



Health plans are administered by:



**BlueCross BlueShield
of Vermont**

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

Health Care Benefits
University of Vermont Open Access
Summary Plan Description

This Summary Plan Description provides you with a description of your benefits while you are enrolled under the health plan offered by your employer (as Plan Administrator). You should read this document to familiarize yourself with Your Plan's main provisions and keep it handy for reference.

Blue Cross and Blue Shield of Vermont (BCBSVT) is the Contract Administrator and has been designated by your employer to provide administrative services to Your Plan such as:

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

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

Your Plan is a non-insured, self-funded health benefits plan and is financed by contributions, by your employer and/or its enrolled employees. BCBSVT is not an underwriter or insurer of the benefits provided by Your Plan. For more details concerning contributions contact your employer.

This Summary Plan Description is current until BCBSVT updates it. If you are missing part of your Summary Plan Description or not sure whether you have the most recent copy, please call BCBSVT customer service to request another copy. If the benefits described in this document differ from descriptions in other materials, your Summary Plan Description language prevails.

As the Contract Administrator, Blue Cross and Blue Shield of Vermont provides administrative claims payment services only and does not assume any financial risk or obligations with respect to claims under this Plan.

How to Use This Document

- Read Chapter One, "Guidelines for Coverage." Information there applies to all services.
- Pay special attention to the "Prior Approval Program" on page 1.
- Find the service you need in Chapter Two, "Covered Services." You may use the Index or Table of Contents to find it. Read the section thoroughly.
- Check "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 Summary Plan Description.
- Some terms in your Summary Plan Description have special meanings. Capitalized terms are explained in the last chapter of this document.
- If you need translation services such as telecommunications devices for the deaf (TDD) or telephone typewriter teletypewriter (TTY), please call (800) 535-2227.

Get It All Online

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

For instance:

- You can find this document, along with claims and benefit information on BCBSVT's Member Resource Center.
- You can find doctors and Other Providers in BCBSVT's Networks on their "Find-a-Doctor" tool on their website.
- You can order ID cards and much more—visit www.bcbsvt.com and see for yourself.

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Guidelines for Coverage

This Summary Plan Description describes benefits under Your University of Vermont Open Access plan. It is a Point-of-Service (POS) plan and is administered for your employer by Blue Cross and Blue Shield of Vermont (BCBSVT). A POS plan provides Preferred benefits when you follow managed care guidelines, but includes another, lower level of benefits ("Standard Benefits") for some services.

Chapter One explains what you must do to get benefits through your health plan. Your *Outline of Coverage* shows what you must pay. Read this entire chapter carefully, as it is your responsibility to follow its guidelines.

General Guidelines

As you read your Summary Plan Description, please keep these facts in mind:

- Capitalized words have special meanings. See "Definitions" in Chapter Nine to understand your coverage.
- Your Plan will only pay benefits for services defined as Covered by this Summary Plan Description. You must also use Providers (see definition in Chapter Nine). For some services, you must use Providers who are Network Providers.
- The provisions of this Summary Plan Description only apply as provided by law.
- Certain services are excluded from coverage under Your Plan. 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 Summary Plan Description.
- Services not considered Medically Necessary are not covered by Your Plan. You may appeal BCBSVT's decisions, see page 26 for more information.
- This is not a long-term care policy as defined by Vermont State law at 8 V.S.A. §8082 (5).
- You must follow the guidelines in this Summary Plan Description even if this coverage is secondary to other health care coverage for you or one of your Dependents.
- Your Plan Administrator may interpret and apply the terms of your Coverage. Your Plan may determine if you have coverage for care. Your Plan Administrator may also decide how much coverage you have. This applies even when a provider has prescribed or recommended a service.

Prior Approval Program

Your Plan requires Prior Approval for certain services and drugs. Services requiring Prior Approval appear as a list later in this section. Your plan does not require Prior Approval for Emergency Medical services.

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

Network Providers get Prior Approval for you. If you use a Non-Network Provider, it is your responsibility to get Prior Approval. Failure to get Prior Approval could lead to a denial of benefits. If you use a Network Provider and the Provider fails to get Prior Approval for services that require it, the Provider may not bill you.

The Prior Approval list can change. You can find out about changes through newsletters and other mailings. To get the most up-to-date list, visit BCBSVT's website at www.bcbsvt.com/priorapproval or call customer service at the number on the back of your ID card.

How to Request Prior Approval

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

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

Prior Approval List

To receive benefits you need Prior Approval to use out-of-Network Providers and for services printed on our Prior Approval list. This list includes:

- non-emergency Ambulance transport including air or water transport;
- anesthesia for colonoscopy or endoscopy;
- treatment of Autism Spectrum Disorder;
- bilevel positive airway pressure (BPAP) equipment;
- hospital-grade electric breast pump;
- capsule endoscopy;
- chemodenervation;
- chiropractic care after 12 visits in a Plan Year;

- chondrocyte transplants;
- cochlear implants and aural rehabilitation;
- continuous passive motion (CPM) equipment;
- continuous positive airway pressure (CPAP) equipment;
- oral Surgery, dental trauma, orthognathic Surgery except oral lesion excision and biopsy (your Plan does not cover wisdom teeth extraction);
- Durable Medical Equipment (DME) and orthotics with a purchase price over \$500;
- Electroconvulsive Therapy (ECT);
- gender reassignment services for gender dysphoria;
- genetic testing;
- Habilitation services;
- hip resurfacing;
- hyperbaric oxygen therapy;
- medical nutrition for inherited metabolic disease (medical supplies, pumps, enteral formulae and parenteral nutrition);
- new procedures considered Investigational or Experimental;
- orthotics with a purchase price over \$500;
- osteochondral Autograft Transfer system (OATS/mosaicplasty);
- out-of-state Inpatient and partial Inpatient care;
- percutaneous radiofrequency ablation of liver;
- plastic and Cosmetic procedures except breast reconstruction for patients with a diagnosis of breast cancer;
- polysomnography (sleep studies) and multiple sleep latency testing (MSLT);
- Prescription Drugs (certain Prescription Drugs; please see Rx Center at www.bcbsvt.com);
- prosthetics with a purchase price over \$500;
- psychological testing;
- radiation treatment;
- radiology services (examples include CT, MRI, MRA, MRS, PET, echocardiogram and nuclear cardiology);
- Rehabilitation (Skilled Nursing Facility, Inpatient Rehabilitation treatment for medical conditions, intensive outpatient services or residential treatment for mental health and substance abuse conditions);
- certain surgical procedures including bariatric (obesity) Surgery, gastric electrical stimulation, percutaneous vertebroplasty, vertebral augmentation, temporomandibular joint manipulation/Surgery and anesthesia and tumor embolization;

- transcutaneous electrical nerve stimulation (TENS) units/neuromuscular stimulators;
- transplants (except corneal and kidney);
- uvulopalatopharyngoplasty (UPPP)/somnoplasty.

Case Management Program

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

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

Choosing a Network Provider

For many services, you may use any Provider. For some services, you must use Network Providers. Most times, using Network Providers will save you money. Also, Network Providers will:

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

If you are a new Participant and are seeing a Non-Network Provider who does not Participate, BCBSVT may allow you to keep going to that Provider for up to 60 days after you join or until BCBSVT finds you a Network Provider. This can happen if:

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

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

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

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.

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

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

- provider.bcbs.com; and
- use your three-letter prefix, located on your ID card, to find a network provider using the Blue Cross and Blue Shield Association's Find-a-Doctor tool.

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

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

How BCBSVT Chooses Providers

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

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

Primary Care Providers

If you live in Vermont, you must choose a primary care provider (PCP) from BCBSVT's Network of primary care providers when you join the Open Access Plan. To get Preferred benefits for most services, you must receive services from your primary care provider or another Network Provider. You have the right to designate any primary care provider who is available to accept you or your family members. Each family member may select a different primary care provider. You may select a pediatrician for your child.

Your coverage does not require you to get referrals from your primary care provider when you use other Providers. However, you must get Prior Approval for certain services

(see page 1). For instance, you must get Prior Approval for any services you receive from Providers outside your Network to receive the highest level of benefits.

If you do not live in Vermont, you do not need to choose a primary care provider (PCP). BCBSVT encourages you to do so, though, because it benefits your health to have one doctor coordinate your care. You only pay the PCP co-payment listed on your *Outline of Coverage* if you use a Provider who practices:

- family medicine;
- general practice;
- internal medicine;
- pediatrics.

Access to Care

Your Plan requires its Network Providers in the state of Vermont to provide care for you:

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

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

- a 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 abuse care from a Network Provider within a 30-minute drive; and
- a Network pharmacy within a 60-minute drive.
- You'll find Network specialists for most types of care within a 60-minute drive from your home. They include optometry, laboratory, imaging and Inpatient medical Rehabilitation Providers, as well as intensive Outpatient, partial hospital, residential or Inpatient mental health and substance abuse services.

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

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

Non-Network Providers

You must get Prior Approval to use non-Network Providers or you pay more for the cost of your care. For some services, Your Plan provides standard benefits. For others, you get no benefits when you use non-Network providers. Your Plan reserves the right to direct you to contracted providers.

If you use a Non-Network Provider for a Covered service, Your Plan pays the Allowed Amount and you pay any balance between the Provider's charge and what Your Plan pays. You must also pay Deductibles and Co-insurance. (See your *Outline of Coverage*.) If you use one of the following Providers that is not a Network Provider, Your Plan will not Cover your care and you must pay the full cost:

- athletic trainers;
- cardiac rehabilitation Providers;
- Chiropractors;
- Durable Medical Equipment providers;
- home infusion therapy Providers;
- certified nurse midwives and licensed Professional midwives;
- lactation consultants;
- nutritional counseling Providers (including registered dietitians, licensed nutritionists, certified diabetic educators, medical doctors, naturopaths, doctors of osteopathy and nurse practitioners);
- oral surgeons;
- pharmacies;
- primary care Providers;
- Physical Rehabilitation Facilities; and
- Skilled Nursing Facilities.

Out-of-State Providers

If you need out-of-state care you may save money by using Providers that are Providers with their local Blue Plan. See the BlueCard section on page 6.¹

¹ 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, performed or delivered in order for you to receive benefits. To verify the participation status of a laboratory, durable medical equipment supplier or specialty pharmacy, please call customer service at the number on the back of your ID card.

Standard Benefits

You may be eligible for standard benefits if you receive certain services from a Provider who is not in the BCBSVT Network of Providers without receiving Prior Approval from BCBSVT. To get standard benefits, you must meet the "General Guidelines" in this section.

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

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

For all other out-of-Network services, you must receive Prior Approval or your care will not be Covered. When not following the guidelines for Preferred benefits, try to use a provider that has a participating agreement with BCBSVT or a local Blue Cross and/or Blue Shield Plan. This will save you money.

After-hours and Emergency Care

Emergency Medical Services

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

Emergencies might include:

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

You will receive care right away in an emergency.

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

If you receive Medically Necessary, Covered Emergency Medical Services from a Non-Network Provider, BCBSVT will Cover your Emergency Care as if you had been treated by a Network Provider. You must pay any cost-sharing amounts listed in your *Outline of Coverage* as if

you received those services from a Network Provider. These may include Deductibles, Co-insurance or Co-payments. If a Non-Network Provider requests any payment from you other than your cost-sharing amounts, please contact BCBSVT at the number on the back of your ID card, so that BCBSVT can work directly with the Provider to resolve the request.

Care After Office Hours

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

How Your Plan Determines Your Benefits

When BCBSVT receives your claim, it determines:

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

In general, Your Plan pays the Allowed Amount (explained later in this section). BCBSVT may subtract any:

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

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

Payment Terms

Allowed Amount

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

Note:

- Network Providers accept the Allowed Amount as full payment. You do not have to pay the difference between their total charges and the Allowed Amount.

- If you use a Non-Network Provider, Your Plan pays the Allowed Amount and you must pay any balance between the Provider's charge and what Your Plan pays.

Deductible

Your Deductible amounts are listed on your *Outline of Coverage*. You must meet your Deductibles each Plan Year before Your Plan covers certain services. Your Plan applies your Deductible to your Out-of-Pocket Limit for each Plan Year. You may have more than one Deductible. Deductibles can apply to certain services or certain Provider types.

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

Aggregate Deductible

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

Stacked Deductible

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

Check your *Outline of Coverage* for details on Your Plan.

Co-payment

You must pay Co-payments to Providers for specific services shown on your *Outline of Coverage*. Your Provider may require payment at the time of the service. Your Plan may apply Co-payments toward your Out-of-Pocket-Limit. Check your *Outline of Coverage* for details on your Plan.

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

Co-insurance

You must pay Co-insurance to Providers for specific services shown in this Summary Plan Description. Your Plan calculates the Co-insurance amount by multiplying

the Co-insurance percentage by the Allowed Amount after you meet your Deductible (for services subject to a Deductible). Your Plan applies your Co-insurance toward your Out-of-Pocket Limit for each Plan Year.

Out-of-Pocket Limit

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

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

Prescription Drug Out-of-Pocket Limit

Your Plan applies payments you make for prescription drugs to your Out-of-Pocket Limit for Prescription Drugs. After you meet your Out-of-Pocket Limit, you pay no cost-sharing for the rest of that Plan Year.

Aggregate Out-of-Pocket Limit

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

Stacked Out-of-Pocket Limit

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

Aggregate Prescription Drug Out-of-Pocket Limit

If you have prescription drug coverage, your plan may have an aggregate prescription drug out-of-pocket limit. Please see your *Outline of Coverage* for details. If your plan has an aggregate prescription drug out-of-pocket limit, and you are on a family plan, a combination of covered family members may meet the overall out-of-pocket limit for most services.

Please check your *Outline of Coverage* for details.

Plan Year Benefit Maximums

Your Plan Year Benefit maximums are listed on your *Outline of Coverage*. After Your Plan has provided maximum benefits, you must pay all charges. Please contact your employer or BCBSVT if you have specific questions about the terms of your Plan.

Self-Pay Allowed by HIPAA

Federal law gives you the right to keep your Provider from telling BCBSVT that you received a particular health care item or service. If you choose to exercise this right, you must pay the Provider the Allowed Amount. In this case, the amount you pay your Provider will not count toward your Deductible, other cost-sharing obligations or your Out-of-Pocket Limits.

Out-of-Area Services

Whenever you obtain health care services outside of the Vermont service area, the claims for these services may be processed through the BlueCard Program².

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

BlueCard® Program

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

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

and providing benefits for Covered services. The Host Blue will receive claims from its participating Providers for your care and submit those claims directly to us.

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

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

Special Case: Value-Based Programs

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

Out-of-Area Services – Non-Participating Providers

In certain situations, you may receive Covered health care services from non-participating health care Providers outside of our service area that do not have a contract with the Host Blue. In most cases, Your Plan 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, Your Plan may base the amount you pay for such services on billed Covered charges, the payment BCBSVT would make if the services had been obtained within our service area or a special negotiated payment. In these situations, you may owe the difference between the amount that the non-participating Provider bills and the payment Your Plan will make for the Covered services as set forth above.

CHAPTER TWO

Covered Services

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

Preventive Services

Your Plan provides benefits for Preventive Services. BCBSVT encourages you to get Preventive Services that are appropriate for you. Examples of preventive care include colonoscopies for men fifty and over, mammographies for women forty and over and Coverage for women's reproductive health as required by law.

Your Plan pays for some Preventive Services with no cost-sharing (like Co-payments, Deductibles and Co-insurance). Your Plan provides such Coverage for services rated A or B by the United States Preventive Services Task Force. You can find this list on BCBSVT's website at www.bcbsvt.com/preventive. Or you can call BCBSVT's customer service team at the number listed on the back of your ID card to get a list.

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

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

Office Visits

For up to two routine OB-GYN visits with a network OB-GYN Provider (that are not considered Preventive), you pay the Co-payment for Primary Care Physician Services. For all other OB-GYN office visits, you pay the Co-payment for specialists. See your *Outline of Coverage* for your Co-payment amounts.

Please read this entire section carefully. Some office visit benefits have special requirements or limits. Your Plan covers professional services in an office setting for the following services when they don't meet the definition of Preventive above:

- examination, diagnosis and treatment of an injury or illness;
- injections (other than immunizations covered under Preventive Care);

- Diagnostic Services, such as X-rays;
- Emergency Services
- Surgery; and
- therapy Services.

Notes:

- You pay only one Co-payment for all Professional maternity care you receive during a pregnancy.
- We describe office visit Benefits for Mental Health Services, Substance Abuse treatment Services and chiropractic Services elsewhere in this chapter. Please see those sections for Benefits.
- You must get Prior Approval for certain Services in order to receive Benefits. See our website or call customer service for the newest list of Services that require Prior Approval.

Please remember that General Exclusions in Chapter Three also apply.

Exclusions

We do not Cover:

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

General Exclusions in Chapter Three also apply.

Ambulance

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

Your Plan Covers transportation of the sick and injured:

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

Limitations

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

Autism Spectrum Disorder

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

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

General Exclusions in Chapter Three also apply.

Cancer Clinical Trials (Approved)

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

General exclusions in Chapter Three also apply.

Chiropractic Services

Your Plan Covers care by Network Chiropractors who are:

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

Your Plan Covers Acute and Supportive Chiropractic care (only for services that require constant attendance of a Chiropractor), including:

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

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

If you use more than 12 chiropractic visits in one Plan Year, your Provider must get Prior Approval for any visits after the 12th. See page 1 for more information about the Prior Approval program.

Exclusions

Your Plan does not provide chiropractic benefits for:

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

Please remember that General Exclusions in Chapter Three also apply.

Cosmetic and Reconstructive Procedures

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

- Reconstruction of a breast after breast cancer Surgery, and Reconstruction of the other breast to produce a symmetrical appearance;
- prostheses (which your Plan Covers under Medical Equipment and Supplies on page 13); and
- treatment of physical complications resulting from breast Surgery.

Dental Services

Your Plan covers only the following dental procedures:

- gingivectomy;
- osseus surgery;
- pedicle/soft grafts;
- accidental injury to sound natural teeth;
- apicoectomy;
- gingival flap procedure;
- osseus grafting all sites; and
- surgical extractions of impacted teeth.

There is only one level of Benefits for dental Services. You must obtain Prior Approval from us.

Exclusions

Your Plan provides no Benefits for:

- dental procedures not listed above;
- repair or replacement of damaged dental prosthesis;
- injury to teeth or gums as a result of chewing or biting; and
- pre- and post-operative care (Your Plan considers most pre- and post-operative visits part of the surgical benefit, so Your Plan does not provide additional Benefits for these Services).

Diabetes Services

Your Plan Covers treatment of diabetes. For example, it Covers syringes, insulin, nutritional counseling, Outpatient self-management training and education for people with diabetes. Your Plan pays benefits subject to the same terms

and conditions used for other medical treatments. You must get nutritional counseling from one of the following Network Providers or Your Plan will not Cover your care:

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

Diagnostic Services

Your Plan Covers the following Diagnostic Services to help find or treat a condition, including:

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

You must get Prior Approval for special radiology procedures (including CT, MRI, MRA, MRS and PET scans) and polysomnography (sleep studies). For Prior Approval see page 1.

Emergency Care

Your Plan Covers services you receive in the emergency room of a General Hospital. Coverage for Emergency Medical Services outside of the Network will be the same as for those within the Network. If a Non-Network Provider bills you for a balance between the charges and what Your Plan pays, please notify BCBSVT. Call the BCBSVT customer service team at the number on the back of your ID card.

BCBSVT will defend against and resolve any request or claim by a Non-Network Provider of Emergency Medical services.

Requirements

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

Gender Identity Care

Your Plan Covers services related to Gender Reassignment Surgery and Gender Reassignment Therapy from a Network or non-Network Provider. Services are subject to Co-insurance, Deductibles, Co-payments and the following requirements and limitations:

- Your Provider must determine that you are an appropriate candidate for gender reassignment in accordance with World Professional Association for Transgender Health (WPATH) Guidelines; and

In addition to the list of services on your *Outline of Coverage*, you must receive prior approval for your gender reassignment treatment plan from BCBSVT.

Note: Prescription drugs and mental health and substance abuse benefits related to Gender Reassignment are provided as described in other sections of your Summary Plan Description.

Home Care

Your Plan Covers the Acute services of a Home Health Agency or Visiting Nurse Association that:

- performs Medically Necessary skilled nursing procedures in the home;
- trains your family or other caregivers to perform necessary procedures in the home; or
- performs Physical, Occupational or Speech Therapy.

Your Plan also Covers:

- services of a home health aide (for personal care only) when you are receiving skilled nursing or therapy services;
- other necessary services (except drugs and medications) furnished and billed by a Home Health Agency or Visiting Nurse Association; and
- home infusion therapy.

For more information about Therapy Services, see page 16.

Private Duty Nursing

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

There may be limits on your benefits for private duty nursing. Check your *Outline of Coverage*.

- Your Plan provides benefits only if you receive services from a registered or licensed practical nurse.

Your Plan does not Cover private duty nursing services provided at the same time as home health care nursing services.

Requirements

Your Plan Covers home care services only when your Provider:

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

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

Limitations

Your Plan Covers home infusion therapy only if:

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

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

Exclusions

Your Plan does not provide home care benefits for:

- homemaker services;

drugs or medications except as noted above (while drugs and medications are not Covered under your home care benefits, your Plan may Cover them under your Prescription Drug benefits if you have a Prescription Drug rider, see your *Outline of Coverage* for details);

- Custodial Care (see Definitions), as noted in General Exclusions;
- food or home-delivered meals; and
- private-duty nursing services provided at the same time as home health care nursing services.

General Exclusions in Chapter Three also apply.

Hospice Care

Your Plan Covers the following services provided by a Hospice Provider and included in its bill:

- skilled nursing visits;
- home health aide services for personal care services only;
- homemaker services for house cleaning, cooking, etc;

- continuous care services in your home;
- Respite Care services;
- social service visits before the patient's death and up to two bereavement visits following the patient's death (for counseling and emotional support, assessment of social and emotional factors related to the patient's condition, assistance in resolving problems, assessment of financial resources, and use of available community resources); and
- other Medically Necessary services.

Requirements

Your Plan only provides benefits if:

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

Hospital Care

The description of services below does not apply to Inpatient or Outpatient mental health and substance abuse treatment. The requirements for mental health benefits appear on page 14. Requirements for substance abuse treatment benefits appear on page 16.

Inpatient Hospital Services

Your Plan Covers Acute Care during an Inpatient stay in a General Hospital including:

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

Your Plan Covers either the inpatient fee (room and board) for the day of admission or the day of discharge, but not both. Certain Inpatient services require Prior Approval. Please see page 1 for a list of these services.

Inpatient Medical Services

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

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

Notes on Surgery:

You must get Prior Approval for plastic/Cosmetic and Reconstructive procedures. Your Plan Covers sterilization procedures (vasectomy or tubal ligation) even though they are not Medically Necessary.

Your Plan limits Surgery benefits as follows:

- Your Plan Covers only one attempt at reversal of sterilization per individual per lifetime.
- BCBSVT makes global payments for some Surgeries and other procedures. This means that the Allowed Amount for the Surgery includes payment for all office visits and other care that is related to the Surgery.
- Subject to Medical Necessity, your Plan may limit the number of visits Covered for one Provider in a given day.
- If you have several Surgeries at the same time, BCBSVT may not pay a full allowance for each one. If you have questions about the way BCBSVT determines their Allowed Amount for Surgery, please call customer service at the number on the back of your ID card.
- Your Plan Covers services of a Network certified nurse midwife, a Network licensed midwife or a Provider for home delivery of a baby.
- Your Plan excludes many Cosmetic procedures (see General Exclusions in Chapter Three).

Maternity

Your hospital benefits Cover your inpatient maternity stay. (See "Inpatient Hospital Services" above for a description of your hospital benefits.) Your Plan also Covers the following care by a Provider or other Professional during a woman's pregnancy:

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

Your Plan Covers home delivery or delivery in a Facility when you use a Covered Provider. Your Plan Covers services by certified nurse midwives and licensed midwives only if they are Network Providers.

The allowed amount for delivery of a baby includes all of the services listed above. This allowance is called a "global fee." If you change Providers during your pregnancy, Your Plan will divide this fee. In addition to the services included in the global fee, Your Plan Covers care for complications of pregnancy.

Your Plan Covers newborns under this Summary Plan Description for up to 60 days after birth. (See Chapter Six for information on how to continue coverage for your newborn past this period.)

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

Better Beginnings® Maternity Wellness Program

The Better Beginnings program helps expectant mothers and their babies get the best care before and after the babies are born. If you join this program, your Plan provides a selection of benefit options designed for your circumstances. Benefit options include:

- vouchers for personal use breast pumps;
- books and educational tools;
- reimbursement on classes; and
- vouchers for carseats.

Additional options are available. Call customer service at the number on the back of your ID card or visit www.bcbsvt.com for additional, available options. To join the program, please send in appropriate paperwork from the website. To get any benefits from Better Beginnings, you must actively participate. You get the most out of the Better Beginnings program when you contact Better Beginnings in the first three months of your pregnancy.

Note:

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

Medical Equipment and Supplies

You must get Prior Approval for continuous passive motion (CPM) equipment, TENS units or Durable Medical Equipment including orthotics with a purchase price over \$500.

Your Plan Covers Durable Medical Equipment you purchase from a:

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

Your Plan Covers the rental or purchase of Durable Medical Equipment (DME). BCBSVT determines whether rental or purchase of the equipment is more appropriate.

Supplies

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

Orthotics

You must get Prior Approval for orthotics with a purchase price over \$500. Your Plan Covers molded, rigid or semi-rigid support devices that restrict or eliminate motion of a weak or diseased body part.

Prosthetics

Your Plan Covers prosthetics. You must get Prior Approval for prosthetics with a purchase price over \$500. Your Plan Covers the purchase, fitting, necessary adjustments, repairs and replacements of prosthetics. Your Plan Covers a device (and related supplies) only when the device is surgically implanted or worn as anatomic supplement to replace:

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

The benefit Covers prosthetic devices that are attached to (or inserted into) prosthetic shoes, and which replace a missing body part.

Limitations

For wigs (cranial/scalp prosthesis), Your Plan limits the replacement of the original wig (cranial/scalp prosthesis) to one wig every three years.

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

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

Also, your Plan Covers dental prostheses only if required:

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

Exclusions

Your Plan does not provide benefits for:

- prosthetics or orthotics over \$500 for which you have not received Prior Approval from BCBSVT;
- dental appliances or dental prosthetics, except as listed above;
- shoe insert orthotics, lifts, arch supports or special shoes not attached to a brace;
- custom-fabricated or custom-molded knee braces (pre-fabricated, "off-the-shelf" braces are Covered);
- duplicate medical equipment and supplies, orthotics and prosthetics;
- continuous passive motion equipment (unless you get Prior Approval);
- dynamic splinting, patient-actuated end-range motion stretching devices and programmable or variable motion resistance devices;
- replacement of medical equipment and supplies, orthotics and prosthetics that are lost or stolen;
- any treatment, Durable Medical Equipment, supplies or accessories intended principally for participation in sports or recreational activities or for personal comfort or convenience; and
- repair or replacement of dental appliances or dental prosthetics except as listed above.

General Exclusions in Chapter Three also apply.

Note:

To be sure your item meets Your Plan's definition of Durable Medical Equipment, you may call customer service at the number listed on the back of your ID before purchasing or renting a Durable Medical Equipment item.

Mental Health Care

Outpatient

Your Plan Covers Outpatient mental health services including:

- individual and Group Outpatient psychotherapy;
- family and couples therapy;

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

Inpatient

Your Plan Covers Inpatient mental health services including:

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

Your Plan Covers mental health services only if care is provided in the least restrictive setting Medically Necessary.

Exclusions

Your Plan provides no mental health benefits for:

- services ordered by a court of law (unless BCBSVT deems them Medically Necessary);
- treatment without ongoing concurrent review to ensure that treatment is being provided in the least restrictive setting required;
- non-traditional, alternative therapies that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories such as eye movement desensitization, Rubenfeld Synergy, energy polarity therapy and somatization therapy,
- services, including long-term residential programs, adventure-based activities, wilderness programs and residential programs, that focus on education, socialization or delinquency, as noted in General Exclusions;
- Custodial Care, including housing that is not integral to a Medically Necessary level of care or care solely to comply with a court order, to obtain shelter, to deter runaway or truant behavior or to achieve family respite, unless such care is Medically Necessary (see Definitions), as noted in General Exclusions;
- psychoanalysis, hypnotherapy; and
- biofeedback, pain management, stress reduction classes and pastoral counseling.

Remember that the General Exclusions in Chapter Three also apply.

Nutritional Counseling

There is no limit on the number of visits for nutritional counseling for treatment of diabetes. For all other nutritional counseling, your Plan Covers up to three Outpatient nutritional counseling visits each Plan Year.

You must receive nutritional counseling from one of the following Network Providers or your Plan will not provide benefits:

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

Outpatient Hospital Care

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

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

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

For information about therapy services, see page 16.

Outpatient Medical Services

Your Plan Covers care you receive from a Provider or Professional when you are not an Inpatient. These visits include:

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

Limitations

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

Rehabilitation/ Habilitation Services

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

Your Plan Covers:

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

Limitations

You must use a Network Preferred Participating cardiac Rehabilitation Provider.

Requirements

The attending Provider must:

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

Exclusions

Your Plan does not Cover:

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

General Exclusions in Chapter Three also apply.

Skilled Nursing Facility

Your Plan Covers Inpatient services including:

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

Requirements

Your Plan provides benefits only if you:

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

Exclusions

Your Plan does not Cover Skilled Nursing Facility care for:

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

Substance Abuse Treatment Services

Your Plan Covers the following Acute substance abuse treatment services:

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

Requirements

Your Plan Covers substance abuse treatment services only if you get care in the least restrictive setting Medically Necessary.

Please contact Blue Cross and Blue Shield of Vermont at the number listed on the back of your ID card if you have questions.

Exclusions

Your Plan provides no substance abuse treatment benefits for:

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

- Custodial Care, including housing that is not integral to a Medically Necessary level of care or care solely to comply with a court order, to obtain shelter, to deter runaway or truant behavior or to achieve family respite, unless such care is Medically Necessary (see Definitions), as noted in general exclusions; and
- biofeedback, pain management, stress reduction classes and pastoral counseling.

General Exclusions in Chapter Three also apply.

Therapy Services

Your Plan Covers physical therapy/medicine services provided by:

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

Therapy services could include the following:

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

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

- for Physical Therapy/medicine services that require constant attendance of a licensed:
 - physical therapist;
 - medical doctor (M.D.),
 - Network or Chiropractor (D.C.);
 - Network athletic trainer (A.T.);
 - podiatrist (D.P.M.);
 - nurse practitioner (N.P.);
 - advanced practice registered nurse (A.P.R.N.);
 - doctor of naturopathy (N.D.); or
 - a doctor of osteopathy (D.O.).

- up to the specific limits listed on your *Outline of Coverage* (this limitation does not apply to mandated treatment for Autism Spectrum Disorder as required by Vermont law or as explained on page 21 of this document).

Exclusions

Your Plan does not cover the following therapy services:

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

General Exclusions in Chapter Three also apply.

Note:

Your Plan does not Cover group physical medicine services, group exercise or physical therapy performed in a group setting.

Transplant Services

You must get Prior Approval for transplant services. BCBSVT reserves the right to review all requests for Prior Approval based on the:

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

Your Plan pays benefits for the following services related to transplants:

- search for a donor;
- surgical removal of an organ;

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

Your Plan pays benefits for transplants as follows:

- if Your Plan Covers both the recipient and the donor, each receives benefits under his or her own Summary Plan Description;
- if Your Plan Covers the recipient, but not the donor, both receive benefits under the recipient's Summary Plan Description (benefits available to the recipient will be paid first). The donor will only receive benefits for services that occur within 120 days from the date of the donor's Surgery;
- no benefits are available if Your Plan Covers the donor, but not the recipient.

Time Period for Living Donor Benefits

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

Exclusions

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

Please remember that General Exclusions in Chapter Three also apply.

Vision Services (Routine)

Your Plan Covers one comprehensive vision examination by a Vision Service Plan Network Provider each calendar year (for optometry—related services see page 18). This exam assesses your visual functions to:

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

Notes:

- Your Plan does not Cover the evaluation and fitting of contact lenses or eyeglasses or additional supplemental tests as part of this examination.
- Your Plan provides no standard benefits for Vision Care. To get Preferred benefits, you must use a Vision Service Plan Network Provider. For a list of Network Providers, call the number on the back of your ID card or visit the Vision Service Plan website at www.vsp.com.

Exclusions

Your Plan does not Cover services or supplies for:

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

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

Vision Services (Medical)

Your Plan Covers services by an optometrist only when he or she finds or reasonably suspects a disease condition of the eye and refers you to a Provider for treatment of that condition. Your Plan Covers your visit to an optometrist in the same way Your Plan Covers visits to Providers performing Covered eye care.

Your Plan does not Cover eyeglasses, contact lenses or any examination for the prescription, fitting or determination of need for eyeglasses or lenses for refractive purposes unless the examination or fitting is for treatment of aphakia or keratoconus.

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

General Exclusions

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

Your Plan pays benefits only for Covered services described under its terms. Your Plan and any of its incorporated documents may contain specific exclusions.

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

1. Services that a prior health plan must Cover as extended benefits.
2. Services you would not legally have to pay if you did not have your Plan or similar coverage.
3. Services for which there is no charge.
4. Services paid directly or indirectly by a local, state or federal government agency, except as otherwise provided by law.
5. Services you require because you committed or attempted to commit a felony or engaged in an illegal occupation.
6. Services over the limitations or maximums set forth by your Plan.
7. Services or drugs that BCBSVT determines are Investigational, mainly for research purposes or Experimental in nature. To the extent required by law, however, your Plan Covers routine costs for patients who participate in approved clinical trials.
8. Services not provided in accordance with accepted Professional medical standards in the United States.
9. Services beyond those needed to restore your ability to perform Activities of Daily Living (see Definitions in Chapter Nine) 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. Your Plan Covers Medically Necessary Covered services when performed within the scope of a naturopathic Provider's license.
11. Electrical stimulation devices used externally. (This exclusion does not apply to bone growth stimulators, transcutaneous electrical nerve stimulation [TENS] devices or neuromuscular stimulators for which you have received Prior Approval.)
12. Automatic ambulatory home blood pressure monitoring or equipment and all related services.
13. Biofeedback or other forms of self-care or self-help training.
14. Bulk immunizations (those provided to a group of people, such as employees in an office setting) or fluoride treatments performed in school.
15. Whole blood, blood components, costs associated with the storage of blood, testing of blood the patient donates for his or her own use (even if the blood is used), transfusion services for blood and blood components the patient donates for his or her own use in the absence of a Covered surgical procedure. (This exclusion does not apply to blood derivatives and transfusion services for whole blood, blood components and blood derivatives.)
16. Care for which there is no therapeutic benefit or likelihood of improvement.
17. Care, the duration of which is based upon a predetermined length of time rather than the condition of the patient, the results of treatment or the individual's medical progress.
18. (Routine) Circumcision.
19. Clinical ecology, environmental medicine, Inpatient confinement for environmental change or similar treatment.
20. Cognitive training or retraining and educational programs, including any program designed principally to improve academic performance, reading or writing skills.
21. Communication devices and communication augmentation devices. Computer technology or accessories and other equipment, supplies or treatment intended primarily to enhance occupational, recreational or vocational activities, hobbies or academic performance.
22. Consultations, including telephone consultations, except when they occur between Providers and the Providers attach a written report to the patient's medical record.

23. Correction of near- or far-sighted conditions or aphakia (where the lens of the eye is missing either congenitally or accidentally or has been surgically removed, as with cataracts) by means of "laser Surgery," or refractive keratoplasty procedures such as keratomileusis, keratophakia and radial keratotomy and all related services.
24. Cosmetic procedures and supplies that are not Reconstructive. (This exclusion does not apply to services covered as part of your approved treatment plan for Gender Reassignment Surgery or Gender Reassignment Therapy.)
25. Custodial Care, Rest Cures.
26. Dental services and dental-related oral Surgery, unless specifically provided by your Summary Plan Description; procedures designed primarily to prepare the mouth for dentures (including alveolar augmentation, bone grafting, frame implants and ramus mandibular stapling).
27. Treatment of developmental delays. (This exclusion does not apply to mandated treatment of Autism Spectrum Disorder as defined by Vermont law or as explained on page 9.)
28. Drugs and pharmaceuticals, except as required by law (unless your Plan covers Prescription Drugs, see Chapter Two "Covered Services" for details).
29. Eyeglasses or contact lenses for refractive purposes unless you need them for the treatment of aphakia or keratoconus (and the lens was not replaced at the time of Surgery).
30. Education, educational evaluation or therapy, therapeutic boarding schools, services that should be Covered as part of an evaluation for, or inclusion in, a Child's individualized education plan (IEP) or other educational program. (This exclusion does not apply to treatment of diabetes, such as medical nutrition therapy by approved Providers.)
31. 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.
32. Hearing aids or examinations for the prescription or fitting of hearing aids. Tinnitus masking devices.
33. 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.
34. Hot and cold packs.
35. Illnesses or injuries that are:
 - a result of an act of war (declared or undeclared); or
 - sustained in active military service.
36. Infertility services, including:
 - Surgical, radiological, pathological or laboratory procedures or medication leading to or in connection with artificial insemination (intravaginal, intracervical, and intrauterine insemination), in vitro fertilization, embryo transplantation and gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) and any variations of these procedures, including costs associated with collection, washing, preparation or storage of sperm for artificial insemination including donor fees, cryopreservation of donor sperm and eggs.
 - We may Cover up to four months of fertility medications per calendar year when you attempt to conceive through natural means (not by artificial insemination, in vitro fertilization, embryo transplantation and gamete intrafallopian transfer, zygote intrafallopian transfer or any variations of these procedures). You must get prior approval for the fertility medications.
Note: This exclusion does not apply to the evaluation to determine if and why the couple is infertile.
37. An Inpatient stay determined not Medically Necessary while you are waiting for a different level of care, such as Skilled Nursing Facility or home care, whether or not it is available to you.
38. Treatment for willfully uncooperative or intractable patients.
39. Institutional or Custodial Care for the physically or mentally handicapped.
40. Mandated treatment, including court-ordered treatment, unless such treatment is Medically Necessary, ordered by a Provider and Covered under your Summary Plan Description.
41. Non-medical charges, such as:
 - taxes;
 - postage, shipping and handling charges;
 - a penalty for failure to keep a scheduled visit; or
 - fees for completion of a claim form.

42. Nutritional counseling beyond three visits per Plan Year. This limit does not apply to the treatment of diabetes.
43. Food and nutritional formulae or supplements, except for "medical foods" prescribed for the Medically Necessary treatment of an inherited metabolic disease or prescription formulae and supplements administered through a feeding tube.
44. Orthodontics, including orthodontics performed as adjunct to orthognathic Surgery or in connection with accidental injury.
45. Pain management programs.
46. Personal hygiene items.
47. Personal service, comfort or convenience items.
48. Photography services, photographic supplies or film development supplies or services (for example, external ocular photography or photography of moles to monitor changes).
49. Physical fitness equipment, braces and devices (e.g., knee braces for skiing, running or hiking) intended primarily for use with sports or physical activities other than Activities of Daily Living (e.g., knee braces for skiing, running or hiking); weight loss or exercise programs; health club or fitness center memberships.
50. Pneumatic cervical traction devices.
51. Services, including modalities, that do not require the constant attendance of a Provider;
52. Specialized examinations, services or supplies required by your employer or for sports/recreational activities (e.g. driver certifications, pilot flight physicals, etc.).
53. Support therapies, including pastoral counseling, assertiveness training, dream therapy, equine therapy, music or art therapy, recreational therapy, tobacco cessation therapy, stress management, wilderness programs, therapy camps, adventure therapy and bright light therapy.
54. Sterilization reversal (vasectomy reversal, vasovasostomy, vasovasorrhaphy, tubal ligation reversal, tubotubal anastomosis).
55. "Store and forward" telemedicine or telemedicine not conducted at a Network facility.
56. Travel (other than Ambulance transport or Ambulance transport or travel for purposes of Gender Reassignment Therapy or Surgery), lodging and housing (when it is not integral to a Medically Necessary level of care, even if prescribed by a Provider).
57. Treatment solely to establish or re-establish the capability to perform occupational, hobby, sport or leisure activities.
58. Treatment of obesity, except surgical treatment when determined Medically Necessary through Prior Approval.
59. Unattended services or modalities (application of a service or modality) that do not require direct one-on-one patient contact by the provider.
60. Vision training, orthoptics or plano (non-prescription lenses).
61. Work-hardening programs and work-related illnesses or injuries (or those which you claim to be work-related, until otherwise finally adjudicated), provided such illnesses or injuries are Covered by workers' compensation or should be so Covered. (This provision does not require an individual, such as a sole proprietor or an owner/partner to maintain worker's compensation if he or she does not legally need to be Covered.)
62. Services and supplies not specifically described as Covered.

Provider Exclusions

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

- Provider that BCBSVT does not approve for the given service or that is not defined in our “Definitions” section as a Provider.
- Professional who provides services as part of his or her education or training program.
- Member of your immediate family or yourself.
- Veterans Administration Facility treating a service-connected disability.
- Non-Network Provider if your Plan requires use of a Network Provider as a condition for coverage under your Plan.

Claims

Remember, when you contact a Provider, you must:

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

Claim Submission

BCBSVT, as Your Plan's Contract Administrator, 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, BCBSVT may not provide benefits. Your claim must include all information necessary for BCBSVT to administer your benefits. This includes information relating to other coverage you have.

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

Release of Information

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

BCBSVT's approval of your benefits depends on your providing information, even if BCBSVT provide benefits before you do. To avoid duplicate payments, BCBSVT may inform other entities that provide benefits.

To discuss claims for a family member over 12 years of age with you, Your Plan may require a signed "Authorization to Release Information" from the Dependent.

Cooperation

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

Payment of Benefits

Your Plan pays Vermont Network Providers directly. Your Plan may pay out-of-state Network Providers directly. Your Plan usually pays you when you use Non-Network Providers. Your Plan may pay Non-Network Providers directly.

You may not assign your benefit rights to any other party, including Non-Network Providers. Your Plan may refuse to honor any benefit assignment presented.

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

Payment in Error/Overpayments

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

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

How BCBSVT Evaluates Technology

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

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

- have final approval from the appropriate governmental regulatory bodies;
- 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.

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

Complaints and Appeals

When You Have a Complaint

Customer Service

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

If You Don't Agree with Our Decision

You are entitled to several levels of review of BCBSVT's 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 BCBSVT's appeals process before taking judicial action.
- If you don't agree with BCBSVT's decision after your first-level appeal and you have coverage through an employer group, you may file a second-level internal appeal with BCBSVT. You may choose to meet with reviewers in person or by phone. Your health care provider may participate. BCBSVT will work with you to schedule a time. 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, BCBSVT selects reviewers for their clinical expertise and/or their benefits knowledge. In some cases, your health care provider may call BCBSVT to discuss your case with the Provider reviewer. This usually happens prior to the first-level internal appeal. A separate reviewer conducts each level of appeal above. None of the reviewers will be the person who first denied your claim. If your first-level appeal is clinical in nature, at least one of the reviewers will be the clinical peer of your health care provider.

Timing of Appeals

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

When you file an appeal to extend Urgent Services that BCBSVT 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 BCBSVT previously approved will end or BCBSVT will treat it as a regular appeal.

For other appeals related to services not yet provided, BCBSVT will notify you of their decision within 30 days of receiving your appeal. For all other appeals, BCBSVT will notify you of their 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 BCBSVT's denial. When you file a second-level appeal, you must do so within 90 calendar days of BCBSVT's 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 BCBSVT's customer service team. You can also get help from the

Vermont Department of Financial Regulation at (800) 964-1784. To file an emergency or urgent concurrent appeal, call the number on the back of your ID card.

Mail written appeals to:

Blue Cross and Blue Shield of Vermont
P.O. Box 186
Montpelier, VT 05601-1086

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

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

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

Information About Your Claim

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

After BCBSVT's Decision

If your appeal is urgent or concurrent, when BCBSVT has made their decision, they will notify you and your health care provider (if known) by phone right away. BCBSVT will follow up in writing within 24 hours. In all other cases, BCBSVT 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 BCBSVT denies your appeal and the decision is not overturned, you must pay for services BCBSVT didn't cover. You should discuss your payment arrangements with your provider.

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

Other Resources to Help You

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

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

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

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

BCBSVT's Ombudsman

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

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

Other Party Liability

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

Coordination of Benefits

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

BCBSVT 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 Your Plan's Allowed Amount for Covered services.

BCBSVT coordinates benefits based on coverage, not actual payment. Therefore, the BCBSVT treats the following benefits as "payment" from another payer:

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

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

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

- the payer covering a patient as an employee (Participant) is primary to a payer who Covers him or her as a Dependent;
- if a Child or Incapacitated Dependent is the patient, BCBSVT uses the NAIC "Birthday Rule," which makes the coverage of the parent whose birthday is earlier in the calendar year (without regard to year of birth) the primary payer; and

- when the above two rules don't apply, the coverage with the earliest effective date is primary and the other is secondary.

Coordination of Benefits for Children of Divorced Parents

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

- the plan of the parent with custody of the Child; then
- the plan of the Spouse/Party to a Civil Union of the parent with custody (if he or she Covers the Child); then
- the plan of the parent who does not have custody of the Child; and finally
- the plan of the Spouse/Party to a Civil Union 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, BCBSVT uses the "Birthday Rule" described above.

In an Accident

If you have an accident and you are Covered for accident-related expenses under any of the following types of coverage, the other payer is primary and Your Plan is secondary:

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

Reimbursement

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

Medicaid and Tricare

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

Your Plan's Right to Subrogation

If another person or organization caused or contributed to your illness or injuries, or is supposed to pay for your treatment (such as another carrier), then Your Plan has a right to collect back for the benefits provided by Your Plan. This is called the "right of subrogation."

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

- If Your Plan pays benefits for your health care services and then you recover expenses for those services from a third party through a suit, settlement or other means, you must reimburse Your Plan before any other party. Your Plan will have a lien on your recovery from a third party up to the amount of benefits paid.
- Regardless of whether the other party admits liability and regardless of whether the funds you recover are specified for recovery as medical expenses Your Plan may recover anything it paid.
- You must reimburse Your Plan whether or not you have been "made whole" by the third party. Your Plan might reduce what you owe to Cover a share of attorneys' fees and other costs you incur in the process. Your Plan will be responsible for only those fees to which it agrees to pay in writing.
- Your Plan reserves the right to bring a lawsuit in your name or in our name against a third party or parties to recover benefits Your Plan advanced. Your Plan may also settle its claim with a third party.
- This right of subrogation extends to any kind of auto, workers' compensation, property or liability insurance providing medical benefits.
- You must cooperate with BCBSVT and furnish information and assistance that Your Plan requires to enforce its rights.
- You must take no action interfering with Your Plan's rights and interest.
- If you refuse to pay BCBSVT, or fail to cooperate, Your Plan may take legal action against you. Your Plan may seek reimbursement from the funds you recovered from a third party, up to the amount of benefits it paid. If Your Plan does, you must also pay its attorney's fees and collection expenses. Your Plan may reduce or withhold future benefits to recover what you owe.
- You agree that you will not settle your claim against a third party without first notifying BCBSVT. In some cases, Your Plan will compromise the amount of our claim. You will not incur expenses on behalf of Your Plan, in pursuit of Your Plan's rights.

Cooperation

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

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

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

Membership

Eligibility

You are eligible to participate in this Plan if you are an active full-time or part-time employee with a work-base in the United States but excluding any temporary, on-call seasonal employees. Remember, when you add or remove Dependents, your membership (individual, two-person, or family) may change.

You may add or remove Dependents from Your Plan under the conditions noted in this chapter. To do this, contact your employer.

You must Cover either all or none of your Dependents who are eligible under Your Plan, unless otherwise ordered by a court of law.

Adding Dependents

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

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

Marriage/Civil Union

If BCBSVT receives your request within 31 days after the date of marriage/Civil Union, your new type of membership begins the first day of the month following the date of marriage/Civil Union. If BCBSVT receives your request more than 32 days after the date of your marriage/Civil Union, your new membership begins the first day of the month after BCBSVT receives your request.

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

Birth or Adoption

Your Plan Covers your Child for 60 days after:

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

BCBSVT must receive your request for adding a dependent Child to continue benefits for the Child past 60 days. If BCBSVT receives your request within the 60 days:

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

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

Dependent's Loss of Coverage

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

Court-ordered Dependents

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

Incapacitated Dependents

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

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

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

BCBSVT must receive the information within 31 days of the date the individual would lose coverage to avoid interrupting coverage. If BCBSVT receives the above information more than 31 days after the

date the individual would no longer be an eligible Dependent, coverage will begin the first day of the month after BCBSVT receives the information.

Removing Dependents

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

- a Dependent dies;
- the Participant and Spouse/Party to a Civil Union divorce or legally separate;
- a couple legally separates;
- a Child turns 26; or
- a Dependent is no longer Incapacitated.

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

Fraud, Misrepresentation or Concealment of a Material Fact

If you obtain or attempt to obtain coverage or benefits through fraud, Your Plan is void. If you or any family member commits fraud, BCBSVT may use all remedies provided by law and in equity, including recovering from you any benefits provided, attorneys' fees, costs of suits and interest.

Plan Reinstatement

By law, a canceled Plan may be reinstated solely at the discretion of BCBSVT and only on such terms and conditions as BCBSVT decides.

Medicare

Please note that this is not a Medicare supplement Contract. Your Plan will not provide benefits if you are Medicare-eligible unless otherwise required or permitted by federal law. Contact your employer to determine whether you can join the Medicare supplement plan offered through your Group. If you are eligible for Medicare, please review www.medicare.gov/Pubs/pdf/10050.pdf.

BCBSVT's Pledge to You

Blue Cross and Blue Shield of Vermont is committed to creating superior member experiences by providing highly personalized service for each and every one of your interactions with your plan. BCBSVT values and welcomes your opinion about how they execute this pledge. BCBSVT learns from your feedback and uses it to make meaningful progress and innovative changes.

Member Rights and Responsibilities

As a participant, you have the right to:

Respect and Privacy. BCBSVT takes measures to keep your health information private and protect your health care records (Please see page 33). **You have the right to be treated with respect and dignity.**

Receive Information from BCBSVT. BCBSVT will supply you with information to help you understand the organization, your rights and responsibilities as a participant, your network of providers, the benefits available to you and how to use your benefits and services. You also have the right to access records BCBSVT used to make decisions about your health care benefits, services, their practitioners and providers.

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

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

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

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

As a participant, you have the responsibility to:

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

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

Keep your providers informed and understand that your providers need your up-to-date health information to treat you effectively. Talk to your providers about

your medical history (which includes mental health and substance abuse) and your current health and participate in developing treatment goals as much as possible.

Follow plan rules and instructions for your care

that you have agreed to with your provider. To receive care or services, you must identify yourself as a member to providers and follow the policies and procedures described in your Summary Plan Description and other plan materials.

Treat your Providers and BCBSVT with respect.

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

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

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

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

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

Right to Continuation of Coverage

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

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

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

You must pay the entire cost of your coverage.

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

Continuation rights do not apply if:

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

Continuation of insurance ends when:

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

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

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

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

Conversion Rights

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

Legal Information

Applicable Law

Your Plan and this Summary Plan Description shall be construed in accordance with the laws of Vermont, except to the extent such laws are preempted by the law of any other state or federal law. Your Plan is intended for sale and delivery in, and is subject to the laws of, the State of Vermont and the United States. BCBSVT upholds its provision only to the extent allowable by law.

Future of the Plan

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

The benefits under this Plan do not vest. Your Plan Administrator reserves the right, in its sole discretion, to determine the nature and amount of benefits, if any, that will be provided to individuals (and their Dependents) under Your Plan, as well as the right to reduce, terminate or modify the terms or the amount of such benefits.

Limitation on Assignment

Your rights and benefits under Your Plan cannot be assigned, sold or transferred to your creditors or anyone else. However, you may assign your right to benefits to the health provider who rendered the services under Your Plan.

Limitation of Rights

This Summary Plan Description will not be held or construed to give any person any legal or equitable right against Your Plan Administrator, BCBSVT or any other person connected with Your Plan, except as

expressly provided in this Summary Plan Description or as provided by applicable law; or to give any person any legal or equitable right to any assets of Your Plan.

Participant Address

You must notify Your Plan Administrator of any change of address. If you have questions call BCBSVT customer service at the number listed on the back of your ID card.

Non-waiver of Our Rights

Occasionally, Your Plan may choose not to enforce certain terms or conditions of your Summary Plan Description. This does not mean Your Plan gives up the right to enforce them later.

Plan Funding

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

Prudent Actions by Plan Fiduciaries

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

Severability Clause

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

Term of Agreement

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

Third Party Beneficiaries

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

More Information About Your Plan

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

Organizations Covered by this Notice

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

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

BCBSVT may share your protected health information (PHI) as needed for treatment, payment and health care operations.

Notice of Privacy Practices for Protected Health Information

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

Organizations Covered by this Notice

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

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

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

Our Commitment to Protecting Your Privacy

BCBSVT takes your right to privacy very seriously. BCBSVT has invested significant resources to protect your privacy and comply with federal and state laws. BCBSVT safeguards your information physically, electronically and procedurally. BCBSVT requires all of our employees, business associates, Providers and vendors to adhere to privacy policies and procedures.

Federal and state laws require BCBSVT to maintain the privacy of your protected health information (PHI) and to provide this notice to you of our legal duties and privacy practices. PHI is information about you, including demographic data, that can reasonably be used to identify

you and that relates to your past, present or future physical or mental health, the provision of health care to you or the payment for that care. BCBSVT may use PHI they receive or maintain, including PHI that you may have entered on BCBSVT's Member Resource Center at www.bcbsvt.com.

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

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

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

This notice of privacy practices became effective on September 1, 2013 and replaces the previous notice of privacy practices, which became effective on September 1, 2012. BCBSVT is required to abide by the terms of the notice currently in effect.

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

BCBSVT Uses and Disclosures of Your Protected Health Information

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

Disclosures to You or Your Authorized Representative

BCBSVT may disclose PHI to you. See the section on Right to Access (Inspect and Copy) for more details. BCBSVT may also disclose your PHI to your authorized personal representative. How much PHI BCBSVT can share with

a personal representative will depend on his or her legal authority. If you would like to authorize someone to have access to some or all of your PHI, call customer service at the number listed on the back of your ID card.

Treatment

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

Payment

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

Health Care Operations

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

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

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

Appointment/Service Reminders

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

Business Associates and other Covered Entities

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

Required by Law

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

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

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

Victims of Abuse, Neglect or Domestic Violence

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

Public Health or Safety

BCBSVT may use or disclose your PHI to a public health authority that is authorized by law to collect or receive such information. For example, BCBSVT may use or disclose information for the purpose of preventing or controlling disease, injury or disability. In addition, BCBSVT may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. BCBSVT may disclose your PHI to the extent necessary to avert a serious and imminent threat to your health or safety or to that of the public. If directed by a public health authority to do so, BCBSVT also may disclose PHI to a foreign government agency that is collaborating with that public health authority.

Health Oversight Activities

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

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

Research, Death or Organ Donation

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

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

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

Your Group Health Plan or Plan Administrator (If Applicable)

Plan Administrators are employers or other organizations that sponsor group health plans. BCBSVT may disclose PHI to Your Plan Administrator of your group health plan. BCBSVT may disclose your PHI to your group's

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

Others Involved in Your Health Care

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

Your Rights

Right to Access (Inspect or Copy)

Upon your request, in accordance with the HIPAA Privacy Regulations, you have the right to examine and to receive a copy of your PHI in our possession. If requested, this may include an electronic copy in certain circumstances. Your request must be in writing, on our designated form. BCBSVT will provide the information no later than 30 days after receiving your request, unless BCBSVT maintains the information off site, in which case it may take up to 60 days for us to comply with your request. If necessary, BCBSVT may request an extension to provide you with your information. If BCBSVT denies your request, you may request that the denial be reviewed. Under certain limited conditions, our denial may not be reviewable. In the event you are entitled to a review, a licensed health care professional not involved in the original denial decision will review BCBSVT's denial. If you request a copy of the information, BCBSVT reserves the right to

charge a fee for the costs of copying, mailing or other supplies associated with your request. BCBSVT will notify you of the cost involved before you incur any costs.

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

Right to Amend

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

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

Right to a Disclosure Accounting

You have the right to a list of instances in which BCBSVT discloses your PHI in the last six years for purposes other than treatment, payment or health care operations, as

authorized by you or for certain other activities. Most disclosures of your PHI will be for purposes of payment or health care operations or made with your authorization.

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

Right to Request Confidential Communications

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

Right to Request a Restriction

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

Breach Notification

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

Non-public Personal Financial Information

BCBSVT closely guards all of the personal information they collect about their members. State and federal laws require that BCBSVT tells you how they protect private

information. This particular section deals with how BCBSVT treats “financial information.” BCBSVT does not maintain a lot of financial information about their members, but the fact that you are a member of one of BCBSVT’s health plans, is, in itself, considered “financial information.”

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

How we protect information: Except as explained below, the only people who see your non-public personal financial information are our employees who need to use the information to provide you with coverage. BCBSVT maintains physical, electronic and procedural safeguards that meet the applicable legal requirements to make sure no one else has access to your non-public personal financial information. BCBSVT keeps this information private even after your coverage ends.

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

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

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

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

Questions and Complaints

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

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

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

Telephone: (802) 371-3394

Fax: (802) 229-0511

Email: privacyofficer@bcbsvt.com

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

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

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

Newborns’ and Mothers’ Health Protection Act

Health Plans generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, Your Plan or issuer may pay for a shorter stay if the attending Provider discharges the mother or newborn earlier.

Also, under federal law, Plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a Plan or issuer may not, under federal law, require that a Provider or other health care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain Prior Approval. For information on such requirements of Your Plan, please read your documents (Summary Plan Description, *Outline of Coverage*, endorsements or riders).

If you have any questions regarding your rights under this Act, please contact BCBSVT's customer service team at the phone number on the back of your ID card.

Women's Health and Cancer Rights Act of 1998

Federal law requires us to notify you of our benefits for Reconstructive Surgery following mastectomy.

The Women's Health and Cancer Rights Act of 1998 requires that Your Plan Covers reconstruction of the breast on which a mastectomy has been performed and/or the other breast (to produce a symmetrical appearance). Your Plan also Covers prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas, as required by the Act.

Benefits for the above services are subject to all terms and conditions of Your Plan. For example, they require the same Co-insurance, Co-payments and Deductibles as the rest of your coverage.

If you have any questions about your rights under this Act, please contact BCBSVT's customer service team at the number on the back of your ID card.

BCBSVT's Quality Improvement Program

BCBSVT's quality improvement (QI) program seeks to improve your experience. It can also improve the care you get. Through QI, BCBSVT:

- makes sure you can get the care you need;
- looks at the quality of care you get from Providers; and
- works with BCBSVT staff and Providers to fix any problems.

QI studies and projects focus on:

- promoting well-care and early treatment;
- making sure all BCBSVT Providers give the same good care;
- finding and keeping the best Providers in BCBSVT Networks;
- helping Participants live with chronic diseases like asthma or diabetes;
- protecting Participants; and
- telling them about Your Plan.

Many of our QI projects involve Participant input. From time to time BCBSVT will ask you to complete surveys to help BCBSVT serve you better. BCBSVT

uses your answers to surveys to improve our policies. BCBSVT also uses the complaints you make. BCBSVT listens to you to improve Your Plan.

BCBSVT also has quality committees with Participant representatives. If you would like to be on the Participant quality committee or participate in one of BCBSVT's QI projects, please call BCBSVT's customer service team at the number on the back of your ID card. Also call if you would like to suggest a change in one of our policies. BCBSVT keeps track of these suggestions. BCBSVT looks at them when writing new policies.

Information About Your Health Plan

BCBSVT will provide you with any information about your health Plan, except if BCBSVT can't by law. Call customer service at the number on the back of your ID card.

Here are examples of information you may want:

- a copy of BCBSVT's quality improvement program;
- facts about how BCBSVT chooses Providers;
- BCBSVT Health Plan Employer Data and Information Set (HEDIS);
- results (showing how BCBSVT did in providing a list of Preventive services like pap smears);
- standards BCBSVT uses to choose Providers in BCBSVT's Network and medical review staff;
- standards BCBSVT uses to review the quality of care;
- a summary of the guidelines BCBSVT uses to make medical decisions;
- listings of BCBSVT Providers (Specialists, primary care and others);
- a list of mental health and substance abuse Providers; and
- advice on how to get a copy of your medical records.

Participating in BCBSVT Policy Making

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

Notice of Special Enrollment Rights for Group Health Plan Members

Loss of Other Coverage

If you are declining enrollment for yourself or your Dependents (including your Spouse) because of other health insurance or Group health plan coverage, you may be able to enroll yourself and your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage), otherwise you must wait until the next open enrollment period.

Marriage/Civil Union

If you have a new Dependent as a result of marriage or Civil Union and BCBSVT receives your application within 31 days after the date of marriage/Civil Union, your new type of membership is effective the first day of the month following the date of marriage/Civil Union. If BCBSVT receives your request within 32 to 60 days after the date of your marriage/Civil Union, your new membership becomes effective the first day of the month after BCBSVT receives your request.

If you fail to add your new Dependent within 60 days of your marriage/Civil Union, you must wait until an open enrollment date to do so.

Birth, Adoption or Placement for Adoption

If you have a new Dependent as a result of birth, adoption or placement for adoption, you may be able to enroll yourself and your Dependents without waiting for the next open enrollment period. If you already have a family membership, Your Plan Covers your new Child from the date of birth, legal placement for adoption or legal adoption. You should, however, notify BCBSVT of your family addition within 60 days. If you do not have a family membership, Your Plan Covers your Child for 60 days after:

- birth;
- legal placement for adoption (when placement occurs prior to adoption finalization); or
- legal adoption (when placement occurs at the same time as adoption finalization). However, BCBSVT must receive your application for a membership change in order to continue Benefits for the Child past 60 days.

If BCBSVT receives your request within the 60 days,

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

If BCBSVT receives your request within 60 days, the Child's membership and the new type of membership are effective the first day of the month following our receipt of your request.

If you fail to add your new Dependents within 60 days, you must wait until an open enrollment date to do so. To request special enrollment or obtain more information, please contact our customer service department at the number on the back of your ID card or see "Membership" in this document.

Definitions

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

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

Allowed Amount: the amount Your Plan considers reasonable for a Covered service or supply.

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

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

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.

Benefit Booklet :

your Summary Plan Description document, Your Plan and the documents listed on your *Outline of Coverage*;

- your Identification Card; and
- your application and any supplemental applications that you submitted and BCBSVT approved.

Your Summary Plan Description is subject to all of our agreements with Network Providers and other Blue Cross or Blue Shield Plans, as amended from time to time.

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

Child: see Dependent.

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

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

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

Contract Administrator: the party designated in the plan document and appointed by the Plan Administrator to adjust claims for a self-funded plan.

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

Cosmetic: primarily intended to improve appearance.

Cover(ed): describes a service or supply for which you are eligible for benefits under your Summary Plan Description.

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

- help in walking, bathing and other personal hygiene, toileting, getting in and out of bed;
- dressing;
- feeding;
- preparation of special diets;
- administration of oral medications;
- care not requiring skilled Professionals;
- child care;
- adult day care;

- Domiciliary Care (as further defined in this chapter);
- care solely to comply with a court order, to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite, unless such care is Medically Necessary;
- housing that is not integral to a Medically Necessary level of care.

Deductible: the amount you must pay toward the cost of specific services each Plan Year before Your Plan pays any benefits. Your *Outline of Coverage* shows your Deductible, benefit, Co-insurance and Co-payment amounts. (Refer also to Chapter One.)

Aggregate Deductible: Your plan may have an aggregate overall deductible. Please see your *Outline of Coverage* for details. If your plan has an aggregate overall deductible, and you are on a family plan, any combination of covered family members may meet the family overall deductible and your plan will pay post-deductible benefits. There is no individual deductible.

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

Dependent: a Participant's Spouse, the other Party to a Participant's Civil Union, Domestic Partner (if your employer allows Domestic Partner coverage) or the Participant's Child or Incapacitated Dependent Covered under Your Plan. (See Child, Spouse and Party to a Civil Union definitions.)

Child: a Participant's son, daughter or stepchild (through marriage or Civil Union), whether biological or legally adopted (including a Child living with the adoptive parents during a period of probation); or a Child for whom the Participant is legal guardian. A Child must be under age 26 unless he or she is an Incapacitated Dependent.

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

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

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

- imaging (radiology, X-rays, ultrasound and nuclear);

- studies of the nature and cause of disease (laboratory and pathology tests);
- medical procedures (ECG and EEG);
- allergy testing (percutaneous, intracutaneous, patch and RAST testing);
- mammography; and
- hearing tests by an audiologist if your doctor suspects you have a disease condition of the ear (see also exclusion number 32 on , page 41).

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

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

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

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

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

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

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

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

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

Episode: the Acute onset of a new illness or injury or the Acute exacerbation of an old illness or injury.

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

Facility (Facilities): the following institutions or entities:

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

Gender Reassignment Surgery: the reconstruction of male or female genitals, specifically, or the reconstruction by any surgical procedure of a male body into a body with female appearance, or vice versa.

Gender Reassignment Therapy: all medical procedures (including hormone replacement therapy) relating to gender reassignment of both transgender people and people born with sex characteristics of indeterminate sex.

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

- is a duly licensed institution;
- primarily provides diagnostic and therapeutic services for the diagnosis, treatment and care of injured and sick people by or under the supervision of Providers;

- has organized departments of medicine and major Surgery; and
- provides 24-hour nursing services by or under the supervision of registered nurses.

Group: the organization that has agreed to forward subscription rates due under Your Plan.

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

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

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

Incapacitated Dependent: a Dependent who meets BCBSVT's definition of Child (except he or she is over the age of 26) and who:

- is incapable of self-support by reason of mental or physical disability that has been found to be a disability that qualifies or would qualify for benefits using the definitions, standards and methodology in 20 C.F.R. Part 404, Subpart P;
- became incapable of self-support when he or she was a Child; and
- is chiefly dependent on the Participant or the Participant's estate for support and maintenance.

Incurred Date: is the date on which a Covered expense was incurred by a Covered person under your Plan. The Covered expenses, for a covered person, only for the hospital charges for all consecutive days of a single hospital confinement shall have a single incurred date considered to be the date of the original hospital admission. Each successive hospital confinement separated by one or more days will be considered new confinements with new Incurred dates.

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

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

Investigative/Investigational:
(see Experimental)

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

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

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

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

- peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
- peer-reviewed literature, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health’s National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS database Health services Technology Assessment Research (HSTAR);
- medical journals recognized by the federal Secretary of Health and Human Services, under Section 1861 (t)(2) of the federal Social Security Act;
- the following standard reference compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics and the United States Pharmacopoeia-Drug Information;

- findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and
- peer-reviewed abstracts accepted for presentation at major medical association meetings.

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

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

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

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

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

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

Ombudsman: BCBSVT has an Ombudsman members may contact with complex issues regarding care or service. BCBSVT’s Ombudsman works as a liaison between the member and Your Plan reviewing and solving issues.

In most cases, the professionals in BCBSVT’s customer service call center can answer member questions and resolve most issues. It is the role of the member

ombudsman to get involved in the process when unforeseen complications arise in the regular course of problem resolution and information gathering.

Other Provider: one of the following entities:

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

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

Your family Out-of-Pocket Limit is listed on your Summary of Benefit and Coverage. When your family meets the family Out-of-Pocket Limit, all family Participants are considered to have met their individual Out-of-Pocket Limits.

Aggregate Out-of-Pocket Limit: Your plan may have an aggregate out-of-pocket limit. Please see your Outline of Coverage for details. If your plan has an aggregate out-of-pocket limit, and you are on a family plan, any combination of covered family members may meet the overall out-of-pocket limit.

Aggregate Prescription Drug Out-of-Pocket Limit: Your plan may have an aggregate prescription drug out-of-pocket limit. Please see your *Outline of Coverage* for details. If your plan has an aggregate prescription drug out-of-pocket limit, and you are on a family plan, any combination of covered family members may meet the prescription drug out-of-pocket limit.

Stacked Out-of-Pocket Limit: Your plan may have a stacked out-of-pocket limit. Please see your *Outline of Coverage* for details. If your plan has a stacked out-of-pocket limit, and you are on a family plan, a covered family member may meet the individual out-of-pocket limit. Additionally, any combination of covered family members may meet the family out-of-pocket limit.

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

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

Participant: an individual who enrolls in the Plan.

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

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

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

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

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

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

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

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

Prescription Drugs: drugs that are:

- prescribed by a Provider for a medical condition;
- FDA-approved; and
- approved by us for reimbursement for the specific medical condition being treated or diagnosed, or as otherwise required by law.

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

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

Prior Approval: the required approval that you must get from BCBSVT before you receive specific services noted in your Summary Plan Description. In most cases, BCBSVT requires that you get our Prior Approval in writing. BCBSVT may request a treatment plan or a letter of medical need from your Provider. If you do not get approval from BCBSVT before you receive certain services as noted in your Summary Plan Description, benefits may be reduced or denied.

Professional: one of the following practitioners:

- athletic trainers
- audiologists
- Chiropractors (as further defined in this chapter)
- mental health professionals:
 - clinical mental health counselors
 - clinical psychologists
 - clinical social workers
 - marriage and family therapists
 - psychiatric nurse practitioners
- nurses:
 - certified nurse midwives or licensed Professional midwives
 - certified registered nurse anesthetists
 - licensed practical nurses (LPNs)
 - nurse practitioners
 - registered nurses (RNs)
- nutritional counselors
- optometrists
- Providers (as further defined in this chapter)
- podiatrists
- substance abuse counselors
- therapists (Occupational, Physical and Speech)
- some Providers must be in-Network in order for their services to be Covered. See Network Providers in Chapter One, "Guidelines for Coverage."

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

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

Network Provider: When you receive care in Vermont, for most Provider types in Vermont, "Network Provider" means any Provider that has a Network Provider agreement with BCBSVT. It only includes mental health and substance abuse treatment Providers who make agreements with BCBSVT's behavioral health Network. It includes only pharmacies that make agreements with our Pharmacy Benefit Manager.

When you receive care outside of Vermont, "Network Provider" means any provider that has a Preferred Provider agreement with the local Blue Cross and/or Blue Shield Plan. You may find a Network Provider on BCBSVT's website at www.bcbsvt.com. You may also get a directory of Network Providers from your Group Benefits Manager or from BCBSVT's customer service team. Some Providers must be Network in order for their services to be Covered. For some types of service, BCBSVT does not provide benefits if you do not use a Network Provider. See Choosing a Provider on page 7.

Non-Network Provider: a Provider that does not meet the definition of a Network Provider. For some types of service, BCBSVT does not provide benefits if you use a Non-Network Provider. They are listed in Chapter One.

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

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

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

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

Rehabilitative/Habilitative Services: Habilitation and Rehabilitation services may include respiratory therapy, Speech Therapy, Occupational Therapy and physical medicine treatments. Habilitation and Rehabilitation

services may be performed by those who are qualified to perform such services and do so within the scope of their license. Such services are evaluated based on objective documentation of measurable progress toward functional improvement goals. Measurement methods must be valid, reliable, repeatable, and evidence-based.

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

Residential Treatment Program: a 24-hour level of care that provides patients with long-term or severe mental disorders or substance abuse-related disorders with residential care. Care is medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. Care includes treatment with a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs. Residential care also includes training in the basic skills of living as determined necessary for each patient.

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

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

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

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

Specialty Medications: injectable and non-injectable drugs with key characteristics, including: frequent dosing adjustments and intensive clinical monitoring; intensive patient training and compliance assistance; limited product availability, specialized product handling and administration requirements. Speech Therapy (Speech-Language Pathology): Speech-language pathology (SLP) services are the treatment of swallowing, speech-language and cognitive- communication disorders. SLP services facilitate the development and maintenance of human communication and swallowing through assessment, diagnosis, and rehabilitation.

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

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

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

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

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

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

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

Benefits Enhancement Rider

Your *Summary Plan Description* is amended as described in this document. This rider becomes a part of your *Summary Plan Description* and is subject to all provisions of your Contract. Please see your *Outline of Coverage* for specific details.

I. Infertility Treatment

General Exclusions

The chapter in your *Summary Plan Description* entitled "General Exclusions" is hereby amended.

The following exclusion is stricken:

Infertility Services, including:

- All medications for treatment of infertility, including but not limited to Clomid, Clomiphene, Serophene, Bravelle, Gonal-F, Follistim AQ, Novarel, Ovidrel, Pregnyl, Profasi and Repronex (the four-cycle limitation in your Prescription Drug Rider is hereby stricken) when used for treatment of infertility; and
- Surgical, radiological, pathological or laboratory procedures leading to or in connection with artificial insemination (intravaginal, intracervical, and intrauterine insemination), in vitro fertilization, embryo transplantation and gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) and any variations of these procedures, including costs associated with collection, washing, preparation or storage of sperm for artificial insemination including donor fees, cryopreservation of donor sperm and eggs.

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

The following exclusion is added:

- Infertility services, including Surgical, radiological, pathological or laboratory procedures or medication leading to or in connection with artificial insemination (intravaginal, intracervical, and intrauterine insemination), in vitro fertilization, embryo transplantation and gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) and any variations of these procedures, including costs associated with collection, washing, preparation or storage of sperm for artificial insemination including donor fees, cryopreservation of donor sperm and eggs.

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

BCBSVT may Cover up to four months of fertility medications per calendar year when you attempt to conceive through natural means (not by artificial insemination, in vitro fertilization, embryo transplantation and gamete intrafallopian transfer, zygote intrafallopian transfer or any variations of these procedures). You must get prior approval for the fertility medications.

II. Sterilization

General Exclusions

The following exclusion is stricken from the chapter in your *Summary Plan Description* entitled "General Exclusions":

- Sterilization reversal (vasectomy reversal, vasovasostomy, vasovasorrhaphy, tubal ligation reversal, tubotubal anastomosis).

Covered Services

The "Notes on Surgery" section within the "Covered Services" chapter in your *Summary Plan Description* has been replaced with the following:

Notes on Surgery:

You must get Prior Approval for the Services listed on your Outline of Coverage, including plastic/Cosmetic and Reconstructive procedures or your care will not be Covered. BCBSVT Covers sterilization procedures (vasectomy or tubal ligation) even though they are not Medically Necessary.

BCBSVT limits Surgery Benefits as follows:

- BCBSVT Covers only one attempt at reversal of sterilization per individual per lifetime.
- BCBSVT makes global payments for some Surgeries and other procedures. This means that BCBSVT's Allowed Amount for the Surgery includes payment for all office visits and other care that is related to the Surgery.
- Subject to Medical Necessity, BCBSVT may limit the number of visits they Cover by one Provider in a given day.
- If you have several Surgeries at the same time, BCBSVT may not pay a full allowance for each

one. If you have questions about the way BCBSVT determines their Allowed Amount for Surgery, please call customer service at the number on the back of your ID card.

- BCBSVT Covers Services of a Network or Preferred certified nurse midwife (not a lay or professional midwife) or a Physician for home delivery of a baby.

BCBSVT excludes many types of Cosmetic procedures (see General Exclusions in Chapter Three).

III. Noncovered Surgery

General Exclusions

The following exclusions found in the “General Exclusions” chapter in your *Summary Plan Description* have been stricken:

Unless expressly covered in other parts of this Contract or required by law, BCBSVT does not cover:

- Excision, 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 or lower extremity;
- Breast lift (mastopexy);
- Surgery to improve the appearance of the ear (otoplasty);
- Mastectomy for gynecomastia;
- Blepharoplasty; repair of brow ptosis, repair of blepharoptosis, correction of lid retraction, reduction of overcorrection of lid ptosis; and
- Surgery to improve the appearance of the nose (rhinoplasty).

Note:

This exclusion does not apply to (1) Surgery when such service is incidental to or follows Surgery resulting from trauma, infection or other diseases of the involved part; or (2) medically diagnosed congenital disease or birth abnormality of a Covered dependent child.

IV. Dental Services

The chapter in your *Summary Plan Description* entitled “Covered Services” is hereby amended by replacing the section of Covered Services entitled Dental Services with the following:

You must get Prior Approval for some dental services (except wisdom teeth extraction) or your care may not be Covered. Please see your *Summary Plan Description*, Chapter One, “General Guidelines” for more information.

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

BCBSVT Covers only the following dental Services:

- Treatment for or in connection with an accidental injury to jaws, sound natural teeth, mouth or face, provided a continuous course of dental treatment is started within six months of the accident¹;
- 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);
- Surgical removal of bone-impacted teeth; and
- Gingivectomy only for general or systemic conditions or conditions resulting from the effects of drugs.

Exclusions

Unless expressly Covered in other parts of this Contract or required by law, BCBSVT does not Cover:

- tooth implants;
- care for periodontitis;
- injury to teeth or gums as a result of chewing or biting;
- pre- and post-operative dental care;
- orthodontics (including orthodontics performed as an adjunct to orthognathic Surgery);

¹ **Note:** A sound, natural tooth is a tooth that is whole or properly restored (restoration with amalgams only); is without impairment, periodontal conditions, or other conditions; and is not in need of treatment provided for any reason other than accidental injury. A tooth previously restored with a crown, inlay, onlay or porcelain restoration, or treated by endodontics, is not a sound natural tooth

- procedures designed primarily to prepare the mouth for dentures (including alveolar augmentation, bone grafting, frame implants and ramus mandibular stapling); or
- charges related to non-covered dental procedures (for example, anesthesia or facility charges), except when Medically Necessary for children under seven years old or any members with disabilities, medical or mental health conditions, or exceptional medical circumstances, which prevent care from being safely delivered in an office setting or under local anesthesia.

General Exclusions in Chapter Three also apply. Please remember that the General Exclusions in your *Summary Plan Description* also apply.

A handwritten signature in black ink, reading "Don C. George". The signature is written in a cursive, flowing style.

Don C. George
President and CEO

Telemedicine services benefits (M)

This document is part of your Summary Plan **Description** and explains your telemedicine benefits. Please see your Outline of Coverage for specific cost-sharing details.

1. Covered Services

The Chapter in your Summary Plan Description entitled Covered Services is hereby amended by adding the following language.

Telemedicine Services

Your Plan covers the following medically necessary, clinically appropriate telemedicine consultations performed by a Network Provider regardless of whether you're in a health facility, at work, at home or anywhere else:

- Consultations, including second opinions;
- Initial or follow-up inpatient consultations;
- Office or other outpatient visits;
- Follow-up visits after a skilled nursing facility or hospital stay;
- Psychology and psychiatric examinations intended to provide a diagnosis;
- Prescription drug management (applies only if have Prescription Drug Coverage);
- Nutritional counseling visits (Limited to three visits per Plan Year. This visit limit does not apply to treatment of diabetes. Some services require Prior Approval. For details 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 abuse and alcohol abuse treatment;
- Education and training services for managing your illness; and
- Transitional Care Management services.

Please see your Outline of Coverage for the appropriate service or supply and its corresponding

cost-sharing amount. All other terms and conditions related to in-person consultations apply.

Limitations

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

Exclusions

Your plan does not cover:

- telemedicine services via email, facsimile or non-HIPAA-compliant software;
- telemonitoring;
- store and forward medicine; or
- services otherwise excluded by your Certificate of Coverage.

2. General Exclusions

The Chapter in your Summary Plan Description entitled General Exclusions is hereby amended by adding the following language.

Your plan does not cover store and forward medicine, telemedicine services via email, facsimile or non-HIPAA-compliant software, and telemonitoring.

3. Definitions

The chapter in your Summary Plan Description entitled Definitions is hereby amended by adding the following language.

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. Telemedicine does not include the use of audio-only telephone, e-mail or facsimile.



Don C. George
President and CEO

Telemedicine program benefits (V)

This document is part of your Summary Plan **Description** and explains your telemedicine benefits. Please see your Outline of Coverage for specific cost-sharing details.

1. Covered Services

The Chapter in your Summary Plan Description entitled Covered Services is hereby amended by adding the following language.

Telemedicine Program

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

- Sick visits;
- Nutritional counseling visits (Limited to three visits per Plan Year. This visit limit does not apply to treatment of diabetes. Some services require Prior Approval. For details visit www.bcbsvt.com/priorapproval.
- Lactation consultations; and
- Mental health consultations.

BCBSVT administers this program via a contract with American Well. American Well provides you with online access to medical care for common, uncomplicated, non-emergency cases. To access these services, visit AMwell.com, or download the app from iTunes or Google Play. Please see your Outline of Coverage for details.

Limitations

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

If you have a prescription drug rider, your plan covers medically necessary, clinically appropriate Prescription Drugs and Biologics prescribed through a third-party vendor. Providers cannot prescribe any controlled substances, medication for erectile dysfunction or any state-specific controlled medications such as pseudoephedrine (subject to state law), or otherwise excluded by your Certificate of Coverage. Controlled substances include drugs such as:

- narcotics;
- anxiety medications;
- ADHD medications; and
- muscle relaxants.

Providers may not write prescriptions to patients with whom they consult by telephone (subject to state law).

Exclusions

Your plan does not cover:

- telemedicine services via email, facsimile or non-HIPAA-compliant software;
- telemonitoring;
- store and forward medicine; or
- services otherwise excluded by your Summary Plan Description.

2. General Exclusions

The Chapter in your Summary Plan Description entitled General Exclusions is hereby amended by adding the following language.

Your plan does not cover store and forward medicine, telemedicine services via email, facsimile or non-HIPAA-compliant software, and telemonitoring.

3. Definitions

The chapter in your Summary Plan Description entitled Definitions is hereby amended by adding the following language.

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. Telemedicine does not include the use of audio-only telephone, e-mail or facsimile.



Don C. George
President and CEO

Prescription Drug Rider

Your **Summary Plan Description** is amended as described in this document. This rider becomes a part of your **Summary Plan Description**. Please see your **Outline of Coverage** for specific details.

1. Covered Services

The Chapter in your **Summary Plan Description** entitled Covered Services is hereby amended by adding the following Covered Service if it is not in your **Summary Plan Description** or by replacing any Prescription Drug Covered Services already included in your **Summary Plan Description**.

Prescription Drugs

You must use a Network Pharmacy or Network home delivery pharmacy to receive benefits. To locate a Network Pharmacy, visit Blue Cross and Blue Shield of Vermont's (BCBSVT's) website at **www.bcbsvt.com** and click on the "Find A Doctor" link. BCBSVT provides benefits for Outpatient use of:

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

Benefits are subject to the exclusions listed in this rider and General Exclusions in your **Summary Plan Description**.

The Preferred Brand-name drug list can change and will be updated from time to time. BCBSVT will inform you of changes using newsletters and other mailings. To get the most up-to-date listing, you may visit BCBSVT's website at **www.bcbsvt.com** or call the pharmacy phone number on the back of your ID Card.

Home Delivery Service

The home delivery pharmacy can provide you with drugs you take on an ongoing basis.

To obtain prescriptions through the home delivery service, you must complete and send a home delivery form and submit it with your prescription. Drugs are

delivered to your home address, and you can order refills by phone, fax or on the internet. For more information about our home delivery service, call the pharmacy phone number on the back of your ID Card or visit BCBSVT's website at **www.bcbsvt.com**.

You may also save money by using BCBSVT's home delivery service. See your **Outline of Coverage** for detailed cost-sharing information about home delivery.

Limitations

Your Plan covers up to a 90-day supply for each refill. Narcotics, antibiotics, Specialty Medications, controlled substances, covered over-the-counter products and compound drugs (see below) are limited to a 30-day supply. Your Plan limits benefits for:

- Viagra to six pills per month;
- Cialis to six pills per month;
- Levitra to six pills per month;
- prescribed tobacco cessation drugs to a three-month supply per plan year; and
- Tamiflu to 10 capsules per 6 months.

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

Prior Approval Program

You must get Prior Approval for drugs on the Prior Approval drug list or your drugs will not be covered. See your **Summary Plan Description** for details regarding BCBSVT's Prior Approval Program.

BCBSVT's Prior Approval drug list changes from time to time. Visit BCBSVT's website at **www.bcbsvt.com** for the most current list. BCBSVT will inform you of changes using newsletters and other mailings. You can find the most current list at the Rx Center on BCBSVT's website or by calling the customer service department at the number listed on the back of your ID card.

Your Plan also requires prior approval for drugs that have been on the market less than 12 months, "dispense as written" prescriptions, compounded medications and for medications without National Drug Code numbers. For example:

- Biologics and other medications
- Chemotherapeutics
- Growth hormone replacement therapy

- Hepatitis C medications
- Low molecular weight heparin anticoagulants (for use in excess of 30 days per Plan year)
- Primary pulmonary hypertension therapy

Quantity Limits

BCBSVT reviews certain Prescription Drugs 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, BCBSVT may ask for documentation about why you need more of the drug. Visit BCBSVT's website at **www.bcbsvt.com** or call the pharmacy phone number listed on the back of your ID card to get a current list of drugs covered by this review or to learn the quantity limit for a particular drug.

At present, quantity limits apply to drugs in categories such as:

- Glucose test strips
- Inhalers (like Advair®)
- Pain medications (like OxyContin®)
- Anti-migraine medications (like Maxalt or Zomig®)
- Sleeping agents (such as Ambien CR® or Lunesta®)

Step Therapy

BCSBVT's step therapy program saves members money by encouraging patients and their doctors to try less expensive drugs in a therapeutic class before using the newest, most expensive ones. BCBSVT may require Prior Approval if they do not have information stating you first tried a generic drug or covered-over-the-counter drug. Step therapy applies to drugs in the following categories:

- Non-sedating antihistamines (like Clarinex® or Xyzal®)
- Angiotensin Receptor Blockers for hypertension (like Cozaar® or Diovan®)
- Anti-virals (like Valtrex® or Famcyclovir®)
- Asthma control medications (like Symbicort® and Advair®)
- Bisphosphonates (like Boniva® or Actonel®)
- COX-2 inhibitors (like Celebrex®)
- Certain medications for depression (like Lexapro® or Cymbalta®)

- Diabetes management and treatment drugs (like blood glucose supplies, DPP IV and TZDs)
- Hypertension drugs for treating high blood pressure and other heart diseases (like Bystolic® and Coreg®)
- Hypnotics (sleeping pills like Lunesta® or Rozerum®)
- Lyrica® (for treating several conditions associated with the nervous system, including neuropathy)
- Nasal steroids (Like Rhinocort AQ® or Nasacort AQ®)
- Statins (cholesterol-lowering drugs like Lipitor® 10 and 20 mg)
- Stomach acid medications (like Nexium® or Prevacid®)
- Triptans for the treatment of migraine headaches

BCBSVT also reviews certain Prescription Drugs if you do not first try the generic drug or covered over-the-counter drug. Visit BCBSVT's website at **www.bcbsvt.com** or call the pharmacy phone number listed on the back of your ID card to get a current list of drugs covered by this review or to learn the procedures to follow for review of your prescription use.

How to Get Prior Approval for Your Drugs

To get Prior Approval for your prescription drug, your provider must write to BCBSVT's integrated health management department, or its designee, with the following information:

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

If you have an emergency or an urgent need for a drug on the Prior Approval list, call the pharmacy phone number on the back of your ID Card. If BCBSVT denies your request for Prior Approval, see your **Summary Plan Description** for instructions on how to appeal BCBSVT's decision. You may also see your **Outline of Coverage** for details regarding BCBSVT's Prior Approval Program.

BCBSVT's quantity limits, step therapy and Prior Approval drug lists change from time to time. BCBSVT will inform you of changes using newsletters and other mailings. Check with your doctor or visit BCBSVT's website at **www.bcbsvt.com** to see if a specific drug needs Prior Approval or other review. You may also call

the pharmacy phone number on the back of your ID Card.

Payment Terms

Please refer to your **Outline of Coverage** to determine the specific payment requirements of your prescription drug benefit. You may have a Deductible, Co-insurance and/or Co-payments for prescription drugs. Your Plan does not apply both Co-insurance and Co-payments to the same Prescription Drug purchase.

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

Mail Order Program

Your prescription drug benefit may include access to BCBSVT's mail order pharmacy. Your **Outline of Coverage** will indicate if this is included in your benefit. The mail order pharmacy can provide you with drugs you take on an ongoing basis. To obtain prescriptions through the mail order service, you must complete and send a patient profile to BCBSVT's mail order company along with your prescription. Drugs are delivered to your home address, and you can order refills by phone, fax or on the internet. For more information call BCBSVT's customer service department at the number on the back of your ID card for a copy.

Co-payment

A Co-payment is a fixed dollar amount that you must pay for specific services. Your **Outline of Coverage** lists your Co-payment amounts. You must pay one Co-payment for each 30-day supply. You pay two Co-payments for a 90-day supply of a drug when you use the mail order pharmacy or a retail pharmacy that agrees to accept the same reimbursement as the mail order pharmacy. (Not all retail pharmacies participate in this program.)

Some prescriptions on BCBSVT's Quantity Limits list may have different Co-pay arrangements than what is noted here. Please refer to the current list by visiting BCBSVT's website at www.bcbsvt.com/pharmacy/drug-lists/rx-quantity-limits.

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 Code (NDC) for the most

expensive legend ingredient. Your cost depends on the NDC submitted for the compounded drug:

Exclusions

Your Plan does not provide prescription drug benefits for:

- refills beyond one year from the original prescription date;
- replacement of Prescription Drugs that are lost, destroyed or stolen;
- devices of any type other than prescription contraceptives, even though such devices may require a prescription including, but not limited to: Durable Medical Equipment, prosthetic devices, appliances and supports (although benefits may be provided under other sections of your Contract);
- any drug considered to be Experimental or Investigational (see definition in your **Summary Plan Description**);
- vitamins, except those which, by law, require a prescription;
- drugs that do not require a prescription, except insulin and covered over-the-counter products, even if your doctor prescribes or recommends them; and
- nutritional formulae except for "covered medical foods" prescribed for the Medically Necessary treatment of an inherited metabolic disease or those administered through a feeding tube.

2. Claim Filing

Network Pharmacy

A Network Pharmacy will collect the amount you owe (Deductible, Co-payment and/or Co-insurance) and submit claims on your behalf. BCBSVT will reimburse Network Pharmacies directly. You must use a Network Pharmacy or BCBSVT's Network home delivery pharmacy to receive benefits. However, if you need to be reimbursed, attach itemized bills for the dispensed drugs to a Prescription Reimbursement Form. Contact the pharmacy number on the back of your ID Card for assistance.

3. Definitions

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

Prescription Drugs: insulin and drugs that are:

- prescribed by a Physician for a medical condition;
- FDA-approved; and
- approved by us for reimbursement for the specific medical condition being treated or diagnosed, or as otherwise required by law.

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

A handwritten signature in black ink, reading "Don C. George". The signature is written in a cursive, flowing style with a large, stylized "D" and "G".

Don C. George
President and CEO

Preventive Care Rider (ASO)

Your *Summary Plan Description* is amended as described in this document. This rider becomes a part of your Contract and is subject to all its provisions. Please refer to all sections of your Contract, including your *Outline of Coverage*, for guidelines on coverage, including out-of-pocket expenses. Please also note that General Exclusions in your Contract apply to this Benefit.

I. Covered Services

Chapter Two in your *Summary Plan Description* is hereby amended by adding the following sections:

Preventive Services

BCBSVT provides benefits for Preventive Services. BCBSVT encourages you to get Preventive Services that are appropriate for you. BCBSVT pays for some Preventive Services with no cost sharing (like Co-payments, Deductibles and Co-insurance). BCBSVT provides such Coverage for services rated A or B by the United States Preventive Services Task Force. You can find this list on BCBSVT's website at www.bcbsvt.com/preventive. Or you can call their customer service team at the number on the back of your ID card to get a list.

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

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

Chapter Two in your *Summary Plan Description* is hereby amended by adding the following section:

Women's Health

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

This benefit Covers the following Services if they are appropriate for the member (for a detailed list, visit BCBSVT's website at www.bcbsvt.com/preventive or call our customer service team at the number on the back of your ID card):

- well-women visits;
- gestational diabetes screening;
- human papilloma virus testing;

- sexually transmitted infections counseling;
- human immunodeficiency virus counseling and screening;
- generic female contraception methods (or brand name methods if no generic is available) and contraceptive counseling;¹
- breastfeeding support and counseling from Network Providers if you have a Vermont Health Partnership or Accountable Blue *Summary Plan Description*, Preferred Providers if you have a Vermont Freedom Plan *Summary Plan Description* or Participating Providers if you have a Plan J/ Comprehensive *Summary Plan Description*;
- breastfeeding supplies (you must get Prior Approval for hospital-grade breast pumps and, if you have a Vermont Health Partnership or Accountable Blue plan, use a Network Provider); and
- domestic violence screening.

II. Definitions

The definition of Screening/Preventive in the Definitions chapter of your *Summary Plan Description* is hereby replaced by the following:

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.



Don C. George
President & CEO

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

Vision Examination Rider

Your *Summary Plan Description* is amended as described in this document. This rider becomes a part of your Contract and is subject to all its provisions. Please refer to all sections of your Contract, including your *Outline of Coverage*, for guidelines on coverage, including out-of-pocket expenses.

I. Covered Services

BCBSVT covers one comprehensive vision examination each calendar year. This exam assesses your visual functions to:

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

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

II. General Provisions

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

BCBSVT has a different allowed amount for Out-of-Network Providers than they have for Network Providers. If you decide not to see a VSP Network Provider, you may pay a larger share of the cost. You must pay for your services at the time of your appointment. Follow the instructions below to be reimbursed for out-of-network services.

III. Claim Filing

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

When you use an Out-of-Network Provider, you must pay for your services up front. BCBSVT reimburses you only up to our allowed amount for covered services. To receive reimbursement when you visit a non-VSP Provider, sign on to www.vsp.com, select the "Out-of-Network Reimbursement Form" and follow the instructions. Or, you may send an itemized receipt

listing the services received along with the patient's name and covered subscriber's name and I.D. number to VSP. Out-of-Network claims must be submitted to VSP within six months of service. Send the original claims reimbursement request and receipts to VSP, P.O. Box 997105, Sacramento, CA 95899-7105.

IV. Exclusions

BCBSVT does not cover services or supplies for:

- orthoptics, vision training or plano (nonprescription) lenses;
- vision materials (lenses, frames, etc.); and
- any eye examination or corrective eyewear required by an employer as a condition of employment.

Also refer to General Exclusions in your *Summary Plan Description*.



Don C. George
President
Blue Cross and Blue Shield of Vermont

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Health plans are administered by:



**BlueCross BlueShield
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