We'll see you through.

BlueCross BlueShield of Vermont

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

2018 Certificate of Coverage for

Platinum, Gold, Silver and Bronze Plans

NOTICE: Discrimination is Against the Law

Blue Cross and Blue Shield of Vermont (BCBSVT) and its affiliate The Vermont Health Plan (TVHP) comply with applicable federal and state civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, gender identity or sex.

BCBSVT provides free aids and services to people with disabilities to communicate effectively with us. We provide, for example, qualified sign language interpreters and written information in other formats (e.g., large print, audio or accessible electronic format).

BCBSVT provides free language services to people whose primary language is not English. We provide, for example, qualified interpreters and information written in other languages.

If you need these services, please call (800) 247-2583. If you would like to file a grievance because you believe that BCBSVT has failed to provide services or discriminated on the basis of race, color, national origin, age, disability, gender identity or sex, contact:

Civil Rights Coordinator
Blue Cross and Blue Shield of Vermont
PO Box 186
Montpelier, VT 05601
(802) 371-3394
TDD/TTY: (800) 535-2227
civilrightscoordinator@bcbsvt.com

You can file a grievance by mail, or email at the contacts above. If you need assistance, our civil rights coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of
Health and Human Services
Office for Civil Rights
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019
(800) 537-7697 (TDD)

For free language-assistance services, call (800) 247-2583.

ARABIC

للحصول على خدمات المساعدة اللغوية المجانية، اتصل على الرقم (800) 247-2583.

CHINESE

如需免費語言協助服務，請致電(800) 247-2583。

CUSHITE (OROMO)

Tajaajila gargaarsa afaan hiikuu kaffaltii malee argachuuf (800) 247-2583 bilbilaa.

FRENCH

Pour obtenir des services d'assistance linguistique gratuits, appelez le (800) 247-2583.

GERMAN

Kostenlose fremdsprachliche Unterstützung erhalten Sie unter (800) 247-2583.

ITALIAN

Per i servizi gratuiti di assistenza linguistica, chiamare il numero (800) 247-2583.

JAPANESE

無料の通訳サービスのご利用は、(800) 247-2583までお電話ください。

NEPALI

निःशुल्क भाषा सहायता सेवाहरूका लागि, (800) 247-2583 मा कल गर्नुहोस्।

PORTUGUESE

Para serviços gratuitos de assistência linguística, ligue para o (800) 247-2583.

RUSSIAN

Чтобы получить бесплатные услуги переводчика, позвоните по телефону (800) 247-2583.

SERBO-CROATIAN (SERBIAN)

Za besplatnu uslugu prevođenja, pozovite na broj (800) 247-2583.

SPANISH

Para servicios gratuitos de asistencia con el idioma, llame al (800) 247-2583.

TAGALOG

Para sa libreng mga serbisyo ng tulong pangwika, tumawag sa (800) 247-2583.

THAI

สำหรับการให้บริการความช่วยเหลือด้านภาษาฟรี โทร (800) 247-2583

VIETNAMESE

Để biết các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi số (800) 247-2583.

TABLE OF CONTENTS

This is the Contract for your health plan.

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

- The Certificate of Coverage is 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.
- 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.

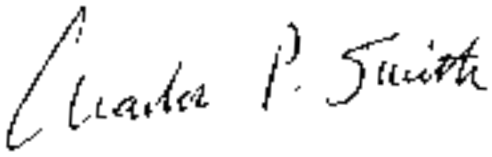
If the Benefits described in your Contract differ from descriptions in our other materials, your Contract language prevails.

How to Use This Document

- Read Chapter One, "Guidelines for Coverage." 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 Outline of 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 or would like to access an interpreter via the telephone, please 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.

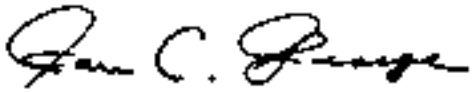
After we accept your application, we cover the health care Services in your Contract, subject to all Contract conditions. Coverage continues from month to month until your Contract ends as allowed by its provisions. (See Chapters Six and Seven.)

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.



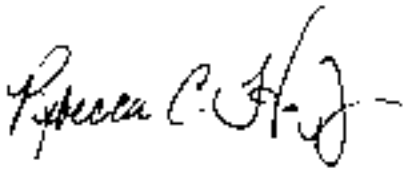
Charles P. Smith

Chair of the Board



Don C. George

President & CEO



Rebecca C. Heintz

General Counsel & Secretary

CHAPTER ONE

Guidelines for Coverage

This Certificate describes benefits for your Blue Cross and Blue Shield of Vermont (BCBSVT) Health Plan. Vermont Health Connect, Vermont's health benefit exchange, has selected this program as a "qualified health plan." We will refer to this plan as "your Health Plan" in this document.

Chapter One explains what you must do to get benefits through your Health Plan. Read this entire chapter carefully, as it is your responsibility to follow its guidelines. Your *Outline of Coverage* shows what you must pay (your cost-sharing).

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 most services, you must use Network Providers (see Chapter Nine "Definitions") or get Prior Approval (see below).
- 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 applicable 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 all services from Non-Network Providers. We also require Prior Approval for certain services and drugs even when you use Network Providers. They appear on the list later in this section. We do not require Prior Approval for Emergency Medical Services.

BCBSVT Network Providers should get Prior Approval for you. If you use a Non-Network Provider it is your responsibility to get Prior Approval. Failure to get Prior Approval could lead to a denial of benefits. If you use a BCBSVT Network 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 our customer service team at (800) 310-5249.

How to Request Prior Approval

To get Prior Approval, you or your Network Provider must provide supporting clinical documentation to BCBSVT. When receiving care from a Non-Network 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 at (800) 310-5249.

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.

If the request for Prior Approval is denied, you may appeal this decision by following the steps outlined in Chapter Four, Claims.

Prior Approval List

You need Prior Approval for services outside of our Network. You also need Prior Approval for other services on our Prior Approval list, even if you use a Network Provider. This list includes:

- Ambulance (non-emergency transport including air or water transport);
- anesthesia (monitored);
- Autism Spectrum Disorder and intellectual disability treatment;
- bilevel positive airway pressure (BIPAP) equipment:
- capsule endoscopy (wireless);
- 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;
- Cosmetic procedures except breast reconstruction for patients with a diagnosis of breast cancer;

- dental trauma, orthognathic Surgery, oral Surgery except oral lesion excision and biopsy;
- Durable Medical Equipment (DME) and orthotics with a purchase price of $500 or more;
- Electroconvulsive Therapy (ECT);
- gender reassignment services for gender dysphoria;
- genetic testing;
- hip resurfacing;
- hospital beds;
- hyperbaric oxygen therapy;
- Investigational or Experimental services or procedures;
- medical nutrition for inherited metabolic disease (medical supplies, pumps, enteral formulae and parenteral nutrition);
- Non-Network services;
- oral appliances for sleep apnea;
- orthodontia for pediatric members up to age 21;
- orthotics with a purchase price of $500 or more;
- osteochondral autograph transfer system (OATS/mosaicplasty);
- out-of-state inpatient and partial inpatient care;
- percutaneous radiofrequency ablation of liver;
- polysomnography (sleep studies) and multiple sleep latency testing (MSLT);
- certain Prescription Drugs and Biologics (please see **www.bcbsvt.com/pharmacy)**;
- prosthetics with a purchase price of $500 or more;
- psychological testing;
- radiation treatment and high-dose electronic brachytherapy;
- radiology services (certain services including CT, CTA, 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 (examples include bariatric and gastric bypass Surgery, gastric electrical stimulation, percutaneous vertebroplasty, vertebral augmentation, temporomandibular joint manipulation/ Surgery and anesthesia and tumor embolization;
- transcranial magnetic stimulation;
- transcutaneous electrical nerve stimulation [TENS] units/neuromuscular electrical stimulators [NMES];
- transplants (except corneal and kidney);
- uvulopalatopharyngoplasty (UPPP)/somnoplasty;
- wheelchairs.

Case Management Program

Our case management program is a voluntary program. 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.

Choosing a Provider

If you want a list of BCBSVT Network Providers or want information about one, please visit our website at **www.bcbsvt.com/find-a-doctor**. 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 use the three-letter prefix, located on your ID card, to find a network Provider using the Blue Cross and Blue Shield Association National Doctor and Hospital Finder.

You must verify Your Plan covers the Provider you choose outside of the BCBSVT network.

You may also call customer service at (800) 310-5249. BCBSVT 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.

You must use Network Providers or get Prior Approval to get care outside of the Network. In Vermont, you must use BCBSVT Network Providers. This Network includes a wide array of Primary Care Providers, Specialists and Facilities in our state and in bordering communities in other states. Outside of this area, you will use our BlueCard Network (PPO/EPO). It includes Providers that contract with other Blue Cross and/or Blue Shield Plans.

Network Providers

In most instances Network Providers will save you money. Also, Network 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).

Although you receive services at a Network facility, the individual Providers there may not be Network Providers. Please make every effort to check the status of all Providers prior to treatment.

We have separate Networks for some types of Providers. You must use a separate Network Provider for the following Provider types:

- dentists (for pediatric dental services);
- Pharmacies; and
- Routine vision care Providers (if your coverage includes routine vision benefits).

Primary Care Providers

When you join this Health Plan, you must select a Primary Care Provider (PCP) from our Network of Primary Care Providers. You must receive services from your PCP or another Network Provider to receive benefits. You have the right to designate any PCP who is available to accept you or your family members. Each family member may select a different Primary Care Provider. For instance, you may select a pediatrician for your Child.

Your coverage does not require you to get referrals from your Primary Care Provider. However, you must get Prior Approval for certain services. (See page 6.) You must get Prior Approval for any services you receive from Providers outside our Network.

If you do not live in Vermont, you do not need to choose a Primary Care Provider (PCP). We encourage you to do so, though, because it benefits your health to have one Provider coordinate your care. You only pay the PCP Co-payment listed on your *Outline of Coverage* if you use a Provider who practices as a PCP and is one of the following Provider types:

- family medicine;
- general practice;
- internal medicine;
- naturopaths;
- nurse practitioner;
- pediatrics.

Non-Network Providers

You must get Prior Approval from us to use Non-Network Providers. If you get Prior Approval to use a Non-Network Provider, we pay the Allowed Amount and you pay any balance between the Provider's charge and what we pay. You must also pay any Deductibles, Co-insurance and Co-payments that apply. (See your *Outline of Coverage* for details.)

If you are a new member and are seeing a Non-Network Provider we shall allow you to keep going to that Provider for up to 60 days after you join or until we find you a Network Provider, whichever is shorter. This can happen if:

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

A woman in her second or third trimester of pregnancy may continue to obtain care from her previous Provider until the completion of postpartum care.

We only allow this if your Non-Network Provider will accept the Health Plan's rates and follow the Health Plan's standards. The Health Plan's medical staff must decide that you qualify for the service. To find out, call (800) 922-8778.

Out-of-Area Providers

If you need care outside of Vermont, you may save money by using Providers that are Preferred Providers with their local Blue Health Plan. See the BlueCard® Program section.

How We Choose Providers

When we choose Network Providers, we check their backgrounds. We use standards of the National Committee on Quality Assurance (NCQA). We choose Network 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 Network Providers are not employees of BCBSVT; they just contract with us.

Access to Care

We require our Network 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 services, imaging, general optometry, and all other routine services.

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

- a 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 treatment from a Network Provider within a 30-minute drive; and
- a Network 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 treatment services.

You can find Network 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 Network 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.

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 don't need Prior 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-Network Provider, we will cover your emergency care as if you had been treated by a Network Provider. You must pay any cost-sharing amounts required under your Contract as if you received those services from a Network Provider. These may include Deductibles, Co-insurance or Co-payments. If a Non-Network Provider requests any payment from you other than your cost-sharing amounts, please contact us at (800) 310-5249 so that we can work directly with the Provider to resolve the request.

Care After Office Hours

In most non-emergency cases, call your Provider's office when you need care—even after office hours. He or she (or a covering Provider) 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.

BlueCard® Program

In certain situations (as described elsewhere in this Certificate) you may obtain health care services outside of the Vermont service area. The claims for these services may be processed through the BlueCard® Program[1].

Typically, when accessing care outside of the service area, you will obtain care from health care Providers that have a contractual agreement 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 health care Providers that have contracts with Blue Cross and Blue Shield plans (e.g., Participating Providers). You must get Prior Approval to get care from non-contracting providers.

If you obtain care from a contracting Provider in another geographic area, we will honor our contract with you, including all cost-sharing provisions and providing benefits for Covered services as long as you fulfill other requirements of this contract. The Host Blue will receive claims from its contracting 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.

1 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 (800) 310-5249.

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 with non-contracting Providers

In certain situations (as described elsewhere in this certificate), you may receive Covered health care services from 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-contracting Provider bills and the payment we will make for the Covered services as set forth above.

For contracting or non-contracting Providers, in no event will you be entitled to benefits for health care services, wherever you received them, that are specifically excluded from, or in the excess of, the limits of coverage provided by your contract.

Blue Cross Blue Shield Global Core™ Program

If you are outside the United States, the Commonwealth of Puerto Rico, or the U.S. Virgin Islands, (which we will call the "BlueCard service area"), you may be able to take advantage of the Blue Cross Blue Shield Global Core™ Program when accessing Covered Services. The Blue Cross Blue Shield Global Core Program is unlike the BlueCard Program in certain ways. For instance, although the Blue Cross Blue Shield Global Core Program helps you get care through a network of inpatient, outpatient and professional Providers, the network is not hosted by Blue plans. When you receive care from Providers outside the BlueCard service area, you will typically have to pay the Providers and submit the claims yourself to obtain reimbursement for these services.

You must get Prior Approval from us for all non-emergency services outside of the Preferred Network.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, please call the Blue Cross Blue Shield Global Core Service Center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if you contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require you to pay for covered Inpatient services, except for your cost-sharing amounts. In such cases, the hospital will submit your claims to the Blue Cross Blue Shield Global Core Service Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services.

Outpatient Services

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from BCBSVT, the Blue Cross Blue Shield Global Core Service Center or online at **www.bcbsglobalcore.com.** If you need assistance with your claim submission, you should call the Blue Cross Blue Shield Global Core Service Center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, seven days a week.

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:

- Network 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-Network Provider, we pay the Allowed Amount and you must pay any balance between the Provider's charge and what we pay.

Cost-Sharing

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 Deductible. Please see your *Outline of Coverage* to see what type of Deductible you have. If your plan has an Aggregate Deductible, and you are on a two-person or 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 Deductible. Please see your *Outline of Coverage* to see what type of Deductible you have. If your plan has a Stacked Deductible, and you are on a two-person or 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 apply Co-payments toward your Out-of-Pocket Limit. Check your *Outline of Coverage* for details on your Health Plan.

You may have different Co-payments depending on the Providers 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. We apply your Deductible, your Co-payments and your Co-insurance toward this limit. Check your *Outline of Coverage* for details on your plan. After you meet your Out-of-Pocket Limit, you pay no Co-insurance or Co-payments for the rest of that Plan Year. 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 and you are on a two-person or family plan, 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 your *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.

Aggregate Prescription Drugs and Biologics Out-of-Pocket Limit

Your plan may have an Aggregate Prescription Drugs and Biologics Out-of-Pocket limit. Please see your *Outline of Coverage* for details. Once any combination of Covered family members meets the Prescription Drugs and Biologics Out-of-Pocket limit, we begin to pay Prescription Drugs and Biologics at 100 percent of the Allowed Amount.

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.

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 directly. The amount you pay your Provider will not count toward your Deductible, other cost-sharing obligations or your Out-of-Pocket Limits.

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 cost-sharing such as Co-insurance and Deductibles.

Preventive Services

We provide benefits for Preventive Services. We encourage you to get Preventive Services that are appropriate for you. Examples of preventive care include colonoscopies for people age 50 and over, mammograms for women age 40 and over and Coverage for women's reproductive health as required by law.

We pay for some Preventive Services with no Cost-Sharing (like Co-payments, Deductibles and Co-insurance). We provide such Coverage for services rated A or B by the United States Preventive Services Task Force. You can find this list on our website at **www.bcbsvt.com/preventive.** Or you can call our customer service team at (800) 310-5249 to get a list.

Note that the list includes many Preventive Services, but not all. Coverage for other preventive, diagnostic and treatment services may be subject to cost-sharing. The list also includes some services that are appropriate for individuals at increased risk for certain conditions.

Please note that if your Provider finds or treats a condition while performing Preventive Services, cost-sharing may apply.

Women's Health

We pay benefits for certain services and supplies that support women's health with no cost-sharing (like Co-payments, Deductibles and Co-insurance).

This benefit covers the following Services if they are appropriate for the Member (for a detailed list, visit our website at **www.bcbsvt.com/preventive** or call our customer service team at (800) 310-5249):

- well-women visits;
- gestational diabetes screening;
- human papillomavirus testing;
- sexually transmitted infections counseling;
- human immunodeficiency virus counseling and screening;
- generic female contraception methods (or brand name methods if no generic is available) and contraceptive counseling;[1]
- breastfeeding support and counseling from Network Providers;
- breastfeeding supplies (you must get Prior Approval for hospital-grade breast pumps); and
- domestic violence screening.

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 such as these in an office setting:

- examination, diagnosis and treatment of an injury or illness;
- injections;
- Diagnostic Services, such as X-rays;
- nutritional counseling (See page 22);
- Surgery; and
- therapy services (See page 24).

Some office visits may fall under your preventive services benefit.

Exclusions

We do not cover immunizations that the law mandates an employer to provide. General exclusions in Chapter Three also apply.

Notes:

- We describe office visits 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 6 for a description of the Prior Approval program. Visit our website or call our customer service team at (800) 310-5249 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-Network Provider bills you for a balance

[1] Please note if you use brand-name contraceptives, we will cover them at the applicable Co-payment.

between the charges and what we pay, please notify us by calling our customer service team at (800) 310-5249. We will defend against and resolve any request or claim by a Non-Network 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.

Please remember General Exclusions in Chapter Three also apply.

Clinical Trials (Approved)

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

General Exclusions in Chapter Three apply.

Chiropractic Services

We cover services by our Network 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 6 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 is not in our Network;
- services, including modalities, that do not require the constant attendance of a Chiropractor;
- treatment of any "visceral condition," that is a dysfunction of the abdominal or thoracic organs, or other condition that is not neuromusculoskeletal in nature;
- acupuncture;
- hot and cold packs;
- 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 prenatal and post-natal care;

- Custodial Care (see Definitions), as noted in General Exclusions;
- Surgery;
- unattended services or modalities that do not require one-on-one patient contact by the Provider; or
- any other procedure not listed as a Covered chiropractic service.

General Exclusions in Chapter Three also apply.

Cosmetic and Reconstructive Procedures

We exclude Cosmetic procedures (see General Exclusions in Chapter Three). Your benefits cover Reconstructive procedures that are not Cosmetic. (Please see the definitions of Reconstructive and Cosmetic.) For example, we cover:

- Reconstruction of a breast after breast Surgery and Reconstruction of the other breast to produce a symmetrical appearance;
- prostheses (which we cover under Medical Equipment and Supplies on page 19); and
- treatment of physical complications resulting from breast Surgery.

You must get Prior Approval for these services.

Dental Services

We cover only the following dental services for individuals over age 21; you may use any Network Provider:

- 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.[1]
- 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).
- 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.
- Facility and anesthesia charges for members who are:
  - 7 years of age or younger;
  - 12 years of age or younger with phobias or a mental illness documented by a licensed physician or mental health professional; and
  - members with severe disabilities that preclude office-based dental care due to safety consideration (examples include, but are not limited to, severe autism, cerebral palsy, hemorrhagic disorders, and severe congestive heart failure).

Note: the professional charges for the dental services may not be covered.

For individuals up to age 21 (and through the end of the Plan year in which a member turns 21) we provide the services above and also the following pediatric dental services:

- Class I services including semiannual examinations, semiannual cleaning, X-rays and diagnosis.
- Class II (basic) services including simple restoration (fillings), crowns and jackets, repair of crowns, wisdom tooth removal, extractions and endodontics (root canal).
- Class III (major) services including dentures, bridges, replacement of bridges and dentures and Medically Necessary orthodontia.

For pediatric dental services you must use a Provider in our pediatric dental network. For a list of dentists please visit **www.bcbsvt.com/find-a-doctor** or call (800) 310-5249.

Please see your *Outline of Coverage* to see how much you must pay for each level of service.

You must get Prior Approval for the services beginning on page 6, including some dental services, or your care may not be Covered. In the event of an emergency, you must contact us as soon as possible afterward for approval of continued treatment.

Exclusions

Unless expressly Covered in other parts of this Contract or required by law, we do not cover the following services:

- 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 or in connection with an accidental injury);

1 Note: 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.

- procedures designed primarily to prepare the mouth for dentures (including alveolar augmentation, bone grafting, frame implants and ramus mandibular stapling);
- charges related to non-Covered dental procedures or anesthesia (for example, facility charges, except when Medically Necessary as noted above).

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 Network Providers or we will not cover your care:

- medical doctor (M.D.);
- doctor of osteopathy (D.O.);
- registered dietitian (R.D.);
- certified dietitian (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 these 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);
- mammograms; and
- hearing tests by an audiologist only if your doctor suspects you have a disease condition.

You must get Prior Approval for special radiology procedures (including CT, MRI, MRA, MRS and PET scans) and polysomnography (sleep studies). See page 6 for more information regarding Prior Approval.

Emergency 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-Network Provider bills you for a balance between the charges and what we pay, please notify us. Call us at (800) 310-5249. We will defend against and resolve any request or claim by a Non-Network 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 24.

Private Duty Nursing

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

- We limit benefits for private duty nursing. Check your *Outline of Coverage*.
- We provide benefits only if you receive services from a registered or licensed practical nurse.

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 caregiver 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 Network home infusion therapy Provider; or
- your doctor-prescribed drug is approved for treatment.

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 Drugs and Biologics benefits);
- Custodial Care (see Definitions);
- 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:

- skilled nursing visits;
- home health aide services for personal care services;
- homemaker services for housecleaning, cooking, etc;
- continuous care in your home;
- Respite Care services;
- Medical social worker visits before the patient's death and bereavement visits and counseling for family members up to one year following the patient's death; 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

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 Network Skilled Nursing Facility.

We cover either the inpatient fee (room and board) for the day of admission or the day of discharge, but not both.

Certain Inpatient services require Prior Approval. Please see page 6 for a list of these services.

Inpatient Medical Services

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

- Surgery;
- 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 Reconstructive procedures.

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.

- 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:

- prenatal 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 Network 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 birth. If you join this program, we provide a selection of benefit options, including:

- personal-use breast pumps;
- books and other educational tools;
- reimbursement for classes; and
- reimbursement toward infant car seats.

You get the most out of the Better Beginnings program when you contact us in the first three months of your pregnancy. To get any benefits from Better Beginnings, you must actively participate. If you have questions, please call our customer service team at (800) 310-5249. If you'd like to enroll online, or learn more about the program, please visit **www.bcbsvt.com/betterbeginnings**.

Note:

We may provide benefits through the Better Beginnings program for services that we do not generally cover. (We explain these services 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 certain Durable Medical Equipment including continuous passive motion equipment, TENS units or Durable Medical Equipment including orthotics and prosthetics with a purchase price of $500 or more. See the Prior Approval list on page page 6. We cover Durable Medical Equipment you purchase from a Network:

- 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.

Replacement of lost, stolen or destroyed Durable Medical Equipment

We will replace one lost, stolen or destroyed Durable Medical Equipment, prosthetic or orthotic per Plan Year if not covered by an alternative entity (including but not limited to homeowners insurance and automobile insurance) if:

- the Durable Medical Equipment, prosthetic or orthotic's absence would put the member at risk of death, disability or significant negative health consequences such as a hospital admission;
- the Durable Medical Equipment is still under warranty.

Note: In order to replace a stolen item we require you to submit documentation, such as a police report, with the request.

Exclusions

We do not cover the replacement of a lost, stolen or destroyed Durable Medical Equipment, prosthetic or orthotic:

- if the criteria above have not been met; and

- for more than one lost, stolen or destroyed Durable Medical Equipment, prosthetic or orthotic per Plan Year.

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 with a purchase price of $500 or more. 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, third-degree burns, traumatic scalp 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.

Limitations

For wigs (cranial/scalp prosthesis), we limit the replacement of the original wig (cranial/scalp prosthesis) 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.

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, congenital anomalies that result in impaired physical function or Surgery;
- to treat obstructive sleep apnea; or
- to treat craniofacial disorders, including temporomandibular joint syndrome.

Exclusions

We provide no benefits for:

- treatment for hair loss due to male or female pattern baldness and/or natural or premature aging;
- prosthetics or orthotics with a purchase price of $500 or more for which you have not received Prior Approval from us;
- dental appliances or dental prosthetics, except as listed on page 15;
- shoe insert orthotics, lifts, arch supports or special shoes not attached to a brace (except with a diagnosis of diabetes);
- 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;
- 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 our customer service team at (800) 310-5249 before purchasing or renting a Durable Medical Equipment item.

Mental Health Care

Some services require Prior Approval. See page 6.

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.

Coverage for Emergency Medical Services outside the service area will be the same as for those within the service area. If a Non-Network Provider bills you for a balance between the charges and what we pay, please notify us. Call our customer service team at (800) 310-5249. We will defend against and resolve any request or claim by a Non-Network Provider of Emergency Medical Services.

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 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 (see Definitions);
- psychoanalysis;
- hypnotherapy; and
- biofeedback, pain management, stress reduction classes and pastoral counseling.

General Exclusions in Chapter Three also apply.

National Preferred Formulary Prescription Drugs and Biologics

This section explains your Prescription Drugs and Biologics benefits. Please see your *Outline of Coverage* for specific cost-sharing details.

We follow Express Scripts℠ (ESI's) National Preferred Formulary (NPF). You must use a licensed Network Pharmacy or Network home delivery pharmacy to receive benefits. To locate a Network Pharmacy, visit **www.bcbsvt.com/find-a-doctor**. We provide benefits for medically necessary Outpatient use of:

- Prescription Drugs and Biologics (including contraceptive drugs and devices that require a prescription) if the Food and Drug Administration approves them for the treatment of your condition;
- insulin and other supplies for people with diabetes (blood sugar testing materials including home glucose testing machines, needles and syringes).

Please note We cover Off-label Prescription Drugs and Biologics used to treat cancer as required by law. We may provide benefits for Prescription Drugs and Biologics that are not approved by the Food and Drug Administration for the treatment of your condition if their use meets the definition of medical necessity and is not considered Investigational.

Benefits are subject to the exclusions listed in this section and in Chapter Three "General Exclusions." Please refer to your *Outline of Coverage* to determine the specific payment requirements of your Prescription Drugs and Biologics benefit.

Preferred and Non-Preferred Drugs

We may require different amounts of cost-sharing when you purchase generic, preferred Brand or non-preferred Brand drugs. Generally, generics require lower cost-sharing and non-preferred drugs require the most cost-sharing.

The NPF Brand-name drug list can change from time to time. To get the most up-to-date listing, visit our website at **www.bcbsvt.com/pharmacy** or call ESI at (800) 313-7879.

Home Delivery Service

Our Network home delivery pharmacy can provide you with Prescription Drugs and Biologics you take on an ongoing basis.

To use the home delivery service please complete a home delivery form and submit it to Blue Cross and Blue Shield of Vermont with your prescription. See your *Outline of Coverage* for detailed cost-sharing information about home delivery.

For more information about home delivery service, call ESI at (800) 313-7879 or visit **www.bcbsvt.com/pharmacy**.

Limitations

We cover up to a 90-day supply for each refill (We cover contraceptives up to a 12-month supply). We may limit coverage for narcotics, antibiotics, Specialty Medications, controlled substances and compound drugs to a 30-day supply or less for each refill. We limit benefits for prescribed tobacco cessation drugs to a six-month supply per Plan Year. Please also see the "Quantity Limits" section below.

Prior Approval Program

We require Prior Approval for some drugs listed on the National Preferred Formulary. This drug list can change from time to time. Please visit our website at **www.bcbsvt.com/pharmacy** or call ESI at (800) 313-7879 for the most current list.

How to Get Prior Approval for Your Drugs

To get Prior Approval for your prescription drug or have us adjust quantity limits or step therapy edits, your Provider must write to our medical services department, or its designee, with the following information:

- your name;
- your diagnosis;
- your ID number;
- clinical information explaining the medical necessity for the medication; and
- the expected frequency and duration of the medication.

If you have an emergency or an urgent need for a drug on the Prior Approval list, call ESI at (877) 493-1947. If we deny your request for Prior Approval, see Chapter Four for instructions on how to appeal our decision. You may also see your *Outline of Coverage* for details regarding our Prior Approval Program.

Our quantity limits, step therapy and Prior Approval drug lists change from time to time. For the most up-to-date list visit our website at **www.bcbsvt.com** to see if a specific drug needs Prior Approval or other review. You may also call the customer service team at (800) 310-5249.

Quantity Limits

We review certain Prescription Drugs and Biologics for medical necessity to see if the amount of a drug your doctor has prescribed exceeds quantity limits. If your doctor prescribes a drug in an amount that exceeds certain criteria, such as the FDA approved dosing, We may ask for documentation about why you need more of the drug. Visit **www.bcbsvt.com/pharmacy** or call ESI at (800) 313-7879 to get a current list of drugs covered by this review or to learn the quantity limit for a particular drug.

Step Therapy

Our NPF step therapy program saves you money by encouraging patients and their doctors to try less expensive drugs in a therapeutic class before using the newest, most expensive ones. We may require Prior Approval if they do not have information stating you first tried a less expensive drug.

We also review certain Prescription Drugs and Biologics if you do not try the generic drug first. Visit **www.bcbsvt.com/pharmacy** or call ESI at (800) 313-7879 to get a current list of drugs covered by this review or to learn the procedures to follow for review of your prescription use.

Cost-Sharing

Please refer to your *Outline of Coverage* to determine the specific cost-sharing requirements of your Prescription Drugs and Biologics benefit. You may have a Deductible, Co-insurance and/or Co-payments for your Prescription Drugs and Biologic purchases, but We do not apply both Co-insurance and Co-payments to the same Prescription Drugs and Biologics purchase.

If your Provider determines that you should not take a generic drug (lowest-tier drug) your cost-sharing responsibility for a Preferred or Non-Preferred drug can be no greater than the amount that you would have paid for the lowest-tier Co-payment or Co-insurance.

Some prescriptions on the NPF Quantity Limits list may have different cost-sharing arrangements. Please refer to the current list by visiting **www.bcbsvt.com/pharmacy.**

Compounded Prescriptions

Pharmacists must sometimes prepare medicines from raw ingredients by hand. These medicines are called compounded prescriptions. The pharmacist submits a claim using the National Drug Codes (NDC) for the ingredients. Your cost depends on the NDC submitted for the compounded drug.

Exclusions

We do not provide Prescription Drugs and Biologics benefits for:

- refills beyond one year from the original prescription date;
- devices of any type other than prescription contraceptives, even though such devices may require a prescription including, but not limited to: Durable Medical Equipment, prosthetic devices, appliances and supports (although benefits may be provided under other sections of your Contract);
- any drug considered to be Experimental or Investigational, except for certain Off-label cancer drugs and drugs administered as part of certain clinical cancer trials;
- vitamins, except those which, by law, require a prescription;
- drugs that do not require a prescription, except insulin, even if your doctor prescribes or recommends them;
- 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; and
- any drugs listed under Excluded Medications on the National Preferred Formulary drug list.

Replacement of lost, stolen or destroyed Prescription Drugs and Biologics

We will replace one lost, stolen or destroyed Prescription Drug or Biologic per Plan Year if not covered by an alternative entity (including but not limited to homeowners insurance and automobile insurance) if:

- the Prescription Drug or Biologic's absence would put the member at risk of death, disability or significant negative health consequences such as a hospital admission.

Note: In order to replace a stolen Prescription Drug or Biologic we require you to submit documentation, such as a police report, with the request.

Exclusions

We do not cover the replacement of a lost, stolen or destroyed Prescription Drug or Biologic:

- if the criteria above have not been met; and
- for more than one lost, stolen or destroyed Prescription Drug or Biologic per Plan Year.

Claim Filing

A Network Pharmacy will collect the amount you owe (Deductible, Co-payment and/or Co-insurance) and submit claims on your behalf. We will reimburse Network Pharmacies directly. You must use a Network Pharmacy or our Network home delivery pharmacy to receive benefits. However, if you need to be reimbursed, attach itemized bills for the dispensed drugs to a Prescription Reimbursement Form. Contact our customer service team at (800) 310-5249 for assistance.

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 Network Providers or we will not provide benefits:

- medical doctor (M.D.);
- doctor of osteopathy (D.O.);
- registered dietitian (R.D.);
- certified dietitian (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 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 6. For more information about Therapy Services, see page 24.

Outpatient Medical Services

We cover care you receive from a Provider or Professional when you are not an Inpatient. These visits may 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 Prior Approval list on page 6.

We cover:

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

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; and
- receive Acute Care in the Skilled Nursing Facility.

Exclusions

We do not cover Skilled Nursing Facility care for:

- Cognitive re-training
- Custodial Care

Substance Abuse Treatment 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 treatment 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-Network Provider bills you for a balance between the charges and what we pay, please notify us. Call our customer service team at (800) 310-5249. We will defend against and resolve any request or claim by a Non-Network 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) 310-5249 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 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 or delinquency;
- Custodial Care (see Definitions);
- biofeedback, pain management, stress reduction classes and pastoral counseling;
- psychoanalysis; and
- hypnotherapy.

General Exclusions in Chapter Three also apply.

Surgery

We cover Surgery in both Inpatient and Outpatient settings with the following limitations and conditions:

- 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.
- You must get Prior Approval for Cosmetic and Reconstructive procedures.
- We cover sterilization procedures (vasectomy or tubal ligation) even though they are not Medically Necessary.

Telemedicine Services

We cover general consultative telemedicine services such as:

- colds and flu;
- sinus, ear and eye infections;
- headaches; and
- allergies.

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

Limitations

You must use American Well Providers or a Provider using secure technology in accordance with Vermont statute.

Please note we cover Prescription Drugs and Biologics but Providers:

- may not write prescriptions to patients with whom they consult by telephone (subject to state law); and
- cannot prescribe any controlled substances, medication for erectile dysfunction or any state-specific controlled medications (subject to state law; such as pseudoephedrine). Controlled substances include drugs such as:
  - narcotics;
  - anxiety medications;
  - ADHD medications; and
  - muscle relaxants.

Exclusions

Our telemedicine benefit does not cover:

- Telemedicine services via email, Skype or facsimile.
- "Store and Forward" telemedicine.

Therapy Services

We cover Therapy or physical medicine services provided by:

- an eligible 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 Chiropractor (D.C.) in an office or home setting; or
- an 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.),
  - Chiropractor (D.C.),
  - athletic trainer (A.T.),
  - podiatrist (D.P.M.),
  - nurse practitioner (N.P.),
  - advanced practice registered nurse (A.P.R.N.)
  - doctor of naturopathy (N.D.); or
  - doctor of osteopathy (D.O.);
- up to the 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 Care

Vision Care benefits are available for members up to 21 years of age (and to the end of the Plan year in which the member turns 21). Your vision benefits are administered by Vision Service Plan (VSP). To receive the best benefits for vision care, you must obtain services and materials through a VSP Network Provider. For a list of Providers, visit **www.vsp.com** or call VSP at (800) 877-7195.

When seeing your child's vision service provider for services, or calling VSP to inquire about his or her benefits, make sure to specify your child's two-part identification number, which consists of your **subscriber ID** (located on the front, left-hand side of your ID care) and the **member number** (located on the front, right-hand side of your ID card.) Please note that your dependents have their own unique member number.

We cover one routine vision examination each calendar year for a Member under 21 years of age (and to the end of the Plan year in which the member turns 21). This exam assesses the Member's visual functions to:

- determine if he or she has any visual problems and/or abnormalities; and
- prescribe any necessary corrective eyewear.

Vision Materials

We cover the following supplies and services for Members up to 21 years of age (and to the end of the Plan year in which the member turns 21):

- one pair of frames and/or lenses for prescription glasses and related Professional services each calendar year; or
- one pair of contact lenses and related Professional services each calendar year.

Frames and/or lenses may be subject to Co-payments, Deductibles and Co-insurance amounts as shown on your *Outline of Coverage* and explained in your Certificate. These Co-payments, Deductibles or Co-insurance amounts may be separate from your Co-payments, Deductibles and Co-insurance amounts for your vision exam.

Frames for Prescription Glasses

We cover one pair of frames from those on our Network Provider list of Covered frames. If you choose a frame that costs more than the Allowed Amount, you must pay the difference between the cost of the frame and the Allowed Amount. Discounts may be available.

Lenses for Prescription Glasses

We cover single vision, lined bifocal and lined trifocal lenses. When you select any of the non-Covered Cosmetic extras indicated below or any other items not necessary to correct your vision, we will pay the basic cost of the allowed lenses (minus any Co-payment due) and you must pay the additional costs for Cosmetic extras. Non-Covered Cosmetic extras include:

- blended or progressive multi-focal lenses;
- oversize lenses; and/or
- tinted or coated lenses (other than solid pink #1 and #2).

Contact Lenses

When you choose contact lenses instead of glasses, we cover costs associated with one pair of contact lenses of equal value as if you were purchasing lenses for prescription glasses. Please see your *Outline of Coverage* for cost-sharing details.

We do not cover:

- contact lenses that are solely for Cosmetic purposes (for example, to change your eye color); or
- the evaluation and fitting of contact lenses.

Necessary Contact Lenses

When contact lenses are necessary because of eye conditions such as aphakia, anisometropia, high ametropia, nystagmus, keratoconus or other medical conditions that would inhibit the use of glasses, you pay only your Co-payment for vision materials if you use a VSP Network Provider. Your Provider must get Prior Approval from VSP.

If you choose a Non-Network Provider for necessary contact lenses, you must pay for your services up front. VSP will review your claim and decide if your contact lenses are "necessary." If your services are approved, you will be reimbursed up to the Allowed Amount minus your Co-payment.

Related Professional Services

When your annual vision exam (as described in your Contract) indicates that prescription glasses or contact lenses are necessary for your proper vision, we cover Professional services necessary to:

- prescribe and order proper lenses;
- assist you in the selection of a frame;
- verify the accuracy of the finished lenses;
- adjust and fit your prescription glasses properly;
- perform necessary follow-up work; and/or
- adjust your frames to maintain comfort and efficiency at a later date, if necessary.

Claim Filing for Vision Benefits

Your Network Provider will file your claim on your behalf. We will reimburse your Provider directly.

To receive reimbursement when you visit a non-VSP Provider, sign on to **www.vsp.com**, select the "Non-Network Reimbursement Form" and follow the instructions. Or, you may send an itemized receipt listing the services received along with the patient's name and Covered subscriber's name and I.D. number to VSP. Non-Network claims must be submitted to

VSP within six months of service. Send the original claims reimbursement request and receipts to VSP, P.O. Box 997105, Sacramento, CA 95899-7105.

Exclusions

We do not cover services or supplies for:

- orthoptics, vision training or plano (non-prescription lenses);
- lenses and frames furnished under this program which are lost, broken or scratched (these will only be replaced at the normal intervals when benefits are otherwise available);
- vision services for Members 21 years or older (except to the end of the Plan year in which the member turns 21); or
- any eye exam or corrective eyewear required by an employer as a condition of employment.

General Exclusions in Chapter Three also apply. Coverage for Medical or Surgical treatment of the eyes appears in other sections of this Certificate.

Vision Services (Medical)

We cover services by an optometrist or ophthalmologist 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. (Please see page 25 for vision-related services.) We cover your visit to an optometrist or ophthalmologist in the same way we cover visits to Providers performing Covered eye care.

Eyeglasses, contact lenses, and refraction

We do not 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 18).

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. We also cover non-refractive therapeutic contact lenses.

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 for which 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 establish or 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. This exclusion does not apply to 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 electrical stimulators [NMES] 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. Immunizations purchased in bulk, such as those provided to a group of people, and billed collectively rather than individually.
15. Fluoride treatments performed in school.
16. Whole blood, blood components, costs associated with the storage of blood, testing of blood the patient donates for his or her own use (even if the blood is used), transfusion services for blood and blood components the patient donates for his or her own use in the absence of a Covered surgical procedure. (This exclusion does not apply to blood derivatives and transfusion services for whole blood, blood components and blood derivatives.)
17. Care for which there is no therapeutic benefit or likelihood of improvement.
18. Care, the duration of which is based upon a predetermined length of time rather than the condition of the patient, the results of treatment or the individual's medical progress.
19. 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.
22. Computer technology or accessories and other equipment, supplies or treatment intended primarily to enhance occupational, recreational or vocational activities, hobbies or academic performance.
23. Consultations, including telephone consultations, except when they occur between Providers and the Providers attach a written report to the patient's medical record.
24. 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.

25. Cosmetic procedures and supplies that are not Reconstructive.
26. 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 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).
27. Custodial Care, Rest Cures.
28. 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).
29. 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.
30. 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).
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: 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 (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. We will only cover the rate payable for the appropriate Medically Necessary level of care received.
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 copies of medical records, transcripts or 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 (this exclusion does not apply if orthodontics are Covered in other sections of this Contract).
46. Orthoptics, vision training or plano (non-prescription lenses).
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 except when the patient has a diagnosis of Temporomandibular Joint Syndrome (TMJ); gravity assisted 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. Sterilization reversal (vasectomy reversal, vasovasostomy, vasovasorrhaphy, tubal ligation reversal, tubotubal anastomosis).
55. Support therapies, including pastoral counseling, assertiveness training, dream therapy, equine therapy, music or art therapy, recreational therapy, tobacco cessation support therapy, stress management, wilderness programs, therapy camps, adventure therapy and bright light therapy.
56. "Store and Forward" telemedicine or telemedicine not conducted at a Network 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 do not require one-on-one patient contact by the Provider.
61. 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.)

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-Network Provider if we require use of a Network 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.

Network Providers will usually submit claims on your behalf if this is your primary coverage. When you use Non-Network 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 12 years of age or older 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 Network Providers directly. We may pay BlueCard Network Providers directly. We usually pay you when you use Non-Network Providers. We may pay Non-Network Providers directly.

You may not assign your benefit rights to any other party, including Non-Network 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 (800) 310-5249. 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 health care 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 customer service team at (800) 310-5249.

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 treatment claim, send 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 (800) 310-5249.

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 (800) 310-5249. 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 (for group coverage only)
(866) 444-EBSA (3272)

Office of the 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.

Office of the Health Care Advocate

The 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 Office of the 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, our customer service team 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. To contact our Ombudsman, call (800) 437-6298.

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 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 have coverage 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 plan provides benefits that we should have paid, we have the right to reimburse the other 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, single head of household or family) may change. You may add or remove Dependents from your membership as allowed by state and federal law. You can see additional details about adding and removing Dependents at **www.bcbsvt.com/enroll**.

If you have coverage through an employer, contact your Group Benefits Manager. If you do not have coverage through your employer, please call (800) 310-5249. You can also visit our secure Web portal, the BCBSVT Member Resource Center, for information about your Health Plan and enrollment.

Coverage Effective Dates

If you enrolled through Vermont Health Connect, Vermont Health Connect will determine whether you are eligible for coverage or a change in coverage. Vermont Health Connect will decide when your coverage is effective after it determines that you are eligible for coverage. Generally, coverage will be effective as follows: if you have submitted complete information to Vermont Health Connect between the first and the 15th of the month, your coverage will become effective on the first day of the following month. If you have submitted complete information to Vermont Health Connect between the 16th and the last day of the month, your coverage will become effective on the first day of the second following month.

If you are not receiving a federal premium tax credit and you are enrolled directly through us, we will determine whether you are eligible for a change in coverage based on the same rules that apply to Vermont Health Connect. However, if you are eligible for a change, we can generally make a requested change effective on the first of the next month, provided you have requested the change prior to the last day of the prior month.

Open Enrollment

Open enrollment is the period each year during which you may enroll in or make changes to your coverage. You may add dependents during this period.

The federal government sets the annual open enrollment dates for Groups and individuals purchasing coverage through Vermont Health Connect or enrolling directly through us. If you are eligible for benefits under the Indian Health Care Improvement Act, you may be able to change coverage every month. Contact Vermont Health Connect to see if this applies to you.

Special Enrollment Periods

Federal and state laws define your rights to purchase insurance outside of applicable open enrollment periods. Generally, the law provides that if you lose coverage due to a legally-defined qualifying event (such as divorce) or you gain a new Dependent (such as through marriage or birth), you are entitled to purchase new coverage outside of an applicable open enrollment period. You can see additional details about these rights at **www.bcbsvt.com/enroll**.

Cancellation of Coverage

Cancellation of Individual Coverage through Vermont Health Connect

If you enrolled directly through Vermont Health Connect, you must contact Vermont Health Connect to cancel your coverage. Vermont Health Connect will determine when your cancellation is effective. Generally, you are expected to give at least 14 days' notice prior to the effective date of the cancellation.

If you are enrolled as an individual through Vermont Health Connect and are cancelling coverage for which you have paid premiums because you purchased other coverage through Vermont Health Connect, your coverage will terminate on the date the other coverage becomes effective if premiums are paid in full.

If you are cancelling coverage because you are eligible for Medicaid or Dr. Dynasaur, Vermont Health Connect will determine the date your coverage cancellation is effective. Generally, your coverage will end on the date your Medicaid or Dr. Dynasaur coverage becomes effective. If you are enrolled through Vermont Health Connect, Vermont Health Connect will determine any amounts owed to you for any unearned premiums they may have collected.

If Vermont Health Connect determines that you are no longer eligible for coverage, Vermont Health Connect will determine the date your coverage is no longer effective. Generally, your coverage will terminate on the last day of the month following the month Vermont Health Connect sends you a notice that you are no longer eligible.

Cancellation of Individual Coverage through Us

If you enrolled directly through us, you may cancel this Contract without cause at any time by giving us prior written notice. We may cancel coverage in accordance with state and federal law. Upon contract cancellation we refund any amount of any unearned premium we may have collected to you. Such payment constitutes a full and final discharge of all of our obligations under this Contract, unless otherwise required by law. We will continue to provide benefits for all Covered Services received before the effective date of cancellation.

Cancellation of Group Coverage

If your employer is enrolled through us, your Group may cancel this Contract without cause at any time by giving us prior written notice. We may cancel coverage in accordance with state and federal law. Upon contract cancellation we refund any amount of any unearned premium we may have collected to your employer. Such payment constitutes a full and final discharge of all of our obligations under this Contract, unless otherwise required by law. We will continue to provide benefits for all Covered Services received before the effective date of cancellation.

Default in Subscription Payment

If you enrolled directly through Vermont Health Connect, Vermont Health Connect will determine when your premiums are due. You must make your monthly payment as specified by Vermont Health Connect.

If you enrolled through Vermont Health Connect and receive advanced payment of the premium tax credit to help pay for the cost of insurance, you are entitled to a three-month grace period for payment of your premium before your coverage will be canceled. In order to avoid cancellation of your coverage, you must pay all premiums due before the three-month grace period ends. Partial payment of overdue amounts will not reinstate your coverage or restart your grace period.

If you fail to pay your premium in full within the first three months:

- your coverage will be canceled to the last day of the first month of the grace period;
- we do not pay your claims incurred after the first month; and
- you will be responsible for those costs.

If you do not pay your premiums in full and your coverage is canceled, when you file your federal income tax return, you may also be responsible for repaying the U.S. Internal Revenue Service any premium tax credit received by us on your behalf or paying a tax penalty for failing to have coverage.

If you are enrolled directly through us, receive coverage through your employer or you enrolled through Vermont Health Connect but are not receiving a federal tax credit, you are entitled to a one month grace period before your coverage is canceled for nonpayment. In order to avoid cancellation, you or your Group must pay all outstanding amounts due, not just past due amounts. A partial payment will not reinstate your coverage or restart the grace period.

If your coverage is canceled:

- we will not pay your claims and you will be responsible for those costs; and
- you will have to wait until open enrollment or a special enrollment period to purchase coverage again.

We will cancel your coverage at the end of the month in which we send your cancellation notice. If you enrolled directly through us or chose us as your plan administrator, we will allow you to reinstate your coverage once per year, provided you pay all outstanding premiums and you make the request for reinstatement within 30 days of your cancellation. If you purchase insurance through your employer, your employer may only reinstate coverage that has been canceled for failure to pay twice in a year. We consider non-payment a request to cancel coverage, and therefore, a cancellation of your coverage by you.

Benefits after Cancellation of Group Coverage

If your employer purchased coverage through us, and you are entitled to benefits for a continuous total disability existing on your group's 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.

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 and who is not eligible to be covered as a dependent under a succeeding group policy or plan without a Pre-existing Condition exclusion applicable to the disability.

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, we will suspend coverage for active service military members. We will repay any subscription rates prepaid by someone actively serving in the military for the portion of the prepaid period in which coverage is suspended.

Fraud, Misrepresentation or Concealment of a Material Fact

If you obtain or attempt to obtain coverage or benefits through fraud, this Contract is void. If you are disenrolled due to fraud, we will not provide any extension of benefits after this Contract is canceled.

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.

Medicare

Please note that this is not a Medicare supplement contract. If you are eligible for Medicare, please visit **www.medicare.gov.**

Our Pledge to You

Here at Blue Cross and Blue Shield of Vermont, we're committed to creating superior member experiences and providing highly personalized service for each and every one of our interactions. We value and welcome your opinion about how we execute this pledge. We 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. You have the right to be treated with respect and dignity. We take measures to ensure your right to privacy.

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

Participate in Your Health care. You have the right to engage in a candid discussion about 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.

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) 310-5249.

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 quality and care management.

As a member, you have the responsibility to:

Choose a Primary Care Provider (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 up-to-date health information to treat you effectively. Talk to your Providers about your medical history, your current health status and participate in developing treatment goals as much as possible.

Follow plan rules and instructions for your care that you agreed to with your Provider. Identify yourself as a member to Providers to receive care or services and follow the policies and procedures described in your plan materials.

Treat your Providers and us with respect by keeping your scheduled appointments and notifying your Provider ahead of time if you will be late or need to reschedule.

Better understand your health problems by participating with your Provider and the plan's care management team (as appropriate) to develop a treatment plan.

Pay all applicable Deductibles, Co-insurance amounts and Co-payments to your health care Providers.

Notify us right away if there's a change in your family size, address, 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 Health 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.

Contact your Group Benefits administrator to determine how to obtain Domestic Partner coverage.

Effective Date of Coverage

The effective date of coverage of an eligible Domestic Partner and any eligible Dependents of the Domestic Partner will be determined by your Employer's Health Plan.

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, you must notify your employer.

Conversion Rights for Domestic Partnership

If the subscriber becomes employed by another Group that does not have Domestic Partnership coverage or files a termination, the Domestic Partner may be eligible to purchase individual market coverage through Vermont Health Connect or may enroll directly through us.

Right to Continuation of Coverage

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

If You have coverage through an employer, 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 or by enrolling directly through us. By enrolling in coverage through Vermont Health Connect, 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 or directly with us 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 at the earliest of:

- 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 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 direct coverage. If you are eligible, you will have the opportunity to enroll in a product offered through Vermont Health Connect or by enrolling directly with us without a break in coverage. To do this, your coverage must be effective within 30 days after your group enrollment terminates.

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. If material modifications are necessary, we will provide notification as required by Federal law.
- 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 Regulation (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, canceled or voided.

Subscriber Address

If you enrolled through your employer you should notify your employer of any change of address. If you enrolled individually through Vermont Health Connect, you must notify Vermont Health Connect of any change of address.

Vermont Health Connect
312 Hurricane Lane
Suite 201
Williston, Vermont 05495

If you enrolled directly through Blue Cross and Blue Shield of Vermont, you must notify us of any change of address.

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

All notices are sent to the subscriber's address on file. This represents the full responsibility to notify the subscriber and member, regardless of whether they receive 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 section describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice applies to the privacy practices of Blue Cross and Blue Shield of Vermont. We 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 Notice of Privacy Practices 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 Notice.

This Notice of Privacy Practices became effective on September 1, 2014 and replaces the previous Notice of Privacy Practices, which became effective on September 1, 2013. 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 (800) 310-5249.

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 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;
- wellness 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; or
- 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 (800) 310-5249.

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, or 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 (800) 310-5249.

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.

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 notice 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 you 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 (800) 310-5249.

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 the 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

Federal law requires us to tell you that health plans must offer coverage for at least 48 hours of inpatient hospital care following normal vaginal deliveries, and for at least 96 hours of care following caesarean deliveries. The time periods begin from the time of delivery or the time of hospital admission, if the delivery occurs outside of the hospital.

We do not have standard day-limit restrictions on the length of maternity stays. Instead, we review each admission for medical necessity. In any event, we do not limit hospital stays to less than the durations required by the law. As always, if you have questions about your maternity benefits please call our customer service team at (800) 310-5249.

Women's Health and Cancer Rights Act of 1998

Do you know your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy, including lymphedema?

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

If you have questions about these benefits, please call our customer service team at (800) 310-5249.

Our Quality Improvement Program

Our quality improvement (QI) program seeks to improve our service to you. It also works to 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 health 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 health plan better.

We also have focus groups with Member representatives. If you would like to participate on a member focus group or in one of our QI projects, please call our customer service team at (800) 310-5249. 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 our customer service team at (800) 310-5249.

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 treatment 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 team at (800) 310-5249 and a representative will help you initiate the process.

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 Sectrum 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.

BlueCard Service Area: the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands.

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: a subscriber's son, daughter or stepchild through marriage, Domestic Partnership 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.

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 and 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.

Covered: 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 certain benefits. Your *Outline of Coverage* shows your Deductible, benefit, Co-insurance and Co-payment amounts. (Refer also to Chapter One.) Some services are not subject to the Deductible amount.

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 two-person or 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 two-person or 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 (only if your employer allows Domestic Partner coverage) or the subscriber's Child or Incapacitated Dependent Covered under this Health Plan. (See Child, Domestic Partner, Spouse and Party to a Civil Union definitions.)

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);
- mammograms; and
- hearing tests by an audiologist if your doctor suspects you have a disease condition of the ear (see also General Exclusions).

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 legally 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.

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 Health 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.

Habilitative/Rehabilitative: Habilitative and Rehabilitative services are health care services and devices provided to achieve normal functions and skills necessary to perform age-appropriate basic activities of daily living, including ambulation, eating, bathing, dressing, speech, and elimination.

Habilitation and Rehabilitation services may include respiratory therapy, speech language therapy, Occupational Therapy and physical medicine treatments.

Habilitative services and devices help a person attain a skill or function never learned or acquired due to a disabling condition. Rehabilitative services and devices, on the other hand, help a person regain,

maintain or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition.

Health Plan: your Blue Cross and Blue Shield of Vermont health benefits.

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 if the individual is age 26 and older) 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: care for 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)

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 Health Plan.

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

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

Off-label Use of a Drug: use of a drug for other than the particular condition for which the Food and 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, Co-payments and Co-insurance you pay. 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.

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.

Aggregate Prescription Drugs and Biologics Out-of-Pocket Limit: Your plan may have an Aggregate Prescription Drugs and Biologics Out-of-Pocket limit. Please see your *Outline of Coverage* for details. If your plan has an Aggregate Prescription Drugs and Biologics Out-of-Pocket limit, and you are on a family plan, any combination of Covered family members may meet the Prescription Drugs and Biologics Out-of-Pocket limit.

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.

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

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.

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, which is January 1.

Policy: is a word that insurance companies may use for the document that governs coverage, we use Certificate of Coverage.

Prescription Drugs and Biologics: products 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
  - lactation consultants
  - 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

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

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

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

Network Provider: for most Network Providers this includes:

- pharmacies who make an agreement with our pharmacy benefit manager;
- vision Providers who make an agreement with our vision service partner;
- Providers in our pediatric dental Network; and
- mental health and substance abuse treatment Providers who make an agreement with our behavioral health Network.

Providers located outside of Vermont are not generally Network Providers. We consider the following Providers to be Network Providers if they participate with their local Blue Cross and/or Blue Shield Plan:

- cardiac rehabilitation Providers;
- home infusion therapy Providers;
- Skilled Nursing Facilities; and
- Physical Rehabilitation Facilities.

You may find a Network Provider on our website at **www.bcbsvt.com/find-a-doctor**. You may also get a directory of Network Providers from your Group Benefits Manager or from our customer service team. Providers must be Network Providers in order for their services to be Covered. We do not provide benefits if you do not use a Network Provider. See Choosing a Provider on page 7

Non-Network Provider: a Provider that does not meet the definition of a Network Provider.

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

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

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

- Surgery to timely correct a medically diagnosed congenital disorder or birth abnormality of a Covered Dependent Child; and
- Surgery to treat, repair or reconstruct an involved part affected by trauma, infection or other disease; and
- Surgery for initial reconstruction of breasts after mastectomy.

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 delivered or directed by Providers. 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.

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

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;
- some 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.

Telemedicine: the delivery of health care services through interactive audio and video over a secure connection that complies with applicable state laws.]

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.

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.

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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