We'll see you through.

BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association.

2016 Health Care Benefits

Plan J and Comprehensive

Certificate of Coverage

This is the Contract for your health plan.

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

- The Certificate of Coverage in this booklet, which describes your Benefits in detail. It explains requirements, limitations and exclusions for coverage.
- The Outline of Coverage, which shows what you must pay Providers. This will arrive in a separate mailing.
- Any Riders or Endorsements that follow your Certificate, which describe additional coverage or changes to your Contract.
- Your ID card, which you should take with you when you need care. This will arrive in a separate mailing.
- Your Group Enrollment Form (your application) and any supplemental applications that you submitted and we approved.
- This Contract is current until we update it. We sometimes replace just one part of your Contract. 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." Information there applies to all Services. Pay special attention to the section on our "Prior Approval Program."
- 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 see if the Service you need is on this list.
- Please remember that to know the full terms of your coverage, you should read your entire Contract.
- To find out what you must pay for care, check your Summary of Benefits and Coverage.
- 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. We define the terms "We," "Us," "You" and "Your," but we do not capitalize them in the text.
- If you need materials translated into a different language call the customer service number on the back of your ID card.
- If you need translation services such as telecommunications devices for the deaf (TDD) or telephone typewriter teletypewriter (TTY), please call (800) 535-2227.

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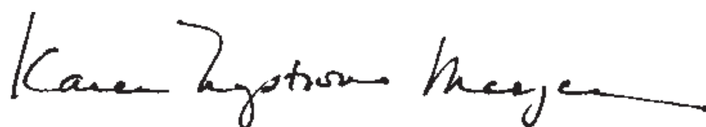
After we accept your application, we Cover the health care Services in your Contract, subject to all Contract conditions. Coverage continues from month to month until your Contract ends as allowed by its provisions. (See Chapters Six and Seven.)

The service area for your health plan is the state of Vermont. We sell health plans to people who live in Vermont. We sell plans to employer Groups located in the state of Vermont. Our plans are issued, renewed and delivered in Vermont without respect to where any Covered Dependent or employee resides. You may receive care both inside and outside of the service area. Please read the *Guidelines for Coverage* chapter carefully to find out when you may receive care outside the area.

Karen Nystrom Meyer

Chair of the Board



Don C. George

President & CEO

Christopher Gannon

General Counsel & Secretary

CHAPTER ONE

Guidelines for Coverage

This Certificate describes benefits under your health Plan. You have a Plan J or Comprehensive Plan issued by Blue Cross and Blue Shield of Vermont (BCBSVT). If you have Plan J, a Plan J rider accompanies this Certificate.

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 its guidelines.

General Guidelines

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

- Capitalized words have special meanings. We define them in Chapter Nine. Read "Definitions" to understand your coverage.
- We only pay benefits for services we define as Covered by this contract. For some services, you must use Providers who Participate with us.
- The provisions of this contract only apply as provided by law.
- We exclude certain services from coverage under this contract. You'll find general exclusions in Chapter Three. They apply to all services. Exclusions that apply to specific services appear in other sections of your contract.
- We do not Cover services we do not consider Medically Necessary. You may appeal our decisions.
- This is not a long-term care policy as defined by Vermont State law at 8 V.S.A. §8082 (5).
- 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.

Prior Approval Program

We require Prior Approval for certain services and drugs. They appear on the list later in this section. We do not require Prior Approval for Emergency Medical services.

Participating Providers get Prior Approval for you. If you use a Non-Participating Provider, it is your responsibility to get Prior Approval. Failure to get Prior Approval could lead to a denial of benefits. If you can show that the services you received were Medically Necessary, we will provide benefits. If you use a Vermont Participating Provider and the Provider fails to get Prior Approval for services that require it, the Provider may not bill you.

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

How to Request Prior Approval

To get Prior Approval, your Participating Provider must provide supporting clinical documentation to BCBSVT. When receiving care from a Non-Participating Provider or an out-of-state Provider, it is your responsibility to get Prior Approval. Forms are available on our website at **www.bcbsvt.com**. You may also get them by calling our customer service team. The phone number is located on the back of your ID card.

Any Provider may 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 form and respond in writing to you and your provider.

Prior Approval List

You need Prior Approval for services printed on our Prior Approval list. This list includes:

- non-emergency Ambulance transport including air or water transport;
- anesthesia for colonoscopy or endoscopy;
- treatment of Autism Spectrum Disorder;
- bilevel positive airway pressure (BPAP) equipment:
- hospital-grade electric breast pump;
- capsule endoscopy;
- chemodenervation;
- chiropractic care after 12 visits in a Plan Year;
- chondrocyte transplants;
- cochlear implants and aural rehabilitation;
- continuous passive motion (CPM) equipment;
- continuous positive airway pressure (CPAP) equipment;
- dental services (please see page 12 for details) (your Plan does not cover wisdom teeth extraction);
- Durable Medical Equipment (DME) and with a purchase price over $500;
- Electroconvulsive Therapy (ECT);
- gender reassignment services for gender dysphoria;
- genetic testing;
- Habilitation services;
- hip resurfacing;
- hyperbaric oxygen therapy;

- medical nutrition for inherited metabolic disease (medical supplies, pumps, enteral formulae and parenteral nutrition);
- new procedures considered Investigational or Experimental;
- orthognathic surgery;
- orthotics with a purchase price over $500;
- osteochondral autograph transfer system (OATS/mosaicplasty);
- out-of-state Inpatient and partial Inpatient care;
- percutaneous radiofrequency ablation of liver;
- plastic and Cosmetic procedures except breast reconstruction for patients with a diagnosis of breast cancer;
- polysomnography (sleep studies) and multiple sleep latency testing (MSLT);
- Prescription Drugs (certain Prescription Drugs; please see Rx Center at **www.bcbsvt.com**);
- prosthetics with a purchase price over $500;
- psychological testing;
- radiation treatment;
- radiology services (examples include CT, MRI, MRA, MRS, PET, echocardiogram and nuclear cardiology);
- Rehabilitation (Skilled Nursing Facility, Inpatient Rehabilitation treatment for medical conditions, intensive outpatient services or residential treatment for mental health and substance abuse conditions);
- certain surgical procedures including bariatric (obesity) Surgery, gastric electrical stimulation, percutaneous vertebroplasty, vertebral augmentation, temporomandibular joint manipulation/Surgery and anesthesia and tumor embolization;
- transcutaneous electrical nerve stimulation (TENS) units/neuromuscular stimulators;
- transplants (except corneal and kidney);
- uvulopalatopharyngoplasty (UPPP)/somnoplasty.

Case Management Program

Our case management program is a voluntary program. It is available in certain circumstances. Your case manager will work with you, your family and your Provider to coordinate Medical Care for you.

Your case manager will help you manage your benefits. He or she may also find programs, services and support systems that can help. To find out if you are eligible for the program, call (800) 922-8778 and choose option 1.

Choosing a Participating Provider

For many services, you may use any Provider. For some services, you must use Participating Providers. Most times, using Participating Providers will save you money. If you see an out-of-state participating Provider, it is your responsibility to request Prior Approval for services. Also, Participating Providers will:

- secure Prior Approval for you;
- bill us directly for your services, so you don't have to submit a claim;
- not ask for payment at the time of service (except for Deductible, Co-insurance or Co-payments you owe); and
- accept the allowed amount as full payment (you do not have to pay the difference between their total charges and the allowed amount).

If you are a new member and are seeing a Provider who does not Participate, we may allow you to keep going to that Provider for up to 60 days after you join or until we find you a Participating Provider. This can happen if:

- you have a life-threatening illness;
- you have an illness that is disabling or degenerative;

Women in their second or third trimester of pregnancy may continue to obtain care from their previous provider until the completion of postpartum care.

We only allow this if your Non-Participating Provider will take the Plan's rates and follow the Plan's standards. The Plan's medical staff must decide that you qualify for the service. To find out, call customer service at the number on the back of your ID card.

If you want a list of our Participating Providers or want information about one, please visit our website at **www.bcbsvt.com** and use the Find-a-Doctor tool. Use the Network drop-down menu and select *BCBSVT Network Providers* to find a list of Providers.

If you live or travel outside of the BCBSVT provider-network area please visit:

- **provider.bcbs.com**; and
- select the Blue Cross and Blue Shield Association's *BlueCard Traditional* network.

Please note, you may use your three-letter prefix, located on your ID card, to find a network provider using the Find-a-Doctor tool.

You may also call our customer service team at the number on the back of your ID card. We will send you a paper Provider directory if you wish. Both electronic and paper directories give you information on Provider qualifications, such as training and board certification.

You may change Providers whenever you wish. Follow the guidelines in this section when changing Providers.

How We Choose Providers

When we choose Participating Providers, we check their backgrounds. We use standards of the National Committee on Quality Assurance (NCQA). We choose Participating Providers who can provide the best care for our members. We do not reward Providers or staff for denying services. We do not encourage Providers to withhold care.

Please understand that our Participating Providers are not employees of BCBSVT. They just contract with us.

Primary Care Providers

You do not need to select a Primary Care Provider (PCP) for this Plan. We encourage you to form a relationship with a Provider who will coordinate your care. Your coverage does not require you to get referrals. You must get Prior Approval, however, for certain services. (See page 5)

Access to Care

We require our Participating Providers in the state of Vermont to provide care for you:

- immediately when you have an Emergency Medical Condition;
- within 24 hours when you need Urgent Services;
- within two weeks when you need non-Emergency, non-Urgent Services;
- within 90 days when you need Preventive care (including routine physical examinations);
- within 30 days when you need routine laboratory, imaging, general optometry, and all other routine services.

If you live in the state of Vermont, you should find:

- a Participating Primary Care Provider (like a family practitioner, pediatrician or internist) within a 30-minute drive from your home;
- routine, office-based mental health and/or substance abuse care from a Participating Provider within a 30-minute drive; and
- a Participating pharmacy within a 60-minute drive.

You'll find specialists for most common types of care within a 60-minute drive from your home. They include optometry, laboratory, imaging and Inpatient medical rehabilitation Providers, as well as intensive Outpatient, partial hospital, residential or Inpatient mental health and substance abuse services.

You can find Participating Providers for less common specialty care within a 90-minute drive. This includes kidney transplantation, major trauma treatment, neonatal intensive care and tertiary-level cardiac care.

Our Vermont Participating Providers offer reasonable access for other complex specialty services including major burn care, organ transplants and specialty pediatric care. We may direct you to a "center of excellence" to ensure you get quality care for less common medical procedures.

For many types of care, you may use Non-Preferred or Non-Participating Providers (see below). If you do use a Non-Participating Provider or a Non-Preferred Provider (your Provider network is dependent upon your Plan), you may pay more for the cost of your care.

Non-Participating Providers

If you use a Non-Participating Provider for a Covered service, we pay the allowed amount and you pay any balance between the Provider's charge and what we pay. You must also pay Deductibles and Co-insurance. (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 and licensed Professional midwives;
- lactation consultants;
- nutritional counseling Providers (including registered dietitians, licensed nutritionists, certified diabetic educators, medical doctors, naturopaths, doctors of osteopathy and nurse practitioners);
- pharmacies;
- Physical Rehabilitation Facilities; and
- Skilled Nursing Facilities.

Out-of-State Providers

If you need care out of state, you may save money by using Providers that are considered Participating Providers with their local Blue Plan. See the BlueCard section on page 9.[1]

1 Ancillary providers such as independent clinical laboratories, Durable Medical Equipment Suppliers and specialty pharmacies must contract directly with the Blue Plan in the state where the services were ordered or delivered in order for you to receive Participating Provider benefits. To verify provider participation status, please call customer service at the number on the back of your ID card.

After-hours and Emergency Care

Emergency Medical Services

In an emergency, you need care right away. Please read our definition of an Emergency Medical Condition in Chapter Nine.

Emergencies might include:

- broken bones;
- heart attack; or
- choking.

You will receive care right away in an emergency.

If you have an emergency at home or away, call 9-1-1 or go to the nearest doctor or emergency room. You do not need approval for Emergency Care. If an out-of-area hospital admits you, call us as soon as reasonably possible.

If you receive Medically Necessary, Covered Emergency Medical Services from a Non-Participating Provider, we will Cover your Emergency Care as if you had been treated by a Participating Provider. You must pay any cost sharing amounts required under your contract as if you received those services from a Participating Provider. These may include Deductibles, Co-insurance or Co-payments. If a Non-Participating Provider requests any payment from you other than your cost sharing amounts, please contact us at the number on the back of your ID card, so that we can work directly with the Provider to resolve the request.

Care After Office Hours

In most non-emergency cases, call your doctor's office when you need care—even after office hours. He or she (or a covering doctor) can help you 24 hours a day, seven days a week. Do you have questions about care after hours? Ask now before you have an urgent problem. Then keep your doctor's phone number handy in case of late-night illnesses or injuries.

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 the allowed amount (explained later in this section). We may subtract any:

- benefits paid by Medicare;
- Deductibles (explained below);
- Co-payments (explained below);
- Co-insurance (explained below);
- amounts paid or due from other insurance carriers through coordination of benefits (see Chapter Five).

Your Deductible, Co-insurance and Co-payment amounts appear on your *Outline of Coverage*. We may limit benefits to the Plan Year maximums shown on your *Outline of Coverage*.

Payment Terms

Allowed Amount

The Allowed Amount is the amount we consider reasonable for a Covered service or supply.

Note:

- Participating Providers accept the Allowed Amount as full payment. You do not have to pay the difference between their total charges and the allowed amount.
- If you use a Non-Participating Provider, we pay the Allowed Amount 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 Plan Year before we make payment on certain services. We apply your Deductible to your Out-of-Pocket Limit for each Plan Year. You may have more than one Deductible. Deductibles can apply to certain services or certain Provider types. Please see your *Outline of Coverage* for details.

When your family meets the family Deductible, no one in the family needs to pay Deductibles for the rest of the Plan Year.

Aggregate Deductible

Your plan may have an aggregate overall deductible. Please see your *Outline of Coverage* to see what type of deductible you have. If your plan has an aggregate overall deductible, and you are on a family plan, you do not have an individual deductible. Your family members' Covered expenses must reach the family deductible before any of your family members receive post-deductible benefits. When your family's expenses reach this amount, all family members receive post-deductible benefits.

Stacked Deductible

Your plan may have a stacked overall deductible. Please see your *Outline of Coverage* to see what type of deductible you have. If your plan has a stacked overall deductible, and you are on a family plan, a covered family member may meet the individual deductible and begin receiving

post-deductible benefits. When your family members' Covered expenses reach the family deductible, all family members receive post-deductible benefits.

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 may apply Co-payments toward your Out-of-Pocket-Limit. Check your *Outline of Coverage* for details on your plan.

You may have different Co-payments depending on the Provider you see. Check your *Outline of Coverage* for details.

Co-insurance

You must pay Co-insurance to Providers for specific services shown on your *Outline of Coverage*. We calculate the Co-insurance amount by multiplying the Co-insurance percentage by the Allowed Amount after you meet your Deductible (for services subject to a Deductible). We apply your Co-insurance toward your Out-of-Pocket Limit for each Plan Year.

Out-of-Pocket Limit

Your *Outline of Coverage* lists your Out-of-Pocket Limit if applicable. We apply your Deductible and your Co-insurance toward this limit. We may apply Co-payments toward your Out-of-Pocket-Limit. Check your *Outline of Coverage* for details on your plan. After you meet your Out-of-Pocket Limit, you pay no Co-insurance for the rest of that Plan Year. You may still be responsible for any Co-payments when they apply. Please check your *Outline of Coverage* for details.

When your family meets the family Out-of-Pocket Limit, all family members are considered to have met their individual Out-of-Pocket Limits. You may have separate Out-of-Pocket Limits for certain services.

Aggregate Out-of-Pocket Limit

Your plan may have an aggregate out-of-pocket limit. Please see your Outline of Coverage to see which kind of Out-of-Pocket limit you have. If your plan has an aggregate Out-of-Pocket Limit, you do not have an individual Out-of-Pocket Limit. Your family members' Covered expenses must reach the family Out-of-Pocket Limit before we pay 100 percent of the Allowed Amount for eligible services. When your family's expenses reach this amount, all family members receive 100 percent coverage.

Stacked Out-of-Pocket Limit

Your plan may have a stacked out-of-pocket limit. Please see you Outline of Coverage to see which kind of Out-of-Pocket limit you have. If your plan has a stacked out-of-pocket limit, and you are on a family plan, a covered family member may meet the individual out-of-pocket limit and we will begin to pay 100 percent of the Allowed Amount for his or her services. Additionally, any combination of covered family members may meet the family out-of-pocket limit and we will begin to pay 100 percent of the Allowed Amount for all family members' eligible services.

Plan Year Benefit Maximums

Your Plan Year benefit maximums are listed on your *Outline of Coverage* or in this Certificate. 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.

Self-Pay Allowed by HIPAA

Federal law gives you the right to keep your Provider from telling us that you received a particular health care item or service. You must pay the Provider the allowed amount. The amount you pay your PrFovider will not count toward your Deductible, other cost sharing obligations or your Out-of-Pocket Limits.

Out-of-Area Services

Whenever you obtain health care services outside of the Vermont service area, the claims for these services may be processed through the BlueCard Program[2].

Typically, when accessing care outside of the service area, you will obtain care from health care Providers that have a contractual agreement (i.e., are "participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating health care Providers. Our payment practices, in both instances are described below.

BlueCard® Program

The BlueCard® Program allows you to obtain Out-of-Area Covered health care services from participating health care Providers within the geographic area of a Host Blue. If you obtain care from a participating Provider in another geographic area, we will honor our

2 In order to receive Network Provider benefits as defined for ancillary services, ancillary providers such as independent clinical laboratories, Durable Medical Equipment Suppliers and specialty pharmacies must contract directly with the Blue Plan in the state where the services were ordered or delivered. To verify provider participation status, please call our customer service team at the number listed on the back of your ID card. .

contract with you, including all cost sharing provisions and providing benefits for Covered services. The Host Blue will receive claims from its participating Providers for your care and submit those claims directly to us.

We will base the amount you pay on these claims processed through the BlueCard Program on the lower of:

- The billed Covered charges for your Covered services; or
- The price that the Host Blue makes available to us.

Special Case: Value-Based Programs

If you receive Covered Services under a value-based program inside a Host Blue's service area, you may be responsible for paying any of the Provider Incentives, risk sharing, and/or Care Coordinator Fees that are part of such an arrangement.

Out-of-Area Services – Non-Participating Providers

In certain situations, you may receive Covered health care services from non-participating health care Providers outside of our service area that do not have a contract with the Host Blue. In most cases, we will base the amount you pay for such services on either the Host Blue's local payment or the pricing arrangements under applicable state law.

In some cases, we may base the amount you pay for such services on billed Covered charges, the payment we would make if the services had been obtained within our service area or a special negotiated payment.

In these situations, you may owe the difference between the amount that the non-participating Provider bills and the payment we will make for the Covered services as set forth above.

CHAPTER TWO

Covered Services

This chapter describes Covered services, guidelines and policy rules for obtaining benefits. Please see your *Outline of Coverage* for benefit maximums and payment terms such as Co-insurance and Deductibles.

Office Visits

When you receive care in an office setting, you must pay the amount listed on your *Outline of Coverage*. Please read this entire section carefully. Some office visit benefits have special requirements or limits. We Cover Professional services in an office setting for:

- examination, diagnosis and treatment of an injury or illness;
- Preventive care including routine physical examinations, immunizations and Well-child Care;
- injections;
- diagnostic services, such as X-rays;
- Emergency Medical Services (See page 13);
- nutritional counseling (See page 17);
- Surgery; and
- therapy services (See page 19).

Exclusions

We do not Cover:

- bulk immunizations (those provided to a group of people, such as employees in an office setting) or fluoride treatments performed in school;
- hearing aids (this includes hearing aids used as tinnitus masking device); and
- immunizations that the law mandates an employer to provide.

General exclusions in Chapter Three also apply.

Notes:

- We describe office visit benefits for mental health services, substance abuse treatment services, and chiropractic services elsewhere in this Chapter. Please see those sections for benefits.
- You must get Prior Approval for certain services in order to receive benefits. See page 5 for a description of the Prior Approval program. Visit our website or call customer service for the newest list of services that require Prior Approval.

Ambulance

We Cover Ambulance services as long as your condition meets our definition of an Emergency Medical Condition. Coverage for Emergency Medical services outside of the service area is the same as coverage within the service area. If a Non-Participating Provider bills you for the balance between the charges and what we pay, please notify us by calling our customer service team at the number on the back of your ID card. We will defend against and resolve any request or claim by a Non-Participating Provider of Emergency Medical Services.

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 non-emergency transport including air or water transport.
- We Cover transportation only to the closest Facility that can provide services appropriate for the treatment of your condition.
- We do not cover ambulance services when the patient can be safely transported by any other form of transportation. This applies whether or not the transportation is available.
- We do not Cover Ambulance transportation when it is solely for the convenience of the Provider, family or member.

Autism Spectrum Disorder

We Cover Medically Necessary services related to Autism Spectrum Disorder (ASD), which includes Asperger's Syndrome, moderate or severe Intellectual Disorder, Rett Syndrome, Childhood Disintegrative Disorder (CDD) and Pervasive Developmental Disorder—Not Otherwise Specified (PDD-NOS) for members up to age 21.

You must get Prior Approval for services or your benefits will not be Covered.

Please remember General Exclusions in Chapter Three also apply.

Cancer Clinical Trials (Approved)

We Cover Medically Necessary, routine patient care services for members enrolled in Approved Cancer Clinical Trials as required by law.

General exclusions in Chapter Three also apply.

Chiropractic Services

We Cover services by Participating Providers Chiropractors who are:

- working within the scope of their licenses; and
- treating you for a neuromusculoskeletal condition.

We Cover Acute and Supportive chiropractic care (only for services that require constant attendance of a Chiropractor), 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 Plan Year, you must get Prior Approval from us for any visits after the 12th. See page 5 for more information about the Prior Approval program.

Exclusions

We provide no chiropractic benefits for:

- treatment after the 12th visit if you don't get Prior Approval;
- services by a Provider who does not Participate with us;
- services, including modalities, that do not require the constant attendance of a Provider;
- 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 the patient's symptoms, physical findings, the chiropractor'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 pre-natal and post-natal care;
- Custodial Care (see Definitions), as noted in General Exclusions;
- hot and cold packs;
- Surgery;
- any other procedure not listed as a Covered chiropractic service; or
- unattended services or modalities (application of a service or modality) that do not require one-on-one patient contact by the provider.

Please remember General Exclusions in Chapter Three also apply.

Cosmetic and Reconstructive Procedures

We exclude many types of Cosmetic procedures (see exclusions in Chapter Three). You must get Prior Approval for all of these services. Your benefits include Reconstructive procedures that are not plastic/Cosmetic. (Please see the definitions of Reconstructive and Cosmetic.) For example, we Cover:

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

Dental Services

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 begins within six months of the accident.[3]
- 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).

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3 A sound, natural tooth is a tooth that is whole or properly restored using direct restorative dental materials (i.e. amalgams, composites, glass ionomers or resin ionomers); is without impairment, untreated periodontal conditions or other conditions; and is not in need of the treatment provided for any reason other than accidental injury. A tooth previously restored with a dental implant, crown, inlay, onlay, or treated by endodontics, is not a sound natural tooth.

- Surgery related to head and neck cancer where sound natural teeth may be affected primarily or as a result of the chemotherapy or radiation treatment of that cancer.

You must get Prior Approval for the services listed above as well as listed on page 5. If you fail to obtain Prior Approval, your care will not be Covered.

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 or in connection with an accidental injury);
- 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 or anesthesia (for example, facility charges, except when Medically Necessary for children under age 7 or members with disabilities or medical conditions that cannot receive care in an office setting).

General Exclusions in Chapter Three also apply.

Diabetes Services

We Cover 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. You must get nutritional counseling from one of the following Participating Providers or we will not Cover your care:

- medical doctor (M.D.);
- doctor of osteopathy (D.O.);
- registered dietitian (R.D.);
- certified dietician (C.D.);
- naturopathic doctor (N.D.);
- advanced practice registered nurse (A.P.R.N.); or
- certified diabetic educator (C.D.E.).

Diagnostic Tests

We Cover the following Diagnostic Tests to help find or treat a condition, including:

- 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 (read General Exclusions).

You must get Prior Approval for special radiology procedures (including CT, MRI, MRA, MRS and PET scans) and polysomnography (sleep studies). See page 5 for more information regarding Prior Approval.

Emergency Room Care

We Cover services you receive in the emergency room of a General Hospital. Coverage for Emergency Medical Services outside of the service area will be the same as for those within the service area. If a Non-Participating Provider bills you for a balance between the charges and what we pay, please notify us. Call our customer service team at the number on the back of your ID card. We will defend against and resolve any request or claim by a Non-Participating Provider of Emergency Medical services.

Requirements

We provide benefits only if you require Emergency Medical services as defined in this Certificate.

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 necessary services (except drugs and medications) furnished and billed by a Home Health Agency or Visiting Nurse Association; and
- home infusion therapy.

For more information about therapy services, see page 19.

Private Duty Nursing

We Cover skilled nursing services by a private-duty nurse outside of a hospital, subject to these limitations:

- We may limit benefits for private duty nursing. Check your *Outline of Coverage*.
- 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 Provider:

- 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 a member or a lay care-giver with the appropriate training can perform them. Also, we provide benefits only if the patient or a legally responsible individual consents in writing to the home care treatment plan.

Limitations

We Cover home infusion therapy only if:

- your Provider prescribes a home infusion therapy regimen;
- you use services from a Participating home infusion therapy Provider.

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 (while drugs and medications are not Covered under your home care benefits, we may Cover them under your Prescription Drug benefits if you have Prescription Drug coverage);
- 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:

- the patient and the Provider consent to the Hospice care plan; and
- a primary caregiver (family member or friend) will be in the home.

Hospital Care

The description of services below does not apply to Inpatient or Outpatient mental health and substance abuse treatment. The requirements for mental health benefits appear on page 17. Requirements for substance abuse treatment benefits appear on page 18.

Inpatient Hospital Services

We Cover Acute Care during an Inpatient stay in a General Hospital including:

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

- We Cover either the day of admission or the day of discharge, but not both. Certain Inpatient services require Prior Approval. Please see page 5 for a list of these services.

Inpatient Medical Services

We Cover services by a Provider or Professional Provider who sees you when you are an Inpatient in a hospital or Participating 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:

You must get Prior Approval for plastic/Cosmetic and Reconstructive procedures. 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 the allowed amount 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 for 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 the allowed amount for Surgery, please call customer service at the number on the back of your ID card.
- We Cover services of a Participating certified nurse midwife, a licensed midwife or a Provider for home delivery of a baby.
- We exclude many Cosmetic procedures (see General Exclusions in Chapter Three).

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 Provider or other Professional during a woman’s pregnancy:

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

We Cover home delivery or delivery in a Facility when you use a Covered Provider. We Cover services by certified nurse midwives and licensed midwives only if they are Participating Providers.

The allowed amount 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. 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 60 days after birth. (See Chapter Six for information on how to continue coverage for your newborn past this period.)

Please see your *Outline of Coverage* for cost-sharing details.

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 join this program, we provide a selection of benefit options designed for your circumstances. Benefit options include:

- books and other educational tools;
- reimbursement for classes; and
- vouchers for carseats.

Additional 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, please send in appropriate paperwork from the website. To get any benefits from Better Beginnings, you must actively participate. You get the most out of the Better Beginnings program when you contact us in the first three months of your pregnancy.

Note:

We may provide benefits through the Better Beginnings program for services that we do not generally cover. (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.

Medical Equipment and Supplies

You must get Prior Approval for continuous passive motion (CPM) equipment, TENS units or Durable Medical Equipment including orthotics with a purchase price of $500 or more. We Cover Durable Medical Equipment you purchase from a Participating

- medical doctor (M.D.);
- doctor of osteopathy (D.O.);
- therapist (physical or occupational);
- podiatrist (D.P.M);
- naturopathic provider (N.D.); or
- Durable Medical Equipment supplier.

We Cover the rental or purchase of Durable Medical Equipment (DME). We reserve the right to determine whether rental or purchase of the equipment is more appropriate.

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 use.

Orthotics

You must get Prior Approval for orthotics with a purchase price of $500 or more. We Cover 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 Prosthetics. We Cover 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 an anatomic supplement to replace:

- all or part of an absent body organ (including contiguous tissue and hair);
- hair loss due to chemotherapy and/or radiation therapy for the treatment of cancer, burns, traumatic injury, congenital baldness present since birth and medical conditions resulting in alopecia areata or alopecia totalis (excluding male or female pattern baldness and/or natural or premature aging);
- 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.

For wigs (cranial/scalp prothesis), we limit the replacement of the original wig (cranial/scalp prothesis) to one wig every three years.

We only Cover eyeglasses or contact lenses to treat aphakia or keratoconus. We Cover only:

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

Also, we Cover dental prostheses only if required:

- to treat an accidental injury (except injury as a result of chewing or biting);
- 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);
- duplicate medical equipment and supplies, orthotics and prosthetics;
- continuous passive motion equipment (unless you get Prior Approval);
- dynamic splinting, patient-actuated end-range motion stretching devices and programmable or variable motion resistance devices;
- replacement of medical equipment and supplies, orthotics and prosthetics that are lost or stolen;
- any treatment, Durable Medical Equipment, supplies or accessories intended principally for participation in sports or recreational activities or for personal comfort or convenience; and
- repair or replacement of dental appliances or dental prosthetics except as listed above.

General Exclusions in Chapter Three also apply.

Note:
To be sure your item meets our definition of Durable Medical Equipment, you may call customer service before purchasing or renting a Durable Medical Equipment item.

Mental Health Care

You must get Prior Approval for services on our Prior Approval list.

Coverage for Emergency Medical Services outside of the service area is the same as for those within the service area. Please contact Blue Cross and Blue Shield of Vermont at (800) 922-8778 if you have questions.

If a Non-Participating Provider bills you for a balance between the charges and what we pay, please notify us. Call our customer service team at the number on the back of your ID card. We will defend against and resolve any request or claim by a Non-Participating Provider of Emergency Medical Services.

Call as soon as possible after the emergency to arrange follow-up care.

Outpatient

We Cover 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.

Inpatient

We Cover Inpatient mental health services including:

- hospitalization; and
- short-term Residential Treatment Programs.

We Cover mental health services only if care is provided in the least restrictive setting Medically Necessary.

Exclusions

We provide no mental health benefits for:

- services ordered by a court of law (unless we deem them Medically Necessary);
- 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, Rubenfeld Synergy, energy polarity therapy and somatization therapy, that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories;
- services, including long-term residential programs, adventure-based activities, wilderness programs and residential programs, that focus on education, socialization or delinquency, as noted in General Exclusions;
- 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;
- biofeedback, pain management, stress reduction classes and pastoral counseling; and
- psychoanalysis, hypnotherapy.

Remember that the General Exclusions in Chapter Three also apply.

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 Plan Year.

You must receive nutritional counseling from one of the following Participating Providers or we will not provide benefits:

- medical doctor (M.D.);
- doctor of osteopathy (D.O.);
- registered dietitian (R.D.);
- certified dietician (C.D.);
- naturopathic doctor (N.D.);
- advanced practice registered nurse (A.P.R.N.); or
- certified diabetic educator (C.D.E.).

Outpatient Hospital Care

We Cover services such as chemotherapy (including including growth cell stimulating factor injections), Outpatient Surgery, diagnostic testing (like X-rays), or other Outpatient care in a General Hospital or ambulatory surgical center. Care may include:

- facility services;
- professional services; and
- related supplies.

You must get Prior Approval for certain radiology procedures (including CT, MRI, MRA, MRS and PET scans) and polysomnography (sleep studies). For our Prior Approval list see page 5. For more information about therapy services, see page 19.

Outpatient Medical Services

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

- surgery;
- abortion services;
- services of an assistant surgeon when necessary; and
- anesthesia services for Covered procedures.

Limitations

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

Rehabilitation/Habilitation

Rehabilitation or Habilitation services may require Prior Approval. Please check our list on page 18.

We Cover:

- Inpatient treatment in a Participating Physical Rehabilitation Facility for a medical condition requiring Acute Care;
- Outpatient cardiac or pulmonary rehabilitation for a condition requiring Acute Care;
- Rehabilitative or Habilitative services Covered elsewhere in your Contract (e.g.; under Therapy Services).

You must use a Participating cardiac rehabilitation Provider.

Requirements

The attending Provider must:

- certify that services of a Physical Rehabilitation Facility are required and are the most appropriate level of care for the condition being treated; and
- re-certify 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.

Exclusions

We do not Cover:

- Custodial Care (see Definitions), as noted in General Exclusions; or
- cognitive re-training or educational programs.

General Exclusions in Chapter Three also apply.

Skilled Nursing Facility

We Cover Inpatient services including:

- room, board (including special diets) and general nursing care;
- medication and drugs given to you by the Skilled Nursing Facility during a Covered stay; and
- medical services included in the rates of a Skilled Nursing Facility.

Requirements

We provide benefits only if you:

- request Prior Approval for Inpatient services;
- receive Acute Care in the Skilled Nursing Facility; and
- receive services from a Participating Skilled Nursing Facility.

Exclusions

We do not Cover Skilled Nursing Facility care for:

- Cognitive re-training
- Custodial Care

Substance Abuse Services

You must get Prior Approval for services on our Prior Approval list.

We Cover the following Acute substance abuse treatment services:

- detoxification;
- intensive outpatient programs (IOP);
- short term residential programs;
- Outpatient rehabilitation (including services for the patient's family when necessary); and
- Inpatient rehabilitation.

Coverage for Emergency Medical Services outside the service area will be the same as for those within the service area. If a Non-Participating Provider bills you for a balance between the charges and what we pay, please notify us. Call our customer service team at the number on the back of your ID card. We will defend against and resolve any request or claim by a Non-Participating Provider of Emergency Medical Services.

Requirements

We Cover substance abuse treatment services only if you get Medically Necessary care in the least restrictive setting.

Please contact Blue Cross and Blue Shield of Vermont at (800) 922-8778 if you have questions.

Exclusions

We provide no substance abuse treatment benefits for:

- services ordered by a court of law (unless we deem them Medically Necessary);
- non-traditional, alternative therapies such as eye movement desensitization, Rubenfeld 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 long-term residential programs, adventure-based activities, wilderness programs and residential programs, that focus on education, socialization, delinquency or Custodial Care (see Definitions), as noted in General Exclusions; and
- 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 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.

General Exclusions in Chapter Three also apply.

Therapy Services

We Cover physical therapy/medicine services provided by:

- an eligible Participating hospital, Skilled Nursing Facility or Home Health Agency/Visiting Nurse Association;
- a licensed physical therapist (P.T.);
- a medical doctor (M.D.), doctor of osteopathy (D.O.) or Participating Chiropractor (D.C.) in an office or home setting; or
- a Participating athletic trainer (A.T.) in a clinical setting (an Outpatient orthopedic or sports medicine clinic that employs an M.D., D.O., D.C. or licensed physical therapist).

Therapy services could include the following:

- radiation therapy;
- chemotherapy (including growth cell stimulating factor injections);
- dialysis treatment;
- Physical Therapy/physical medicine;
- Occupational Therapy;
- Speech Therapy; and
- infusion therapy.

We Cover Occupational, Speech and Physical Therapy/medicine only:

- for Physical Therapy/physical medicine services that require constant attendance of a licensed:
  - physical therapist;
  - medical doctor (M.D.);
  - Participating chiropractor (D.C.);
  - Participating athletic trainer (A.T.);
  - podiatrist (D.P.M.);
  - nurse practitioner (N.P.);
  - advanced practice registered nurse (A.P.R.N.);
  - doctor of naturopathy (D.N.); or
  - doctor of osteopathy (D.O.).
- up to specific benefit limits listed on your outline of coverage. (This limitation does not apply to mandated treatment for Autism Spectrum Disorder up to age 21 as defined by Vermont law).

Exclusions

We do not Cover the following therapy services:

- care for which there is no therapeutic benefit or likelihood of improvement;
- care, the duration of which is based upon a predetermined length of time rather than the condition of the patient, the result of treatment or the individual's medical progress;
- care provided but not documented with clear, legible notes indicating the patient's symptoms, physical findings, the provider's assessment, and treatment modalities used (billed);
- therapy services that are considered part of custodial care;
- services, including modalities, that do not require the constant attendance of a Provider;
- hot and cold packs;
- treatment of developmental delays. (This exclusion does not apply to mandated treatment of Autism Spectrum Disorder as defined by Vermont law.)
- unattended services or modalities (application of a service or modality) that do not require one-on-one patient contact by the provider.

General Exclusions in Chapter Three also apply.

Note:

We do not Cover group physical medicine services, group exercise or physical therapy performed in a group setting.

Transplant Services

You must get Prior Approval for transplant services.

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

- the patient's medical condition;
- the qualifications of the Providers 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:

- 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). The donor will only receive benefits for services that occur within 120 days from the date of the donor's Surgery;
- No benefits are available if we Cover the donor, but not the recipient.

Time Period for Living Donor Benefits

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.

Exclusions

We do not Cover 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.

Vision Services (Medical)

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 Provider for treatment of that condition. We Cover your visit to an optometrist in the same way we Cover visits to Providers performing Covered eye care.

Eyeglasses, contact lenses, and refraction

We don't Cover any determination of refractive state or any examination, prescription or fitting of eyeglasses or contact lenses unless the refraction, examination, prescription or fitting is for treatment of aphakia or keratoconus (see Prosthetics page 16).

If you need lenses to replace the lens of the eye (for treatment of aphakia or keratoconus), we will Cover only one pair of lenses per prescription.

CHAPTER THREE

General Exclusions

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 services and supplies that are not Medically Necessary. Also, we do not Cover the following even if they are Medically Necessary:

1. Services that a prior health plan must Cover as extended benefits.
2. Services you would not legally have 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 because you committed or attempted to commit a felony or engaged in an illegal occupation.
6. Services over the limitations or maximums set forth in your contract.
7. Services or drugs that we determine are Investigational, mainly for research purposes or Experimental in nature. To the extent required by law, however, we Cover routine costs for patients who participate in approved clinical trials.
8. Services not provided in accordance with accepted Professional medical standards in the United States.
9. Services beyond those needed to restore your ability to perform Activities of Daily Living (see Definitions) or to establish or re-establish the capability to perform occupational, hobby, sport or leisure activities.
10. Acupuncture, acupressure or massage therapy; hypnotherapy, rolfing, homeopathic or naturopathic remedies. We Cover Medically Necessary Covered services when performed within the scope of a naturopathic provider's license.
11. 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.)
12. Automatic ambulatory home blood pressure monitoring or equipment and all related services.
13. Biofeedback or other forms of self-care or self-help training.
14. Bulk immunizations (those provided to a group of people, such as employees in an office setting) or fluoride treatments performed in school.
15. 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.)
16. Care for which there is no therapeutic benefit or likelihood of improvement.
17. 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.
18. (Routine) Circumcision.
19. Clinical ecology, environmental medicine, Inpatient confinement for environmental change or similar treatment.
20. Cognitive training or retraining and educational programs, including any program designed principally to improve academic performance, reading or writing skills.
21. Communication devices and communication augmentation devices. Computer technology or accessories and other equipment, supplies or treatment intended primarily to enhance occupational, recreational or vocational activities, hobbies or academic performance.
22. Consultations, including telephone consultations, except when they occur between Providers and the Providers attach a written report to the patient's medical record.
23. Correction of near- or far-sighted 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.
24. Cosmetic procedures and supplies that are not Reconstructive.
25. Unless expressly Covered in other parts of this contract or required by law, we do not Cover:

- excision of 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;
- suction-assisted removal of fatty tissue (lipectomy) in the head, neck, trunk, upper extremity or lower extremity;
- breast lift (mastopexy) except when a necessary component of reconstruction of breasts following breast cancer surgery;
- Surgery to improve the appearance of the ear (otoplasty);
- mastectomy for gynecomastia;
- blepharoplasty repair of brow ptosis, repair of blepharoptosis, correction of lid retraction, reduction of overcorrection of lid ptosis; and
- Surgery to improve the appearance of the nose (rhinoplasty).

26. Custodial Care, Rest Cures.
27. Dental services and dental related 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).
28. Treatment of developmental delays. (This exclusion does not apply to mandated treatment of Autism Spectrum Disorder up to age 21 as defined by Vermont law.)
29. Drugs and pharmaceuticals, except as required by law (unless you have a drug rider).
30. Eyeglasses or contact lenses for refractive purposes unless you need them for the treatment of aphakia or keratoconus (and the lens was not replaced at the time of Surgery).
31. Education, educational evaluation or therapy, 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 diabetes, such as medical nutrition therapy by approved participating Providers.)
32. 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.
33. Hearing aids or examinations for the prescription or fitting of hearing aids (tinnitus masking devices).
34. Home or automobile modifications or equipment like air conditioners, HEPA filters, humidifiers, stair glides, elevators, lifts, motorized scooters, whirlpools, furniture or "barrier-free" construction, even if prescribed by a Provider.
35. Hot and cold packs.
36. Illnesses or injuries that are:
    - a result of an act of war (declared or undeclared); or
    - sustained in active military service
37. Infertility services, including:
    - all medications for treatment of infertility, including but not limited to Clomid, Clomiphene, Serophene, Bravelle, Gonal-F, Follistim AQ, Novarel, Ovidrel, Pregnyl, Profasi and Repronex when used for treatment of infertility; and
    - surgical, radiological, pathological or laboratory procedures leading to or in connection with artificial insemination (intravaginal, intracervical, and intrauterine insemination), 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.

    Note: This exclusion does not apply to the evaluation to determine if and why a couple is infertile.
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 Provider 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 Plan Year. This limit does not apply to the treatment of diabetes.

44. Food and nutritional formulae or supplements, except for "medical foods" prescribed for the Medically Necessary treatment of an inherited metabolic disease or prescription 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. Pain management programs.
47. Personal hygiene items.
48. Personal service, comfort or convenience items.
49. Photography services, photographic supplies or film development supplies or services (for example, external ocular photography or photography of moles to monitor changes).
50. 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.
51. Pneumatic cervical traction devices.
52. Services, including modalities, that do not require the constant attendance of a Provider;
53. Specialized examinations, services or supplies 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, equine therapy, music or art therapy, recreational therapy, tobacco cessation therapy, stress management, wilderness programs, therapy camps, adventure therapy and bright light therapy.
55. Sterilization reversal (vasectomy reversal, vasovasostomy, vasovasorrhaphy, tubal ligation reversal, tubotubal anastomosis).
56. "Store and forward telemedicine" or telemedicine not conducted at a Participating facility.
57. Travel (other than Ambulance transport), lodging and housing (when it is not integral to a Medically Necessary level of care, even if prescribed by a Provider).
58. Treatment solely to establish or re-establish the capability to perform occupational, hobby, sport or leisure activities.
59. Treatment of obesity, except surgical treatment when determined Medically Necessary through Prior Approval.
60. Unattended services or modalities (application of a service or modality) that does not require direct one-on-one patient contact by the provider.
61. Vision training, orthoptics or plano (non-prescription lenses).
62. 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 does not require an individual, such as a sole proprietor or an owner/partner to maintain worker's compensation if he or she does not legally need to be Covered.)
63. Services and supplies not specifically described as Covered.

Provider Exclusions

Also, your contract does not Cover services prescribed or provided by a:

- Provider that we do not approve for the given service or that is not defined in our "Definitions" section as a Provider.
- Professional who provides services as part of his or her education or training program.
- Member of your immediate family or yourself.
- Veterans Administration Facility treating a service-connected disability.
- Non-Participating Provider if we require use of a Participating Provider as a condition for coverage under your contract.

CHAPTER FOUR

Claims

Remember, when you contact a Provider, you must:

- tell your Provider that you have coverage with us; 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. Your claim must include all information necessary for us to administer your benefits. This includes information relating to other coverage you have.

Participating Providers will usually submit claims on your behalf if this is your primary coverage (see Chapter 5). When you use Non-Participating Providers, you must file your own claims.

Release of Information

We may need 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.

Our approval of your benefits depends on your giving us information, even if we provide benefits before you do. To avoid duplicate payments, we may inform other entities that provide benefits.

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

You must fully cooperate with us to obtain benefits. We may require you to provide signed or recorded statements. You must answer all reasonable questions we ask. Otherwise, we may deny benefits.

Payment of Benefits

We pay Vermont Participating Providers directly. We may pay out-of-state Participating Providers directly. We usually pay you when you use Non-Participating Providers. We may pay Non-Participating Providers directly.

You may not assign your benefit rights to any other party, including Non-Participating Providers. We may refuse to honor any benefit assignment presented to us.

For information on how we determine your benefit amount, see Chapter One. The fact that we provide benefits in one instance does not obligate us to do so again.

Payment in Error/Overpayments

If we provide more benefits than we should, we have the right to recover the overpayment. If we pay benefits to you incorrectly, we may require you to repay us. If so, we will notify you. You must cooperate with us during recovery. We may reduce or withhold future benefits to recover incorrect payments.

Regardless of whether we seek recovery, a wrong payment on one occasion will not obligate us to provide benefits on another occasion.

How We Evaluate Technology

Our Medical Policy committee (consisting of doctors and nurses and other health care Professionals) meets monthly to establish, review, update and revise medical policies. Medical policies document whether a new or existing health care technology has been scientifically validated to improve health outcomes for specific illnesses, injuries or conditions. Outcomes could include length or quality of life or functional ability. We set medical policies solely on a scientific basis.

We do not Cover technology that is Investigational or Experimental. To be Covered, a technology must:

- have final approval from the appropriate governmental regulatory bodies;
- permit conclusions concerning its effect on health outcomes;
- improve net health outcomes;
- be as beneficial as any established alternatives; and
- be attainable outside the Investigational settings.

We may seek additional sources of information and expertise about a new technology or application. We might use peer review or review by a medical advisory panel of local experts.

Complaints and Appeals

When You Have a Complaint

Customer Service

You may make an inquiry to our customer service team at any time if you have concerns. This is usually the best, first course of action. Our customer service team can solve most problems. Contact our customer service team at the number listed on the back of your ID card. Please have your ID card handy when you call. Also, call if you need help understanding our decision to deny a service or coverage.

If You Don't Agree with Our Decision

You are entitled to several levels of review of our decisions. Two of the levels are internal appeals (with BCBSVT):

- You may make a **complaint with customer service**. 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 for visits;
  - After-hours access to your doctor; or
  - The service at your doctor's office.
- You may file a **first-level internal appeal**. You may do this without making a complaint to customer service. If you make a complaint with customer service as outlined above, the complaint counts as the first-level internal appeal. By accepting this contract, you agree to follow our appeals process before taking judicial action.
- If you don't agree with our decision after your first-level appeal and you have coverage through an employer group, you may file a **second-level internal appeal** with us. (Federal regulations do not allow individual purchasers this option.) You may choose to meet with reviewers in person or by phone. Your health care provider may participate. We will work with you to schedule a time. This appeal is voluntary and free to you. Your decision to pursue or not to pursue a second-level appeal will not affect your right to pursue other avenues.
- In some circumstances, you may request that the State of Vermont do an **independent external review** of our decision. You do this by calling the State at (800) 964-1784.
- Your plan may be subject to **ERISA**. If so, you may have the right to bring legal action under ERISA. Ask your Group Benefits Manager if this applies to you.

Reviewers

Depending on the nature of the case, we select reviewers for their clinical expertise and/or their benefits knowledge. In some cases, your healthcare provider may call us to discuss your case with the Provider reviewer. This usually happens prior to the first-level internal appeal. A separate reviewer conducts each level of appeal above. None of the reviewers will be the person who first denied your claim. If your first-level appeal is clinical in nature, at least one of the reviewers will be the clinical peer of your health care provider.

Timing of Appeals

If your appeal involves Emergency Medical Services or Urgent Services, we will conduct a review of your appeal as soon as possible, but no later than 72 hours.

When you file an appeal to extend Urgent Services that we previously approved and you are currently receiving (Urgent concurrent review), we will review your appeal within 24 hours. You must make the appeal at least 24 hours before the care we have approved will end or we will treat it as a regular appeal.

For other appeals related to services not yet provided, we will notify you of our decision within 30 days of receiving your appeal. For all other appeals, we will notify you of our decision within 60 days of receiving your appeal request.

When you file an appeal about a denial of benefits, you must do so within 180 calendar days of when you receive our denial. When you file a second-level appeal, you must do so within 90 calendar days of our decision. When requesting an independent review, you must do so within 120 days of our decision. If you opt for an internal second-level appeal, the time you spend pursuing it will not count toward the 120 days.

How to Request an Appeal

You or someone you name to act for you (your authorized representative) may request an appeal review. Your doctor may serve as your representative. At any time, you can get help with filing your appeal from our customer service team. You can also get help from the Vermont Department of Financial Regulation at (800) 964-1784. To file an emergency or urgent concurrent appeal, call the number on the back of your ID card.

Mail written appeals to:
Blue Cross and Blue Shield of Vermont
PO Box 186
Montpelier, VT 05601-1086

If you are asking our customer service team to review, send your information to the attention of “Customer Service.” If you are filing an appeal, send it to the attention of “First Level Appeals” or “Voluntary Second Level of Appeals” as appropriate. If you are filing a first-level appeal about a mental health or substance abuse claim, sent it to the attention of “Mental Health and Substance Abuse, First-Level Appeals.” Please include your phone number with your request.

If you are unable to file a written appeal, you may appeal by phone. We will record your appeal in writing. Please call our customer service team at the number on the back of your ID card.

We will provide information about how to file or participate in an appeal in another language if you request it.

Information About Your Claim

If you appeal, you will receive instructions on how to supply relevant information. You may submit documents, records or other information about your appeal. You may request copies of information about your claim (free of charge) by contacting us at the number on the back of your ID card. We will provide this immediately for an urgent or concurrent appeal or within two business days for other appeals.

After Our Decision

If your appeal is urgent or concurrent, when we have made our decisions, we will notify you and your health care provider (if known) by phone right away. We will follow up in writing within 24 hours. In all other cases, we will notify you by mail. At any point during the appeal review process, we may decide to overturn our decision. If so, we will provide coverage or payment for your health care item or service. If we deny your appeal and our decision is not overturned, you must pay for services we didn’t Cover. You should discuss your payment arrangements with your provider.

Please note that this certificate provides only a summary of your rights. State and federal regulations provide more detail.

Other Resources to Help You

For questions about your rights, this notice, or for assistance, you can contact:

Employee Benefits Security Administration
(866) 444-EBSA (3272)

State of Vermont’s Health Care Advocate
(800) 917-7787 or (802) 863-2316

Vermont Department of Financial Regulation
(800) 964-1784.

The Department of Financial Regulation’s Health Insurance Consumer Services unit can provide free help to you if you need general information about health insurance, have concerns about our activities, or are not satisfied with how we resolved your complaint.

Vermont Office of the Health Care Advocate

The Vermont Office of the Health Care Advocate’s telephone hotline service can provide you with free help if you have problems or questions about health care or health insurance. Call the Vermont Office of Health Care Advocate’s telephone number at (800) 917-7787 or (802) 863-2316.

BCBSVT’s Ombudsman

BCBSVT has an Ombudsman to whom we refer members with complex issues regarding care or service. Our Ombudsman works as a liaison between the member and the plan reviewing and solving issues.

In most cases, the professionals in our customer service call center can answer member questions and resolve most issues. It is the role of the member ombudsman to get involved in the process when unforeseen complications arise in the regular course of problem resolution and information gathering. Call our customer service team at the number listed on the back of your ID card.

CHAPTER FIVE

Other Party Liability

This chapter gives us the right to prevent duplicate payments for a service that would exceed the allowed amount for the service. It applies, for instance, when a person Covered under your contract has other coverage. Remember, you must disclose information about all other coverage to us.

Coordination of Benefits

This chapter applies when another health plan or insurance policy provides benefits for some or all of the same expenses as we do through this contract. (For the purposes of this chapter, we'll call the other party a "payer.")

We may reduce your benefits so that the sum of the reduced benefits and all benefits payable for Covered services by the other payer does not exceed the allowed amount for Covered services.

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 determine whether we are the "primary" or "secondary" payer according to guidelines of the National Association of Insurance Commissioners (NAIC). The guidelines say that, in general, if the other payer has no coordination of benefits provision or has a different provision than ours, that payer is primary. If the other payer uses the NAIC provisions, 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 Incapacitated 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 coverage 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 or domestic partner 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 or Domestic Partner 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:

- any kind of auto insurance;
- homeowners 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 Tricare

We will always be "primary" payer to Medicaid or Tricare (for military personnel, military retirees, and their Dependents). Tricare and Medicaid are always secondary payers.

Subrogation

If another person or organization caused or contributed to your illness or injuries, or is supposed to pay for your treatment (such as another carrier), then we have a right to collect back for benefits provided by this contract. This is called our "right of subrogation." In this section we will call the person or organization a "third party." The third party might or might not be an insurer. Our right of subrogation means that:

- If we pay benefits for your health care services and then you recover expenses for those services from a third party through a suit, settlement or other means, you must reimburse us. We will have a lien on your recovery from a third party up to the amount of benefits we paid.
- You must reimburse us whether or not you have been "made whole" by the third party. We might reduce what you owe us to Cover a share of attorneys' fees and other costs you incur in the process.
- We reserve the right to bring a lawsuit in your name or in our name against a third party or parties to recover benefits we have advanced. We may also settle our claim with a third party.
- This right of subrogation extends to any kind of auto, workers' compensation, property or liability insurance providing medical benefits.
- You must cooperate with us and furnish information and assistance that we require to enforce our rights.
- You must take no action interfering with our rights and interests under your contract.
- If you refuse to pay us or to cooperate with us, we may take legal action against you. We may seek reimbursement from the funds you recovered from a third party, up to the amount of benefits we paid. If we do, you must also pay our attorney's fees and collection expenses. We may reduce or withhold future benefits to recover what you owe us.
- You agree that you will not settle your claim against a third party without first notifying us. In some cases, we will compromise the amount of our claim.

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 recovery of the costs of benefits we have provided;
- obtaining our consent before providing any release from liability for medical expenses; and
- 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 provide and any costs we incur in obtaining repayment.

CHAPTER SIX

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, contact your Group Benefits Manager. If you do not have coverage through your employer, please call customer service at the number on the back of your ID card. You can also visit our secure Web portal, the BCBSVT Member Resource Center, for information about your Plan and enrollment.

In most circumstances, 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.

Marriage/Civil Union

If we receive your request within 31 days after the date of marriage/civil union, your new type of membership begins the first day of the month following the date of marriage/civil union. If we receive your request more than 32 days after the date of your marriage/civil union, your new membership begins the first day of the month after we receive your request.

If you fail to add your new Dependents within 60 days, you must wait until an open enrollment date to do so.

Birth or Adoption

We Cover your Child for 60 days after:

- birth;
- legal placement for adoption (if it occurs prior to adoption finalization); or
- legal adoption (when placement occurs when the adoption finalizes).

We must receive your request for a membership change to continue benefits for the Child past 61 days. If we receive your request within the 60 days:

- the Child's effective date is retroactive to the date of birth, placement for adoption or adoption; and
- the new type of membership begins 60 days following birth, placement for adoption or adoption.

If you fail to add your new Dependents within 60 days, you must wait until an open enrollment date to do so.

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 ends employment. Within 31 days after loss of coverage, your Dependent may enroll on 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 if your employer has an open enrollment.

Court-ordered Dependents

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 when we receive the court order, whichever is sooner. If the court order specifies a different effective date, we will use that date. We will calculate any additional subscription costs from the effective date of enrollment. Please remember your request for Dependent coverage under any court order must include proof of the court order.

Incapacitated Dependents

To continue coverage for an Incapacitated Dependent over age 26, we require proof of the continuing existence of a qualifying disabling condition. We must receive the following:

- an application form for Incapacitated Dependents (which you may get from our customer service team or on our website); and
- Provider certification of the extent and nature of the disability.

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

We must receive the information within 60 days of the date the individual would otherwise lose coverage to avoid interrupting coverage. If we receive the above information more than 60 days after the date the individual would no longer be an eligible Dependent, coverage will begin the first day of the month after we receive the information.

Removing Dependents

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

- a Dependent dies;

- the subscriber and Spouse/Party to a civil union or Domestic Partner divorce;
- a couple legally separates;
- a Child turns 26; or
- the Dependent is no longer Incapacitated.

Dependents become ineligible for coverage at the end of the month after the event occurs.

Cancellation of Coverage

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

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

Upon contract cancellation, 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 cancellation.

Default in Subscription Payment

We allow no more than a 10-day grace period for payment.

If we do not receive your payment on or before the end of the grace period.

- We will mail you a cancellation notice.
- This contract ends after midnight on the 14th day after we send you a cancellation notice.

We consider non-payment of your Plan a stop to service, and therefore, a cancellation of your Plan by you.

Benefits after Cancellation of Group Coverage

If you are entitled to benefits for a continuous total disability existing on the cancellation date, we provide Benefits for Covered services received in connection with your total disability until the earliest of:

- the date your total disability ends;
- 12 months from the date of cancellation;
- the date you become Covered for medical benefits under another health plan or policy without a Pre-existing Condition exclusion applicable to your total disability; or
- the date you exhaust your benefit maximums.

We will consider You to have a total disability if, because of an illness or injury, You are unable to engage in any employment or occupation for which You are or have become qualified by reason of education, training, or experience and You are not engaged in any employment or occupation for wage or profit.

A minor Dependent is considered to have a total disability only if, because of an illness or injury, he or she is unable to engage in activities that are normal for a person of the same age, gender and ability.

If your group coverage at termination covers your Dependents, any extension under this section applies only to the individual who has a continuous total disability at the time of termination.

We provide no benefits if your coverage was cancelled for non-payment of subscriber fees, fraud or material misrepresentation by you or your Dependent.

Note: Upon receipt of written request BCBSVT will suspend coverage in active service military members. We will repay any subscription rates paid by someone actively serving in the military according to the proportion owed.

Fraud, Misrepresentation or Concealment of a Material Fact

If you obtain or attempt to obtain coverage or benefits through fraud, 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 a family member committed the fraud, that person will be permanently disenrolled. If you are disenrolled due to fraud, we will not provide any extension of benefits after this contract is cancelled.

Any falsehood on your application for coverage voids this contract if discovered within three years of the effective date. After three years of enrollment, only fraudulent misstatements made on your application can be used to void this contract or as a basis to deny a claim.

If you or any family member commits fraud, we may use all remedies provided by law and in equity, including recovering from you any benefits provided, attorneys' fees, costs of suits and interest.

Warning: It is a crime punishable by fines and imprisonment under Vermont law to make a claim under this contract that contains lies or hides material information.

Contract Reinstatement

By law, we may reinstate a cancelled contract solely at our discretion and only on such terms and conditions as we decide.

Voidance and Modification

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

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

Only a Blue Cross and Blue Shield of Vermont officer can bind us legally by changing or waiving any provisions of your contract.

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 whether you can join a Medicare supplemental plan offered through your Group. If you are eligible for Medicare, please review **www.medicare.gov/Pubs/pdf/10050.pdf**.

Our Pledge to You

Here at Blue Cross and Blue Shield of Vermont, we're committed to creating superior member experiences and we'll provide highly personalized service for each and every one of our interactions. We value and welcome your opinion about how we execute this pledge. We'll learn from your feedback and use it to make meaningful progress and innovative changes.

Member Rights and Responsibilities

As a member, you have the right to:

Respect and Privacy. We take measures to keep your health information private and protect your healthcare records (Please see "Notice of Privacy Practices for Protected Health Information" on page 35). **You have the right to be treated with respect and dignity.**

Receive Information from us. We'll supply you with information to help you understand our organization, your rights and responsibilities as a member, your network of providers, the benefits available to you and how to use your benefits and services. You also have the right to access records we've used to make decisions about your health care benefits, services, our practitioners and our providers.

Receive Information from Your Providers. Your providers will supply you with information so that you can better understand your condition and plans for care.

Participate in Your Health care. You have the right to engage in a candid discussion of appropriate or medically necessary treatment options, regardless of cost or benefit coverage. You have the right to participate with practitioners in making decisions about your care. If you choose to receive services outside of your provider network, we encourage you to learn about and understand your plan benefits. Non-participating, out-of-state providers can bill you for the balance between what we pay and what the provider billed.

Disagree. We welcome your complaints or appeals about our organization and the care you receive. For more information about how to file a complaint or an appeal please call our customer service team at (800) 247-2583. Helpful information is also available on our website, **www.bcbsvt.com**, or by reviewing your enrollment materials.

Recommend Changes. You have the right to suggest changes regarding our member rights and responsibilities policy. You can also provide feedback on our programs, including our quality improvement and care management programs.

As a member, you have the responsibility to:

Choose a Primary Care Provider (PCP). This only applies if your plan requires a PCP.

Present your ID card each time you receive services and protect your ID card from improper use.

Keep your providers informed and understand that your providers need your up-to-date health information to treat you effectively. Talk to your providers about your medical history (which includes mental health and substance abuse) and your current health and participate in developing treatment goals as much as possible.

Follow plan rules and instructions for your care that you have agreed to with your provider. To receive care or services, you must identify yourself as a member to providers and follow the policies and procedures described in your subscriber certificate and other plan materials.

Treat your Providers and us with respect. This includes keeping scheduled appointments and notifying your provider ahead of time if you are late or need to reschedule.

Better understand your health problems. To the degree possible, we encourage you to participate with the plan's care management team and your provider (as appropriate) to develop a treatment plan.

Pay all applicable Deductibles, Co-insurance amounts and Co-payments to your health care providers as outlined on your Outline of Coverage.

Notify us right away if there's a change in your family size, address or phone number, primary care provider or any other change in your membership.

If you have your health care benefits through an employer group, please report your membership changes directly to your group benefits administrator.

Rules About Coverage for Domestic Partners

If your Group allows domestic partners to be Covered under your Plan, the following provisions apply.

Enrollment Eligibility

Domestic Partners (and their Dependents) are eligible to enroll during:

- the subscriber or Group's initial enrollment period;
- the Group's open enrollment; or
- within 31 days after a domestic partner loses coverage with his or her employer.

To enroll an eligible Domestic Partner, both the subscriber (employee) and the Domestic Partner must complete and sign a Statement of Domestic Partnership. You may obtain these forms from your Group Benefits Manager. A notary public must witness the signature of this document. You need to provide the following documentation in support of the Statement of Domestic Partnership:

- proof of common residence; and
- proof of financial interdependence, e.g., joint bank accounts or credit cards, executed powers of attorney, listing of your Domestic Partner as a beneficiary on your insurance policy and/or designated signatures on safety deposit boxes.

Effective Date of Coverage

The effective date of coverage of an eligible Domestic Partner and any initially eligible Dependents of the Domestic Partner will be as follows:

When we replace your Group's prior carrier, if the Group already had Domestic Partnership coverage and a partner qualified for coverage under the Group's previous Domestic Partnership policy, coverage may begin on the Group's effective date. If your Group is adding Domestic Partnership coverage for the first time, and a partner qualifies for coverage under the new Domestic Partnership policy, coverage may begin on the Group's effective date if we receive a Statement of Domestic Partnership with the subscriber's application.

When an existing Group obtains Domestic Partnership coverage for the first time, an eligible Domestic Partner's coverage may begin the first of the month after we receive a Statement of Domestic Partnership and an application. We must receive this request within 30 days of when your Group obtains coverage for Domestic Partners.

When an employee is first hired, an eligible Domestic Partner's coverage may begin on the subscriber's effective date if we receive a Statement of Domestic Partnership with the subscriber's application.

In all other cases, an eligible Domestic Partner's coverage may begin:

- on an open enrollment date if we receive a Statement of Domestic Partnership and an application form *before* the open enrollment date; or
- the first of the month following the open enrollment date, if the Plan receives the Statement of Domestic Partnership and application during the month in which the open enrollment date occurs.

Other effective date provisions in your Certificate apply.

Continuation of Group Coverage for Domestic Partners

Domestic Partners and their Dependents do not meet the definition of qualified beneficiaries under the Consolidated Omnibus Budget Reconciliation Act (COBRA). Check with your Group Benefits Manager to see if you are eligible for state continuation coverage.

Termination of Domestic Partnership

When two parties no longer meet requirements for Domestic Partnership status, the subscriber must complete and file a Termination of Domestic Partnership form within 30 days of the change in status. Forms are available from your Group Benefits Manager.

The subscriber must mail a copy of the termination notice to the Domestic Partner within 14 days of completing the notice. Termination will be effective on the first day of the month following our receipt of the notice.

If a subscriber cancels coverage for a Domestic Partner, he or she may not include another Domestic Partner on the membership until nine months from the date of cancellation.

Conversion Rights for Domestic Partners

If the subscriber becomes employed by another Group that does not have Domestic Partnership coverage or files a Termination, the Domestic Partner may convert to available direct-pay coverage in accordance with the Certificate in effect at the time. If both the subscriber and the Partner convert to direct-pay coverage, they must obtain separate contracts.

Right to Continuation of Coverage

Note: This is a summary of the law. Please contact Your Group Benefits Manager for details about continuation coverage.

If You have coverage through an employer or other group, Vermont law requires that You be able to continue your group coverage for up to 18 months when one of the following qualifying events occurs:

- you lose your job or are no longer eligible for employer-sponsored coverage because of a reduction in your hours;
- a divorce, dissolution of a civil union or legal separation causes you or a family member to lose coverage;
- a dependent no longer qualifies as a dependent child; or
- the covered employee or subscriber dies.

You must pay the entire cost of your coverage.

Note: You may have other options available to you when you lose group health coverage and continuation with your group coverage may not be your best option. You may be eligible to buy an individual plan through Vermont Health Connect. By enrolling in coverage through Vermont Health Connect (**healthconnect.vermont.gov**), you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. If you choose to continue your group coverage, you may be ineligible to enroll in an individual plan through Vermont Health Connect until a new open or special enrollment period.

Continuation rights do not apply if:

- you are covered by Medicare
- the covered employee (subscriber) was not covered on the date of the qualifying event.
- you are newly eligible for coverage in a group in which you were not covered before the qualifying event, and no preexisting condition exclusion applies; or
- you have lost your job due to misconduct as defined by law.

Continuation of insurance ends when:

- 18 months pass from the date you would have lost coverage;
- you fail to make timely payment of the required contribution;
- you become eligible for Medicare or another group plan; or
- your employer stops offering any group plan (if your group replaces this coverage with a similar plan, you may continue coverage under that plan).

Remember you are required to maintain minimum essential coverage beginning January 1, 2014 to avoid paying a government fee or penalty for any months you are without that coverage.

Continuation Rights under the Consolidated Omnibus Budget Reconciliation Act (COBRA)

You may also be eligible for continuation coverage under federal law (COBRA). If you are eligible, your Group Benefits Manager administers COBRA. Please ask your Group Benefits Manager if this applies to you.

Conversion Rights

When continuation of group coverage ends, You may be eligible for non-group coverage. If you are eligible, you will have the opportunity to enroll in a product offered through Vermont Health Connect without a break in coverage. To do this, your Vermont Health Connect coverage must be effective within 30 days after your group enrollment terminates. Contact Vermont Health Connect (**healthconnect.vermont.gov**) at least 30 days before your continued group health plan terminates for more details.

CHAPTER SEVEN

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. We uphold its provision only to the extent allowable by law.

Entire Agreement

Your Contract is the entire agreement between you and us. Your Contract governs your benefits. The following documents are included as part of 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, which enhance or amend your Coverage.
- Your ID card.
- Your Group Enrollment Form (your application) and any supplemental applications that you submitted and we approved.

We may only change this Contract in writing and with the approval of the Vermont Department of Financial Regulations (DFR).

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 them later.

Term of Contract

Coverage continues monthly until this contract is discontinued, cancelled or voided.

Subscription Rate

We have different rates for single and multi-person memberships. Your rate or rating formula is on file with and approved by DFR.

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.

Changes in the Subscription Rate

We may change rates only if we receive approval from DFR. We will notify your Group of any rate change in accordance with state law.

Subscriber Address

You must notify us of any change of address. Call customer service at the number listed on the back of your ID card, or mail your change of address to:

Blue Cross and Blue Shield of Vermont
PO Box 186
Montpelier, VT 05601-0186

You may also change your address by visiting our Member Resource Center on our website at **www.bcbsvt.com**.

We send all notices to the subscriber's address on file. This represents our full responsibility to notify the subscriber, regardless of whether the subscriber receives the notice.

Third Party Beneficiaries

All members Covered under this contract (except the subscriber) are Third Party Beneficiaries to the contract.

CHAPTER EIGHT

More Information About Your Contract

Your Contract is solely between you and us. We are an independent corporation operating under a controlled affiliate license with the Blue Cross and Blue Shield Association (BCBSA), an association of independent Blue Cross and Blue Shield Plans. BCBSA permits us to use the Blue Cross and Blue Shield Service Marks in the state of Vermont. We do not contract as the agent of BCBSA. You have not entered into your Contract based upon representations by any person other than us. 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.

Notice of Privacy Practices for Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Organizations Covered by this Notice

This notice applies to the privacy practices of the following organizations:

- Blue Cross and Blue Shield of Vermont
- The Vermont Health Plan

These organizations may share your protected health information as needed for treatment, payment and health care operations.

Our Commitment to Protecting Your Privacy

We take your right to privacy very seriously. We have invested significant resources to protect your privacy and comply with federal and state laws. We safeguard your information physically, electronically and procedurally. We require all of our employees, business associates, Providers and vendors to adhere to privacy policies and procedures.

Federal and state laws require us to maintain the privacy of your protected health information (PHI) and to provide this notice to you of our legal duties and privacy practices. PHI is information about you, including demographic data, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health, the provision of health care to you or the payment for that care. We may use PHI we receive or maintain, including PHI that you may have entered on our website's Member Resource Center at **www.bcbsvt.com**.

This chapter describes our privacy practices, which include how we may use, disclose, collect, handle and protect your PHI. The federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule requires us to give you this notice of our privacy practices, our legal duties and your rights concerning PHI.

In some situations, Vermont law may provide you with greater privacy protections. In that situation, we will use or disclose your PHI according to Vermont law.

If you have any questions or want additional information about this notice or the policies and procedures described in this Notice, please contact us at the address, Email or phone number provided in the Questions and Complaints section at the end of this chapter.

This notice of privacy practices became effective on September 1, 2013 and replaces the previous Notice of Privacy Practices, which became effective on September 1, 2012. We are required to abide by the terms of the notice currently in effect.

We reserve the right to change the provisions of the notice and make the new provisions effective for all PHI that we maintain. If we make a material change to this notice, we will mail a revised notice to the address that we have on record for the subscriber of your contract.

Our Uses and Disclosures of Your Protected Health Information

Without your written authorization, we will not use or disclose your PHI for any purpose other than those described in this notice. We do not sell your PHI or disclose your PHI to anyone who may want to sell their products to you. We will not use or disclose your PHI for marketing communications without your authorization, except where permitted by law. We will not sell your PHI without your authorization, except where permitted by law. We must have your written authorization to use and disclose your PHI, except for the following uses and disclosures:

Disclosures to You or Your Authorized Representative

We may disclose PHI to you. See the section on Right to Access (Inspect and Copy) for more details. We may also disclose your PHI to your authorized personal representative. How much PHI we can share with a personal representative will depend on his or her legal

authority. If you would like to authorize someone to have access to some or all of your PHI, call customer service at the number listed on the back of your ID card.

Treatment

We may disclose your PHI without your permission, to a physician or other health care Provider to treat you.

Payment

We may use or disclose your PHI to obtain subscription fees or make payments. We may also disclose your PHI to fulfill our responsibilities for coverage and providing benefits under your subscriber contract. For example, we may use your PHI to pay claims from Physicians, hospitals and other health care providers for services delivered to you that are covered by your subscriber contract, to determine your eligibility for benefits, to determine the medical necessity of care delivered to you, to obtain premiums for your health coverage, to issue Explanations of Benefits to the subscriber of the contract under which you are enrolled, and for similar payment related purposes. We may disclose or share your PHI with other health care programs or insurance carriers to coordinate benefits if you or your Dependents have Medicare, Medicaid or any other form of health care coverage.

Health Care Operations

We may use or disclose your PHI for our health care operations. Health care operations include:

- quality assessment, wellness and improvement activities;
- reviewing Provider performance;
- reviewing and evaluating health plan performance;
- preventing, detecting and investigating fraud, waste and abuse;
- coordinating case and disease management activities;
- certification, licensing or credentialing; and
- performing business management and other general administrative activities related to our business management, planning and development, including de-identifying PHI, and creating limited data sets for health care operations and public health activities.

We may disclose your PHI to another health plan or Provider, consistent with applicable law, as long as the health plan or Provider has or had a relationship with you and the PHI is for that plan's or Provider's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Appointment/Service Reminders

We may contact you to remind you to obtain preventive health services or to inform you of treatment alternatives and/or health-related benefits and services that may be of interest to you.

Business Associates and other Covered Entities

We contract with individuals, other covered entities and business associates to perform various functions on our behalf or to provide certain types of services for us. To perform these functions or to provide the services, business associates may receive, create, maintain, use or disclose your PHI. We require business associates and others to agree in writing to contract terms designed to safeguard your information. For example, we may disclose your PHI to business associates to conduct utilization review activities, to provide member service support or to administer pharmacy claims.

Required by Law

We must disclose your PHI when we are required to do so by law. For example, we may disclose your PHI to comply with court or administrative orders, subpoenas, national security laws or workers' compensation laws. We may disclose limited information to law enforcement officials with regard to:

- crime victims;
- crimes on our premises;
- crime reporting in emergencies; and
- identifying or locating suspects or other persons.

We will disclose your PHI to the Secretary of the U.S. Department of Health and Human services and state regulatory authorities when required to do so by law. When we are mandated by law to disclose your PHI, additional legal protections may exist and we abide by those protections.

Victims of Abuse, Neglect or Domestic Violence

We may disclose your PHI to a government authority authorized by law to receive such information if we reasonably believe you to be a victim of abuse, neglect or domestic violence. In the event of such disclosure, you would be notified, unless such notification is reasonably believed to put you at risk of serious harm.

Public Health or Safety

We may use or disclose your PHI to a public health authority that is authorized by law to collect or receive such information. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury or disability. In addition, we may disclose

such information to a public health authority authorized to receive reports of child abuse or neglect. We may disclose your PHI to the extent necessary to avert a serious and imminent threat to your health or safety or to that of the public. If directed by a public health authority to do so, we also may disclose PHI to a foreign government agency that is collaborating with that public health authority.

Health Oversight Activities

We may disclose your PHI to a health oversight agency for activities authorized by law, such as:

- audits;
- investigations;
- inspections;
- licensure or disciplinary actions;
- civil, administrative or criminal investigations, proceedings or actions;
- Oversight agencies seeking this information include government agencies that oversee:
  - the health care system;
  - government benefit programs;
  - other government regulatory programs;
  - health insurance carriers; and
  - compliance with civil rights laws.

Research, Death or Organ Donation

We may disclose your PHI for research when an institutional review board or privacy board has:

- reviewed the research proposal and established protocols to ensure the privacy of the information; and
- approved the research.

We may disclose the PHI of a deceased person to the medical examiner if authorized by law. We may disclose the PHI of a deceased person to an organ procurement organization for certain purposes.

Your Group Health Plan or Plan Sponsor (If Applicable)

Plan sponsors are employers or other organizations that sponsor group health plans. We may disclose PHI to the plan sponsor of your group health plan. We may disclose your PHI to your group's plan sponsor to allow the performance of plan administration functions. We may disclose summary health information to your employer to use to obtain premium bids for health insurance coverage or to modify, amend or cancel its group health plan. Summary health information is information that summarizes claims history, claims expenses or types of claims experience for individuals that participate in the health plan. In order to receive PHI, your employer must comply with the HIPAA Privacy Rule. Your employer is not permitted to use your PHI for any purpose other than administration of your health benefit plan, including employment decisions. See your employer's health benefit plan documents for more information.

Others Involved in Your Health Care

Using our best judgment, we may make your PHI known to a family member, other relative, close personal friend or any other person identified by you if such PHI is directly relevant to that person's involvement with your care or payment for your care. We may also disclose your PHI to notify or assist in the notification of your location, general condition or death. If we disclose for these purposes, we will give you the opportunity to object to the disclosure, unless we determine, in the exercise of our professional judgment, you do not object or cannot object to the disclosure due to an emergency or incapacity. We also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Your Rights

Right to Access (Inspect or Copy)

Upon your request, in accordance with the HIPAA Privacy Regulations, you have the right to examine and to receive a copy of your PHI in our possession. If requested, this may include an electronic copy in certain circumstances. Your request must be in writing, on our designated form. We will provide the information no later than 30 days after receiving your request, unless we maintain the information off site, in which case it may take up to 60 days for us to comply with your request. If necessary, we may request an extension to provide you with your information. If we deny your request, you may request that the denial be reviewed. Under certain limited conditions, our denial may not be reviewable. In the event you are entitled to a review, a licensed health care professional not involved in the original denial decision will review our denial. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We will notify you of the cost involved before you incur any costs.

We will disclose your PHI to an individual who has been designated as your personal representative and who has qualified for such designation in accordance with relevant state law and the HIPAA Privacy Regulations. Before we will disclose PHI to such a person, you should sign and submit our Authorization to Release Information form. We may be able to honor a power of attorney or other legally enforceable document granting your

personal representative access to your PHI. We may not be able to honor such a document, however, if it is not compliant with the HIPAA Privacy Regulations or is otherwise legally unenforceable. If you grant such authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. For more information about how best to ensure access to your PHI consistent with your wishes, please call customer service at the number listed on the back of your ID card.

Right to Amend

You have the right to request that we amend your PHI in our possession. If you believe that your PHI created by us is incorrect or incomplete, you may request that we amend your information. You must submit your request in writing at the address provided in the Questions and Complaints section. Your request should include the reason(s) the amendment is necessary and what specifically you want amended. Requests sent to persons, offices or addresses other than the one indicated in this section could delay processing your request.

It is important to note that we cannot usually amend PHI created by another entity, such as your Provider. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We will link your statement of disagreement with the disputed information and all future disclosures of the disputed information will include your statement. If we approve your request for amendment, we will make reasonable efforts to inform others, including people you have authorized, of the amendment and to include the changes in future disclosures of that information.

Right to a Disclosure Accounting

You have the right to a list of instances in which we disclose your PHI in the last six years for purposes other than treatment, payment or health care operations, as authorized by you or for certain other activities. Most disclosures of your PHI will be for purposes of payment or health care operations or made with your authorization.

You must submit to us in writing your request for an accounting at the address listed in the in the “Questions and Complaints” section. You have the right to receive one accounting every 12 months. For additional requests, we reserve the right to charge you a fee to cover the costs of providing the list. We will notify you of the cost involved before any costs are incurred. We will provide your accounting within 60 days, unless we notify you in writing that we need a 30-day extension.

Right to Request Confidential Communications

We communicate decisions related to payment and benefits, which may include PHI, to the subscriber’s address. Individual members who believe that this practice might endanger them may request that we communicate with them using a reasonable alternative means or location. All requests must be in writing using our designated form. All requests must clearly state that failure to honor the request could endanger your physical safety. Your request must provide the alternative means of communication and/or location for communicating your PHI. To receive additional information about this right and to get the appropriate request form, please call customer service at the phone number listed on the back of your ID card.

Right to Request a Restriction

You have the right to request that we restrict our use or disclosure of your PHI. We are not required to agree to a restriction you request. If we do agree to the restriction, we will comply with our agreement, except in a medical emergency or as required or authorized by law. You must submit a request for a restriction to us in writing to the Privacy Officer at the address listed in the Questions and Complaints section of this chapter.

Breach Notification

In the event of a breach of your unsecured PHI, we will provide you notification of such breach as required by law or where we otherwise deem appropriate.

Non-public Personal Financial Information

We closely guard all of the personal information we collect about our members. State and federal laws require that we tell you how we protect private information. This particular section deals with how we treat “financial information.” We do not maintain a lot of financial information about our members, but the fact that you are a member of one of our health plans, is, in itself, considered “financial information.”

Information we collect and maintain: We collect non-public personal financial information about your from applications or other forms and transactions with us, our affiliates or other organizations.

How we protect information: Except as explained below, the only people who see your non-public personal financial information are our employees who need to use the information to provide you with coverage. We maintain physical, electronic and

procedural safeguards that meet the applicable legal requirements to make sure no one else has access to your non-public personal financial information. We keep this information private even after your coverage ends.

Information we disclose: We may disclose non-public personal financial information about you to our "affiliates." Our affiliates include financial service providers, such as other carriers, and non-financial companies, such as third party administrators. The law also allows us to disclose your non-public personal financial information in certain circumstances without providing notice to you and without your authorization. We reserve the right to make those legally permitted disclosures including, but not limited to, the disclosure of your non-public personal financial information to our affiliates and other parties in order to:

- process claims;
- coordinate benefits; and
- accomplish other tasks related to providing you with our services.

No other disclosures to non-affiliated third parties: We otherwise will not disclose non-public personal financial information about our customers or former customers to non-affiliated third parties except as permitted or required by law.

Please share this important information with other members of your household who have coverage under your contract.

Questions and Complaints

If you have questions about this chapter or protecting your privacy, please call customer service at the phone number listed on the back of your ID card.

If you are concerned that we may have violated your privacy rights or otherwise not complied with this notice and the HIPAA Privacy Regulations, please contact us at:

Mail: Privacy Officer
Blue Cross and Blue Shield of Vermont
PO Box 186
Montpelier, VT 05601

Telephone: (802) 371-3394
Fax: (802) 229-0511
Email: privacyofficer@bcbsvt.com

You may also file a complaint with the Office for Civil Rights at the U. S. Department of Health and Human Services. You may submit a written complaint to:

Office for Civil Rights of the United States
Department of Health and Human services
Government Center
J.F. Kennedy Federal Building, Room 1875
Boston, MA 02203.

We support your right to the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human services.

Newborns' and Mothers' Health Protection Act

Health Plans 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 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. 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 team 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 Cover 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 Co-insurance, 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 team 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 team 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 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 (Specialists, primary care and others);
- a list of mental health and substance abuse Providers; and
- advice on how to get a copy of your medical records.

Participating in Our Policy Making

If you would like to participate in the development of our organizational policies, please call our customer service department and a representative will help you initiate the process. You can find the number on the back of your ID card.

CHAPTER NINE

Definitions

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 or 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 Amount: 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.

Annual Maximum: The limit on benefits we will provide for a particular kind of service in one Plan Year. Your *Outline of Coverage* lists your annual limits. We only impose annual limits on "non-essential health benefits" as defined by law.

Approved Cancer Clinical Trial: is an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment, palliation or prevention of cancer in human beings.

Autism Spectrum Disorder (ASD): is characterized by levels of persistent deficits in social communication and social interaction—including deficits in social-emotional reciprocity; nonverbal communication behaviors; and developing, maintaining and understanding relationships. It is also characterized by restrictive, repetitive patterns of behavior, interests or activities. Autism Spectrum Disorder encompasses disorders previously referred to as early infantile autism, childhood autism, Kanner's autism, high-functioning autism, atypical autism, pervasive developmental disorder-not otherwise specified, childhood disintegrative disorder, Rett's disorder and Asperger's disorder.

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

Certificate/Certificate of Coverage: this document.

Child: see Dependent.

Chiropractor: a duly licensed doctor of chiropractic, acting within the scope of his or her license to treat and prevent neuromusculoskeletal disorders.

Chronic Care: health services provided by a health care Professional for an established clinical condition that is expected to last a year or more and that requires ongoing clinical management attempting to restore the individual to highest function, minimize the negative effects of the condition and prevent complications related to chronic conditions. Examples of chronic conditions include anxiety disorder, asthma, bipolar disorder, COPD, diabetes, heart disease, major depression, post-traumatic stress disorder, schizophrenia or substance abuse.

Co-insurance: a percentage of the allowed amount you must pay, as shown on your *Outline of Coverage*, after you meet your Deductible. (Refer also to Chapter One.)

Contract: 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 Plan Year before we pay any benefits. Your *Outline of Coverage* shows your Deductible, benefit, Co-insurance and Co-payment amounts. (Refer also to Chapter One.)

Aggregate Deductible: Your plan may have an aggregate overall deductible. Please see your *Outline of Coverage* to see what type of deductible you have. If your plan has an aggregate overall deductible, and you are on a family plan, you do not have an individual deductible. Your family members' Covered expenses must reach the family deductible before any of your family members receive post-deductible benefits. When your family's expenses reach this amount, all family members receive post-deductible benefits.

Stacked Deductible: Your plan may have a stacked overall deductible. Please see your *Outline of Coverage* to see what type of deductible you have. If your plan has a stacked overall deductible, and you are on a family plan, a covered family member may meet the individual deductible and begin receiving post-deductible benefits. When your family members' Covered expenses reach the family deductible, all family members receive post-deductible benefits.

Dependent: a subscriber's Spouse, the other Party to a subscriber's civil union, Domestic Partner (if your employer allows Domestic Partner coverage) or the subscriber's Child or Incapacitated Dependent Covered under this Plan. (See Child, Spouse and Party to a civil union definitions.)

Child: a subscriber's son, daughter or stepchild (through marriage or civil union), 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 26 unless he or she is an Incapacitated Dependent.

Domestic Partners (Partnership): a Domestic Partnership exists between two persons of the same or opposite sex when:

- each party is the sole Domestic Partner of the other;
- each party is at least 18 years of age and competent to enter into a contract in the state in which he or she resides;
- the parties currently share a common legal residence and have shared the residence for at least six months prior to applying for Domestic Partnership coverage;
- neither party is married;
- the partners are not related by adoption or blood to a degree of closeness that would bar marriage in the state in which they legally reside;
- the parties are in a relationship of mutual support, caring, and commitment and intend to remain in such a relationship in the indefinite future;
- the parties are jointly responsible for basic living expenses such as the cost of basic food, shelter, and any other expenses of the common household (the partners need not contribute equally or jointly to the payment of these expenses as long as they agree that both are responsible for them); and
- neither party filed a Termination of Domestic Partnership within the preceding nine months.

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

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

Diagnostic Services: services ordered by a Provider 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 #32 on page 41).

Domiciliary Care: services in your home or in a home-like environment if you are unable to live alone because of demonstrated difficulties:

- in accomplishing Activities of Daily Living;
- in social or personal adjustment; or
- 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 Provider;

- 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: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- a condition that places the health of the individual (or, with respect to a pregnant woman, the health of the woman and/or her unborn Child) in serious jeopardy; or
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Emergency Medical Services: Medical screening examinations that are within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an Emergency Medical Condition, and further medical examination and treatment necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from the Facility, or, with respect to childbirth, that the woman has delivered her baby and the placenta.

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 Providers;
- 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 Plan. The Group Benefits Manager is the agent of the subscriber and your Group. 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.

Health Care Ombudsman: The Vermont Office of Health Care Advocacy telephone hotline service can provide you with free help if you have problems or questions about health care or health insurance.

BCBSVT has an Ombudsman to whom we refer members with complex issues regarding care or service. Our Ombudsman works as a liaison between the member and the plan reviewing and solving issues.

In most cases, the professionals in our customer service call center can answer member questions and resolve most issues. It is the role of the member ombudsman to get involved in the process when unforeseen complications arise in the regular course of problem resolution and information gathering.

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 26) 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; and
- is chiefly dependent on the subscriber or the subscriber's estate for support and maintenance.

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: programs 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)

Lifetime Maximum: the limit on benefits we will pay for a particular service while you are enrolled with this health plan. Your *Outline of Coverage* lists your lifetime limits. We only impose lifetime limits on "non-essential health benefits" as defined by law.

Maintenance Care: treatment that is provided when there are minimal or no current symptoms and is provided regularly on a schedule unmodified by the member's current symptoms.

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

Medical or Scientific Evidence: evidence supported by clinically controlled studies and/or other indicators of scientific reliability from 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 after-care appropriate, in terms of type, amount, frequency, level, setting and duration to the member's diagnosis or condition. Medically Necessary Care must be informed by generally accepted medical or scientific evidence and 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 a developing problem.

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

Member: an individual who enrolls in the Plan.

Network Provider/Non-Network Provider: see "Provider."

Network Pharmacy: any Pharmacy that has been entered into an agreement with us.

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
- independent clinical laboratories
- Network home infusion therapy Provider
- medical equipment/supply Provider (DME)
- Pharmacy
- podiatrist (D.P.M.)

Outline of Coverage: the part of your Contract that gives information about what the health plan pays and what you must pay.

Out-of-Pocket Limit: the Out-of-Pocket Limit is made up of the Deductibles and Co-insurance you pay. Co-payments may also apply to your Out-of-Pocket Limit. Check your *Outline of Coverage*. After you meet your Out-of-Pocket Limit, you pay no Co-insurance for the rest of that Plan Year. You will still be responsible for Co-payments, when they apply.

Your family Out-of-Pocket Limit 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.

Aggregate Out-of-Pocket Limit: Your plan may have an aggregate out-of-pocket limit. Please see your Outline of Coverage to see which kind of Out-of-Pocket limit you have. If your plan has an aggregate Out-of-Pocket Limit, you do not have an individual Out-of-Pocket Limit. Your family members' Covered expenses must reach the family Out-of-Pocket Limit before we pay 100 percent of the Allowed Amount for services. When your family's expenses reach this amount, all family members receive 100 percent coverage.

Stacked Out-of-Pocket Limit: Your plan may have a stacked out-of-pocket limit. Please see you Outline of Coverage to see which kind of Out-of-Pocket limit you have. If your plan has a stacked out-of-pocket limit, and you are on a family plan, a covered family member may meet the individual out-of-pocket limit and we will begin to pay 100 percent of the Allowed Amount for his or her services. Additionally, any combination of covered family members may meet the family out-of-pocket limit and we will begin to pay 100 percent of the Allowed Amount for all family members' services.

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.

Partnership: see Domestic Partnership under Dependent.

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 Providers. 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 and Blue Shield of Vermont

Plan Year: The date your Deductibles, Out-of-Pocket Limits and other totals begin to accumulate. Limits on visits and other limits also begin to accumulate on the first day of your Plan Year. This year may or may not begin on January 1.

Policy: is a word that insurance companies may use for the document that governs Coverage.

Prescription Drugs: insulin and drugs that are:

- prescribed by a Provider 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 used to find or reduce your risks when you do not have symptoms, signs, or specific increased risk for the condition being targeted. They may include immunizations, screening, counseling or medications that can prevent or find a condition. Please note that if you receive a Preventive

Service and during its delivery, the Provider suspects, finds or treats a disease condition, the Provider and/ or BCBSVT may not consider the service preventive.

Prior Approval: the required approval that you must get from us before you receive specific services noted in your Certificate of Coverage. 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 Provider. 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)
- mental health Professionals:
  - clinical mental health counselors
  - clinical psychologists
  - clinical social workers
  - marriage and family therapists
  - psychiatric nurse practitioners
- nurses:
  - certified nurse midwives or licensed Professional midwives
  - certified registered nurse anesthetists
  - licensed practical nurses (LPNs)
  - nurse practitioners
  - registered nurses (RNs)
- nutritional counselors
- optometrists
- Providers (as further defined in this chapter)
- podiatrists
- substance abuse counselors
- therapists (Occupational, Physical and Speech

Some Providers must be Participating in order for their services to be Covered. See Chapter One, Guidelines of Coverage for more details.

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.

Participating Provider: For most Provider types in Vermont this includes:

- Pharmacies who make an agreement with our Pharmacy Benefit Manager;
- Vision Providers who make an agreement with our vision service partner if you have a vision care rider;
- (for pediatric dental care) Providers in our pediatric dental Network if you have a pediatric dental care rider; or
- any Provider that has a Participating agreement with us.

We consider Providers to be Participating Providers if they participate with their local Blue Cross and/ or Blue Shield Plan. You may find a Participating Provider by using our Find-a-Doctor tool on our website at **www.bcbsvt.com**. Select *BCBSVT Network Providers* from the drop-down menu. You may also get a directory of Participating Providers from your Group Benefits Manager or from our customer service team. Some Providers must be Participating in order for their services to be Covered. For some types of service, we do not provide benefits if you do not use a Participating Provider. See Choosing a Participating Provider in Chapter One, Guidelines of Coverage.

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 Providers. A Psychiatric Hospital must:

- provide 24 hour nursing sqervice 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. Reconstructive services include:

- surgery (performed in a timely manner) to correct a medically diagnosed congenital disorder or birth abnormality of a Covered Dependent Child;
- surgery to treat, repair or reconstruct a body part affected by trauma, infection or other disease; and
- surgery for initial reconstruction of breasts after mastectomy for cancer.

Rehabilitative/Habilitative: Habilitation and Rehabilitation services may include respiratory therapy, Speech Therapy, Occupational Therapy and physical medicine treatments. Habilitation and Rehabilitation services may be performed by those who are qualified to perform such services and do so within the scope

of their license. Such services are evaluated based on objective documentation of measurable progress toward functional improvement goals. Measurement methods must be valid, reliable, repeatable and evidence-based.

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.

Skilled Nursing Facility: a Facility that primarily provides 24 hour Inpatient skilled nursing care and related services that Providers deliver 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.

Specialty Medications: injectable and non-injectable drugs with key characteristics, including: frequent dosing adjustments and intensive clinical monitoring; intensive patient training and compliance assistance; limited product availability, specialized product handling and administration requirements.

Speech Therapy (Speech-Language Pathology): Speech-language pathology (SLP) services are the treatment of swallowing, speech-language and cognitive- communication disorders. SLP services facilitate the development and maintenance of human communication and swallowing through assessment, diagnosis, and rehabilitation.

Outline of Coverage: Standard format used to describe your benefits and coverage under your Plan.

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;
- shots, allergy and other;
- 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 Provider 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.

Urgent Concurrent Services: Urgent Services that you are currently receiving with our Prior Approval and that you (or your provider) wish to extend for a longer period of time or number of treatments than we have approved.

Utilization Review: Review to determine the medical necessity of a service or supply. Utilization Review includes Prior Approval or other cost management programs.

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

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

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