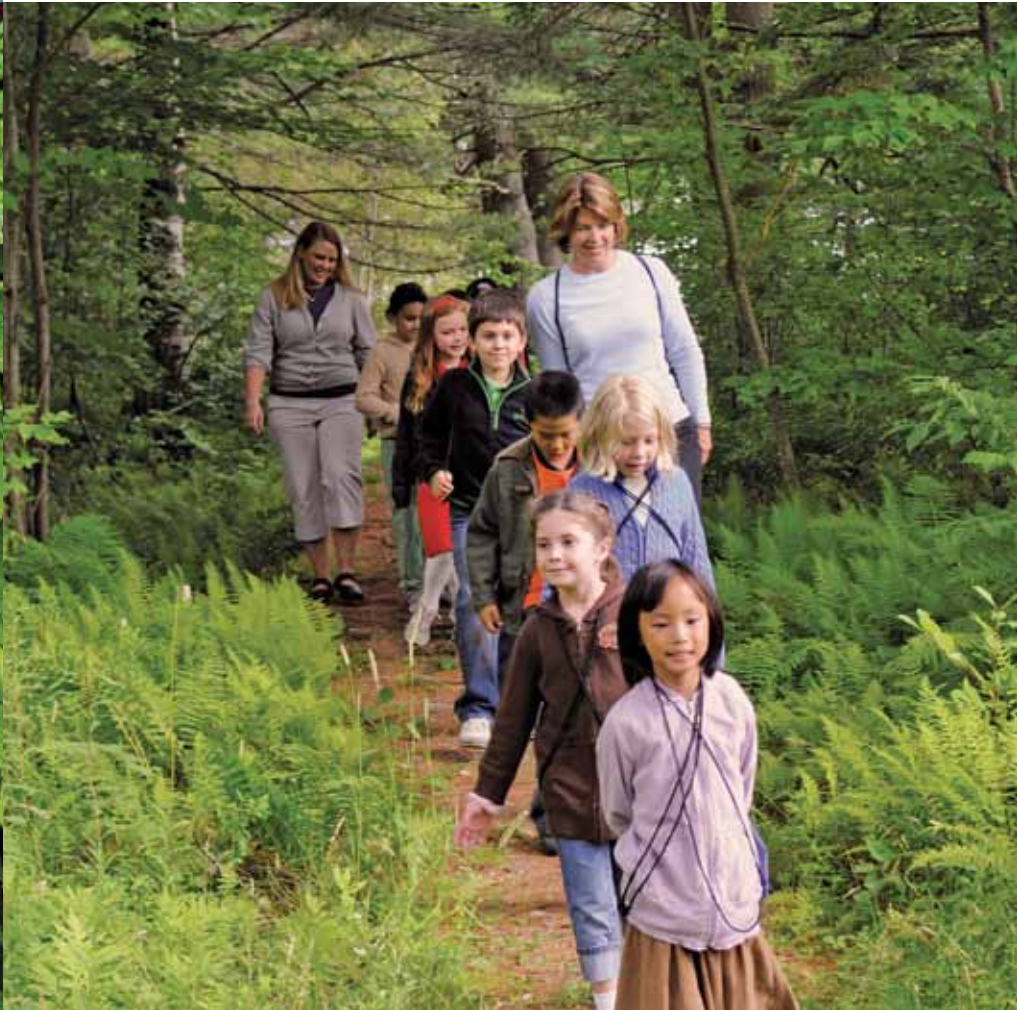




The *signs*
of a healthier Vermont



Plan J and Comprehensive

Certificate of Coverage



This is your Certificate of Coverage, a part of your Contract.

Your Contract governs your Benefits. These are the documents in your Contract:

- This **Certificate of Coverage**, which describes your Benefits in detail and explains requirements, limitations and exclusions for Coverage.
- Your **Outline of Coverage**, which shows what you must pay Providers and which services require Prior Approval.
- Any **riders** or **endorsements** listed on your **Outline of Coverage**, which describe additional Coverage or changes to your Contract.
- Your **ID card**.
- Your **Group Enrollment Form** (your application) and any supplemental applications that you submitted and we approved.

We sometimes replace just one part of your Contract. This Certificate is current until we update it. If you are missing part of your Contract, please call customer service to request another copy.

If the Benefits described in your Contract differ from descriptions in our other materials, your Contract language prevails.

How to Use This Document

- Read Chapter One, "How We Determine Your Benefits." That information applies to all services. Pay special attention to the "Prior Approval Program" on page 6.
- Find the service you need in Chapter Two, "Covered Services." You may use the Index or Table of Contents to find it. Read the section thoroughly.
- Check "General Exclusions" to be sure the service you need is not on this list.
- To find out what you must pay for a service or supply and whether you need Prior Approval, check your Outline of Coverage.
- Please remember that to know the full terms of your Coverage, you should read your entire Contract.
- Some terms in your Certificate have special meanings. We capitalize these terms in the text. We define them in the last chapter of this booklet. Read "Definitions" to fully understand your Coverage. The terms "we," "us," "our," "include(s)," "including," "you" and "your" are also defined, but not capitalized in the text.
- If you need materials translated into a different language or if you need translation services to work with our customer service department, call the customer service number on the back of your ID card.

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After we accept your application, we Cover the health care Services in your Contract, subject to all Contract conditions.

Coverage continues from month to month until your Contract is discontinued, terminated or voided as allowed by its provisions. (See Chapters Seven and Eight.)



Guy Boyer
Chair of the Board



Don C. George
President and CEO



Christopher Gannon
General Counsel & Secretary



CHAPTER ONE

Guidelines for Coverage

This Certificate describes Benefits under your health plan. You have a Plan J, Comprehensive or HSA Blue Plan issued by Blue Cross and Blue Shield of Vermont. If you have Plan J, you will see the Plan J Rider on your Outline of Coverage and you will find that rider with your Contract documents. If you have HSA Blue, we will include an HSA rider. If you have neither rider, you have a regular Comprehensive program.

Chapter One explains what you must do to get Benefits through your health plan. Your Outline of Coverage shows what you must pay. Read this entire chapter carefully, as it is your responsibility to follow the guidelines it lists.

General Guidelines

As you read your Contract, please keep these facts in mind:

- Some terms in your Certificate have special meanings. We capitalize these terms in the text. We define them in the last chapter of this booklet. Read “Definitions” to fully understand your Coverage. The terms “we,” “us,” “our,” “include(s),” “including,” “you” and “your” are also defined, but not capitalized in the text.
- To receive Benefits, the Services you receive must be Covered Services under this Contract. You must also use Providers (see our definition). For some Services, the Providers must be Participating Providers. For other Services, Providers must belong to one of our Networks, except as otherwise provided by law.

- Certain Services are excluded from Coverage under this Contract. General exclusions are set forth in Chapter Three. Specific exclusions may be listed in other sections of your Contract.
- Subject to your rights under the law, including the right to appeal a denial of Benefits, only those Services that we deem to be Medically Necessary are Covered.
- This is not a long-term care policy as defined by Vermont State law at 8 V.S.A. §8082 (5).
- Subject to your rights under the law, including the right to appeal a denial of Benefits, we have the authority to interpret and apply the terms of the Contract and to determine whether and to what extent you have Coverage for a requested Service, even when a Provider has prescribed or recommended the Service.
- You must follow the guidelines in this Certificate even if this Coverage is secondary to other health care Coverage for you or one of your Dependents.

Pre-certification

You or your Provider must notify us if you have an Inpatient hospital stay. Calling us may protect you from having to pay for unnecessary and nonCovered stays. See page 18 for requirements for obtaining Inpatient Mental Health and Substance Abuse treatment Benefits.

Call (800) 922-8778:

- two weeks before a scheduled Inpatient admission (notify us if your admission or Service date changes);
- within 48 hours or as soon as reasonably possible after an emergency or maternity admission;

- within 48 hours or as soon as reasonably possible after the mother's discharge from the hospital if the newborn is not discharged at the same time.

Throughout your hospitalization, we monitor the length of your Inpatient stay. If you choose to remain Inpatient after we determine that continued hospitalization is not Medically Necessary or your level of care is inappropriate, you may have to pay all charges after the date we determined you could have left the Inpatient Facility.

Notes:

- A family member, Physician or Facility may make precertification calls for you.
- Call the number on the back of your ID card for Mental Health or Substance Abuse treatment admissions.

Prior Approval Program

BCBSVT requires Prior Approval for certain Services and drugs. **If you do not get approval in advance, your care will not be Covered. Prior Approval is not required for Emergency Services, although we request that you or your Provider contact us as soon as possible. See definition of Emergency Services on page 53.** See your Outline of Coverage for the list of Services that require Prior Approval. Obtaining Prior Approval for these Services ensures that they are diagnostically appropriate, Medically Necessary and cost-effective.

Our Prior Approval list can change and will be updated from time to time. We will inform you of changes using newsletters and other mailings. To get the most up-to-date listing, you may visit our website at www.bcbsvt.com or call customer service at the number on the back of your ID card.

To get Prior Approval, you or your Physician must send a letter with supporting documentation to BCBSVT. Our approval request forms can help you make your request. The forms are available on our website at www.bcbsvt.com or by calling our customer service department. Your

Provider may also help you fill out the form and give you other information you need to submit your request. The medical staff at BCBSVT will review the information and respond in writing to you and to your doctor.

We do not allow Benefits for Services that require Prior Approval if you do not get Prior Approval.

Prior Approval for Mental Health Services and Substance Abuse Treatment Services

You must get Prior Approval from us before you receive Inpatient or Outpatient treatment. Prior Approval is not required for Emergency Services, although we request that you or your Provider contact us as soon as possible. See definition of Emergency Services on page 53. Call the number on the back of your ID card to get approval from our Mental Health and Substance Abuse Network. We will not Cover Mental Health Services or Substance Abuse treatment unless you obtain Prior Approval and are treated by a Professional or Facility Provider in the Network.

Case Management Program

Our specialty case management program is a voluntary program available in certain circumstances. Your case manager will work with you, your family and your Physician to coordinate the medical care most appropriate for you.

Understanding the components of your health plan's Coverage can be confusing. Your case manager will work as an advocate, assisting you in managing the Benefits you receive through your health plan, as well as identifying other programs, Services and support systems available to you. For more information or to determine if you are eligible for the program, call 1-800-922-8778 and choose option 1.

Choosing a Provider

You may usually select any Provider you want

to use for a Service you need. However, for some types of Services, you must choose a Participating Provider or you will have no Benefits, except as otherwise provided by law.

For many types of care, you may use Non-participating Providers (see “Non-participating Providers” on page 7). If you do, however, you may pay more of the cost of your care, except as otherwise provided by law.

Participating Providers

Here’s how choosing a Participating Provider helps you:

- Participating Providers bill us directly for your Services, so you don’t have to do the paperwork to submit a claim;
- Participating Providers do not ask for payment at the time of Service (except for Deductible, Coinsurance or Co-payments you owe); and
- Participating Providers accept our Allowed Price as full payment. You do not have to pay the difference between their total charge and our Allowed Price.

Non-participating Providers

If you use a Non-participating Provider **and the Service is Covered when performed by a Non-participating Provider**, we pay our Allowed Price and you must pay any balance between the Provider’s charge and what we pay. You must also pay Deductibles and Coinsurance, which may be higher for Coverage of Services by Non-participating Providers, except as otherwise provided by law. (See your Outline of Coverage.)

If you use one of the following Providers that is not a Participating Provider, we will not Cover your care and you must pay the full cost:

- athletic trainers
- cardiac rehabilitation Providers;
- Chiropractors;
- home infusion therapy Providers;

- certified nurse midwives (not lay or professional midwives, whose Services are not Covered);
- nutritional counseling Providers (including registered dietitians, licensed nutritionists, medical doctors, doctors of osteopathy, naturopathic physicians, certified diabetic educators and nurse practitioners);
- Physical Rehabilitation Facilities; and
- Skilled Nursing Facilities.

Out-of-State Providers

Providers located out of state that have a Participating Provider agreement with another Blue Cross and Blue Shield plan are also Participating with us. See “The BlueCard Program” on page 9.

The local plan determines which Providers are Participating. To find out which Providers are Participating Providers in a given state, you may call the customer service department number listed on your ID card or consult a Participating Provider directory for the region where you will seek Service. To obtain a copy of a directory for a plan in another state, call the BlueCard ACCESS Provider Locator at 1-800-810-BLUE (2583) or visit www.bluecares.com.

Network Providers

We have special Networks for some types of Providers. For example, we have a Network of Mental Health and Substance Abuse treatment Providers. **You receive Mental Health and Substance Abuse treatment Benefits only if you use a Provider in our Mental Health Network. The Mental Health Network of Providers is separate from our Participating Provider Network.**

If you have a Prescription Drug rider, you may be required to use Network Pharmacies to get Coverage for Prescription Drugs. Read all the documents included with your Contract carefully. Your Outline of Coverage lists the riders included in your Contract. Call our customer service department at the number on the back of your ID card if you

have questions.

How We Determine Your Benefits

When we receive your claim, we determine:

- If this Contract Covers the Medical Services you received; and
- your Benefit amount.

In general, we pay our Allowed Price (explained later in this section). We may subtract any:

- Benefits paid by Medicare;
- Deductibles (explained below);
- Co-payments (explained below);
- Coinsurance (explained below);
- any amounts paid or due from other insurance carriers through coordination of Benefits (refer to Chapter Six).

Your Deductible, Coinsurance and Co-payment amounts are shown on your Outline of Coverage. We may limit Benefits to any calendar year or lifetime maximums shown on your Outline of Coverage.

Payment Terms

Allowed Price

The Allowed Price is the amount we consider reasonable for a Covered Service or supply.

Note:

- Participating Providers accept our Allowed Price as full payment. You do not have to pay the difference between their total charge and our Allowed Price.
- If you use a Non-participating Provider, we pay our Allowed Price and you must pay any balance between the Provider's charge and what we pay.

Deductible

Your Deductible amounts are listed on your Outline of Coverage. You must meet your Deductibles each calendar year before we make payment on certain Services. We apply your Deductible to

your out-of-pocket limit for each calendar year. Your Deductible amount may change during the year if your Group changes your plan on the Group anniversary date.

Some plans limit the amount of Deductible a family must pay in a calendar year. If your plan has a family Deductible, it is listed on your Outline of Coverage. When your family meets the family Deductible, all family members are considered to have met their individual Deductibles.

Co-payment

You must pay Co-payments to Providers for specific Services shown on your Outline of Coverage. Your Provider may require payment at the time of the Service. We do not apply Co-payments toward your out-of-pocket limit.

Coinsurance

You must pay Coinsurance to Providers for specific Services shown on your Outline of Coverage. We calculate the Coinsurance amount by multiplying the Coinsurance percentage by the Allowed Price after you meet your Deductible. We apply your Coinsurance toward your out-of-pocket limit for each calendar year.

Out-of-Pocket Limit

Your Outline of Coverage lists your out-of-pocket limit, if you have one. The out-of-pocket limit is made up of Deductibles and Coinsurance. After you meet your out-of-pocket limit, you pay no Coinsurance for the rest of that calendar year. You will still be responsible for Co-payments, when they apply.

If your plan has a family out-of-pocket limit, it is listed on your Outline of Coverage. When your family meets the family out-of-pocket limit, all family members are considered to have met their individual out-of-pocket limits.

Calendar Year and Lifetime Benefit Maximums

Your calendar year and lifetime Benefit maximums are listed on your Outline of Coverage.

The lifetime maximum is the total amount we will provide for each enrolled individual, even if your employer offers more than one health plan Benefit option. The Benefit limits in your Outline of Coverage apply across all such plan options unless your employer's summary plan description states otherwise. After we have provided maximum Benefits, you must pay all charges. Please contact your employer if you have questions about the content of the summary plan description associated with this Certificate.

The BlueCard Program

Blue Cross and Blue Shield plans contract with Providers in every state in the country, as well as in nearly 200 countries worldwide. We can take advantage of discounts negotiated by other Blue Cross and Blue Shield plans. When you receive health care Services outside the geographic area we serve, we coordinate claims processing with the out-of-area Blue Cross and Blue Shield plans through the BlueCard Program. The amount you pay for Covered Services is usually calculated on the lower of:

- the actual billed charges for your Covered Services; or
- the negotiated price that the local Blue Cross and/or Blue Shield Plan passes on to us.

Often, this "negotiated price" will consist of a simple discount. But sometimes it is an estimated final price that factors in expected settlements or other non-claims transactions with your health care Provider or with a specified group of Providers. The negotiated price may also be a discount from billed charges that reflects average expected savings. The estimated or average price may be prospectively adjusted to correct for over- or underestimation of past prices.

In addition, laws in a small number of states require Blue Cross and/or Blue Shield plans to use a basis for calculating your payment for Covered Services that does not reflect the entire savings realized or expected to be realized on a particular claim. When you receive Covered health care Services in those states, your required payment for these Services will be calculated using their statutory methods.

CHAPTER TWO

Covered Services

Note:

Chapter Two describes Covered Services, guidelines and policy rules for obtaining Benefits. Please refer to your Outline of Coverage for Benefit maximums and payment terms such as Co-payments and Deductibles.

For information about Mental Health Providers' Services, please read the "Mental Health Care" section. Limitations may apply, so please read each section of this Certificate carefully.

For members who participate in approved cancer clinical trials, we Cover routine medical costs as required by law. The cancer trial itself is not Covered by your health plan.

Ambulance

We provide Benefits for Ambulance Services as long as your condition meets our definition of an Emergency Medical Condition.

We Cover transportation of the sick and injured:

- to the nearest Facility from the scene of an accident or medical emergency; or
- between Facilities or between a Facility and home (but not solely according to the patient's or the Provider's preference).

Limitations

- You must get Prior Approval for Services listed on your Outline of Coverage including certain Ambulance Services, or your care will not be Covered. You do not need Prior Approval if your condition meets our definition of an Emergency Medical Condition. You do need Prior Approval for non-emergency transport.
- To receive Benefits, your Services must meet guidelines in Chapter One.

- We Cover transportation only to the closest Facility that can provide Services appropriate for the treatment of your condition.
- We do not Cover Ambulance Service when the patient can be transported by private car, whether or not a private car is available.

Chiropractic Services

We Cover care by Chiropractors who are:

- in our Participating Provider Network;
- working within the scope of their licenses; and
- treating you for a neuromusculoskeletal condition (that is, a condition of the bones, joints or muscles).

We Cover Acute and Supportive chiropractic Care, including:

- office visits, spinal and extraspinal manipulations and associated modalities;
- home, hospital or nursing home visits; or
- Diagnostic Services (e.g., labs and X-rays).

Requirements and conditions that apply to Coverage for Services by Providers other than Chiropractors also apply to this Coverage. If you use more than 12 chiropractic visits in one calendar year, you must get Prior Approval from us for any visits after the 12th. Please have your Chiropractor submit a treatment plan with a written request for Prior Approval to BCBSVT Medical Services, P.O. Box 186, Montpelier, VT 05601-0186 or fax to (802) 371-3491. See page 6 for more information about the Prior Approval program.

Exclusions

We provide no chiropractic Benefits for:

- Wellness (Maintenance) Chiropractic Care (see Definitions);
- treatment after the 12th visit if you don't get Prior Approval;
- Services by a Provider who is not in our Participating Provider Network;
- Services, including modalities, that do not require the constant attendance of a Chiropractor;
- treatment of any "visceral condition," that is a dysfunction of the abdominal or thoracic organs, or other condition that is not neuromusculoskeletal in nature;
- acupuncture;
- massage therapy;
- care provided but not documented with clear, legible notes indicating patient's symptoms, physical findings, Physician's assessment, and treatment modalities used (billed);
- low-level laser therapy, which is considered Investigational;
- vertebral axial decompression (i.e. DRS System, DRX 9000, VAX-D Table, alpha spina system, lordex lumbar spine system, internal disc decompression (IDD)), which is considered Investigational;
- supplies or Durable Medical Equipment;
- treatment of a Mental Health Condition;
- prescription or administration of drugs;
- obstetrical procedures including prenatal and postnatal care;
- Custodial Care (see Definitions), as noted in General Exclusions;
- Surgery; or
- any other procedure not listed as a Covered chiropractic Service.

Please remember that General Exclusions in Chapter Three also apply.

Dental Services

You must get Prior Approval from us for the Services listed on your Outline of Coverage, including dental Services or your care will not be Covered. In the event of an emergency, you must contact us as soon as possible afterward for approval of continued treatment. We Cover only the following dental Services:

- treatment for or in connection with an accidental injury to jaws, sound natural teeth, mouth or face provided a continuous course of dental treatment is started within six months of the accident.
Note: A sound, natural tooth is a tooth that is whole or properly restored (restoration with amalgams only); is without impairment, periodontal conditions, or other conditions; and is not in need of treatment provided for any reason other than accidental injury. A tooth previously restored with a crown, inlay, onlay or porcelain restoration, or treated by endodontics, is not a sound natural tooth;
- Surgery to correct gross deformity resulting from major disease or Surgery. Surgery must take place within six months of the onset of disease or within six months after Surgery, except as otherwise required by law.

Exclusions

Unless expressly Covered in other parts of this Contract or required by law, we do not Cover:

- Surgical removal of teeth, including removal of wisdom teeth;
- gingivectomy;
- tooth implants;
- care for periodontitis;
- injury to teeth or gums as a result of chewing or biting;
- pre- and post-operative dental care;

- orthodontics (including orthodontics performed as an adjunct to orthognathic Surgery); procedures designed primarily to prepare the mouth for dentures (including alveolar augmentation, bone grafting, frame implants and ramus mandibular stapling); or charges related to non-Covered dental procedures (for example, facility charges, except when Medically Necessary for children under five years old or members with disabilities or medical conditions which prevent care from being safely delivered in an office setting, or anesthesia).
- General Exclusions in Chapter Three also apply.
- imaging (radiology, X-rays, ultrasound and nuclear imaging);
 - studies of the nature and cause of disease (laboratory and pathology tests);
 - medical procedures (ECG and EEG);
 - allergy testing (percutaneous, intracutaneous, patch and RAST testing);
 - mammography; and
 - hearing tests by an audiologist only if your doctor suspects you have a disease condition (see exclusion number 35 in General Exclusions).
- Note:** Screening mammography is Covered as indicated on your Outline of Coverage.

Diabetes Services

We provide Benefits for Services for treatment of diabetes. For example, we Cover syringes, insulin, nutritional counseling, Outpatient self-management training and education for people with diabetes. We pay Benefits subject to the same terms and conditions we use for other medical treatments.

Nutritional counseling must be provided by one of the following Participating Providers or your care will not be Covered:

- medical doctor (M.D.);
- doctor of osteopathy (D.O.);
- registered dietitian (R.D.);
- nutritionist licensed in Vermont;
- certified diabetic educator (C.D.E.);
- naturopathic physician (N.D.); or
- nurse practitioner.

General Exclusions in Chapter Three also apply.

Diagnostic Services

You must get Prior Approval for special radiology procedures (including CT, MRI, MRA, MRS and PET scans) and polysomnography (sleep studies) or your care will not be Covered.

We Cover the following Diagnostic Services (tests to help find or treat a condition):

Emergency Care

We Cover Services you receive in the emergency room of a General Hospital when you need treatment for an Emergency Medical Condition.

Requirements

We provide Benefits only if you require Emergency Services as defined in this Certificate. We do not provide Benefits for the emergency room if Services do not meet the definition of Emergency Services on page 53.

Home Care

We Cover the Acute Services of a Home Health Agency or Visiting Nurse Association that:

- performs Medically Necessary skilled nursing procedures in the home;
- trains your family or other caregivers to perform necessary procedures in the home; or
- performs Physical, Occupational or Speech Therapy.

We also Cover:

- Services of a home health aide (for personal care only) when you are receiving skilled nursing or therapy Services;

- other Medically Necessary Services (except drugs and medications) furnished and billed by a Home Health Agency or Visiting Nurse Association; and
- home infusion therapy (only if you get Prior Approval).

For more information about therapy Services, see page 22.

Private Duty Nursing

You must get Prior Approval for private duty nursing or your care will not be Covered. We Cover skilled nursing Services by a private-duty nurse outside of a hospital, subject to these limitations:

- We limit Benefits for private duty nursing to \$2,000 per member, per year.
- We provide Benefits only if you receive Services from a registered or licensed practical nurse.

We do not Cover private duty nursing Services provided at the same time as home health care nursing Services.

Requirements

We Cover home care Services only when your Physician:

- approves a plan of treatment for a reasonable period of time;
- includes the treatment plan in your medical record;
- certifies that the Services are not for Custodial Care; and
- re-certifies the treatment plan every 60 days.

We do not Cover home care Services if these Services can be provided by the member or a lay care giver with the appropriate training, which may be provided as noted above.

Also, we provide Benefits only if the patient, or a legally responsible individual, consents in writing to the home care treatment plan.

Limitations

You must get Prior Approval for home infusion therapy or your treatment will not be Covered. We provide Benefits for home infusion therapy only if:

- your Physician prescribes a home infusion therapy regimen;
- you use Services from a Participating home infusion therapy Provider; and
- you get Prior Approval.

We provide no Benefits for a Provider to administer therapy when the patient or an alternate caregiver can be trained to do so.

Exclusions

We provide no home care Benefits for:

- homemaker Services;
- drugs or medications except as noted above (although drugs and medications are not Covered under your home care Benefits, they may be Covered by your Prescription Drug Benefits if you have a rider).
- Custodial Care (see Definitions), as noted in General Exclusions;
- food or home-delivered meals; and
- private duty nursing Services provided at the same time as home health care nursing Services.

General Exclusions in Chapter Three also apply.

Hospice Care

We Cover the following Services provided by a Hospice Provider and included in its bill:

- up to two skilled nursing visits per day;
- up to 100 hours per month of home health aide Services for personal care Services only;
- up to 100 hours per month of homemaker Services for house cleaning, cooking, etc;
- up to five days or 120 hours of continuous care Services in your home;

- up to 72 hours per month of Respite Care Services;
- up to six social service visits before the patient's death and up to two bereavement visits following the patient's death (for counseling and emotional support, assessment of social and emotional factors related to the patient's condition, assistance in resolving problems, assessment of financial resources, and use of available community resources); and
- other Medically Necessary Services.

Requirements

We only provide Benefits if:

- a Physician certifies that the illness has a prognosis of six months life expectancy or less;
- the patient and the Physician consent to the Hospice care plan; and
- a primary caregiver (family member or friend) will be in the home.

Hospital Care

Note on Mental Health and Substance Abuse Treatment Services: The description of Services below does not apply to Inpatient or Outpatient Mental Health and Substance Abuse treatment. The requirements for Mental Health Benefits are listed on page 18. Requirements for Substance Abuse treatment Benefits are listed on page 21.

Inpatient Hospital Services

We Cover Acute Care during an Inpatient stay in a General Hospital or Participating Skilled Nursing Facility including:

- room and board;
- "ancillary" Services, such as tests done in the hospital; and
- supplies, including drugs given to you by the hospital or Skilled Nursing Facility during a Covered stay.

We Cover either the day of admission or the day of discharge, but not both. Certain Inpatient Services require Prior Approval. Please see your Outline of Coverage for a list of these Services. You must comply with our precertification program when you have an Inpatient stay. See page 5 for pre-certification program requirements.

This section explains Benefits for charges by the hospital only. We also Cover care by Physicians and other Professionals while you are in the Hospital. See "Physician (and Other Professionals') Services" for a description of that Coverage.

Requirements

We provide Benefits only if you:

- receive Acute Care in the Facility; and
- use only Participating Skilled Nursing Facilities.

Outpatient Services

You must get Prior Approval for the Services listed on your Outline of Coverage, including certain radiology procedures (including CT, MRI, MRA, MRS and PET scans) and polysomnography (sleep studies) or your care will not be Covered.

We Cover Services such as chemotherapy, Outpatient Surgery, diagnostic testing (like x-rays), or other Outpatient care in a General Hospital or ambulatory surgical center including:

- Facility Services;
- Professional Services; and
- related supplies.

Check your Outline of Coverage to see if you need Prior Approval for the Service you need. Instructions for seeking Prior Approval are on page 6. For more information about therapy Services, see page 22.

Other sections of this Certificate may explain Coverage for care you receive as an Outpatient. Please refer to the kind of treatment you need (for example, "**Emergency Care**" or "**Therapy**"). Also check your Outline of Coverage to see if you need Prior Approval for the Service you need.

Maternity

Your hospital Benefits Cover your Inpatient maternity stay. (See “Inpatient Hospital Services” above for a description of your hospital Benefits.) We also Cover the following care by a Physician or other Professional during a woman’s pregnancy:

- prenatal visits and other care;
- delivery of a baby;
- postnatal visits; and
- well-baby care and an initial hospital visit for the baby while you are an Inpatient.

We provide Benefits for home delivery or delivery in a Facility when you use a Covered Provider. We provide Benefits for Services by certified nurse midwives (not lay or professional midwives) only if they are Participating Providers.

Our Allowed Price for delivery of a baby includes all of the Services listed above. This allowance is called a “global fee.” If you change Providers during your pregnancy, we will divide this fee appropriately. In addition to the Services included in the global fee, we Cover care for complications of pregnancy.

We Cover newborns under this Contract for up to 31 days after birth. (Refer to Chapter Seven for information on how to continue Coverage for your newborn past this period.)

Please see page 5 for pre-certification requirements. You must call for pre-certification when you have a maternity stay.

Better Beginnings® Maternity Wellness Program

The Better Beginnings program helps expectant mothers and their babies get the best care before and after the babies are born. If you participate in this program, we provide a selection of Benefit options designed for your circumstances. Benefit options include:

- breastfeeding/back to work
- twins/multiples
- English as second language

Other options are available. Call customer service at the number on the back of your ID card or visit www.bcbsvt.com for the available options. To join the program, call customer service as soon as possible during your pregnancy. You get the most out of the Better Beginnings program when you contact us in the first three months of your pregnancy.

Notes:

- We Cover Professional Services of a Participating certified nurse midwife (but not a lay or professional midwife) or a Physician for home delivery of a baby.
- We may provide Benefits through the Better Beginnings program for Services that we do not generally Cover, such as electric breast pump purchase, lactation consultant Services or homemaker Services. (These Services are described in the packet you receive when you join Better Beginnings.) The fact that we provide special Benefits in one instance does not obligate us to do so again.
- We offer the Services of a nurse case manager to members who would Benefit from more support and monitoring.

Medical Equipment and Supplies

Durable Medical Equipment (DME)

You must get Prior Approval for continuous passive motion (CPM) equipment, TENS units or Durable Medical Equipment with a purchase price over the dollar amount specified on your Outline of Coverage or your DME will not be Covered. We Cover Durable Medical Equipment you purchase from a:

- medical doctor (M.D.);
- doctor of osteopathy (D.O.);
- therapist (physical or occupational);
- podiatrist (D.P.M.);

- naturopathic physician (N.D.); or
- Durable Medical Equipment supplier.

We provide Benefits for the rental or purchase of Durable Medical Equipment. We reserve the right to determine whether rental or purchase of the equipment is more cost-effective and/or appropriate. The total rental Benefits may not exceed our Allowed Price for the purchase of the equipment.

Supplies

We Cover medical supplies such as needles and syringes and other supplies for treatment of diabetes, dressings for cancer or burns, catheters, colostomy bags and related supplies and oxygen, including equipment Medically Necessary for its administration.

Orthotics

You must get Prior Approval for the Services listed on your Outline of Coverage, including orthotics, or they will not be Covered. When you get Prior Approval, we provide Benefits for molded, rigid or semi-rigid support devices that restrict or eliminate motion of a weak or diseased body part.

Prosthetics

You must get Prior Approval for the Services listed on your Outline of Coverage, including prosthetics, or they will not be Covered. We provide Benefits for the purchase, fitting, necessary adjustments, repairs and replacements of prosthetics. We Cover a device (and related supplies) only when the device is surgically implanted or worn as anatomic supplement to replace:

- all or part of an absent body organ (including contiguous tissue and hair);
- hair lost due to chemotherapy or disease (excluding male pattern baldness);
- the lens of an eye; or
- all or part of the function of a permanently inoperative, absent or malfunctioning body part.

The Benefit Covers prosthetic devices that are attached to (or inserted into) prosthetic shoes, and

which replace a missing body part.

We only provide Benefits for eyeglasses or contact lenses that replace the lens of an eye when the lens was not replaced at the time of Surgery. We Cover only:

- one set of accompanying eyeglasses or contact lenses for the original prescription; and
- one set for each new prescription.

Also, we provide Benefits for dental prostheses only if required:

- to treat an accidental injury (except injury as a result of chewing or biting); or
- to correct gross deformity resulting from major disease or Surgery;
- to treat obstructive sleep apnea; or
- to treat craniofacial disorders, including temporomandibular joint syndrome.

Exclusions

We provide no Benefits for:

- prosthetics or orthotics for which you have not received Prior Approval from us;
- dental appliances or dental prosthetics, except as listed above;
- shoe insert orthotics, lifts, arch supports or special shoes not attached to a brace;
- custom-fabricated or custom-molded knee braces (pre-fabricated, "off-the-shelf" braces are Covered);
- dynamic splinting, continuous passive motion equipment (unless you get Prior Approval) and programmable or variable motion or resistance devices;
- any treatment, DME, supplies or accessories intended principally for participation in sports or recreational activities or for personal comfort or convenience;
- repair or replacement of dental appliances or dental prosthetics; and

- eyeglasses or contact lenses, except when necessary to replace the lens of the eye (and the lens was not replaced at the time of Surgery).

General Exclusions in Chapter Three also apply.

Note:

To be sure your item meets our definition of Durable Medical Equipment, you may call our customer service department before purchasing a DME item.

Mental Health Care

You must use a Network Provider and get Prior Approval for the Services listed on your Outline of Coverage, including all Mental Health Services (except Emergency Services) or your care will not be Covered. We provide Benefits for Outpatient Mental Health Services including:

- individual and group Outpatient psychotherapy;
- family and couples therapy;
- Intensive Outpatient Programs;
- partial hospital day treatment;
- psychological testing when integral to treatment; and
- psychotherapeutic programs directed toward improving compliance with prescribed medical treatment regimens for such chronic conditions as diabetes, hypertension, ischemic heart disease and emphysema.

We provide Benefits for Inpatient Mental Health care Services including:

- hospitalization; and
- Residential Treatment Programs.

We provide Benefits for Mental Health Services only if:

- you obtain Prior Approval for all Mental Health Services (except Emergency Services) by calling the number on the back of your ID card;
- you receive care from Network Mental Health Providers;

- care is provided in the least restrictive setting Medically Necessary; and
- there is clear, measurable progress toward a rehabilitative goal, a less restrictive setting or other Medically Necessary goal.

If you are outside Vermont and need Mental Health Services, the above guidelines still apply. The phone number for our Mental Health Network is on the back of your ID card. You do not need Prior Approval for Emergency Services. Call as soon as possible after the emergency to arrange follow-up care. When you call, you can get the name of a Provider in our Mental Health Network.

Mental Health Exclusions

The plan provides no Mental Health Benefits for:

- Services from Mental Health Providers that are not members of our Mental Health Network, except as otherwise provided by law;
- treatment we do not approve in advance;
- treatment without ongoing concurrent review to ensure that treatment is being provided in the least restrictive setting required;
- non-traditional, alternative therapies such as eye movement desensitization, Rubinfeld Synergy, energy polarity therapy and somatization therapy, that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories;
- Services, including residential programs, adventure-based activities and wilderness programs, that focus on education, socialization or delinquency;

- Custodial Care, including housing that is not integral to a Medically Necessary level of care or care solely to comply with a court order, to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite, unless such care is Medically Necessary (see Definitions), as noted in General Exclusions; and
- biofeedback, pain management, stress reduction classes and pastoral counseling.

Remember that the General Exclusions in Chapter Three also apply.

Cosmetic and Reconstructive Procedures

We exclude many types of Cosmetic procedures (see exclusions in Chapter Three).

You need Prior Approval for the Services listed on your Outline of Coverage, including plastic/Cosmetic or Reconstructive procedures or your care will not be Covered. Your Benefits include Reconstructive procedures that are not just plastic/Cosmetic. (Please see the definitions of Reconstructive and Cosmetic.) For example, we Cover:

- Reconstruction of a breast after breast Surgery;
- Surgery and Reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses (which we Cover under Medical Equipment and Supplies on page 16) and treatment of physical complications resulting from breast Surgery.

Nutritional Counseling

There is no limit on the number of visits for nutritional counseling for treatment of diabetes. For all other nutritional counseling, we Cover up to three Outpatient nutritional counseling visits

each calendar year.

Nutritional counseling must be provided by one of the following Participating Providers or your care will not be Covered:

- medical doctor (M.D.);
- doctor of osteopathy (D.O.);
- registered dietitian (R.D.);
- nutritionist licensed in Vermont;
- certified diabetic educator (C.D.E.);
- naturopathic physician (N.D.); or
- nurse practitioner.

Optometry Services

We Cover Services by an optometrist only when he or she finds or reasonably suspects a disease condition of the eye and refers you to a Physician for treatment of that condition. We Cover your visit to an optometrist in the same way we Cover visits to Physicians performing Covered eye care.

We don't Cover eyeglasses, contact lenses or any examination for the prescription, fitting or determination of need for eyeglasses or lenses unless you need them to replace the lens of the eye and the lens was not replaced at the time of Surgery (see Prosthetics, page 17).

If you need lenses to replace the lens of the eye, we will Cover only one pair of lenses per prescription.

Physician and Professional Services

Inpatient Medical Services

We Cover Services by a Physician or Professional Provider who sees you when you are an Inpatient in a hospital or Skilled Nursing Facility. In a General Hospital, these Services may include:

- Surgery (see below);
- Services of an assistant surgeon when necessary;
- anesthesia Services for Covered procedures;
- intensive care; or

- other specialty care when you need it.

Notes on Surgery:

You must get Prior Approval for the Services listed on your Outline of Coverage, including plastic/Cosmetic and Reconstructive procedures or your care will not be Covered. We Cover sterilization procedures (vasectomy or tubal ligation) even though they are not Medically Necessary.

We limit Surgery Benefits as follows:

- We make global payments for some Surgeries and other procedures. This means that our Allowed Price for the Surgery includes payment for all office visits and other care that is related to the Surgery.
- Subject to Medical Necessity, we may limit the number of visits we Cover by one Provider in a given day.
- If you have several Surgeries at the same time, we may not pay a full allowance for each one. If you have questions about the way we determine our Allowed Price for Surgery, please call customer service at then number on the back of your ID card.
- We Cover Services of a Participating certified nurse midwife (not a lay or professional midwife) or a Physician for home delivery of a baby.
- We exclude many Cosmetic procedures (see General Exclusions in Chapter Three).

Outpatient Medical Services

We Cover care you receive from a Physician or Professional when you are not an Inpatient. These visits include:

- Surgery (see notes on page 20);
- Services of an assistant surgeon when necessary;

- anesthesia Services for Covered procedures.

Limitations

We Cover only up to eight hours of neuropsychological testing per calendar year.

We Cover an audiologist's laboratory hearing test only if your Physician refers you to an audiologist when he or she finds or reasonably suspects a disease condition of the ear or injury of the ear.

Note on Mental Health and Substance Abuse Treatment Services: The description of Services above does not apply to Inpatient or Outpatient Mental Health and Substance Abuse treatment. The requirements for Mental Health Benefits are listed on page 18. Requirements for Substance Abuse treatment Benefits are listed on page 21.

Rehabilitation

You must get Prior Approval for the Services listed on your Outline of Coverage, including rehabilitation Services, or your care will not be Covered.

We Cover:

- Inpatient treatment in a Participating Physical Rehabilitation Facility for a medical condition requiring Acute Care. The attending Physician must certify that Services of a Physical Rehabilitation Facility are required and are the most appropriate level of care for the condition being treated. The rehabilitation Physician must recertify on a schedule based upon your clinical condition, but no less frequently than every 30 days, that the Services are Medically Necessary, and that you are making significant progress.

- Outpatient cardiac or pulmonary rehabilitation for a condition requiring Acute Care. We Cover up to three supervised exercise sessions per week up to a total of 36 sessions for cardiac or pulmonary rehabilitation programs. For cardiac rehabilitation, we Cover an additional 36 sessions for each new Acute cardiac event. You must use a Participating cardiac rehabilitation Provider.

Requirements

Your Physician must obtain certification from us and then get re-certification every 30 days. You must get Prior Approval from us for any rehabilitation Services.

Exclusions

We do not Cover:

- care when there is no clear, measurable progress toward a rehabilitative goal, a less restrictive setting or other Medically Necessary goal;
- Custodial Care (see Definitions), as noted in General Exclusions;
- cognitive retraining or educational programs; or
- rehabilitation Services when you don't get Prior Approval from us.

General Exclusions in Chapter Three also apply.

Note:

We provide Benefits for Mental Health Services and Substance Abuse treatment Services elsewhere in this Chapter. Please see those sections for Benefits.

Substance Abuse Services

You must use a Network Provider and get Prior Approval for the Services listed on your Outline of Coverage, including all Substance Abuse treatment Services, or your care will not be Covered. We provide Benefits for the following Acute Substance Abuse treatment Services:

- detoxification;
- Outpatient rehabilitation (including Services for the patient's family when necessary); and
- Inpatient rehabilitation.

Requirements

We provide Benefits for Substance Abuse treatment Services only if:

- your Services meet guidelines in Chapter One;
- you obtain Prior Approval for all Substance Abuse treatment Services;
- you receive care from Network Substance Abuse treatment Providers; and
- care is provided in the least restrictive setting Medically Necessary; and
- there is clear, measurable progress toward a rehabilitative goal, a less restrictive setting or other Medically Necessary goal.

The number for our Substance Abuse treatment Network is on the back of your ID card.

Exclusions

We provide no Substance Abuse treatment Benefits for:

- Services from Substance Abuse treatment Providers that are not members of our Substance Abuse treatment Network, except as otherwise provided by law;
- treatment we do not approve in advance;
- non-traditional, alternative therapies such as eye movement desensitization, Rubinfeld Synergy, energy polarity therapy and somatization therapy, that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories;

- treatment without ongoing concurrent review to ensure that treatment is being provided in the least restrictive setting required;
- Services, including residential programs, adventure-based activities and wilderness programs, that focus on education, socialization, delinquency or Custodial Care (see Definitions), as noted in General Exclusions; and
- biofeedback, pain management, stress reduction classes and pastoral counseling.

General Exclusions in Chapter Three also apply.

Therapy Services

We Cover therapy Services that are not Custodial Care when the Services are provided by an eligible hospital, Skilled Nursing Facility or Home Health Agency/Visiting Nurse Association or included on a bill from one of those Providers. We also Cover the Services of a registered physical therapist, medical doctor (M.D.), doctor of osteopathy or Chiropractor in an office or home setting or a Participating athletic trainer in a clinical setting. A clinical setting is defined as an Outpatient orthopedic or sports medicine clinic that employs one of the following:

- medical doctor (M.D.);
- doctor of osteopathy (D.O.);
- Chiropractor; or
- physical therapist.

Therapy Services could include the following:

- radiation therapy;
- chemotherapy;
- dialysis treatment;
- Physical Therapy;
- Occupational and Speech Therapy; and
- infusion therapy (see page 14 for details).

We Cover Occupational, Physical and Speech Therapy only:

- for Physical Therapy Services that require constant attendance of a registered physical therapist, a medical doctor (M.D.), a chiropractor, an athletic trainer or a doctor of osteopathy (D.O.);
- for up to 30 Outpatient sessions combined per calendar year or up to six months after initiation of therapy for a particular Episode, whichever comes first; and
- when there is clear, measurable progress toward a rehabilitative goal, a less restrictive setting or other Medically Necessary goal.

Notes:

- We do not Cover group therapy, group exercise or Physical Therapy performed in a group setting.
- We Cover only Participating athletic trainers. We do not Cover Services of Non-participating athletic trainers.

Transplant Services

You must get Prior Approval for the Services listed on your Outline of Coverage, including transplant Services, or your care will not be Covered.

We reserve the right to review all requests for Prior Approval based on:

- the patient's medical condition;
- the qualifications of the Physicians performing the transplant procedure; and
- the qualifications of the Facility hosting the transplant procedure.

We pay Benefits for the following Services related to transplants:

- search for a donor;
- surgical removal of an organ;
- storage and transportation costs for the organ, partial organ or bone marrow; and

- costs directly related to the solid organ or bone marrow donation, including costs resulting from complications of the donor's Surgery.

We pay Benefits for transplants as follows:

- for transplants using a deceased donor, we limit Benefits for the search, removal, storage and transportation of the organ to \$35,000 per solid organ transplant;
- for transplants using a live donor, we limit Benefits for the live donor's surgical expenses and storage and transportation of the organ to \$65,000 for each Covered organ transplant procedure completed;
- if we Cover both the recipient and the donor, each receives Benefits under his or her own Contract;
- if we Cover the recipient, but not the donor, both receive Benefits under the recipient's Contract (Benefits available to the recipient will be paid first);
- no Benefits are available if we Cover the donor, but not the recipient.

Benefits for transplant-related office visits, labs or Prescription Drugs are subject to the terms and conditions in the other sections of your Contract, including Co-payments and the General Exclusions in Chapter Three.

Time Period for Recipient Benefits

This section Covers the transplant recipient's expenses directly related to the transplant procedures when they are incurred:

- from 30 days before the procedure to 365 days after the procedure for bone marrow transplants; or
- from five days before the procedure to 365 days after the procedure for all other transplants.

Benefits for transplant-related Services within this time period are subject to the lifetime transplant Benefit maximum listed on your Outline of Coverage.

Time Period for Living Donor Benefits

To be Covered, costs must be incurred within 120 days from the date of the donor's Surgery.

If the Covered organ transplant procedure is not completed, we provide Benefits only if the Covered organ transplant procedure was scheduled to occur within 24 hours of the donor's Surgery.

Such Covered donor expenses will be reimbursed subject to the Deductibles, Co-payments and Coinsurance and terms of the transplant recipient's Contract.

Lifetime Transplant Maximum

We provide Benefits for all transplant Services within the time periods specified above up to a lifetime transplant maximum that is listed on your Outline of Coverage. This maximum transplant Benefit is separate from your lifetime Benefit maximums for other Services Covered under your Contract.

Exclusions

We provide no Benefits for the purchase price of any organ or bone marrow that is sold rather than donated. Please remember that General Exclusions in Chapter Three also apply.

CHAPTER THREE

General Exclusions

Subject to your rights under the law, including the right to appeal a denial of Benefits, we have the authority to interpret and apply the terms of this Contract and to determine whether and to what extent you have Coverage for a requested Service, even when a Provider has prescribed or recommended the Service.

We pay Benefits only for Covered Services described in your Contract. This Certificate and any of your riders or endorsements may contain specific exclusions.

In addition to the specific exclusions listed elsewhere in this Contract, the following general exclusions apply. We do not Cover the following even if they are Medically Necessary:

1. Services that must be Covered by a prior health plan as extended Benefits.
2. Services for which you would have no legal obligation to pay if you did not have your Contract or similar Coverage.
3. Services for which there is no charge.
4. Services paid directly or indirectly by a local, state or federal government agency, except as otherwise provided by law.
5. Services you require as a result of your commission or attempt to commit a felony, or your engagement in an illegal occupation.
6. Services in excess of the limitations or maximums set forth in your Contract.
7. Services or medications we determine are not Medically Necessary.
8. Services or medications that we determine are Investigational, mainly for research purposes or Experimental in nature. However, to the extent required by law, we Cover routine costs for patients who participate in approved cancer clinical trials.
9. Services that are not provided in accordance with accepted professional medical standards in the United States.
10. Services beyond those needed to restore your ability to perform Activities of Daily Living (see Definitions).
11. Acupuncture, acupressure or massage therapy; hypnotherapy, rolfing, homeopathic or naturopathic remedies. Benefits will be provided for Medically Necessary Covered Services when performed within the scope of a naturopathic Physician's license.
12. Electrical stimulation devices used externally. (This exclusion does not apply to bone growth stimulators, transcutaneous electrical nerve stimulation (TENS) devices or neuromuscular stimulators for which you have received Prior Approval.)
13. Automatic ambulatory home blood pressure monitoring or equipment.
14. Biofeedback or other forms of self-care or self-help training.
15. Bulk immunizations (those provided to a group of people, such as employees in an office setting) or fluoride treatments performed in school.
16. Whole blood, blood components, costs associated with the storage of blood, testing of blood the patient donates for his or her own use (even if the blood is used), transfusion Services for blood and blood components the patient donates for his or her own use in the absence of a Covered surgical procedure. (This exclusion does not apply to blood derivatives and transfusion Services for whole blood, blood components and blood derivatives.)
17. Care for which there is no therapeutic Benefit or likelihood of improvement.
18. Care, the duration of which is based upon a predetermined length of time rather than the condition of the patient, the results of treatment or the individual's medical progress.

19. (Routine) circumcision.
20. Clinical ecology, environmental medicine, Inpatient confinement for environmental change or similar treatment.
21. Cognitive training or retraining and educational programs, including any program designed principally to improve academic performance, reading or writing skills, except for diabetes education.
22. Screening colonoscopies except in patients over age 50 or patients with risk factors for colorectal disorders.
23. Communication devices, communication augmentation devices and computer technology or accessories and other equipment, supplies or treatment intended primarily to enhance occupational, recreational or vocational activities, hobbies or academic performance.
24. Consultations, except when they occur between Providers and the Providers attach a written report to the patient's medical record.
25. Correction of near- or farsighted conditions or aphakia (where the lens of the eye is missing either congenitally or accidentally or has been surgically removed, as with cataracts) by means of "laser Surgery," or refractive keratoplasty procedures such as keratomileusis, keratophakia and radial keratotomy and all related Services.
26. Cosmetic procedures and supplies that are not Reconstructive.
27. Unless expressly Covered in other parts of this Contract or required by law, we do not Cover:
 - a. excision, excessive skin and subcutaneous tissue, and tightening (plication) of underlying structures (includes abdominoplasty, panniculectomy, correction of diastasis rectus, lipectomy and umbilical transposition) of the chest, abdomen, thigh, leg, hip, buttocks, arm, forearm, hand, neck (submental fatpad) and all other areas not specified;
 - b. suction assisted removal of fatty tissue (lipectomy) in the head, neck, trunk, upper extremity or lower extremity;
 - c. breast lift (mastopexy);
 - d. Surgery to improve the appearance of the ear (otoplasty);
 - e. mastectomy for gynecomastia;
 - f. blepharoplasty; repair of brow ptosis, repair of blepharoptosis, correction of lid retraction, reduction of overcorrection of lid ptosis; and
 - g. Surgery to improve the appearance of the nose (rhinoplasty).
- Note:** This exclusion does not apply to (1) Surgery when such Service is incidental to or follows Surgery resulting from trauma, infection or other diseases of the involved part; or (2) medically diagnosed congenital disease or birth abnormality of a Covered Dependent Child.
28. Custodial Care, Rest Cures.
29. Dental Services and oral Surgery, unless specifically provided by your Contract; procedures designed primarily to prepare the mouth for dentures (including alveolar augmentation, bone grafting, frame implants and ramus mandibular stapling).
30. Drugs and pharmaceuticals (except those for treatment of diabetes) that you purchase on an Outpatient basis (unless your Group purchases a Prescription Drug rider).
31. Routine eye care (such as examinations), eye exercises or visual training.
32. Eyeglasses or contact lenses unless you need them to replace the lens of an eye (and the lens was not replaced at the time of Surgery).
33. Education, educational evaluation or therapy or treatment of developmental delays, therapeutic boarding schools, Services that should be Covered as part of an evaluation for or inclusion in a Child's individualized education plan (IEP) or other educational program. (This exclusion does not apply to treatment of dia-

- betes, such as medical nutrition therapy by approved Participating Providers.)
34. Foot care or supplies that are Palliative or Cosmetic in nature, including supportive devices and treatment for bunions (except capsular or bone Surgery), flat-foot conditions, subluxations of the foot, corns, callouses, toenails, fallen arches, weak feet, chronic foot strain and symptomatic complaints of the feet. This exclusion does not apply to necessary foot care for treatment of diabetes.
 35. Hearing aids or examinations for the prescription or fitting of hearing aids.
 36. Home or automobile modifications or equipment like air conditioners, HEPA filters, humidifiers, stair glides, elevators, lifts, motorized scooters, furniture or "barrier-free" construction, even if prescribed by a Provider.
 37. Illnesses or injuries that are:
 - a result of an act of war (declared or undeclared); or
 - sustained in active military service (**Note:** upon receipt of written request, the Plan will suspend Coverage for the military member and make a refund on a pro rata basis for subscription rates paid for the time period the member is in active military service).
 38. An Inpatient stay determined not Medically Necessary while you are waiting for a different level of care, such as Skilled Nursing Facility or home care, whether or not it is available to you.
 39. Treatment for willfully uncooperative or intractable patients.
 40. Institutional or Custodial Care for the physically or mentally handicapped.
 41. Mandated treatment, including court-ordered treatment, unless such treatment is Medically Necessary, ordered by a Physician and Covered under your Contract.
 42. Non-medical charges, such as:
 - taxes;
 - postage, shipping and handling charges;
 - a penalty for failure to keep a scheduled visit; or
 - fees for completion of a claim form.
 43. Nutritional counseling beyond three visits per calendar year. (This exclusion does not apply to nutritional counseling for the treatment of diabetes.)
 44. Nutritional formulae or supplements, except for up to \$2,500 per year for "medical foods" prescribed for the Medically Necessary treatment of an inherited metabolic disease or formulae and supplements administered through a feeding tube.
 45. Orthodontics, including orthodontics performed as adjunct to orthognathic Surgery or in connection with accidental injury.
 46. Osteopathic manipulation treatment.
 47. Pain management programs.
 48. Personal hygiene items.
 49. Personal Service, comfort or convenience items.
 50. Photography Services, photographic supplies or film development supplies or Services (for example, external ocular photography or photography of moles to monitor changes).
 51. Physical fitness equipment, braces and devices intended primarily for use with sports or physical activities other than Activities of Daily Living (e.g., knee braces for skiing, running or hiking); weight loss or exercise programs; health club or fitness center memberships.
 52. Pneumatic cervical traction devices.
 53. Specialized examinations required by your employer or for sports/recreational activities (e.g., driver certifications, pilot flight physicals, etc.)
 54. Support therapies, including pastoral counseling, assertiveness training, dream therapy, music or art therapy, recreational therapy,

- smoking cessation therapy, stress management, wilderness programs, adventure therapy and bright light therapy.
55. Sterilization reversal (vasectomy reversal, vasovasostomy, vasovasorrhaphy, tubal ligation reversal, tubotubal anastomosis).
 56. Telephone consultations (between Provider and patient).
 57. Therapy Services provided as a part of chronic pain control, developmental, pulmonary or other form of rehabilitation, except:
 - treatment of diabetes by a Participating Provider; or
 - Services for which you have prior written approval by the Plan.
 58. Travel (other than transport), lodging and housing that is not integral to a Medically Necessary level of care, even if prescribed by a Physician.
 59. Infertility Services, including:
 - All medications for treatment of infertility, including but not limited to Clomid, Clomiphene, Serophene, Bravelle, Gonadotropin Releasing Hormone (GnRH), Follistim AQ, Novarel, Ovidrel, Pregnyl, Profasi and Repronex (the four-cycle limitation in your Prescription Drug Rider is hereby stricken) when used for treatment of infertility; and
 - Surgical, radiological, pathological or laboratory procedures leading to or in connection with artificial insemination (intrauterine, intracervical, and intravaginal), in vitro fertilization, embryo transplantation and gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) and any variations of these procedures, including costs associated with collection, washing, preparation or storage of sperm for artificial insemination including donor fees, cryopreservation of donor sperm and eggs. This exclusion does not apply to the evaluation to determine if and why the couple is infertile.
 60. Treatment leading to, or in connection with, transsexual Surgery.
 61. Treatment solely to establish or re-establish the capability to perform occupational, hobby, sport or leisure activities.
 62. Non-prescription treatment of obesity, except surgical treatment when:
 - your Physician determines that your body mass index is over 40 (according to Table 1 in the "Methods for Voluntary Weight Loss and Control" booklet by the National Institute of Health Technology Assessment Conference Statement of March 1992); and
 - you have other medical conditions that could be significantly and adversely affected by this degree of obesity.

This exclusion does not apply to nutritional counseling Benefits as explained on page 19.
 63. Work-hardening programs and work-related illnesses or injuries (or those which you claim to be work-related, until otherwise finally adjudicated), provided such illnesses or injuries are Covered by workers' compensation or should be so Covered. (This provision shall not be deemed to require an individual, such

as a sole proprietor or an owner partner, as a condition to obtaining Coverage, to obtain workers' compensation if he or she is not under a legal obligation to be so Covered.)

64. Services and supplies not specifically described as Covered.

Provider Exclusions

Also, your Contract does not Cover Services prescribed or provided by a:

65. Provider that we do not approve for the given Service or that is not defined in our "Definitions" section as a Provider.
66. Professional who provides Services as part of his or her education or training program.
67. Member of your immediate family or yourself.
68. Veterans Administration Facility treating a Service-connected disability.
69. Non-participating Provider if we require Participation as a condition for Coverage under your Contract, unless otherwise provided by law.
70. Non-Network Provider if we require use of a Network Provider as a condition for Coverage under your Contract, unless otherwise provided by law.

CHAPTER FOUR

Pre-existing Conditions

We define Pre-existing Condition as a condition for which you have sought medical advice, diagnosis, care or treatment, or for which medical advice, diagnosis, care or treatment has been recommended during the six months before your enrollment date. We reserve the right to review any claim to determine whether it meets the definition of Pre-existing Condition. Erroneous payment of a claim for Services related to a Pre-existing Condition on one or more occasions does not obligate us to provide Benefits for a Pre-existing Condition on another occasion within the waiting period. Your enrollment date is defined as the earlier of:

- the first day you are Covered under this Contract; or
- the first day of any probationary period or waiting period your employer applies.

Waiting Period

We do not provide Benefits for Services related to Pre-existing Conditions until nine months after the effective date of this Coverage.

Exceptions

Emergencies

We provide Benefits for Pre-existing Conditions within the nine-month waiting period when you are treated on an emergency basis, as documented by medical records and as determined by us.

Maternity

Maternity Coverage has no waiting periods. You may use Services regardless of how long you have had this Coverage.

Previous Coverage

If you or your Dependents had previous Coverage with us or any other carrier, we will credit all or part of your waiting periods for Pre-existing Conditions:

- if you or your Dependents have not had more than a “90-day break in Coverage” (as defined by law) before obtaining this Coverage; and
- if your previous Coverage was “creditable Coverage” as defined by law.

We will credit your waiting periods to the extent that you met all or part of the previous carrier’s waiting periods. (For example, if you met six months of the waiting period for your previous Coverage, you will get six months of credit toward the waiting period for this Coverage.)

Children Born or Adopted After the Effective Date

Coverage for Children born, adopted, or placed for adoption after the Subscriber’s effective date is not subject to Pre-existing Condition limitations. They must, however, become Covered within 94 days after they are first eligible for Coverage under your Contract. Dependents without prior “creditable Coverage” (as defined by law) who do not become Covered under your Contract during these 94 days must fulfill their own waiting periods for Pre-existing Conditions.

Waiver

If your Group purchases a waiver of waiting periods, you do not have to fulfill waiting periods in this section. In this case, a waiver of waiting periods document should be included in your Contract and be listed on your Outline of Coverage.

Credit for Subscriber Waiting Periods

Dependents who become Covered under your Contract during their initial eligibility period (see Adding Dependents in Chapter Seven) are not required to fulfill waiting periods for Pre-existing Conditions to the extent that the Subscriber has fulfilled his or her waiting periods. Dependents who do not become Covered under your Contract during their period of initial eligibility must fulfill their own waiting periods unless other exceptions apply.

CHAPTER FIVE**Claims**

Remember, when you contact a Provider, you must:

- tell your Provider that you have Coverage with Blue Cross and Blue Shield of Vermont; and
- give information about all other health Coverage you have.

Claim Submission

We must receive your claim within 12 months after you receive a Service, or as soon thereafter as is reasonably possible. If you file a claim more than 12 months after you receive a Service, we may not provide Benefits. Additionally, your claim must include all information necessary for us to administer your Benefits. We cannot provide Benefits until we receive all information necessary to process your claim, including information relating to other insurance or Coverage you have.

Network and Participating Providers will usually submit claims on your behalf if this is your primary Coverage (see “Other Party Liability”). If you receive Services from a Non-participating Provider, however, you must file your own claims.

Release of Information

We may need records, copies of records, verbal statements or other information to administer your Benefits. By accepting your Contract, you give us the right to obtain, from any source, any information we need for use in connection with policy administration, subject to applicable state and federal laws. We also have the right to obtain information to perform utilization review and care management studies and analyses of Benefit programs.

Our approval of your Benefits is conditional upon your furnishing us with such information, even if we provide Benefits before we obtain the

information. In order to avoid duplicate payments, we may furnish information to other entities that provide similar Benefits, unless otherwise prohibited by law.

To discuss claims for a family member over 12 years of age with you, we may require a signed “Authorization to Release Information” from the Dependent.

Cooperation

Remember you must fully cooperate with us in order to obtain Benefits under this Certificate. We may require you and any person seeking Benefits under any part of this Certificate to provide signed or recorded statements. You must answer all reasonable questions we may ask, when and as often as we may reasonably require. Failure to cooperate may result in a denial of Benefits.

Payment of Benefits

We pay Network and Vermont Participating Providers directly. We reserve the right to pay out-of-state Participating Providers directly. We usually pay you directly for Services you receive from Non-participating Providers. We reserve the right, however, to pay Non-participating Providers directly.

Your rights under this Contract are personal. This means that you may not assign your Benefit rights to any other party, including a Non-participating Provider. We may refuse to honor any Benefit assignment presented to us.

For information on how we determine your Benefit amount, see Chapter One.

**Payment in Error/
Overpayments**

If we provide more Benefits than we should have, we have the right to reCover the overpayment from you or from any other person, insurance company, agency or organization. If we pay Benefits to you incorrectly, we may require you to repay us for any incorrect payment. If this oc-

curs, we will send you written notice requesting return of the overpayment or incorrect payment. You must cooperate with us to reCover any overpayment or incorrect payment. We may reduce or withhold future Benefits to reCover incorrect payments.

Regardless of whether we seek reCover, an erroneous payment on one occasion will not obligate us to provide Benefits on another occasion.

When You Have a Complaint

The following sections explain what to do when you don't agree with one of our decisions or when you have a complaint about our Service, health plan rules, waiting times to get appointments, after-hours access to your doctor, the Service at a doctor's office or a doctor's care. You may get assistance in any of the following ways. Instructions to follow when you have a complaint about Mental Health or Substance Abuse treatment are on page 37. At any time, you may call the Vermont Division of Health Care Administration for help at (800) 631-7788 or (802) 828-2900.

Complaint (Inquiry) to Customer Service

Our customer service team can solve most problems. We encourage you to contact customer service before filing a grievance (below) because it may save you time. Contact us at the number on the back of your ID card and we will review your complaint. Please have your ID card handy when you call. If you wish, another person—perhaps a Provider—may call for you. You may also write to:

Blue Cross and Blue Shield of Vermont
Customer Service
P.O. Box 186
Montpelier, VT 05601-0186

We resolve complaints as soon as possible. You can make a medical complaint if you have problems with the medical care or advice that you got from your doctor. You may also make a

non-medical complaint. Non-medical complaints might be about:

- BCBSVT services
- BCBSVT rules
- waiting times to get appointments
- after-hours access to your doctor
- the Service at the doctor's office

Claim Appeal (Grievance)

You may file a grievance after a customer service review (above) or without one. You have the right to obtain copies of all information related to your appeal. (We suggest you make a complaint to customer service first. This may save you time.) If your grievance is related to Emergency or Urgent Services, you may submit your grievance verbally. All other grievances should be submitted in writing. We provide alternatives for members who aren't able to file their grievances in writing. Call customer service at the number on the back of your ID card for help. (If you have a Mental Health or Substance Abuse grievance, see page 37.) Send your grievance to:

Blue Cross and Blue Shield of Vermont
Grievances
P.O. Box 186
Montpelier, VT 05601-0186

Please be specific about your grievance. If it involves a decision to deny Coverage for Services, deny eligibility, or reduce your Benefits, call or write within 180 calendar days of when you receive notice of the denial or reduction in Benefits. Once you make a formal grievance, an impartial reviewer will conduct a review to attempt to resolve it. If it is about a decision to deny or reduce Benefits, we will see if we should pay your claim.

For a grievance related to medical care not yet rendered, we will complete the review and send you notice of our decision within 30 calendar days of receiving your request for review. For a grievance related to medical care you have already received, we will complete the review and send you notice of our decision within 60 calendar days of

receiving your request for review.

If your grievance involves a request for Emergency or Urgent Services (see Definitions), we will review it and notify you of our decision within 72 hours of receiving your request. For reviews not related to medical care, we will notify you of our decision within 30 days of receiving your request. For all other reviews, we will notify you of our decision within 60 days of receiving your request.

Notes:

- The State of Vermont has a Health Care Ombudsman's office. If you have a problem with your plan, this office may be able to help. Call (800) 917-7787 or (802) 863-2316.
- By accepting your Contract, you agree to seek a decision of the impartial reviewer before taking any judicial action. After you receive our decision, you may choose to pursue a voluntary appeal of the grievance decision (below) or, in certain circumstances, you may request an independent review with the State of Vermont by calling (800) 631-7788 or (802) 828-2900.
- Your plan may be subject to ERISA. If you are not satisfied with the outcome of the internal-appeal process, and your plan is subject to ERISA, you may have the right to bring legal action under section 502(a) of ERISA. Consult your Benefit administrator to determine whether this applies to you. You are not required to pursue the voluntary second-level of appeal prior to bringing legal action. You are not required to submit your claim to the State of Vermont external appeal process prior to filing a suit under section 502(a) of ERISA.

If you choose to take advantage of our voluntary second level of appeal (below) and still are not satisfied, you will have the right to file an external appeal with the State of Vermont and/or file suit under ERISA (if applicable) as described above after receiving the second level decision.

Voluntary Appeal of Grievance Decision

If you are not satisfied with the outcome of the grievance, you may file an appeal. The appeal is voluntary and is offered at no cost to you. You may also, in certain circumstances, request an external appeal with the State of Vermont by calling (800) 631-7788 or (802) 828-2900.

If you choose to file a voluntary appeal, you must do so within 90 days after you receive our grievance decision. If your appeal involves a request for Emergency or Urgent Services, you may submit your appeal verbally. All other appeals should be submitted in writing. We provide alternatives for members who aren't able to file their grievances in writing. Give as much information as you can, including what happened when you took the steps above. If needed, we will help you with your appeal. Mail your appeal to:

Blue Cross and Blue Shield of Vermont
Voluntary Second Level of Appeals
P.O. Box 186
Montpelier, VT 05601-0186

A different reviewer will conduct a "Second-Level" voluntary review. You have the right to obtain copies of all information related to your appeal. You also have the right to meet with the reviewer before we make our final decision. If you are not able to participate by phone, we will make arrangements for you to participate in person.

If your appeal involves a request for Emergency or Urgent Services, we will review it and notify you of our decision within two calendar days of receiving your request for an appeal. For all other reviews, we will notify you of our decision within 30 days of receiving your request for appeal.

Notes:

If you do not take advantage of the voluntary second level of appeal before you choose to pursue an external appeal, we will not later claim that you were required to take a second level of appeal (i.e., exhaust your administrative remedies). However, please note that if you choose to file an external appeal without going through the second level of appeal, you may not later request a second level of appeal.

If you choose to take advantage of the voluntary second level of appeal, the Plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal is pending.

After you receive our decision, in certain circumstances, you may request an external appeal with the State of Vermont by calling (800) 631-7788 or (802) 828-2900.

Mental Health and Substance Abuse Customer Service Complaint (or Inquiry)

If you have a complaint about Mental Health or Substance Abuse care that was denied, call our customer service department at the number on the back of your ID card. The customer service team can solve most problems. You may also file an appeal. (See below.)

Mental Health and Substance Abuse Claim Appeal (Grievance)

You may file a grievance after a customer service complaint (described above). Or you may file an appeal right away. (We suggest you make a complaint to customer service first. This may save you time.) You have the right to obtain copies of all information related to your appeal. If you have an Emergency Medical Condition or require Urgent Services, we will notify you of our decision within 24 hours of receiving your request. On other appeals about Mental Health or Substance Abuse health care we will send you notice of our decision in writing within 10 calendar days of receiving your

request. If your appeal is about Service (not actual health care), we will resolve it within 30 calendar days of receiving your request.

You must submit your appeal within 180 days of receiving our denial. You may submit an appeal in writing or by phone. Send written appeals to:

Magellan Health Services
199 Pomeroy Road
Parsippany, NJ 07054

Or call the number on the back of your ID card to submit your appeal by phone or if you need help in submitting your appeal.

Notes:

The State of Vermont has a Health Care Ombudsman's office. If you have a problem with your plan, this office may be able to help. Call (800) 917-7787 or (802) 863-2316.

By accepting your Contract, you agree to seek a decision of our grievance reviewer before taking any judicial action. After you receive our decision, you may choose to pursue a voluntary appeal of the grievance decision (below) or, in certain circumstances, you have the right to ask the State's Independent Panel of Mental Health Care Providers to review your case. The panel is not connected to us. For more information about the independent panel, or to ask for a review, call (800) 631-7788 or (802) 828-2900.

Voluntary Appeal of First-Level Mental Health or Substance Abuse Grievance Decision

You can have a second committee review your appeal if you aren't satisfied with the first decision. You have the right to get copies of all information related to your appeal. You also have the right to participate by phone. If you are not able to participate by phone, we will make arrangements for you to participate in person. To have this review, write to:

Blue Cross and Blue Shield of Vermont
Mental Health Second-Level Appeals

P.O. Box 186
Montpelier, VT 05601-0186

If you have an Emergency Medical Condition, we will notify you of our decision on your appeal within 24 hours. For all other appeals, we will send you our decision within 30 calendar days of receiving your request.

Independent Review

Are you dissatisfied with either of our review committees' decisions? After the first review, you have the right to ask the State's Independent Panel of Mental Health Care Providers to review your case. The panel is not connected to BCBSVT. Or, if you choose to take advantage of our second level of review, and are still not satisfied, you can call the independent panel at that time and ask for a review. For more information about the independent panel, or to ask for a review, call (800) 631-7788 or (802) 828-2900.

Vermont's Mental Health Law

Vermont has a law that makes Mental Health and Substance Abuse treatment Benefits equal to those for other physical problems. Your Benefits comply with this law.

When You Have to Pay

If your appeal is denied, you must pay for Services we didn't Cover. Make your payment to your Provider.

CHAPTER SIX

Other Party Liability

This chapter gives us the right to prevent duplicate payments for a Service that would exceed our Allowed Price for the Service. It applies, for instance, when a person Covered under your Contract also receives Benefits or is entitled to receive Benefits as a result of any other health Coverage or insurance. Remember, you must disclose information about all other Coverage to us.

Coordination of Benefits

This chapter applies when you are entitled to Benefits or reCover under your Contract and also under another health plan or insurance policy that provides Benefits for some or all of the same expenses as this one provides. (For the purposes of this chapter, we'll call the other party a "payer.")

We may reduce your Benefits under your Contract so that the sum of the reduced Benefits and all Benefits payable for Covered Services under another health plan or insurance policy does not exceed our Allowed Price for Covered Services.

Although we call the other plan or policy a "payer," we coordinate Benefits based on Coverage, not actual payment. Therefore, we treat the following Benefits as "payment" from another payer:

- any Benefits that would be payable if you made a claim (even if you don't); and/or
- Benefits in the form of Services.

When two payers coordinate Benefits, one becomes "primary" and one becomes "secondary." The primary payer considers the claim first and makes its Benefit determination. The secondary payer then makes payment based on any amount the primary payer did not Cover.

We make our determination of whether we are the "primary" or "secondary" payer according to the Order of Benefit Determination Rules of the Group Coordination of Benefits Model Regulation, provided by the National Association of Insurance Commissioners (NAIC).

The NAIC guidelines say that, in general, if the other payer has no Coordination of Benefits provision or if the payer has a provision that differs from ours, that payer is primary. If they use the same NAIC provisions we use, we determine who is primary as follows:

- the payer Covering a patient as an employee (Subscriber) is primary to a payer who Covers him or her as a Dependent;
- if a Child or Over-age Dependent is the patient, we use the NAIC "Birthday Rule," which makes the Coverage of the parent whose birthday is earlier in the calendar year (without regard to year of birth) the primary payer; and
- when the above two rules don't apply, the Coverage with the earliest effective date is primary and the other is secondary.

Coordination of Benefits for Children of Divorced Parents

If two or more plans Cover a Dependent Child of divorced or separated parents, a court often decrees that one parent should be responsible for the health insurance of the Child. In that case, the plan of the parent with that responsibility is primary. If no such decree exists, Benefits are determined in this order:

- the plan of the parent with custody of the Child; then
- the plan of the Spouse/Party to a Civil Union of the parent with custody (if he or she Covers the Child); then
- the plan of the parent who does not have custody of the Child; and finally

- the plan of the Spouse/Party to a Civil Union of the parent who does not have custody.

If a court decrees that parents will share custody of the Child, without stating that one parent is responsible for health care expenses for the Child, we use the “Birthday Rule” described above.

In an Accident

If you have an accident and you are Covered for accident-related expenses under any of the following types of Coverage, the other payer is primary and we are secondary:

- no-fault auto insurance;
- group auto insurance;
- traditional fault-type auto insurance;
- uninsured or underinsured motorist insurance;
- automobile-medical payment insurance;
- homeowner’s insurance;
- personal injury protection insurance;
- financial responsibility insurance;
- medical reimbursement insurance Coverage that you did not purchase; or
- any other property and liability insurance providing medical payment Benefits.

Reimbursement

If another health plan provides Benefits that we should have paid, we have the right to reimburse the other health plan directly. That payment satisfies our obligation under your Contract.

Medicaid and CHAMPUS

We will always be “primary” payer to Medicaid or CHAMPUS (Civilian Health and Medical Program of the Uniformed Services)/Tricare). CHAMPUS/Tricare and Medicaid are always secondary payers.

Subrogation

To the extent that we pay or are obligated to pay Benefits under your Contract, we shall be subrogated to your rights of reCover from any person or organization that caused or contributed to your illness or injuries or paid or should pay as a result of your illness or injuries. This means that:

- If you receive health care Services for injuries or illness, and we pay Benefits for any part of those Services, you shall pay us all amounts you reCover by suit, settlement or otherwise from any third party, its insurer or your insurer, to the extent of the Benefits paid under your Contract. You are required to reimburse us whether or not you have been “made whole” by the reCover from the third party or insurer. In appropriate cases, we will reduce the amounts you owe us by a proportionate share of the reasonable attorneys’ fees and costs incurred by you to obtain your reCover.
- We reserve the right to bring a lawsuit in your name or in our name against any responsible party or parties to reCover Benefits we have advanced or to settle our claim for such Benefits with such responsible party or parties.
- This right of subrogation includes any reCover you may have under no-fault auto insurance, group auto insurance, traditional fault-type auto insurance, uninsured or underinsured motorist insurance, automobile-medical payment insurance, homeowner’s insurance, personal injury protection insurance, financial responsibility insurance, medical reimbursement insurance Coverage that you did not purchase, or any other property and liability insurance providing medical payment Benefits.

- You shall take such action, furnish such information and assistance, and execute such papers (including a reimbursement agreement) as we may require to enforce our rights, and you shall take no action prejudicing our rights and interests under your Contract.
- If you refuse to pay us or to provide the necessary information, we may take legal action against you seeking a reimbursement from the funds you reCovered from the third party, up to the amount of Benefits we paid. In the event it is necessary for us to take such action, you will also be responsible for our attorney's fees and expenses in collecting the amounts owed by you. Your future Benefits may be reduced or withheld to reCover monies owed to us.
- You agree that you will not settle your claim against the party responsible for your illness or injuries without first notifying us. We reserve the right to compromise the amount of our claim if, in our opinion, it is appropriate to do so. We shall have a lien on your reCover from the responsible party up to the amount of Benefits we paid.

Cooperation

You must fully cooperate with us to protect our rights to coordination, reimbursement or subrogation. Cooperation includes:

- providing us all information relevant to your claim or eligibility for Benefits under this Certificate;
- providing any actions needed to assure we are able to obtain a full reCover of the costs of Benefits we have provided;
- obtaining our consent before providing any release from liability for medical expenses;
- not taking any action that would prejudice our rights to coordination, reimbursement or subrogation.

If you or any person Covered under this Certificate fails to cooperate, you will be responsible for all Benefits we have provided in addition to any costs we have incurred in obtaining repayment.

CHAPTER SEVEN

Membership

Remember, when you add or remove Dependents, your type of membership (individual, two-person or family) may change.

You may add or remove Dependents from your membership under the conditions noted in this chapter. To do this, obtain a Group Enrollment Form from your Group Benefits Manager. Fill out the form and give it to your Group Benefits Manager. He or she will submit this request form to us.

You must Cover either all or none of your Dependents who are eligible under your Contract, unless otherwise ordered by a court of law.

Adding Dependents

You may add a Dependent when any of the following events occurs:

Open Enrollment

You may add Dependents for any reason on the Group's open enrollment date. If we receive your request before this date, we will make the change effective on the open enrollment date. If we receive your request during the month in which your open enrollment occurs, we will make the change effective on the first of the following month.

If you belong to a small Group plan (a Group of 50 or fewer employees), we do not impose open enrollment periods. Provisions in your Contract regarding open enrollment do not apply if you belong to a small Group. Your Group or association may do so, however (most associations do). Check with your Group Benefits Manager for information.

Marriage/Civil Union

If we receive your application within 31 days after the date of marriage/Civil Union, your new type of membership is effective the first day of the month following the date of marriage/Civil Union. If we receive your request within 32 to 60 days after the date of your marriage/Civil Union, your

new membership becomes effective the first day of the month after we receive your request.

Your Dependent may enroll in your current plan, or you and your Dependents may change to any other plan your employer offers.

If you fail to add your new Dependent within 60 days of your marriage/Civil Union, you must wait until an open enrollment date to do so. If you belong to a small Group (a Group of 50 or fewer employees) plan, check with your Group Benefits Manager to see if your Group or association imposes an open enrollment period.

Birth or Adoption

If you already have a family membership, we Cover your new Child from the date of birth, legal placement for adoption or legal adoption. You should, however, notify us of your family addition within 31 days.

If you do not have a family membership, we Cover your Child for 31 days after:

- birth;
- legal placement for adoption (when placement occurs prior to adoption finalization); or
- legal adoption (when placement occurs at the same time as adoption finalization).

We must, however, receive your application for a membership change in order to continue Benefits for the Child past 31 days. If we receive your request within the 31 days:

- the Child's effective date is retroactive to the date of birth, placement for adoption or adoption; and
- the new type of membership is effective the first day of the month following birth, placement for adoption or adoption.

If we receive your request within 32 to 60 days, the Child's membership and the new type of membership are effective the first day of the month following our receipt of your request.

Note:

You may enroll your new Dependent on your current plan, or you and your Dependents may change to any other plan your employer offers.

If you fail to add your new Dependents within 60 days, you must wait until an open enrollment date to do so. If you belong to a small Group (a Group of 50 or fewer employees) plan, check with your Group Benefits Manager to see if your Group or association imposes an open enrollment period. Dependents who do not become Covered within 94 days must fulfill their own waiting periods for Pre-existing Conditions.

Group plans approved by the State of Vermont may be required to offer a special enrollment period as provided by Vermont law.

Dependent’s Loss of Coverage

Any Dependents Covered under health Coverage with another health plan are eligible for membership under your Contract if the Dependent loses his or her Group health Coverage or terminates employment. Within 31 days after loss of Coverage, your Dependent may enroll in your current plan, or you and your Dependents may change to any other plan your employer offers. If you fail to add your Dependent within 31 days after loss of Coverage, you must wait until an open enrollment date to do so.

Court-ordered Dependents

The effective date of a court-ordered addition of a Dependent is the first of the month after we receive your request. In the case of an order issued in compliance with Vermont’s child medical support order law, the effective date will be three days after you mail the court order to us or our receipt of the court order, whichever is sooner, unless the order specifies a different effective date. If additional premiums are required, they will be calculated from the effective date of enrollment. Please remember your request for Dependent Coverage under any court order must include proof of the court order.

Over-age Dependents

Dependent Students

You may include unmarried, full-time students (taking 12 credits or more per semester or on a Medically Necessary leave of absence from the college) between the ages of 19 and 25 as Dependents on your membership. To include a Dependent student on your membership, you must provide us with the following information:

- written notice of your Child’s student status on our student certification form; and
- written proof (acceptable to us) of student status.

If a Child is a full-time student on his or her 19th birthday, he or she may continue on your membership without meeting new waiting periods for Pre-existing Conditions. To continue the membership, however, we must receive the request before the first of the month following the student’s 19th birthday.

If your Child becomes a student after his or her 19th birthday, waiting periods may apply. If we receive your request for student status within 60 days after he or she becomes a student, the student’s Coverage is effective the first of the month following our receipt of your request. If we don’t receive the request within 60 days, you must wait until an open enrollment date to add the student to your membership. If you belong to a small Group plan (a Group of 50 or fewer employees), check with your Group Benefits Manager to see if your Group or association imposes an open enrollment period.

Dependent student Coverage ceases the first day of the month after a student:

- marries;
- is no longer a full-time student;
- no longer lives in the Subscriber’s home; or
- turns 25 years of age.

Incapacitated Dependents

In order to provide continued Coverage for an Incapacitated Dependent, we must receive the following:

- an application form for Incapacitated Dependents (which you may obtain from our customer service department or on our website at www.bcbsvt.com); and
- Physician certification of the extent and nature of the handicap.

Our medical director must review the above information and deem the Dependent Incapacitated as defined by law before we will provide Coverage.

We must receive the above information within 31 days of the date the individual would no longer be eligible in order to continue Coverage without interruption. If we receive the above information more than 31 days after the date the individual would no longer be an eligible Dependent, Coverage will become effective the first day of the month after we receive the information. The Over-age Dependent may be subject to his or her own waiting periods for Pre-existing Conditions.

Removing Dependents

You must remove Dependents from membership with us if any of the following events occurs:

- a Dependent dies;
- the Subscriber and Spouse/Party to a Civil Union divorce (Spouse/Party to a Civil Union is removed);
- a child no longer meets the definition of a Child (marries, turns 19 or no longer lives in the Subscriber's home);
- an Incapacitated Dependent is no longer Incapacitated; or
- a student ceases to be a student.

Dependents become ineligible for Coverage under your Contract at the end of the month after the event occurs.

Termination of Group Coverage

Termination of Coverage by You, by the Group or by Us

You or your Group may terminate this Contract without cause at the end of any calendar month by giving 15 days prior written notice. BCBSVT may terminate this Contract in accordance with state and federal law.

Upon Contract termination, we refund your Group the amount of any unearned prepaid subscription rates we hold. Such payment constitutes a full and final discharge of all our obligations under this Contract, unless otherwise required by law. We will continue to provide Benefits for all Covered Services received before the date of termination.

Default in Subscription Payment

If we do not receive your payment on or before the end of the grace period referred to in Chapter Eight:

- We will mail you a cancellation notice.
- This Contract automatically terminates after midnight on the 14th day after we send you a cancellation notice.

We consider a termination for non-payment a cancellation by you.

Fraud, Misrepresentation or Concealment of a Material Fact

If you obtain or attempt to obtain Coverage or Benefits through fraud, including material misrepresentation or concealment of a material fact, this Contract is void. You will be permanently disenrolled and all of your family members Covered under this Contract will be disenrolled for 18 months. If the fraud was committed by a member of your family, that person will also be permanently disenrolled. If you are disenrolled due to fraud, we will not provide any extension of Benefits after this Contract is terminated.

Any misrepresentation on your application for Coverage shall void this Contract if discovered within three years of the effective date. After you have been enrolled for three years, only fraudulent misstatements made on your application shall be used to void this Contract or as a basis to deny a claim.

If you or any member of your family commit fraud, we are entitled to all remedies provided by law and in equity, including, but not limited to, recovery from you for the charges for Benefits provided, attorneys' fees, costs of suit and interest.

Warning: It is a crime punishable by fines and imprisonment under Vermont law to present a claim for payment or Benefit under this Contract that contains false representations or which conceals material information.

Contract Reinstatement

We may reinstate a terminated Contract solely at our discretion and only on such terms and conditions as we decide, as allowed by law.

Voidance and Modification

Unless your application or an exact copy of it is included in, or attached to, your Contract, no representation you make on your application for a Contract shall:

- make this Contract void; or
- be used in any legal proceeding under your Contract.

Only an officer of Blue Cross and Blue Shield of Vermont is authorized to bind us legally by changing or waiving any provisions of your Contract.

Benefits After Termination of Coverage

If you are entitled to Benefits for a continuous total disability, as defined by the Social Security Act, existing on the cancellation date, we provide Benefits for Services until the earlier of:

- the date your disability ends;

- 12 months beyond the date of cancellation; or
- the date you exhaust your Benefit maximums.

Continuation of Group Coverage

Various state and federal laws may entitle you to continue your Group Coverage after it would otherwise terminate. Contact your Group Benefits Manager to determine which laws apply to your circumstances.

Conversion to Non-group Coverage

When continuation of Group Coverage ceases, you may be eligible for non-group Coverage. If so, we will give you the opportunity to convert without a break in Coverage and without evidence of insurability. To do this, your non-group Coverage must be effective within 30 days after your Group Coverage terminates.

Remember, the terms of your Contract with us may change if you transfer from one Group to another, or change to non-group Coverage.

If your Group cancels Coverage with us and obtains Coverage with another health insurer or you are otherwise eligible for Group Coverage, we cannot continue your Group Coverage or offer you non-group Coverage.

Medicare

Please note that this is not a Medicare supplement Contract. We will not provide Benefits under this Contract if you are Medicare-eligible unless otherwise required or permitted by federal law. Contact your Group Benefits Manager to determine eligibility for the Medicare supplemental Certificate offered through your Group. If you are eligible for Medicare, please review the Medicare Supplement Buyer's Guide available from Blue Cross and Blue Shield of Vermont.

CHAPTER EIGHT

General Contract Provisions

Applicable Law

This Contract is intended for sale and delivery in, and is subject to the laws of, the State of Vermont and the United States.

Entire Agreement

Your Contract is the entire agreement between you and us. Subject to applicable state and federal laws, you have no rights or privileges not specifically provided in this Contract. This Contract may only be changed in writing and with the approval of the Vermont Department of Banking, Insurance, Securities and Health Care Administration. Notification of any change in this Contract will be in accordance with applicable law.

Severability Clause

If any provisions of your Contract are declared invalid or illegal for any reason, the remaining terms and provisions will remain in full force and effect.

Non-waiver of Our Rights

Occasionally, we may choose not to enforce certain terms or conditions of your Contract. This does not mean we give up the right to enforce these terms or conditions later.

Term of Contract

Coverage continues from month to month until this Contract is discontinued, terminated or voided as allowed by this Contract.

Subscription Rate

Amount of Subscription Rate

We have different rates for single and multi-person memberships. Your Group's rate or rating formula has been filed with and approved by the Vermont Department of Banking, Insurance, Securities and Health Care Administration.

Changes in the Subscription Rate

We may change rates only if we receive approval from the Vermont Department of Banking, Insurance, Securities and Health Care Administration. We will notify your Group of any rate change in accordance with state law.

Subscription Rate Payments

The subscription rate must be paid in advance directly to us. We allow no more than a 10-day grace period for payment.

Subscriber Address

You must notify us, in writing or by phone, of any change of address. Call customer service at (800) 247-2583 or mail your change of address to:

Blue Cross and Blue Shield of Vermont

P.O. Box 186

Montpelier, VT 05601-0186

You may also change your address on our website at www.bcbsvt.com.

We send all notices by first class postage to the Subscriber's address that we have on file. This constitutes our full responsibility to notify the Subscriber, regardless of whether the Subscriber receives such notice.

Third Party Beneficiaries

All members Covered under this Contract (except the Subscriber) shall be third party beneficiaries to the Contract.

CHAPTER NINE

Definitions

Note: Subject to your rights under the law, including the right to appeal a denial of Benefits, we have the authority to interpret and apply the terms of this Contract and to determine whether and to what extent you have Coverage for a requested Service, even when a Provider has prescribed or recommended the Service.

Activities of Daily Living: includes eating, toileting, transferring, bathing, dressing and mobility.

Acute (Care): (treatment of) an illness, injury or condition, marked by a sudden onset or abrupt change of your health status that requires prompt medical attention. Acute Care may range from Outpatient evaluation and treatment to intensive Inpatient care. Acute Care is intended to produce measurable improvement, to arrest, if possible, natural deterioration from illness/injury or to obtain rehabilitative potential within a reasonable and medically predictable period of time. Acute Care should be provided in the least restrictive setting. Acute Services means Services which, according to generally accepted professional standards, are expected to provide or sustain significant, measurable clinical effect within a reasonable and medically predictable period of time.

Allowed Price: the amount we consider reasonable for a Covered Service or supply.

Ambulance: a specially designed and equipped vehicle for transportation of the sick and injured.

Benefit(s): the amount we allow for a Covered Service or supply as shown on your explanation of Benefits. Your Benefit includes amounts applied to Deductible, Coinsurance and Co-payments.

Cardiac Event: acute myocardial infarction, coronary artery bypass graft, coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris and compensated heart failure.

Certificate (of Coverage): this document.

Child: (refer to Dependent definition)

Chiropractor: a duly licensed doctor of chiropractic, acting within the scope of his or her license.

Civil Union: a relationship established between two persons of the same sex pursuant to 15 V.S.A. Chapter 23 that entitles the parties to the Benefits and protections of Spouses and subjects them to the responsibilities of Spouses.

Coinsurance: a percentage of our Allowed Price you must pay, as shown on your Outline of Coverage, after you meet your Deductible. (Refer also to Chapter One.)

Contract: consists of:

- your Outline of Coverage, this Certificate and the documents listed on your Outline of Coverage;
- your Identification Card; and
- your application and any supplemental applications that you submitted and we approved.

Your Contract is subject to all of our agreements with Participating Providers and other Blue Cross or Blue Shield Plans, as amended from time to time.

Co-payment (Visit Fee): a fixed dollar amount you must pay for specific Services, if any, as shown on your Outline of Coverage. (Refer also to Chapter One.)

Cosmetic: primarily intended to improve appearance.

Cover(ed): describes a Service or supply for which you are eligible for Benefits under your Contract.

Custodial Care: Services primarily designed to help in your daily living activities. Custodial Care includes, but is not limited to:

- help in walking, bathing and other personal hygiene, toileting, getting in and out of bed;
- dressing;
- feeding;
- preparation of special diets;
- administration of oral medications;
- care not requiring skilled Professionals;
- child care;
- adult day care;
- Domiciliary Care (as further defined in this chapter);
- care solely to comply with a court order, to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite, unless such care is Medically Necessary;
- housing that is not integral to a Medically Necessary level of care.

Deductible: the amount you must pay toward the cost of specific Services each calendar year before we pay any Benefits. Your Outline of Coverage shows your Deductible amounts. (Refer also to Chapter One.)

Dependent: a Subscriber's Spouse, the other Party to a Subscriber's Civil Union, or the Subscriber's Child or Over-age Dependent (refer to Chapter Seven) Covered under this Contract.

Child: a Subscriber's unmarried stepchild (through marriage or Civil Union), son or daughter, whether biological or legally adopted (including a Child living with the adoptive parents during a period of probation); or a Child for whom the Subscriber is legal guardian.

A Child must be under age 19 and live in the Subscriber's household unless Coverage has been ordered by a court of law.

Spouse: the Subscriber's Spouse under a legally valid marriage.

Over-age Dependent: a full-time student or In-capacitated Dependent as defined in this chapter.

Party to a Civil Union: a partner with whom the Subscriber has entered into a legally valid Civil Union.

Diagnostic Services: Services, ordered by a Physician or podiatrist, to determine a definite condition or disease. Diagnostic Services include:

- imaging (radiology, X-rays, ultrasound and nuclear);
- studies of the nature and cause of disease (laboratory and pathology tests);
- medical procedures (ECG and EEG);
- allergy testing (percutaneous, intracutaneous, patch and RAST testing);
- mammography; and
- hearing tests by an audiologist if your doctor suspects you have a disease condition of the ear (see also exclusion number 35 on page 27).

Domiciliary Care: Services in your home (or in a home-like environment if you are unable to live alone because of demonstrated difficulties: (1) in accomplishing Activities of Daily Living; (2) in social or personal adjustment; or (3) resulting from disabilities) that are personal care or are designed to help you in walking, bathing and other personal hygiene, toileting, getting in and out of bed, dressing, feeding or with normal household activities such as laundry, shopping and housekeeping.

Durable Medical Equipment (DME): equipment that:

- requires a prescription from your Physician;
- is primarily and customarily used only for a medical purpose;

- is appropriate for use in the home;
- is designed for prolonged and repeated use; and
- is not generally useful to a person who is not ill or injured.

DME includes wheelchairs (manual and electric), hospital-type beds, walkers, canes, crutches, kidney machines, ventilators, oxygen, monitors, pressure mattresses, nebulizers, traction equipment, bili blankets, bili lights and respirators.

DME does not include items such as air conditioners, chair lifts, bathroom equipment, dehumidifiers, whirlpool baths, exercise equipment, motorized scooters and other equipment that has both non-medical and medical uses.

Emergency Medical Condition: the sudden and, at the time, unexpected onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by the prudent layperson, who possesses an average knowledge of health and medicine, to result in:

- placing the member's physical or Mental Health in serious jeopardy; or
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Emergency Services: health care items and Services furnished or required to evaluate and treat an Emergency Medical Condition.

Episode: the Acute onset of a new illness or injury or the Acute exacerbation of an old illness or injury.

Experimental or Investigational Services: health care items or Services that are either not generally accepted by informed health care Providers in the United States as effective in treating the condition, illness or diagnosis for which their

use is proposed, or are not proven by Medical or Scientific Evidence to be effective in treating the condition, illness or diagnosis for which their use is proposed.

Facility (Facilities): the following institutions or entities:

- ambulatory surgical centers
- birthing centers
- community Mental Health centers
- *General Hospitals
- *Home Health Agencies/Visiting Nurse Associations
- *Physical Rehabilitation Facilities
- *Psychiatric Hospitals
- *Residential Treatment Center
- *Skilled Nursing Facilities
- *Substance Abuse Rehabilitation Facilities

*Facilities further defined in this chapter. The patient's home is not considered a Facility.

General Hospital: a short-term, Acute Care hospital that:

- is a duly licensed institution;
- primarily provides diagnostic and therapeutic Services for the diagnosis, treatment and care of injured and sick people by or under the supervision of Physicians;
- has organized departments of medicine and major Surgery; and
- provides 24-hour nursing Services by or under the supervision of registered nurses.

Group: the organization that has agreed to forward subscription rates due under your Contract.

Group Benefits Manager: the individual (or organization) who has agreed to forward all subscription rates due under your Contract. The Group Benefits Manager is the agent of the Subscriber. Your Group Benefits Manager has no

authority to act on our behalf and is not our employee or agent. We disclaim all liability for any act or failure to act by your Group Benefits Manager.

Home Health Agency/Visiting Nurse

Association: an organization that provides skilled nursing and other Services in your home. It must be certified under Title 18 of the Social Security Act, as amended (Medicare-certified).

Hospice: an organization engaged in providing care to the terminally ill. It must be federally certified to provide Hospice Services or accredited as a Hospice by the Joint Committee of Accreditation of Healthcare Organizations.

Incapacitated Dependent: a Dependent who meets our definition of Child (except he or she is over the age of 19) and who:

- is incapable of self-support by reason of mental or physical disability that has been found to be a disability that qualifies or would qualify for Benefits using the definitions, standards and methodology in 20 C.F.R. Part 404, Subpart P;
- became incapable of self-support when he or she was a Child or a student; and
- is chiefly dependent on the Subscriber or the Subscriber's estate for support and maintenance.

Include(s), Including: to have as a part or member of a whole; contain. To put into a group, class or total. "Include," followed by a list, does not imply the list is complete, unless used with the word "only."

Inpatient: a patient at a Facility who is admitted and incurs a room and board charge. We compute the length of an Inpatient stay by counting either the day of admission or the day of discharge, but not both.

Intensive Outpatient Programs: pro-

grams that have the capacity for planned, structured Service provision of at least two hours per day and three days per week. The Services offered address Mental Health or Substance Abuse-related disorders and could include group, individual, family or multi-family group psychotherapy, psychoeducational Services, and adjunctive Services such as medical monitoring. These Services would include multiple or extended treatment, rehabilitation or counseling visits or professional supervision and support.

Investigative/Investigational: (see Experimental)

Medical Care: non-surgical treatment of an illness or injury by a Professional Provider.

Medical or Scientific Evidence: the following sources:

- peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
- peer-reviewed literature, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS database Health Services Technology Assessment Research (HSTAR);
- medical journals recognized by the federal Secretary of Health and Human Services, under Section 1861 (t)(2) of the federal Social Security Act;
- the following standard reference compendia: the American Hospital Formulary Service-Drug Information,

the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics and the United States Pharmacopoeia-Drug Information;

- findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health Services; and
- peer-reviewed abstracts accepted for presentation at major medical association meetings.

Medically Necessary Care: health care Services including diagnostic testing, preventive Services and aftercare appropriate, in terms of type, amount, frequency, level, setting and duration to the member's diagnosis or condition. Medically Necessary Care must be consistent with generally accepted practice parameters as recognized by health care Providers in the same or similar general specialty as typically treat or manage the diagnosis or condition, and:

- help restore or maintain the member's health; or
- prevent deterioration of or palliate the member's condition; or
- prevent the reasonably likely onset of a health problem or detect an incipient problem.

Even if a Provider prescribes, performs, orders, recommends or approves a Service or supply, we may not consider it Medically Necessary.

Mental Health Condition: nervous or mental condition, only as listed in the Mental Disorders section in the International Classification of Diseases Manual (ICD-9-CM). The following conditions are not considered Mental Health Conditions in this Contract and are Covered under other sections of this Certificate (subject to all terms, limitations and exclusions):

- conditions related to Substance Abuse (refer to Substance Abuse definition);
- hyperkinetic syndrome of childhood (ICD-9-CM codes 314.1, 314.2 and 314.8), except for intervention for Acute, brief episodes when other diagnoses are present;
- specific delays in development (ICD-9-CM codes 315.00 through 315.99);
- psychic factors associated with diseases classified elsewhere in the ICD-9-CM (ICD-9-CM code 316.00); and
- mental retardation (ICD-9-CM codes 317.00 through 319.99), except for interventions for Acute, brief episodes when other diagnoses are present.
- Mental Health disorders also include only the following nervous or Mental Conditions as listed in the "V Codes" section in the International Classification of Diseases Manual (ICD-9-CM):
- personal history of mental disorder (ICD-9-CM codes V11.00 through V11.99);
- psychological trauma (ICD-9-CM code V15.40);
- psychiatric condition (ICD-9-CM code V17.00);
- other family circumstances and other psychosocial circumstances (ICD-9-CM codes V61.00 through V62.99); and
- observation for suspected mental condition (ICD-9-CM code V71.00).

To find out if your condition is Covered, please call your Network Provider.

Mental Health Services: Services to diagnose or treat a Mental Health Condition.

Network: (see Provider)

Non-participating: (see Provider)

Occupational Therapy: therapy that promotes the restoration of a physically disabled person's ability to accomplish the ordinary tasks of daily living or the requirements of the person's particular occupation. Occupational Therapy must include constructive activities designed and adapted for a specific condition.

Off-label Use of a Drug: use of a drug for other than the particular condition for which the Federal Drug Administration gave approval.

Other Provider: one of the following entities:

- Ambulance
- Participating home infusion therapy Provider
- medical equipment/supply Provider (DME)
- Pharmacy
- podiatrist (D.P.M.)

Outline of Coverage: the summary of your Contract Benefits.

Outpatient: a patient who receives Services from a Professional or Facility while not an Inpatient.

Palliative: intended to relieve symptoms (such as pain) without altering the underlying disease process.

Participating (Participates): (see Provider)

Parties to a Civil Union: (see Dependent)

Pharmacist: a person who is legally licensed to practice the profession of Pharmacy.

Pharmacy: any establishment that is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

Physical Rehabilitation Facility: a Facility that primarily provides rehabilitation Services on an Inpatient basis. Care consists of the combined use of medical, Pharmacy, social, educational and vocational Services. These Services enable patients disabled by disease or injury to achieve continued improvement of functional ability. Services must be provided by or under the supervision of Physicians. Nursing Services must be provided under the supervision of registered nurses (RNs).

Physical Therapy: therapy that relieves pain of an Acute condition, restores function and prevents disability following disease, injury or loss of body part.

Physician: a doctor of medicine (includes psychiatrists), dental Surgery, medical dentistry, naturopathy or osteopathy.

Consulting: describes a Professional Provider whom your attending Physician asks for Professional advice about your condition.

Plan: Blue Cross Blue Shield of Vermont.

Pre-existing Condition: a condition for which you have sought medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment has been recommended during the six months before you became Covered under this Contract.

Prescription Drugs: insulin and drugs that are:

- prescribed by a Physician for a medical condition;
- FDA-approved; and

- approved by us for reimbursement for the specific medical condition being treated or diagnosed, or as otherwise required by law.

Preventive Services: Services performed in the absence of known or suspected disease, which are rendered for the purpose of early detection and prevention of health issues. Examples include periodic comprehensive, age specific evaluation and management Services (well person examinations) and administration of nationally recommended immunizations.

Prior Approval: the required approval that you must get from us before you receive specific Services noted in your Contract. In most cases, we require that you get our Prior Approval in writing. We may request a treatment plan or a letter of medical need from your Physician. If you do not get approval from us before you receive certain Services as noted in your Contract, Benefits may be reduced or denied.

Professional: one of the following practitioners:

- athletic trainers
- audiologists
- Chiropractors (as further defined in this chapter)
- independent clinical laboratories
- Mental Health Professionals:
 - clinical Mental Health counselors
 - clinical psychologists
 - clinical social workers
 - marriage and family therapists
 - psychiatric nurse practitioners
- nurses:
 - certified nurse midwives (not lay or professional midwives)
 - certified registered nurse anesthetists
 - licensed practical nurses (LPNs)
 - nurse practitioners
 - registered nurses (RNs)
- nutritional counselors

- optometrists
- Physicians (as further defined in this chapter)
- podiatrists
- Substance Abuse counselors
- therapists (Occupational, Physical and Speech)

Some Professionals must have a Participating Provider agreement with us in order for their Services to be Covered. See Choosing a Provider on page 6.

Provider: a Facility, Professional or Other Provider that is:

- approved by us;
- licensed and/or certified where required; and
- acting within the scope of that license and/or certification.

Network Provider: any Provider identified as being a member of one of our Networks (for example, our Pharmacy Network). You may find a Network Provider on our website at www.bcbsvt.com. You may also get a directory of Network Providers from your Group Benefits Manager or from our customer service department. Some Providers must be in our Network in order for their Services to be Covered. See Choosing a Provider on page 6.

Participating Provider: any Provider that has a Participating Provider agreement with us; or any Provider located out of state that has a similar agreement with another Blue Cross and Blue Shield Plan. (See also Non-participating Provider, below.)

For some types of Service, we do not provide Benefits if you do not use a Participating Provider.

Non-participating Provider: a Provider that does not meet the definition of a Participating Provider. For some types of Service, we do not provide Benefits if you use a Non-participating Provider.

Psychiatric Hospital: a Facility that provides

diagnostic and therapeutic Facilities for the diagnosis, treatment and Acute Care of mental and personality disorders. Care must be directed by a staff of Physicians. A Psychiatric Hospital must:

- provide 24-hour nursing Service by or under the supervision of registered nurses (RNs);
- keep permanent medical history records; and
- be a private psychiatric or public mental hospital, licensed in the state where it is located.

Reconstructive: Medically Necessary procedures to correct gross deformities with physiological and functional impairments attributable to congenital defects, injury (including birth) or disease.

Residential Treatment Center: a Facility that is licensed at the residential intermediate level or as an intermediate care facility (ICF) and provides Residential Treatment Program Services.

Residential Treatment Program: a 24-hour level of care that provides patients with long-term or severe mental disorders or Substance Abuse-related disorders with residential care. Care is medically monitored, with 24-hour medical availability and 24-hour onsite nursing Services. Care includes treatment with a range of diagnostic and therapeutic behavioral health Services that cannot be provided through existing community programs. Residential care also includes training in the basic skills of living as determined necessary for each patient.

Respite Care: care that relieves family members or caregivers by providing temporary relief from the duties of caring for Covered terminally

ill patients. Respite Care is provided in a General Hospital or in your home, whichever is most appropriate.

Rest Cure: treatment by rest and isolation such as, but not limited to, hot springs or spas.

Screening/Preventive: Screening/Preventive: Screening/Preventive procedures are performed when there is no reason to suspect the presence of disease. Screening procedures are performed for the purposes of early detection and intervention (prevention). We follow national guidelines for the normal frequency for these procedures.

When disease is known to be present, these same procedures are surveillance or diagnostic/therapeutic procedures. When disease has been present in the past, these same procedures may be surveillance and/or diagnostic/therapeutic procedures. What is initiated as a Screening procedure may turn out to be a surveillance or diagnostic/therapeutic procedure if a disease condition is found or suspected during the course of the Screening. In such cases, we pay benefits based on your Provider's bill and medical documentation, as well as the terms and conditions of your Contract. Depending on the bill submitted by your Provider, you may pay more for a Service that the Provider has determined to be diagnostic rather than screening/preventive.

Services: health care treatment including but not limited to evaluations, examinations or supplies.

Skilled Nursing Facility: a Facility that primarily provides 24-hour Inpatient skilled nursing care and related Services. Physicians provide or direct Services. Facilities must keep permanent medical history records. The Facility is not, other than incidentally, a place that provides:

- minimal care, Custodial Care, ambulatory care or part-time care Services;

- care or treatment of Mental Health Conditions, Substance Abuse or pulmonary tuberculosis; or
- rehabilitation.

Speech Therapy: therapy to correct speech impairment resulting from an Acute disease or occurrence.

Spouse: (see Dependent)

Subscriber: the individual who enters into this Contract with us.

Substance Abuse: Substance Abuse conditions only as listed in the Mental Disorders section in the International Classification of Diseases Manual (ICD-9-CM) as follows:

- alcohol and drug psychoses (ICD-9-CM codes 291.00 through 292.99);
- alcohol dependence syndromes (ICD-9-CM codes 303.00 through 303.99);
- drug dependence (ICD-9-CM codes 304.00 through 304.99); and
- non-dependent abuse of drugs (ICD-9-CM codes 305.00 through 305.99), except tobacco use disorder (ICD-9-CM code 305.10) and other, mixed or unspecified drug abuse (ICD-9-CM code 305.90).

Substance Abuse Rehabilitation Facility:

a Facility that primarily provides 24-hour rehabilitation treatment seven days per week for Substance Abuse. Facility must offer sufficient availability of medical and nursing Services to manage ancillary detoxification needs. Treatment must follow a written plan. Facilities located in Vermont must be state-approved. Out-of-state Facilities must be accredited by the Joint Commission for Accreditation of Rehabilitation Facilities.

Supportive Care: Services provided for a known relapsing or recurring condition to prevent an exacerbation of symptoms that would require additional Services to restore an individual to his or her usual state of health or to prevent progressive deterioration.

Surgery: generally accepted invasive, operative and cutting procedures. Surgery includes:

- specialized instrumentations;

- endoscopic examinations;
- treatment of burns;
- correction of fractures and dislocations; and
- anesthesia and the administration of anesthetics to get general or regional (but not local) muscular relaxation, loss of sensation or loss of consciousness.

Urgent Services: those health care Services that are necessary to treat a condition or illness of an individual that if not treated within 24 hours presents a serious risk of harm, or, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, could seriously jeopardize the ability of the individual to regain maximum function, or, in the opinion of a Physician with knowledge of the individual's medical condition, would subject the individual to severe pain that cannot be adequately managed without care within 24 hours.

We, Us, Our: Blue Cross and Blue Shield of Vermont, or any designated agent(s) or reinsurers (where applicable) of Blue Cross and Blue Shield of Vermont.

Well-child Care: normal periodic evaluation of a well child.

Wellness (Maintenance) Care: treatment in the absence of an Acute event or a known relapsing or recurring condition that is provided when there are minimal or no current symptoms and which is designed to promote health, enhance quality of life, or prevent the onset over time of future symptoms or disability. Wellness Care is usually provided on a regularly scheduled basis.

You, Your: the Subscriber and any Dependents Covered under the Subscriber's Contract.

More Information About Your Contract

You hereby expressly acknowledge your understanding that your Contract constitutes a contract solely between you and Blue Cross and Blue Shield of Vermont, that we are an independent corporation operating under a controlled affiliate license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans, (the "Association") permitting us to use the Blue Cross and Blue Shield Service Marks in the state of Vermont, and that we are not contracting as the agent of the Association. You further acknowledge and agree that you have not entered into your Contract based upon representations by any person other than us and that no person, entity or organization other than us shall be held accountable or liable to you for any of our obligations to you created under your Contract. This paragraph will not create any additional obligations whatsoever on our part, other than those obligations created under other provisions of your Contract.

Newborns' and Mothers' Health Protection Act

Under federal law, Group health plans and health insurance issuers offering Group health insurance Coverage generally may not restrict Benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Provider (e.g., your Physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may

not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain Prior Approval or precertification. For information on such requirements of your Contract, please read your Contract documents (Certificate, Outline of Coverage, endorsements or riders).

If you have any questions regarding your rights under this Act, please contact our customer service department at the phone number on the back of your ID card.

Women's Health and Cancer Rights Act of 1998

Federal law requires us to notify you of our Benefits for Reconstructive Surgery following mastectomy.

The Women's Health and Cancer Rights Act of 1998 requires that we provide Benefits for reconstruction of the breast on which a mastectomy has been performed and/or the other breast (to produce a symmetrical appearance). We also Cover prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas, as required by the Act.

Benefits for the above Services are subject to all terms and conditions of your Contract. For example, they require the same Coinsurance, Co-payments and Deductibles as the rest of your Coverage.

If you have any questions about your rights under this Act, please contact our customer service depart-

ment at the number on the back of your ID card.

Our Quality Improvement Program

Our Quality Improvement (QI) program seeks to improve our service to you. It can also improve the care you get. Through QI:

- we make sure you can get the care you need;
- look at the quality of care you get from Providers; and
- work with BCBSVT staff and Providers to fix any problems we find.

QI studies and projects focus on:

- promoting well-care and early treatment;
- making sure all of our Providers give the same good care;
- finding and keeping the best Providers in our Networks;
- helping members live with chronic diseases like asthma or diabetes;
- protecting members; and
- telling them about the plan.

Many of our QI projects involve member input. From time to time we will ask you to complete surveys to help us serve you better. We use your answers to surveys to improve our policies. We also use the complaints you make. We listen to you so we can make the plan better.

We also have quality committees with member representatives. If you would like to be on our member quality committee or participate in one of our QI projects, please call our customer service department at the number on the back of your ID card. Also call if you would like to suggest a change in one of our

policies. We keep track of these suggestions. We look at them when writing new policies.

Information About Your Health Plan

We will provide you with any information about your health plan, except if we can't by law. Call customer service at the number on the back of your ID card.

Here are examples of information you may want:

- a copy of BCBSVT's quality improvement program;
- facts about how we choose Providers;
- our Health Plan Employer Data and Information Set (HEDIS); results (showing how we did in providing care)
- a list of preventive Services like pap smears);
- standards we use to choose Providers in our network and medical review staff;
- standards we use to review the quality of care;
- a summary of the guidelines we use to make medical decisions;
- listings of our Providers;
- a list of Mental Health and Substance Abuse Providers; and
- advice on how to get a copy of your medical records.

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