



Health plans are administered by:



BlueCross BlueShield
of Vermont

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

Health Care Benefits
Blue Edge Business Exclusive Provider Organization (PCP)
Summary Plan Description

This document provides you with a description of your health benefits while you are enrolled under the Group Health Plan (your Plan) offered by your employer. This document is current until your employer updates it.

- You should read this document to familiarize yourself with your Plan's main provisions and keep it handy for reference.
- If you are missing part of this document, or not sure whether you have the most recent copy, please call BCBSVT customer service to request another copy.
- If the benefits described in this document differ from descriptions in other materials, this document prevails.

Blue Cross and Blue Shield of Vermont (BCBSVT) administers your Plan on behalf of your employer to provide administrative services such as:

- claims processing;
- individual case management;
- utilization review;
- quality assurance programs;
- disease monitoring and management services;
- claim review and other related services; and
- to arrange for a network of health care providers whose services are covered by your Plan.

BCBSVT has entered into a contract with your employer to provide these administrative services to the Plan. BCBSVT's customer service team can help you understand the terms of your Plan and what you need to get your maximum benefits.

Your Plan is a self-funded health benefit plan. BCBSVT is not an underwriter or insurer of the benefits provided by Your Plan.

BCBSVT provides administrative services only and does not assume any financial risk with respect to claims under this Plan.

How to Use This Document

- Read Chapter One, Guidelines for Coverage. Information there applies to all services. Pay special attention to the Prior Approval Program on page 1.
- 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 Chapter Three, 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 this entire document, any additional riders and endorsements, as well as the *Outline of Coverage* or your *Summary of Benefits and Coverage*.
- Some terms in this document have special meanings. Capitalized terms are explained in the last chapter of this document.
- If you need translation services such as telecommunications devices for the deaf (TDD) or telephone typewriter teletypewriter (TTY), please call (800) 535-2227.

Get It All Online

You can find a lot of information about your coverage on BCBSVT's website at www.bcbsvt.com.

For instance:

- You can find this document, along with claims and benefit information on the Member Resource Center.
- You can find doctors and Other Providers in BCBSVT's Networks on the "Find-a-Doctor" tool.
- You can order ID cards and much more.

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

नःशुल्क 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 prevodjenja,
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

สำหรับการให้บริการความ
ช่วยเหลือด้านภาษาฟรี โทร
(800) 247-2583

VIETNAMESE

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

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CHAPTER ONE

Guidelines for Coverage

This document describes benefits for your Exclusive Provider Organization (EPO) Plan with Primary Care Provider coverage. You must see a Network Provider to receive benefits.

Chapter One explains what you must do to get benefits through your health plan. Your *Outline of Coverage* or *Summary of Benefits and Coverage* shows what you must pay Out-of-Pocket. Read this entire chapter carefully as it is your responsibility to follow these guidelines. Failure to follow these guidelines may mean your Plan will not provide benefits.

General Guidelines

As you read this document, please keep these facts in mind:

- Capitalized words have special meanings. See Definitions in Chapter Nine to understand your coverage. The terms “You” and “Your” are defined but they are not capitalized in text.
- Your Plan will only pay benefits for services defined as Covered.
- You must use Network Providers or get Prior Approval (see below). Your Plan does not require Prior Approval for Emergency Medical Services.
- Certain services are excluded from coverage under your Plan. You’ll find General Exclusions applicable to all services in Chapter Three. Additionally, exclusions that apply to specific services may appear in other sections of this document.
- Services that are not Medically Necessary are not covered by your Plan. You may appeal the decision. See page 32 for more information.
- 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 document even if this coverage is secondary to other health care coverage for you or one of your Dependents.

Prior Approval Program

Your Plan requires Prior Approval for all services from Out-of-Network Providers. Out-of-Network benefits are generally not available under this plan.

In most circumstances, your Plan only approves services from Out-of-Network Providers if appropriate services are not available within the Network. You may request Prior Approval to see an Out-of-Network Provider if there is not a Network Provider with appropriate training and experience to provide the Medically Necessary services needed to meet your particular health care needs. In this case, if you get Prior Approval, Cost-Sharing will be the same as if the service was obtained by a Network Provider. You will not be required to pay any difference between the Provider’s charge and what we pay. If an Out-of-Network Provider bills you for the difference, please notify us by calling our customer service team at the number on the back of your ID card.

Your Plan also requires 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 an Out-of-Network Provider, it is your responsibility to get Prior Approval. If you use an out-of-state Network Provider (BlueCard Provider), it is your responsibility to get Prior Approval for services that require Prior Approval under your Contract. 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.

The Prior Approval list can change. To get the most up-to-date list, visit BCBSVT’s website at www.bcbsvt.com/priorapproval or call customer service at the number on the back of your ID card.

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 an Out-of-Network Provider, it is your responsibility to get Prior Approval. Forms are available on BCBSVT’s website at www.bcbsvt.com/priorapproval. You may also get them by calling customer service at the number on the back of your ID card.

Any Provider may help you fill out the form and give you other information you need to submit your request. The medical staff at BCBSVT will review the form and respond in writing to you and your Provider. 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 BCBSVT's Network. You also need Prior Approval for services printed on this Prior Approval list, even if you use a Network Provider. This list includes:

- adoptive immunotherapy including CAR-T and gene therapy drugs;
- Ambulance (non-emergency transport including air or water transport);
- ambulatory event monitoring (Zio®Patch);
- anesthesia (monitored);
- Applied Behavior Analysis (ABA);
- artificial pancreas device system;
- Autism Spectrum Disorder related Occupational, Speech, and Physical Therapy/medicine after 30 combined visits;
- autologous chondrocyte transplants;
- blood and blood components;
- breast pump, hospital grade;
- capsule endoscopy (wireless);
- chiropractic care (after 12 visits in a Plan Year);
- cochlear implants and Implantable Bone Conduction Hearing Aids;
- cognitive testing;
- continuous passive motion (CPM) equipment;
- Cosmetic and Reconstructive procedures except breast reconstruction for patients with a diagnosis of breast cancer;
- dental services, please see page <?> for details;
- Durable Medical Equipment (DME) and supplies with a purchase price of \$500 or more;
- electrical and ultrasound stimulation, including Transcutaneous Electrical Nerve Stimulation (TENS) and Neuromuscular Electrical Stimulation (NMES);
- enteral and parenteral formulae, supplies and pumps;
- genetic testing;
- hospital beds;
- hyperbaric oxygen therapy;
- Investigational or Experimental Services or procedures;
- Out-of-Network services when there is not a Network Provider with appropriate training and experience to provide the Medically Necessary services needed to meet your particular health care needs.
- medical nutrition for inherited metabolic disease;
- neurodevelopmental screening (pediatric);

- neuropsychological testing;
- nutritional counseling after three initial visits if you have a diagnosis for metabolic disease or an eating disorder (Prior Approval does not apply if you have diabetes.);
- orthognathic Surgery;
- orthotics and prosthetics with a purchase price of \$500 or more;
- out-of-state Inpatient care and partial hospitalization care;
- percutaneous radiofrequency ablation of liver;
- polysomnography (sleep studies) and multiple sleep latency testing (MSLT);
- positive airway pressure devices (APAP, CPAP, BiPAP);
- certain Prescription Drugs and Biologics (please see www.bcbsvt.com/pharmacy);
- 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 Programs for mental health and substance use disorder conditions);
- certain surgical procedures and related services (examples include disc arthroplasty, lumbar spinal fusion, Sacroiliac joint pain treatment, Temporomandibular joint manipulation (TMJ) , and varicose veins);
- transcranial magnetic stimulation;
- transgender services;
- transplants (except corneal and kidney);
- wearable cardioverter defibrillators;
- wheelchairs.

Case Management Program

Case Management provides Members who have complex health care needs with Professional services to assess, coordinate, evaluate, support and monitor the Member's treatment plan and health care needs. Professional services may include a registered nurse, licensed social worker, or other licensed health care Professional practicing within the scope of their license and/or certified as a case manager.

If your Plan approves benefits for care provided by Out-of-Network Providers and/or treatment Facilities for Inpatient and Outpatient care, your Plan may require you to participate in Case Management

prior to receiving ongoing care and services. This plan generally does not cover services provided by Out-of-Network Providers. To find out more information about the program, call (800) 922-8778.

Choosing a Provider

You must use Network Providers or get Prior Approval to get care outside of the Network if appropriate services are not available in Network. In Vermont, you must use BCBSVT Network Providers. It includes a wide array of Primary Care Providers (PCP), Specialists and Facilities in Vermont and in bordering communities in other states. Outside of Vermont, you will use the BlueCard Network (PPO/EPO), which includes Providers that contract with other Blue Cross and/or Blue Shield Plans.

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

If you live or travel outside of the BCBSVT Provider Network area please visit:

- **provider.bcbs.com**; and
- use your three-letter prefix, located on your ID card, to find a Network Provider using the Blue Cross and Blue Shield Association's National Doctor and Hospital Finder.
- You must select a BlueCard PPO/EPO Network Provider in order to receive benefits.

For pharmacy and vision services (if your Plan provides vision services), please use the separate Provider directories.

You may also call customer service at the number on the back of your ID card. BCBSVT will send you a paper Provider directory without charge. 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.

Network Providers

Network Providers will:

- secure Prior Approval for you (if the Provider is located in the BCBSVT Network);
- bill BCBSVT 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.

There are separate Provider directories for the following types of Providers:

- Primary Care Providers;
- Pharmacies; and
- routine vision care Providers.

Please visit **www.bcbsvt.com/find-a-doctor** to access the different Provider directories. Out-of-Network benefits are generally not available under this plan.

Primary Care Providers

When you join this health plan, if you live in Vermont, you must select a Primary Care Provider (PCP) from BCBSVT's Network of Primary Care Providers. If you do not live in Vermont, you do not need to choose a PCP. However, if you would like to select a PCP, you may do so from the BlueCard National Network. For information on how to select a PCP and for a list of the participating PCPs, please visit **www.provider.bcbs.com** and select BlueCard PPO/EPO Network or contact customer service at the number on the back of your ID card.

To receive benefits for your services, you must receive services from your PCP or another Network Provider. You have the right to designate any PCP who participates in our Network and who is available to accept you or your family members. Each family member may select a different PCP. For children, you may designate a pediatrician as the PCP. Until you make this designation, we will designate one for you.

Your coverage does not require you to get referrals from your PCP. However, you must get Prior Approval for certain services (see page 2). For instance, if appropriate services are not available with a Network Provider, you must get Prior Approval.

BCBSVT encourages you to choose a PCP 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* or your *Summary of Benefits and Coverage* if you use a Provider who practices in a PCP office and is one of the following Provider types:

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

Out-of-Network Providers

This plan generally does not cover services provided by Out-of-Network Providers. However, BCBSVT will approve services provided by Out-of-Network Providers if appropriate services are not available within the Network. You may request Prior Approval to see an Out-of-Network Provider if there is not a Network Provider with appropriate training and experience to provide the Medically Necessary services needed to meet your particular health care needs. In this case, if you get Prior Approval, the Cost-Sharing will be the same as if the service was obtained by a Network Provider and you will not pay the balance between the Provider's charge and the Allowed Amount.

If you get Prior Approval to use an Out-of-Network Provider for reasons other than when there is not a Network Provider who can provide the Medically Necessary services, your Plan pays the Allowed Amount and you pay any balance between the Provider's charge and what your Plan pays. You must also pay any applicable Cost-Sharing amounts (Deductibles, Co-insurance and Co-payments). See your *Outline of Coverage* or your *Summary of Benefits and Coverage* for details.

Out-of-Network Providers at Network Facilities

If you receive Medically Necessary, Covered services from an Out-of-Network Provider at a Network facility without your informed consent, your Plan will cover your care as if you had been treated by a Network Provider. You must pay any Cost-Sharing amounts required under your Contract, which will in no event be more than as if you received those services from a Network Provider. These may include Deductibles, Co-insurance or Co-payments. Under federal law, unless you give your informed consent, Providers are prohibited from billing you for these services beyond your Cost-Sharing amounts. If the Out-of-Network Provider requests any payment from you other than your Cost-Sharing amounts, please contact BCBSVT customer service at the number on the back of your ID card so they can work directly with the Provider to resolve the request.

Out-of-Area Providers

If you need care outside of Vermont, you may save money by using Providers that are Network Providers with their local Blue Plan. See the BlueCard® Program section below. You must get Prior Approval for most Out-of-Network care.

BlueCard® Program

In certain situations (as described elsewhere in this document), you may obtain health care services outside of the Vermont service area. The claims for these services may be processed through the BlueCard® Program¹.

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"). These Providers are called "BlueCard Providers." You do not need Prior Approval to see an out-of-state BlueCard Provider, unless the service requires Prior Approval under your Contract.

If you obtain care from a contracting Provider in another geographic area, BCBSVT will honor their contract with you, including all Cost-Sharing provisions and providing benefits for Covered services as long as you fulfill other requirements specified in this document. The Host Blue will receive claims from its contracting Providers for your care and submit those claims directly to BCBSVT.

BCBSVT 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 BCBSVT.

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, you may receive Covered health care services from health care Providers outside of the service area that does not have a contract with the Host Blue. In

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 customer service at the number listed on the back of your ID card.

most cases, BCBSVT 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, BCBSVT may base the amount you pay for such services on billed Covered charges, the payment BCBSVT would make if the services had been obtained within BCBSVT's 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 BCBSVT makes 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 the Plan.

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, (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 BCBSVT 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 BCBSVT Chooses Providers

BCBSVT chooses Network Providers by checking their backgrounds. BCBSVT uses standards of the National Committee on Quality Assurance (NCQA). BCBSVT chooses Network Providers who can provide the best care for BCBSVT Participants. BCBSVT does not reward Providers or staff for denying services. BCBSVT does not encourage Providers to withhold care.

Please understand that BCBSVT's Network Providers are not employees of BCBSVT. They just contract with BCBSVT.

Access to Care

Your Plan requires its 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 Services (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 Network 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 use disorder 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 use disorder 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.

BCBSVT's Network Providers offer reasonable access for other complex specialty services including major burn care, organ transplants and specialty pediatric care. BCBSVT may direct you to a specialty Network Provider 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 the definition of an Emergency Medical Condition in Chapter Nine.

Emergencies might include:

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

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 BCBSVT as soon as reasonably possible.

If you receive Medically Necessary, Covered Emergency Medical Services from an Out-of-Network Provider, BCBSVT will cover your emergency care as if you had been treated by a Network Provider. You must pay any Cost-Sharing amounts listed in your *Outline of Coverage* as if you received those services from a Network Provider. These may include Deductibles, Co-insurance or Co-payments. If an Out-of-Network Provider requests any payment from you other than your Cost-Sharing amounts, please contact BCBSVT at the number on the back of your ID card, so that BCBSVT 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. Your Provider (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. Keep your doctor's phone number handy in case of late-night illnesses or injuries.

BCBSVT also offers Telemedicine services that allow you to see a licensed Provider via computer, tablet or telephone anytime. See Telemedicine Services on page 21.

How Your Plan Determines Your Benefits

When BCBSVT receives your claim, it determines:

- if your Plan covers the Medical services you received; and
- your benefit amount.

In general, your Plan pays the Allowed Amount (explained later in this section). BCBSVT 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* and your *Summary of Benefits and Coverage*. Your Plan may limit benefits to the Plan Year maximums, which are also shown on these documents.

Payment Terms

Allowed Amount

The Allowed Amount is the amount your Plan considers reasonable for a Covered service or supply.

Notes:

- 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 an Out-of-Network Provider, your Plan pays the Allowed Amount and you must pay any balance between the Provider's charge and what your Plan pays.

Cost-Sharing

Cost-Sharing are the costs for Covered services that you pay out of your own pocket. This includes Deductibles, Co-payments, and Co-insurance, or similar charges, but it doesn't include premiums, any balance between the Provider's charge and what your Plan pays for Out-of-Network Providers, or the cost of non-Covered services. All information about your Deductible amounts, type of Deductible, Co-payments and Co-insurance amounts, and type of Out-of-Pocket Limits is shown on your *Outline of Coverage* and your *Summary of Benefits and Coverage*.

Deductible

You must meet your Deductibles each Plan Year before your Plan make payments on certain services. Your Plan applies 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.

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. If your Plan has this Deductible, and you are on a two-person, parent and Child or family plan, you do not have an individual Deductible.

Covered expenses must meet the family Deductible before any of your family members receive post-Deductible benefits unless a single individual on the plan meets their Out-of-Pocket Limit, in which case your Plan pays 100 percent of the Allowed Amount for eligible services for that individual for the rest of the Plan Year.

Stacked Deductible

Your Plan may have a Stacked Deductible. If your Plan has this Deductible, and you are on a two-person, parent and Child or family plan, a covered family member may meet the individual Deductible and begin receiving post-Deductible benefits.

When your family's 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. You may have different Co-payments depending on the Provider you see. Your Provider may require payment at the time of the service. Your Plan applies Co-payments toward your Out-of-Pocket-Limit for each Plan Year.

Co-insurance

You must pay Co-insurance to Providers for specific services. Your Plan calculates 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). Your Plan applies your Co-insurance toward your Out-of-Pocket Limit for each Plan Year.

Out-of-Pocket Limit

Your Plan applies your Deductible, your Co-payments and your Co-insurance toward your Out-of-Pocket Limit. You may have separate Out-of-Pocket Limits for pharmacy benefits or other services. After you meet your Out-of-Pocket Limit, you pay no Co-insurance or Co-payments for the rest of that Plan Year for Covered services.

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. If your Plan has this limit, and you're on a two-person, parent and Child or family plan, and you do not have an individual Out-of-Pocket Limit, your family members' Covered expenses must reach the family Out-of-Pocket Limit before your Plan pays 100 percent

of the Allowed Amount for eligible services. When your family's expenses reach this amount, your Plan will begin to pay 100 percent of the Allowed Amount for the rest of the Plan Year for Covered services.

Some two-person, parent and Child or family plans include individual Out-of-Pocket Limits. If your Plan does, a covered family member may meet the individual Out-of-Pocket Limit and your Plan will begin to pay 100 percent of the Allowed Amount for that covered family member.

Stacked Out-of-Pocket Limit

Your Plan may have a Stacked Out-of-Pocket Limit. If your Plan has this limit, and you are on a two-person, parent and Child or family plan, a covered family member may meet the individual Out-of-Pocket Limit and your Plan 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 your Plan will begin to pay 100 percent of the Allowed Amount for all family members' eligible services for the rest of the Plan Year for Covered services.

Aggregate Prescription Drugs and Biologics Out-of-Pocket Limit

Your Plan may have an Aggregate Prescription Drugs and Biologics Out-of-Pocket Limit. If your Plan has this limit, and you are on a two-person, parent and child or family plan, once any combination of covered family members meets the Prescription Drugs and Biologics Out-of-Pocket Limit, your Plan begins to pay eligible 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* and your *Summary of Benefits and Coverage*. After your Plan provides maximum benefits, you must pay all charges.

Self-Pay Allowed by HIPAA

Federal law gives you the right to keep your Provider from telling your Plan 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.

Third Party Premium Payments

Third parties, including Hospitals and other Providers, are not allowed to make your premium payments. Your Plan reserves the right to reject such payments.

Your Plan only accepts premium and Cost-Sharing payments made by Participants or on behalf of Participants by the following:

- The Ryan White HIV/AIDS Program;
- local, state, or federal government programs, including grantees directed by a government program to make payments on its behalf, that provide premium support for specific individuals;
- Indian tribes, tribal organizations/governments, and urban Indian organizations;
- Immediate Family Member;
- religious institutions and other not-for profit organizations when:
 - the assistance is provided on the basis of the insured's financial need;
 - the organization is not a health care Provider; and
 - the organization is financially disinterested (that is the organization does not receive funding from entities with a financial interest in the payment for services).

CHAPTER TWO

Covered Services

This chapter describes Covered services, guidelines and policy rules for obtaining benefits. Please see your *Outline of Coverage* or your *Summary of Benefits and Coverage* for benefit maximums and Cost-Sharing amounts such as Co-payments, Deductibles, and Co-insurance.

Preventive Services

Your Plan provides benefits for Preventive Services. You should get Preventive Services that are appropriate for you. Examples of preventive care include colonoscopies for people age 45 and over and those at high risk for colorectal cancer, prostate screenings, mammograms for women age 40 and over and coverage for women's reproductive health as required by law.

Your Plan pays for some Preventive Services with no Cost-Sharing (like Co-payments, Deductibles and Co-insurance) based on the recommendations of four expert medical and scientific bodies:

- The United States Preventive Services Task Force (USPSTF) list of A- or B-rated services;
- The Advisory Committee on Immunization Practices (ACIP);
- The Health Resources and Services Administration's (HRSA) infant, children and adolescent preventive services guidelines; and
- The Health Resources and Services Administration's (HRSA) women's preventive services guidelines.

You can find the list of Covered Preventive Services on BCBSVT's website at www.bcbsvt.com/preventive or you can call the customer service number on the back of your ID card.

Notes:

- The list includes many Preventive Services covered at zero Cost-Share, but not all. Coverage for other preventive, diagnostic and treatment services not recommended by the above noted entities may be subject to Cost-Sharing.
- If your Provider finds or treats a condition while performing Preventive Services, Cost-Sharing may apply.

Office Visits

When you receive care in an office setting, you must pay the amount listed on your *Outline of Coverage* and your *Summary of Benefits and Coverage*. Please read this entire section carefully. Some office visit benefits have special requirements or limits. Your Plan covers 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 16);
- Surgery; and
- therapy services (see page 22).

Some office visit services may fall under your Preventive Services benefit.

General Exclusions in Chapter Three also apply.

Notes:

- Office visits for mental health services, substance use disorder treatment services, and chiropractic services are described 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 1 for a description of the Prior Approval program. Visit BCBSVT's website at www.bcbsvt.com/priorapproval or call customer service at the number on the back of your ID card for the newest list of services that require Prior Approval.

Ambulance

Your Plan covers Ambulance services as long as your condition meets the 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 an Out-of-Network Provider bills you for the balance between the charges and what your Plan pays, please notify BCBSVT by calling the customer service number on the back of your ID card.

Your Plan covers 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.
- Your Plan covers transportation only to the closest Facility that can provide services appropriate for the treatment of your condition.
- Your Plan does not cover Ambulance services when the patient can be safely transported by any other means. This applies whether or not transportation is available by any other means.
- Your Plan does not cover Ambulance transportation when it is solely for the convenience of the Provider, family or member.

Autism Spectrum Disorder

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

You must get Prior Approval for services or your Plan will not cover them. Please Remember General Exclusions in Chapter Three also apply.

Bariatric Surgery

Your Plan only covers bariatric Surgery at Blue Distinction Centers. Blue Distinction Centers are Facilities that have been assessed and identified to deliver the highest quality care. Blue Distinction Centers must maintain their high quality to maintain the Blue Distinction Center designation. To find a Blue Distinction Center appropriate for your Surgery, please visit www.bcbs.com/blue-distinction-center/facility or call customer service at the number on the back of your ID card.

Clinical Trials (Approved)

Your Plan covers Medically Necessary, routine patient care services for members enrolled in Approved Clinical Trials as required by law.

General Exclusions in Chapter Three also apply.

Chiropractic Care

Your Plan covers care by Network Chiropractors who are:

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

Your Plan covers 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, your Provider must get Prior Approval for any visits after the 12th. See page 1 for more information about the Prior Approval program.

Exclusions

Your Plan does not provide chiropractic benefits for:

- treatment after the 12th visit if your Provider doesn't get Prior Approval for you;
- services by an Out-of-Network Provider;
- services, including modalities, that do not require the constant attendance of a Chiropractor;
- treatment of any "visceral condition," that is a dysfunction of the abdominal or thoracic organs, or other condition that is not neuromusculoskeletal in nature;
- acupuncture;
- massage therapy;
- care provided but not documented with clear, legible notes indicating 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;
- hot and cold packs;
- supervised services or modalities that do not require the skill and expertise of a licensed Provider;
- Surgery;
- unattended services or modalities (application of a service or modality) that does 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

Your Plan excludes Cosmetic procedures (see General Exclusions in Chapter Three). Your benefits cover Reconstructive procedures that are not Cosmetic unless the procedure is expressly excluded in this document. (Please see the definitions of Reconstructive and Cosmetic in Chapter Nine.)

For example, your Plan covers:

- reconstruction of a breast after breast Surgery, and Reconstruction of the other breast to produce a symmetrical appearance;
- prostheses (which your Plan covers under Medical Equipment and Supplies on page 15); and
- treatment of physical complications resulting from breast Surgery.

You must get Prior Approval for these services.

Dental Services

In the event of an emergency, you must contact BCBSVT as soon as possible afterward for approval of continued treatment. Your Plan covers only the following dental services:

- Treatment for, or in connection, with an accidental injury to jaws, sound natural teeth, mouth or face, provided a continuous course of dental treatment begins within six months of the accident and covers a reasonable course of treatment defined as not exceeding five years from the beginning of treatment.²

² A sound, natural tooth is a tooth that is whole or properly restored using direct restorative dental materials (i.e. amalgams, composites, glass ionomers or resin ionomers); is without impairment, untreated periodontal conditions or other conditions; and is not in need of the treatment provided for any reason other than accidental injury. A tooth previously restored with a dental implant, crown, inlay, onlay, or treated by endodontics, is not a sound natural tooth.

- Surgery 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 and cover a reasonable course of treatment defined as not exceeding five years from the beginning of treatment, 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.
- Treatment for a congenital or genetic disorder, such as but not limited to the absence of one or more teeth, up to the first molar, or abnormal enamel (example lateral peg).
- 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 (of any age) 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.

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

Exclusions

Unless expressly required by law, your Plan does not cover:

- Surgical removal of teeth, including removal of wisdom teeth;
- gingivectomy;
- tooth implants, including those for the purpose of anchoring oral appliances (this exclusion does not apply for the treatment of an accidental injury, trauma, cancer-related treatment or diagnosis for which you have received Prior Approval);
- care for periodontitis;
- injury to teeth or gums as a result of chewing or biting;
- pre- and post-operative dental care;
- orthodontics (including orthodontics performed as an adjunct to orthognathic Surgery or in connection with an accidental injury);
- procedures designed primarily to prepare the mouth for dentures (including alveolar augmentation, bone grafting, frame implants and ramus mandibular stapling); or

- charges related to non-Covered dental procedures or anesthesia (for example, Facility charges, except when Medically Necessary as noted above).

General Exclusions in Chapter Three also apply.

Diabetes Services

Your Plan covers treatment of diabetes. For example, it covers syringes, insulin, nutritional counseling, Outpatient self-management training and education for people with diabetes. Your Plan pays benefits subject to the same terms and conditions used for other medical treatments. You must get nutritional counseling from one of the following Network Providers or your Plan 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

Your Plan covers the following Diagnostic Tests to help find or treat a condition, including:

- imaging (radiology, X-rays, ultrasound and nuclear imaging);
- studies of the nature and cause of disease (laboratory and pathology tests);
- medical procedures (ECG and EEG);
- allergy testing (percutaneous, intracutaneous, patch and RAST testing);
- mammograms; and
- hearing tests by an audiologist only if your Provider suspects you have a disease condition.

You must get Prior Approval for special radiology procedures (including CT, MRI, MRA, MRS, PET scans, and echocardiograms) and polysomnography (sleep studies). See page 1 for more information regarding Prior Approval.

Emergency Care

Your Plan covers 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 an Out-of-Network Provider bills you for a

balance between the charges and what your Plan pays, please notify BCBSVT by calling the customer service number on the back of your ID card.

The Plan will defend against and resolve any request or claim by an Out-of-Network Provider of Emergency Medical Services.

Requirements

Your Plan provides benefits only if you require Emergency Medical Services as defined in this document.

Home Care

Your Plan covers 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 (see Therapy Services on page 22).

Your Plan also covers:

- a Provider's visit to your home for Palliative care (does not include non-medical charges);
- 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.

Private Duty Nursing

Your Plan covers skilled nursing services by a private-duty nurse outside of a hospital, subject to these limitations:

- There may be limits on your benefits for private duty nursing. Check your *Outline of Coverage* or your *Summary of Benefits and Coverage*.
- Your Plan provides benefits only if you receive services from a registered or licensed practical nurse.

Requirements

Your Plan covers 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.

Your Plan does not cover home care services if a Member or a lay caregiver with the appropriate training can perform them. Also, benefits are provided only if the patient or a legally responsible individual consents in writing to the home care treatment plan.

Limitations

Your Plan covers home infusion therapy only if:

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

Your Plan provides no benefits for a Provider to administer therapy when the patient or an alternate caregiver can be trained to do so.

Exclusions

Your Plan does not provide 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, your Plan may cover them under your Prescription Drugs and Biologics benefits);
- Custodial Care (see Definitions);
- food or home-delivered meals;
- non-medical charges; 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

Your Plan covers the following services by a Hospice Provider:

- skilled nursing visits;
- home health aide services for personal care services;
- homemaker services for house cleaning, cooking, etc;
- continuous care in your home;
- Respite Care services;
- Hospice services in a Facility;
- social worker visits before the patient's death;
- bereavement visits and counseling for family members up to one year following the patient's death; and
- other Medically Necessary services.

Requirements

Your Plan only provides 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

Your Plan covers 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.

Your Plan covers the day of admission or the day of discharge, but not both. Certain Inpatient services require Prior Approval. Please see page 2 for a list of these services.

Inpatient Medical Services

Your plan covers services by a Physician or 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 (see page 21 for details);
- 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. Your Plan limits Surgery benefits as follows:

- Subject to Medical Necessity, your Plan may limit the number of visits Covered for one Provider in a given day.
- If you have several Surgeries at the same time, your Plan may not pay a full allowance for each one.
- Your Plan excludes many Cosmetic procedures (see General Exclusions in Chapter Three).

Independent Clinical Laboratories

You must use BCBSVT's Network of independent clinical laboratories. This includes services such as genetic testing and molecular pathology procedures. Please visit BCBSVT's website at www.bcbsvt.com and use the Find a-Doctor tool to find a Network independent clinical laboratory location.

You must get Prior Approval for certain laboratory services in order to receive benefits. See page 1 for a description of the Prior Approval program. Visit BCBSVT's website at www.bcbsvt.com/priorapproval or call customer service at the number on the back of your ID card for the newest list of services that require Prior Approval.

Maternity

Your hospital benefits cover your Inpatient maternity stay. See Inpatient Hospital Services above for a description of your hospital benefits. Your Plan also covers the following care by a Provider or other Professional during a person'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.

Your Plan covers home delivery or delivery in a Facility when you use a covered Provider. Your Plan covers services by certified nurse midwives and licensed midwives only if they are Network Providers. We also cover non-hospital grade breast pumps with no Cost-Sharing.

Your Plan covers newborns for up to 60 days after birth. Your newborn will be subject to their own Cost-Sharing for Covered services beginning on their date of birth, whether or not you add your newborn to coverage permanently. (See Chapter Six for information on how to continue coverage for your newborn past this period.)

Please see your *Outline of Coverage* or your *Summary of Benefits and Coverage* for Cost-Sharing details.

Better Beginnings® Maternity Wellness Program

The Better Beginnings program helps pregnant persons and their babies get the best care before and after birth. If you join this program, your Plan provides a selection of benefit options that may include:

- other educational tools;
- reimbursement for classes; and
- reimbursement towards infant car seats.

You get the most out of the Better Beginnings program when you contact Better Beginnings 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 BCBSVT customer service at the number on the back of your ID card. If you'd like to enroll online, or learn more about the program, please visit www.bcbsvt.com/betterbeginnings.

Note: Your Plan may provide benefits through the Better Beginnings program for services not generally covered (these services are explained in the packet you receive when you join Better Beginnings). The fact that your Plan provides special benefits in one instance does not obligate your Plan to do so again.

Medical Equipment and Supplies

You must get Prior Approval for certain Durable Medical Equipment and supplies including but not limited to continuous passive motion (CPM) equipment, TENS units or Durable Medical Equipment including orthotics and prosthetics with a purchase price of \$500 or more. See Prior Approval on page 1 or visit www.bcbsvt.com/priorapproval.

Your Plan covers 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);
- lactation consultants for breast pumps only;
- naturopathic Provider (N.D.); or
- Durable Medical Equipment supplier.

Your Plan covers the rental or purchase of Durable Medical Equipment. Your Plan reserves the right to determine whether rental or purchase of the equipment is more appropriate.

Replacement of lost, stolen or destroyed Durable Medical Equipment

Your Plan will replace one lost, stolen or destroyed Durable Medical Equipment, prosthetic or orthotic per Plan Year if not covered by an alternative entity or if it is still under warranty (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.

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

Your Plan does not cover:

- the replacement of a lost, stolen or destroyed Durable Medical Equipment, prosthetic or orthotic if the above criteria is not met; and
- for more than one lost, stolen or destroyed Durable Medical Equipment, prosthetic or orthotic per Plan Year.

Supplies

Your Plan covers medical supplies such as needles, 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. Your Plan covers 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. Your Plan covers the purchase, fitting, necessary adjustments, repairs and replacements of prosthetics. Your Plan covers 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, third-degree burns, traumatic scalp injury, congenital baldness present since birth, and medical conditions resulting in alopecia areata or alopecia totalis (excluding androgenic alopecia, alopecia barbae, postpartum alopecia, traction alopecia, or other hair loss due to 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), your Plan limits the replacement of the original wig (cranial/scalp prosthesis) to one wig every three years.

Your Plan only covers eyeglasses or contact lenses to treat aphakia or keratoconus. Your Plan covers only:

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

Also, your Plan covers 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

Your Plan does not provide benefits for:

- treatment for hair loss due to androgenic alopecia, alopecia barbae, postpartum alopecia, traction alopecia, 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;
- dental appliances or dental prosthetics, except as listed above;
- 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 for which you have not received Prior Approval (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;

- items or equipment that do not meet the definition of Durable Medical Equipment;
- 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 your Plan's definition of Durable Medical Equipment, you may call customer service at the number listed on the back of your ID card before purchasing or renting a Durable Medical Equipment item.

Mental Health Care

Some services require Prior Approval.
See page 1 for details.

Outpatient

Your Plan covers Outpatient mental health services including:

- individual and Group Outpatient psychotherapy;
- family and couples therapy;
- Intensive Outpatient Programs (IOP);
- 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

Your Plan covers Inpatient mental health services including:

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

Your Plan covers 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 an Out-of-Network Provider bills you for a balance between the charges and what your Plan pays, please notify BCBSVT customer service team at the number on the back of your ID card. BCBSVT will defend against and resolve any request or claim by an Out-of-Network Provider of Emergency Medical Services.

Exclusions

Your Plan provides no mental health benefits for:

- services ordered by a court of law (unless BCBSVT deems 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);
- biofeedback, pain management, stress reduction classes and pastoral counseling;
- psychoanalysis; and
- hypnotherapy.

General Exclusions in Chapter Three also apply.

Nutritional Counseling

Your Plan covers up to three Outpatient visits each Plan Year. For treatment of diabetes, there is no limit on the number of Outpatient visits for nutritional counseling. For the treatment of metabolic diseases or eating disorders, nutritional counseling beyond three Outpatient visits in a Plan Year requires Prior Approval. Please see the Prior Approval list on page 1 for details or visit www.bcbsvt.com/priorapproval.

You must receive nutritional counseling from one of the following Network Providers or your Plan 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

Your Plan covers 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, PET scans, and echocardiograms) and polysomnography (sleep studies). For the Prior Approval list, see page 2.

For information about Therapy Services, see page 22.

Outpatient Medical Services

Your Plan covers 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

Your Plan covers 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.

Prescription Drugs and Biologics

Your Plan follows the National Performance Formulary (NPF). You must use a Network Pharmacy or Network home delivery pharmacy to receive benefits. To locate a Network Pharmacy, visit BCBSVT's website at www.bcbsvt.com/pharmacy and click on the "Find-A-Pharmacy" link.

Your Plan provides 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, prevention or diagnosis of your condition;

- insulin and other supplies for people with diabetes (glucose testing materials including home glucose testing machines, needles and syringes). Your total out-of-pocket responsibility for prescription insulin medications will not be more than \$100 per 30-day supply, regardless of the amount, type, or number of insulin medications being prescribed. This Out-of-Pocket maximum will apply even if you have not met your deductible.

Please note your Plan covers Off-label Prescription Drugs and Biologics used to treat cancer as required by law. Your Plan 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 the prescribed use meets the definition of Medical Necessity and is not considered Investigational.

Benefits are subject to the exclusions listed in Chapter Three General Exclusions.

Preferred and Non-Preferred Drugs

Your Plan may require different amounts of Cost-Sharing when you purchase generic, preferred brand or non-preferred brand drugs. Generally, generic drugs require lower Cost-Sharing and non-preferred drugs require the most Cost-Sharing.

The NPF brand-name drug list can change and will be updated from time to time. To get the most up-to-date listing, visit our website at www.bcbsvt.com/formulary-lists or call the pharmacy phone number on the back of your ID card.

Home Delivery Service

BCBSVT's home delivery pharmacy can provide you with Prescription Drugs and Biologics you take on an ongoing basis.

To use the home delivery service, visit BCBSVT's website at www.bcbsvt.com/pharmacy and log onto your Member Resource Center, or call the pharmacy number on the back of your ID card. You may receive drugs at your home or office address. You can order refills by phone, fax or on the internet.

You may also save money by using the home delivery service. See your *Outline of Coverage* for detailed Cost-Sharing information about home delivery.

Limitations

Your Plan limits:

- coverage for controlled substances, antibiotics, Specialty Medications and compound drugs to a 30-day supply for each refill;
- for other medications, a 90-day supply for each refill;
- contraceptives up to a 12-month supply;
- Viagra, Cialis, or Levitra to six pills per month; and
- prescribed tobacco cessation drugs to a six-month supply per plan year.

Please also see the “Quantity Limits” section later in this document.

Prior Approval Program

You must get Prior Approval for the Prescription Drugs or Biologics listed on the National Performance Formulary Prior Approval list or your drugs will not be Covered. This drug list can change and will be updated from time to time. For the most up-to-date list, visit BCBSVT’s website at www.bcbsvt.com/formulary-lists or call pharmacy phone number at the number listed on the back of your ID card.

Your Plan requires Prior Approval:

- for compounded medications;
- for brand name drugs when a therapeutically equivalent, generic drug is available (also known as “dispense as written” prescriptions); and
- when the Plan’s criteria necessitates a review of the drug’s clinical appropriateness.

How to Get Prior Approval for Your Drugs

To get Prior Approval for your Prescription Drugs or Biologics or to adjust quantity limits or step therapy edits, your Provider must contact BCBSVT’s pharmacy benefit manager or go to www.covermymeds.com 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 the pharmacy phone number on the back of your ID card. If your request for Prior Approval is denied, see page 30 for instructions on how to appeal the decision.

Quantity limits, step therapy and Prior Approval drug lists can change and will be updated from time to time. For the most up-to-date list, visit BCBSVT’s website at www.bcbsvt.com/formulary-lists to see if a specific drug needs Prior Approval or other review. You may also call the pharmacy phone number on the back of your ID card.

Quantity Limits

Your Plan reviews certain Prescription Drugs and Biologics for Medical Necessity 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, documentation about why you need more of the drug may be required. Visit www.bcbsvt.com/formulary-lists or call the pharmacy phone number listed on the back of your ID card to get the most up-to-date list of drugs covered by this review or to learn the quantity limit for a particular drug.

Step Therapy

The 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. Prior Approval may be required if there is no information to show you first tried a less-expensive drug. Visit www.bcbsvt.com/formulary-lists or call the pharmacy phone number listed on the back of your ID card 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* or your *Summary of Benefits and Description* 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 Biologics purchases. Your Plan does 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 brand 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/formulary-lists.

Specialty Medications

For some specialty drugs and supplies, you will need to receive your drug or supply from a covered pharmacy in BCBSVT's Exclusive Specialty Medication Network. You must get Prior Approval for some specialty drugs and supplies. If you fail to obtain Prior Approval, your drug or supply will not be Covered.

See www.bcbsvt.com/pharmacy for more information.

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 each of the ingredients. Your cost depends on the NDC submitted for the compounded drug.

Exclusions

Your Plan does 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 and insulin pumps, 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, 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 formulas and supplements administered through a feeding tube as determined to be Medically Necessary (Note: This exclusion does not apply to 100% amino acid formula, which may be determined as Medically Necessary for children under 5.);
- the replacement of lost, stolen, or destroyed Prescription Drugs or Biologics received through your medical benefit;

- any drugs listed under Excluded Medications on the National Performance Formulary drug list. (Note: If you are currently using a medication that is excluded from the NPF, you may request a benefit exception. See the section under the National Performance Formulary at www.bcbsvt.com/formulary-lists related to Benefit Exceptions for Excluded Medications, or call the pharmacy phone number on the back of your ID card.);
- any drugs on the list of Excluded Drugs with Unique Packaging and Therapeutic Alternatives. (You can view the list at www.bcbsvt.com/formulary-lists or call the pharmacy phone number on the back of your ID card.); and
- Drugs newly approved by the Food and Drug Administration until they have been reviewed by our Pharmacy and Therapeutics Committee.

Replacement of lost, stolen or destroyed Prescription Drugs and Biologics

Your Plan will replace one lost, stolen or destroyed non-specialty Prescription Drug or Biologic per Plan Year for Prescription Drugs or Biologics filled through a pharmacy if not covered by an alternative entity (including but not limited to homeowners insurance and automobile insurance) if:

- the non-specialty 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, you are required to submit documentation, such as a police report, with the request.

Exclusions

Your Plan does not cover the replacement of a lost, stolen or destroyed Prescription Drug or Biologic if:

- if the above criteria is not met;
- for more than one lost, stolen or destroyed Prescription Drug or Biologic per Plan Year filled through a pharmacy;
- for lost, stolen or destroyed Prescription Drugs and Biologics received through your medical benefit; or
- for a Prescription Drug or Biologic that was prepared specifically for a Member and not administered.

Claim Filing

A Network Pharmacy will collect the amount you owe (Deductible, Co-payment and/or Co-insurance) and submit claims on your behalf. Your Plan 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 request reimbursement

for dispensed drugs, please attach itemized bills to a *Prescription Reimbursement Form*, which can be found at www.bcbsvt.com/member/member-forms. For assistance, contact customer service at the number on the back of your ID card.

Rehabilitation/Habilitation

Rehabilitation or Habilitation services may require Prior Approval. Please check the Prior Approval list on page 2.

Your Plan covers:

- 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 this document (e.g.; under Therapy Services on page 22).

Limitations

You must use a Network cardiac Rehabilitation Provider.

Requirements

The attending Provider must:

- certify that services of a Physical Rehabilitation Facility are required and are the most appropriate level of care for the condition being treated; and
- re-certify on a schedule based upon your clinical condition, but no less frequently than every 30 days, that the services are Medically Necessary, and that you are making significant progress.

Exclusions

Your Plan does not cover:

- Custodial Care (see Definitions); or
- cognitive re-training or educational programs.

General Exclusions in Chapter Three also apply.

Skilled Nursing Facility

Your Plan covers 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

Your Plan provides benefits only if you:

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

Exclusions

Your Plan does not cover:

- cognitive re-training;
- Custodial Care (see Definitions).

General Exclusions in Chapter Three also apply.

Substance Use Disorder Treatment Services

Some services require Prior Approval. Your Plan covers the following Acute substance use disorder 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 an Out-of-Network Provider bills you for a balance between the charges and what your Plan pays, please notify BCBSVT customer service team at the number on the back of your ID card. BCBSVT will defend against and resolve any request or claim by an Out-of-Network Provider of Emergency Medical Services.

Requirements

Your Plan covers substance use disorder treatment services only if you get Medically Necessary care in the least restrictive setting.

Please contact BCBSVT customer service at the number listed on the back of your ID card if you have questions.

Exclusions

Your Plan provides no substance use disorder treatment benefits for:

- services ordered by a court of law (unless BCBSVT deems them Medically Necessary);
- non-traditional, alternative therapies such as Rubinfeld Synergy, energy polarity therapy and somatization therapy, that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories;

- treatment without ongoing concurrent review to ensure that treatment is being provided in the least restrictive setting required;
- services, including long-term residential programs, adventure-based activities, wilderness programs and residential programs, that focus on education, socialization, 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

Your Plan covers surgery in both Inpatient and Outpatient settings with the following limitations and conditions:

- Subject to Medical Necessity, your Plan may limit the number of covered visits for one Provider in a given day.
- If you have several Surgeries at the same time, your Plan may not pay a full allowance for each one.
- You must get Prior Approval for Cosmetic and Reconstructive procedures.

Your Plan covers sterilization procedures (vasectomy or tubal ligation) even though they are not Medically Necessary.

General Exclusions in Chapter Three also apply.

Telemedicine Program

Your Plan covers Medically Necessary, clinically appropriate consultations through a third-party vendor via your computer, tablet or cell phone, regardless of where you are located, for the following services:

- sick visits;
- nutritional counseling visits (Limited to three visits per Plan Year. This visit limit does not apply to treatment of diabetes. Nutritional counseling for the treatment of metabolic diseases or eating disorders beyond three Outpatient visits in a Plan Year requires Prior Approval. See Prior Approval Program on page 1 for details or visit www.bcbsvt.com/priorapproval.)
- lactation consultations; and
- mental health consultations.

BCBSVT administers this program via a contract with American Well. American Well provides you with online access to Medical Care for common, uncomplicated,

non-emergency cases. To access these services, visit **AMwell.com**, or download the app from iTunes or Google Play. Please see your *Outline of Coverage* for details.

Limitations

When seeking Telemedicine services through a third-party vendor, you must use a secure connection (in accordance with Vermont statute) that complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Exclusions

Your Plan does not cover:

- Telemedicine services via email, facsimile or non-HIPAA-compliant software (such as Skype, FaceTime, etc.); or
- telemonitoring except as part of specific value-based provider arrangements.

General Exclusions in Chapter Three also apply.

Telemedicine Services

Your Plan covers the following Medically Necessary, clinically appropriate Telemedicine consultations performed by a Network Provider regardless of whether you're in a health Facility, at work, at home or anywhere else:

- consultations, including second opinions;
- initial or follow-up Inpatient consultations;
- office or other Outpatient visits;
- follow-up visits after a Skilled Nursing Facility or hospital stay;
- psychology and psychiatric examinations intended to provide a diagnosis;
- Prescription Drug and Biologic management;
- nutritional counseling visits (Limited to three visits per Plan Year. This visit limit does not apply to treatment of diabetes. Nutritional counseling for the treatment of metabolic diseases or eating disorders beyond three Outpatient visits in a Plan Year requires Prior Approval. See Prior Approval Program on page 1 for details or visit www.bcbsvt.com/priorapproval.)
- end-stage renal disease services;
- medical genetic and genetic counseling services (please note genetic testing services require Prior Approval);
- neuro-cognitive testing;
- intervention and behavior change counseling to quit tobacco or smoking tobacco;

- intervention and behavior change counseling for substance use disorder and alcohol abuse treatment;
- education and training services for managing your illness; and
- transitional care management services.

Please see your *Outline of Coverage* for the appropriate service or supply and its corresponding Cost-Sharing amount. All other terms and conditions related to in-person consultations apply.

Limitations

When seeking Telemedicine services, your Provider must use a secure connection (in accordance with Vermont statute) that complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Exclusions

Your Plan does not cover:

- services by an Out-of-Network Provider;
- Telemedicine services via email, facsimile or non-HIPAA-compliant software (such as Skype, FaceTime, etc.); or
- telemonitoring except as part of specific value-based provider arrangements.

General Exclusions in Chapter Three also apply.

Therapy Services

Your Plan covers therapy or physical medicine services provided by:

- an eligible hospital, Network Skilled Nursing Facility or Home Health Agency/Visiting Nurse Association;
- a licensed therapist (Occupational, Physical and Speech);
- 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.

Your Plan covers Occupational, Speech and Physical Therapy/medicine only:

- for services that require constant attendance of a licensed:
 - therapist (Occupational, Physical and Speech);
 - medical doctor (M.D.);
 - Network Chiropractor (D.C.);
 - Network athletic trainer (A.T.);
 - podiatrist (D.P.M.);
 - nurse practitioner (N.P.);
 - advanced practice registered nurse (A.P.R.N.);
 - doctor of naturopathy (D.N.); or
 - a doctor of osteopathy (D.O.).
- up to the specific benefit limits listed on your *Outline of Coverage* and your *Summary of Benefits and Coverage*. (This limitation does not apply to mandated treatment for Autism Spectrum Disorder up to age 21 as defined by Vermont law.)

If you use more than 30 combined Occupational, Speech and Physical Therapy/medicine services in one Plan Year for the treatment of Autism Spectrum Disorder, you must get Prior Approval for any visits after the 30th. See page 1 for more information about the Prior Approval program.

Exclusions

Your Plan does 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 results 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 (see Definitions);
- 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 up to age 21 as defined by Vermont law.);
- supervised services or modalities that do not require the skill and expertise of a licensed Provider; or

- 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: Your Plan does not cover group physical medicine services, group exercise or Physical, Occupational, or Speech Therapy performed in a group setting.

Transplant Services

You must get Prior Approval for transplant services.

BCBSVT reserves 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.

Your Plan pays 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.

Your Plan pays benefits for transplants as follows:

- if your Plan covers both the recipient and the donor, each receives benefits under his or her own plan;
- if your Plan covers the recipient, but not the donor, both receive benefits under the recipient's plan (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 your Plan covers the donor, but not the recipient.

Time Period for Living Donor Benefits

If the Covered organ transplant procedure is not completed, your Plan provides benefits only if the Covered organ transplant procedure was scheduled to occur within 24 hours of the donor's Surgery.

Exclusions

Your Plan does not cover the purchase price of any organ or bone marrow that is sold rather than donated.

General Exclusions in Chapter Three also apply.

Vision Care

Your Plan covers one routine vision examination each calendar year. This exam assesses your visual functions to:

- determine if you have any visual problems and/or abnormalities; and
- prescribe any necessary corrective eyewear.

Your Plan does not cover the evaluation and fitting of contact lenses or additional supplemental tests as part of this examination.

Your vision benefits are administered by Vision Service Plan (VSP). To receive the best benefits for vision care, you must obtain services through a VSP Network Provider. For a list of Providers, visit www.vsp.com or call VSP at (800) 877-7195.

Your Plan has a different Allowed Amount for Out-of-Network Providers than for Network Providers. If you decide not to see a VSP Network Provider, you may pay a larger share of the cost. You must pay for your services at the time of your appointment. Follow the instructions below to be reimbursed for Out-of-Network services.

Exclusions

Your Plan does not cover services or supplies for:

- vision training, orthoptics or plano (non-prescription) lenses;
- vision materials (lenses, frames, etc.) for refractive purposes unless you need them to replace the lens of the eye and the lens was not replaced at the time of Surgery (unless your Group has purchased a vision materials rider); and
- any eye examination or corrective eyewear required by an employer as a condition of employment.

General Exclusions in Chapter Three also apply.

VSP Claim Filing

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

To receive reimbursement when you visit a non-VSP Provider, you must pay for your services up front. Your Plan reimburses you only up to the Allowed Amount for Covered Services. To receive reimbursement when you visit a non-VSP Provider, sign on to www.vsp.com, select the *Out-of-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 ID number to VSP. Out-of-Network claims must be

submitted to VSP within six months of service. Mail the original claims reimbursement request and receipts to the address included on the form.

Vision Services (Medical)

Your Plan covers services by an optometrist or ophthalmologist only when they find or reasonably suspect a disease condition of the eye and refers you to a Provider for treatment of that condition. Your Plan covers your visit to an optometrist or ophthalmologist in the same way your Plan covers visits to Providers performing Covered eye care.

Eyeglasses, contact lenses, and refraction

Your Plan does 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 15).

If you need lenses to replace the lens of the eye (for treatment of aphakia or keratoconus), your Plan will cover only one pair of lenses per prescription. Your Plan also covers non-refractive therapeutic contact lenses.

CHAPTER THREE

General Exclusions

Your Plan pays benefits only for Covered services described under its terms. Your Plan and any of its incorporated documents, such as your riders or endorsements, may contain specific exclusions.

In addition to the specific exclusions listed elsewhere in your Plan, the following general exclusions apply. Your Plan does not cover services and supplies that are not Medically Necessary. Also, your Plan does not cover the following even if they are Medically Necessary:

1. Services that a prior health plan must cover.
2. Services for which you would not legally have to pay if you did not have your Plan 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 over the limitations or maximums set forth by your Plan.
6. Services or drugs that BCBSVT determines are Investigational, mainly for research purposes or Experimental in nature. To the extent required by law, however, your Plan covers routine costs for patients who participate in approved clinical trials.
7. Services not provided in accordance with accepted Professional medical standards in the United States.
8. 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.
9. Acupuncture, acupressure or massage therapy; hypnotherapy, rolfing, homeopathic or naturopathic remedies. Your Plan covers Medically Necessary Covered services when performed within the scope of a naturopathic Provider's license.
10. 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.)
11. Automatic or manual home blood pressure cuffs.
12. Bariatric Surgery, unless performed at a Blue Distinction Center.
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. Computer technology or accessories and other equipment, supplies or treatment intended primarily to enhance occupational, recreational or vocational activities, hobbies or academic performance.
22. Annual or subscription or retainer fees charged by concierge medicine practices.
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 required by law, your Plan does 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;
- repair of brow ptosis, repair of blepharoptosis, correction of lid retraction, reduction of overcorrection of lid ptosis;
- Surgery to improve the appearance of the ear (otoplasty); and
- Surgery to improve the appearance of the nose (rhinoplasty).

Note: This exclusion does not apply to abdominoplasty or panniculectomy when abdominoplasty and/or panniculectomy is performed in connection with herniorrhaphy (hernia repair). This exclusion also does not apply to lipectomy performed as part of the treatment of lipedema.

27. Custodial Care, Rest Cures.

28. Dental services and dental-related oral Surgery, unless specifically provided by this document; procedures designed primarily to prepare the mouth for dentures (including alveolar augmentation, bone grafting, frame implants and ramus mandibular stapling).

29. 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.)

30. 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.

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 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.

34. Tinnitus masking devices.

35. 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.

36. Hot and cold packs.

37. Infertility services. This includes but is not limited to:

- medications for treatment of infertility such as Clomid, Clomiphene, Serophene, Bravelle, Gonal-F, Follistim AQ, Novarel, Ovidrel, Pregnyl, Profasi and Repronex when used for treatment of infertility; and
- surgical, radiological, pathological or laboratory procedures leading to or in connection with (for example):
 - insemination (intravaginal, intracervical, and intrauterine insemination);
 - in vitro fertilization, embryo transplantation and gamete intrafallopian transfer (GIFT);
 - zygote intrafallopian transfer (ZIFT); and
 - any variations of these procedures, including costs associated with collection, washing, preparation or storage of sperm for artificial insemination including donor fees, cryopreservation of donor sperm and eggs.

Note: This exclusion does not apply to the evaluation to determine if and why a couple is infertile.

38. An Inpatient stay determined not Medically Necessary while you are waiting for a different level of care, such as Skilled Nursing Facility or home care, whether or not it is available to you.

39. Treatment for willfully uncooperative or intractable patients.

40. Institutional or Custodial Care for the physically or mentally handicapped.

41. Mandated treatment, including court-ordered treatment, unless such treatment is Medically Necessary, ordered by a Provider and covered under this document.

42. Non-medical charges, such as:
 - taxes;
 - postage, shipping and handling charges;
 - charges for Home Health Medical Social Work visits;
 - 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 Outpatient visits per Plan Year. This exclusion does not apply to the treatment of diabetes, metabolic diseases or eating disorders. Prior approval beyond three Outpatient visits is required for the treatment of metabolic diseases or eating disorders.
44. Food and nutritional formulae or supplements except for "medical foods" prescribed for the Medically Necessary treatment of an inherited metabolic disease or formulas and supplements administered through a feeding tube as determined to be Medically Necessary.
Note: This exclusion does not apply to 100% amino acid formula, which may be determined as Medically Necessary for children under 5.
45. Orthodontics, including orthodontics performed as adjunct to orthognathic Surgery or in connection with accidental injury.
46. Personal hygiene items.
47. Personal service, comfort or convenience items.
48. Photography services, photographic supplies or film development supplies or services (for example, external ocular photography or photography of moles to monitor changes).
49. 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.
50. Pneumatic cervical traction devices except when the patient has a diagnosis of Temporomandibular Joint Syndrome (TMJ); gravity assisted traction devices.
51. Prescription Drugs and Biologics newly approved by the Food and Drug Administration until they have been reviewed by the Pharmacy and Therapeutics Committee.
52. Replacement of lost, stolen, or destroyed Prescription Drugs or Biologics received through your medical benefit.
53. Services, including modalities, that do not require the constant attendance of a Provider.
54. Specialized examinations, services or supplies required by your employer or for sports/recreational activities (e.g. driver certifications, pilot flight physicals, etc.).
55. Supervised services or modalities that do not require the skill and expertise of a licensed Provider.
56. Support therapies, including pastoral counseling, assertiveness training, dream therapy, equine therapy, hippotherapy, music or art therapy, recreational therapy, stress management, wilderness programs, therapy camps, retreat centers, adventure therapy and bright light therapy. This includes non-medical tobacco cessation programs, such as hypnotherapy and other alternative approaches for tobacco cessation.
57. Sterilization reversal (vasectomy reversal, vasovasostomy, vasovasorrhaphy, tubal ligation reversal, tubotubal anastomosis).
58. Telemedicine services via email, facsimile or non-HIPAA-compliant software, and telemonitoring.
59. 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).
60. Treatment solely to establish or re-establish the capability to perform occupational, hobby, sport or leisure activities.
61. Treatment of obesity, except surgical treatment when determined Medically Necessary.
62. Unattended services or modalities (application of a service or modality) that do not require direct one-on-one patient contact by the Provider.
63. Vision training, orthoptics or plano (non-prescription lenses).
64. Work-hardening programs.
65. 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.

Provider Exclusions

Also, your Plan does not cover services prescribed or provided by a:

- Provider that your Plan does not approve for the given service or that is not defined in the Definitions chapter as a Provider.
- Professional who provides services as part of his or her education or training program.
- Immediate Family Member or yourself.
- Veterans Administration Facility treating a service-connected disability.
- Out-of-Network Provider if your Plan requires use of a Network Provider as a condition for coverage under your Plan unless appropriate services are not available with a Network Provider and you have received Prior Approval for those services.
- Provider practicing outside the scope of that Provider's license or certification.
- Provider whose participation with BCBSVT has been terminated within the last three years, unless their participation has been reinstated.

CHAPTER FOUR

Claims

Remember, when you contact a Provider, you must:

- tell your Provider that you have coverage under your specific Plan; and
- give information about all other health coverage you have.

Claim Submission

BCBSVT 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, your Plan may not provide benefits. Your claim must include all information necessary 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 (see Chapter 5). When you use Out-of-Network Providers, you must file your own claims. You can find a Member Claim Form at www.bcbsvt.com/member/member-forms or request one by calling the customer service number on the back of your ID card.

Release of Information

BCBSVT may need records, verbal statements or other information to administer your benefits. By accepting your benefits under your Plan, you give BCBSVT the right to obtain, from any source, any information it needs.

Approval of your benefits depends on you providing sufficient information, even if your Plan pays for benefits before you do. To avoid duplicate payments, BCBSVT may inform other entities that provide benefits about your claim.

A signed *Authorization to Release Information* form from any Dependent over the age of 12 is required before discussing any claims with you.

Cooperation

You must fully cooperate with your Plan and BCBSVT to receive benefits. BCBSVT may require you to provide signed or recorded statements. You must provide all reasonably required information. Otherwise, your Plan may deny benefits.

Payment of Benefits

Your Plan pays Vermont Network Providers directly. Your Plan usually pays out-of-state Network Providers directly. Your Plan usually pays you when you use Out-of-Network Providers. Your Plan reserves the right to pay Out-of-Network Providers directly. If your Plan pays you directly, you are responsible for paying your Out-of-Network Provider.

You may not assign or transfer your benefit rights under this document to another party, including an Out-of-Network Provider, without the Plan's express written consent. Any attempt to assign by you without express written consent shall be deemed void and the assignee shall acquire no rights. Regardless of the prohibition on assignment, the Plan may, in its sole discretion, pay an Out-of-Network Provider directly for Covered services. Any payments made by the Plan will discharge its obligation to pay for Covered services. The Plan's payment to an Out-of-Network Provider, routine processing of a claim form, issuing payment at an Out-of-Network Provider rate, or denying informal or formal appeal(s) does not constitute a waiver by the Plan and the Plan shall retain a full reservation of all rights and defenses to enforce this provision.

For information on how your Plan determines your benefit amount, see Chapter One. The fact that your Plan provides benefits in one instance does not obligate your Plan to do so again.

Payment in Error/Overpayments

If your Plan provides more benefits than it should, your Plan has the right to recover the overpayment. If your Plan pays benefits to you incorrectly, your Plan may require you to repay them. If so, you will be notified. You must cooperate with your Plan and BCBSVT during recovery. Your Plan may reduce or withhold future benefits to recover incorrect payments.

Regardless of whether your Plan seeks recovery, a wrong payment on one occasion will not obligate your Plan to provide benefits on another occasion.

How BCBSVT Evaluates Technology

Your Plan has delegated to BCBSVT the responsibilities to establish medical policies to facilitate the administration of benefits. BCBSVT's Medical Policy committee (consisting of doctors, nurses, and other Professionals) meets periodically 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.

Your Plan does not cover technology that is Investigational or Experimental. To be Covered a technology must:

- have final approval from the appropriate governmental regulatory bodies;
- be of such a nature as to be able to permit conclusions concerning its effect on health outcomes;
- be documented in peer-reviewed literature to measurably improve net health outcomes;
- be as beneficial as any established alternatives; and
- be attainable outside the Investigational setting.

BCBSVT may rely on numerous sources of information and expertise when reviewing a new technology or application.

Complaints and Appeals

When You Have a Complaint

Customer Service

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

If You Don't Agree with a Coverage Decision

You are entitled to several levels of review of coverage decisions:

- 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;
 - Your Plan's 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. Your Plan requires that you file a first level appeal before you take judicial action.
- If you don't agree with the decision after your first-level appeal, you may file a **second-level internal appeal**. You may choose to meet with reviewers in person or by phone. Your health care Provider may participate. BCBSVT will work with you to schedule a time for this appeal. 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 the decision. You do this by calling the State at (800) 964-1784.

Reviewers

Reviewers are selected for their clinical expertise and/or their benefits knowledge. In some cases, your health care provider may call BCBSVT 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 the health care Provider that provided, or seeks to provide, the service that is the subject of the appeal.

Timing of Appeals

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

When you file an appeal to extend Urgent Services that were previously approved and you are currently receiving (Urgent Concurrent review), the review of your appeal will occur within 24 hours. You must make the appeal at least 24 hours before the care previously approved will end or your appeal will be treated as a regular appeal.

For other appeals related to services not yet provided, you will be notified of the decision within 30 days of receiving your appeal. For all other appeals, you will be notified of the 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 the denial. When you file a second-level

appeal, you must do so within 90 calendar days of the decision. When requesting an independent review, you must do so within 120 days of the 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 BCBSVT's customer service team. You can also get help from the Vermont Department of Financial Regulation at (800) 964-1784. To file an emergency or urgent concurrent appeal, call the number on the back of your ID card.

Mail written appeals to:

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

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

BCBSVT 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 BCBSVT at the number on the back of your ID card. BCBSVT will provide this immediately for an urgent or concurrent appeal or within two business days for other appeals.

After the Decision

If your appeal is urgent or concurrent, after a decision has been made, you and your health care Provider (if known) will be notified by phone right away with follow up in writing within 24 hours. In all other cases, you will be notified of the decision by mail. At any point during the appeal review process, the initial decision may be overturned. If the decision is overturned, your Plan will provide coverage or payment for your

health care item or service. If your appeal is denied and the decision is not overturned, you must pay for services your Plan does not cover. You should discuss your payment arrangements with your Provider.

Please note that this document 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, please contact:

Employee Benefits Security Administration
(866) 444-EBSA (3272) (for Group coverage only)

Vermont Office of the Health Care Advocate
(800) 917-7787 or (802) 863-2316

Vermont Department of Financial Regulation
(800) 964-1784 or (802) 828-3302

The Department of Financial Regulation's Health Insurance Consumer Services unit can provide free help to you if you need general information about health care, have concerns about BCBSVT or your Plan, or are not satisfied with how your complaint was resolved.

Vermont Office of the Health Care Advocate

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

BCBSVT's Ombudsman

BCBSVT has an Ombudsman to whom they refer members with complex issues regarding care or service. BCBSVT's Ombudsman works as a liaison between the member and your Plan reviewing and solving issues.

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

CHAPTER FIVE

Other Party Liability

This chapter gives BCBSVT the right to prevent duplicate payments for a service that would exceed your Plan's Allowed Amount for the service. It applies, for instance, when a person covered under your Plan has other coverage. Remember, you must disclose information about all other coverage to BCBSVT.

Coordination of Benefits

This chapter applies when another health plan or insurance policy provides benefits for some or all of the same expenses as your Plan. (For the purposes of this chapter, the other party is called a "payer.")

Your benefits may be reduced so that the sum of the reduced benefits and all benefits payable for Covered services by the other payer does not exceed your Plan's Allowed Amount for Covered services.

Your Plan coordinates benefits based on coverage, not actual payment. Your Plan treats 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.

Your Plan determines whether it is 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 your Plan, that payer is primary. If the other payer uses the NAIC provisions, your Plan determines who is primary as follows:

- the payer covering a patient as an employee (Participant) is primary to a payer who covers him or her as a Dependent;
- if a Child or Incapacitated Dependent is the patient, your Plan uses 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 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, your Plan uses the "Birthday Rule" described above.

In an Accident

If you have an accident and you are covered for accident-related expenses under any of the following types of coverage, the other payer is primary and your Plan is 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 expense payments.

Reimbursement

If another health plan provides benefits that your Plan should have paid, BCBSVT has the right to reimburse the other health plan directly. That payment satisfies your Plan's obligation.

Medicaid and Tricare

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

Your Plan's Right to 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 your Plan has a right to collect back for the benefits provided by your Plan. This is called the "right of subrogation."

In this section, the person or organization shall be referred to as a "third party." The third party might or might not be an insurer. Your Plan's right of subrogation means that:

- If your Plan pays 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 your Plan before any other party. Your Plan will have a lien on your recovery from a third party up to the amount of benefits paid.
- Regardless of whether the other party admits liability and regardless of whether the funds you recover are specified for recovery as medical expenses your Plan may recover anything it paid.
- You must reimburse your Plan whether or not you have been "made whole" by the third party. Your Plan reserves the right to reduce what you owe to cover a share of attorneys' fees and other costs you incur in the process. Your Plan will be responsible for only those fees to which it agrees to pay in writing.
- Your Plan reserves the right to bring a lawsuit in your name or in its name against a third party or parties to recover benefits your Plan advanced. Your Plan may also settle its claim with a third party.
- This right of subrogation extends to any kind of auto, workers' compensation, property or liability insurance providing medical expense payments.
- You must cooperate with BCBSVT and furnish information and assistance that your Plan requires to enforce its rights.
- You must take no action interfering with your Plan's rights and interest.
- If you refuse to reimburse BCBSVT or your Plan, or fail to cooperate, either entity may take legal action against you. Your Plan or BCBSVT on behalf of your Plan may seek reimbursement from the funds you recovered from a third party, up to the amount of benefits it paid. You must also pay attorney's fees and collection expenses incurred by your Plan or BCBSVT at the direction of your Plan. Your Plan may reduce or withhold future benefits to recover what you owe.
- You agree that you will not settle your claim against a third party without first notifying BCBSVT. In some cases, your Plan will compromise the amount of its claim. Neither BCBSVT nor your Plan shall be responsible for expenses incurred by you in pursuit of your Plan's rights.

Cooperation

You must fully cooperate to protect your Plan's rights to coordination, reimbursement or subrogation. Cooperation Includes:

- providing BCBSVT all information relevant to your claim or eligibility for benefits under your Plan;
- providing any actions needed to assure your Plan is able to obtain a full recovery of the costs of benefits provided;
- obtaining BCBSVT consent before providing any release from liability for medical expenses; and
- not taking any action that would prejudice BCBSVT or your Plan's rights to coordination, reimbursement or subrogation.

If you or your Dependent fails to cooperate, you will be responsible for all benefits your Plan provides and any costs incurred in obtaining repayment.

CHAPTER SIX

Membership

Remember, when you add or remove Dependents, your type of coverage (individual, two-person, or family) may change. You may add or remove Dependents from your Plan under the conditions noted in this chapter. To do this, contact your employer.

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.

Adding Dependents

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

Marriage

If BCBSVT receives your request within 31 days after the date of marriage, your Spouse will be covered under your Plan beginning the first day of the month following the date of marriage. If BCBSVT receives your request more than 32 days after the date of your marriage, your Spouse will be covered under your Plan the first day of the month after BCBSVT receives your request.

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

Birth or Adoption

Your Plan covers your Child for 60 days after:

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

BCBSVT must receive your request for adding a dependent Child to continue benefits for the Child past 61 days. If BCBSVT receives your request within the 60 days, the Child's effective date is retroactive to the date of birth, placement for adoption, or adoption, and the new type of coverage begins 60 days following birth, placement for adoption, or adoption.

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

Dependent's Loss of Coverage

Any Dependents covered under another health plan are eligible for coverage under your Plan if the Dependent loses his or her Group health coverage or ends employment. Within 31 days after loss of coverage, your Dependent may enroll on your current Plan. If you fail to add your Dependent within 31 days after loss of coverage, you must wait until an open enrollment date to do so if your employer has an open enrollment.

Court-ordered Dependents

In the case of an order issued in compliance with Vermont's Child medical support order law, the effective date will be three days after you mail the court order to BCBSVT or when BCBSVT receives the court order, whichever is sooner. If the court order specifies a different effective date, BCBSVT will use that date. BCBSVT will calculate any additional subscription costs from the effective date of enrollment. Please remember your request for Dependent coverage under any court order must include proof of the court order.

Qualified Medical Child Support Orders (QMCSO)

The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) mandates that Group health plans provide benefits according to qualified medical child support order requirements. Contact your Plan Administrator to obtain, without charge, a copy of the QMCSO procedures.

Incapacitated Dependents

To continue coverage for an Incapacitated Dependent over age 26, BCBSVT must receive the following:

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

BCBSVT's medical director will review this information and must deem the Dependent Incapacitated as defined by law before your Plan will provide coverage.

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

Removing Dependents

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

- a Dependent dies;
- You divorce (including Civil Union dissolution) or legally separate from the Dependent;
- Your domestic partnership dissolves;
- a Child turns 26; or
- a Dependent is no longer Incapacitated.

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

Active Military Service

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

Fraud, Misrepresentation or Concealment of a Material Fact

If you or your employer (if applicable) obtain or attempt to obtain coverage or benefits through fraud, your Plan is void. If you are disenrolled due to fraud, BCBSVT will not provide any extension of benefits after your Plan is canceled.

If you or any family member commits fraud, BCBSVT 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 Plan that contains material false statements or hides material information.

Plan Reinstatement

A canceled Plan may be reinstated solely at the discretion of your Plan and only on such terms and conditions as your Plan decides.

Medicare

Please note that this is not a Medicare supplement Contract. Your Plan will not provide benefits if you are Medicare-eligible unless otherwise required or permitted by federal law. Contact your employer to determine whether you can join the Medicare supplement plan offered through your Group.

Rules About Coverage for Domestic Partners

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

Enrollment Eligibility

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

- the subscriber or Group's initial enrollment period;
- the Group's open enrollment;
- the subscriber's special enrollment period (where applicable); or
- the Domestic Partner's special enrollment period.

Contact your employer 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 as required by law.

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).

Termination of Domestic Partnership

When two parties no longer meet requirements for Domestic Partnership status, you must notify your employer.

Statement of Rights

As a Participant in your Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights. For more specific information, see page 36. You will not be eligible for subsidies through an Exchange offering Qualified Health Plans (like Vermont Health Connect) if you elect to continue your Group health plan coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons

beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Continuation Coverage Rights Under COBRA

You're getting this notice because you are gaining coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. **Please share this Notice with any individuals covered by the Plan, such as your spouse and dependent children.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other

members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator. Please review elsewhere in this document or contact your Plan Administrator for further information on your continuation coverage rights under COBRA.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, 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.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Please review elsewhere in this document or contact your Plan Administrator for further information on electing COBRA continuation coverage.

If you're an employee covered by the Plan, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If the Plan covers employee's spouses, your spouse will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than gross misconduct;
- You become entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

If the Plan covers dependent children, your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Please review elsewhere in this document or contact your Plan Administrator for further information on qualifying events.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. Please review elsewhere in this document or contact your Plan Administrator for further information on when COBRA continuation coverage is available.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Please review elsewhere in this document or contact your Plan Administrator for further information on disability extension of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov. If you are a Vermont resident, you can also learn about many of these options through Vermont Health Connect at <https://portal.healthconnect.vermont.gov> or by contacting Vermont Health Connect at (855) 899-9600.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov or visit Vermont Health Connect at <https://portal.healthconnect.vermont.gov> or by contacting Vermont Health Connect at (855) 899-9600.

Please review elsewhere in this document or contact your Plan Administrator for further information on how to contact the Plan to learn more about COBRA continuation coverage.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

CHAPTER SEVEN

Legal Information

Applicable Law

Your Plan and this document shall be construed in accordance with the laws of Vermont, except to the extent such laws are preempted by federal law.

Future of the Plan

Your Plan Sponsor reserves the right, in its sole discretion, to change, modify, amend or terminate your Plan, in whole or in part, to the extent it deems advisable, at any time for any reason. Such changes, modifications, amendments or termination will be undertaken by action of your Plan Sponsor or an authorized officer, or as otherwise required by your Plan. Furthermore, your Plan reserves the right, in its sole discretion, to change any third party providing services to your Plan, including the contract administrator. Upon termination of your Plan, any amounts payable under the terms of your Plan as in effect immediately before the termination will be paid as determined by the Plan Sponsor. Significant changes to your Plan, including termination, will be communicated to Participants as required by applicable law.

Upon termination of BCBSVT as your contract administrator, amounts payable under the terms of your Plan prior to such termination shall be paid as determined by the Plan Sponsor.

The benefits under this Plan do not vest. Your Plan Administrator reserves the right, in its sole discretion, to determine the nature and amount of benefits, if any, under your Plan, as well as the right to reduce, terminate or modify the terms or the amount of such benefits.

Limitation of Rights

This document will not be held or construed to give any person any legal or equitable right against your Plan Administrator, BCBSVT or any other person connected with your Plan, except as expressly provided in this document or as provided by applicable law, or to give any person any legal or equitable right to any assets of your Plan.

Non-waiver of Rights

Occasionally, your Plan or BCBSVT may choose not to enforce certain terms or conditions of your Plan. This does not mean your Plan or BCBSVT gives up the right to enforce them in the future.

Plan Funding

Your Plan is a self-funded plan. Benefits are paid from employee contributions, as applicable, and from general assets of the Company or Plan Administrator.

Severability Clause

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

Term of Agreement

Coverage continues monthly until this Plan is discontinued, canceled or voided.

Third Party Beneficiaries

All Participants Covered under your Plan (except the primary Participant) are Third Party Beneficiaries to your Plan.

CHAPTER EIGHT

More Information About Your Plan

Notice of Privacy Practices for Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Organizations Covered by this Notice

This Notice applies to the privacy practices of the Plan. Your Plan may share your protected health information as needed for treatment, payment and health care operations.

Your Plan's Commitment to Protecting Your Privacy

Federal and state laws requires your Plan to maintain the privacy of your protected health information (PHI) and to provide this notice to you of your Plan's 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. Your Plan may use PHI it receives or maintain, including PHI that you may have entered on BCBSVT website's Member Resource Center at www.bcbsvt.com.

This Notice of Privacy Practices describes your Plan's privacy practices, which include how your Plan may use, disclose, collect, handle and protect your PHI. The federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule requires your Plan to give you this notice of your Plan's privacy practices, your Plan's legal duties and your rights concerning PHI. As a group health plan, your Plan is a covered entity under HIPAA.

If you have any questions or want additional information about this Notice or the policies and procedures described in this Notice, please contact your Plan's Privacy Officer at the address, email or phone number provided by your Plan.

This Notice of Privacy Practices became effective on September 1, 2014. Your Plan is required to abide by the terms of the notice currently in effect.

Your Plan reserves the right to change the provisions of the notice and make the new provisions effective for all PHI that your Plan maintains. If your Plan makes a material change to this notice, your Plan will mail a revised notice.

Your Plan's Uses and Disclosures of Your Protected Health Information

Without your written authorization, your Plan will not use or disclose your PHI for any purpose other than those described in this notice. Your Plan does not sell your PHI or disclose your PHI to anyone who may want to sell their products to you. Your Plan will not use or disclose your PHI for marketing communications without your authorization, except where permitted by law. Your Plan will not sell your PHI without your authorization, except where permitted by law. Your Plan 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

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

Treatment

As a group health plan, while your Plan does not provide treatment, your Plan may disclose your PHI without your permission to support the provision, coordination, or management of your care. For example, your Plan may disclose your PHI to a physician or other health care provider to treat you.

Payment

Your Plan may use or disclose your PHI to obtain subscription fees or make payments. Your Plan may also disclose your PHI to fulfill your Plan's responsibilities for coverage and providing benefits under your Plan. For example, your Plan 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 Plan, 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 you, and for similar payment related purposes. Your Plan 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

Your Plan may use or disclose your PHI for its health care operations that your Plan must perform as a group health plan. 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 your Plan's business management, planning and development, including de-identifying PHI, and creating limited data sets for health care operations and public health activities.

Your Plan 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.

Your Plan will not use or disclose your PHI that is genetic information for underwriting purposes.

Appointment/Service Reminders

Your Plan 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

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

Required by Law

Your Plan must disclose your PHI when required to do so by law. For example, your Plan may disclose your PHI to comply with court or administrative

orders, subpoenas, national security laws or workers' compensation laws. Your Plan may disclose limited information to law enforcement officials with regard to:

- crime victims;
- crimes on your Plan's premises;
- crime reporting in emergencies; and
- identifying or locating suspects or other persons.

Your Plan 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 mandated by law to disclose your PHI, additional legal protections may exist and your Plan abides by those protections.

Victims of Abuse, Neglect or Domestic Violence

Your Plan may disclose your PHI to a government authority authorized by law to receive such information if your Plan reasonably believes 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

Your Plan may use or disclose your PHI to a public health authority that is authorized by law to collect or receive such information. For example, your Plan may use or disclose information for the purpose of preventing or controlling disease, injury or disability. In addition, your Plan may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. Your Plan 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, your Plan also may disclose PHI to a foreign government agency that is collaborating with that public health authority.

Health Oversight Activities

Your Plan 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

Your Plan 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.

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

Your Plan Sponsor

Plan sponsors are employers or other organizations that sponsor group health plans. Your Plan may disclose PHI to the plan sponsor of your group health plan. Your Plan may disclose your PHI to your group's plan sponsor to allow the performance of Plan administration functions as set for in the "Disclosures for Plan Administrative Functions" section below. Your Plan may disclose summary health information to your plan sponsor to use to obtain premium bids for health insurance coverage under the group health plan or to modify, amend or cancel the 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 group health plan. In order to receive this information, your Plan sponsor must comply with the HIPAA Privacy Rule. Your Plan sponsor is not permitted to use your PHI for any purpose other than administration of your health benefit plan, including employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan sponsor.. Please see the "Disclosures for Plan Administrative Functions" section below for further details.

Others Involved in Your Health Care

Your Plan 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. Your Plan may also disclose your PHI to notify or assist in the notification of your location, general condition or death. If your Plan discloses for these purposes,

your Plan will give you the opportunity to object to the disclosure, unless your Plan determines, in the exercise of your Plan's discretion, you do not object or cannot object to the disclosure due to an emergency or incapacity. Your Plan 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 your Plan's possession. If requested, this may include an electronic copy in certain circumstances. Your request must be in writing, on your Plan's designated form. Your Plan will provide the information no later than 30 days after receiving your request, unless your Plan maintain the information off site, in which case it may take up to 60 days for it to comply with your request. If necessary, your Plan may request an extension to provide you with your information. If your Plan denies your request, you may request that the denial be reviewed. If you request a copy of the information, your Plan reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. Your Plan will notify you of the cost involved before you incur any costs.

Your Plan 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 your Plan will disclose PHI to such a person, you should sign and submit to BCBSVT an Authorization to Release Information form. Your Plan may be able to honor a power of attorney or other legally enforceable document granting your personal representative access to your PHI. Your Plan may not be able to honor such a document, however, if it is not compliant with the HIPAA Privacy Regulations or is otherwise legally unenforceable. If you grant such authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. For more information about how best to ensure access to your PHI consistent with your wishes, please call customer service at the number listed on the back of your ID card.

Right to Amend

You have the right to request that your Plan amend your PHI in your Plan's possession. If you believe that your PHI maintained by your Plan is incorrect or incomplete, you may request that your Plan 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 your Plan cannot usually amend PHI created by another entity, such as your physician. If your Plan denies your request for amendment, you have the right to file a statement of disagreement with us. Your Plan will link your statement of disagreement with the disputed information and all future disclosures of the disputed information will include your statement. If your Plan approves your request for amendment, your Plan 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 your Plan 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 your Plan in writing your request for an accounting as directed by your Plan. You have the right to receive one accounting every 12 months. For additional requests, your Plan reserve the right to charge you a fee to cover the costs of providing the list. Your Plan will notify you of the cost involved before any costs are incurred. Your Plan will provide your accounting within 60 days, unless your Plan notifies you in writing that your Plan needs a 30-day extension.

Right to Request Confidential Communications

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

Right to Request a Restriction

You have the right to request that your Plan restrict its use or disclosure of your PHI. Your Plan is not required to agree to a restriction you request. If your Plan does agree to the restriction, your Plan will comply with its agreement, except in a medical emergency or as required or authorized by law. You must submit a request for a restriction to your Plan in writing to your Plan's Privacy Officer.

Breach Notification

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

Non-public Personal Financial Information

Your Plan guards all of the personal information your Plan collects or maintains about Participants. State and federal laws require that your Plan tell you how your Plan protects private information. This particular notice deals with how your Plan treats "financial information." The fact that you are a Participant of the group health plan, is, in itself, considered "financial information."

Information your Plan collects and maintains: Your Plan collect non-public personal financial information about you from applications or other forms and transactions with Plan, Plan affiliates or other organizations.

How your Plan protects information: Except as explained below, the only people who see your non-public personal financial information are Plan employees who need to use the information to provide you with coverage. Your Plan maintain safeguards that meet the applicable legal requirements. Your Plan keep this information private even after your coverage ends.

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

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

No other disclosures to non-affiliated third parties: your Plan otherwise will not disclose non-public personal financial information about Participants or former Participants 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 Plan.

Questions and Complaints

You may ask for a paper copy of this notice at any time. If you have questions about this notice or protecting your privacy, please call customer service at the phone number listed on the back of your ID card.

If you are concerned that your Plan may have violated your privacy rights or otherwise not complied with this notice and the HIPAA Privacy Regulations, please contact your Plan's Privacy Officer.

You can also review a complete copy of BCBSVT's Notice of Privacy Practices at www.bcbsvt.com/privacypolicies. You may ask for a paper copy of the Notice of Privacy Practices at any time by calling customer service at the number on the back of your ID card.

If you have any questions or want additional information about the privacy of your information at BCBSVT, please contact BCBSVT at:

Mail: Privacy Officer
Blue Cross and Blue Shield of Vermont
P.O. Box 186
Montpelier, VT 05601-0186
Telephone: (802) 371-3394
Fax: (802) 229-0511
Email: privacyofficer@bcbsvt.com

Disclosures for Plan Administrative Functions

In order that the Plan sponsor may receive, use, and disclose PHI for Plan administration purposes, the Plan sponsor hereby agrees to:

- Maintain the privacy and security of your PHI as required by law and follow the duties and privacy practices described in this section and provide a copy upon request;
- Ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan or the Plan sponsor, as the case may be, with respect to such information;
- Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan sponsor nor use or share your information other than as described in this section unless authorized by you in writing;
- Promptly notify you if a breach occurs that may have comprised the privacy or security of your information;
- Make available Protected Health Information in accordance with Federal medical privacy regulations;
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with Federal medical privacy regulations;
- Make available the information required to provide an accounting of disclosures in accordance with Federal medical privacy regulations and promptly advise you if a breach occurs that may have compromised the privacy or security of your information;
- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services, or any other officer or employee whom the authority involved has been delegated, for purposes of determining compliance by the Plan.
- If feasible, return or destroy all Protected Health Information received from the Administrator that the Plan and/or the Plan sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure that the Plan sponsor and the Plan are adequately separated.

The Plan shall disclose PHI to the Plan sponsor only upon receipt of a certification by the Plan sponsor that (a) Plan documents have been amended to incorporate the above requirements and (b) the Plan sponsor agrees to comply with such provision.

The Plan may disclose to the Plan sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan.

The Plan sponsor hereby authorizes and directs the Plan through the Plan Administrator, broker, or the third party administrator or contract administrator, to disclose PHI to stop-loss carriers, excess loss

carriers, insurance companies, or managing general underwriters for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage or insurance coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the HIPAA Privacy Standards.

Your rights under the Women's Health and Cancer Rights Act

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 Co-insurance amounts that are consistent with those that apply to other benefits under your Plan.

If you have questions about these benefits, please call BCBSVT's customer service team at the number on the back of your ID card.

Newborns' and Mothers' Health Protection Act

Federal law requires that health plans 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.

Your Plan does not have standard day-limit restrictions on the length of maternity stays. Instead, each admission is reviewed for Medical Necessity. In any event, your Plan does 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 customer service at the phone number on the back of your ID card.

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. BCBSVT takes measures to ensure your right to privacy.

Receive information from us. BCBSVT supplies you with information to help you understand the organization, your rights and responsibilities as a member, the Network

of Providers, benefits and services available to you and how to use them. You also have the right to access records BCBSVT 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. BCBSVT welcomes your complaints or appeals about the organization and the care you receive. For more information about how to file a complaint or an appeal, please call BCBSVT's customer service team at the number on the back of your ID card.

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

As a member, you have the responsibility to:

Choose a Primary Care Provider (PCP) if your Plan requires a PCP.

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

Keep your Providers informed and understand that your Providers need 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 mutually agreed-upon 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 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 BCBSVT or your Group Benefits Manager if there's a change in your family size, address, phone number, PCP, or any other change in your membership.

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 your Plan considers reasonable for a Covered service or supply.

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

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

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

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

Blue Distinction Centers: health care Facilities and Providers recognized for their expertise in delivering specialty care by the Blue Cross and Blue Shield Association. Blue Distinction Centers must maintain their high quality to maintain the Blue Distinction Center designation.

Child: a Participant's son, daughter or stepchild through marriage, Domestic Partnership³ 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 Participant 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 care, 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 three months 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 use disorder.

Co-insurance: a percentage of the Allowed Amount you must pay, as shown on your *Outline of Coverage* or your *Summary of Benefits and Coverage*, after you meet your Deductible. (Refer also to Chapter One, Payment Terms.)

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

Cosmetic: primarily intended to improve appearance.

Cost-Sharing: costs for Covered services that you pay out of your own pocket. This term includes Deductibles, Co-insurance, and Co-payments, or similar charges, but it doesn't include premiums, any balance between the Provider's charge and what your Plan pays for Out-of-Network Providers, or the cost of non-Covered services.

Covered: describes a service or supply for which you are eligible for benefits under this document.

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;

³ Note: Only if your employer allows coverage for children of a Domestic Partnership.

- 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 your Plan pays certain benefits. Check your *Outline of Coverage* or your *Summary of Benefits and Coverage* for your Deductible amounts and to see if you have a specific kind of Deductible (Aggregate or Stacked as explained in Chapter One, Payment Terms.)

Dependent: a Participant's Spouse, the other Party to a Participant's Civil Union, Domestic Partner (if your employer allows Domestic Partner coverage) or the Participant's Child or Incapacitated Dependent Covered under your Plan. (See Child, 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 Chapter Three, 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 or of an independent free-standing emergency department, 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.

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 use disorder 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 Plan.

Group Benefits Manager: the individual (or organization) who has agreed to forward all subscription rates due under your Plan. The Group Benefits Manager is the agent of the Participant and your Group. Your Group Benefits Manager has no authority to act on BCBSVT's behalf and is not a BCBSVT employee or agent. BCBSVT disclaims 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.

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.

Immediate Family Member: a Spouse (or spousal equivalent), parent, grandparent, Child, sibling, parent-in-law, son/daughter-in-law, brother/sister-in-law, step-parent, step-Child, step-sibling, or any other person who is permanently residing in the same residence as the licensee. The listed familial relationships do not require residing in the same residence.

Incapacitated Dependent: a Dependent who meets BCBSVT's definition of Child, but who 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 Participant or the Participant's estate for support and maintenance.

Inpatient: care at a Facility for a patient who is admitted and incurs a room and board charge. BCBSVT computes 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 use 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;
- standard reference compendia including: the American Hospital Formulary service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, the United States Pharmacopoeia-Drug Information, Facts & Comparisons eAnswers® under the Indications section with a level of evidence scale of A, B, or G, or the DRUGDEX System by Micromedex with a strength of recommendation rating of Class I, Class IIa, OR IIb under the Therapeutic Uses section;
- 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, your Plan may not consider it Medically Necessary.

Network Provider/Out-of-Network Provider: see "Provider."

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

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.

Ombudsman: BCBSVT has an Ombudsman you may contact with complex issues regarding care or service. BCBSVT's Ombudsman works as a liaison between you and your Plan reviewing and solving issues.

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

Out-of-Pocket Limit: the Out-of-Pocket Limit is made up of the Deductibles, Co-payments and Co-insurance you pay. After you meet your Out-of-Pocket Limit, you pay no Co-insurance or no Co-payments for the rest of that Plan Year. Check your *Outline of Coverage* or your *Summary of Benefits and Coverage* to see all your Out-of-Pocket Limits and if you have a specific kind of limit (Aggregate or Stacked as explained in Chapter One, Payment Terms).

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.

Participant: an individual who enrolls in the Plan.

Partnership: see Domestic Partners (Partnership).

Party to a Civil Union: a partner with whom the Participant 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) or osteopathy, dental Surgery, medical dentistry, or naturopathy.

Plan: an employee welfare benefit plan (as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 (ERISA)), established by the Company effective as of January 1, 2013.

Plan Administrator: The person or group of persons formally charged, or named in the plan document, as having the responsibility, and given the authority, of overseeing the operation of your Plan.

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

Prescription Drugs and Biologics: products that are:

- prescribed to treat, prevent or diagnose a medical condition;
- FDA-approved (or not FDA-approved if the use meets the definition of Medical Necessity and is not considered Investigational); and
- approved 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.

Primary Care Provider (PCP): a health care Provider who, within that Provider's scope of practice as defined under the relevant state licensing law, provides primary care services, and who is designated as a Primary Care Provider by a managed care organization.

Prior Approval: the required approval that you must get from BCBSVT before you receive specific services noted in this document. In most cases, BCBSVT requires that you get Prior Approval in writing. BCBSVT may request a treatment plan or a letter of medical need from your Provider. If you do not get approval from BCBSVT before you receive certain services as noted in this document, 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
- podiatrists
- Providers (as further defined in this chapter)
- substance use disorder counselors
- therapists (Occupational, Physical and Speech)

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

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

Network Provider: for most Provider types in Vermont, this includes:

- Pharmacies who make an agreement with BCBSVT's Pharmacy Benefit Manager ("Network Pharmacy");
- Vision Providers who make an agreement with BCBSVT's vision service partner if your Plan has vision benefits; or
- Network Providers for all other services.

Your Plan considers Providers outside of Vermont to be Network Providers if they are Preferred Providers with their local Blue Cross and/or Blue Shield health plans.

You may find a Network Provider by using BCBSVT's Find-a-Doctor tool at www.bcbsvt.com. Select *BCBSVT Network Providers* from the drop-down menu. You may also get a directory of Network Providers from your Group Benefits Manager or from BCBSVT customer service. Providers must be in Network in order for their services to be Covered. Your Plan does not provide benefits if you do not use a Network Provider. See Choosing a Provider in Chapter One.

Out-of-Network Provider: a Provider that does not meet the definition of a Network Provider. Your Plan does not provide benefits if you use an Out-of-Network Provider and Prior Approval is not granted. See Out-of-Network Providers in Chapter One.

Other Provider: one of the following entities:

- Ambulance
- independent clinical laboratories
- Network home infusion therapy Provider
- medical equipment/supply Provider (DME)
- Pharmacy

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

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 use 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 use disorder or pulmonary tuberculosis; or
- Rehabilitation.

Specialty Medications: injectable and non-injectable drugs with key characteristics, including (but not limited to): frequent dosing adjustments and intensive clinical monitoring; intensive patient training and compliance assistance; limited product availability, specialized product handling and administration requirements. For a full list of specialty drugs, please visit www.bcbsvt.com/pharmacy.

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 Participant'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 such as diagnosis, consultation or treatment through the use of live interactive audio and video over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

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

Urgent Concurrent Services: Urgent services that you are currently receiving with Prior Approval and that you (or your Provider) wish to extend for a longer period of time or number of treatments than your Plan has approved.

You, Your: the Participant and any Dependents covered under the Participant's Plan.

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