BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

Standard Silver 73% AV

$20 PCP / $40 Specialist co-payment, $1,900 / $3,800 Deductible
Pharmacy: $12 co-payment / $50 co-payment / 50% co-insurance; $100 Rx Deductible (waived for Generics)
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period Begins: 01/01/2014
Coverage For: All **Plan Type:** EPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsvt.com/standard-cert or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall **deductible**?	$1,900 individual / $3,800 family. Co-insurance and co-payments do not count towards the deductible. Does not apply to preventive care, office visits, urgent care, emergency medical transportation, or prescription drugs. *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. The plan pays benefits when an individual or the family meets the deductible. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2014 through 12/31/2014.
Are there other **deductibles** for specific services?	Yes. $100 prescription drug deductible per member. Does not apply to generic drugs.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an **out-of-pocket limit** on my expenses?	Yes. $4,000 individual / $8,000 family. Prescription drugs are limited to $1,200 individual / $2,400 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the **out-of-pocket limit**?	Premiums, balance-billed charges, adult vision care, adult dental services, prescription drugs and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a **network** of **providers**?	Yes. For a list of network providers see www.bcbsvt.com/findadoctor or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a **specialist**?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.

Questions: Call (800) 255-4550 or visit us at www.bcbsvt.com/standard-cert. If you aren't clear about any of the bolded terms used in this form, see the **Glossary**. You can view the **Glossary** at www.bcbsvt.com/glossary or call (800) 255-4550 to request a copy. *Deductible applies to these services.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing.**)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care **provider's** office or clinic	Primary care visit to treat an injury or illness	$20 co-payment per visit for primary care physician and mental health / substance abuse	Not covered	Some services require prior approval. For clarification on mental heatlh services visit www.bcbsvt.com/mental-health-primary care.
	Specialist visit	$40 co-payment per visit	Not covered	Some services require prior approval.
	Other practitioner office visit	$40 co-payment per visit for chiropractic services, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	Not covered	For clarification on preventive services visit www.bcbsvt.com/preventive.
If you have a test	Diagnostic test (x-ray, blood work)	40% co-insurance* for office-based and outpatient hospital	Not covered	Some services require prior approval.
	Imaging (CT/PET scans, MRIs)	40% co-insurance*	Not covered	Most services require prior approval.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is at www.bcbsvt.com/rxcenter.	Generic drugs	$12 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	$100 deductible, then $50 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Non-preferred brand drugs	$100 deductible, then 50% co-insurance	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Wellness drugs	Wellness prescription drugs process the same as any other prescription.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	40% co-insurance*	Not covered	Some services require prior approval.
	Physician / surgeon fees	40% co-insurance*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	$250 co-payment* per visit for facility services; no charge for physician services	$250 co-payment* per visit for facility services; no charge for physician services	Must meet emergency criteria.
	Emergency medical transportation	$100 co-payment per member per day	$100 co-payment per member per day	Must meet emergency criteria.
	Urgent care	$60 co-payment per visit	$60 co-payment per visit	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% co-insurance*	Not covered	None
	Physician / surgeon fee	40% co-insurance*	Not covered	Some services require prior approval.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	40% co-insurance*	Not covered	Some services require prior approval.
	Mental / Behavioral health inpatient services	40% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	40% co-insurance*	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	40% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	40% co-insurance*	Not covered	None
If you need help recovering or have other special health needs	Home health care	40% co-insurance*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	40% co-insurance* inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	40% co-insurance* for inpatient services	Not covered	Requires prior approval.
	Skilled nursing care (facility)	40% co-insurance*	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	40% co-insurance*	Not covered	May require prior approval.
	Hospice	40% co-insurance*	Not covered	None
If you or your child needs dental or eye care	Eye exam	$40 co-payment per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your child needs dental or eye care	Glasses	$40 co-payment for child glasses; 100% of charges for adult glasses	Not covered	One pair of exchange-level frames and lenses for prescription glasses or one pair of equivalent contact lenses per calendar year.
	Dental check-up	Child: Class I: No charge, Class II: 30% co-insurance, Class III: 50% co-insurance Adult: 100% of charges	Not covered	Some services require prior approval. Deductible does not apply to Preventive fluoride supplements for children with non-fluoridated drinking water.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check the policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic Surgery (except with prior approval for reconstruction)
- Dental care (age 21 and older)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care (age 21 and older)
- Routine foot care (except for treatment of diabetes)
- Weight loss programs

Other Covered Services (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery (requires prior approval)
- Chiropractic Care (requires prior approval after 12 visits)
- Non-emergency care when traveling outside the U.S. (www.bcbsvt.com/coveragewhiletraveling)
- Private-duty nursing (covered up to 14 hours per member per plan year)

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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at (800) 247-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: (800) 255-4550.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

- SPANISH (Español): Para obtener asistencia en Español, llame al (800) 255-4550.
- TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 255-4550.
- CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 (800) 255-4550.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 255-4550.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan Pays:** $4,160
- **Patient pays :** $3,380

Sample care costs:

Hospital charges (mother)	$2,700
Routine Obstetric Care	$2,100
Hospital Charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient pays:

Deductibles	$1,900
Co-pays	$20
Coinsurance	$1,310
Limits or exclusions	$150
Total	$3,380

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan Pays:** $2,490
- **Patient pays :** $2,910

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient pays:

Deductibles	$1,900
Co-pays	$560
Coinsurance	$370
Limits or exclusions	$80
Total	$2,910

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you' ll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Standard Silver 77% AV

$20 PCP / $40 Specialist co-payment, $1,500 / $3,000 Deductible
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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period Begins: 01/01/2014
Coverage For: All **Plan Type:** EPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsvt.com/standard-cert or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall **deductible**?	$1,500 individual / $3,000 family. Co-insurance and co-payments do not count towards the deductible. Does not apply to preventive care, office visits, urgent care, emergency medical transportation, or prescription drugs. *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. The plan pays benefits when an individual or the family meets the deductible. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2014 through 12/31/2014.
Are there other **deductibles** for specific services?	Yes. $100 prescription drug deductible per member. Does not apply to generic drugs.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an **out-of-pocket limit** on my expenses?	Yes. $3,000 individual / $6,000 family. Prescription drugs are limited to $1,000 individual / $2,500 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the **out-of-pocket limit**?	Premiums, balance-billed charges, adult vision care, adult dental services, prescription drugs and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a **network** of **providers**?	Yes. For a list of network providers see www.bcbsvt.com/findadoctor or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a **specialist**?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.

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- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing.**)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care **provider's** office or clinic	Primary care visit to treat an injury or illness	$20 co-payment per visit for primary care physician and mental health / substance abuse	Not covered	Some services require prior approval. For clarification on mental heatlh services visit www.bcbsvt.com/mental-health-primary care.
	Specialist visit	$40 co-payment per visit	Not covered	Some services require prior approval.
	Other practitioner office visit	$40 co-payment per visit for chiropractic services, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	Not covered	For clarification on preventive services visit www.bcbsvt.com/preventive.
If you have a test	Diagnostic test (x-ray, blood work)	40% co-insurance* for office-based and outpatient hospital	Not covered	Some services require prior approval.
	Imaging (CT/PET scans, MRIs)	40% co-insurance*	Not covered	Most services require prior approval.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is at www.bcbsvt.com/rxcenter.	Generic drugs	$12 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	$100 deductible, then $50 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Non-preferred brand drugs	$100 deductible, then 50% co-insurance	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Wellness drugs	Wellness prescription drugs process the same as any other prescription.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	40% co-insurance*	Not covered	Some services require prior approval.
	Physician / surgeon fees	40% co-insurance*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	$250 co-payment* per visit for facility services; no charge for physician services	$250 co-payment* per visit for facility services; no charge for physician services	Must meet emergency criteria.
	Emergency medical transportation	$100 co-payment per member per day	$100 co-payment per member per day	Must meet emergency criteria.
	Urgent care	$60 co-payment per visit	$60 co-payment per visit	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% co-insurance*	Not covered	None
	Physician / surgeon fee	40% co-insurance*	Not covered	Some services require prior approval.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	40% co-insurance*	Not covered	Some services require prior approval.
	Mental / Behavioral health inpatient services	40% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	40% co-insurance*	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	40% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	40% co-insurance*	Not covered	None
If you need help recovering or have other special health needs	Home health care	40% co-insurance*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	40% co-insurance* inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	40% co-insurance* for inpatient services	Not covered	Requires prior approval.
	Skilled nursing care (facility)	40% co-insurance*	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	40% co-insurance*	Not covered	May require prior approval.
	Hospice	40% co-insurance*	Not covered	None
If you or your child needs dental or eye care	Eye exam	$40 co-payment per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your child needs dental or eye care	Glasses	$40 co-payment for child glasses; 100% of charges for adult glasses	Not covered	One pair of exchange-level frames and lenses for prescription glasses or one pair of equivalent contact lenses per calendar year.
	Dental check-up	Child: Class I: No charge, Class II: 30% co-insurance, Class III: 50% co-insurance Adult: 100% of charges	Not covered	Some services require prior approval. Deductible does not apply to Preventive fluoride supplements for children with non-fluoridated drinking water.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check the policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic Surgery (except with prior approval for reconstruction)
- Dental care (age 21 and older)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care (age 21 and older)
- Routine foot care (except for treatment of diabetes)
- Weight loss programs

Other Covered Services (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery (requires prior approval)
- Chiropractic Care (requires prior approval after 12 visits)
- Non-emergency care when traveling outside the U.S. (www.bcbsvt.com/coveragewhiletraveling)
- Private-duty nursing (covered up to 14 hours per member per plan year)

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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at (800) 247-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: (800) 255-4550.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

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- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 255-4550.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan Pays:** $4,400
- **Patient pays :** $3,140

Sample care costs:

Hospital charges (mother)	$2,700
Routine Obstetric Care	$2,100
Hospital Charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient pays:

Deductibles	$1,500
Co-pays	$20
Coinsurance	$1,470
Limits or exclusions	$150
Total	$3,140

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan Pays:** $2,800
- **Patient pays :** $2,600

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient pays:

Deductibles	$1,500
Co-pays	$600
Coinsurance	$420
Limits or exclusions	$80
Total	$2,600

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you' ll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

Standard Silver 87% AV

$10 PCP / $30 Specialist co-payment, $750 / $1,500 Deductible
Pharmacy: $10 co-payment / $50 co-payment / 50% co-insurance; $100 Rx Deductible (waived for Generics)
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period Begins: 01/01/2014
Coverage For: All **Plan Type:** EPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsvt.com/standard-cert or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall **deductible**?	$750 individual / $1,500 family. Co-insurance and co-payments do not count towards the deductible. Does not apply to preventive care, office visits, urgent care, emergency medical transportation, or prescription drugs. *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. The plan pays benefits when an individual or the family meets the deductible. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2014 through 12/31/2014.
Are there other **deductibles** for specific services?	Yes. $100 prescription drug deductible per member. Does not apply to generic drugs.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an **out-of-pocket limit** on my expenses?	Yes. $1,250 individual / $2,500 family. Prescription drugs are limited to $400 individual / $800 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the **out-of-pocket limit**?	Premiums, balance-billed charges, adult vision care, adult dental services, prescription drugs and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a **network** of **providers**?	Yes. For a list of network providers see www.bcbsvt.com/findadoctor or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a **specialist**?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.

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- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing.**)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care **provider's** office or clinic	Primary care visit to treat an injury or illness	$10 co-payment per visit for primary care physician and mental health / substance abuse	Not covered	Some services require prior approval. For clarification on mental heatlh services visit www.bcbsvt.com/mental-health-primary care.
	Specialist visit	$30 co-payment per visit	Not covered	Some services require prior approval.
	Other practitioner office visit	$30 co-payment per visit for chiropractic services, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	Not covered	For clarification on preventive services visit www.bcbsvt.com/preventive.
If you have a test	Diagnostic test (x-ray, blood work)	40% co-insurance* for office-based and outpatient hospital	Not covered	Some services require prior approval.
	Imaging (CT/PET scans, MRIs)	40% co-insurance*	Not covered	Most services require prior approval.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is at www.bcbsvt.com/rxcenter.	Generic drugs	$10 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	$100 deductible, then $50 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Non-preferred brand drugs	$100 deductible, then 50% co-insurance	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Wellness drugs	Wellness prescription drugs process the same as any other prescription.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	40% co-insurance*	Not covered	Some services require prior approval.
	Physician / surgeon fees	40% co-insurance*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	$250 co-payment* per visit for facility services; no charge for physician services	$250 co-payment* per visit for facility services; no charge for physician services	Must meet emergency criteria.
	Emergency medical transportation	$100 co-payment per member per day	$100 co-payment per member per day	Must meet emergency criteria.
	Urgent care	$50 co-payment per visit	$50 co-payment per visit	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% co-insurance*	Not covered	None
	Physician / surgeon fee	40% co-insurance*	Not covered	Some services require prior approval.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	40% co-insurance*	Not covered	Some services require prior approval.
	Mental / Behavioral health inpatient services	40% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	40% co-insurance*	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	40% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	40% co-insurance*	Not covered	None
If you need help recovering or have other special health needs	Home health care	40% co-insurance*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	40% co-insurance* inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	40% co-insurance* for inpatient services	Not covered	Requires prior approval.
	Skilled nursing care (facility)	40% co-insurance*	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	40% co-insurance*	Not covered	May require prior approval.
	Hospice	40% co-insurance*	Not covered	None
If you or your child needs dental or eye care	Eye exam	$30 co-payment per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your child needs dental or eye care	Glasses	$30 co-payment for child glasses; 100% of charges for adult glasses	Not covered	One pair of exchange-level frames and lenses for prescription glasses or one pair of equivalent contact lenses per calendar year.
	Dental check-up	Child: Class I: No charge, Class II: 30% co-insurance, Class III: 50% co-insurance Adult: 100% of charges	Not covered	Some services require prior approval. Deductible does not apply to Preventive fluoride supplements for children with non-fluoridated drinking water.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check the policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic Surgery (except with prior approval for reconstruction)
- Dental care (age 21 and older)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care (age 21 and older)
- Routine foot care (except for treatment of diabetes)
- Weight loss programs

Other Covered Services (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery (requires prior approval)
- Chiropractic Care (requires prior approval after 12 visits)
- Non-emergency care when traveling outside the U.S. (www.bcbsvt.com/coveragewhiletraveling)
- Private-duty nursing (covered up to 14 hours per member per plan year)

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

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Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan Pays:** $6,140
- **Patient pays :** $1,400

Sample care costs:

Hospital charges (mother)	$2,700
Routine Obstetric Care	$2,100
Hospital Charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient pays:

Deductibles	$750
Co-pays	$0
Coinsurance	$500
Limits or exclusions	$150
Total	$1,400

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan Pays:** $4,070
- **Patient pays :** $1,330

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient pays:

Deductibles	$750
Co-pays	$320
Coinsurance	$180
Limits or exclusions	$80
Total	$1,330

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you' ll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Standard Plan Name: BCBS-EPO-X-STANDARD-SILVER-X-87AV(MD15348) BCBS-RxHIX-100-400-x-10-50-0.5-x-P(RX15352) CY 1014732

Template Name : MedHIX-2-Network-012014

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

Standard Silver 94% AV

$5 PCP / $15 Specialist co-payment, $100 / $200 Deductible
Pharmacy: $5 co-payment / $20 co-payment / 30% co-insurance
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period Begins: 01/01/2014
Coverage For: All **Plan Type:** EPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsvt.com/standard-cert or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall **deductible**?	$100 individual / $200 family. Co-insurance and co-payments do not count towards the deductible. Does not apply to preventive care, office visits, urgent care, emergency medical transportation, or prescription drugs. *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. The plan pays benefits when an individual or the family meets the deductible. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2014 through 12/31/2014.
Are there other **deductibles** for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart, starting on page 2, for other costs for services this plan covers.
Is there an **out-of-pocket limit** on my expenses?	Yes. $500 individual / $1,000 family. Prescription drugs are limited to $200 individual / $400 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the **out-of-pocket limit**?	Premiums, balance-billed charges, adult vision care, adult dental services, prescription drugs and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a **network** of **providers**?	Yes. For a list of network providers see www.bcbsvt.com/findadoctor or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a **specialist**?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.

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- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing.**)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care **provider's** office or clinic	Primary care visit to treat an injury or illness	$5 co-payment per visit for primary care physician and mental health / substance abuse	Not covered	Some services require prior approval. For clarification on mental heatlh services visit www.bcbsvt.com/mental-health-primary care.
	Specialist visit	$15 co-payment per visit	Not covered	Some services require prior approval.
	Other practitioner office visit	$15 co-payment per visit for chiropractic services, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	Not covered	For clarification on preventive services visit www.bcbsvt.com/preventive.
If you have a test	Diagnostic test (x-ray, blood work)	10% co-insurance* for office-based and outpatient hospital	Not covered	Some services require prior approval.
	Imaging (CT/PET scans, MRIs)	10% co-insurance*	Not covered	Most services require prior approval.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is at www.bcbsvt.com/rxcenter.	Generic drugs	$5 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	$20 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Non-preferred brand drugs	30% co-insurance	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Wellness drugs	Wellness prescription drugs process the same as any other prescription.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	10% co-insurance*	Not covered	Some services require prior approval.
	Physician / surgeon fees	10% co-insurance*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	$75 co-payment* per visit for facility services; no charge for physician services	$75 co-payment* per visit for facility services; no charge for physician services	Must meet emergency criteria.
	Emergency medical transportation	$50 co-payment per member per day	$50 co-payment per member per day	Must meet emergency criteria.
	Urgent care	$35 co-payment per visit	$35 co-payment per visit	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance*	Not covered	None
	Physician / surgeon fee	10% co-insurance*	Not covered	Some services require prior approval.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	10% co-insurance*	Not covered	Some services require prior approval.
	Mental / Behavioral health inpatient services	10% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	10% co-insurance*	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	10% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	10% co-insurance*	Not covered	None
If you need help recovering or have other special health needs	Home health care	10% co-insurance*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	40% co-insurance* inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	10% co-insurance* for inpatient services	Not covered	Requires prior approval.
	Skilled nursing care (facility)	10% co-insurance*	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	10% co-insurance*	Not covered	May require prior approval.
	Hospice	10% co-insurance*	Not covered	None
If you or your child needs dental or eye care	Eye exam	$15 co-payment per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your child needs dental or eye care	Glasses	$15 co-payment for child glasses; 100% of charges for adult glasses	Not covered	One pair of exchange-level frames and lenses for prescription glasses or one pair of equivalent contact lenses per calendar year.
	Dental check-up	Child: Class I: No charge, Class II: 30% co-insurance, Class III: 50% co-insurance Adult: 100% of charges	Not covered	Some services require prior approval. Deductible does not apply to Preventive fluoride supplements for children with non-fluoridated drinking water.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check the policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic Surgery (except with prior approval for reconstruction)
- Dental care (age 21 and older)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care (age 21 and older)
- Routine foot care (except for treatment of diabetes)
- Weight loss programs

Other Covered Services (This isn't a complete list. Check the policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery (requires prior approval)
- Chiropractic Care (requires prior approval after 12 visits)
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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at (800) 247-2583. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: (800) 255-4550.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

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- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 255-4550.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan Pays:** $6,890
- **Patient pays :** $650

Sample care costs:

Hospital charges (mother)	$2,700
Routine Obstetric Care	$2,100
Hospital Charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient pays:

Deductibles	$100
Co-pays	$0
Coinsurance	$400
Limits or exclusions	$150
Total	$650

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan Pays:** $4,820
- **Patient pays :** $580

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient pays:

Deductibles	$100
Co-pays	$290
Coinsurance	$110
Limits or exclusions	$80
Total	$580

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you' ll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

Standard Silver

$20 PCP / $40 Specialist co-payment, $1,900 / $3,800 Deductible
Pharmacy: $12 co-payment / $50 co-payment / 50% co-insurance; $100 Rx Deductible (waived for Generics)
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period Begins: 01/01/2014
Coverage For: All **Plan Type:** EPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsvt.com/standard-cert or by calling (800) 255-4550.

Important Questions	Answers	Why this matters:
What is the overall **deductible**?	$1,900 individual / $3,800 family. Co-insurance and co-payments do not count towards the deductible. Does not apply to preventive care, office visits, urgent care, emergency medical transportation, or prescription drugs. *Deductible applies to these services.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. The plan pays benefits when an individual or the family meets the deductible. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. Your accumulators, such as deductibles and out-of-pocket limits and benefit limits apply to your plan year for all medical and prescription drug benefits. Your plan year: 01/01/2014 through 12/31/2014.
Are there other **deductibles** for specific services?	Yes. $100 prescription drug deductible per member. Does not apply to generic drugs.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an **out-of-pocket limit** on my expenses?	Yes. $5,100 individual / $10,200 family. Prescription drugs are limited to $1,250 individual / $2,500 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the **out-of-pocket limit**?	Premiums, balance-billed charges, adult vision care, adult dental services, prescription drugs and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a **network** of **providers**?	Yes. For a list of network providers see www.bcbsvt.com/findadoctor or call (800) 255-4550.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a **specialist**?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See your policy or plan document for additional information about excluded services.

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- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing.**)
- This plan may encourage you to use network **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care **provider's** office or clinic	Primary care visit to treat an injury or illness	$20 co-payment per visit for primary care physician and mental health / substance abuse	Not covered	Some services require prior approval. For clarification on mental heatlh services visit www.bcbsvt.com/mental-health-primary care.
	Specialist visit	$40 co-payment per visit	Not covered	Some services require prior approval.
	Other practitioner office visit	$40 co-payment per visit for chiropractic services, nutritional counseling and outpatient physical, speech and occupational therapy	Not covered	Some services require prior approval. Frequency limits apply.
	Preventive care / Screening / Immunization	No charge	Not covered	For clarification on preventive services visit www.bcbsvt.com/preventive.
If you have a test	Diagnostic test (x-ray, blood work)	40% co-insurance* for office-based and outpatient hospital	Not covered	Some services require prior approval.
	Imaging (CT/PET scans, MRIs)	40% co-insurance*	Not covered	Most services require prior approval.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is at www.bcbsvt.com/rxcenter.	Generic drugs	$12 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
	Preferred brand drugs	$100 deductible, then $50 co-payment per prescription	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Non-preferred brand drugs	$100 deductible, then 50% co-insurance	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
	Wellness drugs	Wellness prescription drugs process the same as any other prescription.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	40% co-insurance*	Not covered	Some services require prior approval.
	Physician / surgeon fees	40% co-insurance*	Not covered	Some services require prior approval.
If you need immediate medical attention	Emergency room services	$250 co-payment* per visit for facility services; no charge for physician services	$250 co-payment* per visit for facility services; no charge for physician services	Must meet emergency criteria.
	Emergency medical transportation	$100 co-payment per member per day	$100 co-payment per member per day	Must meet emergency criteria.
	Urgent care	$60 co-payment per visit	$60 co-payment per visit	Applies to urgent care facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% co-insurance*	Not covered	None
	Physician / surgeon fee	40% co-insurance*	Not covered	Some services require prior approval.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	40% co-insurance*	Not covered	Some services require prior approval.
	Mental / Behavioral health inpatient services	40% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
	Substance use disorder outpatient services	40% co-insurance*	Not covered	Some services require prior approval.
	Substance use disorder inpatient services	40% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	None
	Delivery and all inpatient services	40% co-insurance*	Not covered	None
If you need help recovering or have other special health needs	Home health care	40% co-insurance*	Not covered	Private duty nursing and home infusion therapy require prior approval.
	Rehabilitation services	40% co-insurance* inpatient and cardiac / pulmonary services	Not covered	Inpatient rehabilitation services require prior approval. Frequency limits apply.
	Habilitation services	40% co-insurance* for inpatient services	Not covered	Requires prior approval.
	Skilled nursing care (facility)	40% co-insurance*	Not covered	Requires prior approval.
	Durable medical equipment (including supplies)	40% co-insurance*	Not covered	May require prior approval.
	Hospice	40% co-insurance*	Not covered	None
If you or your child needs dental or eye care	Eye exam	$40 co-payment per child exam; 100% of charges for adult exam	Not covered	One routine vision exam per calendar year.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your child needs dental or eye care	Glasses	$40 co-payment for child glasses; 100% of charges for adult glasses	Not covered	One pair of exchange-level frames and lenses for prescription glasses or one pair of equivalent contact lenses per calendar year.
	Dental check-up	Child: Class I: No charge, Class II: 30% co-insurance, Class III: 50% co-insurance Adult: 100% of charges	Not covered	Some services require prior approval. Deductible does not apply to Preventive fluoride supplements for children with non-fluoridated drinking water.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check the policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic Surgery (except with prior approval for reconstruction)
- Dental care (age 21 and older)
- Hearing aids
- Infertility treatment
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See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan Pays:** $4,160
- **Patient pays :** $3,380

Sample care costs:

Hospital charges (mother)	$2,700
Routine Obstetric Care	$2,100
Hospital Charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient pays:

Deductibles	$1,900
Co-pays	$20
Coinsurance	$1,310
Limits or exclusions	$150
Total	$3,380

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan Pays:** $2,490
- **Patient pays :** $2,910

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient pays:

Deductibles	$1,900
Co-pays	$560
Coinsurance	$370
Limits or exclusions	$80
Total	$2,910

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- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you' ll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

We'll see you through.

BlueCross BlueShield of Vermont

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

2013 Health Care Benefits

Standard Plan

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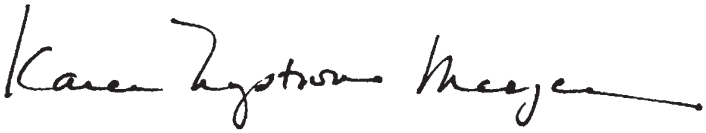
After we accept your application, we Cover the health care Services in your Contract, subject to all Contract conditions. Coverage continues from month to month until your Contract ends as allowed by its provisions. (See Chapters Six and Seven.)

The service area for your health plan is the state of Vermont. We sell health plans to people who live in Vermont. We sell plans to employer Groups located in the state of Vermont. You may receive care both inside and outside of the service area. Please read the *Guidelines for Coverage* chapter carefully to find out when you may receive care outside the area.

Karen Nystrom Meyer

Chair of the Board



Don C. George

President & CEO

Christopher Gannon

General Counsel & Secretary

IMPORTANT INFORMATION

Vermont Mandates

The State of Vermont requires we provide you with a list of state-required benefits. These benefit mandates may be subject to limitations set forth in applicable law and elsewhere in your contract documents, including your Certificate of Coverage, your *Outline of Coverage* and any accompanying riders or endorsements. They are also subject to our medical management policies as applicable. This list may not be exhaustive and may be amended from time to time based on new state laws or directives of the state of Vermont. Please review your *Outline of Coverage*, the Covered Services section of your Certificate of Coverage and, when necessary, refer to Vermont State law for the most up to date information regarding state mandated benefits.

Benefit Mandates

Your Contract is required to Cover the following benefit mandates:

- Mental health and substance abuse care, 8 V.S.A. § 4089b
- Routine costs related to approved cancer clinical trials, 8 V.S.A § 4088b; Vermont Department of Financial Regulation H-2005-03
- Chemotherapy (growth-cell stimulated factor injections), 8 V.S.A. § 4088c
- Colorectal Screening, 8 V.S.A. § 4100g
- Contraception-Reproductive Health Equity, 8 V.S.A. § 4099c
- Craniofacial Disorders, 8 V.S.A. § 4089g
- Diabetes equipment, supplies, services and education, 8 V.S.A. § 4089c
- Mammography, 8 V.S.A. § 4100a
- Maternity, Regulation 89-1; Department of Financial Regulation Insurance Bulletin I-54; Vermont Department of Financial Regulation Insurance Bulletin I-96
- Off-label prescription drugs for cancer treatment, 8 V.S.A. § 4100e; Vermont Department of Financial Regulation (Health Care Administration) Bulletin 121
- Orally administered anticancer medication, 8 V.S.A. § 4100h
- Treatment of Inherited Metabolic Diseases, 8 V.S.A. §4089c
- Prescription Drug Parity, 8 V.S.A. §4089j; Vermont Department of Financial Regulation (Health Care Administration) Bulletin HCA 114
- Prostate Screenings, 8 V.S.A. §4100f
- Prosthetic Limb Parity, 8 V.S.A. §4088f
- Medical Expenses of Live Transplant Donor, Vermont Department of Financial Regulation 80-1, §7(A)(9)
- Autism Spectrum Disorder, 8 V.S.A. § 4088i
- Anesthesia coverage for certain dental procedures, 8 V.S.A. §4100i.
- Coverage for tobacco cessation programs, 8 V.S.A. §4100j.Chapter One

CHAPTER ONE

Guidelines for Coverage

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

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

General Guidelines

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

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

Prior Approval Program

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

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 can show that the services you received were Medically Necessary, we will provide benefits. In most instances, if you use a Provider in our Blue Cross and Blue Shield of Vermont Network and the Provider fails to get Prior Approval for services that require it, the Provider may not bill you.

Our Prior Approval list can change. We inform you of changes using newsletters and other mailings. To get the most up-to-date list, visit our website at **www.bcbsvt.com** or call our customer service team at (800) 310-5249.

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

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

Prior Approval List

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

- 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;
- continuous passive motion (CPM) equipment;
- continuous positive airway pressure (CPAP) equipment;
- oral Surgery, dental trauma, orthognathic Surgery except oral lesion excision and biopsy (your Health Plan does not Cover wisdom teeth extraction for Members over age 21; see page 8 for details);
- Durable Medical Equipment (DME) and orthotics with a purchase price over $500;
- electro-shock therapy;
- gender reassignment services for gender dysphoria;
- genetic testing;
- Habilitation services;
- hyperbaric oxygen therapy;

- Inpatient or partial-Inpatient mental health or substance abuse services;
- medical nutrition for inherited metabolic disease (medical supplies, pumps, enteral formulae and parenteral nutrition);
- mental health care after 10 Outpatient visits in a Plan year;
- new procedures considered Investigational or Experimental;
- Non-Network services;
- medically necessary orthodontia for pediatric members up to age 21;
- osteochondral Autograft Transfer System (OATS)/mosaicplasty;
- out-of-state 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;
- psychological testing;
- radiology services (examples include CT, MRI, MRA, MRS, PET, echocardiogram and nuclear cardiology);
- Inpatient Rehabilitation (Skilled Nursing Facility/Inpatient Rehabilitation Facility);
- substance abuse treatment after 10 visits in a Plan year;
- 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 kidney);
- uvulopalatopharyngoplasty (UPPP)/somnoplasty.

Case Management Program

Our 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) 310-5249 and choose option 1.

Choosing a Network Provider

For most services, you must use Network Providers or get Prior Approval to get care outside of the Network. In Vermont, you will use our preferred Network. It includes a wide array of Primary Care Physicians, Specialists and Facilities in our state and in bordering communities in other states. Outside of this area, you will use our BlueCard Network. It includes Providers that contract with other Blue Cross and/or Blue Shield Health Plans. For pediatric dental, pharmacy and vision services please use our special Network Providers.

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

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

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

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

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

We only allow this if your Non-Network Provider will accept the Health Plan's rates and follow the Health Plan's standards. The Health Plan's medical staff must decide that you qualify for the service. To find out, call our customer service team at (800) 310-5249.

If you want a list of our Network Providers or want information about one, please visit our website at **www.bcbsvt.com** and use the Find-a-Doctor tool. Or call our customer service team at (800) 310-5249. We 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 We Choose Providers

When we choose Network Providers, we check their backgrounds. We use standards of the National Committee on Quality Assurance (NCQA). We choose Network

Providers who can provide the best care for our Members. We do not reward Providers or staff for denying services. We do not encourage Providers to withhold care.

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

Primary Care Physicians

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

Your coverage does not require you to get referrals from your PCP when you use Other Providers. However, you must get Prior Approval for certain services. (See page 1.) You must get Prior Approval for any services you receive from Providers outside our Network.

If you do not live in Vermont, you do not need to choose a PCP. We encourage 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;
- naturopaths;
- pediatrics.

Access to Care

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

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

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

- a Network Primary Care Physician (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 specialists for most common types of care within a 60-minute drive from your home. They include optometry, laboratory, imaging and Inpatient medical rehabilitation Providers, as well as intensive Outpatient, partial hospital, residential or Inpatient mental health and substance abuse services.

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

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

Non-Network Providers

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

Out-of-State Providers

If you need care outside of Vermont, you may save money by using Providers that are Preferred Providers with their local Blue Health Plan. See the BlueCard section on page 5.[1] You must get Prior Approval for most out-of-state care.

After-hours and Emergency Care

Emergency Medical Services

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

Emergencies might include:

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

1 Independent clinical laboratories, Durable Medical Equipment Suppliers and specialty pharmacies must contract directly with the Blue Health Plan in the state where the services were ordered, performed or delivered in order to be considered Network Providers. To verify the participation status of a laboratory, Durable Medical Equipment supplier or specialty pharmacy, please call our customer service team at (800) 310-5249.

You will receive care right away in an emergency.

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

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

Care After Office Hours

In most non-emergency cases, call your 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. Ask questions about care after hours before you have an urgent problem. Then keep your doctor's phone number handy in case of late-night illnesses or injuries.

How We Determine Your Benefits

When we receive your claim, we determine:

- If this Contract Covers the medical services you received; and
- your benefit amount.

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

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

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

Payment Terms

Allowed Amount

The Allowed Amount is the amount we agree to pay for a Covered service or supply.

Note:

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

Deductible

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

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

Co-payment

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

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

Co-insurance

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

Out-of-Pocket Limit

Your *Outline of Coverage* lists your Out-of-Pocket Limit. We apply your Deductible, your Co-payment and your Co-insurance toward this limit. Check your *Outline of Coverage* for details on your Health Plan. After you meet your Out-of-Pocket Limit, you pay no Co-insurance or Co-payments for the rest of that Plan Year.

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.

Plan Year Benefit Maximums

Your Plan Year benefit maximums are listed on your *Outline of Coverage* or in this Certificate. After we have provided maximum benefits, you must pay all charges.

Self-Pay Allowed by HIPAA

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

Out-of-Area Services

We have relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain health care services outside of the Vermont service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between us and other Blue Cross and Blue Shield Licensees. [1]

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. We will still honor our contract with you. The Host Blue will contract with, and submit claims received from, its Providers that provide your care directly to us.

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

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

Often, this "negotiated price" is a discount that reflects an actual price that the Host Blue pays to the Provider. In some cases it may be an estimated price that takes into account a special arrangement with a single Provider or a group of Providers. In other cases, it may be an average price, based on a discount that results in expected average savings for services from similar types of Providers.

For estimated and average prices, Host Blues may use a number of factors to establish these prices. These may include types of settlements; incentive payments; and/or other credits or charges. Host Blues may also need to adjust their prices to correct for over- or underestimation of past prices. We will not apply any further adjustments to the price on the claim that we will use to determine the amount you pay now.

Also, federal and/or state law may require a Host Blue to add other items, including a surcharge, to the price of a claim. If that occurs, we will calculate what you owe for any Covered health care services according to applicable law.

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 we will base the amount you pay for such services on either the Host Blue's local payment or the pricing arrangements under applicable state law.

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

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

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 Network Provider benefits. To verify the participation status of a laboratory, Durable Medical Equipment supplier or specialty pharmacy, please call our customer service team at (800) 310-5249.

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-insurance and Deductibles.

Preventive Services

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

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

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

Women's Health

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

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

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

Office Visits

When you receive care in an office setting, you must pay the amount listed on your *Outline of Coverage*. Please read this entire section carefully. Some office visit benefits have special requirements or limits. We Cover Professional services in an office setting for:

- examination, diagnosis and treatment of an injury or illness;
- Preventive care including routine physical examinations, immunizations and Well-Child Care;
- injections;
- Diagnostic Services, such as X-rays;
- Emergency Medical Services (See page 3);
- nutritional counseling (See page 12);
- Surgery; and
- therapy services (See page 16).

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.

Notes:

- 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 page 1 for a description of the Prior Approval program. Visit our website or call our customer service team at (800) 310-5249 for the newest list of services that require Prior Approval.

Ambulance

We Cover Ambulance services as long as your condition meets our definition of an Emergency Medical Condition. Coverage for Emergency Medical Services outside of the service area is the same as coverage within the service area. If a Non-Network Provider bills you for a balance

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

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

We Cover transportation of the sick and injured:

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

Limitations

- You must get Prior Approval for non-emergency transport including air or water transport.
- We Cover transportation only to the closest Facility that can provide services appropriate for the treatment of your condition.
- We do not Cover Ambulance services when the patient can travel by private car, whether or not a car is available.

Autism Spectrum Disorder

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

Your must get Prior Approval for services or your benefits will not be covered.

Please remember General Exclusions in Chapter Three also apply.

Chiropractic Services

We Cover services by our Network Chiropractors who are:

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

We Cover Acute and Supportive chiropractic care, including:

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

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

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

Exclusions

We provide no chiropractic benefits for:

- treatment after the 12th visit if you don't get Prior Approval;
- services by a Provider who is not in our Network;
- services, including modalities, that do not require the constant attendance of a Chiropractor;
- treatment of any "visceral condition," that is a dysfunction of the abdominal or thoracic organs, or other condition that is not neuromusculoskeletal in nature;
- acupuncture;
- 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), as noted in General Exclusions;
- Surgery; or
- any other procedure not listed as a Covered chiropractic service.

General Exclusions in Chapter Three also apply.

Cosmetic and Reconstructive Procedures

You must get Prior Approval for most Cosmetic and Reconstructive Procedures. Your benefits Cover Reconstructive procedures that are not plastic/Cosmetic. (Please see the definitions of Reconstructive and Cosmetic.) For example, we Cover:

- Reconstruction of a breast after breast cancer Surgery;

- Surgery and Reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses (which we Cover under Medical Equipment and Supplies on page 11); and
- treatment of physical complications resulting from breast Surgery.

Dental Services

We Cover only the following dental services for individuals over age 21 (you may use any Network Provider):

- treatment for, or in connection with, an accidental injury to jaws, sound natural teeth, mouth or face, provided a continuous course of dental treatment begins within six months of the accident.[1]
- Surgery to correct gross deformity resulting from major disease or Surgery (Surgery must take place within six months of the onset of disease or within six months after Surgery, except as otherwise required by law).

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

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

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

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

You must get Prior Approval for the services beginning on page 1, including some dental services, or your care may not be Covered. In the event of an emergency, you must contact us as soon as possible afterward for approval of continued treatment.

Exclusions

Unless expressly Covered in other parts of this Contract, or required by law for individuals age 21 and older, we do not Cover:

- Surgical removal of teeth, including removal of wisdom teeth;
- gingivectomy;
- tooth implants;
- care for periodontitis;
- injury to teeth or gums as a result of chewing or biting;
- pre- and post-operative dental care;
- orthodontics (including orthodontics performed as an adjunct to orthognathic Surgery or in connection with an accidental injury);
- procedures designed primarily to prepare the mouth for dentures (including alveolar augmentation, bone grafting, frame implants and ramus mandibular stapling).

Also, we do not Cover charges related to dental procedures or anesthesia. For example, we do not Cover Facility charges, except when Medically Necessary for children under age seven or members with disabilities or medical conditions that cannot receive care in an office setting.

General Exclusions in Chapter Three also apply.

Diabetes Services

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

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

Diagnostic Tests

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

- imaging (radiology, X-rays, ultrasound and nuclear imaging);
- studies of the nature and cause of disease (laboratory and pathology tests);
- medical procedures (ECG and EEG);
- allergy testing (percutaneous, intracutaneous, patch and RAST testing);

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.

- 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). See page 1 for more information regarding Prior Approval.

Emergency Care

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

Requirements

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

Home Care

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

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

We also Cover:

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

For more information about therapy services, see page 16.

Private Duty Nursing

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

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

We do not Cover private duty nursing services provided at the same time as home health care nursing services.

Requirements

We Cover home care services only when your Physician:

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

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

Limitations

We Cover home infusion therapy only if:

- your Physician prescribes a home infusion therapy regimen;
- you use services from a Network home infusion therapy Provider; or
- your doctor-prescribed drug is approved for treatment.

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

Exclusions

We provide no home care benefits for:

- homemaker services;
- drugs or medications except as noted above (while drugs and medications are not Covered under your home care benefits, we may Cover them under your Prescription Drug benefits);
- 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

We Cover the following services provided by a Hospice Provider and included in its bill:

- up to two skilled nursing visits per day;
- up to 100 hours per month of home health aide services for personal care services only;
- up to 100 hours per month of homemaker services for house cleaning, cooking, etc;

- up to five days or 120 hours of continuous care services in your home;
- up to 72 hours per month of Respite Care services;
- up to six 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

We only provide benefits if:

- a Physician certifies that the illness has a prognosis of six-months life expectancy or less; or
- the patient and the Physician consent to the Hospice care plan.

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 12. Requirements for substance abuse treatment benefits appear on page 16.

Inpatient Hospital Services

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

- room and board;
- covered "ancillary" services, such as tests done in the hospital; and
- supplies, including drugs given to you by the hospital or a Network Skilled Nursing Facility.
- We Cover either the inpatient fee (room and board) for the day of admission or the day of discharge, but not both.
- Certain Inpatient services require Prior Approval. Please see page 1 for a list of these services.

Inpatient Medical Services

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

- Surgery (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:

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

We limit Surgery benefits as follows:

- We make global payments for some Surgeries and other procedures. This means that our Allowed Amount for the Surgery includes payment for all office visits and other care that is related to the Surgery.
- Subject to Medical Necessity, we may limit the number of visits we Cover for one Provider in a given day.
- If you have several Surgeries at the same time, we may not pay a full allowance for each one. If you have questions about the way we determine our Allowed Amount for Surgery, please call our customer service team at (800) 310-5249.
- We Cover services of a Network certified nurse midwife, a licensed midwife or a Physician for home delivery of a baby.
- We exclude many Cosmetic procedures (see General Exclusions in Chapter Three).

Maternity

Your hospital benefits Cover your Inpatient maternity stay. (See "Inpatient Hospital services" above for a description of your hospital benefits.) We also Cover the following care by a Physician 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.

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

Our Allowed Amount for delivery of a baby includes all of the services listed above. This allowance is called a "global fee." If you change Providers during your pregnancy, we will divide this fee. In addition to the services included in the global fee, we Cover care for complications of pregnancy.

We Cover newborns under this Contract for up to 60 days after birth. (See Chapter Six for information on how to continue coverage for your newborn past this period.)

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, we provide a selection of benefit options designed for your circumstances. Benefit options may include:

- books and other educational tools;
- reimbursement for pre- and post-natal classes; and
- vouchers for car seats.

Additional options are available. Call our customer service team at (800) 310-5249 or visit **www.bcbsvt.com** for the 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 us in the first three months of your pregnancy.

Note:

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

Medical Equipment and Supplies

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

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

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

Supplies

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

Orthotics

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

Prosthetics

You must get Prior Approval for Prosthetics. We Cover the purchase, fitting, necessary adjustments, repairs and replacements of prosthetics. We Cover a device (and related supplies) only when the device is surgically implanted or worn as an anatomic supplement to replace:

- all or part of an absent body organ (including contiguous tissue and hair);
- hair loss due to chemotherapy or disease (excluding male pattern baldness);
- 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.

We only Cover eyeglasses or contact lenses that replace the lens of an eye when the lens was not replaced at the time of Surgery. We Cover only:

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

Also, we Cover dental prostheses only if required:

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

Exclusions

We provide no benefits for:

- prosthetics or orthotics for which you have not received Prior Approval from us;
- dental appliances or dental prosthetics, except as listed on page 8;
- 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;

- dynamic splinting, continuous passive motion equipment (unless you get Prior Approval) and programmable or variable motion or 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 our definition of Durable Medical Equipment, you may call our customer service team at (800) 310-5249 before purchasing or renting a Durable Medical Equipment item.

Mental Health Care

We Cover 10 Outpatient mental health visits each Plan Year without Prior Approval. If you require more than 10 sessions of these services, you must get Prior Approval beginning with the 11th session.

You do not need Prior Approval for Emergency Medical Services. Coverage for Emergency Medical Services outside of the service area is the same as for those within the service area. Please contact Blue Cross and Blue Shield of Vermont at (800) 922-8778 if you have questions.

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

Call as soon as possible after the emergency to arrange follow-up care.

Outpatient

We Cover Outpatient mental health services including:

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

Inpatient

We Cover Inpatient mental health services including:

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

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

Exclusions

We provide no mental health benefits for:

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

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, we Cover up to three Outpatient nutritional counseling visits each Plan Year.

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

- medical doctor (M.D.);
- doctor of osteopathy (D.O.);
- registered dietitian (R.D.);
- certified dietician (C.D.);

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

You must get Prior Approval for certain services in order to receive benefits. Please see page 1 for our Prior Approval program.

Outpatient Hospital Care

We Cover services such as chemotherapy, Outpatient Surgery, diagnostic testing (like X-rays), or other Outpatient care in a General Hospital or ambulatory surgical center. Care may include:

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

You must get Prior Approval for certain radiology procedures (including CT, MRI, MRA, MRS and PET scans) and polysomnography (sleep studies). For our Prior Approval list see page 1. For more information about therapy services, see page 16.

Outpatient Medical Services

We Cover care you receive from a Physician 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

We Cover only up to eight hours of neuropsychological testing per Plan Year. You can, however, request extended testing through our case management program.

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

Optometry Services

We Cover services by an optometrist only when he or she finds or reasonably suspects a disease condition of the eye and refers you to a Physician for treatment of that condition. We Cover your visit to an optometrist in the same way we Cover visits to Physicians performing Covered eye care.

We don't Cover eyeglasses, contact lenses or any examination for the prescription, fitting or determination of need for eyeglasses or lenses 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 (see Prosthetics page 11).

If you need lenses to replace the lens of the eye, we will Cover only one pair of lenses per prescription.

Prescription Drugs

You must use a Network Pharmacy or Network home delivery pharmacy to receive benefits. To locate a Network Pharmacy, visit our website at **www.bcbsvt.com** and click on the "Find A Doctor" link. We provide benefits for 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 exclusions listed in Chapter Three "General Exclusions." 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. We do not apply both Co-insurance and Co-payments to the same Prescription Drug purchase. Your cost for generic drugs will be the lowest, for drugs on the Non-Preferred Drug list your cost will be higher and for drugs on the Preferred Brand-name drug list they will be highest. The Preferred Brand-name drug list can change and will be updated from time to time. We will inform you of changes using newsletters and other mailings. To get the most up-to-date listing, you may visit our website at **www.bcbsvt.com** or call the pharmacy customer service team at (800) 310-5249.

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 customer service team at (800) 310-5249 or visit our website at **www.bcbsvt.com**.

You may also save time and money by using our home delivery service.

Limitations

We cover up to a 90-day supply for each refill. Narcotics, antibiotics, Specialty Medications, covered over-the-counter products and compound drugs (see below) are limited to a 30-day supply. We limit benefits for:

- 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 our Prior Approval drug list or your drugs will not be covered. See Chapter One for details regarding our Prior Approval Program.

Our Prior Approval drug list changes from time to time. Visit our website at **www.bcbsvt.com** for the most current list. We will inform you of changes using newsletters and other mailings. You can find the most current list at the Rx Center on our website or by calling our customer service team at (800) 310-5249.

We require Prior Approval for drugs that have been on the market less than 12 months 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

We will review 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, we may ask for documentation about why you need more of the drug. Visit our website at **www.bcbsvt.com** or call the pharmacy customer service team at (800) 310-5249 to get a current list of drugs covered by this review or to learn the quantity limit for a particular drug.

At present, Prior Approval applies 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

Our 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. We may require Prior Approval if we 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

We also review certain Prescription Drugs if you do not first try the generic drug or covered over-the-counter drug. Visit our website at **www.bcbsvt.com** or call the the pharmacy customer service team at (800) 310-5249 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 our medical services department, or its designee, with the following information:

- your name;
- your diagnosis;
- your ID number;

- clinical information explaining the medical necessity for the medication; and
- the expected frequency and duration of the medication.

If you have an emergency or an urgent need for a drug on the Prior Approval list, call the pharmacy customer service team at (800) 310-5249. If we deny your request for Prior Approval, see your Certificate for instructions on how to appeal our decision. You may also see your *Outline of Coverage* for details regarding our Prior Approval Program.

Our quantity limits, step therapy and Prior Approval drug lists change from time to time. We will inform you of changes using newsletters and other mailings. Check with your doctor or visit our website at **www.bcbsvt.com** to see if a specific drug needs Prior Approval or other review. You may also call the pharmacy customer service team at (800) 310-5249.

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. We do not apply both Co-insurance and Co-payments to the same Prescription Drug purchase.

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

We provide no Prescription Drug benefits for:

- all medications for treatment of infertility, including but not limited to Clomid, Clomiphene, Serophene, Bravelle, Gonal-F, Follistim AQ, Novarel, Ovidrel, Pregnyl, Profasi and Repronex when used for treatment of infertility;
- refills beyond one year from the original prescription date;
- 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 Certificate of Coverage) except for certain off-label cancer drugs and drugs administered as part of certain clinical cancer trials;
- Viagra, Cialis, Levitra and other drugs to treat sexual dysfunction;
- 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 up to 11 cases per year for "covered medical foods" prescribed for the Medically Necessary treatment of an inherited metabolic disease or those administered through a feeding tube.

Claim Filing

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

Rehabilitation/Habilitation

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

We Cover:

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

Limitations

We Cover up to three supervised exercise sessions per week, up to a total of 36 sessions for cardiac or pulmonary Rehabilitation programs.

For cardiac Rehabilitation, we Cover an additional 36 sessions for each new Acute Cardiac Event. You must use a Network cardiac Rehabilitation Provider.

Requirements

The attending Physician must:

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

Exclusions

We do not Cover:

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

General Exclusions in Chapter Three also apply.

Skilled Nursing Facility

We Cover Inpatient services including:

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

Requirements

We provide benefits only if you:

- request Prior ApprGeval for Inpatient services; and
- receive Acute Care in the Skilled Nursing Facility.

Exclusions

We do not Cover Skilled Nursing Facility care for:

- cognitive re-training; and
- custodial Care.

Substance Abuse Services

We Cover 10 Outpatient substance abuse visits each Plan Year without Prior Approval. If you require more than 10 sessions of these services, you must get Prior Approval beginning with the 11th session.

You must get Prior Approval for all non-emergency Inpatient, partial-Inpatient and Intensive Outpatient substance abuse services. This applies whether you use a Network or Non-Network substance abuse Provider.

We Cover 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.

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

Requirements

We Cover substance abuse treatment services only if you get Medically Necessary Care in the least restrictive setting.

Please contact Blue Cross and Blue Shield of Vermont at (800) 922-8778 if you have questions.

Exclusions

We provide no substance abuse treatment benefits for:

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

We Cover therapy or physical medicine services provided by:

- an eligible Network hospital, Skilled Nursing Facility or Home Health Agency/Visiting Nurse Association;
- a licensed physical therapist (P.T.);
- a medical doctor (M.D.), doctor of osteopathy (D.O.) or Network Chiropractor (D.C.) 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. or licensed physical therapist).

Therapy services could include the following:

- radiation therapy;
- chemotherapy;
- dialysis treatment;
- Physical Therapy/physical medicine;
- Occupational Therapy;
- Speech Therapy; and
- infusion therapy.

We Cover Occupational, Speech and Physical Therapy/medicine only:

- for Physical Therapy/physical medicine services that require constant attendance of a licensed:
  - physical therapist,
  - a medical doctor (M.D.),
  - a Network Chiropractor (D.C.),
  - a 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 30 Outpatient sessions combined per Plan Year. (This limitation does not apply to mandated treatment for Autism Spectrum Disorder up to age 21 as defined by Vermont law.)

Note:

We do not Cover group therapy, group exercise or Physical Therapy performed in a group setting.

Transplant Services

You must get Prior Approval for transplant services.

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

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

We pay benefits for the following services related to transplants:

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

We pay benefits for transplants as follows:

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

Time Period for Living Donor Benefits

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

Exclusions

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

Vision Care

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

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

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

Vision Materials

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

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

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

Frames for Prescription Glasses

We Cover one pair of frames on our Network Providers list of Covered frames. If you choose a frame outside of the Network's covered frames you must pay any additional costs. Discounts may be available.

Lenses for Prescription Glasses

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

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

Contact Lenses

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

We do not Cover:

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

Necessary Contact Lenses

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

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

Related Professional Services

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

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

Claim Filing for Vision Benefits

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

To receive reimbursement when you visit a non-VSP Provider, sign on to **www.vsp.com**, select the "Non-Network Reimbursement Form" and follow the instructions. Or, you may send an itemized receipt listing the services received along with the patient's name and Covered subscriber's name and I.D. number to VSP. Non-Network claims must be submitted to VSP within six months of service. Send the original claims reimbursement request and receipts to VSP, P.O. Box 997105, Sacramento, CA 95899-7105.

Exclusions

We do not Cover services or supplies for:

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

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

CHAPTER THREE

General Exclusions

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

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

1. Services that a prior health plan must Cover as extended benefits.
2. Services you would not legally have to pay if you did not have your Contract or similar coverage.
3. Services for which there is no charge.
4. Services paid directly or indirectly by a local, state or federal government agency, except as otherwise provided by law.
5. Services you require because you committed or attempted to commit a felony or engaged in an illegal occupation.
6. Services over the limitations or maximums set forth in your Contract.
7. Services or drugs that we determine are Investigational, mainly for research purposes or Experimental in nature. To the extent required by law, however, we Cover routine costs for patients who participate in approved clinical trials.
8. Services not provided in accordance with accepted Professional medical standards in the United States.
9. Services beyond those needed to establish or restore your ability to perform Activities of Daily Living (see Definitions), including those needed only 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. We Cover Medically Necessary Covered services when performed within the scope of a naturopathic Physician'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.
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; Maintenance Care.
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. (This exclusion does not apply to Autism Spectrum Disorder to the extent required by law.)
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.
25. Unless expressly Covered in other parts of this Contract or required by law, we do not Cover:

- excision of excessive skin and subcutaneous tissue, and tightening (plication) of underlying structures (includes abdominoplasty, panniculectomy, correction of diastasis rectus, lipectomy and umbilical transposition) of the chest, abdomen, thigh, leg, hip, buttocks, arm, forearm, hand, neck (submental fatpad) and all other areas not specified;
- suction-assisted removal of fatty tissue (lipectomy) in the head, neck, trunk, upper extremity or lower extremity;
- breast lift (mastopexy) except when a necessary component of reconstruction of breasts following breast cancer surgery;
- Surgery to improve the appearance of the ear (otoplasty);
- mastectomy for gynecomastia;
- blepharoplasty repair of brow ptosis, repair of blepharoptosis, correction of lid retraction, reduction of overcorrection of lid ptosis; and
- Surgery to improve the appearance of the nose (rhinoplasty).

  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.*

26. Custodial Care, Rest Cures.
27. Dental services and dental related oral Surgery, unless specifically provided by your Contract; procedures designed primarily to prepare the mouth for dentures (including alveolar augmentation, bone grafting, frame implants and ramus mandibular stapling).
28. Treatment of developmental delays. (This exclusion does not apply to mandated treatment of Autism Spectrum Disorder up to age 21 as defined by Vermont law.)
29. Eyeglasses or contact lenses for Members 21 years old and older for refractive purposes unless you need them to replace the lens of an eye (and the lens was not replaced at the time of Surgery).
30. Education, educational evaluation or therapy or treatment of developmental delays, therapeutic boarding schools, services that should be Covered as part of an evaluation for, or inclusion in, a Child's individualized education plan (IEP) or other educational program. (This exclusion does not apply to treatment of diabetes, such as medical nutrition therapy by approved participating Providers.)
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.
33. Home or automobile modifications or equipment like air conditioners, HEPA filters, humidifiers, stair glides, elevators, lifts, motorized scooters, furniture or "barrier-free" construction, even if prescribed by a Provider.
34. Illnesses or injuries that are:
    - a result of an act of war (declared or undeclared); or
    - sustained in active military service
35. Infertility services, including: surgical, radiological, pathological or laboratory procedures leading to or in connection with artificial insemination (intravaginal, intracervical, and intrauterine insemination), in vitro fertilization, embryo transplantation and gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) and any variations of these procedures, including costs associated with collection, washing, preparation or storage of sperm for artificial insemination including donor fees, cryopreservation of donor sperm and eggs.

    Note: This exclusion does not apply to the evaluation to determine if and why a couple is infertile.
36. An Inpatient stay determined not Medically Necessary while you are waiting for a different level of care, such as Skilled Nursing Facility or home care. We will only Cover the rate payable for the appropriate Medically Necessary level of care received.
37. Treatment for willfully uncooperative or intractable patients.
38. Institutional or Custodial Care for the physically or mentally handicapped.
39. Mandated treatment, including court-ordered treatment, unless such treatment is Medically Necessary, ordered by a Physician and Covered under your Contract.
40. 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.
41. Nutritional counseling beyond three visits per Plan Year. This limit does not apply to the treatment of diabetes.

42. Nutritional formulae or supplements, except for up to 11 cases per year for "medical foods" prescribed for the Medically Necessary treatment of an inherited metabolic disease or prescription formulae and supplements administered through a feeding tube.
43. Orthodontics, including orthodontics performed as adjunct to orthognathic Surgery or in connection with accidental injury. This exception does not apply if orthodontics are Covered in other sections of this Contract.
44. Pain management programs.
45. Personal hygiene items.
46. Personal service, comfort or convenience items.
47. Photography services, photographic supplies or film development supplies or services (for example, external ocular photography or photography of moles to monitor changes).
48. Physical fitness equipment, braces and devices intended primarily for use with sports or physical activities other than Activities of Daily Living (e.g., knee braces for skiing, running or hiking); weight loss or exercise programs; health club or fitness center memberships.
49. Pneumatic cervical traction devices.
50. Specialized examinations, services or supplies required by your employer or for sports/recreational activities (e.g. driver certifications, pilot flight physicals, etc.).
51. 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.
52. Sterilization reversal (vasectomy reversal, vasovasostomy, vasovasorrhaphy, tubal ligation reversal, tubotubal anastomosis).
53. "Store and forward" telemedicine.
54. Travel (other than Ambulance transport), lodging and housing (when it is not integral to a Medically Necessary level of care, even if prescribed by a Provider).
55. Treatment solely to establish or re-establish the capability to perform occupational, hobby, sport or leisure activities.
56. Treatment of obesity, except surgical treatment when determined Medically Necessary through Prior Approval.
57. Work-hardening programs and work-related illnesses or injuries (or those which you claim to be work-related, until otherwise finally adjudicated), provided such illnesses or injuries are Covered by workers' compensation or should be so Covered. (This provision does not require an individual, such as a sole proprietor or an owner/partner to maintain worker's compensation if he or she does not legally need to be Covered.)

Provider Exclusions

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

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

CHAPTER FOUR

Claims

Remember, when you contact a Provider, you must:

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

Claim Submission

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

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

Release of Information

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

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

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

Cooperation

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

Payment of Benefits

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

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

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

Payment in Error/Overpayments

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

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

How We Evaluate Technology

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

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

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

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

Complaints and Appeals

When You Have a Complaint

The following sections explain what to do when you don't agree with one of our decisions or when you have a complaint about our service, health plan rules, waiting times to get appointments, after-hours access to your doctor, the service at a doctor's office or a doctor's care. At any time, you may call the Vermont Department of Financial Regulation for help at (800) 964-1784.

Complaint (Inquiry) to Customer Service

Our customer service team can solve most problems. We encourage you to contact customer service before filing an appeal (below) because it may save you time. Contact our customer service team at (800) 310-5249 and we will review your complaint. Please have your ID card handy when you call. If you wish, another person—perhaps a Provider—may call for you. You may also write to:

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

We resolve complaints as soon as possible. You can make a complaint if you have problems with the 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 to get appointments
- after-hours access to your doctor
- the service at the doctor's office

Claim Appeal (Grievance)

You may file an appeal after a customer service review (above) or without one. You have the right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your appeal within two (2) business days. (We suggest you make a complaint to our customer service team first at (800) 310-5249. This may save you time.) If your appeal is related to Emergency or Urgent Services, you may submit your appeal orally. All other appeals should be submitted in writing.

If your primary language is not English, you may request an interpreter and/or a written transcript of this document in your primary language, both of which will be provided free of charge, by calling our customer service team at (800) 310-5249. If requested, reasonable accommodation will be provided to you if you have a disability for filing and for participating in the appeal process. If you are unable to file written appeals, you may notify the Plan of an appeal orally or through another alternative mechanism.

Call our customer service team at (800) 310-5249 for help. Send your appeal to:

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

Please be specific about your appeal. Be sure to include a telephone number where you may be reached in regard to your appeal. If it involves an adverse Benefit determination, which means a denial, reduction, modification or termination of, or a failure to provide or make payment (in whole or in part) for a Benefit, call or write within 180 calendar days of when you receive notice of the adverse Benefit determination.

Once you make a formal appeal, an impartial reviewer, one who has not been involved before and who is not a subordinate of the person who reviewed the previous decision, will conduct a review to attempt to resolve it. If it is about a decision to deny or reduce Benefits, we will see if we should pay your claim.

For an appeal related to medical care not yet rendered (but not Emergency or Urgent Services, see below), we will complete the review and send you notice of our decision within 30 calendar days of receiving your request for review. For an appeal related to medical care you have already received, we will complete the review and send you notice of our decision within 60 calendar days of receiving your request for review.

If your appeal involves a request for urgent concurrent care, we will review it and notify you of our decision within 24 hours of receiving your request.

If your appeal is related to a denial of Prior Approval for Emergency or Urgent Services (see how these terms are defined in the Definitions section in Chapter Nine of this Certificate) we will review it and notify you of our decision within 72 hours of receiving your request.

Effective January 1, 2011, if your appeal is related to a denial of Prior Approval for prescriptions you have not yet received, we will review it and notify you of our decision within 72 hours of receiving your request.

For reviews not related to medical care, we will notify you of our decision within 60 days of receiving your request. For all other reviews, we will notify you of our decision within 60 days of receiving your request.

Notes:

- The State of Vermont has a Health Care Ombudsman's office. If you have a problem with your plan, this office may be able to help. Call (800) 917-7787 or (802) 863-2316.

- By accepting your Contract, you agree to seek a decision of the impartial reviewer before taking any judicial action. After you receive our decision, you may choose to pursue a voluntary second level appeal of the adverse Benefit determination decision (below) or you may request an independent external review with the State of Vermont Department of Financial Regulation within 120 calendar days after receiving our denial by calling (800) 964-1784.
- Your plan may be subject to ERISA. If you are not satisfied with the outcome of the internal-appeal process, and your plan is subject to ERISA, you may have the right to bring legal action under section 502(a) of ERISA. Consult your benefit administrator to determine whether this applies to you. You are not required to pursue the voluntary second-level of appeal prior to bringing legal action. You are not required to submit your claim to the State of Vermont independent external review process prior to filing a suit under section 502(a) of ERISA.
- If you choose to take advantage of our voluntary second level of appeal (below) and still are not satisfied, you will have the right to file an external appeal with the State of Vermont and/or file suit under ERISA (if applicable) as described above after receiving the second-level decision.

Voluntary Second Level Appeal of First-Level Decision

If you get coverage through an employer or other group, and you are not satisfied with the outcome of the first level appeal, you may file a voluntary second level appeal. The appeal is voluntary. The Plan will not impose any fees or costs to you or your Provider if you elect to pursue a voluntary second-level appeal. You may also, in certain circumstances, request an independent external review with the State of Vermont Department of Financial Regulation by calling (800) 964-1784

If you choose to file a voluntary second-level appeal, you must do so within 90 days after you receive our first-level appeal decision. If your appeal involves a request for Emergency or Urgent Services, you may submit your appeal verbally. All other appeals should be submitted in writing. If your primary language is other than English, you may request an interpreter and/or a written transcript of this document in your primary language, both of which will be provided free of charge, by calling the customer service number on the back of your ID card. If requested, reasonable accommodation will be provided to you if you have a disability for filing and for participating in the appeal process. The Plan ensures that persons who are unable to file written appeals may notify the managed care organization of an appeal orally or through another alternative mechanism. Give as much information as you can, including what happened when you took the steps above. Be sure to include a telephone number where you may be reached in regard to your appeal. If needed, we will help you with your appeal. Mail your appeal to:

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

The reviewer who will conduct the second-level appeal will not have been involved in your appeal. Our process is to select a qualified reviewer(s) who has not been involved before and who is not a subordinate of the person who reviewed the previous decision. You have the right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your appeal within two (2) business days. You have the right to meet with the second-level reviewer(s) by phone before a final decision is made. If you are not able to participate by phone, we will make arrangements for you to participate in person. You or your authorized representative, your treating Provider(s), or any other person(s) you request are entitled but not required to participate in such a meeting or call. Your decision whether or not to pursue the voluntary second-level appeal will have no effect on your rights to any other Benefits.

If your appeal involves a request for urgent concurrent care, we will review it and notify you within 24 hours of receiving the request. If your appeal involves a request for Emergency or Urgent Services, we will review it and notify you within 72 hours of receiving the request. Effective January 1, 2011, if your request involves a denial of Prior Approval for prescriptions you have not yet received, we will review it and notify you of our decision within 72 hours of receiving your request for an appeal. For all other reviews, the Plan may have up to 60 days after receiving your request to notify you of our decision.

Notes:

- If you do not take advantage of the voluntary second level of appeal before you choose to pursue an independent external review, we will not later claim that you were required to take a second level of appeal (i.e., exhaust your administrative remedies). However, please note that if you choose to file an independent external review without going through the second level of appeal, you may not later request a second level of appeal.
- If you choose to take advantage of the voluntary second level of appeal, the Plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal is pending.

- After you receive our decision, in certain circumstances, you may request an independent external review with the State of Vermont, Department of Financial Regulation within 120 calendar days after receiving our denial by calling (800) 964-1784.

Independent External Review

Are you dissatisfied with either of our review committees' decisions? After the first review, you have the right to ask the State's Independent External Review committee of health care Providers to review your case within 120 calendar days of receiving our denial. The committee is not connected to BCBSVT. Or, if you choose to take advantage of our second level of review, and are still not satisfied, you can call the Vermont Department of Financial Regulation at that time and ask for a review. For more information about the Vermont Department of Financial Regulation's review process, or to ask for a review, call (800) 964-1784.

Vermont's Mental Health and Substance Abuse Law

Vermont has a law that makes mental health and Substance Abuse treatment Benefits equal to those for other physical problems. Your Benefits comply with this law.

When You Have to Pay

If your appeal is denied, you must pay for Services we didn't Cover. Make your payment to your Provider.

Other Resources to Help You

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

- Employee Benefits Security Administration (866) 444-EBSA (3272)
- State of Vermont's Health Care Ombudsman (800) 917-7787 or (802) 863-2316
- Vermont Department of Financial Regulation (800) 964-1784 or (802) 828-2900.

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.

Health Care Ombudsman

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

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

In most cases, the professionals in our 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 our customer service team at (800) 310-5249.

CHAPTER FIVE

Other Party Liability

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

Coordination of Benefits

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

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

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

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

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

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

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

Coordination of Benefits for Children of Divorced Parents

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

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

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

In an Accident

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

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

Reimbursement

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

Medicaid and Tricare

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

Subrogation

If another person or organization caused or contributed to your illness or injuries, or is supposed to pay for your treatment (such as another carrier), then we have a right to collect back for benefits provided by this

Contract. This is called our "right of subrogation." In this section we will call the person or organization a "third party." The third party might or might not be an insurer. Our right of subrogation means that:

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

Cooperation

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

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

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

CHAPTER SIX

Membership

Remember, when you add or remove Dependents, your type of membership (individual, two-person, single head of household or family) may change.

You may add or remove Dependents from your membership under the conditions noted in this chapter.

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

Coverage Effective Dates

Vermont Health Connect will determine whether you are eligible for coverage or a change in coverage. When your coverage is effective will depend on when Vermont Health Connect determines that you are eligible for coverage. Generally, these are your effective dates unless explained otherwise. Coverage will be effective as follows:

- If you have submitted complete information to Vermont Health Connect between the first and the fifteenth of the month, your coverage will become effective on the first day of the following month; or
- If you have submitted complete information to Vermont Health Connect between the sixteenth and the last day of the month, your coverage will become effective on the first day of the second following month.

Open Enrollment

Your open enrollment period is the period each year during which you may enroll in or make changes to your coverage. You may add dependents during this period and also during special enrollment periods which we discuss below.

If you purchase your coverage through Vermont Health Connect as an individual (not through your employer), the initial open enrollment period is October 1, 2013 to March 31, 2014. Open enrollment is October 15 to December 7 of each subsequent calendar year. As discussed below, you may also make changes to your coverage if you have a qualifying event that allows for a special enrollment period.

If you are eligible for benefits under the Indian Health Care Improvement Act , you may be able to change coverage every month. Contact Vermont Health Connect to see if this applies to you.

If you purchase coverage through an employer or other Group, your Group sets your open enrollment period. Open enrollment is typically some period, at least thirty days before the anniversary of your effective date. Ask your Group Benefits Manager when your open enrollment occurs. As discussed below, you may also make changes to your coverage if you have a qualifying event which allows for a special enrollment period.

Special Enrollment Periods

You may add a Dependent or change your coverage during open enrollment or during a special enrollment period. Generally, you have 60 days from the date of the triggering event to change your coverage. If you fail to add or change your coverage within 60 days, you will have to wait until open enrollment to change your coverage. You are entitled to a special enrollment period when one of the following events occur:

- marriage;
- birth or adoption;
- loss of coverage;
- non-enrollment due to errors of exceptional circumstance;
- newly established eligibility;
- newly qualified employee;
- eligibility based on permanent move;
- court-ordered dependents; or
- incapacitated dependents.

Marriage

If you get married, you have 60 days to change your coverage to add your spouse or other new Dependents. Your new coverage will become effective on the first day of the month following the eligibility determination by Vermont Health Connect. If you fail to make a change within 60 days, you must wait until open enrollment to do so.

Birth or Adoption

We Cover 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).

Vermont Health Connect must receive your request for a membership change to continue benefits for the Child within 60 days of the birth. If Vermont Health Connect 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 the first day of the month following birth, placement for adoption or adoption.

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

Loss of Coverage

If you lose minimum essential coverage, as defined by law, you may enroll in a health plan outside of open enrollment. You may enroll in a health plan outside of open enrollment if you lose minimum essential coverage due to:

- loss in employment;
- a change in education status;,
- death of a spouse;
- turning 26 while on a caregiver's plan and becoming ineligible for coverage;
- divorce or civil union dissolution; or
- loss of Medicaid or Medicare.

Vermont Health Connect will determine whether you are entitled to special enrollment outside of open enrollment.

Likewise, Dependents Covered under health coverage with another health plan are eligible for membership under your contract if the Dependent loses his or her health coverage through:

- loss of employment;
- change in education status;
- death of a spouse;
- divorce or civil union dissolution; or
- loss of Medicaid or Medicare.

Vermont Health Connect will determine whether your Dependent is entitled to special enrollment.

When you lose minimum essential coverage, your new coverage will be effective on the first day of the month following your selection of coverage through Vermont Health Connect as accepted by Vermont Health Connect.

Non-Enrollment Due to Errors or Exceptional Circumstances

You or your Dependent may also be entitled to a special enrollment period if your failure to enroll during open enrollment is unintentional, inadvertent or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee or agent of Vermont Health Connect or the United States Department of Health and Human Services or its instrumentalities. You may also enroll outside of open enrollment if, consistent with Federal and State guidelines, you can show exceptional circumstances justifying the right to a special enrollment period. Vermont Health Connect will determine whether you are entitled to a special enrollment period outside of open enrollment due to error or exceptional circumstances.]

Newly Established Eligibility

You or your Dependent may be entitled to special enrollment if you are newly eligible for Federal premium tax credits or cost share reductions. You may also be entitled to a special enrollment period if your citizenship status changes. Vermont Health Connect will determine whether you are entitled to a special enrollment period outside of open enrollment due to changes in eligibility or citizenship.

Newly Qualified Employee

If you purchase your insurance through your employer, you may purchase coverage outside of the open enrollment period if you become newly qualified for insurance through your employer. This could happen when you are newly hired or when you become a full time employee. Contact your Group Benefits Manager to determine your eligibility and to determine how long you have to elect to purchase coverage.

Eligibility Based on Permanent Move

You or your Dependent may be entitled to a special enrollment period if you have moved to Vermont and are eligible to purchase insurance through Vermont Health Connect. Vermont Health Connect will determine whether you are entitled to a special enrollment period due to a permanent move.

Court-ordered Dependents

In the case of a valid court order, you must contact Vermont Health Connect consistent with the terms of the order. Coverage will be effective on the date determined by Vermont Health Connect or as directed by the court.

Incapacitated Dependents

You may continue coverage for an Incapacitated Dependent over the age of 26. In order to do this, you must contact Vermont Health Connect.

Removing Dependents

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

- a Dependent dies;
- the subscriber and Spouse/Party to a civil union divorce;
- a couples legal separation;
- a Child turns 26; or
- the Dependent is no longer Incapacitated.

Dependents become ineligible for coverage at the end of the month after the event occurs. You must notify Vermont Health Connect of these changes.

Cancellation of Coverage

Cancellation of Coverage by You, by the Group, by Vermont Health Connect or by Us

You or your Group may cancel this contract without cause by giving BCBSVT 14 days prior written notice. You may also contact Vermont Health Connect to cancel coverage. Coverage will end on the date you specify, or 14 days after BCBSVT or Vermont Health Connect receives notice, whichever is later. BCBSVT may cancel coverage in accordance with state and federal law.

If you are cancelling coverage because you are eligible for Medicaid or Dr. Dynasaur, your coverage will end on the date your Medicaid or Dr. Dynasaur coverage becomes effective. If you are cancelling coverage because you have purchased other coverage through Vermont Health Connect, your coverage will terminate on the date the other coverage becomes effective.

If Vermont Health Connect determines that you are no longer eligible for coverage, your coverage will terminate on the last day of the month following the month Vermont Health Connect sends you a notice that you are no longer eligible. Coverage can end on an earlier date if you request it with 14 days notice.

Upon contract cancellation, we refund Vermont Health Connect any amount of any unearned premium we may have collected. Such payment constitutes a full and final discharge of all our obligations under this contract, unless otherwise required by law. We will continue to provide benefits for all Covered services received before the date of cancellation.

Default in Subscription Payment

You must pay your monthly premium as defined by Vermont Health Connect. If you receive a Federal premium tax credit to help pay for the cost of insurance, you are entitled to a 90 day grace period for payment of your premium from the day your payment is due before your coverage will be canceled. If you fail to pay your premium on the due date, you have 90 days to pay before your coverage will be canceled. However, in order to avoid cancellation of your coverage, you must pay all premiums due by day 90 (typically three months premium). Partial payment of overdue amounts will not reinstate your coverage or restart your grace period. If you fail to pay your premium in full within the 90 days, coverage will be canceled on day 31 after your last month of fully paid coverage. We do not pay your medical claims incurred by you after day 31 and you will be responsible for those costs. If you do not pay your premiums in full and your coverage is canceled, when you file your Federal income tax return, you may also be responsible for refunding to the U.S. Internal Revenue Service any premium tax credit received by us on your behalf.

If you are not receiving a Federal tax credit, or you have purchased your insurance through your employer, we allow a 10-day grace period for payment. If we do not receive your payment on or before the end of the grace period, we will mail you a cancellation notice.

If your coverage is canceled:

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

Coverage will be canceled at midnight on the 30th day after we send you a cancellation notice.

We consider non-payment a stop to service, and therefore, a cancellation of your coverage by you.

Benefits after Cancellation of Group Coverage

If you are entitled to benefits for a continuous total disability, as defined by the Social Security Act, or pregnancy existing on the cancellation date, we Cover Covered services received in connection with the total disability or pregnancy until the earliest of:

- the date your disability or pregnancy ends;
- 12 months from the date of cancellation;
- the date you become Covered for medical benefits under another health plan or policy without a Pre-existing Condition exclusion; or
- the date you exhaust your benefit maximums.

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

Note: Upon receipt of written request the Health Plan will suspend coverage in active service military members. We will repay any subscription rates paid by someone actively serving in the military according to the proportion owed.

Fraud, Misrepresentation or Concealment of a Material Fact

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

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

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

Medicare

Please note that this is not a Medicare supplement contract.

Our Pledge to You

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

Member Rights and Responsibilities

As a Member, you have the right to:

Respect and Privacy. We take measures to keep your health information private and protect your health care records (privacy policy).

Receive Information from us. We'll supply you with information to help you understand our organization, your rights and responsibilities, as a Member, 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 we've used to make decisions about your healthcare benefits, its services, our practitioners and our 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 or your benefits.

Disagree. We welcome your complaints or appeals about our organization and the care we provide.

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

As a Member, you have the responsibility to:

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 doctors need your up-to-date health information to treat you effectively. Talk to your Providers about your medical history and current health, and participate in developing treatment goals as much as possible;

Follow Health Plan rules and instructions for care;

Treat your Providers and us with respect;

Pay all applicable Deductibles, Co-insurance amounts and Co-payments to your health care Providers as outlined on your *Outline of Coverage*;

Notify Vermont Health Connect right away if there's a change in your family size, address or phone number or any other change in your membership; and

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

Rules About Coverage for Domestic Partners

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

Enrollment Eligibility

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

- the subscriber or Group's initial enrollment period;
- the Group's open enrollment; or
- within 31 days after a domestic partner loses coverage with his or her employer.

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

Effective Date of Coverage

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

Continuation of Group Coverage

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

Termination of Domestic Partnership

When two parties no longer meet requirements for Domestic Partnership status, you must notify Vermont Health Connect.

Right to Continuation of Coverage

Note: This is a summary of the law. Please contact an attorney 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.

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).

You may also be eligible for continuation coverage under federal law. Please ask your Group Benefits Manager if this applies to you.

Conversion Rights

If the subscriber becomes employed by another Group that does not have Domestic Partnership coverage or files a Termination, the Domestic Partner may convert to available individual market coverage through Vermont Health Connect. If both the subscriber and the Partner convert to individual coverage, they must obtain separate contracts.

CHAPTER SEVEN

General Contract Provisions

Applicable Law

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

Entire Agreement

Your Contract is the entire agreement between you and us. Your Contract governs your benefits. The following documents are included as part of your Contract:

- This Certificate of Coverage, which describes your benefits in detail and explains requirements, limitations and exclusions for Coverage.
- Your *Outline of Coverage*, which shows what you must pay Providers and which services require Prior Approval. If material modifications are necessary, we will provide notification as required by Federal law.
- Any riders or endorsements, which enhance or amend your Coverage.
- Your ID card.
- Your Group Enrollment Form (your application) and any supplemental applications that you submitted and we approved.

We may only change this Contract in writing and with the approval of the Vermont Department of Financial Regulations (DFR).

Severability Clause

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

Non-waiver of Our Rights

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

Term of Contract

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

Subscriber Address

You must notify Vermont Health Connect of any change of address.

312 Hurricane Lane
Suite 201
Williston, Vermont 05495

All notices are to the subscriber's address on file. This represents the full responsibility to notify the subscriber, regardless of whether the subscriber receives the notice.

Third Party Beneficiaries

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

CHAPTER EIGHT

More Information About Your Contract

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

Notice of Privacy Practices for Protected Health Information

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

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

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

Federal and state laws require us to maintain the privacy of your protected health information (PHI) and to provide this notice to you of our legal duties and privacy practices. PHI is information about you, including demographic data, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health, the provision of health care to you or the payment for that care. We may use PHI we receive or maintain, including PHI that you may have entered on our website's Member Resource Center at **www.bcbsvt.com.**

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

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

If you have any questions or want additional information about this notice or the policies and procedures described in this Notice, please contact us at the address, email or phone number provided in the Questions and Complaints section at the end of this 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. We are required to abide by the terms of the notice currently in effect.

We reserve the right to change the provisions of the notice and make the new provisions effective for all PHI that we maintain. If we make a material change to this notice, we will mail a revised notice to the address that we have on record for the subscriber of your contract.

Our Uses and Disclosures of Your Protected Health Information

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

Disclosures to You or Your Authorized Representative

We may disclose PHI to you. See the section on Right to Access (Inspect and Copy) for more details. We may also disclose your PHI to your authorized personal representative. How much PHI we can share with a personal representative will depend on his or her legal authority. If you would like to authorize someone to have access to some or all of your PHI, call customer service at the number listed on the back of your ID card.

Treatment

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

Payment

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

Health Care Operations

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

- quality assessment, 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.

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

Appointment/Service Reminders

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

Business Associates and other Covered Entities

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

Required by Law

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

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

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

Victims of Abuse, Neglect or Domestic Violence

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

Public Health or Safety

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

Health Oversight Activities

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

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

Research, Death or Organ Donation

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

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

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

Your Group Health Plan or Plan Sponsor (If Applicable)

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

Others Involved in Your Health Care

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

Your Rights

Right to Access (Inspect or Copy)

Upon your request, in accordance with the HIPAA Privacy Regulations, you have the right to examine and to receive a copy of your PHI in our possession. If requested, this may include an electronic copy in certain circumstances. Your request must be in writing, on our designated form. We will provide the information no later than 30 days after receiving your request, unless we maintain the information off site, in which case it may take up to 60 days for us to comply with your request. If necessary, we may request an extension to provide you with your information. If we deny your request, you may request that the denial be reviewed. Under certain limited conditions, our denial may not be reviewable. In the event you are entitled to a review, a licensed health care professional not involved in the original denial decision will review our denial. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We will notify you of the cost involved before you incur any costs.

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

Right to Amend

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

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

Right to a Disclosure Accounting

You have the right to a list of instances in which we disclose your PHI in the last six years for purposes other than treatment, payment or health care operations, as authorized by you or for certain other activities. Most disclosures of your PHI will be for purposes of payment or health care operations or made with your authorization.

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

Right to Request Confidential Communications

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

Right to Request a Restriction

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

Breach Notification

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

Non-public Personal Financial Information

We closely guard all of the personal information we collect about our members. State and federal laws require that we tell you how we protect private information. This particular section deals with how we treat "financial information." We do not maintain a lot of financial information about our members, but the fact that you are a member of one of our health plans, is, in itself, considered "financial information."

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

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

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

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

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

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

Questions and Complaints

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

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

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

Telephone: (802) 371-3394
Fax: (802) 229-0511
Email: privacyofficer@bcbsvt.com

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

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

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

Newborns' and Mothers' Health Protection Act

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, the health plan or issuer may pay for a shorter stay if the attending Provider discharges the mother or newborn earlier.

Also, under federal law, health 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 health plan or issuer may not, under federal law, require that a Physician 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 or pre-certification. For information on such requirements of your Contract, please read your Contract documents (Certificate, *Outline of Coverage*, endorsements or riders).

If you have any questions regarding your rights under this Act, please contact our customer service team at (800) 310-5249.

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 we Cover reconstruction of the breast on which a mastectomy has been performed and/or the other breast (to produce a symmetrical appearance). We also Cover 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 Contract. For example, they require the same Coinsurance, Co-payments and Deductibles as the rest of your coverage.

If you have any questions about your rights under this Act, please contact our customer service team at (800) 310-5249.

Our Quality Improvement Program

Our quality improvement (QI) program seeks to improve our service to you. It also works to improve the care you get. Through QI, we:

- make sure you can get the care you need;
- look at the quality of care you get from Providers; and
- work with BCBSVT staff and Providers to fix any problems we find.

QI studies and projects focus on:

- promoting well-care and early treatment;
- making sure all of our Providers give the same good care;

- finding and keeping the best Providers in our Networks;
- helping Members live with chronic diseases like asthma or diabetes;
- protecting Members; and
- telling them about the health plan.

Many of our QI projects involve Member input. From time to time we will ask you to complete surveys to help us serve you better. We use your answers to surveys to improve our policies. We also use the complaints you make. We listen to you so we can make the health plan better.

We also have focus groups with Member representatives. If you would like to participate on a member focus group or in one of our QI projects, please call our customer service team at (800) 310-5249. Also call if you would like to suggest a change in one of our policies. We keep track of these suggestions. We look at them when writing new policies.

Information About Your Health Plan

We will provide you with any information about your Health Plan, except if we can't by law. Call our customer service team at (800) 310-5249.

Here are examples of information you may want:

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

Participating in Our Policy Making

If you would like to participate in the development of our organizational policies, please call our customer service team at (800) 310-5249 and a representative will help you initiate the process.

CHAPTER NINE

Definitions

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

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

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

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

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

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 patters 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.

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

Certificate/Certificate of Coverage: this document.

Child: see Dependent.

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

Chronic Care: health services provided by a health care Professional for an established clinical condition that is expected to last a year or more and that requires ongoing clinical management attempting to restore the individual to highest function, minimize the negative effects of the condition and prevent complications related to chronic conditions. Examples of chronic conditions include diabetes, hypertension, cardiovascular disease, asthma, pulmonary disease, substance abuse, mental illness, spinal cord injury and hyperlipidemia.

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

Contract: Your Certificate and any accompanying documents.

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 Contract.

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

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

Deductible: the amount you must pay toward the cost of specific services each Plan Year before we pay any benefits. Your *Outline of Coverage* shows your Deductible, benefit, Co-insurance and Co-payment amounts. (Refer also to Chapter One.) Some services are not subject to the Deductible amount.

Dependent: a subscriber's Spouse, the other Party to a subscriber's civil union, Domestic Partner (only if your employer allows Domestic Partner

coverage) or the subscriber's Child or Incapacitated Dependent Covered under this Health Plan. (See Child, Spouse and Party to a Civil Union definitions.)

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

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

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

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

Party to a Civil Union: a partner with whom the Member 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 #31 in Chapter Three, General Exclusions).

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 Physician;

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

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

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

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

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

Emergency Medical Services: Medical screening examinations that are within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an Emergency Medical Condition, and further medical examination and treatment necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to

result from or occur during the transfer of the individual from the Facility, or, with respect to childbirth, that the woman has delivered her baby and the placenta.

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

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

Facility (Facilities): the following institutions or entities:

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

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

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

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

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

Habilitative/Rehabilitative: 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.

Benefits for Habilitation and Rehabilitation services are available when the services are medically necessary and are Covered benefits under the Member's Contract.

Habilitation is directed at achieving functions and skills that have not developed normally while Rehabilitation is directed at restoring functions and skills lost due to disease, injury or other disabling condition.

The following services are not included and therefore not eligible under the scope of Habilitation services:

- Custodial Care;
- vocational, recreational and educational services, or services that are considered maintenance in nature.

Health Care Ombudsman: The Vermont Office of Health Care Ombudsman's telephone hotline service can provide you with free help if you have problems or questions about health care or health insurance.

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

In most cases, the professionals in our 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.

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

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

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

Incapacitated Dependent: a Dependent who meets our definition of Child (except if the individual is age 26 and older) and who:

- is incapable of self-support by reason of mental or physical disability that has been found to be a disability that qualifies or would qualify for benefits using the definitions, standards and methodology in 20 C.F.R. Part 404, Subpart P;

- became incapable of self-support when he or she was a Child; and
- is chiefly dependent on the subscriber or the subscriber's estate for support and maintenance.

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

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

Investigative/Investigational:
(see Experimental)

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 indicators of scientific reliability from the following sources:

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

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

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

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

Member: an individual who enrolls in the Health Plan.

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.

Other Provider: one of the following entities:

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

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

Out-of-Pocket Limit: the Out-of-Pocket Limit is made up of the Deductibles 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 will 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 members are considered to have met their individual Out-of-Pocket Limits.

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

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

Partnership: see Domestic Partnership under Dependent.

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 Physicians. 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 Physician asks for Professional advice about your condition.

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 coverage, we use Certificate of Coverage.

Prescription Drugs: 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.

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

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

Professional: one of the following practitioners:

- athletic trainers
- audiologists
- Chiropractors (as further defined in this chapter)
- mental health Professionals:
  - clinical mental health counselors
  - clinical psychologists
  - clinical social workers
  - marriage and family therapists
  - psychiatric nurse practitioners
- nurses:
  - certified nurse midwives or licensed Professional midwives
  - certified registered nurse anesthetists
  - licensed practical nurses (LPNs)
  - nurse practitioners
  - registered nurses (RNs)
- nutritional counselors
- optometrists
- Physicians (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 on page 2.

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

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

Network Provider: for most Network Providers this includes:

- Pharmacies who make an agreement with our Pharmacy Benefit Manager;

- Vision Providers who make an agreement with our vision service partner;
- (for pediatric dental care) Providers in our pediatric dental Network; or
- Preferred Providers for all other services.

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

You may find a Network Provider on our website at **www.bcbsvt.com**. You may also get a directory of Network Providers from your Group Benefits Manager or from our customer service team. Some Providers must be Network in order for their services to be Covered. For some types of service, we do not provide benefits if you do not use a Network Provider. See Choosing a Provider on page 2.

Non-Network Provider: a Provider that does not meet the definition of a Network Provider. For some types of service, we do 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 Physicians. 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.

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. Physicians 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.

Speech Therapy: Speech Therapy is the treatment of communication impairment and swallowing disorders. Speech Therapy services facilitate the development and maintenance of human communication and swallowing through assessment, diagnosis, Habilitation and 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.

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

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

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

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 Physician with knowledge of the individual's medical condition, would subject the individual to severe pain that cannot be adequately managed without care within 24 hours.

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

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

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

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

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