BlueCross BlueShield of Vermont

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

2022 Health Care Benefits

BCBSVT Platinum, Gold, Silver and Bronze Plans

Certificate of Coverage

NOTICE: Discrimination is against the law

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

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

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

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

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

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

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

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

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

ARABIC

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

CHINESE

如需免費語言協助服務，請致電(800) 247-2583。

CUSHITE (OROMO)

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

FRENCH

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

GERMAN

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

ITALIAN

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

JAPANESE

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

NEPALI

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

PORTUGUESE

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

RUSSIAN

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

SERBO-CROATIAN (SERBIAN)

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

SPANISH

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

TAGALOG

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

THAI

สำหรับการให้บริการความช่วยเหลือด้านภาษาฟรี โทร (800) 247-2583

VIETNAMESE

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

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This is the Contract for your Health Plan.

Your Contract governs your benefits. Your Contract is the entire agreement between you and us.
These are the documents in your Contract:

- The *Certificate of Coverage* is this booklet, which describes your benefits in detail. It explains requirements, limitations and exclusions for coverage.
- The *Outline of Coverage*, which shows what you must pay Providers and tells you where to find a list of services that require Prior Approval.
- Any riders or endorsements which describe additional coverage or changes to your Contract.
- Your Identification (ID) card, which you should take with you when you need care. We will mail your ID card to you after you are enrolled.
- Your *Group Enrollment Form* or your application and any supplemental applications that you submitted and we approved.

This Contract is current until we update it. We sometimes replace just one part of your Contract. We may only change this Contract in writing and with the approval of the Vermont Department of Financial Regulation (DFR). If you are missing part of your Contract, please call customer service to request another copy.

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

How to Use This Document

- Read Chapter One, Guidelines for Coverage. Information there applies to all services. Pay special attention to the section on our Prior Approval Program.
- Find the service you need in Chapter Two, Covered Services. You may use the Index or Table of Contents to find it. Read the section thoroughly.
- Check 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 your entire Contract.
- To find out what you must pay for care, check your *Outline of Coverage* or your *Summary of Benefits and Coverage*.
- Some terms in your Certificate have special meanings. We capitalize these terms in the text. We define them in Chapter Nine of this Certificate. We define the terms "We," "Us," "You" and "Your," but we do not capitalize them in the text.
- If you need materials translated into a different language or would like to access an interpreter via the telephone, please call the customer service number on the back of your ID card.
- If you need translation services such as telecommunications devices for the deaf (TDD) or telephone typewriter teletypewriter (TTY), please call (800) 535-2227.

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

We sell Health Plans to individuals who live in Vermont. We sell plans to employer Groups located in the State of Vermont. Our plans are issued, renewed and delivered in Vermont without respect to where any covered Dependent or employee resides. You have an Exclusive Provider Organization (EPO) PCP plan. We contract with a network of doctors, hospitals and other health care Facilities and Professionals. These Providers, called Network Providers, agree to special pricing arrangements. This plan generally does not provide benefits for any services you receive from an Out-of-Network Provider. Please read Chapter One, Guidelines for Coverage carefully to find out when you may receive care outside the network.

Charles P. Smith

Chair of the Board

Don C. George

President & CEO

Rebecca C. Heintz

General Counsel & Secretary

CHAPTER ONE

Guidelines for Coverage

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

Chapter One explains what you must do to get benefits through your Health Plan. Read this entire chapter carefully, as it is your responsibility to follow its guidelines. Your *Outline of Coverage* and *Summary of Benefits and Coverage* documents show what you must pay (your Cost-Sharing).

General Guidelines

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

- Capitalized words have special meanings. We define them in Chapter Nine. Read the Definitions to understand your coverage.
- We only pay benefits for services we define as Covered by this Contract.
- You must use Network Providers (see Chapter Nine, Definitions) or get Prior Approval (see below). We do not require Prior Approval for Emergency Medical Services.
- The provisions of this Contract only apply as provided by law.
- We exclude certain services from coverage under this Contract. You'll find General Exclusions in Chapter Three. They apply to all services. Exclusions that apply to specific services appear in applicable sections of your Contract.
- We do not cover services we do not consider Medically Necessary. You may appeal our decisions.
- This is not a long-term care Policy as defined by Vermont State law at 8 V.S.A. §8082 (5).
- You must follow the guidelines in this Certificate even if this coverage is secondary to other health care coverage for you or one of your Dependents.

Prior Approval Program

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

In most circumstances, BCBSVT only approves services from Out-of-Network Providers if appropriate services are not available within the Network. You may request Prior Approval to see an Out-of-Network Provider if there is not a Network Provider with appropriate training and experience to provide the Medically Necessary services needed to meet your particular health care needs. In this case, if you get Prior Approval, Cost-Sharing will be the same as if the service was obtained by a Network Provider. You will not be required to pay any difference between the Provider's charge and what we pay. If an Out-of-Network Provider bills you for the difference, please notify us by calling our customer service team at (800) 310-5249.

We also require Prior Approval for certain services and drugs even when you use Network Providers. They appear on the list later in this section. We do not require Prior Approval for Emergency Medical Services.

BCBSVT Network Providers should get Prior Approval for you. If you use an Out-of-Network Provider, it is your responsibility to get Prior Approval. If you use an out-of-state Network Provider (BlueCard Provider), it is your responsibility to get Prior Approval for services that require Prior Approval under your Contract. Failure to get Prior Approval could lead to a denial of benefits. If you use a BCBSVT Network Provider and the Provider fails to get Prior Approval for services that require it, the Provider may not bill you.

Our Prior Approval list can change. To get the most up-to-date list, visit our website at **www.bcbsvt.com/priorapproval** or call our customer service team at (800) 310-5249.

How to Request Prior Approval

To get Prior Approval, you or your Network Provider must provide supporting clinical documentation to BCBSVT. When receiving care from an Out-of-Network Provider, it is your responsibility to get Prior Approval. Forms are available on our website at **www.bcbsvt.com/priorapproval**. You may also get them by calling our customer service team at (800) 310-5249.

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

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

Prior Approval List

You need Prior Approval for services outside of our Network. You also need Prior Approval for services printed on our Prior Approval list, even if you use a Network Provider. This list includes, but is not limited to:

- adoptive immunotherapy including CAR-T and gene therapy drugs;
- Ambulance (non-emergency transport including air or water transport);
- ambulatory event monitoring (Zio®Patch);
- anesthesia (monitored);
- Applied Behavior Analysis (ABA);
- artificial pancreas device system;
- Autism Spectrum Disorder related Occupational, Speech, and Physical Therapy/ medicine after 30 combined visits;
- autologous chondrocyte transplants;
- blood and blood components;
- breast pump, hospital grade;
- capsule endoscopy (wireless);
- chiropractic care (after 12 visits in a Plan Year);
- cochlear implants and Implantable Bone Conduction Hearing Aids;
- cognitive testing;
- continuous passive motion (CPM) equipment;
- Cosmetic and Reconstructive procedures except breast reconstruction for patients with a diagnosis of breast cancer;
- dental services, please see page 16 for details;
- Durable Medical Equipment (DME) and supplies with a purchase price of $500 or more;
- electrical and ultrasound stimulation, including Transcutaneous Electrical Nerve Stimulation (TENS) and Neuromuscular Electrical Stimulation (NMES);
- enteral and parenteral formulae, supplies and pumps;
- genetic testing;
- hospital beds;
- hyperbaric oxygen therapy;
- Investigational or Experimental Services or procedures;
- medical nutrition for inherited metabolic disease;
- neurodevelopmental screening (pediatric);
- neuropsychological testing;
- 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 the particular health care needs of a Member;
- nutritional counseling after three initial visits if you have a diagnosis for metabolic disease or an eating disorder (Prior Approval does not apply if you have diabetes);
- orthodontia for pediatric Members up to age 21;
- orthognathic Surgery;
- orthotics and prosthetics with a purchase price of $500 or more;
- out-of-state Inpatient care and partial hospitalization care;
- percutaneous radiofrequency ablation of liver;
- polysomnography (sleep studies) and multiple sleep latency testing (MSLT);
- positive airway pressure devices (APAP, CPAP, BiPAP);
- certain Prescription Drugs and Biologics (please see **www.bcbsvt.com/pharmacy**);
- psychological testing;
- radiation treatment and high-dose electronic brachytherapy;
- radiology services (certain services including CT, CTA, MRI, MRA, MRS, PET, echocardiogram and nuclear cardiology);
- Rehabilitation (Skilled Nursing Facility, Inpatient Rehabilitation treatment for medical conditions, intensive Outpatient services or Residential Treatment Programs for mental health and substance use disorder conditions);
- certain surgical procedures and related services (examples include disc arthroplasty, lumbar spinal fusion, Sacroiliac joint pain treatment, Temporomandibular joint manipulation (TMJ) , and varicose veins);
- transcranial magnetic stimulation;
- transgender services;
- transplants (except corneal and kidney);
- wearable cardioverter defibrillators;
- wheelchairs.

Case Management Program

Case Management provides Members who have complex health care needs with Professional services to assess, coordinate, evaluate, support and monitor the Member's treatment plan and health care needs. Professional services may include a registered nurse,

licensed social worker, or other licensed health care Professional practicing within the scope of their license and/or certified as a case manager.

If we approve benefits for care provided by Out-of-Network Providers and/or treatment Facilities for Inpatient and Outpatient care, we may require you to participate in Case Management prior to receiving ongoing care and services. This plan generally does not cover services provided by Out-of-Network Providers. To find out more information about the program, call (800) 922-8778.

Choosing a Provider

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

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

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

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

For pediatric dental, pharmacy and vision services, please use the separate Network directories.

You may also call customer service at (800) 310-5249. BCBSVT will send you a paper Provider Directory without charge. Both electronic and paper directories give you information on Provider qualifications, such as training and board certification.You may change Providers whenever you wish. Follow the guidelines in this section when changing Providers.

Network Providers

Network Providers will:

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

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

We have separate Provider directories for the following types of Providers:

- dentists (for pediatric dental services);
- pharmacies; and
- routine vision care Providers (for pediatric vision services).

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

Primary Care Providers

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

Your coverage does not require you to get referrals from your PCP. However, you must get Prior Approval for certain services (see page 7). For instance, if appropriate services are not available with a Network Provider, you must get Prior Approval.

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

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

Out-of-Network Providers

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

If you get Prior Approval to use an Out-of-Network Provider for reasons other than when there is not a Network Provider who can provide the Medically Necessary services, we pay the Allowed Amount and you 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.

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

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

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

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

Out-of-Network Providers at Network Facilities

If you receive Medically Necessary, Covered Services from an Out-of-Network Provider at a Network facility without your informed consent, we will cover your care as if you had been treated by a Network Provider. You must pay any Cost-Sharing amounts required under your Contract, which will in no event be more than as if you received those services from a Network Provider. These may include Deductibles, Co-insurance or Co-payments. Under federal law, unless you give your informed consent, providers are prohibited from billing you for these services beyond your Cost-Sharing amounts. If the Out-of-Network Provider requests any payment from you other than your Cost-Sharing amounts, please contact us at (800) 310-5249 so that we can work directly with the Provider to resolve the request.

Out-of-Area Providers

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

BlueCard® Program

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

Typically, when accessing care outside of the service area, you will obtain care from health care Providers that have a contractual agreement with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). These Providers are called "BlueCard Providers." You do not need Prior Approval to see an out-of-state BlueCard Provider, unless the service requires Prior Approval under your Contract.

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

1 In order to receive Network Provider benefits as defined for ancillary services, ancillary Providers such as independent clinical laboratories, Durable Medical Equipment Suppliers and specialty pharmacies must contract directly with the Blue Plan in the state where the services were ordered or delivered. To verify Provider participation status, please call our customer service team at (800) 310-5249.

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

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

Special Case: Value-Based Programs

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

Out-of-Area Services with Non-Contracting Providers

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

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

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

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

Blue Cross Blue Shield Global® Core Program

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

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

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

Inpatient Services

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

Outpatient Services

Physicians, urgent care centers and other Outpatient Providers located outside the BlueCard Service Area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered services.

Submitting a Blue Cross Blue Shield Global® Core Claim

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

How We Choose Providers

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

Please understand that our Network Providers are not employees of BCBSVT; they just contract with us.

Access to Care

We require our Network Providers in the State of Vermont to provide care for you:

- immediately when you have an Emergency Medical Condition;
- within 24 hours when you need Urgent Services;
- within two weeks when you need non-emergency, non-Urgent Services;
- within 90 days when you need Preventive 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.

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

After-hours and Emergency Care

Emergency Medical Services

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

Emergencies might include:

- broken bones;
- heart attack;
- 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 us as soon as reasonably possible.

If you receive Medically Necessary, Covered Emergency Medical Services from an Out-of-Network Provider, we will cover your emergency care as if you had been treated by a Network Provider. You must pay any Cost-Sharing amounts required under your Contract as if you received those services from a Network Provider. These may include Deductibles, Co-insurance or Co-payments. If an Out-of-Network Provider requests any payment from you other than your Cost-Sharing amounts, please contact us at (800) 310-5249 so that we can work directly with the Provider to resolve the request.

Care After Office Hours

In most non-emergency cases, call your Provider's office when you need care—even after office hours. 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 and Blue Shield of Vermont also offers Telemedicine services that allow you to see a licensed Provider via computer, tablet or telephone anytime. See Telemedicine Services on page 26.

How We Determine Your Benefits

When we receive your claim, we determine:

- if this Contract covers the medical services you received; and
- your benefit amount.

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

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

Your Deductible, Co-insurance and Co-payment amounts appear on your *Outline of Coverage* and your *Summary of Benefits and Coverage*. We 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 we consider reasonable for a Covered service or supply.

Notes:

- Network Providers accept the Allowed Amount as full payment. You do not have to pay the difference between their total charges and the Allowed Amount.
- If you use an Out-of-Network Provider, we pay the Allowed Amount and you must pay any balance between the Provider's charge and what we pay.

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 we pay 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 we make payment on certain services. We apply your Deductible to your Out-of-Pocket Limit for each Plan Year. You may have more than one Deductible. Deductibles can apply to certain services or certain Provider types.

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

Aggregate Deductible

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

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

Stacked Deductible

Your plan may have a Stacked Deductible. If your plan has this Deductible, and you are on a two-person, parent and Child or family plan, a covered family member may meet the individual Deductible and begin receiving post-Deductible benefits. When your family's Covered expenses reach the family Deductible, all family members receive post-Deductible benefits.

Co-payment

You must pay Co-payments to Providers for specific services. You may have different Co-payments depending on the Provider you see. Your Provider may require payment at the time of the service. We apply Co-payments toward your Out-of-Pocket Limit for each Plan Year.

Co-insurance

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

Out-of-Pocket Limit

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

When your family meets the family Out-of-Pocket Limit, all family members are considered to have met their individual Out-of-Pocket Limits.

Aggregate Out-of-Pocket Limit

Your plan may have an Aggregate Out-of-Pocket Limit. If your plan has this limit and you are on a two-person, parent and Child or family plan, and you do not have an individual Out-of-Pocket Limit, your family members' Covered expenses must reach the

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

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

Stacked Out-of-Pocket Limit

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

Aggregate Prescription Drugs and Biologics Out-of-Pocket Limit

Your plan may have an Aggregate Prescription Drugs and Biologics Out-of-Pocket Limit. If your plan has this limit, and you are on a two-person, parent and Child or family plan, once any combination of covered family members meets the Prescription Drugs and Biologics Out-of-Pocket Limit, we begin to pay eligible Prescription Drugs and Biologics at 100 percent of the Allowed Amount.

Plan Year Benefit Maximums

Your Plan Year benefit maximums are listed on your Outline of Coverage or Summary of Benefits and Coverage. After we provide maximum benefits, you must pay all charges.

Self-Pay Allowed by HIPAA

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

Third Party Premium Payments

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

BCBSVT only accepts premium and Cost-Sharing payments made by Members or on behalf of Members 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-insurance and Deductibles.

Preventive Services

We provide benefits for Preventive Services. We encourage you to get Preventive Services that are appropriate for you. Examples of preventive care include colonoscopies for people age 50 and over 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.

We pay 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 our website at **www.bcbsvt.com/preventive**, or you can call our customer service team at (800) 310-5249 to get a list.

Note: the list includes many Preventive Services, but not all. Coverage for other preventive, diagnostic and treatment services may be subject to Cost-Sharing.

Please note that 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 *Summary of Benefits and Coverage*. Please read this entire section carefully. Some office visit benefits have special requirements or limits and may have additional Cost-Sharing. We cover Professional services such as these in an office setting:

- examination, diagnosis and treatment of an injury or illness;
- injections;
- Diagnostic Services, such as X-rays;
- nutritional counseling (see page 21);
- Surgery; and
- therapy services (see page 27).

Some office visits may fall under your Preventive Services benefit.

Exclusions

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

Notes:

- We describe office visits for mental health services, substance use disorder treatment services, and chiropractic services elsewhere in this chapter. Please see those sections for benefits.
- You must get Prior Approval for certain services in order to receive benefits. See page 6 for a description of the Prior Approval program. Visit our website at **www.bcbsvt.com/priorapproval** or call our customer service team at (800) 310-5249 for the newest list of services that require Prior Approval.

Ambulance

We cover Ambulance services as long as your condition meets our definition of an Emergency Medical Condition. Coverage for Emergency Medical Services outside of the service area is the same as coverage within the service area. If an Out-of-Network Provider bills you for the balance between the charges and what we pay, please notify us by calling our customer service team at (800) 310-5249.

We cover transportation of the sick and injured:

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

Limitations

- You must get Prior Approval for non-emergency transport including air or water transport.
- We cover transportation only to the closest Facility that can provide services appropriate for the treatment of your condition.

- We do not cover Ambulance services when the patient can be safely transported by any other means. This applies whether or not transportation is available by any other means.
- We do not cover Ambulance transportation when it is solely for the convenience of the Provider, family or member.

Autism Spectrum Disorder

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

You must get Prior Approval for some services or we will deny your claim.

Please remember General Exclusions in Chapter Three also apply.

Bariatric Surgery

We only cover bariatric Surgery at Blue Distinction Centers. Blue Distinction Centers are Facilities that have been assessed and identified to deliver the highest quality care. Blue Distinction Centers must maintain their high quality to maintain the Blue Distinction Center designation. To find a Blue Distinction Center appropriate for your Surgery, please visit **www.bcbs.com/blue-distinction-center/facility** or call customer service at (800) 310-5249.

Clinical Trials (Approved)

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

General Exclusions in Chapter Three apply.

Chiropractic Services

We cover services by our Network Chiropractors who are:

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

We cover Acute and Supportive chiropractic care (only for services that require constant attendance of a Chiropractor), including:

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

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

If you use more than 12 chiropractic visits in one Plan Year, you must get Prior Approval from us for any visits after the 12th or your claim will be denied. See page 19 for more information about the Prior Approval program.

Exclusions

We provide no chiropractic benefits for:

- treatment after the 12th visit if you don't get Prior Approval;
- services, including modalities, that do not require the constant attendance of a Chiropractor;
- treatment of any "visceral condition," that is a dysfunction of the abdominal or thoracic organs, or other condition that is not neuromusculoskeletal in nature;
- acupuncture;
- hot and cold packs;
- massage therapy;
- care provided but not documented with clear, legible notes indicating the patient's symptoms, physical findings, the Chiropractor's assessment, and treatment modalities used (billed);
- low-level laser therapy, which is considered Investigational;
- vertebral axial decompression (i.e. DRS System, DRX 9000, VAX-D Table, alpha spina system, lordex lumbar spine system, internal disc decompression [IDD]), which is considered Investigational;
- supplies or Durable Medical Equipment;
- treatment of a mental health condition;
- prescription or administration of drugs;
- obstetrical procedures including prenatal and post-natal care;
- Custodial Care (see Definitions), as noted in General Exclusions;
- supervised services or modalities that do not require the skill and expertise of a licensed Provider;
- Surgery;
- unattended services or modalities (application of a service or modality) that do not require one-on-one patient contact by the Provider; or
- any other procedure not listed as a Covered chiropractic service.

General Exclusions in Chapter Three also apply.

Cosmetic and Reconstructive Procedures

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

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

You must get Prior Approval for these services.

Dental Services

We cover certain dental services for adults and pediatrics as listed below. Please see your *Outline of Coverage* or your *Summary of Benefits and Coverage* to see how much you must pay for each level of service. You must get Prior Approval for these services. If you fail to obtain Prior Approval, your claim will be denied.

In the event of an emergency, you must contact us as soon as possible afterward for approval of continued treatment.

Adult Services

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

- treatment for, or in connection with, an accidental injury to jaws, sound natural teeth, mouth or face, provided a continuous course of dental treatment begins within six months of the accident[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, except as otherwise required by law);
- Surgery related to head and neck cancer where sound natural teeth may be affected primarily or as a result of the chemotherapy or radiation treatment of that cancer;
- treatment for a congenital or genetic disorder, such as but not limited to the absence of one or more teeth, up to the first molar, or abnormal enamel (example lateral peg); and
- Facility and anesthesia charges for Members with severe disabilities that preclude office-based dental care due to safety consideration (examples include, but are not limited to, severe autism, cerebral palsy, hemorrhagic disorders, and severe congestive heart failure).

Note: the Professional charges for the dental services may not be Covered.

Pediatric Services

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

- Class I services including examinations and cleanings every 180 days, X-rays and diagnosis;
- Class II (basic) services including simple restoration (fillings), crowns and jackets, repair of crowns, wisdom tooth removal, extractions and endodontics (root canal);
- Class III (major) services including dentures, bridges, replacement of bridges and dentures and Medically Necessary orthodontia;
- Facility and anesthesia charges for Members who are:
  - 7 years of age or younger; or
  - 12 years of age or younger with phobias or a mental illness documented by a licensed Physician or mental health Professional.

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

Exclusions

Unless expressly required by law, we do 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;

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

- pre- and post-operative dental care;
- orthodontics (including orthodontics performed as an adjunct to orthognathic Surgery or in connection with an accidental injury);
- procedures designed primarily to prepare the mouth for dentures (including alveolar augmentation, bone grafting, frame implants and ramus mandibular stapling); or
- charges related to non-Covered dental procedures or anesthesia (for example, Facility charges, except when Medically Necessary as noted above).

General Exclusions in Chapter Three also apply.

Diabetes Services

We cover treatment of diabetes. For example, we cover syringes, insulin, nutritional counseling, Outpatient self-management training and education for people with diabetes. We pay benefits subject to the same terms and conditions we use for other medical treatments. You must get nutritional counseling from one of the following Network Providers or we will not cover your care:

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

Diagnostic Tests

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

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

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

Emergency Care

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

Requirements

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

Home Care

We cover the Acute services of a Home Health Agency or Visiting Nurse Association that:

- performs Medically Necessary skilled nursing procedures in the home;
- trains your family or other caregivers to perform necessary procedures in the home; or
- performs Physical, Occupational or Speech Therapy (see Therapy Services on page 27).

We also cover:

- a Provider's visit to your home for Palliative care (does not include non-medical charges);
- services of a home health aide (for personal care only) when you are receiving skilled nursing or therapy services;
- other necessary services (except drugs and medications) furnished and billed by a Home Health Agency or Visiting Nurse Association; and
- home infusion therapy.

Private Duty Nursing

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

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

Requirements

We cover home care services only when your Provider:

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

We do not cover home care services if a Member or a lay caregiver with the appropriate training can perform them. Also, we provide benefits only if the patient or a legally responsible individual consents in writing to the home care treatment plan.

Limitations

We cover home infusion therapy only if:

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

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

Exclusions

We provide no home care benefits for:

- homemaker services;
- drugs or medications except as noted above (while drugs and medications are not Covered under your home care benefits, we may cover them under your Prescription Drugs and Biologics benefits);
- Custodial Care (see Definitions);
- food or home-delivered meals;
- non-medical charges; and
- private duty nursing services provided at the same time as home health care nursing services.

General Exclusions in Chapter Three also apply.

Hospice Care

We cover the following services provided 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 and bereavement visits and counseling for family members up to one year following the patient's death; and
- other Medically Necessary services.

Requirements

We only provide benefits if:

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

Hospital Care

Inpatient Hospital Services

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

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

We cover either the day of admission or the day of discharge, but not both.

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

Inpatient Medical Services

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

- Surgery;
- services of an assistant surgeon when necessary;
- anesthesia services for Covered procedures;
- intensive care; or
- other specialty care when you need it.

Notes:

You must get Prior Approval for Reconstructive procedures.

We limit Surgery benefits as follows:

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

Independent Clinical Laboratories

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

You must get Prior Approval for certain laboratory services in order to receive benefits. See page 6 for a description of the Prior Approval program. Visit our website at **www.bcbsvt.com/priorapproval** or call our customer service team at (800) 310-5249 for the newest list of services that require Prior Approval.

Maternity

Your hospital benefits cover your Inpatient maternity stay. (See Inpatient Hospital services above for a description of your hospital benefits.) We also cover 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.

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

We cover newborns under this Contract for up to 60 days after birth. Your newborn will be subject to their own Cost-Sharing for Covered services beginning on their date of birth, whether or not you add your newborn to coverage permanently. (See Chapter Six for information on how to continue coverage for your newborn past this period.) Please see your *Outline of Coverage* or your *Summary of Benefits and Coverage* for Cost-Sharing details.

Better Beginnings® Maternity Wellness Program

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

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

You get the most out of the Better Beginnings program when you contact us in the first three months of your pregnancy. To get any benefits from Better Beginnings, you must actively participate. If you have questions, please call our customer service team at (800) 922-8778. If you'd like to enroll online, or learn more about the program, please visit **www.bcbsvt.com/betterbeginnings**.

Note:
We may provide benefits through the Better Beginnings program for services that we do not generally cover. (We explain these services in the packet you receive when you join Better Beginnings.) The fact that we provide special benefits in one instance does not obligate us to do so again.

Medical Equipment and Supplies

You must get Prior Approval for certain Durable Medical Equipment 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 the Prior Approval list on page 6 or visit **www.bcbsvt.com/priorapproval**. We cover Durable Medical Equipment you purchase from a Network:

- medical doctor (M.D.);
- doctor of osteopathy (D.O.);
- therapist (Physical or Occupational);
- podiatrist (D.P.M);
- lactation consultants for breast pumps only;
- naturopathic Provider (N.D.); or
- Durable Medical Equipment supplier.

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

Replacement of lost, stolen or destroyed Durable Medical Equipment

We will replace one lost, stolen or destroyed Durable Medical Equipment, prosthetic or orthotic per Plan Year if not covered by an alternative entity 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 we require you to submit documentation, such as a police report, with the request.

We do 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

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

Orthotics

You must get Prior Approval for orthotics with a purchase price of $500 or more. We cover molded, rigid or semi-rigid support devices that restrict or eliminate motion of a weak or diseased body part.

Prosthetics

You must get Prior Approval for prosthetics with a purchase price of $500 or more or we will deny your claim. We cover the purchase, fitting, necessary adjustments, repairs and replacements of prosthetics. We cover a device (and related supplies) only when the device is surgically implanted or worn as an anatomic supplement to replace:

- all or part of an absent body organ (including contiguous tissue and hair);
- hair loss due to chemotherapy and/or radiation therapy, 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), we limit the replacement of the original wig (cranial/scalp prosthesis) to one wig every three years.

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

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

We cover dental prostheses only if required:

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

Exclusions

We provide no benefits for:

- treatment for hair loss due to androgenic alopecia, alopecia barbae, postpartum alopecia, traction alopecia, and/or natural or premature aging;
- dental appliances or dental prosthetics, except as listed above;
- shoe insert orthotics, lifts, arch supports or special shoes not attached to a brace (except with a diagnosis of diabetes);
- custom-fabricated or custom-molded knee braces for which you have not received Prior Approval from us (pre-fabricated, "off-the-shelf" braces are Covered);
- 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 our definition of Durable Medical Equipment, you may call our customer service team at (800) 310-5249 before purchasing or renting a Durable Medical Equipment item.

Mental Health Care

Some services require Prior Approval.
See page 6 for details.

Outpatient

We cover Outpatient mental health services including:

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

Inpatient

We cover Inpatient mental health services including:

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

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

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

Exclusions

We provide no mental health benefits for:

- services ordered by a court of law (unless we deem them Medically Necessary);
- treatment without ongoing concurrent review to ensure that treatment is being provided in the least restrictive setting required;
- non-traditional, alternative therapies such as Rubenfeld Synergy, energy polarity therapy and somatization therapy, that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories;
- services, including long-term residential programs, adventure-based activities, wilderness programs and residential programs that focus on education, socialization or delinquency, as noted in General Exclusions;
- Custodial Care (see Definitions);
- psychoanalysis;
- hypnotherapy; and
- biofeedback, pain management, stress reduction classes and pastoral counseling.

General Exclusions in Chapter Three also apply.

Nutritional Counseling

We cover up to three Outpatient visits each Plan Year. For treatment of diabetes, there is no limit on the number of Outpatient visits for nutritional counseling. For the treatment of metabolic diseases or eating disorders, nutritional counseling beyond three Outpatient visits in a Plan Year requires Prior Approval. Please see the Prior Approval list on page 6 for details or visit **www.bcbsvt.com/priorapproval**.

You must receive nutritional counseling from one of the following Provider types or we 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

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

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

You must get Prior Approval for certain radiology procedures (including CT, MRI, MRA, MRS, PET scans, and echocardiograms) and polysomnography (sleep studies). For our Prior Approval list, see page 6. For more information about Therapy Services, see page 27.

Outpatient Medical Services

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

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

Limitations

We cover an audiologist's laboratory hearing test only if your Provider refers you to an audiologist when they find or reasonably suspect a disease condition or injury of the ear.

Prescription Drugs and Biologics

This section explains your Prescription Drugs and Biologics benefits. Please see your *Outline of Coverage* or your *Summary of Benefits and Coverage* for specific Cost-Sharing details.

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

We provide benefits for Medically Necessary Outpatient use of:

- Prescription Drugs and Biologics (including contraceptive drugs and devices that require a prescription) if the Food and Drug Administration approves them for the treatment, prevention or diagnosis of your condition;
- Insulin and other supplies for people with diabetes (glucose testing materials including home glucose testing machines, needles and syringes). Your total out-of-pocket responsibility for prescription insulin medications will not be more than $100 per 30-day supply, regardless of the amount, type, or number of insulin medications being prescribed. This Out-of-Pocket maximum will apply even if you have not met your deductible.

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

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

Preferred and Non-Preferred Drugs

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

The NPF brand-name drug list can change and will be updated from time to time. To get the most up-to-date listing, visit our website at **www.bcbsvt.com/formulary-lists** or call (866) 227-7849.

Home Delivery Service

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

To use the home delivery service, you must complete and send a home delivery form and submit it with your prescription. You can find the home delivery form at **www.bcbsvt.com/pharmacy**. You may receive drugs at your home or office address. You can order refills by phone, fax or on the internet.

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

For more information about home delivery service, call (866) 227-7849 or visit our website at **www.bcbsvt.com/pharmacy**.

Limitations

We limit:

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

Please also see the Quantity Limits section below.

Prior Approval Program

We require Prior Approval for the Prescription Drugs or Biologics listed on the National Performance Formulary Prior Approval list or your drugs will not be Covered. This drug list can change and will be updated from time to time. For the most up-to-date list, visit our website at **www.bcbsvt.com/formulary-lists** or call (866) 227-7849.

We require Prior Approval:

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

How to Get Prior Approval for Your Drugs

To get Prior Approval for your Prescription Drugs or Biologics or have us adjust quantity limits or step therapy edits, your Provider must contact our pharmacy benefit manager or go to **www.covermymeds.com** with the following information:

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

If you have an emergency or an urgent need for a drug on the Prior Approval list, call (800) 313-7879. If we deny your request for Prior Approval, see Chapter Four for instructions on how to appeal our decision.

Our quantity limits, step therapy and Prior Approval drug lists can change and will be updated from time to time. For the most up-to-date list, visit our website at **www.bcbsvt.com/formulary-lists** to see if a specific drug needs Prior Approval or other review. You may also call our customer service team at (866) 227-7849.

Quantity Limits

We review certain Prescription Drugs and Biologics for Medical Necessity if the amount of a drug your doctor has prescribed exceeds quantity limits. If your doctor prescribes a drug in an amount that exceeds certain criteria, such as the FDA approved dosing, we may ask for documentation about why you need more of the drug. Visit our website at **www.bcbsvt.com/formulary-lists** or call (866) 227-7849 to get the most up-to-date list of drugs covered by this review or to learn the quantity limit for a particular drug.

Step Therapy

The NPF step therapy program saves you money by encouraging patients and their doctors to try less expensive drugs in a therapeutic class before using the newest, most expensive ones. We may require Prior Approval if there is no information to show you first tried a less expensive drug.

Visit **www.bcbsvt.com/formulary-lists** or call (866) 227-7849 to get a current list of drugs covered by this review or to learn the procedures to follow for review of your prescription use.

Cost-Sharing

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

If your Provider determines that you should not take a generic drug (lowest-tier drug), your Cost-Sharing responsibility for a preferred or non-preferred brand drug can be no greater than the amount that you would have paid for the lowest-tier Co-payment or Co-insurance.

Some prescriptions on the NPF Quantity Limits list may have different Cost-Sharing arrangements. Please refer to the current list by visiting **www.bcbsvt.com/formulary-lists.**

Specialty Medications

For some specialty drugs and supplies, you will need to receive your drug or supply from a covered pharmacy in BCBSVT's Exclusive Specialty Medication

Network. You must get Prior Approval for some specialty drugs and supplies. If you fail to obtain Prior Approval, your drug or supply will not be Covered.

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

Compounded Prescriptions

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

Exclusions

We do not provide Prescription Drugs and Biologics benefits for:

- all medications for treatment of infertility, including but not limited to Clomid, Clomiphene, Serophene, Bravelle, Gonal-F, Follistim AQ, Novarel, Ovidrel, Pregnyl, Profasi and Repronex when used for treatment of infertility;
- refills beyond one year from the original prescription date;
- devices of any type other than prescription contraceptives and insulin pumps, even though such devices may require a prescription including, but not limited to: Durable Medical Equipment, prosthetic devices, appliances and supports (although benefits may be provided under other sections of your Contract);
- any drug considered to be Experimental or Investigational, except for certain Off-label cancer drugs and drugs administered as part of certain clinical cancer trials;
- Viagra, Cialis, Levitra, Addyi, and other drugs to treat sexual dysfunction;
- vitamins, except those which, by law, require a prescription;
- drugs that do not require a prescription, even if your doctor prescribes or recommends them;
- food and nutritional formulae or supplements except for "medical foods" prescribed for the Medically Necessary treatment of an inherited metabolic disease or formulas and supplements administered through a feeding tube as determined to be Medically Necessary (**Note:** This exclusion does not apply to 100% amino acid formula, which may be determined as Medically Necessary for children under 5.);
- the replacement of lost, stolen, or destroyed Prescription Drugs or Biologics received through your medical benefit;
- any drugs listed under Excluded Medications on the National Performance Formulary drug list. (Note: If you are currently using a medication that is excluded from the NPF, you may request a benefit exception. See the section under the National Performance Formulary at **www.bcbsvt.com/formulary-lists** related to Benefit Exceptions for Excluded Medications, or call (866) 227-7849.);
- any drugs on the list of Excluded Drugs with Unique Packaging and Therapeutic Alternatives. (You can view the list under the National Performance Formulary at **www.bcbsvt.com/formulary-lists** or call (866) 227-7849.); and
- Drugs newly approved by the Food and Drug Administration until they have been reviewed by our Pharmacy and Therapeutics Committee.

Replacement of lost, stolen or destroyed Prescription Drugs and Biologics

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

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

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

Exclusions

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

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

Claim Filing

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

Rehabilitation/Habilitation

Rehabilitation or Habilitation services may require Prior Approval. Please check our Prior Approval list on page 7.

We cover:

- Inpatient treatment in a Network Physical Rehabilitation Facility for a medical condition requiring Acute Care;
- Outpatient cardiac or pulmonary Rehabilitation for a condition requiring Acute Care; and
- Rehabilitative or Habilitative services and devices Covered elsewhere in your Contract (e.g.; under Therapy Services on page 27).

Requirements

The attending Provider must:

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

Exclusions

We do not cover:

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

General Exclusions in Chapter Three also apply.

Skilled Nursing Facility

We cover Inpatient services including:

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

Requirements

We provide benefits only if you:

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

Exclusions

We do not cover Skilled Nursing Facility care for:

- Cognitive re-training; or
- Custodial Care.

Substance Use Disorder Treatment Services

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

We cover the following Acute substance use disorder treatment services:

- detoxification;
- Intensive Outpatient Programs (IOP);
- short-term Residential Treatment Programs;
- Outpatient Rehabilitation (including services for the patient's family when necessary); and
- Inpatient Rehabilitation.

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

Requirements

We cover substance use disorder treatment services only if you get Medically Necessary Care in the least restrictive setting.

Please contact our customer service team at (800) 310-5249 if you have questions.

Exclusions

We provide no substance use disorder treatment benefits for:

- services ordered by a court of law (unless we deem them Medically Necessary);
- non-traditional, alternative therapies such as Rubenfeld Synergy, energy polarity therapy and somatization therapy, that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories;
- treatment without ongoing concurrent review to ensure that treatment is being provided in the least restrictive setting required;
- services, including long-term residential programs, adventure-based activities, wilderness programs and residential programs that focus on education, socialization, delinquency;
- Custodial Care (see Definitions);

- biofeedback, pain management, stress reduction classes and pastoral counseling;
- psychoanalysis; and
- hypnotherapy.

General Exclusions in Chapter Three also apply.

Surgery

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

- Subject to Medical Necessity, we may limit the number of visits we cover for one Provider in a given day.
- If you have several Surgeries at the same time, we may not pay a full allowance for each one.
- You must get Prior Approval for Cosmetic and Reconstructive procedures.
- We cover sterilization procedures (vasectomy or tubal ligation) even though they are not Medically Necessary.

General Exclusions in Chapter Three also apply.

Telemedicine Program

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

- sick visits;
- nutritional counseling visits (Limited to three visits per Plan Year. This visit limit does not apply to treatment of diabetes. Nutritional counseling for the treatment of metabolic diseases or eating disorders beyond three Outpatient visits in a Plan Year requires Prior Approval. See Prior Approval Program on page 6 for details or visit **www.bcbsvt.com/priorapproval**.);
- lactation consultations; and
- mental health consultations.

We administer this program via a contract with American Well. American Well provides you with online access to Medical Care for common, uncomplicated, non-emergency cases. To access these services, visit **Amwell.com**, or download the app from iTunes or Google Play. Please see your *Outline of Coverage* for details.

Limitations

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

Exclusions

We do 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

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

- consultations, including second opinions;
- initial or follow-up Inpatient consultations;
- office or other Outpatient visits;
- follow-up visits after a Skilled Nursing Facility or hospital stay;
- psychology and psychiatric examinations intended to provide a diagnosis;
- Prescription Drug and Biologic management;
- nutritional counseling visits (Limited to three visits per Plan Year. This visit limit does not apply to treatment of diabetes. Nutritional counseling for the treatment of metabolic diseases or eating disorders beyond three Outpatient visits in a Plan Year requires Prior Approval. See Prior Approval Program on page 6 for details or visit **www.bcbsvt.com/priorapproval**.);
- end-stage renal disease services;
- medical genetic and genetic counseling services (please note genetic testing services requires 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

We do 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

We cover therapy or physical medicine services provided by:

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

Therapy services could include the following:

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

We cover 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 (N.D.); or
  - doctor of osteopathy (D.O.);
- up to the specific benefit limits listed on your *Outline of Coverage* and your *Summary of Benefits and Coverage* (this limitation does not apply to mandated treatment for Autism Spectrum Disorder up to age 21 as defined by Vermont law).

If you use more than 30 combined Occupational, Speech and Physical Therapy/medicine services in one Plan Year for the treatment of Autism Spectrum Disorder, you must get Prior Approval from us for any visits after the 30th. See page 6 for more information about the Prior Approval program.

Exclusions

We do not cover the following therapy services:

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

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

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

We pay benefits for the following services related to transplants:

- search for a donor;
- surgical removal of an organ;
- storage and transportation costs for the organ, partial organ or bone marrow; and
- costs directly related to the solid organ or bone marrow donation, including costs resulting from complications of the donor's Surgery.

We pay benefits for transplants as follows:

- If we cover both the recipient and the donor, each receives benefits under his or her own Contract.
- If we cover the recipient, but not the donor, both receive benefits under the recipient's Contract (benefits available to the recipient will be paid first). The donor will only receive benefits for services that occur within 120 days from the date of the donor's Surgery.
- No benefits are available if we cover the donor, but not the recipient.

Time Period for Living Donor Benefits

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

Exclusions

We do not cover the purchase price of any organ or bone marrow that is sold rather than donated. Please remember that General Exclusions in Chapter Three also apply.

Vision Care

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

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

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

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

Vision Materials

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

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

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

Frames for Prescription Glasses

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

Lenses for Prescription Glasses

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

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

Contact Lenses

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

We do not cover contact lenses that are solely for Cosmetic purposes (for example, to change your eye color).

Necessary Contact Lenses

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

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

Related Professional Services

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

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

Claim Filing for Vision Benefits

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

When you visit a non-VSP Provider, you must pay for your services up front. We reimburse you only up to the Allowed Amount for Covered Services. To receive reimbursement, sign on to **www.vsp.com**, select the *Out-of-Network Reimbursement Form* and follow the instructions. Or, you may send an itemized receipt listing the services received along with the patient's name and covered subscriber's name and ID number to VSP. Out-of-Network claims must be submitted to VSP within six months of service. Mail the original claims reimbursement request and receipts to the address included on the form.

Exclusions

We do not cover services or supplies for:

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

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

Vision Services (Medical)

We cover services by an optometrist or ophthalmologist only when they find or reasonably suspect a disease condition of the eye and refers you to a Provider for treatment of that condition. (Please see page 28 for vision-related services.) We cover your visit to an optometrist or ophthalmologist in the same way we cover visits to Providers performing Covered eye care.

Eyeglasses, contact lenses, and refraction

We do not cover any determination of refractive state or any examination, prescription or fitting of eyeglasses or contact lenses unless the refraction, examination, prescription or fitting is for treatment of aphakia or keratoconus (see Prosthetics page 20).

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

CHAPTER THREE

General Exclusions

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

In addition to the specific exclusions listed elsewhere in this Contract, the following General Exclusions apply. We do not cover services and supplies that are not Medically Necessary. Also, we do not cover the following even if they are Medically Necessary:

1. Services that a prior Health Plan must cover as extended benefits.
2. Services for which you would not legally have to pay if you did not have your Contract or similar coverage.
3. Services for which there is no charge.
4. Services paid directly or indirectly by a local, state or federal government agency, except as otherwise provided by law.
5. Services you require because you participated in a felony, riot, or insurrection.
6. Services over the limitations or maximums set forth in your Contract.
7. Services or drugs that we determine are Investigational, mainly for research purposes or Experimental in nature. To the extent required by law, however, we cover routine costs for patients who participate in approved clinical trials.
8. Services not provided in accordance with accepted Professional medical standards in the United States.
9. Services beyond those needed to establish or restore your ability to perform Activities of Daily Living (see Definitions), or to establish or re-establish the capability to perform occupational, hobby, sport or leisure activities.
10. Acupuncture, acupressure or massage therapy; hypnotherapy, rolfing, homeopathic or naturopathic remedies. (This exclusion does not apply to Medically Necessary 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.)
11. Electrical stimulation devices used externally. (This exclusion does not apply to bone growth stimulators, transcutaneous electrical nerve stimulation [TENS] devices or neuromuscular electrical stimulators [NMES] for which you have received Prior Approval.)
12. Automatic or manual home blood pressure cuffs.
13. Bariatric Surgery, unless performed at a Blue Distinction Center.
14. Biofeedback or other forms of self-care or self-help training.
15. Immunizations purchased in bulk, such as those provided to a group of people, and billed collectively rather than individually.
16. Fluoride treatments performed in school.
17. 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.)
18. Care for which there is no therapeutic benefit or likelihood of improvement.
19. 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.
20. Clinical ecology, environmental medicine, Inpatient confinement for environmental change or similar treatment.
21. Cognitive training or retraining and educational programs, including any program designed principally to improve academic performance, reading or writing skills.
22. Communication devices and communication augmentation devices.
23. Computer technology or accessories and other equipment, supplies or treatment intended primarily to enhance occupational, recreational or vocational activities, hobbies or academic performance.
24. Annual or subscription or retainer fees charged by concierge medicine practices.
25. Consultations, including telephone consultations, except when they occur between Providers and the Providers attach a written report to the patient's medical record.
26. 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.

27. Cosmetic procedures and supplies that are not Reconstructive.
28. Unless expressly required by law, we do not cover:
    - excision of excessive skin and subcutaneous tissue, and tightening (plication) of underlying structures (includes abdominoplasty, panniculectomy, correction of diastasis rectus, lipectomy and umbilical transposition) of the chest, abdomen, thigh, leg, hip, buttocks, arm, forearm, hand, neck (submental fatpad) and all other areas not specified;
    - suction-assisted removal of fatty tissue (lipectomy) in the head, neck, trunk, upper extremity or lower extremity;
    - breast lift (mastopexy) except when a necessary component of reconstruction of breasts following breast Surgery;
    - repair of brow ptosis, repair of blepharoptosis, correction of lid retraction, reduction of overcorrection of lid ptosis;
    - Surgery to improve the appearance of the ear (otoplasty); and
    - Surgery to improve the appearance of the nose (rhinoplasty).

    Note: This exclusion does not apply to abdominoplasty or panniculectomy when abdominoplasty and/or panniculectomy is performed in connection with herniorrhaphy (hernia repair). This exclusion also does not apply to lipectomy performed as part of the treatment of lipedema.
29. Custodial Care, Rest Cures.
30. Dental services and dental-related oral Surgery, unless specifically provided by your Contract; procedures designed primarily to prepare the mouth for dentures (including alveolar augmentation, bone grafting, frame implants and ramus mandibular stapling).
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. Treatment of developmental delays (this exclusion does not apply to mandated treatment of Autism Spectrum Disorder up to age 21 as defined by Vermont law).
33. Education, educational evaluation or therapy, therapeutic boarding schools, services that should be Covered as part of an evaluation for, or inclusion in, a Child's individualized education plan (IEP) or other educational program (this exclusion does not apply to treatment of diabetes, such as medical nutrition therapy by approved participating Providers).
34. Foot care or supplies that are Palliative or Cosmetic in nature, including supportive devices and treatment for bunions (except capsular or bone Surgery), flat-foot conditions, subluxations of the foot, corns, callouses, toenails, fallen arches, weak feet, chronic foot strain and symptomatic complaints of the feet. This exclusion does not apply to necessary foot care for treatment of diabetes.
35. Hearing aids or examinations for the prescription or fitting of hearing aids; tinnitus masking devices.
36. 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.
37. Hot and cold packs.
38. Illnesses or injuries that are:
    - a result of an act of war (declared or undeclared); or
    - sustained in active military service.
39. Infertility services. This includes, but is not limited to:
    - medications for treatment of infertility such as Clomid, Clomiphene, Serophene, Bravelle, Gonal-F, Follistim AQ, Novarel, Ovidrel, Pregnyl, Profasi and Repronex when used for treatment of infertility; and
    - surgical, radiological, pathological or laboratory procedures leading to or in connection with (for example):
        - insemination (intravaginal, intracervical, and intrauterine insemination);
        - in vitro fertilization, embryo transplantation and gamete intrafallopian transfer (GIFT);
        - zygote intrafallopian transfer (ZIFT); and
        - any variations of these procedures, including costs associated with collection, washing, preparation or storage of sperm for artificial insemination including donor fees, cryopreservation of donor sperm and eggs.

    Note: This exclusion does not apply to the evaluation to determine if and why a couple is infertile.
40. 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.
41. Treatment for willfully uncooperative or intractable patients.
42. Institutional or Custodial Care for the physically or mentally handicapped.

43. Mandated treatment, including court-ordered treatment, unless such treatment is Medically Necessary, ordered by a Provider and covered under your Contract.
44. 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.
45. Nutritional counseling beyond three Outpatient visits per Plan Year. This limit does not apply to the treatment of diabetes. Prior approval beyond three Outpatient visits is required for with the treatment of metabolic diseases or eating disorders.
46. Food and nutritional formulae or supplements except for "medical foods" prescribed for the Medically Necessary treatment of an inherited metabolic disease or formulas and supplements administered through a feeding tube as determined to be Medically Necessary. **Note:** This exclusion does not apply to 100% amino acid formula, which may be determined as Medically Necessary for children under 5.
47. Orthodontics, including orthodontics performed as adjunct to orthognathic Surgery or in connection with accidental injury (this exclusion does not apply if orthodontics are Covered in other sections of this Contract).
48. Personal hygiene items.
49. Personal service, comfort or convenience items.
50. Photography services, photographic supplies or film development supplies or services (for example, external ocular photography or photography of moles to monitor changes).
51. Physical fitness equipment, braces and devices intended primarily for use with sports or physical activities other than Activities of Daily Living (e.g., knee braces for skiing, running or hiking); weight loss or exercise programs; health club or fitness center memberships.
52. Pneumatic cervical traction devices except when the patient has a diagnosis of Temporomandibular Joint Syndrome (TMJ); gravity assisted traction devices.
53. Services, including modalities, that do not require the constant attendance of a Provider.
54. Specialized examinations, services or supplies required by your employer or for sports/recreational activities (e.g. driver certifications, pilot flight physicals, etc.).
55. Sterilization reversal (vasectomy reversal, vasovasostomy, vasovasorrhaphy, tubal ligation reversal, tubotubal anastomosis).
56. Supervised services or modalities that do not require the skill and expertise of a licensed Provider.
57. 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.
58. Telemedicine services via email, facsimile or non-HIPAA-compliant software, and telemonitoring.
59. Travel (other than Ambulance transport), lodging and housing (when it is not integral to a Medically Necessary level of care, even if prescribed by a Provider).
60. Treatment solely to establish or re-establish the capability to perform occupational, hobby, sport or leisure activities.
61. Treatment of obesity, except surgical treatment when determined Medically Necessary.
62. Unattended services or modalities (application of a service or modality) that do not require direct one-on-one patient contact by the Provider.
63. Vision training, orthoptics, or plano (non-prescription lenses).
64. Work-hardening programs and work-related illnesses or injuries (or those which you claim to be work-related, until otherwise finally adjudicated), provided such illnesses or injuries are covered by workers' compensation or should be so covered. (This provision does not require an individual, such as a sole proprietor or an owner/partner to maintain worker's compensation if they are not legally required to be covered.)

Provider Exclusions

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

- Provider that we do not approve for the given service or that is not defined in our Definitions 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 unless appropriate services are not available with a Network Provider and you have received Prior Approval for those services.
- Provider practicing outside the scope of that Provider's license or certification.
- Provider whose participation with BCBSVT has been terminated within the last three years, unless their participation has been reinstated.

CHAPTER FOUR

Claims

Remember, when you contact a Provider, you must:

- tell your Provider that you have coverage with us; and
- give information about all other health coverage you have.

Claim Submission

We must receive your claim within 12 months after you receive a service, or as soon thereafter as is reasonably possible. If you file a claim more than 12 months after you receive a service, we may not provide benefits. Your claim must include all information necessary for us to administer your benefits. This includes information relating to other coverage you have.

Network Providers will usually submit claims on your behalf if this is your primary coverage. When you use Out-of-Network Providers, you must file your own claims. You can find a Member Claim Form at **www.bcbsvt.com/member/member-forms** or request one by calling our customer service team at (800) 310-5249.

Release of Information

We may need records, verbal statements or other information to administer your benefits. By accepting your Contract, you give us the right to obtain, from any source, any information we need.

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

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

Cooperation

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

Payment of Benefits

We pay Vermont Network Providers directly. We usually pay BlueCard Network Providers directly. We usually pay you when you use Out-of-Network Providers. We reserve the right to pay Out-of-Network Providers directly.

You may not assign or transfer your benefit rights under this Contract to another party, including an Out-of-Network Provider, without our express written consent. Any attempt to assign by you without our express written consent shall be deemed void and the assignee shall acquire no rights. Regardless of the prohibition on assignment, we may, in our sole discretion, pay an Out-of-Network Provider directly for Covered services rendered to a Member. Any payments made by us will discharge our obligation to pay for Covered services. Our 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 us and we retain a full reservation of all rights and defenses to enforce this provision.

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

Payment in Error/Overpayments

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

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

How We Evaluate Technology

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

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

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

Complaints and Appeals

When You Have a Complaint

Customer Service

You may make an inquiry to our customer service team at any time if you have concerns. This is usually the best, first course of action. Our customer service team can solve most problems. Contact our customer service team at (800) 310-5249. Please have your ID card handy when you call. Also, call if you need help understanding our decision to deny a service or coverage.

If You Don't Agree with Our Decision

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

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

Reviewers

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

Timing of Appeals

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

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

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

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

How to Request an Appeal

You or someone you name to act for you (your authorized representative) may request an appeal review. Your doctor may serve as your representative. At any time, you can get help with filing your appeal from our customer

service team. You can also get help from the Vermont Department of Financial Regulation at (800) 964-1784. To file an emergency or urgent concurrent appeal, call the customer service team at (800) 310-5249.

Mail written appeals to:
Blue Cross and Blue Shield of Vermont
PO Box 186
Montpelier, VT 05601-0186

If you are asking our customer service team to review, send your information to the attention of "Customer Service." If you are filing an appeal, send it to the attention of "First Level Appeals" or "Voluntary Second Level of Appeals" as appropriate.

If you are unable to file a written appeal, you may appeal by phone. We will record your appeal in writing. Please call our customer service team at (800) 310-5249.

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

Information About Your Claim

If you appeal, you will receive instructions on how to supply relevant information. You may submit documents, records or other information about your appeal. You may request copies of information about your claim (free of charge) by contacting us at (800) 310-5249. We will provide this immediately for an urgent or concurrent appeal or within two business days for other appeals.

After Our Decision

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

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

Other Resources to Help You

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

Employee Benefits Security Administration
(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 insurance, have concerns about our activities, or are not satisfied with how we resolved your complaint.

Vermont Office of the Health Care Advocate

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

BCBSVT's Ombudsman

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

In most cases, our customer service team can answer Member questions and resolve most issues. It is the role of the Member Ombudsman to get involved in the process when unforeseen complications arise in the regular course of problem resolution and information gathering. To contact our Ombudsman, call (800) 437-6298.

CHAPTER FIVE

Other Party Liability

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

Coordination of Benefits

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

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

We coordinate benefits based on coverage, not actual payment. Therefore, we treat the following benefits as "payment" from another payer:

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

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

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

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

Coordination of Benefits for Children of Divorced Parents

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

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

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

In an Accident

If you are involved in an accident and you are covered for accident-related expenses under any of the following types of coverage, the other payer is primary and we are secondary:

- any kind of auto insurance;
- homeowners insurance;
- personal injury protection insurance;
- financial responsibility insurance;
- medical reimbursement insurance coverage that you did not purchase; or
- any other property and liability insurance providing medical expense payments.

Reimbursement

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

Medicaid and Tricare

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

Subrogation

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

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

Cooperation

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

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

If you or any person covered under this Certificate fails to cooperate, you will be responsible for all benefits we provide and any costs we incur in obtaining repayment.

CHAPTER SIX

Membership

Remember, when you add or remove Dependents, your type of membership (individual, two-person, single head of household or family) may change. You may add or remove Dependents from your membership as allowed by state and federal law. You can see additional details about adding and removing Dependents at **www.bcbsvt.com/enroll**.

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

Open Enrollment

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

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

Special Enrollment Periods

Federal and state laws define your rights to purchase insurance outside of applicable open enrollment periods. Generally, the law provides that if you lose coverage due to a legally-defined qualifying event (such as divorce) or you gain a new Dependent (such as through marriage or birth), you are entitled to purchase new coverage outside of an applicable open enrollment period. You can see additional details about these rights in the Qualifying Event Chart on Vermont Health Connect's website at **https://info.healthconnect.vermont.gov/QualifyingEvents**.

Note: We cover your Child for 60 days after birth, placement for adoption, or adoption. Whether or not you decide to continue benefits for the Child through us, you must notify us of your decision within 60 days of the birth by calling our customer service team at (800) 310-5249. If you are enrolled through your employer, please notify your Group Benefits Manager within 60 days. If you fail to add your new Dependents within 60 days, you may be required to wait until open enrollment to do so.

Coverage Effective Dates

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

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

Cancellation of Coverage

Cancellation of Individual Coverage through Vermont Health Connect

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

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

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

Cancellation of Individual Coverage through Us

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

Cancellation of Group Coverage

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

Default in Subscription Payment

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

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

If you fail to pay your premium in full before your three-month grace period ends:

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

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

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

If your coverage is canceled:

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

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

Benefits after Termination of Group Coverage

If your employer purchased coverage through us, and you are entitled to benefits for a continuous total disability existing on your Group's termination date, we provide benefits for Covered services received in connection with your total disability until the earliest of:

- the date your total disability ends;
- 12 months from the date of termination;
- the date you become covered for medical benefits under another Health Plan or Policy without a Pre-existing Condition exclusion applicable to your total disability.

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

or profit. If BCBSVT continues to provide coverage, we are entitled to collect premium payments for the duration of the extension of benefits period.

A minor Dependent is considered to have a total disability only if, because of an illness or injury, he or she is unable to engage in activities that are normal for a person of the same age, gender and ability. If your Group coverage at termination covers your Dependents, any extension under this section applies only to the individual who has a continuous total disability at the time of termination and who is not eligible to be covered as a dependent under a succeeding Group Policy or plan without a Pre-existing Condition exclusion applicable to the disability.

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

Active Military Service

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

Fraud, Misrepresentation or Concealment of a Material Fact

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

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

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

Medicare

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

If you become Medicare eligible, whether you are enrolled individually or through an employer of 20 or fewer employees, Medicare becomes your primary insurance. This Plan will pay secondary to Medicare. If you do not sign up for Medicare, your claims may not be paid.

If you become Medicare eligible and are enrolled in this Plan through an employer of more than 20 employees, this insurance is primary to Medicare.

Rules About Coverage for Domestic Partners

If your Group allows Domestic Partners to be covered under your Health Plan, the following provisions apply.

Enrollment Eligibility

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

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

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

Effective Date of Coverage

The effective date of coverage of an eligible Domestic Partner and any eligible Dependents of the Domestic Partner will be determined as required by law.

Continuation of Group Coverage for Domestic Partners

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

Termination of Domestic Partnership

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

Right to Continuation of Coverage

This is a summary of state and federal law. Please contact your Group Benefits Manager for details about continuation coverage.

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

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

You must pay the entire cost of your coverage.

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

Continuation rights do not apply if:

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

Continuation of insurance ends at the earliest of:

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

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

Conversion Rights

When continuation of Group coverage ends, you may be eligible for individual coverage. If you are eligible, you will have the opportunity to enroll in a product offered through Vermont Health Connect or by enrolling directly with us. To do this, you must apply within 60 days after your Group enrollment terminates.

CHAPTER SEVEN

General Contract Provisions

Applicable Law

This Contract is intended for sale and delivery in, and is subject to the laws of, the State of Vermont and the United States. We uphold its provision only to the extent allowable by law.

Severability Clause

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

Non-waiver of Our Rights

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

Term of Contract

Coverage continues monthly until this Contract is discontinued, terminated, or voided.

Subscriber Address

If you enrolled through your employer you should notify your employer of any change of address. If you enrolled through Vermont Health Connect, you must notify Vermont Health Connect of any change of address by calling (855) 899-9600 or writing:

Vermont Health Connect
NOB 1 South
280 State Drive
Waterbury, VT 05671-1010

If you enrolled directly through Blue Cross and Blue Shield of Vermont, you must notify us of any change of address by calling (800) 310-5249 or writing:

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

All notices are sent to the subscriber's address on file. This represents the full responsibility to notify the subscriber and member, regardless of whether they receive the notice.

Third Party Beneficiaries

All Members covered under this Contract (except the subscriber) are Third Party Beneficiaries to the Contract.

CHAPTER EIGHT

More Information About Your Contract

Your Contract is solely between you and us. We are an independent corporation operating under a controlled affiliate license with the Blue Cross and Blue Shield Association (BCBSA), an association of independent Blue Cross and Blue Shield Plans. BCBSA permits us to use the Blue Cross and Blue Shield Service Marks in the State of Vermont. We do not contract as the agent of BCBSA. You have not entered into your Contract based upon representations by any person other than us. No person, entity or organization other than us shall be held accountable or liable to you for any of our obligations to you created under your Contract. This paragraph will not create any additional obligations whatsoever on our part, other than those obligations created under other provisions of your Contract.

Our Commitment to Protecting Your Privacy

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

Federal and state laws require us to maintain the privacy of your protected health information (PHI) and to provide notice to you of our legal duties and privacy practices. We make a complete copy of our Notice of Privacy Practices available on our website, **www.bcbsvt.com/privacypolicies**. You may ask for a paper copy of our Notice of Privacy Practices at any time by calling our customer service team at (800) 310-5249.

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. Federal law requires us to maintain the privacy of your PHI by using or disclosing it only with your authorization or as otherwise allowed by law. We may share your PHI as needed for treatment, payment and health care operations. You have the right to gain access to your health information and to information about our privacy practices. If you have any questions or want additional information about the privacy of your information please contact us at:

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

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 the plan.

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

Newborns' and Mothers' Health Protection Act

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

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

Our Pledge to You

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

Member Rights and Responsibilities

As a member, you have the right to:

Respect and privacy. You have the right to be treated with respect and dignity. We take measures to ensure your right to privacy.

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

Participate in your health care. You have the right to engage in a candid discussion about appropriate or Medically Necessary treatment options, regardless of cost or benefit coverage. You have the right to participate with practitioners in making decisions about your care.

Disagree. We welcome your complaints or appeals about our organization and the care you receive. For more information about how to file a complaint or an appeal, please call our customer service team at the number on the back of your ID card.

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

As a member, you have the responsibility to:

Choose a Primary Care Provider (PCP) 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 us if there's a change in your family size, address, phone number, PCP or any other change in your membership.

CHAPTER NINE

Definitions

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

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

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

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

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

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

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

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

Certificate/Certificate of Coverage: this document.

Child: a subscriber'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 subscriber is legal guardian. A Child must be under age 26 unless he or she is an Incapacitated Dependent.

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

Chronic Care: health services provided by a health care Professional for an established clinical condition that is expected to last 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.)

Contract: your *Outline of Coverage*, this Certificate and the documents listed on your *Outline of Coverage*; your Identification (ID) card; and your application and any supplemental applications that you submitted and we approved. Your Contract is subject to all of our agreements with Network Providers and other Blue Cross and Blue Shield Plans, as amended from time to time.

Co-payment (Visit Fee): a fixed dollar amount you must pay for specific services, if any, as shown on your *Outline of Coverage* 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 we pay 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 your Contract.

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

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

Diagnostic Services: services ordered by a Provider to determine a definite condition or disease. Diagnostic Services include:

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

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

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

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

- in accomplishing Activities of Daily Living;
- in social or personal adjustment; or
- resulting from disabilities that are personal care or are designed to help you in walking, bathing and other personal hygiene, toileting, getting in and out of bed, dressing, feeding or with normal household activities such as laundry, shopping and housekeeping.

Durable Medical Equipment (DME): equipment that requires a prescription from your Provider;

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

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

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

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

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

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

Experimental or Investigational Services: health care items or services that are either not generally accepted by informed health care Providers in the United States as effective in treating the condition, illness or diagnosis for which their use is proposed or are not proven by Medical or Scientific Evidence to be effective in treating the condition, illness or diagnosis for which their use is proposed.

Facility (Facilities): the following institutions or entities:

- Ambulatory surgical centers
- Birthing centers
- Community mental health centers
- General Hospitals
- Home Health Agencies/Visiting Nurse Associations
- Physical Rehabilitation Facilities
- Psychiatric Hospitals
- Residential Treatment Center
- Skilled Nursing Facilities
- Substance Use Disorder Rehabilitation Facilities
- Facilities further defined in this chapter. The patient's home is not considered a Facility.

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

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

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

Group Benefits Manager: the individual (or organization) who has agreed to forward all subscription rates due under your Health Plan. The Group Benefits Manager is the agent of the subscriber and your Group. Your Group Benefits Manager has no authority to act on our behalf and is not our employee or agent. We disclaim all liability for any act or failure to act by your Group Benefits Manager.

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

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

Habilitative services and devices help a person attain a skill or function never learned or acquired due to a disabling condition. Rehabilitative services and devices, on the other hand, help a person regain, maintain or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition.

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

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

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

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

Incapacitated Dependent: a Dependent who meets our 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 subscriber or the subscriber's estate for support and maintenance.

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

Intensive Outpatient Programs: programs that have the capacity for planned, structured service provision of at least two hours per day and three days per week. The services offered address mental health or substance use disorders and could include group, individual, family or multi-family group psychotherapy, psychoeducational services and adjunctive services such as medical monitoring. These services would include multiple or extended treatment, Rehabilitation or counseling visits or Professional supervision and support.

Investigative/Investigational: (see Experimental)

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

Medical or Scientific Evidence: evidence supported by clinically controlled studies and/or other indicators of scientific reliability from the following sources:

- peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
- peer-reviewed literature, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS database Health services Technology Assessment Research (HSTAR);
- medical journals recognized by the federal Secretary of Health and Human services, under Section 1861 (t)(2) of the federal Social Security Act;
- standard reference compendia including: the American Hospital Formulary service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, the United States Pharmacopoeia-Drug Information, Facts & Comparisons eAnswers® under the Indications section with a level of evidence scale of A, B, or G, or the DRUGDEX System by Micromedex with a strength of recommendation rating of Class I, Class IIa, OR IIb under the Therapeutic Uses section;
- findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and
- peer-reviewed abstracts accepted for presentation at major medical association meetings.

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

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

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

Member: an individual who enrolls in the Health Plan.

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

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

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

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

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

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

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

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

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

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

Partnership: see Domestic Partners (Partnership).

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

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

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

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

Plan Year: the date your Deductibles, Out-of-Pocket Limits and other totals begin to accumulate. Limits on visits and other limits also begin to accumulate on the first day of your Plan Year, which is January 1.

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

Prescription Drugs and Biologics: products that are:

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

Preventive Services: services used to find or reduce your risks when you do not have symptoms, signs, or specific increased risk for the condition being targeted. They may include immunizations, screening, counseling or medications that can prevent or find a condition. Please note that if you receive a Preventive Service and during its delivery, the Provider suspects, finds or treats a disease condition, the Provider and/or BCBSVT may not consider the service preventive.

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

Professional: one of the following practitioners:

- athletic trainers
- audiologists
- Chiropractors (as further defined in this chapter)
- mental health Professionals:
  - clinical mental health counselors
  - clinical psychologists
  - clinical social workers
  - marriage and family therapists
  - psychiatric nurse practitioners
- nurses:
  - certified nurse midwives or licensed Professional midwives
  - certified registered nurse anesthetists
  - lactation consultants
  - licensed practical nurses (LPNs)
  - nurse practitioners
  - registered nurses (RNs)
- nutritional counselors
- optometrists
- 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 us;
- licensed and/or certified where required; and
- acting within the scope of that license and/or certification.

Network Provider: for most Network Providers this includes:

- pharmacies who make an agreement with our pharmacy benefit manager ("Network Pharmacy");
- (for pediatric vision care) vision Providers who make an agreement with our vision service partner;
- (for pediatric dental care) Providers in our pediatric dental Network; or
- Network Providers for all other services.

We consider Providers outside of Vermont to be Network Providers if they are Preferred Providers with their local Blue Cross and/or Blue Shield Health Plans.

You may find a Network Provider on our website at **www.bcbsvt.com/find-a-doctor.** You may also get a directory of Network Providers from your Group Benefits Manager or from our customer service team. Providers must be Network Providers in order for their services to be Covered. We do not provide benefits if you do not use a Network Provider. See Choosing a Provider on page 8.

Out-of-Network Provider: a Provider that does not meet the definition of a Network Provider. We do not provide benefits if you use an Out-of-Network Provider and Prior Approval is not granted. See Out-of-Network Providers on page 9 for more information.

Other Provider: one of the following entities:

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

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

Residential Treatment Program: a 24-hour level of care that provides patients with long-term or severe mental disorders or substance use disorders with residential care. Care is medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. Care

includes treatment with a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs. Residential care also includes training in the basic skills of living as determined necessary for each patient.

Respite Care: care that relieves family members or caregivers by providing temporary relief from the duties of caring for covered terminally ill patients. Respite Care is provided in a General Hospital or in your home, whichever is most appropriate.

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

Skilled Nursing Facility: a Facility that primarily provides 24-hour Inpatient skilled nursing care and related services delivered or directed by Providers. Facilities must keep permanent medical history records. The Facility is not, other than incidentally, a place that provides:

- minimal care, Custodial Care, ambulatory care or part-time care services;
- care or treatment of mental health Conditions, substance use disorder or pulmonary tuberculosis; or
- Rehabilitation.

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

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

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

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

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

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

Telemedicine: the delivery of health care services 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 our Prior Approval and that you (or your Provider) wish to extend for a longer period of time or number of treatments than we have approved.

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

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

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