attached to and made part of
Managed Care Plan Benefit Description
ASC-NET (1-1-2022)

Schedule of Benefits

Network Blue® New England Options

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 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.

This health plan is a tiered network plan.
Your health plan has a tiered provider network called **HMO Blue New England Options**. Under this tiered network plan, your cost share amount for network primary care providers and general hospitals will be different based on the benefits tier of the primary care provider or general hospital you choose to furnish your *covered services*. The *service area* where your *covered services* will be furnished includes all counties in Massachusetts, Connecticut, Maine, New Hampshire, Rhode Island, and Vermont. Your provider directories for the Massachusetts and New Hampshire *service area* show the benefits tier for each network primary care provider and general hospital. All network primary care providers and general hospitals located in Connecticut, Maine, Rhode Island, and Vermont are designated as the lowest cost share benefits tier. See Part 1 for information about how to find a provider in your health care network.

Your cost share amount may depend on the benefits tier of a network provider.
Under this tiered network plan, you will pay the lowest cost share amount when your *covered services* are furnished by a network primary care provider or network general hospital that is designated as an **Enhanced Benefits Tier** provider (or in New Hampshire, a Tier 1 provider). When you select your *primary care provider*, you should consider whether that *primary care provider* admits patients to an Enhanced Benefits Tier hospital, as this will have a direct effect on the amount of your cost. Your cost for *inpatient covered services* is determined by the general hospital's tier status and not based on your *primary care provider's* tier status or the fact that your admitting physician is a network specialist. You may also choose to obtain your *covered services* from a network primary care provider or network general hospital that is designated as a **Standard Benefits Tier** provider (or in New Hampshire, a Tier 2 provider) or a **Basic Benefits Tier** provider. However, your cost share amount for *covered services* furnished by a Standard Benefits Tier primary care provider or network general hospital will usually be more than the cost that you would pay for the same *covered service* if it is furnished by an Enhanced Benefits Tier primary care provider or general hospital. And, likewise, your cost share for *covered services* that are furnished by a Basic Benefits Tier primary care provider or general hospital will usually be more than the cost share that you would pay for the same *covered service* if it is furnished by an Enhanced Benefits Tier provider or a Standard Benefits Tier provider.

Important Note about Select Standard Benefits Tier Hospitals:	The select hospitals as noted in this chart are: Athol Memorial Hospital, Baystate Franklin Medical Center, Berkshire Medical Center, Falmouth Hospital, Martha's Vineyard Hospital, and Nantucket Cottage Hospital.

You have access to emergency medical services at the lowest cost share level. When you have an emergency medical condition, you should receive care at the nearest emergency room of a general hospital. You will pay the lowest cost share amount for *emergency medical care*, regardless of the benefits tier of the general hospital. If you are admitted directly from the emergency room for *inpatient emergency medical care*, you will also pay the lowest cost share amount for your *inpatient* hospital services, even if the general hospital is not an Enhanced Benefits Tier general hospital.

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*.

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.

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

Overall Member Cost Share Provisions	Enhanced Benefits Tier	Standard Benefits Tier	Basic Benefits Tier
Deductible Your *deductible* per *plan year* is:	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		
	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 *plan 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		Enhanced Benefits Tier Your Cost Is:	Standard Benefits Tier Your Cost Is:	Basic Benefits Tier Your Cost Is:
Admissions for Inpatient Medical and Surgical Care	• In a General Hospital Hospital services	\$250 *copayment* per admission	\$500 *copayment* per admission, except \$300 *copayment* per admission for select hospitals	\$1,000 *copayment* per admission
	Physician and other covered professional provider services	No charge		
	• In a Chronic Disease Hospital	\$250 *copayment* per admission for hospital services; no charge for physician and other covered professional provider services		

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

Covered Services		Enhanced Benefits Tier Your Cost Is:	Standard Benefits Tier Your Cost Is:	Basic Benefits Tier 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		
	Physician and other covered professional provider services	No charge		
	• In a Skilled Nursing Facility (100-day *benefit limit* per *member* per calendar year)			
	Facility services	No charge		
	Physician and other covered professional provider services	No charge		
Ambulance Services (ground or air ambulance transport)	• Emergency ambulance	No charge		
	• Other ambulance	No charge		
Cardiac Rehabilitation	*Outpatient* services	$45 *copayment* per visit		
Chiropractor Services (for *members* of any age)	• *Outpatient* lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests		
	• *Outpatient* medical care services, including spinal manipulation (a *benefit limit* does not apply)	$45 *copayment* per visit		
Dialysis Services	• *Outpatient* services by a general hospital	No charge	No charge	No charge
	• *Outpatient* services by other *covered providers* and for home dialysis	No charge		
Durable Medical Equipment	• Covered medical equipment rented or purchased for home use	20%		
	• One breast pump per birth (rented or purchased)	No charge		
		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		

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

Covered Services		Enhanced Benefits Tier Your Cost Is:	Standard Benefits Tier Your Cost Is:	Basic Benefits Tier Your Cost Is:
Emergency Medical Outpatient Services	• Emergency room services	$150 *copayment* per visit; *copayment* waived if held for observation or admitted within 24 hours	$150 *copayment* per visit; *copayment* waived if held for observation or admitted within 24 hours	$150 *copayment* per visit; *copayment* waived if held for observation or admitted within 24 hours
	• Hospital outpatient department services	No charge	No charge	No charge
	• Office, health center, and home services by a primary care provider	$15 *copayment* per visit	$25 *copayment* per visit	$45 *copayment* per visit
		Your cost share amount for services by a physician assistant, nurse practitioner, or nurse midwife employed by a network primary care physician is based on the benefits tier of the primary care physician.		
	by a nurse midwife (not employed by physician); or other physician assistants or nurse practitioners (not employed by physician) designated by the health plan as primary care	$15 *copayment* per visit		
	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	$45 *copayment* per visit		
Home Health Care	Home care program	No charge		
Hospice Services	*Inpatient* or *outpatient* hospice services for terminally ill	No charge		
Infertility Services	• *Inpatient* services	See Admissions for Inpatient Medical and Surgical Care		
	• *Outpatient* surgical services	See Surgery as an Outpatient		
	• *Outpatient* lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests		
	• *Outpatient* medical care services	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		Enhanced Benefits Tier Your Cost Is:	Standard Benefits Tier Your Cost Is:	Basic Benefits Tier Your Cost Is:
Lab Tests, X-Rays, and Other Tests (diagnostic services)	• *Outpatient* lab tests			
	by a general hospital	No charge	No charge	No charge
	by other *covered providers*	No charge		
	• *Outpatient* x-rays and other imaging tests (other than advanced imaging tests)			
	by a general hospital	No charge	No charge	No charge
	by other *covered providers*	No charge		
	• *Outpatient* advanced imaging tests (CT scans, MRIs, PET scans, nuclear cardiac imaging)			
	by a general hospital	$75 *copayment* per category of test per service date	$150 *copayment* per category of test per service date	$250 *copayment* per category of test per service date
	by other *covered providers*	$75 *copayment* per category of test per service date		
	• Other *outpatient* tests and preoperative tests			
	by a general hospital	No charge	No charge	No charge
	by other *covered providers*	No charge		
Maternity Services and Well Newborn Care (includes $90/$45 for childbirth classes)	• Maternity services			
	Facility services (*inpatient* and *outpatient covered services*)	$250 *copayment* per admission for *inpatient* services, otherwise no charge	$500 *copayment* per admission, except $300 *copayment* per admission for select hospitals for *inpatient* services, otherwise no charge	$1,000 *copayment* per admission for *inpatient* services, otherwise no charge
	Physician and other covered professional provider services (includes delivery and postnatal care)	No charge		

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

Covered Services		Enhanced Benefits Tier Your Cost Is:	Standard Benefits Tier Your Cost Is:	Basic Benefits Tier Your Cost Is:
Maternity Services and Well Newborn Care (continued)	• Prenatal care	No charge		
	• Well newborn care during covered maternity admission	No charge		
Medical Care Outpatient Visits (includes syringes and needles dispensed during a visit)	• Office, health center, and home medical services by a primary care provider	$15 *copayment* per visit	$25 *copayment* per visit	$45 *copayment* per visit
		Your cost share amount for services by a physician assistant, nurse practitioner, or nurse midwife employed by a network primary care physician is based on the benefits tier of the primary care physician.		
	• Office, health center, and home medical services by a limited services clinic; or by a nurse midwife (not employed by physician); or other physician assistants or nurse practitioners (not employed by physician) designated by the health plan as primary care	$15 *copayment* per visit		
	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	$45 *copayment* per visit		
	• Hospital outpatient medical services	No charge	No charge	No charge
	• Acupuncture services (12-visit *benefit limit* per *member* per calendar year)	$45 *copayment* per visit		
Medical Formulas	Certain medical formulas and low protein foods	No charge		

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

Covered Services		Enhanced Benefits Tier Your Cost Is:	Standard Benefits Tier Your Cost Is:	Basic Benefits Tier Your Cost Is:
Mental Health and Substance Use Treatment	• *Inpatient* admissions in a General Hospital Hospital services	$250 *copayment* per admission	$500 *copayment* per admission, except $300 *copayment* per admission for select hospitals	$1,000 *copayment* per admission
	Physician and other covered professional provider services	No charge		
	• *Inpatient* admissions in a Mental Hospital or Substance Use Facility Facility services	$250 *copayment* per admission		
	Physician and other covered professional provider services	No charge		
	• *Outpatient* services	$15 *copayment* per visit, except no charge for hospital services		
Oxygen and Respiratory Therapy	• Oxygen and equipment for its administration	No charge		
	• *Outpatient* respiratory therapy by a general hospital	No charge	No charge	No charge
	by other *covered providers*	No charge		
Podiatry Care	• *Outpatient* lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests		
	• *Outpatient* surgical services	See Surgery as an Outpatient		
	• *Outpatient* medical care services	See Medical Care Outpatient Visits		
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):	$15 *copayment* $30 *copayment* $50 *copayment*		
		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.		

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

Covered Services		Enhanced Benefits Tier Your Cost Is:	Standard Benefits Tier Your Cost Is:	Basic Benefits Tier Your Cost Is:
Prescription Drugs and Supplies (continued)	• Mail Order Pharmacy (90-day supply) Tier 1 (generic): Tier 2 (preferred brand): Tier 3 (non-preferred):	\$30 *copayment* \$60 *copayment* \$150 *copayment*		
		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		
	Routine tests	No charge		
		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		
	• Routine adult care Routine medical exams and immunizations	No charge		
	Routine tests	No charge		
		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		
	Routine Pap smear tests (one test per *member* per calendar year)	No charge		
	• Family planning	No charge		

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

Covered Services		Enhanced Benefits Tier Your Cost Is:	Standard Benefits Tier Your Cost Is:	Basic Benefits Tier Your Cost Is:
Preventive Health Services (continued)	• Routine hearing care			
	Routine hearing exams/tests	No charge		
	Newborn hearing screening tests	No charge		
	Hearing aids/related services	Not covered; you pay all charges		
	• Routine vision care			
	Routine vision exams (one exam per *member* every 24 months)	No charge		
	Vision supplies/related services	Not covered; you pay all charges		
Prosthetic Devices	• Ostomy supplies	No charge		
	• Artificial limb devices (includes repairs) and other external prosthetic devices	20%		
Radiation Therapy and Chemotherapy	• Hospital *outpatient* services	No charge	No charge	No charge
	• Free-standing radiation and chemotherapy facility, office, and health center services	No charge		
Second Opinions	*Outpatient* second and third opinions	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)			
	by a general hospital	$45 *copayment* per visit	$45 *copayment* per visit	$45 *copayment* per visit
	by other *covered providers*	$45 *copayment* per visit		
Speech, Hearing, and Language Disorder Treatment	• *Outpatient* diagnostic tests	See Lab Tests, X-Rays, and Other Tests		
	• *Outpatient* speech therapy	See Short-Term Rehabilitation Therapy		
	• *Outpatient* medical care services	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		Enhanced Benefits Tier Your Cost Is:	Standard Benefits Tier Your Cost Is:	Basic Benefits Tier 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	$150 *copayment* per admission	$250 *copayment* per admission	$500 *copayment* per admission
	Ambulatory surgical facility services	$150 *copayment* per admission		
	Physician and other covered professional provider services	No charge		
	• Sterilization procedure for a female *member* when performed as the primary procedure for family planning reasons	No charge	No charge	No charge
	• Office and health center surgical services by a primary care provider	$15 *copayment* per visit	$25 *copayment* per visit	$45 *copayment* per visit
		Your cost share amount for services by a physician assistant, nurse practitioner, or nurse midwife employed by a network primary care physician is based on the benefits tier of the primary care physician.		
	by a nurse midwife (not employed by physician); or other physician assistants or nurse practitioners (not employed by physician) designated by the health plan as primary care	$15 *copayment* per visit		
	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	$45 *copayment* per visit		

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

Covered Services		Enhanced Benefits Tier Your Cost Is:	Standard Benefits Tier Your Cost Is:	Basic Benefits Tier Your Cost Is:
TMJ Disorder Treatment	• *Outpatient* x-rays	See Lab Tests, X-Rays, and Other Tests		
	• *Outpatient* surgical services	See Surgery as an Outpatient		
	• *Outpatient* physical therapy	See Short-Term Rehabilitation Therapy		
	• *Outpatient* medical care services	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*.

attached to and made part of
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.

Your benefits for *outpatient* advanced imaging tests have been changed.

The total amount you pay for *copayments* for *outpatient* advanced imaging tests as shown in your *Schedule of Benefits* and/or *riders* will not exceed $375 per *member* per calendar year.

All other provisions remain as described in your Benefit Description.

attached to and made part of
Your Health Plan Benefit Description

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	Enhanced Benefits Tier	Standard Benefits Tier	Basic Benefits Tier
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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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 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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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.

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Your Health Plan Benefit Description

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.

attached to and made part of
Your Health Plan Benefit Description

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.

Rider 15-422
Durable Medical Equipment

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 durable medical equipment as described in your Benefit Description has been changed. For these *covered services*, you pay 30% *coinsurance*.

All other provisions remain as described in your Benefit Description.

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Rider
Prosthetic Devices

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 prosthetic devices as shown in your *Schedule of Benefits* has been changed. For these *covered services*, you pay nothing.

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.

Rider 18-374
Chiropractor Services

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

The *copayment* amount that you pay for *outpatient* chiropractor services has been changed from the amount described in your Benefit Description to $25 for each covered visit when the *covered services* are furnished by a Maine network chiropractor.

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
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
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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.

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.

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.

MASSACHUSETTS

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.