equipment as shown in your *Schedule of Benefits* has been changed as follows:

You will pay 30% *coinsurance* for PCP/plan approved benefits or for self-referred benefits, after you have paid your overall *deductible*, you will pay 50% *coinsurance*.

This change does not apply to your coverage for the women's preventive health services (such as one breast pump per birth) that are recommended by the U.S. Department of Health and Human Services for which you have the right to full coverage as described in your Benefit Description.

All other provisions remain as described in your Benefit Description.

Rider 15-423
Prosthetic Devices

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

The amount you pay for *outpatient* covered prosthetic devices has been changed from the amount described in your Benefit Description to: no cost for PCP/Plan Approved benefits or 20% *coinsurance* after *deductible* for Self-Referred benefits.

All other provisions remain as described in your Benefit Description.

Rider 18-308
Chiropractor Services

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

The *outpatient* benefits described in your Benefit Description for *covered services* furnished by a chiropractor have been changed.

Your benefits for *outpatient* chiropractic services furnished by a chiropractor are limited to 20 visits each calendar year for each *member* (regardless of age). Once you reach this *benefit limit*, no more benefits will be provided for chiropractor services during the rest of that year, whether or not these chiropractic services are *medically necessary* for you.

All other provisions remain as described in your Benefit Description.

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Rider
Autism Spectrum Disorders

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

The benefits described in your Benefit Description for applied behavior analysis to treat autism spectrum disorders have been changed.

The cost share that you would normally for applied behavior analysis to treat autism spectrum disorders no longer applies. For these *covered services*, you pay nothing. (Any *deductible*, *copayment*, or *coinsurance* does not apply.)

All other provisions remain as described in your Benefit Description.

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Rider
Allowed Charge

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

The amount that *Blue Cross and Blue Shield* uses to calculate your benefits for *covered services* furnished by non-*network providers* has been changed.

The term "Allowed Charge" as described in Part 2 of your Benefit Description has been changed by replacing the third bullet with the following section:

For Other Health Care Providers. For health care providers who do not have a network payment agreement with *Blue Cross and Blue Shield* or for health care providers outside of Massachusetts who do not have a payment agreement with the local Blue Cross and/or Blue Shield Plan, or an indemnity payment agreement with *Blue Cross and Blue Shield*, the *allowed charge* is based on 150% of the Medicare reimbursement rate. If there is no established Medicare reimbursement rate, the *allowed charge* is based on the amount determined by using current publicly-available data reflecting fees typically reimbursed for the *covered service*, adjusted for geographic differences. (There may be times when the Medicare reimbursement rate is not available for part of a claim for *covered services*. When this happens, the *allowed charge* will be based on the lesser of: the total of the Medicare reimbursement rate for the part for which there is a Medicare reimbursement rate plus the provider's actual charge for the part for which there is no Medicare reimbursement rate; or the amount determined by using the current publicly-available data described above for all parts of the claim for the *covered services*.) *Blue Cross and Blue Shield* has the discretion to determine what current publicly-available data it deems applicable, by using the data maintained by a third party of its choice. In no event will the allowed charge be more than the health care provider's actual charge. However, 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 *covered services* for which you have received an approved referral or authorization from your *primary care provider*. For these *covered services*, the full amount of the health care provider's actual charge is used to calculate your claim payment. This provision also 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 anesthetists, 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.

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 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.

All other provisions remain as described in your Benefit Description.

Rider 12-003

Membership Changes

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

The time limit described in your Benefit Description for making membership changes has been changed.

You must request a membership change (for example, change from an individual membership to a family membership) within 72 days of the reason for the change. If you do not make the change within 72 days, you will have to wait until the *group's* next open enrollment period to make the change.

All other provisions remain as described in your Benefit Description.

attached to and made part of
Your Health Plan Benefit Description

Rider
Dependent Eligibility

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

The eligibility provisions described in your Benefit Description for coverage of dependents have been changed.

Children of an eligible dependent child are **not** eligible to enroll as a dependent for coverage under the *subscriber's group* health plan.

All other provisions remain as described in your Benefit Description.

attached to and made part of
Your Health Plan Benefit Description

Rider

Pharmacy Program

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

The "Prescription Drugs and Supplies" section in Part 5 of your Benefit Description is replaced in its entirety by the following new section:

Prescription Drugs and Supplies

This health plan covers certain drugs and supplies that are furnished by a covered pharmacy. This coverage is provided **only** when all of the following criteria are met.

- The drug or supply is listed on the *Blue Cross and Blue Shield* Drug Formulary as a covered drug or supply. For certain covered drugs, you must have prior approval from *Blue Cross and Blue Shield* in order for you to receive this drug coverage. A covered pharmacy will tell you if your drug needs prior approval from *Blue Cross and Blue Shield*. They will also tell you how to request this approval.
- The drug or supply is prescribed for your use while you are an *outpatient*.
- The drug or supply is purchased from a pharmacy that is approved by *Blue Cross and Blue Shield* for payment for the specific covered drug and/or supply. This means that for most covered drugs and supplies, you may buy your drug or supply from any covered retail pharmacy. However, for some specialty drugs and supplies, you may need to buy your drug or supply from covered pharmacies that specialize in treating specific diseases and that have been approved by *Blue Cross and Blue Shield* for payment for that specific specialty drug or supply. For a list of these specialty drugs and supplies and where to buy them, you can call the *Blue Cross and Blue Shield* customer services office. Or, you can look on the internet Web site at **www.bluecrossma.com**.

The Drug Formulary

The *Blue Cross and Blue Shield* Drug Formulary is a list of approved drugs and supplies. *Blue Cross and Blue Shield* may update its Drug Formulary from time to time. In this case, your coverage for certain drugs and supplies may change. For example, a drug may change from one *member* cost share level to another *member* cost share level. **For information about the *Blue Cross and Blue Shield* Drug Formulary, you can refer to your Pharmacy Program booklet 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.

Finding a Covered Pharmacy

For help to find a pharmacy where you may buy a specific drug or supply, 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.

Buying Brand-Name Drugs Instead of a Generic Equivalent

When you buy a covered drug, the pharmacist will give you a generic equivalent of the prescribed drug whenever it is allowed. However, if you and/or your physician choose to buy the brand-name drug instead of the generic drug equivalent, your out-of-pocket costs will be more. For most of these brand-name drugs, your cost will be calculated based the *allowed charge* for the generic drug equivalent. This means that you will pay your cost share amount (*deductible*, *copayment*, or *coinsurance*, whichever applies) for the brand-name drug plus all charges that are in excess of the *allowed charge* for the generic drug

equivalent. However, for certain brand-name drugs, your cost will be calculated based on the *allowed charge* for the brand-name drug. This means you will only pay your cost share amount (*deductible*, *copayment*, or *coinsurance*, whichever applies). All costs that you pay for these covered drugs will count towards your *out-of-pocket maximum*. For a list of these covered brand-name drugs, refer to your Pharmacy Program booklet.

Important Note: When your plan option includes a *deductible* that applies for prescription drugs, this provision does not apply until the *deductible* has been met.

Using the Mail Order Pharmacy

You have the option to buy covered drugs and supplies from *Blue Cross and Blue Shield* designated mail order pharmacy. However, there are certain covered drugs and supplies that you may not be able to buy from the mail order pharmacy. To find out if your covered drug or supply qualifies for the mail order pharmacy benefit, you can check with the mail order pharmacy. 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.

Member Cost Sharing for Covered Drugs and Supplies

The cost share amount (*deductible*, *copayment* and/or *coinsurance*) you pay for covered drugs and supplies is described in your *Schedule of Benefits* or, when applicable, a *rider* that applies to your coverage in this health plan.

There are certain covered drugs and supplies that are covered in full by this health plan. A *deductible*, *copayment*, and/or *coinsurance* will be waived for:

- Erythromycin ophthalmic ointment for *members* under age one.
- Generic contraceptives (or brand-name contraceptives when a generic is not available) for *members* age 12 through age 54. These include (but are not limited to) birth control drugs, diaphragms, and other covered birth control devices. If you choose to use a brand-name contraceptive when a generic is available, you will have to pay your cost share.
- Folic acid with a prescription or over-the-counter for *members* age 12 through age 54.
- Generic bowel evacuants (or brand-name evacuants when a generic is not available) for *members* age 50 through age 75 (for one supply per year), including over-the-counter evacuants when they are prescribed for you by a health care provider. Bowel evacuants include laxative medicines that are used to cleanse the bowel prior to a procedure such as a colonoscopy or barium enema. If you choose to use a brand-name bowel evacuant when a generic is available, you will have to pay your cost share.
- Other preventive drugs as recommended and supported by the Health Resources and Services Administration and the U.S. Preventive Services Task Force.

Covered Drugs and Supplies

This drug coverage is provided for:

- Drugs that require a prescription by law and are furnished in accordance with *Blue Cross and Blue Shield medical technology assessment criteria*. These covered drugs include: birth control drugs; oral diabetes medication that influences blood sugar levels; hormone replacement therapy drugs for peri- and post-menopausal women; and certain drugs used on an off-label basis (such as: drugs used to treat cancer; and drugs used to treat HIV/AIDS).
- Injectable insulin and disposable syringes and needles needed for its administration, whether or not a prescription is required. If insulin, syringes, and needles are bought at the same time, you will pay two *copayments*: one for the insulin; and one for the syringes and needles.

- Materials to test for the presence of sugar when they are ordered for you by a physician for home use. These include (but are not limited to): blood glucose monitoring strips; ketone strips; lancets; urine glucose testing strips; normal, low, and high calibrator solution/chips; and dextrostik or glucose test strips. You may obtain these testing supplies from a covered pharmacy or appliance company. (For your coverage for glucometers, see "Durable Medical Equipment" in your benefit booklet.)
- Insulin injection pens.
- Insulin infusion pumps and related pump supplies. You may obtain the insulin infusion pump from an appliance company instead of a pharmacy.
- Syringes and needles when they are *medically necessary* for you.
- Drugs that do not require a prescription by law ("over-the-counter" drugs), if any, that are listed on the *Blue Cross and Blue Shield* Drug Formulary as a covered drug. **Your Pharmacy Program booklet will list the over-the-counter drugs that are covered, if there are any.** Or, you can go online and log on to the *Blue Cross and Blue Shield* Web site at **www.bluecrossma.com**.
- Diaphragms and other prescription birth control devices that have been approved by the U.S. Food and Drug Administration (FDA).
- Prescription prenatal vitamins and pediatric vitamins with fluoride.
- Prescription dental topical fluoride, rinses, and gels.
- Smoking and tobacco cessation drugs and aids (such as nicotine gum and patches) for two 90-day treatments for each *member* in each calendar year, when they are prescribed for you by a health care provider. Your cost share will be waived for generic drugs and aids (or for a preferred brand-name drug or aid when a generic is not available). If you choose to use a brand-name drug or aid when a generic is available, you will have to pay your cost share. Your coverage for "Preventive Health Services" includes smoking and tobacco cessation counseling as recommended by the U.S. Preventive Services Task Force.

Non-Covered Drugs and Supplies

No benefits are provided for:

- Anorexiants and non-anorexiant weight loss drugs (such as Belviq).
- Non-sedating antihistamines, except as described in your Pharmacy Program booklet.
- Ophthalmic drug solutions to treat allergies.
- Pharmaceuticals that you can buy without a prescription, except as described in your benefit booklet or in your Pharmacy Program booklet.
- Medical supplies such as dressings and antiseptics.
- The cost of delivering drugs to you.
- Combination vitamins that require a prescription, except for: prescription prenatal vitamins; and pediatric vitamins with fluoride.
- Immunizing agents; toxoids; blood; and blood products.
- Drugs and supplies that you buy from a retail pharmacy that is not covered by this health plan.
- Drugs and supplies that you buy from a non-designated mail order pharmacy.
- Drugs and supplies that you buy from any pharmacy that is not approved by *Blue Cross and Blue Shield* for payment for the specific covered drug and/or supply.

All other provisions remain as described in your Benefit Description.

attached to and made part of
Your Health Plan Benefit Description

Rider
Prescription Drugs

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

Your cost share amount for covered drugs and supplies you buy from a covered retail pharmacy has been changed.

When you obtain certain covered drugs from a covered retail pharmacy, you will only have to pay one *copayment* for up to a 90-day supply. For a list of these covered drugs, refer to your *group's* Pharmacy Program booklet. The *copayment* amount you must pay for these covered drugs is described in your *Schedule of Benefits* or when applicable, a *rider* that applies to your coverage.

All other provisions remain as described in your Benefit Description.

attached to and made part of
Your Health Plan Benefit Description

Rider
Prescription Drugs

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

The exclusions for prescription drug benefits as described in your Benefit Description have been changed.

The exclusion for proton pump inhibitors that you buy on or after January 1, 2019 has been removed. Your benefits for prescription proton pump inhibitors are the same as your prescription drug benefits for other prescription drugs.

All other provisions remain as described in your Benefit Description.

attached to and made part of
Your Health Plan Benefit Description

Rider
Telehealth Services

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

The *outpatient* benefits described in your Benefit Description have been changed to include coverage for telehealth services with *Blue Cross and Blue Shield's* designated telehealth vendor.

Your health plan includes coverage for *outpatient* telehealth visits furnished by *Blue Cross and Blue Shield's* designated telehealth vendor. You may use the designated telehealth vendor when you need care for a minor illness or injury such as a cough, a sore throat, or a fever; or you need care for a chronic condition; or you need mental health and substance use care for conditions or symptoms such as anxiety and depression; or you have a general health and wellness concern. You do not need a referral from your *primary care provider* for covered *outpatient* telehealth services with the designated telehealth vendor.

When medically appropriate *outpatient* telehealth services are furnished by the designated telehealth vendor, your cost share (such as *deductible*, *copayment*, and/or *coinsurance*) is the same cost share that applies when *covered services* are furnished by your *primary care provider* (if you are enrolled in an Options tiered network plan, your cost share is the same as the lowest cost share level for a primary care provider visit) or *mental health provider*. Your *Schedule of Benefits* describes your cost share amount. (Also refer to *riders*—if there are any—that apply to your coverage in this health plan.)

This change does not apply to your coverage for preventive health services as required by the Affordable Care Act and related regulations for which you have the right to full coverage as described in your Benefit Description.

No benefits are provided for these *outpatient* telehealth services if they are furnished by a telehealth vendor other than *Blue Cross and Blue Shield's* designated telehealth vendor. (Your *group* may elect to designate a telehealth vendor that is not *Blue Cross and Blue Shield's* designated telehealth vendor to furnish certain services. If this is the case, this will be described in a different *rider*. Be sure to read each *rider* that applies to your coverage in this health plan.)

All other provisions remain as described in your Benefit Description.

attached to and made part of
Your Health Plan Benefit Description

Rider
Open Drug Formulary

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

The *outpatient* benefits described in your Benefit Description for covered drugs and supplies have been changed.

Under your health plan, the *Blue Cross and Blue Shield* Drug Formulary is an "open" formulary list. This means that the Drug Formulary Exception Process as described in your Benefit Description no longer applies. To find out which *member* cost share level you will pay for a specific covered drug or supply, 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. Or, you can also go online and log on to the *Blue Cross and Blue Shield* Web site at www.bluecrossma.com.

All other provisions remain as described in your Benefit Description.

MASSACHUSETTS

Mind and Body Wellness Program

You may be reimbursed for some costs you pay for qualified Mind and Body Wellness Program services.

Mind and Body Reimbursement

Blue Cross Blue Shield of Massachusetts, on behalf of your employer group, will reimburse you up to $300 each calendar year for costs you pay to receive any of the following mind and body wellness services from a licensed, certified, or accredited practitioner (except as described below for digital applications).

- Hypnosis mind and body therapy
- Massage therapy
- Meditation mind and body therapy
- Tai Chi or Qi Gong
- Digital applications for breathing or meditation mind and body therapy. To receive reimbursement for these services, you may use any digital application that is focused on breathing or meditation. This reimbursement is not provided for digital applications for other services (such as sleep-focused digital applications).

You can claim this maximum mind and body wellness program reimbursement for costs paid by any combination of members (such as the subscriber, spouse, and/or dependent children) enrolled under the same Blue Cross Blue Shield of Massachusetts health plan.

To get these services, you can use any alternative health practitioner that participates in the Blue Cross Blue Shield of Massachusetts Living Healthy Naturally program. To find a list of these alternative health practitioners, you can log on to the Blue Cross Blue Shield of Massachusetts Web site at **www.bluecrossma.org/myblue/find-care/care-options/find-holistic-care**. Also, as a Blue Cross Blue Shield of Massachusetts member, any of these practitioners will offer you discounted fees for any services you receive. Or, you may choose to locate another licensed or certified alternative health practitioner. When locating another alternative health practitioner to get these services, you must be sure to confirm the practitioner is licensed, certified, or accredited to perform the specific wellness service.

If you have questions or need help, you can call your Blue Cross Blue Shield of Massachusetts customer service office toll-free telephone number that is shown on your health plan ID card.

How to Claim Your Reimbursement

To be reimbursed for participation in a mind and body wellness program, you must send your reimbursement request to Blue Cross Blue Shield of Massachusetts no later than March 31st after the year for which you are claiming your reimbursement. To request your reimbursement, you must:

- Fill out a mind and body wellness program reimbursement claim form.
- Follow the instructions to submit the completed claim to Blue Cross Blue Shield of Massachusetts.

To get a claim form, log on to the Blue Cross Blue Shield of Massachusetts Web site at **www.bluecrossma.org**.

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

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MASSACHUSETTS

Wellness Participation Program

Under this Wellness Participation Program, you may be reimbursed for some fees you pay to participate in qualified fitness programs and/or weight loss programs.

Fitness Reimbursement

Blue Cross Blue Shield of Massachusetts, on behalf of your employer group, will reimburse you up to **$200 per participant and up to $400 per family each calendar year** for costs you pay to participate in a qualified fitness program. You can claim this fitness reimbursement for fees paid by any combination of members (such as the subscriber, spouse, and/or dependent children) enrolled under the same Blue Cross Blue Shield of Massachusetts health plan. A qualified fitness program includes services, activities, and products that provide cardiovascular and strength-training benefits.

Reimbursement is provided for:

- Full-service health clubs where you use a variety of cardiovascular and strength-training equipment for fitness.
- Fitness studios where you take instructor-led group classes such as yoga, pilates, zumba, kickboxing, cross-fit, and indoor cycling/spinning; sports/gymnastics camps, teams, or leagues; instructional dance studios; social activity clubs (such as ski, tennis, hiking, running/racing); pool-only facilities; ski passes; and martial arts schools.
- Virtual/online memberships, subscriptions, programs, or classes for fitness using a digital platform.
- Cardiovascular and strength-training equipment for fitness that is purchased for use in the home. This reimbursement is not provided for items that are considered to be recreational equipment and/or sports equipment (such as kayaks, inline skates, ice skates, trampolines, and fitness clothing).

No reimbursement will be provided for any initiation fees or fees or costs you pay for: personal training sessions; country clubs; and spas.

Weight Loss Program Reimbursement

Blue Cross Blue Shield of Massachusetts, on behalf of your employer group, will reimburse you up to **$300 each calendar year** for costs you pay to participate in a qualified weight loss program. You can claim this weight loss program reimbursement for fees paid by any combination of members (such as the subscriber, spouse, and/or dependent children) enrolled under the same Blue Cross Blue Shield of Massachusetts health plan. A qualified weight loss program is a hospital-based or a non-hospital-based weight loss program that focuses on weight loss by modifying eating and physical activity habits and that requires participation in behavioral/lifestyle counseling with nutritionists, registered dieticians, exercise physiologists or other certified health professionals in multiple sessions throughout enrollment in the program. Program delivery and counseling may be in-person, over the phone, or online.

No reimbursement will be provided for any fees or costs you pay for: weight loss programs that do not include sessions with a health professional to support progress toward your weight loss goals; individual nutrition counseling sessions; pre-packaged meals; books; videos; scales; or other weight loss related items or supplies.

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How to Claim Your Reimbursement

To be reimbursed for participation in a qualified wellness program, you must submit your reimbursement request to Blue Cross Blue Shield of Massachusetts no later than March 31st after the year for which you are claiming your reimbursement. To request your reimbursement, you must:

- Fill out a fitness program/weight loss program reimbursement claim form.
- Follow the instructions to submit the completed claim to Blue Cross Blue Shield of Massachusetts.

Reimbursement requests may be mailed to Blue Cross Blue Shield of Massachusetts or submitted online (when available). For additional information on how to file a claim or to get a claim form, log on to the Blue Cross Blue Shield of Massachusetts Web site at **www.bluecrossma.org**.

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

Important Note: Your Blue Cross Blue Shield of Massachusetts health plan does not include health benefits for costs related to activities such as fitness or weight loss programs. This separate Wellness Participation Program offers reimbursement for participation in qualified wellness programs.

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