Health plans are administered by:

BlueCross BlueShield of Vermont

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

2018 Health Care Benefits

VEHI Retiree Vermont Health Partnership Plan

Benefits Description

VSTRS Eligibility

For information about VSTRS eligibility requirements please visit, **www.vermonttreasurer.gov/content/retirement/teacher** or call (800) 253-0191. You may also write them at:

Office of the State Treasurer
109 State Street
Montpelier, VT 05609

This Benefits Description provides you with a description of your benefits. You should read this document to familiarize yourself with the Plan's main provisions and keep it handy for reference. Blue Cross and Blue Shield of Vermont (BCBSVT) is the Contract Administrator and provides administrative services to the Plan such as:

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

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

The Plan is a non-insured, self-funded health benefits plan. BCBSVT is not an underwriter or insurer of the benefits provided by the Plan. As the Contract Administrator, Blue Cross and Blue Shield of Vermont provides administrative claims payment services only and does not assume any financial risk or obligations with respect to claims under this Plan.

This Benefits Description is current until BCBSVT or the Plan Organizer updates it. If you are missing part of your Benefits Description or not sure whether you have the most recent copy, please visit the Member Resource Center at **www.bcbsvt.com/MRC** to view this document. If you'd like a hard copy mailed directly to you, please call BCBSVT's customer service team at the number listed on the back of your ID card. If the benefits described in this document differ from descriptions in other materials, your member materials language prevails.

How to Use This Document

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

Get It All Online

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

For instance:

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

NOTICE: Discrimination is Against the Law

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

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

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

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

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

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

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

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

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

ARABIC

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

CHINESE

如需免費語言協助服務，請致電(800) 247-2583。

CUSHITE (OROMO)

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

FRENCH

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

GERMAN

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

ITALIAN

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

JAPANESE

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

NEPALI

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

PORTUGUESE

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

RUSSIAN

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

SERBO-CROATIAN (SERBIAN)

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

SPANISH

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

TAGALOG

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

THAI

สำหรับการให้บริการความช่วยเหลือด้านภาษาฟรี โทร (800) 247-2583

VIETNAMESE

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

TABLE OF CONTENTS

CHAPTER ONE

Guidelines for Coverage

This Benefits Description describes benefits for the Vermont Health Partnership. It is a Point-of-Service (POS) plan administered by Blue Cross and Blue Shield of Vermont (BCBSVT). A POS plan provides Preferred benefits when you follow managed care guidelines, but includes another, lower level of benefits ("Standard Benefits") for some services.

This Plan is a **"grandfathered health plan"** under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other Plans. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act.

The Plan sponsor must notify you if your contribution rate changes at any point during the Plan Year as this may affect your grandfathered status.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a Plan to change from grandfathered health plan status can be directed to VSTRS Retirement Division. You may also contact the U.S. Department of Health and Human Services at **www.healthreform.gov**.

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

General Guidelines

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

- Capitalized words have special meanings. See "Definitions" in Chapter Nine to understand your coverage.
- The Plan will only pay benefits for services defined as Covered by this Benefits Description. You must also use Providers (see definition in Chapter Nine). For some services, you must use Providers who are Network Providers .
- The provisions of this Benefits Description only apply as provided by law.
- Certain services are excluded from coverage under the Plan. You'll find general exclusions in Chapter Three. They apply to all services. Exclusions that apply to specific services appear in applicable sections of your Benefits Description.
- Services not considered Medically Necessary are not covered by the Plan. You may appeal BCBSVT's decisions, see page 25 for more information.
- This is not a long-term care policy as defined by Vermont State law at 8 V.S.A. §8082 (5).
- You must follow the guidelines in this Benefits Description even if this coverage is secondary to other health care coverage for you or one of your Dependents.
- The Plan Organizer may interpret and apply the terms of your Coverage. The Plan may determine if you have coverage for care. The Plan Organizer may also decide how much coverage you have. This applies even when a provider has prescribed or recommended a service.

Prior Approval Program

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

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

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

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

How to Request Prior Approval

To get Prior Approval, your Network Provider must provide supporting clinical documentation to BCBSVT. When receiving care from a Non-Network Provider or an out-of-state Provider, it is your responsibility to get Prior Approval. Forms are available on BCBSVT's

website at **www.bcbsvt.com**. You may also get them by calling the BCBSVT customer service team. The phone number is located on the back of your ID card.

Any Provider may help you fill out the form and give you other information you need to submit your request. The medical staff at BCBSVT will review the form and respond in writing to you and your provider. If we deny your request for Prior Approval, you may appeal this decision by following the steps outlined in "Chapter Four, Claims."

Prior Approval List

To receive benefits, you need Prior Approval to use out-of-Network Providers and for servicesYou need Prior Approval for services printed on our Prior Approval list. In order to receive Preferred benefits and save the most on out-of-pocket costs for your care, you must get Prior Approval to see any Non-Network providers. This list includes:

- Ambulance (non-emergency transport including air or water transport);
- anesthesia (monitored);
- Autism Spectrum Disorder and intellectual disability treatment;
- bilevel positive airway pressure (BPAP) equipment:
- capsule endoscopy (wireless);
- chiropractic care after 12 visits in a Plan Year;
- chondrocyte transplants;
- cochlear implants and aural rehabilitation;
- continuous passive motion (CPM) equipment;
- continuous positive airway pressure (CPAP) equipment;
- Cosmetic procedures except breast reconstruction for patients with a diagnosis of breast cancer;
- dental services (please see Chapter Two, Covered Services for details);
- Durable Medical Equipment (DME) and orthotics with a purchase price of $500 or more;
- Electroconvulsive Therapy (ECT);
- gender reassignment services for gender dysphoria;
- genetic testing;
- hip resurfacing;
- hospital beds;
- hyperbaric oxygen therapy;
- investigational or experimental services or procedures;
- medical nutrition for inherited metabolic disease (medical supplies, pumps, enteral formulae and parenteral nutrition);
- Non-Network Providers;
- oral appliances for sleep apnea;
- orthotics with a purchase price of $500 or more;
- osteochondral Autograft Transfer system (OATS/mosaicplasty);
- out-of-state Inpatient and partial Inpatient care;
- percutaneous radiofrequency ablation of liver;
- polysomnography (sleep studies) and multiple sleep latency testing (MSLT);
- certain Prescription Drugs and Biologics (please see Rx Center at **www.bcbsvt.com/pharmacy** for a complete list);
- prosthetics with a purchase price of $500 or more;
- psychological testing;
- radiation treatment and high-dose brachytherapy;
- radiology services (examples include CT, MRI, MRA, MRS, PET, echocardiogram and nuclear cardiology);
- Rehabilitation (Skilled Nursing Facility, Inpatient Rehabilitation treatment for medical conditions, intensive outpatient services or residential treatment for mental health and substance abuse conditions);
- certain surgical procedures including bariatric (obesity) Surgery, gastric electrical stimulation, percutaneous vertebroplasty, vertebral augmentation, temporomandibular joint manipulation/Surgery and anesthesia and tumor embolization;
- transcranial magnetic stimulation;
- transcutaneous electrical nerve stimulation (TENS) units/neuromuscular stimulators;
- transplants (except corneal and kidney);
- wheelchairs.

Case Management Program

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

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

Choosing a Provider

In Vermont, in order to receive preferred benefits, you will use *BCBSVT Network Providers*. This includes a wide array of primary care providers, 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 Plans.

For pharmacy and vision services please use the special Network Providers.

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

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

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

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

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

Primary Care Providers

When you join this Plan, you must select a primary care provider from BCBSVT's Network of primary care providers (PCP). 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 primary care provider. For instance, you may select a pediatrician for your Child.

Your coverage does not require you to get referrals from your primary care provider when you use other providers. However, you must get Prior Approval for certain services. (See page 1). For instance, you must get Prior Approval for any services you receive from Providers outside BCBSVT's Network to receive the highest level of benefits.

Network Providers

This is a point-of-service (POS) plan. A POS plan provides Preferred benefits when you follow managed care guidelines, but includes another, lower level of benefits ("Standard Benefits") for some services. In order to receive Preferred benefits you must use a Network Provider or obtain Prior Approval to use a Non-Network Provider.

In most instances, Network Providers will,

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

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

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

Non-Network Providers

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

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

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

- Physical Rehabilitation Facilities; and
- Skilled Nursing Facilities.

Standard Benefits

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

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

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

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

How BCBSVT Chooses Providers

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

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

Out-of-Area Providers Including BlueCard Global Core

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

BlueCard® Program

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

Typically, when you access care outside of the service areas, you will obtain care from a health care Provider that has a contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue").

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

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

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

Special Case: Value-Based Programs

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

Out-of-Area Services with non-contracting Providers

In certain situations, you may receive Covered health care services from a health care Provider outside of the service area that does not have a contract with the Host Blue (Prior Approval Required). In most cases, BCBSVT will base the amount you pay for such services on either the Host Blue's local payment or the pricing arrangements under applicable state law.

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

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

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

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

Blue Cross Blue Shield Global Core™ Program

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

You must get Prior Approval from Blue Cross and Blue Shield of Vermont for all non-emergency services outside of the Preferred Network.

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

Inpatient Services

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

Outpatient Services

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

Submitting a Blue Cross Blue Shield Global Core Claim

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

Access to Care

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

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

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

- a Network primary care provider (like a family practitioner, pediatrician or internist) within a 30-minute drive from your home;
- routine, office-based mental health and/or substance abuse care from a Network Provider within a 30-minute drive; and
- a Network pharmacy within a 60-minute drive.
- You'll find Network specialists for most types of care within a 60-minute drive from your home. They include optometry, laboratory, imaging and Inpatient medical Rehabilitation Providers, as well as intensive Outpatient, partial hospital, residential or Inpatient mental health and substance abuse services.

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

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

After-hours and Emergency Care

Emergency Medical Services

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

Emergencies might include:

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

You will receive care right away in an emergency.

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

If you receive Medically Necessary, Covered Emergency Medical Services from a Non-Network Provider, BCBSVT will Cover your Emergency Care as if you had been treated by a Network Provider. You must pay any cost-sharing amounts listed in your *Outline of Coverage* as if you received those services from a Network Provider. These may include Deductibles, Co-insurance or Co-payments. If a Non-Network Provider requests any payment from you other than your cost-sharing amounts, please contact BCBSVT at the number on the back of your ID card, so that BCBSVT can work directly with the Provider to resolve the request.

Care After Office Hours

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

How The Plan Determines Your Benefits

When BCBSVT receives your claim, it determines:

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

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

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

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

Payment Terms

Allowed Amount

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

Note:

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

Plan Year Benefit Maximums

The Plan Year Benefit maximums are listed on your *Outline of Coverage*. For example the Plan has a visit limit for PT/OT/ST. After the Plan has 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 BCBSVT that you received a particular health care item or service. If you choose to exercise this right, you must pay the Provider the Allowed Amount. In this case, the amount you pay your Provider will not count toward your Deductible, other cost-sharing obligations or your Out-of-Pocket Limits.

Cost-sharing

Deductible

Your Deductible amounts are listed on your *Outline of Coverage*. You must meet your Deductibles each Plan Year before the Plan covers certain services.

Aggregate Deductible

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

Stacked Deductible

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

Co-payment

You must pay Co-payments to Providers or pharmacies for specific services shown on your *Outline of Coverage*. Your Provider may require payment at the time of the service. You may have different Co-payments depending on the Provider you see. Check your *Outline of Coverage* for details.

Co-insurance

You must pay Co-insurance to Providers or pharmacies for specific services shown on your *Outline of Coverage*. The Plan calculates the Co-insurance amount by multiplying the Co-insurance percentage by the Allowed Amount after you meet your Deductible (if applicable).

Out-of-Pocket Limit

If applicable, your *Outline of Coverage* lists your Out-of-Pocket Limit. The Plan may apply Co-insurance, Co-payments and Deductibles towards your Out-of-Pocket-Limit.

Please check your *Outline of Coverage* for details.

Aggregate Out-of-Pocket Limit

If the Plan has an aggregate Out-of-Pocket Limit and you're on a two-person, parent and child or family plan, you do not have an individual Out-of-Pocket Limit. Your family members' Covered expenses must meet the family Out-of-Pocket Limit before the Plan pays 100 percent of the Allowed Amount for eligible services. When your family's expenses reach this amount, all family members receive 100 percent coverage for the rest of the Plan Year.

Check your *Outline of Coverage* for details.

Stacked Out-of-Pocket Limit

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

Check your *Outline of Coverage* for details.

Aggregate Prescription Drug Out-of-Pocket Limit

If the Plan has an Aggregate Prescription Drug Out-of-Pocket Limit, and you're on a two-person, parent and child or family plan, you do not have an individual Prescription Drug Out-of-Pocket Limit. Your family members' Covered expenses must reach the family Prescription Drug Out-of-Pocket Limit before the Plan pays 100 percent of the Allowed Amount for eligible services. When your family's expenses reach this amount, all family members receive 100 percent coverage for the rest of the Plan Year.

Please check your *Outline of Coverage* for details.

Stacked Prescription Drug Out-of-Pocket Limit

If you are on a two-person, parent and child or family plan, a covered family member may meet the individual Prescription Drug Out-of-Pocket Limit and the Plan will begin to pay 100 percent of the Allowed Amount for his or her services. Additionally, any combination of covered family members may meet the family Prescription Drug Out-of-Pocket Limit and the Plan will begin to pay 100 percent of the Allowed Amount for all family members' eligible services for the rest of the Plan Year.

Check your *Outline of Coverage* for details.

CHAPTER TWO

Covered Services

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

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. The Plan Covers 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 room professional services;
- nutritional counseling (see page 14);
- Surgery; and
- therapy services (see page 18).

Exclusions

The Plan does not Cover:

- immunizations the law mandates an employer must provide.

General Exclusions in Chapter Three also apply.

Notes:

- The Plan describes 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 at **www.bcbsvt.com** or call customer service for the newest list of services that require Prior Approval.

Ambulance

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

The Plan Covers transportation of the sick and injured:

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

Limitations

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

Autism Spectrum Disorder

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

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

General Exclusions in Chapter Three also apply.

Clinical Trials (Approved)

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

General exclusions in Chapter Three also apply.

Chiropractic Services

The Plan Covers care by Network Chiropractors who are:

- working within the scope of their licenses; and

- treating you for a neuromusculoskeletal condition (that is, a condition of the bones, joints or muscles).

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

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

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

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

Exclusions

The Plan does not provide chiropractic benefits for:

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

Please remember that General Exclusions in Chapter Three also apply.

Cosmetic and Reconstructive Procedures

The Plan excludes Cosmetic procedures (see General Exclusions in Chapter Three). The Plan Covers Reconstructive procedures that are not Cosmetic. (Please see the definitions of Reconstructive and Cosmetic.) For example, the Plan Covers:

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

You must get Prior Approval for all of these services.

Dental Services

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

You must get Prior Approval for dental services or your care may not be Covered. Please see your Benefits Description, Chapter One, "General Guidelines" for more information. (Prior Approval does not apply to bone impacted teeth.)

BCBSVT Covers only the following dental Services:

- Treatment for or in connection with an accidental injury to jaws, sound natural teeth, mouth or face, provided a continuous course of dental treatment is started within six months of the accident;
- Surgery to correct gross deformity resulting from major disease or Surgery (Surgery must take place within six months of the onset of disease or within six months after Surgery, except as otherwise required by law);
- Surgical removal of bone-impacted teeth;

- Facility and anesthesia charges for members who are:
  - 7-years old or younger;
  - 12-years old or younger with phobias or a mental illness documented by a licensed physician or mental health professional; and
  - members with severe disabilities that preclude office-based dental care due to safety consideration (examples include, but are not limited to, severe autism, cerebral palsy, hemorrhagic disorders and severe congestive heart failure). Please note the professional charges for the dental services may not be covered.
- Surgical removal of bone-impacted teeth; and
- Gingivectomy only for general or systemic conditions or conditions resulting from the effects of drugs.

Exclusions

Unless expressly Covered in other parts of this document or required by law, the Plan does not Cover:

- tooth implants;
- care for periodontitis;
- injury to teeth or gums as a result of chewing or biting;
- pre- and post-operative dental care;
- orthodontics (including orthodontics performed as an adjunct to orthognathic Surgery);
- procedures designed primarily to prepare the mouth for dentures (including alveolar augmentation, bone grafting, frame implants and ramus mandibular stapling); or
- charges related to non-covered dental procedures (for example, anesthesia or facility charges), except when Medically Necessary for children under seven years old or any members with disabilities, medical or mental health conditions, or exceptional medical circumstances, which prevent care from being safely delivered in an office setting or under local anesthesia.

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

Diabetes Services

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

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

Diagnostic Services

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

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

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

Emergency Care

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

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

Requirements

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

Home Care

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

- performs Medically Necessary skilled nursing procedures in the home;

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

The Plan also Covers:

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

For more information about Therapy Services, see page 19.

Private Duty Nursing

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

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

Requirements

The Plan Covers home care services only when your Provider:

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

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

Limitations

The Plan Covers home infusion therapy only if:

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

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

Exclusions

The Plan does not provide home care benefits for:

- homemaker services;
- drugs or medications except as noted above (while drugs and medications are not Covered under your home care benefits, the Plan may Cover them under your Prescription Drug benefits. See your *Outline of Coverage* for cost-sharing details);
- Custodial Care (see Definitions), as noted in General Exclusions;
- food or home-delivered meals; and
- private-duty nursing services provided at the same time as home health care nursing services.

General Exclusions in Chapter Three also apply.

Hospice Care

The Plan Covers the following services by a NetworkHospice Provider:

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

Requirements

The Plan only provides benefits if:

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

Hospital Care

Inpatient Hospital Services

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

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

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

Inpatient Medical Services

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

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

Notes on Surgery:

You must get Prior Approval for Reconstructive procedures.

The Plan limits Surgery benefits as follows:

- BCBSVT makes global payments for some Surgeries and other procedures. This means that the Allowed Amount for the Surgery includes payment for all office visits and other care that is related to the Surgery.
- Subject to Medical Necessity, the Plan may limit the number of visits Covered for one Provider in a given day.
- If you have several Surgeries at the same time, BCBSVT may not pay a full allowance for each one.
- The Plan excludes 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.) The Plan also Covers the following care by a Provider or other Professional during a woman's pregnancy:

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

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

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

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

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

Better Beginnings® Maternity Wellness Program

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

- personal-use breast pumps;
- books and educational tools;
- reimbursement on classes; and
- reimbursement towards infant carseats.

You get the most out of the Better Beginnings program when you contact Better Beginnings in the first three months of your pregnancy. To get any benefits from Better Beginnings, you must actively participate. If you have questions, please call BCBSVT's customer service team at the number on the back of your ID card. If you'd like to enroll online, or learn more about the program, please visit **www.bcbsvt.com/betterbeginnings**.

Note:

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

Medical Equipment and Supplies

You must get Prior Approval for certain medical equipment and supplies such as continuous passive motion (CPM) equipment, TENS units or Durable Medical Equipment including orthotics and prosthetics with a purchase price over $500.

The Plan Covers Durable Medical Equipment you purchase from a Network:

- medical doctor (M.D.);
- doctor of osteopathy (D.O.);
- therapist (physical or occupational);
- podiatrist (D.P.M);

- naturopathic Provider (N.D.); or
- Durable Medical Equipment supplier.

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

Replacement of lost, stolen or destroyed Durable Medical Equipment

The Plan will replace one lost, stolen or destroyed Durable Medical Equipment, prosthetic or orthotic per Plan Year if not covered by an alternative entity (including but not limited to homeowners insurance and automobile insurance) if:

- the Durable Medical Equipment, prosthetic or orthotic's absence would put the member at risk of death, disability or significant negative health consequences such as a hospital admission;
- the Durable Medical Equipment is still under warranty.

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

Exclusions

We do not cover the replacement of a lost, stolen or destroyed Durable Medical Equipment, prosthetic or orthotic:

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

Supplies

The Plan Covers medical supplies such as needles, syringes and other supplies, dressings for cancer or burns, catheters, colostomy bags and related supplies and oxygen, including equipment Medically Necessary for its use. The Plan may cover diabetic medical equipment and supplies. Please see your *Outline of Coverage* for details.

Orthotics

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

Prosthetics

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

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

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

Limitations

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

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

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

Also, the Plan Covers dental prostheses only if required:

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

Exclusions

The Plan does not provide benefits for:

- treatment for hair loss due to male or female pattern baldness and/or natural or premature aging;
- prosthetics or orthotics with a purchase price of $500 or more for which you have not received Prior Approval from BCBSVT;
- dental appliances or dental prosthetics, except as listed above;

- shoe insert orthotics, lifts, arch supports or special shoes not attached to a brace (except with a diagnosis of diabetes);
- custom-fabricated or custom-molded knee braces (pre-fabricated, "off-the-shelf" braces are Covered);
- duplicate medical equipment and supplies, orthotics and prosthetics;
- continuous passive motion equipment (unless you get Prior Approval);
- dynamic splinting, patient-actuated end-range motion stretching devices and programmable or variable motion resistance devices;
- replacement of more than one lost or stolen medical equipment or supply, orthotic or prosthetic;
- 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 the Plan's definition of Durable Medical Equipment, you may call customer service at the number listed on the back of your ID before purchasing or renting a Durable Medical Equipment item.

Mental Health Care

Some services require Prior Approval.

Outpatient

The Plan Covers Outpatient mental health services including:

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

Inpatient

The Plan Covers Inpatient mental health services including:

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

The Plan Covers mental health services only if care is provided in the least restrictive setting Medically Necessary. Coverage for Emergency Medical Services outside the service area is the same as for those within the service area. If a Non-Network Provider bills you for a balance between the charges and what the Plan pays, please notify BCBSVT. Call BCBSVT's customer service team at the number on the back of your ID card. BCBSVT will defend against, and resolve, any request or claim by a Non-Network Provider of Emergency Medical Services.

Exclusions

The Plan provides no mental health benefits for:

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

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, the Plan Covers up to three Outpatient nutritional counseling visits each Plan Year.

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

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

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

Outpatient Hospital Care

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

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

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

For information about therapy services, see page 19.

Outpatient Medical Services

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

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

Limitations

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

Prescription Drugs and Biologics

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

- Prescription Drugs and Biologics (including contraceptive drugs and devices that require a prescription) if the Food and Drug Administration approves them for the treatment of your condition;
- insulin and other supplies for people with diabetes (blood sugar testing materials including home glucose testing machines), needles and syringes. Please see your *Outline of Coverage* for details.

Please note the Plan covers Off-label prescription drug use to treat cancer as required by law. The Plan may provide benefits for Prescription Drugs and Biologics that are not approved by the Food and Drug Administration for the treatment of your condition if their use meets the definition of medical necessity and is not considered investigational.

Please refer to your ***Outline of Coverage*** to determine the specific payment requirements of your Prescription Drug benefit.

Preferred and Non-Preferred Drugs

The Plan may require different amounts of cost-sharing when you purchase generic, preferred or non-preferred drugs. Generally generics require less cost-sharing and non-preferred drugs require the most cost-sharing.

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

Home Delivery Service

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

To use the home delivery service, you must complete and send a home delivery form and submit it with your prescription. You may receive drugs at your home or office address, and you can order refills by phone, fax or on the internet. For more information about BCBSVT's home delivery service, call the pharmacy phone number on the back of your ID Card or visit the BCBSVT website at **www.bcbsvt.com**.

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

Limitations

The Plan covers up to a 90-day supply for each refill. We limit coverage for narcotics, antibiotics, Specialty Medications, controlled substances, covered over-the-counter products and compound drugs (see below) to a 30-day supply per refill. The Plan limits benefits for:

- Viagra to six pills per month;
- Cialis to six pills per month;

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

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

Prior Approval Program

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

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

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

- 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 calendar year)
- Primary pulmonary hypertension therapy

How to Get Prior Approval for Your Drugs

To get Prior Approval for your prescription drug, or have us adjust quality limits or step therapy edits, your provider must write to BCBSVT's 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 phone number on the back of your ID Card. If BCBSVT denies your request for Prior Approval, see your Benefits Description for instructions on how to appeal BCBSVT's decision. You may also see your *Outline of Coverage* for details regarding our Prior Approval Program.

Quantity Limits

BCBSVT reviews certain Prescription Drugs and Biologics for Medical Necessity if the amount of a drug your doctor has prescribed exceeds quantity limits. If your doctor prescribes a drug in an amount that exceeds certain criteria, such as the FDA approved dosing, BCBSVT may ask for documentation about why you need more of the drug. Visit BCBSVT's website at **www.bcbsvt.com** or call the pharmacy phone number listed on the back of your ID card to get a current list of drugs covered by this review or to learn the quantity limit for a particular drug.

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

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

BCBSVT's quantity limits, step therapy and Prior Approval drug lists change from time to time. Check with your doctor or visit BCBSVT's website at **www.bcbsvt.com** to see if a specific drug needs Prior Approval or other review. You may also call the pharmacy phone number on the back of your ID Card.

Step Therapy

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

- Non-sedating antihistamines (like Clarinex® or Xyzal®)
- Angiotensin Receptor Blockers for hypertension (like Cozaar® or Diovan®)
- Anti-virals (like Valtrex® or Famcyclovir®)
- Asthma control medications (like Symbicort® and Advair®)
- Bisphosphonates (like like Boniva® or Actonel®)

- COX-2 inhibitors (like Celebrex®)
- Certain medications for depression (like Lexapro® or Cymbalta®)
- Diabetes management and treatment drugs (like blood glucose supplies, DPP IV and TZDs)
- Hypertension drugs for treating high blood pressure and other heart diseases (like Bystolic® and Coreg®)
- Hypnotics (sleeping pills like Lunesta® or Rozerum®)
- Lyrica® (for treating several conditions associated with the nervous system, including neuropathy)
- Nasal steroids (Like Rhinocort AQ® or Nasacort AQ®)
- Statins (cholesterol-lowering drugs like Lipitor® 10 and 20 mg)
- Stomach acid medications (like Nexium® or Prevacid®)
- Triptans for the treatment of migraine headaches

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

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

BCBSVT provides no prescription drug benefits for:

- refills beyond one year from the original prescription date;
- replacement of more than one lost, destroyed or stolen Prescription Drug and Biologic;
- 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 *Benefits Description*);
- any drug considered to be Experimental or Investigational (see definition in your Benefits Description), except for certain Off-label cancer drugs and drugs administered as part of certain clinical cancer trials;
- vitamins, except those which, by law, require a prescription;
- drugs that do not require a prescription, except insulin and covered over-the-counter products, even if your doctor prescribes or recommends them; and
- food and nutritional formulae or supplements except except for "medical foods" prescribed for the Medically Necessary treatment of an inherited metabolic disease or those prescription formulae and supplements administered through a feeding tube.

Replacement of lost, stolen or destroyed Prescription Drugs and Biologics

The plan will replace one lost, stolen or destroyed Prescription Drug or Biologic per Plan Year

- if not covered by an alternative entity (including but not limited to homeowners insurance and automobile insurance) if:
- the Prescription Drug or Biologic's absence would put the member at risk of death, disability or significant negative health consequences such as a hospital admission.

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

Exclusions

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

- if the criteria above have not been met; and
- for more than one lost, stolen or destroyed Prescription Drug or Biologic per Plan Year.

Please see your *Outline of Coverage* for preventive services and cost-sharing amounts.

Rehabilitation/ Habilitation Services

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

The Plan Covers:

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

You must use a Network cardiac Rehabilitation Provider.

Requirements

The attending Provider must:

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

Exclusions

The Plan does not Cover:

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

General Exclusions in Chapter Three also apply.

Skilled Nursing Facility

The Plan Covers Inpatient services including:

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

Requirements

The Plan provides benefits only if you:

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

Exclusions

The Plan does not Cover Skilled Nursing Facility care for:

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

Substance Abuse Treatment Services

Some services require Prior Approval. The Plan Covers the following Acute substance abuse treatment services:

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

Requirements

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

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

Exclusions

The Plan provides no substance abuse treatment benefits for:

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

General Exclusions in Chapter Three also apply.

Surgery

The Plan covers surgery in both Inpatient and outpatient settings with the following limitations and conditions:

- The Plan covers sterilization procedures (vasectomy or tubal ligation) even though they are not Medically Necessary. The Plan Covers only one attempt at reversal of sterilization per individual per lifetime.
- BCBSVT makes global payments for some Surgeries and other procedures. This means that the Allowed Amount for the Surgery includes payment for all office visits and other care this is related to the Surgery.

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

Telemedicine Services

The Plan covers general consultative telemedicine services such as:

- colds and flu;
- sinus, ear and eye infections;
- headaches; and
- allergies.

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

Limitations

You must use American Well providers. For details, please visit **AMWell.com**.

Please note if the Plan offers prescription drug coverage:

- Providers may not write prescriptions to patients with whom they consult by telephone (subject to state law).
- Providers cannot prescribe any controlled substances, medication for erectile dysfunction or any state-specific controlled medications (subject to state law; such as pseudoephedrine). Controlled substances include drugs such as:
  - narcotics;
  - anxiety medications;
  - ADHD medications; and
  - muscle relaxants.

Exclusions

Your telemedicine benefit does not cover:

- Telemedicine services via e-mail, Skype, fax, or other telehealth vendor.
- "Store and Forward" telemedicine.

Please note BCBSVT does not contract with Amwell to cover specialty services. You may still use Amwell to obtain these services, but you will need to pay Amwell directly.

Therapy Services

The Plan Covers physical therapy or medicine services provided by:

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

Therapy services could include the following:

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

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

- for Physical Therapy/medicine services that require constant attendance of a licensed:
  - physical therapist;
  - medical doctor (M.D.),
  - chiropractor (D.C.);
  - athletic trainer (A.T.);
  - podiatrist (D.P.M.);
  - nurse practitioner (N.P.);
  - advanced practice registered nurse (A.P.R.N.); doctor of naturopathy (N.D.); or
  - a doctor of osteopathy (D.O.).
- up to the specific limits listed on your *Outline of Coverage* (this limitation does not apply to mandated treatment for Autism Spectrum Disorder as required by Vermont law or as explained on page 8 of this document).

Exclusions

The Plan does not cover the following therapy services:

- care for which there is no therapeutic benefit or likelihood of improvement;
- care, the duration of which is based upon a predetermined length of time rather than the condition of the patient, the results of treatment or the individual's medical progress;
- care provided but not documented with clear, legible notes indicating the patient's symptoms, physical findings, the Provider's assessment, and treatment modalities used (billed);

- therapy services that are considered part of custodial care;
- services, including modalities, that do not require the constant attendance of a Provider;
- hot and cold packs;
- treatment of developmental delays;
- unattended services or modalities (or application of a service or modality) that do not require one-on-one patient contact by the provider.

General Exclusions in Chapter Three also apply.

Note:

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

Transplant Services

You must get Prior Approval for transplant services.

BCBSVT reserves the right to review all requests for Prior Approval based on the:

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

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

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

The Plan pays benefits for transplants as follows:

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

Time Period for Living Donor Benefits

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

Exclusions

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

Please remember that General Exclusions in Chapter Three also apply.

Urgent Services

The Plan Covers Urgent Services received at an urgent care facility. You may be balanced billed for services obtained outside of the Network. If you are balanced billed, please call customer service at the number listed on the back of your ID card.

Requirements

The Plan provides benefits only if you require Urgent Services as defined in this Benefits Description. Please see your *Outline of Coverage* for cost-sharing details.

Vision Service (Exam)

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

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

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

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

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

Exclusions

The Plan does not cover services or supplies for:

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

Also refer to General Exclusions in Chapter Three, General Exclusions.

VSP Claim Filing

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

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

Vision Services (Medical)

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

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

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

CHAPTER THREE

General Exclusions

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

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

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

1. Services that a prior health plan must Cover as extended benefits.
2. Services for which you would not legally have to pay if you did not have the Plan or similar coverage.
3. Services for which there is no charge.
4. Services paid directly or indirectly by a local, state or federal government agency, except as otherwise provided by law.
5. Services you require because you committed or attempted to commit a felony or engaged in an illegal occupation.
6. Services over the limitations or maximums set forth by the Plan.
7. Services or drugs that BCBSVT determines are Investigational, mainly for research purposes or Experimental in nature. To the extent required by law, however, the Plan Covers routine costs for patients who participate in approved clinical trials.
8. Services not provided in accordance with accepted Professional medical standards in the United States.
9. Services beyond those needed to restore your ability to perform Activities of Daily Living (see Definitions in Chapter Nine) or to establish or re-establish the capability to perform occupational, hobby, sport or leisure activities.
10. Acupuncture, acupressure or massage therapy; hypnotherapy, rolfing, homeopathic or naturopathic remedies. This exclusion does not apply to Medically Necessary Covered services when performed within the scope of a naturopathic Provider's license.
11. Electrical stimulation devices used externally. (This exclusion does not apply to bone growth stimulators, transcutaneous electrical nerve stimulation [TENS] devices or neuromuscular electrical stimulators [NMES] for which you have received Prior Approval.)
12. Automatic ambulatory home blood pressure monitoring or equipment and all related services.
13. Biofeedback or other forms of self-care or self-help training.
14. Immunizations purchased in bulk, such as those provided to a group of people and billed collectively rather than individually.
15. Fluoride treatments performed in school.
16. Whole blood, blood components, costs associated with the storage of blood, testing of blood the patient donates for his or her own use (even if the blood is used), transfusion services for blood and blood components the patient donates for his or her own use in the absence of a Covered surgical procedure. (This exclusion does not apply to blood derivatives and transfusion services for whole blood, blood components and blood derivatives.)
17. Care for which there is no therapeutic benefit or likelihood of improvement.
18. Care, the duration of which is based upon a predetermined length of time rather than the condition of the patient, the results of treatment or the individual's medical progress.
19. Clinical ecology, environmental medicine, Inpatient confinement for environmental change or similar treatment.
20. Cognitive training or retraining and educational programs, including any program designed principally to improve academic performance, reading or writing skills.
21. Communication devices and communication augmentation devices. Computer technology or accessories and other equipment, supplies or treatment intended primarily to enhance occupational, recreational or vocational activities, hobbies or academic performance.
22. 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. Custodial Care, Rest Cures.
26. Dental services and dental-related oral Surgery, unless specifically provided by your Benefits Description; procedures designed primarily to prepare the mouth for dentures (including alveolar augmentation, bone grafting, frame implants and ramus mandibular stapling).
27. Treatment of developmental delays. This exclusion does not apply to mandated treatment of Autism Spectrum Disorder as defined by Vermont law or as explained on page 8 .
28. Drugs and pharmaceuticals, except as required by law (unless the Plan covers Prescription Drugs, see Chapter Two "Covered Services" for details).
29. Any determination of refractive state or any examination, prescription or fitting of eyeglasses or contact lenses unless the refraction, examination, prescription or fitting is for treatment of aphakia or keratoconus.
30. Education, educational evaluation or therapy, therapeutic boarding schools, services that should be Covered as part of an evaluation for, or inclusion in, a Child's individualized education plan (IEP) or other educational program. (This exclusion does not apply to treatment of diabetes, such as medical nutrition therapy by approved Providers.)
31. Foot care or supplies that are Palliative or Cosmetic in nature, including supportive devices and treatment for bunions (except capsular or bone Surgery), flat-foot conditions, subluxations of the foot, corns, callouses, toenails, fallen arches, weak feet, chronic foot strain and symptomatic complaints of the feet. This exclusion does not apply to necessary foot care for treatment of diabetes.
32. Hearing aids or examinations for the prescription or fitting of hearing aids. Tinnitus masking devices.
33. Home or automobile modifications or equipment like air conditioners, HEPA filters, humidifiers, stair glides, elevators, lifts, motorized scooters, whirlpools, furniture or "barrier-free" construction, even if prescribed by a Provider.
34. Hot and cold packs.
35. Illnesses or injuries that are:
    - a result of an act of war (declared or undeclared); or
    - sustained in active military service.
36. Infertility services, including:
    - surgical, radiological, pathological or laboratory procedures 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.
    - The Plan covers up to four months of fertility medications per Plan Year when you attempt to conceive through natural means (not by artificial insemination, in vitro fertilization, embryo transplantation and gamete intrafallopian transfer, zygot intrafallopian transfer or any variations of these procedures). You must get Prior Approval for fertility medications.

      Note: This exclusion does not apply to the evaluation to determine if and why the couple is infertile.
37. An Inpatient stay determined not Medically Necessary while you are waiting for a different level of care, such as Skilled Nursing Facility or home care, whether or not it is available to you.
38. Treatment for willfully uncooperative or intractable patients.
39. Institutional or Custodial Care for the physically or mentally handicapped.
40. Mandated treatment, including court-ordered treatment, unless such treatment is Medically Necessary, ordered by a Provider and Covered under your Benefits Description.
41. Non-medical charges, such as:
    - taxes;
    - postage, shipping and handling charges;
    - a penalty for failure to keep a scheduled visit; or
    - fees for copies of medical records, transcripts or completion of a claim form.
42. Nutritional counseling beyond three visits per Plan Year. This limit does not apply to the treatment of diabetes.
43. Food and nutritional formulae or supplements, except for "medical foods" prescribed for the Medically Necessary treatment of an inherited metabolic disease or prescription formulae and supplements administered through a feeding tube.

44. Orthodontics, including orthodontics performed as adjunct to orthognathic Surgery or in connection with accidental injury.
45. 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 (e.g., knee braces for skiing, running or hiking) intended primarily for use with sports or physical activities other than Activities of Daily Living; weight loss or exercise programs; health club or fitness center memberships.
49. Pneumatic cervical traction devices except when the patient has a diagnosis of Temporomandibular Joint Syndrome (TMJ); gravity-assisted traction devices.
50. Services, including modalities, that do not require the constant attendance of a Provider;
51. Specialized examinations, services or supplies required by your employer or for sports/recreational activities (e.g. driver certifications, pilot flight physicals, etc.).
52. Support therapies, including pastoral counseling, assertiveness training, dream therapy, equine therapy, music or art therapy, recreational therapy, tobacco cessation support therapy, stress management, wilderness programs, therapy camps, adventure therapy and bright light therapy.
53. "Store and forward" telemedicine or telemedicine not conducted at a Network facility.
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. Unattended services or modalities (application of a service or modality) that do not require direct one-on-one patient contact by the provider.
58. Vision training, orthoptics or plano (non-prescription) lenses.
59. 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, the Plan does not Cover services prescribed or provided by a:

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

CHAPTER FOUR

Claims

Remember, when you contact a Provider, you must:

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

Claim Submission

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

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

Release of Information

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

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

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

Cooperation

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

Payment of Benefits

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

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

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

Payment in Error/Overpayments

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

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

How BCBSVT Evaluates Technology

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

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

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

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

Complaints and Appeals

When You Have a Complaint

Customer Service

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

If You Don't Agree with Our Decision

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

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

Reviewers

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

Timing of Appeals

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

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

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

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

How to Request an Appeal

You or someone you name to act for you (your authorized representative) may request an appeal review. Your doctor may serve as your representative. At any time, you can get help with filing your appeal from BCBSVT's customer service team. You can also get help from the Vermont Department of Financial Regulation at (800) 964-1784. To file an emergency or urgent concurrent appeal, call the number on the back of your ID card.

Mail written appeals to:
Blue Cross and Blue Shield of Vermont

P.O. Box 186
Montpelier, VT 05601-1086

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

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

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

Information About Your Claim

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

After BCBSVT's Decision

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

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

Other Resources to Help You

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

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

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

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

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

BCBSVT's Ombudsman

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

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

CHAPTER FIVE

Other Party Liability

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

Coordination of Benefits

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

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

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

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

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

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

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

Coordination of Benefits for Children of Divorced Parents

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

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

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

In an Accident

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

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

Reimbursement

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

Medicaid and Tricare

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

The Plan's Right to Subrogation

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

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

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

Cooperation

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

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

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

CHAPTER SIX

Legal Information

Applicable Law

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

Future of the Plan

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

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

Limitation on Assignment

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

Limitation of Rights

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

Participant Address

You must notify the VSTRS retirement division of any change of address. If you have questions, call BCBSVT customer service at the number listed on the back of your ID card.

Non-waiver of Our Rights

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

Plan Funding

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

Severability Clause

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

Term of Agreement

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

Third Party Beneficiaries

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

CHAPTER EIGHT

More Information About The Plan

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

Organizations Covered by this Notice

This notice applies to the Vermont Education Health Initiative (VEHI).

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

VEHI notice of privacy practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please Review It Carefully.

You have received this notice because you receive medical and/or dental insurance coverage under a health benefits plan offered by the Vermont Education Health Initiative ("VEHI") and/or you participate in VEHI's wellness programs. VEHI is an inter-municipal insurance association that is approved and overseen by the Vermont Department of Financial Regulation. VEHI offers non-insured, self-funded health benefit plans, wellness programs and compliance services to schools and other educational organizations in Vermont. The enrollees of VEHI's health benefits plan are active and retired school employees and their dependents. VEHI's health benefit plans are financed by employer and/or employee contributions.

This notice refers to VEHI by using the terms "us," "we" or "our."

Generally, "protected health information" or "PHI" is information that relates to your past, present or future physical or mental health or condition (including your genetic information, as defined by federal law) the provision of health care to you or the payment for that health care, and that identifies you or with respect to which there is a reasonable basis to believe that the information can be used to identify you.

This notice describes our privacy practices, which include how we may use and disclose your protected health information. We are required by certain federal and state laws to maintain the privacy of your PHI. We also are required by the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Rule") developed by the Department of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to give you this notice of our privacy practices and legal duties and your rights concerning your PHI.

Use and Disclosure of Your Protected Health Information

The following categories describe the different ways in which we may use and disclose your protected health information. Please note that every permitted use or disclosure of your PHI is not listed below. However, the different ways we will, or might, use or disclose your PHI do fall within one of the permitted categories described below.

To Make or Obtain Payment. We may use or disclose your protected health information to make payment to or collect payment from third parties, such as other health plans or health care providers, for the care you receive. For example, we may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits or we may use your PHI to pay claims for services provided to you by doctors or hospitals which are covered by your health plan.

To Conduct Health Care Operations

We may use or disclose your protected health information for our operations, to facilitate our administration and as necessary to provide coverage and services to all of our participants. These activities may include:

- quality assessment and improvement activities;
- activities designed to improve health care or reduce health care costs;
- clinical guideline and protocol development, case management and care coordination;
- contacting health care providers and participants with information about treatment alternatives and other related functions;
- competence or qualifications reviews and performance evaluations of health care professionals;
- accreditation, certification, licensing or credentialing activities;

- underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits, provided that we are prohibited from using or disclosing your protected health information that is genetic information, as defined by federal law, for such purposes;
- review and auditing, including compliance reviews, medical reviews, legal services and compliance programs;
- business planning and development including cost management and planning related analyses and formulary development; and
- business management and general administrative activities, including customer service and resolution of internal grievances.

For example, we may use and disclose your protected health information to conduct case management, quality improvement, utilization review and provider credentialing activities or to engage in customer service and grievance resolution activities.

We may also use and disclose your PHI to determine the types of wellness programs we may offer and to offer those wellness programs to you and, with your written authorization, to advocate on your behalf.

For Treatment Purposes

We may disclose your protected health information to doctors, dentists, pharmacies, hospitals and other health care providers who take care of you. For example, we may disclose your PHI to doctors who request medical information from us to supplement their own records.

To Plan Sponsors.

Plan sponsors are employers or other organizations that sponsor a group health plan. We may disclose your protected health information to the plan sponsor of your group health plan. For example:

- We may disclose "summary health information" to the plan sponsor of your group health plan to use to obtain premium bids for providing health insurance coverage or to modify, amend or terminate its group health plan. "Summary health information" is information that summarizes claims history, claims expenses or types of claims experienced by the individuals who participate in the plan sponsor's group health plan.
- We may disclose your PHI to the plan sponsor of your group health plan to verify enrollment or disenrollment in your group health plan.
- If the plan sponsor of your group health plan has met certain requirements of the Privacy Rule, we may disclose your PHI to the plan sponsor of your group health plan so that the plan sponsor can administer the group health plan. The plan sponsor of your group health plan may be your employer. You should talk to your employer to find out how your employer might use this information.
- For Treatment Alternatives. We may use and disclose your protected health information to tell you about or recommend possible treatment options or alternatives that may interest you.
- For Distribution of Health-Related Benefits and Services. We may use or disclose your protected health information to provide you with information on health-related benefits and services that may interest you.
- When Required by Law. We will disclose your protected health information when we are required to do so by any federal, state or local law. For example, we may be required to disclose your PHI if the Department of Health and Human Services investigates our HIPAA compliance efforts.
- To Conduct Health Oversight Activities. We may disclose your protected health information to health oversight agencies for their authorized activities including audits, civil administrative or criminal investigations, inspections and licensure or disciplinary actions.

In Connection with Public Health Activities.

We may disclose your protected health information to public health agencies for public health activities that are permitted or required by law, such as to:

- prevent or control disease, injury or disability;
- maintain vital records, such as births and deaths;
- report child abuse and neglect;
- notify a person about potential exposure to a communicable disease;
- notify a person about a potential risk for spreading or contracting a disease or condition;
- report reactions to drugs or problems with products or devices;
- notify individuals if a product or device they may be using has been recalled; and
- notify appropriate government agencies and authorities about the potential abuse or neglect of an adult patient, including domestic violence.

In Connection With Judicial and Administrative Proceedings

As permitted or required by state or other law, we may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process.

For Law Enforcement Purposes

As permitted or required by state or other law, we may disclose your protected health information to law enforcement officials for certain law enforcement purposes, including, but not limited to, if we have a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

In the Event of a Serious Threat to Health or Safety

We may, consistent with applicable law and ethical standards of conduct, disclose your protected health information if we, in good faith, believe that disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions

In certain circumstances, federal regulations require us to use or disclose your protected health information to facilitate specified government functions related to the military, veterans affairs, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

For Workers' Compensation

We may release your protected health information to the extent necessary to comply with laws related to workers' compensation or similar programs.

For Research

We may use or disclose your protected health information for research purposes, subject to strict legal restrictions.

To You

Upon your request and in accordance with applicable provisions of the Privacy Rule, we may disclose to you your protected health information that is in a "designated record set." Generally, a designated record set contains enrollment, payment, claims adjudication and case or medical management records we may have about you, as well as other records that we use to make decisions about your health care benefits. You can request the PHI from your designated record set as described below in the section titled "Your Rights with Respect to Your Protected Health Information."

To Our Business Associates

We may disclose your protected health information to contractors, agents and other business associates of ours who need the information to provide services to us, for us or on our behalf. When we disclose your PHI in this manner we obtain a written agreement that our business associate will protect the confidentiality of your PHI.

Authorization to Use or Disclose Your Protected Health Information

Other than as stated above, and as otherwise permitted by applicable law, we will not use or disclose your protected health information other than with your written authorization. You may give us a written authorization permitting us to use or disclose your PHI for any purpose, including any marketing or sale of PHI that is permitted by law. We will not sell you PHI, or use or disclose it for marketing purposes, without your written authorization.

You may revoke an authorization that you provide to us at any time. Your revocation must be in writing. After you revoke an authorization, we will no longer use or disclose your protected health information for the reasons described in that authorization, except to the extent that we have already relied on the authorization.

Your Rights with Respect to Your Protected Health Information

You have the following rights regarding your protected health information that we maintain:

Right to Request Restrictions

You have the right to request that we restrict certain uses and disclosures of your protected health information. You have the right to request a limit on our use or disclosure of your PHI in connection with your treatment, payment for your care and our health care operations. We are not required to agree to your request. If we do agree to your request, we will be bound by our agreement except in emergency situations and as otherwise required by law. If we do not agree to a request, we are required to give you notice. An agreed to restriction continues until you terminate the restriction (either orally or in writing) or until we inform you that we are terminating the restriction. If you wish to request a restriction, please contact our Privacy Officer by mail at 52 Pike Drive, Berlin, Vermont 05602, by fax at (802) 229-1446 or by telephone at (802) 223-5040.

Right to Receive Confidential Communications

You have the right to request that we communicate with you in a certain way if you feel the disclosure of your protected health information could endanger you. For example, you may ask that we only communicate with you by mail, rather than by telephone, or at work, rather than at home. If you wish to receive confidential communications, please make your request in writing to our Privacy Officer by mail at 52 Pike Drive, Berlin, Vermont 05602 or by fax at (802) 229-1446. Your written request must clearly state that the disclosure of all or part of your PHI could endanger you. We will make every reasonable effort to honor your requests for confidential communications.

Right to Inspect and Copy Your Protected Health Information

You have the right to inspect and copy your protected health information contained in a "designated record set," other than psychotherapy notes and certain other information. Generally, a designated record set contains enrollment, payment, claims adjudication and case or medical management records we may have about you, as well as other records that we use to make decisions about your health care benefits. A request to inspect and copy records containing your PHI must be made in writing to our Privacy Officer by mail at

52 Pike Drive, Berlin, Vermont 05602 or by fax at (802) 229-1446. If you request a copy of your PHI, we may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

Right to Amend Your Protected Health Information

If you believe that any of your protected health information contained in a "designated record set" is inaccurate or incomplete, you have the right to request that we amend the PHI. Generally, a designated record set contains enrollment, payment, claims adjudication and case or medical management records we may have about you, as well as other records that we use to make decisions about your health care benefits. The request to amend may be made as long as we maintain the information. A request for an amendment of records must be made in writing to our Privacy Officer by mail at 52 Pike Drive, Berlin, Vermont 05602 or by fax at (802) 229-1446. We may deny the request if the request does not include a reason to support the amendment. We may also deny the request if we did not create your PHI records, if the PHI you are requesting to amend is not part of the designated record set, if you are not permitted to inspect or copy the PHI you are requesting to amend, or if we determine the records containing your PHI are accurate and complete. If we deny your request, you have the right to submit a written statement of disagreement.

Right to an Accounting

You have the right to request an accounting of certain disclosures of your protected health information we have made or that were made on our behalf. Any accounting will not include certain disclosures, including, without limitation:

- disclosures to carry out treatment, payment or health care operations;
- disclosures we made to you;
- disclosures that were incident to another use or disclosure; and
- disclosures which you authorized.

The request for an accounting of disclosures must be made in writing to our Privacy Officer by mail at 52 Pike Drive, Berlin, Vermont 05602 or by fax at (802) 229-1446. The request should specify the time period for which you are requesting the information. Accounting requests may not be made for periods of time going back more than six years. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests in a 12-month period may be subject to a reasonable cost-based fee. We will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice

You have the right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive this Notice electronically. To obtain a paper copy, please contact our Privacy Officer by mail at 52 Pike Drive, Berlin, Vermont 05602, by fax at (802) 229-1446 or by telephone at (802) 223-5040. You also may obtain a copy of the current version of our Notice at our website, **www.vehi.org**.

Right to File Complaints

You have the right to file complaints with us if you believe that your privacy rights have been violated. Any complaints to us should be made in writing to our Privacy Officer by mail at 52 Pike Drive, Berlin, Vermont 05602 or by fax at (802) 229-1446. We encourage you to express any concerns to us that you may have regarding the privacy of your information. You also may complain to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been

violated. We will not retaliate against you in any way for filing a complaint against us or with the Secretary of the Department of Health and Human Services.

Appointment Reminders And Fundraising

We may call you to remind you of appointments. Please inform us if you do not wish to be called. We may also provide your contact information (name, address, and phone number) and the dates you received services from us to others in connection with our fundraising efforts. You have the right to opt-out of our use of your contact information in connection with our fundraising efforts. If you wish to opt-out, please inform us and we will respect your wishes.

Our Duties with Respect to Your Protected Health Information

We are required by law to maintain the privacy of your protected health information as set forth in this Notice and to provide you this Notice of our legal duties and privacy practices with respect to your PHI. We are required to abide by the terms of this Notice, which we may amend from time to time. We are also required by law to notify you if the event of any breach of the privacy of your PHI and to accommodate reasonable requests by you to communicate health information to you by alternative means and /or at alternative locations.

We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that we maintain. If we materially change this Notice we will provide a copy of the revised Notice to you within 60 days of the change.

Potential Impact of State Law

In some situations, we may choose or be required to follow state privacy or other applicable laws that provide greater privacy protections for your protected health information. If a state law requires that we not use or disclose certain of your PHI, then we will use or disclose that PHI according to applicable state law.

Contact Person

We have designated our Privacy Officer as the contact person for all issues regarding participant privacy and your privacy rights, including any further information about this Notice. You may contact this person by mail at 52 Pike Drive, Berlin, Vermont 05602, by fax at (802) 229-1446 or by telephone at (802) 223-5040.

Effective Date

This Notice is effective September 1, 2013, with non-material revisions on May 1, 2017.

IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, OR DESIRE MORE INFORMATION ABOUT THIS NOTICE, PLEASE CONTACT OUR PRIVACY OFFICER BY MAIL AT 52 Pike Drive, Berlin, Vermont 05602, BY FAX AT (802) 229-1446 OR BY TELEPHONE AT (802) 223-5040.

BCBSVT's Pledge to You

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

Member Rights and Responsibilities

As a member, you have the right to:

- **Respect and privacy.** You have the right to be treated with respect and dignity. BCBSVT takes measures to ensure your right to privacy.
- **Receive information from us.** BCBSVT supplies you with information to help you understand the organization, your rights and responsibilities as a member, the network of providers, benefits and services available to you and how to use them. You also have the right to access records BCBSVT used to make decisions about your health care benefits, services, practitioners and providers.
- **Participate in your health care.** You have the right to engage in a candid discussion about appropriate or medically necessary treatment options, regardless of cost or benefit coverage. You have the right to participate with practitioners in making decisions about your care.
- **Disagree.** BCBSVT welcomes your complaints or appeals about the organization and the care you receive. For more information about how to file a complaint or an appeal, please call BCBSVT's customer service team at the number on the back of your ID card.
- **Recommend changes.** You have the right to suggest changes regarding BCBSVT's member rights and responsibilities policy. You can also provide feedback on programs, including quality and care management.

As a member, you have the responsibility to:

- **Choose a primary care provider** (PCP) if your plan requires a PCP.
- **Present your ID car**d each time you receive services; and protect your ID card from improper use.

- **Keep your providers informed** and understand that your doctors need up-to-date health information to treat you effectively. Talk to your providers about your medical history, your current health status and participate in developing treatment goals as much as possible.
- **Follow plan rules and instructions for your care** that you agreed to with your provider. Identify yourself as a member to providers to receive care or services and follow the policies and procedures described in your plan materials.
- **Treat your providers with respect** by keep your scheduled appointments and notifying your provider ahead of time if you will be late or need to reschedule.
- **Better understand your health problems** by participating with your provider and the plan's care management team (as appropriate) to develop a treatment plan.
- **Pay** all applicable Deductibles, Co-insurance amounts and Co-payments to your health care providers.
- **Notify BCBSVT** when there's a change in your family size, address, phone number, PCP or any other change in your membership.

Please report your membership changes directly to your group benefits administrator.

Newborns' and Mothers' Health Protection Act

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

BCBSVT does not have standard day-limit restrictions on the length of maternity stays. Instead, BCBSVT reviews each admission for medical necessity. In any event, BCBSVT does not limit hospital stays to less than the durations required by the law. As always, if you have questions about your maternity benefits please call BCBSVT's customer service team at the number listed on the back of your ID card.

Women's Health and Cancer Rights Act of 1998

Do you know your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy, including lymphedema?

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

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

CHAPTER NINE

Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Clinical Trial (approved) an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment, palliation or prevention of cancer in human beings.

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

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

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

Cosmetic: primarily intended to improve appearance.

Covered: a service or supply for which you are eligible for benefits under your Benefits Description.

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

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

Deductible: the amount you must pay toward the cost of specific services each Plan Year before the Plan pays certain benefits. Your *Outline of Coverage* shows your Deductible amounts. (Refer also to Chapter One.)

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

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

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

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

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

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

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

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

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

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

- hearing tests by an audiologist if your doctor suspects you have a disease condition of the ear (see General Exclusions in Chapter Three).

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

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

Durable Medical Equipment (DME): equipment that requires:

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

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

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

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

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

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

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

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

Facility (Facilities): the following institutions or entities:

- Ambulatory surgical centers
- Birthing centers
- Community mental health centers
- General Hospitals
- Home Health Agencies/Visiting Nurse Associations
- Physical Rehabilitation Facilities
- Psychiatric Hospitals
- Residential Treatment Center
- Skilled Nursing Facilities
- Substance abuse Rehabilitation Facilities

Facilities further defined in this chapter. The patient's home is not considered a Facility.

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

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

Group Benefits Manager: the employer or organization who has agreed to forward all subscription rates due under the Plan. The Group Benefits Manager is the agent of the Participant and the group. The Group Benefits Managers has no authority to act on behalf of BCBSVT or the Plan and is not an employee of BCBSVT or the Plan. BCBSVT and the Plan disclaims all liability for any act or failure to act by the Group Benefits Manager.

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

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

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

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

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

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

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

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

Investigative/Investigational:
(see Experimental)

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

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

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

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

Medically Necessary Care: health care services including diagnostic testing, Preventive services and after-care appropriate, in terms of type, amount, frequency, level, setting and duration to the member's diagnosis or condition. Medically Necessary Care must be informed by generally accepted medical or scientific evidence and consistent with generally accepted practice

parameters as recognized by health care Providers in the same or similar general specialty as typically treat or manage the diagnosis or condition, and:

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

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

Member Materials: consists of;

- your Identification Card;
- *Outline of Coverage*; and
- this document, your Benefits Description.

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

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

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

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

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

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

Other Provider: one of the following entities:

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

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

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

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

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

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

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

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

Participant: an individual who enrolls in the Plan.

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

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

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

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

Plan: a plan established and maintained by the Plan Organizer for purposes of providing benefits to employees and participants of the Plan Organizer's member constituent groups.

Plan Organizer: the organization that has the responsibility of overseeing operation of the Plan.

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

Prescription Drugs and Biologics: products that are:

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

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

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

Professional: one of the following practitioners:

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

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

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

Network Provider: For most Provider types in Vermont, includes:

- Pharmacies who make an agreement with BCBSVT's Pharmacy Benefit Manager;
- Vision Providers who make an agreement with BCBSVT's vision service partner; or
- Network Providers for all other services.

Providers located outside of Vermont are not generally Network Providers. The Plan considers Skilled Nursing Facilities to be Network Providers if they participate with their local Blue Cross and/or Blue Shield Plan.

You may find a Network Provider on BCBSVT's website at www.bcbsvt.com. You may also get a directory of Network Providers from VSTRS Retirement Division or from BCBSVT's customer service team. Some Providers must be Network Providers in order for their services

to be Covered. For some types of service, the Plan does 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, the Plan does not provide benefits if you use a non-Network Provider. They are listed in Chapter One.

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

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

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

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

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 care program 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 delivered or directed by Providers. Facilities must keep permanent medical history records. The Facility is not, other than incidentally, a place that provides:

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

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

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

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

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

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

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

Telemedicine: the delivery of health care services through interactive audio and video over a secure connection that complies with applicable state laws.

Urgent Services: those health care services that are necessary to treat a condition or illness of an individual that if not treated within 24 hours presents a serious

risk of harm, or, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, could seriously jeopardize the ability of the individual to regain maximum function, or, in the opinion of a Provider with knowledge of the individual's medical condition, would subject the individual to severe pain that cannot be adequately managed without care within 24 hours.

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

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

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

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