HEALTH CARE BENEFITS

State of Vermont SelectCare

Summary Plan Description

Health plans are administered by:

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

This document describes the medical benefit plan (the Plan or your Plan) available to State of Vermont employees and their dependents, retirees and their dependents, and other groups of individuals and their dependents associated with State government as defined by 3 V.S.A. Section 631, except for the Vermont State Employee Credit Union.

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, State of Vermont. 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 Blue Cross 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 (Blue Cross) is the Contract Administrator and has been designated by State of Vermont 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.

Blue Cross has entered into a contract with your employer to provide these administrative services to the Plan. Blue Cross'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. Blue Cross is not an underwriter or insurer of the benefits provided by Your Plan. Blue Cross 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 Blue Cross's website at **www.bluecrossvt.org**.

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 Blue Cross's Networks on the "Find-a-Doctor" tool.
- You can order ID cards and much more.

Fraud, Waste, and Abuse

Help us control rising healthcare costs. If you suspect fraud, waste, or abuse in the healthcare system, you should report it to Blue Cross and Blue Shield of Vermont (Blue Cross), and we will investigate. Your actions may help to improve the healthcare system and reduce costs for our Members, customers and business partners.

You may remain anonymous if you prefer. The Blue Cross FWA Special Investigations Unit (SIU) will treat all information received or discovered as confidential, and we will only discuss the results of investigations with persons having a legitimate reason to receive the information.

Mail: Payment Integrity Department
Blue Cross and Blue Shield of Vermont
PO Box 186
Montpelier, VT 05601
Fraud Hotline: (833) 225-3810
Email: Fraud_issues@bcbsvt.com

NOTICE: Discrimination is against the law

Blue Cross and Blue Shield of Vermont (Blue Cross) 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.

Blue Cross 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).

Blue Cross 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 Blue Cross 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

नि:शुल्क भाषा सहायता सेवाहरूका लागि, (800) 247-2583 मा कल गर्नुहोस्।

PORTUGUESE

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

RUSSIAN

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

SERBO-CROATIAN (SERBIAN)

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

SPANISH

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

TAGALOG

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

THAI

สำหรับการให้บริการความช่วยเหลือด้านภาษาฟรี โทร (800) 247-2583

VIETNAMESE

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

TABLE OF CONTENTS

CHAPTER ONE

Guidelines for Coverage 1
- General Guidelines 1
- Prior Approval Program 1
- Case Management Program 2
- Choosing a Provider 3
- Network Providers 3
- Primary Care Providers 3
- Out-of-Network Providers 3
- Standard Benefits 4
- Continuity of Care 5
- Out-of-Area Providers 5
- BlueCard® Program 5
- Blue Cross Blue Shield Global® Core Program 6
- How Blue Cross Chooses Providers 6
- Access to Care 7
- After-hours and Emergency Care 7
- How Your Plan Determines Your Benefits 7
- Payment Terms 8

CHAPTER TWO

Covered Services 10
- Preventive Services 10
- Office Visits 10
- Acupuncture 10
- Ambulance 10
- Autism Spectrum Disorder 11
- Clinical Trials (Approved) 11
- Chiropractic Care 11
- Christian Science Services 12
- Contraceptive Services 12
- Cosmetic and Reconstructive Procedures 12
- Dental Services 12
- Diabetes Services 13
- Diagnostic Tests 13
- Dry Needling 13
- Emergency Care 13
- Hearing Aids 14
- Home Care 14
- Hospice Care 14
- Hospital Care 14
- Infertility Treatment Services 15
- Massage Therapy 15
- Medical Equipment and Supplies 15
- Mental Health Care 17
- Nutritional Counseling 17
- Outpatient Hospital Care 18
- Outpatient Medical Services 18
- Pregnancy Care 18
- Rehabilitation/Habilitation 19
- Second and Third Opinions 19
- Skilled Nursing Facility 19
- Substance Use Disorder Treatment Services 19
- Surgery 20
- Telemedicine Program 20
- Telemedicine Services 20
- Therapy Services 21
- Transplant Services 22
- Vision Services (Medical) 23
- Vision Services (Routine) 23

CHAPTER THREE

General Exclusions 24

CHAPTER FOUR

Claims 27
- Claim Submission 27
- Release of Information 27
- Cooperation 27
- Payment of Benefits 27
- Payment in Error/Overpayments 27
- How Blue Cross Evaluates Technology 27
- Complaints and Appeals 28
- Other Resources to Help You 29

CHAPTER FIVE

Other Party Liability 30
- Coordination of Benefits 30
- Your Plan's Right to Subrogation 31
- Cooperation 31

CHAPTER SIX

Membership Rights 32
- Eligibility for Coverage 32
- Enrollment For and Start of Coverage 33
- What is COBRA continuation coverage? 39

CHAPTER SEVEN

Legal Information 42
- Applicable Law 42
- Future of the Plan 42
- Limitation of Rights 42
- Non-waiver of Rights 42
- Severability Clause 42
- Term of Agreement 42
- Third Party Beneficiaries 42

CHAPTER EIGHT

More Information About Your Plan 43
- Notice of Privacy Practices for Protected Health Information 43
- Disclosures for Plan Administrative Functions 47
- Your rights under the Women's Health and Cancer Rights Act 48
- Newborns' and Mothers' Health Protection Act 48
- Member Rights and Responsibilities 48

CHAPTER NINE

Definitions 50

CHAPTER ONE

Guidelines for Coverage

This document describes benefits for your SelectCare Plan. This plan provides Network benefits when you use Network Providers, but includes another, lower level of benefits for some Out-of-Network services you receive.

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.
- For some services, you must use Network Providers .
- 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 30 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.
- Your Plan Administrator may interpret and apply the terms of your Coverage. Your Plan may determine if you have coverage for care. Your Plan Administrator may also decide how much coverage you have. This applies when a Provider has prescribed or recommended a service.

Prior Approval Program

In most circumstances, your Plan only approves services from Out-of-Network Providers at the highest level of benefits (Preferred benefits) 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 Blue Cross by calling the customer service team at the number on the back of your ID card.

Your Plan also requires Prior Approval for certain services even when you use Network Providers. They appear on the list later in this section. Your Plan does not require Prior Approval for Emergency Medical Services.

Blue Cross Network Providers should get Prior Approval for you. If you use an Out-of-Network Provider or an out-of-state Network Provider (BlueCard Provider), it is your responsibility to get Prior Approval for services that require Prior Approval under your Plan. Failure to get Prior Approval could lead to a denial of benefits. If you use a Blue Cross 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 Blue Cross's website at **www.bluecrossvt.org/members/member-forms** 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 Blue Cross. When receiving care from an Out-of-Network Provider, it is your responsibility to get Prior Approval. Forms are available on Blue Cross's website at **www.bluecrossvt.org/members/member-forms**. 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 Blue Cross 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 printed on this Prior Approval list. This list includes, but is not limited to:

- ambulatory event monitoring ;

- Applied Behavior Analysis (ABA);
- artificial pancreas device system;
- Autism Spectrum Disorder related Occupational, Speech, and Physical Therapy/ medicine after 60 combined visits;
- autonomic function testing;
- autologous chondrocyte transplants;
- biofeedback;
- blood and blood components;
- breast pump, hospital grade;
- cerebrovascular arterial study, non-invasive;
- charged particle radiotherapy;
- continuous passive motion (CPM) equipment;
- Cosmetic and Reconstructive procedures except breast reconstruction for patients with a diagnosis of breast cancer;
- dental services for accidental injury, gross deformity, head and neck cancers, and congenital/genetic disorders;
- Durable Medical Equipment (DME) and supplies (including rentals) with a purchase price of $500 or more;
- electrical and ultrasound stimulation, including Transcutaneous Electrical Nerve Stimulation (TENS) and Neuromuscular Electrical Stimulation (NMES);
- endovascular stent grafts;
- enteral formulae and total parenteral nutrition, supplies and pumps;
- gender affirming services (trans services);
- genetic testing;
- hematopoietic cell transplantation;
- hospital beds and accessories;
- intravascular ultrasound (IVUS)/optical coherence tomography (OCT)
- medical nutrition for inherited metabolic disease;
- nasopharyngoscopy;
- neurorrhaphy procedures;
- oral appliances;
- orthognathic Surgery;
- orthotics and prosthetics (including custom knee brace(s)) with a purchase price of $500 or more;
- 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.
- out-of-state Inpatient care; Residential Treatment Centers for mental health and substance use disorder;
- positive airway pressure devices (APAP, CPAP, BiPAP);
- radiation treatment and high-dose electronic brachytherapy;
- radiology services (certain advanced imaging services including CT, MRI, and PET);
- Rehabilitation (Skilled Nursing Facility, Inpatient Rehabilitation treatment for medical conditions);
- Scintimammography gamma imaging;
- certain surgical procedures and related services (examples include bariatric (obesity) Surgery, disc arthroplasty, lumbar spinal fusion, Sacroiliac joint pain treatment, Temporomandibular joint manipulation (TMJ), and varicose veins);
- surgery and related services;
- Temporary Codes for emerging technologies, services, procedures, and service paradigms, also known as Category III Codes CPT;
- transcranial magnetic stimulation;
- transplants (except corneal and kidney);
- vestibular evoked myogenic potential testing (VEMP);
- vision services and medical coverage for ocular disease;
- 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. To find out more information about the program, Blue Cross's website at **www.bluecrossvt.org/health-community/your-health-and-wellness/help-managing-your-health** or call (800) 922-8778.

Choosing a Provider

For many services, you may use any Provider. For some services, you must use Network Providers. You may have higher Cost-Sharing when you use Out-of-Network Providers.

To access a Network Provider when in Vermont, you must use BCBSVT Network Providers. This Network 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 Blue Cross's Network Providers or information about a Provider, please visit Blue Cross's website at **www.bluecrossvt.org/find-doctor** and use the Find-a-Doctor tool. Use the Network drop-down menu and select *BCBSVT Network* Providers to find a list of Providers.

If you live or travel outside of the Blue Cross 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 may also call Blue Cross's customer service at the number on the back of your ID card. Blue Cross 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;
- bill Blue Cross directly for your services, so you don't have to submit a claim;
- not ask for payment at the time of service except they may ask 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 by using the Find-a-Doctor tool on Blue Cross's website or call customer service at the number on the back of your ID card.

If you want a list of Blue Cross's Network Providers or information about a Provider, please visit Blue Cross's website at **www.bluecrossvt.org/find-doctor** and use the Find-a-Doctor tool. Use the Network drop-down menu and select *BCBSVT Network* Providers to find a list of Providers.

Primary Care Providers

When you join this Plan, you may select a Primary Care Provider (PCP) from Blue Cross's Network of Primary Care Providers. 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.

Your coverage does not require you to get referrals from your PCP. You must get Prior Approval for certain services (see page 1). For instance, if appropriate services are not available with a Network Provider, you must get Prior Approval to receive the highest level of benefits. This does not include Emergency Medical Services.

You do not need to choose a PCP. However, Blue Cross encourages you to do so because it benefits your health to have one doctor coordinate your care. You only pay the PCP Cost-Sharing listed on your Outline of Coverage if you see a Network Provider who practices:

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

Out-of-Network Providers

You must get Prior Approval to use Out-of-Network Providers to receive Preferred benefits. For some services, your Plan provides standard benefits. For other services (see list below), you receive no benefits when you use Out-of-Network Providers. Your Plan reserves the right to direct you to contracted Providers.

In most circumstances, your Plan only approves services from Out-of-Network Providers at the highest level of benefits (Preferred benefits) under certain specific exceptions as described in the following sections, 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. You must still 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. For example, if the Provider's charge is $100 for the Emergency Services and the Blue Cross Allowed Amount is $70, the Provider may not bill you for the remaining $30. If an Out-of-Network Provider bills you for the balance between the charges and what your Plan pays, please notify Blue Cross by calling customer service at the number on the back of your ID card so that Blue Cross can work directly with the Provider to resolve the request. You can also get help from the Vermont Department of Financial Regulation (DFR) at (800) 964-1784.

If you get Prior Approval to use an Out-of-Network Provider for reasons other than the specific exceptions described in the following sections, 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*.

If you use one of the following Provider types that is not a Network Provider, your Plan will not cover your care and you must pay the full cost:

- athletic trainers;
- certified nurse midwives and licensed Professional midwives;
- infertility services Providers; and
- Primary Care Providers.

Out-of-Network Providers when no Network Provider Available

You may request Prior Approval to see an Out-of-Network Provider if there is not a Network Provider available with appropriate training and experience to provide the Medically Necessary services needed to meet your particular health care needs.

Out-of-Network Providers in Emergencies

Your Plan covers Ambulance services and Emergency Medical Services you receive from an Out-of-Network Provider when you have an Emergency Medical Condition (see Definition).

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 you consenting to waive your rights, your Plan will cover your care as if you had been treated by a Network Provider. Under federal law, unless you waived your right to be protected from additional bills, Providers are prohibited from billing you for these services beyond your Cost-Sharing amounts.

Standard Benefits

You may be eligible for standard benefits if you receive certain services from a Provider who is not a Network Provider (an Out-of-Network Provider) without receiving Prior Approval from Blue Cross. To get standard benefits, you must meet the General Guidelines in this section.

You may receive standard benefits for the following services without using a Network Provider or getting Prior Approval if you follow all other guidelines in this document:

- office visits (other than for Primary Care);
- home care;
- General Hospital care (except for services on the Prior Approval list in this document, which always require Prior Approval);
- Outpatient care in a General Hospital or ambulatory surgical center; and
- therapy services.

For all other Out-of-Network services, you must receive Prior Approval or your care will not be Covered. Refer to the Out-of-Network Providers section above for more information. When not following the guidelines for Preferred benefits, try to use a Provider that has a participating agreement with Blue Cross or a local Blue Cross and/or Blue Shield Plan.

Continuity of Care

Continuity of care allows certain patients the opportunity to continue care with their current Provider if their Provider or Facility is no longer in their new plan's Network and they have a qualifying condition. Under federal law, if your provider is no longer a Network Provider, you may elect to continue seeking treatment from them for a qualifying condition (outlined below) for 90 days as if they were Network Provider with Blue Cross.

The following conditions may qualify you for continuity of care protections:

- You are receiving care for a serious or complex condition. A serious or complex condition is one that (a) requires specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (b) is a chronic illness or condition that is life-threatening, degenerative, potentially disabling, or congenital and that requires specialized medical care over a prolonged period of time.
- You are in the course of institutional or inpatient care.
- You have a scheduled nonelective surgery. This includes post-operative care.
- You are receiving pregnancy care, which includes through the completion of postpartum care.
- You are receiving care or treatment for a terminal illness.

If you believe you are entitled to continuity of care, you or your Provider may visit Blue Cross's website at **www.bluecrossvt.org/members/member-forms** to complete the Continuity of Care enrollment form or contact Blue Cross's customer service team at the number listed on the back of your ID card to request the necessary paperwork.

If you are entitled to continuity of care, Blue Cross will treat your Provider as though they were Network Provider for the current period of active treatment for the qualifying condition or up to ninety (90) calendar days from the date you requested continuity of care, whichever is less. After this period has run, Blue Cross can support you in finding a Network Provider to offer quality care. If you continue using the same Provider, your claims may be denied or, if Prior Approval is obtained to continue using your Provider, we will pay the Allowed Amount and you will pay any balance between the Provider's charge and what we pay. 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-Area Providers

If you need care outside of Vermont, you pay Network Cost-Sharing 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.

If you need care outside of the United States or Canada, you pay Network Cost-Sharing for all urgent care or emergency room services. All other care for services incurred in a country outside of the United States or Canada in which a Member maintains residence or is obtained while traveling on business or for pleasure are covered at Out-of-Network Cost-Sharing.

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® Program[1].

Typically, when accessing care outside of the service area, you will obtain care from health care Providers that have a contractual agreement with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). 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 Plan. In some instances, you may obtain care from health care Providers that have contracts with Blue Cross and Blue Shield plans (e.g., Participating or Preferred Providers).

If you obtain care from a contracting Provider in another geographic area, Blue Cross 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 Blue Cross.

Blue Cross 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 Blue Cross.

[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.

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

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 Blue Cross, 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 Blue Cross Chooses Providers

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

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

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.

Blue Cross's Network Providers offer reasonable access for other complex specialty services including major burn care, organ transplants and specialty pediatric care. Blue Cross may direct you to a specialty Network Provider to ensure you get quality care for less common medical procedures.

For many types of care, you may use Out-of-Network Providers. If you do use an Out-of-Network Provider, you may pay more for the cost of your care.

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 Blue Cross as soon as reasonably possible.

If you receive Medically Necessary, Covered Emergency Medical Services from an Out-of-Network Provider, Blue Cross 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 Blue Cross at the number on the back of your ID card, so that Blue Cross 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.

Blue Cross also offers Telemedicine services that allow you to see a licensed Provider via computer, tablet or telephone anytime. See Telemedicine Services on page 20.

How Your Plan Determines Your Benefits

When Blue Cross 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). Blue Cross 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 your Plan approves services with an Out-of-Network Provider for circumstances outside of the situations noted in the Out-of-Network Providers section on page 3, 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. Your Deductible is not included in the Out-of-pocket Limit.

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. 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. Your Deductible is not included in the Out-of-Pocket Limit.

When your family meets the family Out-of-Pocket Limit, all family members are considered to have met their individual Out-of-Pocket Limits. You may have separate Out-of-Pocket Limits for certain services (and if you have a Prescription Drug coverage, you may have separate Out-of-Pocket Limits for pharmacy benefits).

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.

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. Information about Contraceptive Services can be found on page 12.

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 Blue Cross's website at **www.bluecrossvt.org/members/coverage** 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 17);
- Surgery; and
- therapy services (see page 21).

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.
- See page 1 for a description of the Prior Approval program. Visit Blue Cross's website at **www.bluecrossvt.org/members/member-forms** or call customer service at the number on the back of your ID card for the newest list of services that require Prior Approval.

Acupuncture

Your Plan covers acupuncture performed by a licensed acupuncturist or other providers who are practicing within the scope of their license. There are Network and Out-of-Networkbenefits available under the Plan.

Ambulance

Your Plan covers Ambulance services as long as your condition meets the definition of an Emergency Medical Condition. Coverage for Emergency Medical Services, including air ambulance 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 Blue Cross 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

- 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).

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

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); or
- hot and cold packs.

Requirements and conditions that apply to coverage for services by Providers other than Chiropractors also apply to this coverage.

There is a combined limit for chiropractic care, Massage Therapy (as described on page 15), and Therapy Services (as described on page 21). Please see your *Outline of Coverage* or your *Summary of Benefits and Coverage* for details.

Exclusions

Your Plan does not provide chiropractic benefits for:

- 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;
- 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 (includes over-the-counter drugs, vitamins, supplements, homeopathic preparations, etc.);
- obstetrical procedures including prenatal and post-natal care;
- Custodial Care (see Definitions), as noted in General Exclusions;
- supervised services or modalities that do not require the skill and expertise of a licensed Provider;
- Surgery;
- operative or cutting procedures;
- ultrasound tests, colonics, Transcutaneous Electrical nervice Stimulation; or
- any other procedure not listed as a Covered chiropractic service.

General Exclusions in Chapter Three also apply.

Limitations

There is a combined limit for chiropractic services, massage therapy (as described on page 15) and therapy services (as described on page 21). See your *Outline of Coverage* for details.

Christian Science Services

Your Plan covers services with a Christian Science Practitioner. Your Out-of-Network Cost-Sharing applies to this benefit.You must use a provider who is listed in the Christian Science Journal Directory, which can be found at **http://journal.christianscience.com/directory**.

Contraceptive Services

Your Plan covers outpatient contraceptive services as per HRSA guidelines for all FDA approved contraceptive methods including office visits and consultations. Your Plan also covers office visits associated with insertion, removal, counseling, and monitoring of contraceptive devices as Medically Necessary, and sterilization procedures (vasectomy or tubal ligation) even though they are not Medically Necessary. With the exception of voluntary male sterilization, your Plan pays for contraceptive services with no Cost-Sharing (like Co-payments, Deductibles, and Co-insurance). See your *Outline of Coverage* or your *Summary of Benefits and Coverage* for Cost-Sharing details.

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 16); 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 Blue Cross 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]
- 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 related to 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 with phobias or a mental illness documented by a licensed Physician or mental health Professional; or with severe disabilities that preclude office-based dental care due to safety considerations; or who are developmentally unable to safely tolerate office-based dental care.
- Diagnostic Imaging, including but not limited to, plain film radiographs and Cone Beam CT (CBCT), performed as part of evaluation of an accidental injury to the jaws, sound natural teeth, mouth or face, or as part of evaluation to correct gross deformity resulting from major disease or surgery.

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.

[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.

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);
- charges related to non-Covered dental procedures or anesthesia (for example, Facility charges, except when Medically Necessary as noted above);
- dental prosthetics, dental services, or dental supplies of any kind, even if necessary because of symptoms, illness or injury affecting another part of the body;
- expenses for appliances (other than a mandibular orthopedic repositioning appliance); or
- services and procedures to change the height of teeth or otherwise restore occlusion.

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 also covers Medically Necessary foot care for the treatment of 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 dietician (R.D.);
- certified dietician (C.D.);
- naturopathic doctor (N.D.);
- advanced practice registered nurse (A.P.R.N.); or
- certified diabetic educator (C.D.E.).

Diagnostic Tests

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.

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.

Dry Needling

Your Plan covers dry needling performed by a licensed provider practicing within the scope of their license.

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 Blue Cross 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.

Hearing Aids

Your Plan covers hearing aids. The purchase of hearing aids is limited to $1500 per ear every 60 months. Please see your *Outline of Coverage* for Cost-Sharing details. Prior Approval is not required for the hearing aids.

Other related services including examinations, fittings, adjustments, and supplies are not subject to the hearing aid limit. These services are subject to the applicable medical benefit Cost-Sharing and any applicable requirements for coverage (such as Office Visits).

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 21).

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

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.

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;
- Custodial Care (see Definitions);
- food or home-delivered meals;
- non-medical charges; and
- private-duty 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, except when respite care services are being provided.

General Exclusions in Chapter Three also apply.

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 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 1 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 Skilled Nursing Facility. In a General Hospital, these services may include:

- Surgery (see page 20 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:

- Your Plan makes one payment for some surgeries and other procedures. This means that the Allowed Amount for the Surgery includes payment for all office visits and other care that is related to the Surgery.
- Subject to Medical Necessity, 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).

Infertility Treatment Services

When using a Network Provider, your Plan covers the following services related to the diagnosis and treatment for infertility:

- diagnostic testing, such as sonograms and X-rays, and evaluation leading to the diagnosis of infertility;
- ongoing drug therapy;
- laboratory studies, including ultrasound;
- surgery to extract and/or fertilize mature eggs (Inpatient or Outpatient);
- Gamete Intrafallopian Transfer (GIFT);
- Zygote Intrafallopian Transfer (ZIFT);
- Intra-uterine Insemination (IUI);
- Artificial insemination (AI); and
- counseling.

Exclusions

Your Plan does not cover the following:

- donor related services or specimens;
- any Experimental or Investigational procedures or therapies;
- infertility services rendered to a surrogate and/or surrogate fees; or
- infertility services with an Out-of-NetworkProvider.

Note

- There is a lifetime benefit limit for infertility treatment services. Please see your *Outline of Coverage* for details. The benefit limit does not apply to the diagnostic services performed to determine if and why a person is infertile.

Massage Therapy

Your Plan covers massage therapy services provided by:

- Acupuncturist;
- Chiropractor (D.C.);
- Physical therapist;
- Medical Doctor (M.D.); or
- a doctor of osteopathy (D.O.).

Limitations

There is a combined limit for massage therapy, Chiropractic Care (as described on page 11) and Therapy Services (as described on page 21). Please see your *Outline of Coverage* or your *Summary of Benefits and Coverage* for details.

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 list on page 1 or visit **www.bluecrossvt.org/members/member-forms**.

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.);
- Chiropractor (D.C);
- Christian Science practitioner; or
- Durable Medical Equipment supplier.

Your Plan covers the rental or purchase of Durable Medical Equipment if they have been ordered or prescribed by a Provider. Your Plan reserves the right to determine whether rental or purchase of the equipment is more appropriate.

Some equipment typically obtained through a DME supplier may also be available through your pharmacy benefit at the applicable pharmacy Cost-Sharing amounts. Refer to your Pharmacy Benefits Manager.

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, Blue Cross 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 and ostomy 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 (oral appliances) 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;
- Continuous Glucose Monitoring (CGM) purchased through a DME supplier (These supplies may be eligible through your pharmacy benefit)
- 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;
- lifts, arch supports or special shoes not attached to a brace (except with a diagnosis of diabetes);
- duplicate medical equipment and supplies, orthotics and prosthetics;
- 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
- 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 Blue Cross's customer service team at the number on the back of your ID card. Blue Cross 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 Blue Cross deems them Medically Necessary);
- non-traditional, alternative therapies such as Rubenfeld Synergy, energy polarity therapy and somatization therapy, that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories;
- 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);
- stress reduction classes and pastoral counseling; and
- hypnotherapy.

General Exclusions in Chapter Three also apply.

Nutritional Counseling

Nutritional evaluation and counseling are covered as Medically Necessary for the management of organic disease, including such conditions as diabetes, anorexia, Crohn's, hyperlipidemia, metabolic disorders, celiac disease and the like. There is no limit on the number of visits for nutritional

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 dietician (R.D.);
- certified dietician (C.D.);
- naturopathic doctor (N.D.);
- advanced practice registered nurse (A.P.R.N.); or
- certified diabetic educator (C.D.E.).

Outpatient Hospital Care

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 1.

For information about Therapy Services, see page 21.

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 they find or reasonably suspect a disease condition or injury of the ear.

Pregnancy Care

Your hospital benefits cover your Inpatient labor-and-delivery 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. Your Plan also covers 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. If you are on an individual policy, your Cost-Sharing will be based on a family plan during those 60 days.

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 Blue Cross 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.bluecrossvt.org/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.

Rehabilitation/Habilitation

Rehabilitation or Habilitation services may require Prior Approval. Please check the Prior Approval list on page 1.

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 up to three supervised sessions per week for up to 12 weeks; and
- Rehabilitative or Habilitative services and devices Covered elsewhere in this document (e.g., under Therapy Services on page 21).

Limitations

Coverage is for up to 60 days per plan year.

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.

Second and Third Opinions

If you have been given a recommendation for elective Surgery, your Plan covers a second consultation from a Physician who is qualified to treat the diagnosis, injury or sickness for which Surgery has been recommended.

If the second opinion differs from the initial recommendation and the disagreement cannot be resolved by discussion between the two Physicians, a third opinion from another qualified Physician is covered.

Second opinions for elective Surgery are Covered with no Cost-Sharing. A second opinion is not Covered if the opinion is requested for Cosmetic or dental surgical procedures not Covered by your Plan. Third opinions sought by a Member are subject to Cost-Sharing.

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

Limitations

Coverage is for up to 60 days per plan year.

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);
- 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 Blue Cross's customer service team

at the number on the back of your ID card. Blue Cross 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 Blue Cross 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 Blue Cross deems them Medically Necessary);
- non-traditional, alternative therapies such as Rubenfeld Synergy, energy polarity therapy and somatization therapy, that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories;
- services, including long-term residential programs, adventure-based activities, wilderness programs and residential programs that focus on education, socialization, delinquency;
- Custodial Care (see Definitions);
- stress reduction classes and pastoral counseling; 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;
- lactation consultations; and
- mental health consultations.

This program provides you with online access to Medical Care for common, uncomplicated, non-emergency cases. Please see your *Outline of Coverage* for details. Visit Blue Cross's website at **www.bluecrossvt.org/find-doctor/telemedicine-care** or call the customer service number on the back of your ID card to get started.

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 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;
- nutritional counseling visits;
- 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:

- 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, 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.);
  - Chiropractor (D.C.);
  - athletic trainer (A.T.);
  - podiatrist (D.P.M.);
  - nurse practitioner (N.P.);
  - advanced practice registered nurse (A.P.R.N.);
  - doctor of naturopathy (D.N.); or
  - a doctor of osteopathy (D.O.).
- up to the combined benefit limit for Chiropractic Care (as described on page 11), Massage Therapy (as described on page 15), and Occupational, Speech and Physical Therapy/medicine that is listed on your *Outline of Coverage* or your *Summary of Benefits and Coverage*. (This limitation does not apply to mandated treatment for Autism Spectrum Disorder as defined by Vermont law, but Prior Approval after 60 combined visits is required.)

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 (this exclusion does not apply to physical therapy);
- treatment of developmental delays (This exclusion does not apply to mandated treatment of Autism Spectrum Disorder 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, excluding kidney and cornea transplants.

Blue Cross 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.

Special Transplant Benefits

Members who receive a transplant other than a cornea, kidney or autologous bone marrow/stem cell transplant are also entitled to reimbursement for travel expenses up to a maximum of $10,000. The travel benefit is not subject to any deductible and is available for the following pre-approved services:

- evaluation;
- candidacy;
- transplant; and
- post-transplant care.

Travel expenses will be reimbursed for the person receiving the transplant and one companion who accompanies the recipient (a companion may be a spouse, dependent, family member, legal guardian or any other person actively involved as the recipient's caregiver). Reimbursable expenses, based on receipts received, include charges for:

- transportation to, from and around the transplant site (including charges for a rental car used during a period of care at the transplant facility),
- lodging while at, or travel to and from, the transplant site, and
- food and meals purchased while at, or traveling to and from, the transplant site.

Limitations

- Travel benefits are only available if a Member is a potential candidate for or the recipient of an organ or tissue transplant, and
- No travel benefits are available to Members who are donors under the Member's coverage.

Exclusions

Travel expenses will not include any charges for:

- travel costs incurred due to travel within 60 miles of home,
- laundry bills,
- telephone bills,
- alcohol or tobacco products,
- transportation charges in excess of coach class rates, or
- expenses for travel related to cornea, kidney, or autologous bone marrow/stem cell transplants.

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. Your Plan also does not cover voluntary transplants, such as uterine transplants as treatment of infertility.

General Exclusions in Chapter Three also apply.

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 16).

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.

Vision Services (Routine)

Adult Routine Vision

Your Plan covers one routine vision exam, including refraction, and one pair of lenses every 24 months. There is a benefit maximum of $100 every 24 months for exams and lenses combined.

Pediatric Routine Vision

Your Plan covers one routine vision exam, including refraction, and one pair of lenses every 24 months. There is no dollar limit.

Contact Lenses

For contact lenses, “one pair of lenses” is determined by your prescription as follows:

- prescribed annually: benefits are provided for one pair of lenses (one year supply) every 24 months
- prescribed monthly: benefits are provided for six pairs of lenses (six month supply) every 24 months
- prescribed bi-weekly: benefits are provided for six pairs of lenses (three month supply) every 24 months
- prescribed daily: benefits are provided for 30 pairs of lenses (one month supply) every 24 months

Exclusions

The routine visit benefit does not cover:

- sunglasses;
- frames;
- repair of lenses or frames; or
- cosmetic extras such as tinting or coating of lenses.

CHAPTER THREE

General Exclusions

The named fiduciary of your Plan, your Plan Administrator, has the full discretion and authority to interpret and apply the terms of your Coverage, and may delegate such responsibility to a third party. The named fiduciary, your Plan Administrator, also has full discretion and authority to determine if you have coverage for certain care and how much coverage you have. This applies even when a Provider has described or recommended the service.

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 Blue Cross 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. Acupressure, hypnotherapy, rolfing, homeopathic or naturopathic remedies. (This exclusion for naturopathic remedies does not apply to Medically Necessary services that would otherwise be Covered services when such services are performed by a naturopath and within the scope of the 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].)
11. Automatic or manual home blood pressure cuffs.
12. Other forms of self-care or self-help training. (This exclusion does not apply to biofeedback.)
13. Immunizations purchased in bulk, such as those provided to a group of people and billed collectively rather than individually.
14. Fluoride treatments performed in school.
15. Whole blood, blood components, costs associated with the storage of blood, testing of blood the patient donates for his or her own use (even if the blood is used), transfusion services for blood and blood components the patient donates for his or her own use in the absence of a Covered surgical procedure. (This exclusion does not apply to blood derivatives and transfusion services for whole blood, blood components and blood derivatives.)
16. Care for which there is no therapeutic benefit or likelihood of improvement.
17. Care, the duration of which is based upon a predetermined length of time rather than the condition of the patient, the results of treatment or the individual's medical progress.
18. Care obtained while outside the United States or Canada, including hospital care, medical supplies, and provider services, when the primary purpose of being outside the United States or Canada was to obtain medical care.
19. Clinical ecology, environmental medicine, Inpatient confinement for environmental change or similar treatment.
20. Cognitive training or retraining and educational programs, including any program designed principally to improve academic performance, reading or writing skills.
21. Communication devices and communication augmentation devices.
22. Computer technology or accessories and other equipment, supplies or treatment intended primarily to enhance occupational, recreational or vocational activities, hobbies or academic performance.
23. Annual or subscription or retainer fees charged by concierge medicine practices.

24. Consultations, including telephone consultations, except when they occur between Providers and the Providers attach a written report to the patient's medical record.
25. Correction of near- or 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.
26. Cosmetic procedures and supplies that are not Reconstructive.
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 as defined by Vermont law.)
30. Drugs and pharmaceuticals, except as required by law;
31. 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.
32. 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.)
33. 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.
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. (This exclusion does not apply to manual hydraulic patient lifts, commonly known as "Hoyer" lifts.)
36. Infertility services with an Out-of-Network Provider and the following:
    - donor related services or specimens;
    - any Experimental or Investigational procedures or therapies; and
    - infertility services rendered to a surrogate and/or surrogate fees.

    Note: This exclusion does not apply to the evaluation to determine if and why a couple is infertile.
37. 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.
38. Treatment for willfully uncooperative or intractable patients.
39. Institutional or Custodial Care for the physically or mentally handicapped.
40. Mandated treatment, including court-ordered treatment, unless such treatment is Medically Necessary, ordered by a Provider and covered under this document.
41. 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.
42. Food and nutritional formulae or supplements including but not limited to, home meals, formulas, foods, diets, vitamins and minerals (whether they can be purchased over-the-counter or require a prescription) except when provided during hospitalization or for enteral nutrients through a feeding tube.
43. Orthodontics, including orthodontics performed as adjunct to orthognathic Surgery or in connection with accidental injury.
44. Personal hygiene items.
45. Personal service, comfort or convenience items.
46. Photography services, photographic supplies or film development supplies or services (for example, external ocular photography or photography of moles to monitor changes).
47. 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.

48. Pneumatic cervical traction devices except when the patient has a diagnosis of Temporomandibular Joint Syndrome (TMJ); gravity assisted traction devices.
49. Private duty nursing services.
50. Services, including modalities, that do not require the constant attendance of a Provider. (This exclusion does not apply to physical therapy.)
51. Services performed by a Provider that is neither licensed nor certified.
52. Specialized examinations, services or supplies required by your employer or for sports/recreational activities (e.g. driver certifications, pilot flight physicals, etc.). Note: this exclusion does not apply for sports physicals that are billed as a preventive visit and you have not had an annual preventive visit.
53. Supervised services or modalities that do not require the skill and expertise of a licensed Provider.
54. 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.
55. Sterilization reversal (vasectomy reversal, vasovasostomy, vasovasorrhaphy, tubal ligation reversal, tubotubal anastomosis).
56. Telemedicine services via email, facsimile or non-HIPAA-compliant software, and telemonitoring.
57. Travel (other than Ambulance transport), lodging and housing (when it is not integral to a Medically Necessary level of care, even if prescribed by a Provider).
58. Treatment solely to establish or re-establish the capability to perform occupational, hobby, sport or leisure activities.
59. Treatment of obesity, except surgical treatment when determined Medically Necessary through Prior Approval.
60. Unattended services or modalities (application of a service or modality) that do not require direct one-on-one patient contact by the Provider.
61. Vision training, orthoptics, or plano (non-prescription lenses).
62. Work-hardening programs.
63. 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 is neither licensed nor certified.
- 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 Blue Cross 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

Blue Cross must receive your claim within 24 months after you receive a service, or as soon thereafter as is reasonably possible. If you file a claim more than 24 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.bluecrossvt.org/members/member-forms** or request one by calling the customer service number on the back of your ID card.

Release of Information

Blue Cross may need records, verbal statements or other information to administer your benefits. By accepting your benefits under your Plan, you give Blue Cross 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, Blue Cross 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 Blue Cross to receive benefits. Blue Cross 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 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 Blue Cross 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 Blue Cross Evaluates Technology

Your Plan has delegated to Blue Cross the responsibilities to establish medical policies to facilitate the administration of benefits. Blue Cross'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.

Blue Cross 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 Blue Cross's customer service team at any time if you have concerns. This is usually the best, first course of action. Blue Cross's customer service team can solve most problems. Contact Blue Cross's customer service team at the number printed on the back of your ID card or by email at customerservice@bcbsvt.com. 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:
  - Blue Cross 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. Blue Cross 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 Blue Cross 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 Blue Cross'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 Blue Cross'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. Blue Cross will record your appeal in writing. Please call Blue Cross's customer service team at the number on the back of your ID card.

Blue Cross 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 Blue Cross at the number on the back of your ID card. Blue Cross 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 Blue Cross 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 the Health Care Advocate's telephone number at (800) 917-7787 or (802) 863-2316.

Blue Cross's Ombudsman

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

In most cases, the professionals in Blue Cross'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 Blue Cross's customer service team at the number listed on the back of your ID card.

CHAPTER FIVE

Other Party Liability

This chapter gives Blue Cross 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 Blue Cross.

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 Adult Dependent Due to Disability 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, Blue Cross 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 Blue Cross 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 Blue Cross or your Plan, or fail to cooperate, either entity may take legal action against you. Your Plan or Blue Cross 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 Blue Cross 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 Blue Cross. In some cases, your Plan will compromise the amount of its claim. Neither Blue Cross 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 Blue Cross 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 Blue Cross consent before providing any release from liability for medical expenses; and
- not taking any action that would prejudice Blue Cross 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 Rights

Eligibility for Coverage

All of the individuals eligible for coverage identified in this section are collectively referred to as Employees throughout the remainder of this document.

An Employee who is working and eligible for coverage as well as their Eligible Dependents may enroll in any benefit option offered by the Plan. However, enrollment in some benefit options may not be available to retirees if the retiree is Medicare eligible or an Eligible Dependent of the retiree to be enrolled is Medicare eligible.

Except as specified above, temporary personnel, contractual personnel, members of board or commissions, persons whose compensation for service is not paid from the State treasury and any elected or appointed official who is not actively engaged in and devoting substantially full time to the conduct of business of his or her public office are not eligible to participate in the Plan (3 V.S.A. § 635).

State of Vermont Employee

- A classified or exempt permanent employee of the State of Vermont who is expected to work at least 1040 hours per calendar year. The Commissioner of Human Resources may require certification that any employee or group of employees initially meets and continue to meets this requirement.
- A member of the general assembly (legislators) as applicable per statute.
- A session employee of the legislature or the legislative council (3 V.S.A. § 631).

Special Groups

A permanent employee of the Vermont State Employees' Association, Inc., the Vermont Historical Society, or the Vermont Council on the Arts who is expected to work at least 1040 hours per calendar year. All groups cited in the above two sentences are collectively referred to elsewhere in this document as Special Groups (3 V.S.A. § 631).

State of Vermont Retirees

For the purposes of health plan eligibility, a retiree is defined as a State employee who ceases active State employment while covered under the Plan and is determined to be eligible to continue health insurance per 3 V.S.A. § 631, 3 V.S.A. § 500, or 3 V.S.A. § 479(a) (B). Other than Group C and Group F retirement plan members as outlined below, retirees who upon retirement, do not continue enrollment in the plan without an interruption in coverage between active employment and their status as a retiree, cannot elect to participate in the Plan at a later date. (Coverage via COBRA is considered continued enrollment and is not considered an interruption in coverage.) A retiree who elects to continue coverage in retirement must have been a Member of the Plan immediately prior to, up to and including the date of retirement. A retiree who is not in the plan cannot enroll in the Plan.

Effective July 1, 2007, 3 V.S.A. § 479(b) provides that members of the Group C retirement plan who separate from service prior to being eligible for retirement benefits, who have at least 20 years of creditable service, and who actively participated in the Plan at the time of separation from service, shall have a one-time option at the time retirement benefits commence, to reinstate the same level of coverage in the Plan that existed at the date of separation from service.

The only other instance in which a break in coverage is allowed is in the case of a former employee who had coverage upon termination of employment, dropped coverage and was subsequently granted disability retirement. These employees will be eligible for coverage from the date they became disabled, as determined by the Retirement Board. However, they must apply for coverage within 60 days of the decision of the Retirement Board and they must make their premium contribution retroactive to the date of disability. An Enrollment/Change Application must be submitted to change from COBRA coverage to coverage as a disabled retiree if the disabled retiree maintained COBRA coverage through the date of disability. Any premium paid for coverage after the date of disability while awaiting the disability decision from the Retirement Board will be refunded back to the date of disability (See Section IV). The disabled retiree will have their contribution of premium as disabled retiree withheld from their disability pay retroactive to the start date of coverage.

Employees who terminate employment and who are eligible to receive a pension at a later date (vested terminated employees) are not eligible for coverage upon termination except as described elsewhere in this document.

Special Group Retirees

For the purpose of health plan eligibility, a retiree is defined as an employee of a Special Group identified in 3 V.S.A. § 631 who was covered by the Plan when s/he

ceased active employment with the Special Group and had 1) twenty creditable years of service with the same Special Group, or 2) at least 15 years of creditable service with the same Special Group and who had attained the age of 62. Retirees who do not continue enrollment in the Plan upon retirement without an interruption in coverage between active employment and their status as a retiree may not elect to participate in the Plan at a later date. (Coverage via COBRA is considered continued enrollment and is not considered an interruption in coverage).

Dependents

Dependents eligible for coverage include the Employee's:

- Spouse;
- Domestic Partner;
- Children, until the date of their 26th birthday;
- Adult Children over age 26 who qualify for Adult Dependent Due to Disability status under the guidelines in the Definitions section, if they have been a covered dependent prior to turning 26

Enrollment For and Start of Coverage

An Employee and their Eligible Dependents may become covered under the Plan only upon Employee Benefits Division of the Department of Human Resources.

Enrollment Upon Hire

Employees who desire coverage for themselves and their Eligible Dependents must be enrolled no later than 60 days after the Employee's Date of Hire (the Initial Enrollment Period), through the completion of the Online Enrollment Process.

Enrollment of a Domestic Partner requires the additional submission of a completed, signed and notarized Domestic Partner Application. We do not require this documentation for new hires.

Start of Coverage

When the standard 30-day waiting period is in effect, coverage begins on the 31st day after the date of hire if the Employee has completed the Online Enrollment Process. If an Employee fails to enroll within 30 days of the Date of Hire, but enrolls within the next 30 days, coverage begins on the date identified by the Employee in the Online Enrollment Process. Eligible Dependents may be added to the coverage at any time during the 60-day initial Enrollment Period. Coverage will begin on the date they are added to the Employee's coverage.

An Employee may enroll and have coverage without fulfilling the 30-day waiting period if the Employee has coverage under another healthcare plan and the Employee's coverage terminates during or immediately before the 30-day waiting period. "Immediately before" means up to three days before the Date of Hire. For example, the initial 30-day waiting period will be waived if prior coverage ends on a Friday and the Date of Hire is the following Monday or the next State business day.

Under certain conditions and at the direction of an appointing authority, the Employees Benefits Division in the Department of Human Resources may observe an overall suspension of the waiting period.

Failure to Enroll During the Initial Enrollment Period

If an employee does not enroll during the Initial Enrollment Period, the Employee will not be able to enroll they/them and/or any Eligible Dependent(s) until the next Annual Open Enrollment unless the Employee and/or the Employee's Eligible Dependent(s) qualify for the Special Enrollment described in Section D, Special Enrollment.

Annual Open Enrollment

The Open Enrollment period is the period of time during the month of November, during which Employees in Section II of this document may make the elections outlined below.

Elections Available During Open Enrollment

During the Open Enrollment Period, Employees may, subject to the limitations specified elsewhere in this document, elect to:

- Enroll themselves and Eligible Dependents in one of the Plan options for the first time;
- Add Eligible Dependents to the Employee's existing coverage; and/or
- Elect a different Plan option.

Note: Employees may remove themselves and any Covered Dependents from coverage at any time. If the employee discontinues coverage for they/them, coverage for their Covered Dependents will cease simultaneously.

Annual Open Enrollment is the only time an Employee may change from one Plan option to another, unless:

- An Employee has a network-based plan, and
- The Employee permanently moves to an area that does not have a network.

No Election/Changes Made for the Following Year to Previously Elected Plan Options

Annual Open Enrollment elections/changes take effect on January 1st each year. Employees whose retirement date is January 1 may not elect coverage or add dependents during the Annual Open Enrollment period preceding their retirement date, as coverage must be active on or before December 31st.

Restrictions on Elections During Open Enrollment

No Eligible Dependent may be covered unless the Employee of whom they are a dependent is covered. All relevant parts of the Enrollment Process must be completed on or before the last day of the Annual Open Enrollment Period. Retirees who are not members of the Plan may not participate in the Annual Open Enrollment. Retirees who are members of the Plan may not add a Domestic Partner. If a retiree drops coverage for a Domestic Partner, a Domestic Partner may not be subsequently added to coverage.

Start of or Changes to Coverage Following Open Enrollment

All initiation of coverage election or changes in coverage during any Annual Open Enrollment will becomes effective on January 1 of the following year.

Failure to Make a New Election During Open Enrollment (Covered Employees)

- If an Employee has been enrolled in one of the Plan options and fails to make a new plan option during the Annual Open Enrollment period, the Employee will be considered to have made an election to continue with the current plan option coverage they had during the Annual Open Enrollment. If an Employee's plan option will not be available in the following year, they will not have any coverage in the new Plan Year if they have not elected a new plan option during the Annual Open Enrollment.
- Active Employees will not be able to select a Plan option after the Annual Open Enrollment period unless they or their Eligible Dependents qualify for Special Enrollment. Retirees who fail to elect a new Plan option when their current Plan option will not be available in the upcoming Plan Year, will lose coverage permanently on December 31 of the year in which their current plan is terminated.

Failure to Enroll During Open Enrollment

An Employee who fails to enroll they/them and/or any of they/them Eligible Dependents during the Annual Open Enrollment will not be able to enroll they/them and/or any Eligible Dependents until the next Annual Open Enrollment period, unless the Employee and they/them Eligible Dependents qualify for Special Enrollment.

Special Enrollment

New Acquired Eligible Dependent

If a Covered Employee acquires an Eligible Dependent through a qualifying event, that Eligible Dependent may be enrolled no later than 60 days after the date they became an Eligible Dependent. However, a retired Employee may not add a Domestic Partner.

If an Employee who is not covered and not retired acquires an Eligible Dependent through a qualifying event, the Employee may enroll they/them and the new Eligible Dependent and any other Eligible Dependents no later than 60 days after the qualifying event.

If an Employee who is not retired did not enroll their Spouse or Partner for coverage within 60 days of the date on which Spouse or the Partner became an Eligible Dependent, and if the Employee subsequently has a qualifying event through which they acquire an Eligible Dependent child, the Spouse or Partner together with the new dependent child may be enrolled no later than 60 days after the date the child became and Eligible Dependent (e.g., birth date or date on which child was placed for adoption). The Employee does not have to be enrolled prior to enrolling the Spouse or Partner with the child, but the Employee must enroll they/them to enroll the Spouse or Partner and the child.

If a retired Employee who is a member of the Plan did not enroll their Spouse for coverage within 60 days of the date on which the Spouse became an Eligible Dependent, and the Retired Employee subsequently acquires a child who is an Eligible Dependent, the Spouse or Domestic Partner and the newly acquire dependent child may be enrolled no later than 60 days after the date the child became an Eligible Dependent (e.g., birth date or date on which child was placed for adoption).

Dependent Children who are adopted or are in placement awaiting adoption and who are enrolled within 60 days of adoption or placement for adoption, will be eligible for coverage from the date the child is adopted or placed for adoption with the Employee, but in no instance will coverage be retroactive more than 60 days from the date Enrollment is processed. A child is placed for adoption on the date the Employee becomes legally obligated to provide full or partial support and the Employee is in the process of adopting the child. However, if a child is placed for adoption,

and if the adoption does not become final, coverage of that child will terminate as of the date the Employee no longer has a legal obligation to support that child.

Loss of Other Coverage

If:

- an Employee who is not retired did not enroll they/them or any Eligible Dependents within 60 days after the date on which the Employee or the Eligible Dependents first became eligible to enroll for coverage because the Employee or the Eligible Dependents had health care coverage under another health plan, including COBRA Continuation Coverage, individual insurance, Medicare, Medicaid, TRICARE, or other public program; and
- the Employee and/or any Eligible Dependents lose coverage from the other health plan through no fault of their own, to include exhaustion of COBRA coverage, death of a Spouse, Domestic Partner, divorce, dissolution of a domestic partnership, or loss of a job, the Employee may enroll they/them and/or their Eligible Dependents (as long as the Employee is enrolled) within 60 days after the termination of coverage under that other health plan.

If:

- an Employee who is retired and covered did not enroll an Eligible Dependent within 60 days after the date on which the Eligible Dependent first became eligible to enroll for coverage because the Eligible Dependent had health care coverage under another health plan, including COBRA Continuation Coverage, individual insurance, Medicare, Medicaid, TRICARE, or other public program; and
- the Eligible Dependent loses coverage from the other health plan through no fault of their own, to include exhaustion of COBRA coverage, the Employee may enroll his Eligible Dependent within 60 days after the termination of coverage under that other health plan.

COBRA Continuation Coverage is exhausted if it ceases for any reason other than:

- the failure of the individual to pay the applicable COBRA premium on a timely basis, or
- for cause (e.g., making a fraudulent claim or an intentional misrepresentation of material fact in connection with that COBRA Continuation Coverage).

A permanent move to an area that is not a service area of the COBRA HMO or similar program (whether or not by the choice of the individual) constitutes exhaustion of COBRA Continuation Coverage.

Return To Work

If an Employee who was enrolled in a Preferred Provider Organization (PPO) Plan option returns to work after a break in coverage, and is eligible to re-enroll and re-enrolls, all accumulations toward Annual and Limited Lifetime Maximum Benefits (utilization and expenses) that were incurred prior to the break in coverage will apply. Accumulations towards annual Deductibles will also apply if they return to work in the Plan Year in which they left. If Eligible Expenses were incurred in October, November, or December of the year in which they left work and those expenses were applied to their medical or mental health and substance abuse healthcare Deductibles, the amounts applied to the Deductibles will be carried forward and applied towards the Deductibles of the following Plan Year.

Reduction in Force (State Employees Only)

Former State employees who were laid off in a Reduction in Force (RIF) and did not maintain coverage, may enroll themselves and their Eligible Dependents in the Plan within 60 days of return to active State service through exercise of RIF rights if they meet the eligibility requirements outlined in Section II of this Plan Document. In this instance, there is no 30- day waiting period. The employee must re-enroll in the same plan option they had prior to being laid off if that plan is still available, unless an Open Enrollment period occurred while they were in RIF status. Eligible Dependents may be enrolled whether or not they were previously enrolled. If an Employee did not have coverage when laid off, the Employee may enroll as a new hire upon return to active State service through exercise of RIF rights. However, they/them may be subject to a 30-day waiting period.

Parental and Family Leave or Military Leave (all Employees)

Employees on Parental and Family Leave (21 V.S.A. § and 29 U.S.C § 2601 et.seq.) or Military Leave whose coverage ended while on leave may have coverage reinstated upon return to work if they return promptly at the end of that leave and elect to reinstate coverage. They must enroll in the same plan option they had prior to going on leave status unless they have missed the opportunity to change plans during an open enrollment which occurred while on leave status. If they missed an open enrollment, they may re-enroll in a different plan option. Eligible Dependents may be enrolled whether or not they were previously enrolled.

All Other Leave of Absence (all Employees)

Any employee on an approved leave of absence (medical or non-medical, paid or unpaid) or permanent Employee who dropped coverage while in a leave or in an inactive status, may not be reinstated upon

return to active status. They must wait until the next Annual Open Enrollment period or they experience a qualifying event. Even though an Employee dropped coverage during a leave of absence, the period without coverage will not be counted as a break in coverage as required by State or Federal laws (e.g. Vermont Parental and Family Leave law and the Uniformed Services Employment and Re-employment Act).

Special Enrollment – ESIA

In 2007, 33 V.S.A. §1974 was amended to include as a qualifying event, the determination of the Agency of Human Services of eligibility for Employee Sponsored Insurance Premium Assistance (ESIA). If the Agency of Human Services finds an Employee eligible for ESIA, the Employee may enroll within 30 days of the eligibility determination, rather than waiting until the next Open Enrollment period.

Special Enrollment – Documentation Required

Employee who wishes to add an Eligible Dependent to the Plan based on an approved qualifying event, must provide proof of the event at the time of enrollment (e.g., marriage certificate, birth certificate, etc.). If the Enrollment/Change form is submitted without the required documentation, there may be a delay in the start of the coverage until acceptable documentation is received. Employees who are adding a domestic partner must also complete the Domestic Partner Application.

Start of Coverage Following Special Enrollment

Newborn Children of an Enrolled Employee

A newborn child or an enrolled Employee is covered from birth to 60 days of age without any enrollment action required. However, the employee must enroll the child within 60 days of birth to obtain coverage beyond 60 days.

Newborn Children of a Covered Child

A newborn child of a Covered Child is covered for 31 days but is not an Eligible Dependent.

Adopted Children

Adopted or placed children are covered for 60 days from date of birth, placement or adoption, but this coverage is not automatic. The Employee must process their Enrollment with the Employee Benefits Division within 60 days of birth, placement or adoption, for coverage to be effective as of the date of birth, placement or adoption, respectively.

Other Enrollees

Except for the coverage of a newborn or an adopted child, coverage for Employees and coverage of other Eligible Dependents will become effective on the date assigned when the Enrollment is processed by the Employee Benefits Division and must be within 60 days from the date the event which qualified the Employee or the Eligible Dependents for coverage. However, if Eligible Dependents and/or Employee are covered due to the acquisition of a dependent child, coverage will be effective on the date of birth, adoption, or placement for adoption. If an Employee or Eligible Dependent becomes eligible for Special Enrollment due to the loss of coverage from another plan, coverage from this Plan will not begin until coverage from the other plan has terminated.

Failure to Enroll During Special Enrollment

If an Employee fails to enroll they/them and/or any Eligible Dependents, including newborn children, within 60 days after the date on which they first became eligible for Special Enrollment, the Employee will not be able to enroll they/them or any Eligible Dependents until the next Annual Open Enrollment period.

When an Employee and Any Eligible Dependents are Eligible Employees

If an Employee and a Spouse or Partner are Eligible Employees, both may enroll as individuals or one may enroll the other as a dependent. If each Eligible Employee enrolls as an individual, all children for whom coverage is elected must be enrolled by one Eligible Employee. If enrolled separately, out-of-pocket maximum limits will be determined independently for each Covered Employee.

No individual may be covered under the Plan both as an employee and as a dependent, nor may any Eligible Dependent be enrolled by more than one employee.

If, while family coverage is in effect, any Covered Child becomes an Eligible Employee, the Covered Child shall cease to be covered as a dependent as of the date the child is eligible to be covered as an Employee.

Qualified Medical Child Support Orders (QMCSOs)

According to Federal Law, a Qualified Medical Child Support Order, or QMSCO, is a child support order of a court or state administrative agency (usually resulting from a divorce or legal separation) that has been received by the Plan, and that:

- Designates one parent to pay for a child's health plan coverage;
- Indicates the name and last known address of the parent required to pay for the coverage, and, the name and address of each child covered by the QMCSO:

- Contains the reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined;
- States the period for which the QMCSO applies; and
- Identifies each health care plan to which the QMCSO applies.

An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any option that the Plan does not provide, or if it requires an Employee who is not covered by the Plan to provide coverage for a dependent child, except as require by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will the force and effect of law, and the order must be issued through and administrative process established by state law.

If a court or state administrative agency has issued an order with respect to health care coverage for an Eligible Dependent of an Employee, the Plan Administrator will determine if that order is a QMCSO as defined by federal law, and that determination will be binding on the Employee, the other parent, the child, and any other party acting on behalf of the child. If an order is determined to be a QMCSO, and if the Employee is covered by the Plan, the Plan Administrator will notify the parents and each child to be covered, and advise them of the procedures that must be followed to provide coverage.

If the Employee is a participant in the Plan, the QMCSO may require the Plan to provide coverage for the Employee's Eligible Dependents, who are children, and to accept contributions for that coverage from a parent who is not a Plan participant. The Plan will accept a Special Enrollment of the Dependent Child(ren) specified by the QMCSO from either the Employee or the custodial parent. Coverage of the child(ren) shall become effective as of the date the Enrollment/Change Application is received by the Plan, and shall be subject to all terms and provisions of the Plan, including the limits on selection of provider and requirements for authorization of services, insofar as is permitted by applicable law.

If an Employee is not a participant of the Plan at the time the QMCSO is received and the QMCSO orders the Employee to provide coverage for the Eligible Dependent child(ren) of the Employee, the Plan will accept a Special Enrollment of the Employee and the child(ren) specified by the QMCSO. Coverage of the Employee and the child(ren) shall become effective as of the date the Enrollment/Change Application is receive by the Plan, and shall be subject to all terms and provisions of the Plan.

No coverage will be provided for any child(ren) under a QMCSO unless the applicable Employee contributions for that child's coverage are paid, and all of the Plan's requirements for coverage of that child have been satisfied. Contributions required for coverage under a QMCSO are the total employer contributions required for coverage of the Employee and all members of the Employee's family who are enrolled in the Plan, minus the contributions being paid by the Employees.

Coverage a Dependent Child under a QMCSO will terminate when coverage of the Employee-parent terminates for any reason, including failure to pay any required contributions, subject to the dependent child's right to elect COBRA Continuation Coverage if that right applies.

Changing Coverage during the Year

A Covered Employee may not add dependents during the Plan Year (January 1 through December 31) unless a qualifying change in status occurs.

The following qualifying changes are the only ones permitted under the Plan:

- Change in legal marital status, including marriage, divorce, legal separation, annulment, or death of a Spouse
- Change in Domestic Partner status, including termination of a partnership or death of the Partner;
- Change in the number of Eligible Dependents, including birth, adoption, placement for adoption, or death of a Covered Dependent;
- The start or termination of employment by an Eligible Dependent or Covered Dependent, or an increase or decrease in hours of employment by an Employee, and any Covered or Eligible Dependent, including a switch between part-time and full-time employment, which affects their eligibility for coverage by this Plan or another health plan;
- Change in Eligible Dependent status under the terms of this Plan, including changes due to attainment of age or any other reason provided under the definition of Eligible Dependent in the Definitions section of this Plan Document;
- Change required under the terms of a Qualified Medical Child Support Order (QMCSO), including a change in an Employee's election to provide coverage for the child specified in the order, or to cancel coverage for the child if the order requires the Employee's former Spouse or Partner to provide coverage;

- Change consistent with an Employee's right to Special Enrollment when the Employee and/or their Eligible Dependents lose other coverage and the Employee previously declined coverage under this Plan for they/them and/or any of the Employee's Eligible Dependents;
- An Employee or a covered Eligible Dependent becomes entitled to coverage under Medicaid or Medicare.;
- Other qualifying changes as defined by federal law (e.g., eligible dependent who has just entered the country, an employee who has moved out of the coverage area for their non-State of Vermont plan, etc.).

Two rules apply to making changes to benefit coverage during the year:

- An Employee may only change plan options if an Employee has a network plan and the Employee moves to an area that does not have a network.
- To add a dependent and/or select a different coverage level, a properly completed Enrollment/Change Application must be received by the Employee Benefits Division within 60 days of the qualifying event. Otherwise, an Employee must wait until the next Open Enrollment period to make changes in coverage.

When Coverage Ends

Events Causing Coverage to End

Coverage ends:

- On the last day of the bi-weekly pay period in which employment ends;
- When an Employee is no longer eligible to participate in the Plan; or
- When an Employee ceases to make contributions require under the Plan for coverage either through regular biweekly payroll deduction, or via the timely direct payment of the premium amount due while off payroll.

If the Employee ceases to make contributions required under the Plan, coverage will be terminated:

- at the end of the pay period in which the written request for termination is received by the Employee Benefits Division, if the Employee is in active service of the State, or
- in cases where a direct payment owed has not been received 31 days after the due date, but no earlier than 14 days from the date the Employee Benefits Division has mailed a notice of the termination to the last address of the Employee provided by the Payroll Division. If a payment for the full contribution is received by the 31st day following the due date or within 14 days of the notice sent by the Employee Benefits Division, whichever is later, coverage will not be terminated.

If eligibility for continued participation in the Plan ceases because the number of hours a permanent Employee is expected to work in the calendar year is less than 1040 hours, the Employee will be given reasonable notice regarding termination of coverage and the opportunity to have a hearing before the Commissioner of Human Resources.

Coverage of Covered Dependent(s) ends:

- on the last day of the biweekly pay period in which the Employee's employment ends;
- on the date identified by the Employee in a written request for the removal of the Covered Dependent;
- when a Covered Dependent(s) no longer meets the definition of Eligible Dependent; or
- when the Employee ceases to make any contributions require for the Covered Dependent's coverage.

Special Circumstances

Parental and Family Leave

Employees who are granted leave under this policy and are enrolled in the group medical benefit plan may continue their coverage under the same conditions as if they had been continuously employed during the leave. If employees are enrolled in the medical benefit plan, the State will continue to pay 80% of the cost of the premiums. However, in the case of an unpaid family leave, employees are required to pay their 20% share of the premium directly to the Payroll Division each pay period.

Leave for Military Service

If an Employee goes into active military service, coverage will continue in accordance with the negotiated health care provision of the collective bargaining agreements then in force, or state policy then in effect.

Leave to Serve in the General Assembly

Employees on an unpaid leave of absence for service in the General Assembly may remain in the Plan for an approved period of leave if they continue to pay their

contribution each payday. Failure to pay their contribution will result in cessation of coverage at the end of the last pay period for which a contribution was made.

Reduction in Force (RIF)

Employees in a RIF status who retain reemployment rights under the Reemployment Rights Article of the negotiated union agreement may continue coverage for up to two years from the effective date of separation. Contributions toward premiums will be as outlined in the Payment for Coverage section of this Plan Document.

Approved Leave of Absence Other than Parental/Family or Military Leave

If an Employee is on an approved, unpaid leave of absence, other than Parental, Family, or Military Leave, including a leave of absence for medical reasons that exceeds 12 weeks, or if an Employee is a permanent part-time employee in an inactive status, they may remain in the Plan for the approved period of leave or inactive status as long as they continue to pay their contribution each payday.

Extension and Continuation of Medical Coverage

Under certain circumstances, the Employee may be able to continue medical coverage at their own expense for a limited period of time after an event, which may otherwise terminate coverage.

What is COBRA continuation coverage?

In 1985, Congress passed the Consolidated Omnibus Budget Reconciliation Act, commonly called COBRA. This law generally requires that most employees with group health plans offer employees and their covered dependents the opportunity to temporarily continue their health care coverage at a rate no more than 102% of group rates when coverage under the plan would otherwise end. This plan is in compliance with Federal law regarding COBRA. A summary of the features of this law is provided below. If this document conflicts with Federal law regarding COBRA, Federal law applies.

Members can continue coverage for a time if coverage ends from one of several reasons. COBRA does not apply to Partners or children of Partners unless they are considered legal dependents under the governing rules and regulations of the Internal Revenue Services.

Qualifying Events and Maximum Periods of Continuation of Coverage

Qualifying events and maximum periods of continuation of coverage are specified by federal law. In general, Employees who terminate for reasons other than gross misconduct are entitled to coverage for themselves and their Covered Dependents via COBRA for 18 months, dependents of deceased employees are entitled to coverage for 36 months, divorced spouses are entitled to coverage for 36 months and a Covered Child who ceases to maintain Eligible Dependent status (e.g., turns 26 years of age) is entitled to coverage for 36 months. Other qualifying events exist and the periods of continuation vary by event. Detailed information is available from the Plan Administrator.

When the Plan Must be Notified of a Qualifying Event

In order for a Covered Dependent to be entitled to continue coverage, the dependent must notify the Plan of:

1) The death of the employee;

2) The divorce or legal separation from the employee; or

Loss of Eligible Dependent Status

Upon reaching the age of 26, a child will lose Eligible Dependent status and the last day of coverage will be the birth date itself. The Plan Administrator will automatically remove the Dependent from coverage and generate a Notice of Entitlement to COBRA Continuation Coverage.

Notice of Entitlement to COBRA Continuation Coverage

When:

1) employment terminates or hours are reduced so that an Employee is no longer entitled to coverage under the Plan, or

2) the Plan is notified on a timely basis that an Employee died, divorced, became legally separated or became entitled to Medicare, or

3) an Eligible Dependent child lost Covered Dependent status,

the Employee or Covered Dependent(s) will be notified of the right to continue their healthcare coverage. They will then have 60 days to apply for COBRA continuation coverage. If the Employee or the Covered Dependents do not apply within that time, their healthcare coverage will end as of the date of the qualifying event.

Coverage Provided When COBRA Continuation Coverage is Elected

If a Member chooses COBRA Continuation Coverage, the Plan is required to provide coverage that is identical to the current coverage under the Plan that is provided for similarly situated Employees or Eligible Dependents.

If, during the period of COBRA Continuation Coverage, a covered person marries, has a newborn child, or has a child placed with them for adoption; that Spouse or

Dependent Child may be enrolled for coverage for the balance of the period of COBRA Continuation Coverage on the same terms available to active Employees. Enrollment must occur no later than 30 days after the marriage, birth or placement for adoption. A child born or placed for adoption while on COBRA Continuation Coverage (but not a Spouse the former Employee marries while on COBRA Continuation Coverage) will have all the same COBRA rights as Eligible Dependents who were covered by the Plan before the event that resulted in loss of coverage. Adding an Eligible Dependent may cause an increase in the amount paid for COBRA Continuation Coverage.

If, during the period of COBRA Continuation Coverage, the Plan's benefits change for active employees, the same changes will apply to COBRA beneficiaries.

Changes to Maximum Period of COBRA Continuation Coverage

Multiple Qualifying Events

If continuation coverage is for a maximum period of 18 months, and during that period, another qualifying event takes place that would otherwise entitle a Covered Dependent to a 36-month period of continuation coverage, the 18-month period will be extended for that individual. The total period of coverage for any Covered Dependent will never exceed 36 months from the date of the first qualifying event. For example, if an Employee terminated employment and elected COBRA continuation coverage for 18 months for him/herself and their Covered Dependent(s), and died during that 18-month period, the continuation coverage for the Covered Dependent(s) could be extended for the balance of 36 months from the date employment terminated.

However, if an Employee becomes entitled to COBRA continuation coverage because of termination of employment or reduction in hours worked that occurred less than 18 months after the date they became entitled to Medicare, their Covered Dependent(s) would be entitled to a 36-month period of COBRA continuation coverage beginning on the date the Employee became entitled to Medicare. For example, if termination of employment occurred less than 18 months after the date an Employee became entitled to Medicare, Covered Dependent(s) would be entitled to COBRA continuation coverage for a 36-month period beginning on the date the Employee became entitled to Medicare.

Entitlement to Social Security Disability Income Benefits

If a Member is entitled to COBRA continuation coverage for an 18-month period, that period can be extended for the individual on COBRA who is determined to be entitled to Social Security disability income benefits, and for any other covered family members, for up to 11 additional months if all of the following conditions are satisfied:

- the disability occurred or before the start of COBRA Continuation Coverage, or within the first 60 days of COBRA Continuation Coverage; and
- the disabled covered individual receives a determination of entitlement to Social Security disability income benefits from the Social Security Administration; and
- the Plan is notified of the determination (a) no later than 60 days after it was received from Social Security and (b) before the 18-month COBRA continuation period ends.

This extended period of COBRA Continuation Coverage will end at the earlier of the end of 29 months from the date of the qualifying event of the date the disabled individual becomes entitle to Medicare.

Cost for COBRA Continuation Coverage

Members pay 102% of the full cost of the coverage during the COBRA continuation period. The amount is payable monthly. There will be an initial grace period of 45 days to pay the first amount due starting with the date continuation coverage was elected. There will then be a grace period of 31 days to pay any subsequent amount due. If payment of the amount due is not received by the end of the applicable grace period, the COBRA continuation coverage will terminate as specified in Section VI.

Termination of COBRA Continuation Coverage

COBRA Continuation Coverage may be terminated if:

- the State of Vermont no longer provides any medical coverage to any of its similarly situated employees;
- the applicable premium for COBRA Continuation Coverage is not paid on time or within the grace period as specified in Section VI;
- the Covered Individual is or becomes entitled to Medicare; or
- the Covered Individual is or becomes covered under another group health plan that does not contain and exclusion or limitation that applies to any pre-existing condition of the Covered Individual.

Other Information about COBRA Continuation Coverage

If the coverage provided by the Plan is changed in any respect for active Plan participants, those changes will apply at the same time and in the same manner for everyone whose coverage is continued as required by COBRA. If any of those changes

result in either an increase or decrease in the cost of coverage, that increase or decrease will apply to all individuals whose coverage is continued as required by COBRA as of the effective date of those changes.

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

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 Blue Cross website's Member Resource Center at **www.bluecrossvt.org**.

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 Blue Cross 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 Blue Cross's Notice of Privacy Practices at **www.bluecrossvt.org/privacy-policy**. 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 Blue Cross, please contact Blue Cross 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 Blue Cross'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. Blue Cross takes measures to ensure your right to privacy.

Receive information from us. Blue Cross 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 Blue Cross 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. Blue Cross 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 Blue Cross'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 Blue Cross 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 Blue Cross 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.

Adult Dependent Due to Disability: a Dependent who meets Blue Cross'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.

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.

Child: a Participant's son, daughter or stepchild through marriage, Domestic Partnership[3] 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 Adult Dependent Due to Disability.

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.

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

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

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

Deductible: the amount you must pay toward the cost of specific services each Plan Year before 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 (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 Adult Dependent Due to Disability 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 .

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.

Emergency Medical Services includes those services needed to stabilize the patient, as well as post-stabilization services furnished as part of an out-patient observation, or an in-patient or out-patient stay with respect to the visit in which the other emergency services are furnished. Emergency Medical Services also includes instances where a person without specialized medical knowledge would think that immediate medical attention is needed.

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 Blue Cross's behalf and is not a Blue Cross employee or agent. Blue Cross 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.

Inpatient: care at a Facility for a patient who is admitted and incurs a room and board charge. Blue Cross 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 Foods: an amino acid modified preparation that is intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease.

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."

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.

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

In most cases, the professionals in Blue Cross'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 (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: this plan of benefits administered by Blue Cross, adopted by your employer.

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 Blue Cross 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 Blue Cross before you receive specific services noted in this document. In most cases, Blue Cross requires that you get Prior Approval in writing. Blue Cross may request a treatment plan or a letter of medical need from your Provider. If you do not get approval from Blue Cross 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
- pharmacists
- 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 Blue Cross;
- 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 Blue Cross Network Providers. When you receive care outside of Vermont, "Network Provider" means any Provider that has a Preferred Provider agreement with the local Blue Cross and Blue Shield Plan.

You may find a Blue Cross Network Provider on Blue Cross's website at **www.bluecrossvt.org/find-doctor**. Select *BCBSVT Network.* 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. To find a BlueCard Network Provider visit **provider.bcbs.com**. You may also Providers from the drop-down menu. You may also get a directory of Network Providers from your Group Benefits Manager or from Blue Cross's customer service team. Some Providers must be in Network in order for their services to be Covered. For some types of service, 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. For some types of service, your Plan does not provide benefits if you use an Out-of-Network Provider. They are listed in Chapter One.

Other Provider: one of the following entities:

- Ambulance
- 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.

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.

Index

A

Activities of Daily Living
- Definitions 50

Acupuncture 10

Acute (Care)
- Definitions 50

Adult Dependent Due to Disability
- Definitions 50

Allowed Amount 8
- Definitions 50

Ambulance 10
- Definitions 50
- Prior Approval 1

Autism Spectrum Disorder 11
- Definitions 50

B

Better Beginnings® Maternity Wellness Program 18

Biofeedback
- General Exclusions 24

BlueCard Program 5
- BlueCard Service Area 50

C

Child
- Definitions 50

Chiropractic Care 11

Chiropractor
- Definitions 50

Choosing a Provider 3, 4

Christian Science Services 12

Claims 27
- Claim Submission 27
- When You Have a Complaint 27

Clinical Trials 11

Co-insurance 8
- Definitions 50

Communication devices
- General Exclusions 24

Complaints 30

Contraceptive Services 12

Cooperation 31

Coordination of Benefits 30
- for Children of Divorced Parents 30

Co-payment 8
- Definitions 50

Cosmetic 12
- Definitions 50
- General Exclusions 25
- Prior Approval 2

Custodial Care
- Definitions 51
- General Exclusions 25

D

Deductible 8
- Aggregate Deductible 8
- Definitions 51
- Stacked Deductible 8

Dental Services 12
- General Exclusions 25
- Prior Approval 2

Dependent
- Definitions 51

Diabetes Services 13

Diagnostic Services 13
- Definitions 51

Domestic Partners
- Definition 51

Domiciliary Care
- Definitions 51

Dry Needling 13

Durable Medical Equipment 15
- Definitions 51

Durable Medical Equipment (DME)
- Prior Approval 2

E

Educational evaluation
- General Exclusions 25

Electrical stimulation devices
- General Exclusions 24
- Prior Approval 2

Emergency Care 7, 13

Emergency Medical Condition
- Definitions 52

Experimental or Investigational Services
- Definitions 52
- Prior Approval 2

F

Facility (Facilities)
- Definitions 52

Foot care
- General Exclusions 25

G

General Exclusions 24

Group
- Definitions 52

Group Benefits Manager
- Definitions 52

H

Hearing Aids 14
- General Exclusions 25

Home Care 14

Hospice Care 14
- Definitions 53

Hospital Care 14
- Inpatient Hospital Services 14
- Inpatient Medical Services 15
- Outpatient Hospital Care 18

I

Immediate Family Member
- Definitions 53

In an Accident 30

Infertility Services 15
- General Exclusions 25

Inpatient
- Definitions 53
- Hospital Services 14
- Medical Services 15

Intensive Outpatient Programs
- Definitions 53

M

Massage Therapy 15

Medical Care
- Definitions 53

Medical Equipment and Supplies 15
- Orthotics 16
- Prior Approval 2
- Prosthetics 16
- Supplies 16

Medical Foods
- Definitions 53

Medically Necessary Care
- Definitions 53

Medical or Scientific Evidence
- Definitions 53

Member Rights and Responsibilities 48

Membership 32

Mental Health Care 17

N

Network Providers 3

Non-Medical Charges
- General Exclusions 25

Non-prescription treatment of obesity
- General Exclusions 26

Notice of Privacy Practices 43

Nutritional Counseling 17
- General Exclusions 25

Nutritional formulae
- General Exclusions 25

O

Occupational Therapy 21
  Definitions 53
Office Visits 10
Orthodontics
  General Exclusions 25
Other Party Liability 30
  Coordination of Benefits 30
    For Children of Divorced Parents 30
    In an Accident 30
    Medicaid and Tricare 30
    Reimbursement 30
  Subrogation 31
Out-of-Area Providers 5
Out-of-Pocket Limit 8
  Aggregate Out-of-Pocket Limit 9
  Definitions 54
  Stacked Out-of-Pocket Limit 9
Outpatient
  Definitions 54
  Hospital Care 18
  Medical Services 18

P

Palliative
  Definitions 54
Participating Providers
  Definitions 55
Payment in Error/Overpayments 27
Payment Terms 8
  Co-insurance 8
  Co-payment 8
  Deductible 8
  Out-of-Pocket Limit 8
Physical Rehabilitation Facility
  Definitions 54
Physical Therapy 21
  Definitions 54
Plan Year
  Benefit Maximums 9
  Definitions 54
Pregnancy Care 18
  Better Beginnings Maternity Wellness Program 18
Prescription Drugs
  Definitions 54
Preventive Services 10
  Definitions 54
Primary Care Providers 3
  Definitions 54
Prior Approval Program 1
  Definitions 54
  Prior Approval List 1
  Request Prior Approval 1
Professional
  Definitions 54
Psychiatric Hospital
  Definition 55

R

Reconstructive 12
  Definitions 55
  Prior Approval 2
Rehabilitation/Habilitation 19
  Definitions 52
  Prior Approval 2
Reimbursement 30
Residential Treatment Center
  Definitions 55
Residential Treatment Program
  Definitions 55
Respite Care
  Definitions 55
Rest Cure
  Definitions 55

S

Second and Third Opinions 19
Self-Pay Allowed by HIPAA 9
Services covered by a prior health plan
  General Exclusions 24
Skilled Nursing Facility 19
  Definitions 56
Speech Therapy 21
  Definitions 56
Standard Benefits 4
Sterilization reversal
  General Exclusions 26
Subrogation 31
Substance Use Disorder Treatment Services 19
Support Therapies
  General Exclusions 26
Surgery 20
  Definitions 56
  Prior Approval 2

T

Telemedicine
  Definitions 56
  Program 20
  Services 20
Therapy Services 20
Third Party Premium Payments 9
Transplant Services 22
  Prior Approval 2

U

Urgent Services
  Definitions 56

V

Vision Services 23

W

When You Have a Complaint 27
Work-related Illnesses
  General Exclusions 26

Health plans are administered by:

P.O. Box 186
Montpelier, VT 05601-0186
www.bluecrossvt.org

recycled paper