HEALTH CARE BENEFITS



VEHI Platinum and Gold Exclusive Provider Organization (PCP)

Benefits Description

Health plans are administered by:

BlueCross BlueShield of Vermont

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

This Benefits Description provides you with a description of your health benefits while you are enrolled under the Group Health Plan (your Plan) offered by your employer (through the Plan Organizer, Vermont Education Health Initiative [VEHI]). This document is current until the Plan Organizer updates it.

- You should read this document to familiarize yourself with your Plan's main provisions and keep it handy for reference.
- If you are missing part of this document, or not sure whether you have the most recent copy, please call Blue Cross customer service to request another copy.
- If the benefits described in this document differ from descriptions in other materials, this document prevails.

Blue Cross and Blue Shield of Vermont (Blue Cross) is the Contract Administrator and has been designated by VEHI to provide administrative services such as:

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

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

Your Plan is a non-insured, self-funded health benefit plan. The benefits payable and other costs of the plan are financed by contributions made by enrolled employees and/or member employers to VEHI. Blue Cross is not an underwriter or insurer of the benefits provided by your Plan. For more details concerning contributions contact your employer. 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 your Plan.

How to Use This Document

- Read Chapter One, Guidelines for Coverage. Information there applies to all services. Pay special attention to the Prior Approval Program on page 1.
- Find the service you need in Chapter Two, Covered Services. You may use the Index or Table of Contents to find it. Read the section thoroughly.
- Check Chapter Three, General Exclusions, to see if the service you need is on this list.
- Please remember that to know the full terms of your coverage, you should read this entire document, as well as the *Outline of Coverage* or your *Summary of Benefits and Coverage*.
- Some terms in this document have special meanings. Capitalized terms are explained in the last chapter of this document.
- If you need translation services such as telecommunications devices for the deaf (TDD) or telephone typewriter teletypewriter (TTY), please call 711.

Get It All Online

You can find a lot of information about your coverage on Blue Cross's website at www.bluecrossvt.org.

For instance:

- You can find this document, along with claims and benefit information on the Member Resource Center.
- You can find doctors and Other Providers in Blue Cross's Networks on the "Find-a-Doctor" tool.
- You can order ID cards and much more.

Fraud, Waste, and Abuse

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

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

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

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CHAPTER ONE

Guidelines for Coverage

This Benefits Description describes benefits for your Exclusive Provider Organization (EPO) Plan. This Plan is administered for VEHI by Blue Cross and Blue Shield of Vermont (Blue Cross). You must see a Network Provider to receive benefits.

Chapter One explains what you must do to get benefits through your health plan. Your *Outline of Coverage* or *Summary of Benefits and Coverage* shows what you must pay Out-of-Pocket. Read this entire chapter carefully as it is your responsibility to follow these guidelines. Failure to follow these guidelines may mean your Plan will not provide benefits.

General Guidelines

As you read this document, please keep these facts in mind:

- Capitalized words have special meanings. See Definitions in Chapter Eight to understand your coverage. The terms "You" and "Your" are defined but they are not capitalized in text.
- Your Plan will only pay benefits for services defined as Covered.
- You must use Network Providers or get Prior Approval (see below). Your Plan does not require Prior Approval for Emergency Medical Services.
- Certain services are excluded from coverage under your Plan. You'll find General Exclusions applicable to all services in Chapter Three. Additionally, exclusions that apply to specific services may appear in other sections of this document.
- Services that are not Medically Necessary are not covered by your Plan. You may appeal the decision. See page 32 for more information.
- This is not a long-term care Policy as defined by Vermont State law at 8 V.S.A. § 8082 (5).
- You must follow the guidelines in this document even if this coverage is secondary to other health care coverage for you or one of your Dependents.
- Your Plan Organizer and named fiduciary of your Plan, VEHI, 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 prescribed a recommended service. VEHI has the full discretion and authority to interpret and apply the terms of your coverage, and VEHI has delegated this responsibility to Blue Cross. Information on appealing the decisions of Blue Cross can be found in Chapter Four, Claims.

Prior Approval Program

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

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

Your Plan also requires Prior Approval for certain services and drugs even when you use Network Providers except for any admission, item, service, treatment, or procedure ordered by a Provider credentialed and enrolled with the Plan as a Primary Care Provider. Prescription Drugs and Out-of-Network services that appear on the Prior Approval list require Prior Approval regardless of ordering Provider. Services requiring Prior Approval appear on the list later in this section.

Your Plan does not require Prior Approval for Emergency Medical Services.

Blue Cross Network Providers should get Prior Approval for you. If you use an Out-of-Network Provider or an out-of-state 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 Blue Cross Network Provider and the Provider fails to get Prior Approval for services that require it, the Provider may not bill you.

The Prior Approval list can change. To get the most up-to-date list, visit Blue Cross's website at www.bluecrossvt.org/members/member-forms or call customer service at the number on the back of your ID card.

How to Request Prior Approval

To get Prior Approval, you or your Network Provider must provide supporting clinical documentation to Blue Cross. When receiving care from an Out-of-Network Provider, it is your responsibility to get Prior Approval. Forms are available on Blue Cross's website at www.bluecrossvt.org/members/member-forms. You may also get them by calling customer service at the number on the back of your ID card.

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

Prior Approval List

You need Prior Approval for services outside of Blue Cross's Network. You also need Prior Approval for services printed on this Prior Approval list, even if you use a Network Provider except for any admission, item, service, treatment, or procedure ordered by a Provider credentialed and enrolled with the Plan as a Primary Care Provider. Prescription Drugs and Out-of-Network services that appear on the Prior Approval list require Prior Approval regardless of ordering Provider. This list includes, but not limited to:

- adoptive immunotherapy including CAR-T and gene therapy drugs
- Ambulance (all non-emergency transport including transport by land, air, or water)
- anesthesia (monitored)
- artificial pancreas device system
- autologous chondrocyte transplants
- blood and blood components
- breast pump, hospital grade
- cerebrovascular arterial study, non-invasive
- charged particle radiotherapy
- chiropractic services (after 12 visits in a Calendar Year)
- cochlear implants and Implantable Bone Conduction Hearing Aids
- continuous passive motion (CPM) equipment
- Cosmetic and Reconstructive procedures except breast reconstruction for patients with a diagnosis of breast cancer
- dental services for accidental injury, gross deformity, head and neck cancers, and congenital/genetic disorders
- Durable Medical Equipment (DME) and supplies (including rentals) with a purchase price of $1000 or more
- electrical and ultrasound stimulation, including electrical bone growth stimulation, electrical stimulation of the spine, occipital nerve stimulation, Transcutaneous Electrical Nerve Stimulation (TENS) or Neuromuscular Electrical Stimulation (NMES)
- endovascular stent grafts
- enteral formulae and total parenteral nutrition, supplies and pumps
- gender affirming services
- genetic testing
- hospital beds and accessories
- hyperbaric oxygen therapy
- infertility treatment and surgical correction
- intravascular ultrasound (IVUS)/optical coherence tomography (OCT)
- nasopharyngoscopy
- neurodevelopmental screening (pediatric)
- oral appliances
- orthotics and prosthetics (including custom knee brace(s)) with a purchase price of $1000 or more
- Out-of-Network services when there is not a Network Provider with appropriate training and experience to provide the Medically Necessary services needed to meet the particular health care needs of a Member.
- out-of-state Inpatient care, partial hospitalization care, and Residential Treatment Centers for mental health and substance use disorders
- polysomnography (sleep studies) and multiple sleep latency testing (MSLT)
- positive airway pressure devices (APAP, CPAP, BiPAP)
- certain Prescription Drugs and Biologics (administered in an office/outpatient setting) (please see www.bluecrossvt.org/pharmacies-medications
- psychological and neuropsychological testing
- radiology services (certain advanced imaging services including CT, CTA, MRI, MRA, MRS, PET, echocardiogram and nuclear cardiology)

- Rehabilitation (Skilled Nursing Facility, Inpatient Rehabilitation treatment for medical conditions)
- surgery and related services
- certain surgical procedures and related services (examples include disc arthroplasty, lumbar spinal fusion, Sacroiliac joint pain treatment, Temporomandibular joint manipulation (TMJ) , and varicose veins)
- Temporary codes for emerging technologies, services, procedures, and service paradigms, also known as Category III Codes CPT
- transcranial magnetic stimulation
- transplants (except corneal and kidney)
- wearable cardioverter defibrillators
- wheelchairs
- whole body imaging.

Case Management Program

Case Management provides Members who have complex health care needs with Professional services to assess, coordinate, evaluate, support and monitor the Member's treatment plan and health care needs. Professional services may include a registered nurse, licensed social worker, or other licensed health care Professional practicing within the scope of their license and/or certified as a case manager.

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

Choosing a Provider

You must use Network Providers or get Prior Approval to get care outside of the Network if appropriate services are not available in Network. In Vermont, you must use Blue Cross Network Providers. This Network includes a wide array of Primary Care Providers (PCP), Specialists and Facilities in Vermont and in bordering communities in other states. Outside of Vermont, you will use the BlueCard Network (PPO/EPO), which includes Providers that contract with other Blue Cross and/or Blue Shield Plans.

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

If you live or travel outside of the Blue Cross Provider Network area please visit:

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

For pharmacy and vision services, please use the separate Provider directories.

You may also call customer service at the number on the back of your ID card. Blue Cross will send you a paper Provider directory without charge. Both electronic and paper directories give you information on Provider qualifications, such as training and board certification.

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

Network Providers

Network Providers will:

- secure Prior Approval for you (if the Provider is located in the Blue Cross Network);
- bill Blue Cross directly for your services, so you don't have to submit a claim;
- not ask for payment at the time of service except they may ask for Deductibles, Coinsurance and Copayments you owe; and
- accept the Allowed Amount as full payment (you do not have to pay the difference between their total charges and the Allowed Amount).

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

There are separate Provider directories for the following types of Providers:

- Pharmacies;
- Primary Care Providers; and
- routine vision care Providers (if your coverage includes routine vision benefits).

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

Primary Care Providers

When you join this health plan, if you live in Vermont, you must select a Primary Care Provider (PCP) from Blue Cross's Network of Primary Care Providers. If you do not live in Vermont, you do not need to choose a PCP. However, if you would like to select a PCP, you may do so from the BlueCard National Network. For information on how to select a PCP and for a list of the participating PCPs, please visit www.provider.bcbs.com and select BlueCard PPO/EPO or contact customer service at the number on the back of your ID card.

To receive benefits for your services, you must receive services from your PCP or another Network Provider. You have the right to designate any PCP who participates in the Network and who is available to accept you or your family members. Each family member may select a different PCP. For children, you may designate a pediatrician as the PCP. Until you make this designation, we will designate one for you.

Your coverage does not require you to get referrals from your PCP. However, you must get Prior Approval for certain services (see page 1) except for any admission, item, service, treatment, or procedure ordered by a Provider credentialed and enrolled with the Plan as a Primary Care Provider. Prescription Drugs and Out-of-Network services that appear on the Prior Approval list require Prior Approval regardless of ordering Provider. For instance, if appropriate services are not available with a Network Provider, you must get Prior Approval.

This does not include Emergency Medical Services.

Blue Cross encourages you to choose a PCP because it benefits your health to have one Provider coordinate your care. You only pay the PCP Cost-Sharing amounts listed on your *Outline of Coverage* or your *Summary of Benefits and Coverage* if you use a Provider who practices in a PCP office and is one of the following Provider types:

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

Out-of-Network Providers

This plan generally does not cover services provided by Out-of-Network Providers. The following sections describe some specific exceptions applying to coverage for Out-of-Network Providers.

If one of these exceptions applies to your case, then the Cost-Sharing will be the same or less as if the service was obtained by a Network Provider and you will not pay the balance between the Provider's charge and the Allowed Amount. You must still pay any Cost-Sharing amounts required under your Contract, which will in no event be more than as if you received those services from a Network Provider. These may include Deductibles, Coinsurance or Copayments. For example, if the Provider's charge is $100 for the Emergency Services and the Blue Cross Allowed Amount if $70, the Provider may not bill you for the remaining $30. If an Out-of-Network Provider bills you for the balance between the charges and what your Plan pays, please notify us by calling the customer service team at the number on the back of your ID card so that we can work directly with the Provider to resolve the request. You can also get help from the Vermont Department Financial Regulation (DFR) at (800) 964-1784.

Out-of-Network Provider when no Network Provider Available

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

Out-of-Network Provider in Emergencies

We cover Ambulance services and Emergency Medical Services you receive from an Out-of-Network Provider when you have an Emergency Medical Condition (See Definitions).

Out-of-Network Providers at Network Facilities

If you receive Medically Necessary, Covered services from an Out-of-Network Provider at a Network facility without you consenting to waive your rights, your Plan will cover your care as if you had been treated by a Network Provider. Under federal law, unless you waived your right to be protected from additional bills, Providers are prohibited from billing you for these services beyond your Cost-Sharing amounts. If the Out-of-Network Provider requests any payment from you other than your Cost-Sharing amounts, please contact us at the number on the back of your ID card so that we can work directly with the Provider to resolve the request.

Continuity of Care

Continuity of Care allows certain patients the opportunity to continue care with their current Provider for a limited amount of time.

- For existing Members whose Provider is not in the Blue Cross VT Network due to the expiration or non-renewal of a contract with Blue Cross VT and who are undergoing treatment for a qualifying condition.
- For new Members whose Provider is not a Blue Cross VT Network Provider because of a plan change to Blue Cross and who are undergoing treatment for a qualifying condition.

Under federal law, if your Provider is no longer a Network Provider, you may elect to continue seeking treatment from them for a qualifying condition (outlined below) for 90 days which starts when Blue Cross provides you notice of the upcoming provider's disenrollment. Continuity of care protections do not apply when a Provider is terminated from the Network for cause when determined to be violating quality standards or for fraud or for Providers terminated by other Blue plans for cause.

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

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

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

If you are entitled to continuity of care, and are a new member to Blue Cross VT, Blue Cross will treat your Provider as though they were a Network Provider for the current period of active treatment for the qualifying condition or up to ninety (90) calendar days from the date of your enrollment (e.g., the date your coverage with Blue Cross VT is effective). If the existing, treating Provider refuses to accept either the Blue Cross VT rate or the rate from the Member's prior insurer, the Member will pay any balance between the Provider's charge and what we pay. You will need to transition to a new Network Provider if care exceeds the continuity of care protection period. Blue Cross can support you in finding a Network Provider to offer quality care. If you continue using the same Provider, your claims may be denied, or if Prior Approval is obtained to continue using your Provider, we will pay the Allowed Amount and you will pay any balance between the Provider's charge and what your Plan pays. You must also pay any applicable Cost-Sharing amounts (Deductibles, Coinsurance, and Copayments). See your *Outline of Coverage* or your *Summary of Benefits and Coverage* for details.

Out-of-Area Providers

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

BlueCard® Program

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

Typically, when accessing care outside of the service area, you will obtain care from health care Providers that have a contractual agreement with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). You must get Prior Approval to get care from non-contracting providers.

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

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

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

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

Special Case: Value-Based Programs

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

Out-of-Area Services with non-contracting Providers

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

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

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

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

Blue Cross Blue Shield Global® Core Program

If you are outside the United States, the Commonwealth of Puerto Rico, or the U.S. Virgin Islands, (the "BlueCard Service Area"), you may be able to take advantage of the Blue Cross Blue Shield Global® Core Program when accessing Covered services. The Blue Cross Blue Shield Global® Core Program is unlike the BlueCard Program in certain ways. For instance, although the Blue Cross Blue Shield Global® Core Program helps you get care through a network of Inpatient, Outpatient and Professional Providers, the network is not hosted by Blue plans. When you receive care from Providers outside the BlueCard Service Area, you will typically have to pay the Providers and submit the claims yourself to obtain reimbursement for these services. You must get Prior Approval from Blue Cross 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 accurately and within 12 months after you receive a service, or as soon thereafter as is reasonably possible, to receive reimbursement for Covered Services. If you file a claim more than 12 months after you receive a service, we may not provide benefits. Your claim must include all information necessary for us to administer your benefits. This includes information relating to other coverage you have 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 accurately and within 12 months after you receive a service, or as soon thereafter as is reasonably possible, to obtain reimbursement for Covered Services. If you file a claim more than 12 months after you receive a service, your Plan may not provide benefits. Your claim must include all information necessary for us to administer your benefits. This includes information relating to other coverage you have.

Submitting a Blue Cross Blue Shield Global® Core Claim

When you pay for Covered services outside the BlueCard Service Area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global®

Core International claim form and send the claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global® Core Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from Blue Cross, the Blue Cross Blue Shield Global® Core Service Center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the Blue Cross Blue Shield Global® Core Service Center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, seven days a week.

How Blue Cross Chooses Providers

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

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

Access to Care

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

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

If you live in the State of Vermont, whenever possible, you should find:

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

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

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

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 Eight.

Emergencies might include:

- broken bones
- heart attack
- poisoning.

You will receive care right away in an emergency.

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

If you receive Medically Necessary, Covered Emergency Medical Services from an Out-of-Network Provider, Blue Cross will cover your emergency care as if you had been treated by a Network Provider. You must pay any Cost-Sharing amounts listed in your *Outline of Coverage* as if you received those services from a Network Provider. These may include Deductibles, Coinsurance or Copayments. If an Out-of-Network Provider requests any payment from you other than your Cost-Sharing amounts, please contact Blue Cross at the number on the back of your ID card, so that Blue Cross can work directly with the Provider to resolve the request.

Care After Office Hours

In most non-emergency cases, call your Provider's office when you need care, even after office hours. Your Provider (or a covering Provider) can help you 24 hours a day, seven days a week. Do you have questions about care after hours? Ask now before you have an urgent problem. Keep your doctor's phone number handy in case of late-night illnesses or injuries.

Blue Cross also offers Telemedicine services that allow you to see a licensed Provider via computer, tablet or telephone anytime. See Telemedicine Services on page 24.

How Your Plan Determines Your Benefits

When Blue Cross receives your claim, it determines:

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

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

- benefits paid by Medicare
- Deductibles (explained below)
- Copayments (explained below)
- Coinsurance (explained below)
- amounts paid or due from other insurance carriers through coordination of benefits (see Chapter Five)

Your Deductible, Coinsurance and Copayment amounts appear on your *Outline of Coverage* and your *Summary of Benefits and Coverage*. Your Plan may limit benefits to the Calendar Year maximums, which are shown on these documents.

Payment Terms

Allowed Amount

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

Notes:

- Network Providers accept the Allowed Amount as full payment. You do not have to pay the difference between their total charges and the Allowed Amount.
- If your Plan approves services with an Out-of-Network Provider for circumstances outside of the situations noted in the Out-of-Network Providers section on page 4, your Plan pays the Allowed Amount and you must pay any balance between the Provider's charges and what your Plan pays.

Cost-Sharing

Cost-Sharing are the costs for Covered services that you pay out of your own pocket. This includes Deductibles, Copayments, and Coinsurance, or similar charges, but it doesn't include premiums, any balance between the Provider's charge and what your Plan pays for Out-of-Network Providers, or the cost of non-Covered services. All information about your Deductible amounts, type of Deductible, Copayments and Coinsurance amounts, and type of Out-of-Pocket Limits is shown on your *Outline of Coverage* and your *Summary of Benefits and Coverage*.

Deductible

You must meet your Deductibles each Calendar Year before your Plan make payments on certain services. Your Plan applies your Deductible to your Out-of-Pocket Limit for each Calendar Year. You may have more than one Deductible. Deductibles can apply to certain services or certain Provider types.

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

Aggregate Deductible

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

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

Stacked Deductible

Your Plan may have a Stacked Deductible. If your Plan has this Deductible, and you are on a two-person, parent and Child or family plan, a covered family member may meet the individual Deductible and begin receiving post-Deductible benefits.

When your family members' Covered expenses reach the family Deductible, all family members receive post-Deductible benefits.

Copayment

You must pay Copayments to Providers or pharmacies for specific services. You may have different Copayments depending on the Provider you see. Your Provider may require payment at the time of the service. Your Plan applies Copayments toward your Out-of-Pocket-Limit for each Calendar Year.

Coinsurance

You must pay Coinsurance to Providers or pharmacies for specific services. Your Plan calculates the Coinsurance amount by multiplying the Coinsurance percentage by the Allowed Amount after you meet your Deductible (for services subject to a Deductible). Your Plan applies your Coinsurance toward your Out-of-Pocket Limit for each Calendar Year.

Out-of-Pocket Limit

Your Plan applies Coinsurance and Deductibles towards your Out-of-Pocket Limit. Copayments may also apply to your Out-of-Pocket Limit. After you meet your Out-of-Pocket Limit, you pay no Coinsurance for the rest of that Calendar Year. You may still be responsible for Copayments, when they apply.

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

Aggregate Out-of-Pocket Limit

Your Plan may have an Aggregate Out-of-Pocket Limit. If your Plan has this limit, and you're on a two-person, parent and Child[ren] or family plan, and you do not have an individual Out-of-Pocket Limit, your family members' Covered expenses must reach the family Out-of-Pocket Limit before your Plan pays 100 percent of the Allowed Amount for eligible services. When your family's expenses reach this amount, your Plan will begin to pay 100 percent of the Allowed Amount for the rest of the Calendar Year for Covered services.

Stacked Out-of-Pocket Limit

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

Aggregate Prescription Drug Out-of-Pocket Limit

Your Plan may have an Aggregate Prescription Drug Out-of-Pocket Limit. If your Plan has this 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 your Plan pays 100 percent of the Allowed Amount for eligible prescriptions. When your family's expenses reach this amount, your Plan will begin to pay 100 percent of the Allowed Amount for the rest of the Calendar Year for Covered services.

Stacked Prescription Drug Out-of-Pocket Limit

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

Calendar Year Benefit Maximums

The Calendar Year Benefit maximums for certain services are listed on your *Outline of Coverage* and your *Summary of Benefits and Coverage*. After your Plan provides maximum benefits, you must pay all charges.

Self-Pay Allowed by HIPAA

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

Third Party Premium Payments

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

Your Plan only accepts premium and Cost-Sharing payments made by Participants or on behalf of Participants by the following:

- The Ryan White HIV/AIDS Program

- local, state, or federal government programs, including grantees directed by a government program to make payments on its behalf, that provide premium support for specific individuals
- Indian tribes, tribal organizations/governments, and urban Indian organizations
- Immediate Family Member
- religious institutions and other not-for-profit organizations when:
  - the assistance is provided on the basis of the insured's financial need
  - the organization is not a health care Provider and
  - the organization is financially disinterested (that is the organization does not receive funding from entities with a financial interest in the payment for services).

CHAPTER TWO

Covered Services

This chapter describes Covered services, guidelines and policy rules for obtaining benefits. Please see your *Outline of Coverage* or your *Summary of Benefits and Coverage* for benefit maximums and Cost-Sharing amounts such as Copayments, Deductibles, and Coinsurance.

Preventive Services

Your Plan provides benefits for Preventive Services. You should get Preventive Services that are appropriate for you. Examples of preventive care include colonoscopies for people age 45 and over and those at high risk for colorectal cancer, prostate screenings, mammograms for women age 40 and over and coverage for women's reproductive health as required by law. Information about Contraceptive Services can be found on page 13.

Your Plan pays for some Preventive Services with zero Cost- Sharing (like Copayments, Deductibles and Coinsurance) based on the recommendations of four expert medical and scientific bodies:

- The United States Preventive Services Task Force (USPSTF) list of A- or B-rated services
- The Advisory Committee on Immunization Practices (ACIP)
- The Health Resources and Services Administration's (HRSA) infant, children and adolescent preventive services guidelines
- The Health Resources and Services Administration's (HRSA) women's preventive services guidelines.

You can find the list of Covered Preventive Services on Blue Cross's website at www.bluecrossvt.org/members/coverage or you can call the customer service number on the back of your ID card.

Notes:

- The list includes many Preventive Services covered at zero Cost-Share, but not all. Coverage for other preventive, diagnostic and treatment services not recommended by the above noted entities may be subject to Cost-Sharing.
- If your Provider finds or treats a condition while performing Preventive Services, Cost-Sharing may apply.

Office Visits

When you receive care in an office setting, you must pay the amount listed on your *Outline of Coverage* and your *Summary of Benefits and Coverage*. Please read this entire section carefully. Some office visit benefits have special requirements or limits. Your Plan covers Professional services such as these in an office setting for:

- examination, diagnosis and treatment of an injury or illness
- injections
- Diagnostic Services, such as X-rays
- nutritional counseling (see page 18)
- Surgery
- therapy services (see page 24)

Some office visit services may fall under your Preventive Services benefit.

General Exclusions in Chapter Three also apply.

Notes:

- Office visits for mental health services, substance use disorder treatment services, and chiropractic services are described elsewhere in this chapter. Please see those sections for benefits.
- See page 1 for more information regarding Prior Approval and instances where Prior Approval is not required. Visit Blue Cross's website at www.bluecrossvt.org/members/member-forms or call customer service at the number on the back of your ID card for the newest list of services that require Prior Approval.

Ambulance

Your Plan covers Ambulance services as long as your condition meets the definition of an Emergency Medical Condition. Coverage for Emergency Medical Services, including air ambulance services, outside of the service area is the same as coverage within the service area. If an Out-of-Network Provider bills you for the balance between the charges and what your Plan pays, please notify Blue Cross by calling the customer service number on the back of your ID card.

Your Plan covers transportation of the sick and injured:

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

Limitations

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

Autism Spectrum Disorder

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

General Exclusions in Chapter Three also apply.

Bariatric Surgery

Your Plan only covers bariatric Surgery at Blue Distinction Centers. Blue Distinction Centers are Facilities that have been assessed and identified to deliver the highest quality care. Blue Distinction Centers must maintain their high quality to maintain the Blue Distinction Center designation. To find a Blue Distinction Center appropriate for your Surgery, please visit www.bcbs.com/blue-distinction-center/facility or call customer service at the number on the back of your ID card.

Clinical Trials (Approved)

Your Plan covers Medically Necessary, routine patient care services for members enrolled in Approved Clinical Trials as required by law.

General Exclusions in Chapter Three also apply.

Chiropractic Care

Your Plan covers care by Network Chiropractors who are:

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

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

- office visits, spinal and extraspinal manipulations and associated modalities;
- home, hospital or nursing home visits
- 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 Calendar Year, your Provider must get Prior Approval for any visits after the 12th. See page 1 for more information regarding Prior Approval and instances where Prior Approval is not required.

Exclusions

Your Plan does not provide chiropractic benefits for:

- services by an Out-of-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 post-natal care
- Custodial Care (see Definitions in Chapter Eight), as noted in General Exclusions
- hot and cold packs
- supervised services or modalities that do not require the skill and expertise of a licensed Provider
- Surgery

- unattended services or modalities (application of a service or modality) that does not require one-on-one patient contact by the provider
- any other procedure not listed as a Covered chiropractic service.

General Exclusions in Chapter Three also apply.

Contraceptive Services

Your Plan covers outpatient contraceptive services as per HRSA guidelines for all FDA approved contraceptive methods including office visits and consultants. We also cover office visits associated with insertion, removal, counseling, and monitoring of contraceptive devices as Medically Necessary, and sterilization procedures (vasectomy or tubal ligation) even though they are not Medically Necessary. Your Plan pays for contraceptive services with no Cost-Sharing (like Copayments, Deductibles and Coinsurance). The exception is if you are enrolled in a qualified health savings account (HSA) compliant high deductible health plan. If you are enrolled in a qualified HSA, then Cost-Sharing will apply for voluntary male sterilization, Please see your O*utline of Coverage* or your S*ummary of Benefits and Coverage* for Cost-Sharing details.

You can find the list of Covered Preventive Services on Blue Cross's website at www.bluecrossvt.org/members/coverage or you can call the customer service number on the back of your ID card.

Cosmetic and Reconstructive Procedures

Your Plan excludes Cosmetic procedures (see General Exclusions in Chapter Three). Your benefits cover Reconstructive procedures that are not Cosmetic unless the procedure is expressly excluded in this document. (Please see the definitions of Reconstructive and Cosmetic in Chapter Eight.)

For example, your Plan covers:

- reconstruction of a breast after breast Surgery, and Reconstruction of the other breast to produce a symmetrical appearance
- prostheses (which your Plan covers under Medical Equipment and Supplies on page 16)
- treatment of physical complications resulting from breast Surgery.

You must get Prior Approval for these services.

Dental Services

In the event of an emergency, you must contact Blue Cross as soon as possible afterward for approval of continued treatment. Your Plan covers only the following dental services:

- Treatment for, or in connection with, an accidental injury to jaws, sound natural teeth, mouth or face, provided a continuous course of dental treatment begins within six months of the accident and covers a reasonable course of treatment defined as not exceeding five years from the beginning of treatment.[2]
- Surgery to correct gross deformity resulting from major disease or Surgery (Surgery must take place within six months of the onset of disease or within six months after Surgery and cover a reasonable course of treatment defined as not exceeding five years from the beginning of treatment, except as otherwise required by law).
- Surgical removal of bone-impacted teeth.
- Surgery related to head and neck cancer where sound natural teeth may be affected primarily or as a result of the chemotherapy or radiation treatment of that cancer.
- Treatment related to a congenital or genetic disorder, such as but not limited to the absence of one or more teeth, up to the first molar, or abnormal enamel (example lateral peg).
- Facility and anesthesia charges for Members with phobias or a mental illness documented by a licensed Physician or mental health Professional; or with severe disabilities that preclude office-based dental care due to safety considerations; or who are developmentally unable to safely tolerate office-based dental care.
- Diagnostic Imaging, including but not limited to, plain film radiographs and Cone Beam CT (CBCT), performed as part of evaluation of an accidental injury to the jaws, sound natural teeth, mouth or face, or as part of evaluation to correct gross deformity resulting from major disease or surgery.

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

You must get Prior Approval for the services listed above. See page 1 for more information regarding Prior Approval and instances where Prior Approval is not required.

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

Exception: Prior Approval is not required for bone-impacted teeth (partially or fully).

Exclusions

Unless expressly required by law, your Plan does not cover:

- gingivectomy
- tooth implants, including those for the purpose of anchoring oral appliances (this exclusion does not apply for the treatment of an accidental injury, trauma, cancer-related treatment or diagnosis for which you have received Prior Approval)
- care for periodontitis
- injury to teeth or gums as a result of chewing or biting
- pre- and post-operative dental care
- orthodontics (including orthodontics performed as an adjunct to orthognathic Surgery or in connection with an accidental injury)
- dentures and procedures designed primarily to prepare the mouth for dentures (including alveolar augmentation, bone grafting, frame implants and ramus mandibular stapling)
- charges related to non-Covered dental procedures or anesthesia (for example, Facility charges, except when Medically Necessary as noted above).

General Exclusions in Chapter Three also apply.

Diabetes Services

Your Plan covers treatment of diabetes. For example, it covers syringes, insulin, nutritional counseling, Outpatient self-management training and education for people with diabetes. Your Plan also covers Medically Necessary foot care for the treatment of diabetes. Your Plan pays benefits subject to the same terms and conditions used for other medical treatments. You must get nutritional counseling from one of the following Provider types or your Plan will not cover your care:

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

Diagnostic Tests

Your Plan covers the following Diagnostic Tests to help find or treat a condition, including:

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

Your Plan also covers the evaluation and diagnostic testing to determine if and why a couple is infertile. Testing may include:

- ovulation induction and monitoring
- pelvic ultrasound
- hysteroscopy
- laparoscopy
- laparotomy.

You must get Prior Approval for special radiology procedures (including CT, MRI, MRA, MRS, PET scans, and echocardiograms) and polysomnography (sleep studies). See page 1 for more information regarding Prior Approval and instances where Prior Approval is not required.

General Exclusions in Chapter Three also apply.

Emergency Care

Your Plan covers services you receive in the emergency room of a General Hospital. Coverage for Emergency Medical Services outside of the service area will be the same as for those within the service area. If an Out-of-Network Provider bills you for a balance between the charges and what your Plan pays, please notify Blue Cross by calling the customer service number on the back of your ID card.

Your Plan will defend against and resolve any request or claim by an Out-of-Network Provider of Emergency Medical Services.

Requirements

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

Gender Affirming Services

Your Plan covers Gender Affirming Health Care Services that are Medically Necessary and clinically appropriate for the individual's diagnosis or health condition.

You must get Prior Approval for gender affirming services. See page 1 for more information regarding Prior Approval and instances where Prior Approval is not required.

Home Care

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

- performs Medically Necessary skilled nursing procedures in the home;
- trains your family or other caregivers to perform necessary procedures in the home; or
- performs Physical, Occupational or Speech Therapy (see Therapy Services on page 24).

Your Plan also covers:

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

Private Duty Nursing

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

- There may be limits on your benefits for private duty nursing. Check your *Outline of Coverage or* your *Summary of Benefits and Coverage* .
- Your Plan provides benefits only if you receive services from a registered or licensed practical nurse.

Requirements

Your Plan covers home care services only when your Provider:

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

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

Limitations

Your Plan covers home infusion therapy only if:

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

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

Exclusions

Your Plan does not provide home care benefits for:

- homemaker services
- drugs or medications except as noted above (while drugs and medications are not covered under your home care benefits, your Plan may cover them under your Prescription Drug benefits. See your *Outline of Coverage* for Cost-Sharing details)
- Custodial Care (see Definitions in Chapter Eight)
- food or home-delivered meals
- non-medical charges
- private-duty nursing services provided at the same time as home health care nursing services.

General Exclusions in Chapter Three also apply.

Hospice Care

Your Plan covers the following services by a Hospice Provider:

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

Requirements

Your Plan only provides benefits if:

- the patient and the Provider consent to the Hospice care plan; and
- a primary caregiver (family member or friend) will be in the home, except when respite care services are being provided.

General Exclusions in Chapter Three also apply.

Hospital Care

Inpatient Hospital Services

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

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

Your Plan covers the day of admission or the day of discharge, but not both. Certain Inpatient services require Prior Approval. Please see page 1 for more information regarding Prior Approval and instances where Prior Approval is not required.

Inpatient Medical Services

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

- Surgery (see page 23 for details)
- services of an assistant surgeon when necessary
- anesthesia services for Covered procedures
- intensive care
- other specialty care when you need it.

Notes:

You must get Prior Approval for Reconstructive procedures.

Your Plan limits Surgery benefits as follows:

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

Independent Clinical Laboratories

You must use Blue Cross's Network of independent clinical laboratories. This includes services such as genetic testing and molecular pathology procedures. These services must be ordered or prescribed by a Provider. Please visit Blue Cross's website at www.bluecrossvt.org/find-doctor and use the Find-a-Doctor tool to find a Network independent clinical laboratory location.

You must get Prior Approval for certain laboratory services in order to receive benefits. See page 1 for more information regarding Prior Approval and instances where Prior Approval is not required. Visit Blue Cross's website at www.bluecrossvt.org/members/member-forms or call customer service at the number on the back of your ID card for the newest list of services that require Prior Approval.

Medical Equipment and Supplies

You must get Prior Approval for certain Durable Medical Equipment and supplies including but not limited to continuous passive motion (CPM) equipment, TENS units or Durable Medical Equipment including orthotics and prosthetics with a purchase price of $1000 or more. See page 1 for more information regarding Prior Approval and instances where Prior Approval is not required or visit www.bluecrossvt.org/members/member-forms.

Your Plan covers Durable Medical Equipment you purchase from a Network:

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

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

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

Replacement of lost, stolen or destroyed Durable Medical Equipment

Your Plan will replace one lost, stolen or destroyed Durable Medical Equipment, prosthetic or orthotic per Calendar Year if not covered by an alternative entity or if it is still under warranty (including but not limited to homeowners insurance and automobile insurance) if the Durable Medical Equipment, prosthetic or orthotic's absence would put the Member at risk of death, disability or significant negative health consequences such as a hospital admission.

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

Your Plan does not cover:

- the replacement of a lost, stolen or destroyed Durable Medical Equipment, prosthetic or orthotic if the above criteria is not met; and
- for more than one lost, stolen or destroyed Durable Medical Equipment, prosthetic or orthotic per Calendar Year.

Supplies

Your Plan covers medical supplies such as needles, syringes and other supplies for treatment of diabetes, dressings for cancer or burns, catheters, colostomy and ostomy bags and related supplies and oxygen, including equipment Medically Necessary for its use. Please see your *Outline of Coverage* for details.

Orthotics

You must get Prior Approval for orthotics with a purchase price of $1000 or more. Your Plan covers molded, rigid or semi-rigid support devices that restrict or eliminate motion of a weak or diseased body part.

Prosthetics

You must get Prior Approval for prosthetics with a purchase price of $1000 or more. Your Plan covers the purchase, fitting, necessary adjustments, repairs and replacements of prosthetics. Your Plan covers a device (and related supplies) only when the device is surgically implanted or worn as an anatomic supplement to replace:

- all or part of an absent body organ (including contiguous tissue and hair);
- hair loss due to chemotherapy and/or radiation therapy, third-degree burns, traumatic scalp injury, congenital baldness present since birth, and medical conditions resulting in alopecia areata or alopecia totalis (excluding androgenic alopecia, alopecia barbae, postpartum alopecia, traction alopecia, or other hair loss due to natural or premature aging);
- the lens of an eye; or
- all or part of the function of a permanently inoperative, absent or malfunctioning body part.

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

Limitations

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

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

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

Also, your Plan covers dental prostheses (oral appliances) only if required:

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

Exclusions

Your Plan does not provide benefits for:

- treatment for hair loss due to androgenic alopecia, alopecia barbae, postpartum alopecia, traction alopecia, and/or natural or premature aging
- Continuous Glucose Monitoring (CGM) purchased through a DME supplier (These supplies may be eligible through your pharmacy benefit.)
- prosthetics or orthotics with a purchase price of $1000 or more for which you have not received Prior Approval
- dental appliances or dental prosthetics (including dentures), except as listed above

- shoe insert orthotics, lifts, arch supports or special shoes not attached to a brace (except with a diagnosis of diabetes)
- duplicate medical equipment and supplies, orthotics and prosthetics
- continuous passive motion equipment (unless you get Prior Approval)
- patient-actuated end-range motion stretching devices and programmable or variable motion resistance devices
- items or equipment that do not meet the definition of Durable Medical Equipment
- any treatment, Durable Medical Equipment, supplies or accessories intended principally for participation in sports or recreational activities or for personal comfort or convenience
- repair or replacement of dental appliances or dental prosthetics (including dentures) except as listed above.

General Exclusions in Chapter Three also apply.

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

Mental Health Care

Some services require Prior Approval. See page 1 for more information regarding Prior Approval and instances where Prior Approval is not required.

Outpatient

Your Plan covers Outpatient mental health services including:

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

Inpatient

Your Plan covers Inpatient mental health services including:

- hospitalization
- Residential Treatment Programs.

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

Coverage for Emergency Medical Services outside the service area will be the same as for those within the service area. If an Out-of-Network Provider bills you for a balance between the charges and what your Plan pays, please notify Blue Cross customer service team at the number on the back of your ID card. Blue Cross will defend against and resolve any request or claim by an Out-of-Network Provider of Emergency Medical Services.

Exclusions

Your Plan provides no mental health benefits for:

- services ordered by a court of law (unless Blue Cross deems them Medically Necessary)
- non-traditional, alternative therapies such as Rubenfeld Synergy, energy polarity therapy and somatization therapy, that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories
- services, including long-term residential programs, adventure-based activities, wilderness programs and residential programs, that focus on education, socialization or delinquency, as noted in General Exclusions
- Custodial Care (see Definitions in Chapter Eight)
- biofeedback, stress reduction classes and pastoral counseling
- psychoanalysis
- hypnotherapy.

General Exclusions in Chapter Three also apply.

Nutritional Counseling

Your Plan covers nutritional counseling with no limit on the number of Outpatient visits.

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

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

General Exclusions in Chapter Three also apply.

Outpatient Hospital Care

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

- Facility services
- Professional services
- related supplies.

You must get Prior Approval for certain radiology procedures (including CT, MRI, MRA, MRS, PET scans, and echocardiograms) and polysomnography (sleep studies). See page 1 for more information regarding Prior Approval and instances where Prior Approval is not required.

For information about Therapy Services, see page 24.

Outpatient Medical Services

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

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

Limitations

Your Plan covers a laboratory hearing test performed by a hearing care Professional.

Pregnancy Care

Your hospital benefits cover your Inpatient labor-and-delivery stay. See Inpatient Hospital Services above for a description of your hospital benefits. Your Plan also covers the following care by a Provider or other Professional during a person's pregnancy:

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

Your Plan covers home delivery or delivery in a Facility when you use a covered Provider. Your Plan covers services by certified nurse midwives and licensed midwives only if they are Network Providers. Your Plan also covers non-hospital grade breast pumps with zero Cost-Sharing.

Your Plan covers newborns for up to 60 days after birth. Your newborn will be subject to their own Cost-Sharing for Covered services beginning on their date of birth, whether or not you add your newborn to coverage permanently. If you are on an individual policy, your Cost-Sharing will be based on a family plan during those 60 days.

Please see your *Outline of Coverage* or your *Summary of Benefits and Coverage* for Cost-Sharing details.

Better Beginnings® Maternity Wellness Program

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

- other educational tools
- reimbursement for classes
- reimbursement towards infant car seats.

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

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

Prescription Drugs and Biologics

Your Plan follows the National Performance Formulary (NPF). You must use a Network Pharmacy or Network home delivery pharmacy to receive benefits. To locate a Network Pharmacy, visit Blue Cross's website at www.bluecrossvt.org/pharmacies-medications and click on the "Find a Pharmacy" link.

Your Plan 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, prevention or diagnosis of your condition;
- insulin and other supplies for people with diabetes (glucose testing materials including home glucose testing machines, needles and syringes).

Please note your Plan covers Off-label Prescription Drugs and Biologics used to treat cancer as required by law. Your 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 the prescribed use meets the definition of Medical Necessity and is not considered Investigational.

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

Preferred and Non-Preferred Drugs

Your Plan may require different amounts of Cost-Sharing when you purchase generic, preferred brand or non-preferred brand drugs. Generally, generic drugs require lower Cost-Sharing, but not always, and non-preferred drugs require the most Cost-Sharing.

The NPF brand-name drug list can change and will be updated from time to time. To get the most up-to-date listing, visit Blue Cross's website at www.bluecrossvt.org/pharmacies-medications and select Lists for Covered Medications or call the pharmacy phone number on the back of your ID card.

Home Delivery Service

Blue Cross's home delivery pharmacy can provide you with Prescription Drugs and Biologics you take on an ongoing basis.

To use the home delivery service, visit Blue Cross's website at www.bluecrossvt.org/pharmacies-medications and log onto your Member Resource Center, or call the pharmacy number on the back of your ID card. You may receive drugs at your home or office address. You can order refills by phone, fax or on the internet.

See your *Outline of Coverage* for detailed Cost-Sharing information about home delivery.

Limitations

Your Plan limits:

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

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

Prior Approval Program

You must get Prior Approval for the Prescription Drugs or Biologics listed on the National Performance Formulary Prior Approval list or your drugs will not be Covered. This drug list can change and will be updated from time to time. For the most up-to-date list, visit Blue Cross's website at www.bluecrossvt.org/pharmacies-medications and select Lists for Covered Medications or call pharmacy phone number at the number on the back of your ID card.

Prescription Drugs and Biologics that require Prior Approval include:

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

How to Get Prior Approval for Your Drugs

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

- your name
- your diagnosis
- your ID number
- clinical information explaining the Medical Necessity for the medication
- 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 your request for Prior Approval is denied, see your *Summary Plan Description* for instructions on how to appeal the decision.

Quantity limits, step therapy and Prior Approval drug lists can change and will be updated from time to time. For the most up-to-date list, visit Blue Cross's website at www.bluecrossvt.org/pharmacies-medications and select List for Covered Medications 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.

Quantity Limits

Your Plan 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, documentation about why you need more of the drug may be required. Visit www.bluecrossvt.org/pharmacies-medications or call the pharmacy phone number on the back of your ID card to get the most up-to-date list of drugs covered by this review or to learn the quantity limit for a particular drug.

Step Therapy

The NPF step therapy program saves you money by encouraging patients and their doctors to try a less expensive drug in a therapeutic class before using the newest, most expensive one. Prior Approval may be required if there is no information to show you first tried a less-expensive drug. Visit www.bluecrossvt.org/pharmacies-medications or call the pharmacy phone number 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.

Cost-Sharing

Please refer to your *Outline of Coverage* to determine the specific Cost-Sharing requirements of your Prescription Drugs and Biologics benefit. You may have a Deductible, Coinsurance and/or Copayments for your Prescription Drugs and Biologics purchases. Your Plan does not apply both Coinsurance and Copayments to the same Prescription Drugs and Biologics purchase.

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

If your Plan approves a drug as a benefit exception that is listed under Excluded Medications on the NPF drug list, the approved drug will process at the non-preferred drug cost-share regardless if the drug is a generic or brand medication.

Specialty Medications

For some specialty drugs and supplies, you will need to receive your drug or supply from an in-network pharmacy in Blue Cross's Specialty Medication Network. You must get Prior Approval for some specialty drugs and supplies. If you fail to obtain Prior Approval, your drug or supply will not be Covered.

See www.bluecrossvt.org/pharmacies-medications for more information.

Compounded Prescriptions

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

Exclusions

Your Plan does not provide Prescription Drugs and Biologics benefits for:

- all medications for treatment of infertility, including but not limited to Clomid, Clomiphene, Serophene, Bravelle, Gonal-F, Follistim AQ, Novarel, Ovidrel, Pregnyl, Profasi and Repronex when used for treatment of infertility
- refills beyond one year from the original prescription date
- devices of any type other than prescription contraceptives and insulin pumps, even though such devices may require a prescription including, but not limited to: Durable Medical Equipment, prosthetic devices, appliances and supports (although benefits may be provided under other sections of your Plan)
- any drug considered to be Experimental or Investigational, except for certain Off-label cancer drugs and drugs administered as part of certain clinical cancer trials
- prescription drugs containing Glucagon-Like Peptide-agonist (GLP-1) products prescribed for conditions other than diabetes (including but not limited to Wegovy, Zepbound, and Saxenda). Note: Wegovy is not excluded if you are an adult with obesity and established cardiovascular disease defined as a prior heart attack, stroke, or symptomatic peripheral arterial disease and your Provider prescribes Wegovy to reduce the risk of major adverse cardiovascular events.
- vitamins, except those which, by law, require a prescription
- Viagra, Cialis, Levitra, Addyi and other drugs to treat sexual dysfunction
- drugs that do not require a prescription, even if your doctor prescribes or recommends them
- food and nutritional formulas or supplements except for formulas and supplements that are considered to be "Medical Foods" as determined to be Medically Necessary. Note: This exclusion does not apply to 100% amino acid formula, which may be determined as Medically Necessary.
- the replacement of lost, stolen, or destroyed Prescription Drugs or Biologics received through your medical benefit

- any drugs listed under Excluded Medications on the National Performance Formulary drug list. (Note: If you are currently using a medication that is excluded from the NPF, you may request a benefit exception. See the section under the National Performance Formulary at www.bluecrossvt.org/pharmacy-medications and select List of Covered Medications related to Benefit Exceptions for Excluded Medications, or call the pharmacy phone number on the back of your ID card. See the Cost-Sharing section above if your benefit exception is approved.)
- any drugs on the list of Excluded Drugs with Unique Packaging and Therapeutic Alternatives. (You can view the list at www.bluecrossvt.org/pharmacies-medications or call the pharmacy phone number on the back of your ID card.)
- any drug recently approved by the Food and Drug Administration (FDA) is considered a new drug to the market and requires Prior Approval. This applies to drugs through a pharmacy or medical Provider. Visit Blue Cross's website at www.bluecrossvt.org/pharmacy-medications/lists-covered-medications to determine if your drug is a new drug to market and how you or your Provider may request Prior Approval through Vermont Blue Rx.

Replacement of lost, stolen or destroyed Prescription Drugs and Biologics

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

- the non-specialty 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, you are required to submit documentation, such as a police report, with the request.

Exclusions

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

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

Claim Filing

A Network Pharmacy will collect the amount you owe (Deductible, Copayment and/or Coinsurance) and submit claims on your behalf. Your Plan will reimburse Network Pharmacies directly. You must use a Network Pharmacy or Blue Cross's Network home delivery pharmacy to receive benefits. However, if you need to request reimbursement for dispensed drugs, please attach itemized bills to a *Prescription Reimbursement Form*, within 12 months after you receive a service, or as soon thereafter as is reasonably possible. The prescription claim form can be found at www.bluecrossvt.org/members/member-forms. For assistance, contact the pharmacy number on the back of your ID card.

Rehabilitation/Habilitation

Rehabilitation or Habilitation services may require Prior Approval. See page 1 for more information regarding Prior Approval and instances where Prior Approval is not required.

Your Plan covers:

- Inpatient treatment in a Network Physical Rehabilitation Facility for a medical condition requiring Acute Care
- Outpatient cardiac or pulmonary Rehabilitation for a condition requiring Acute Care
- Rehabilitative or Habilitative services and devices Covered elsewhere in this document (e.g. under Therapy Services on page 24).

Limitations

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

Your Plan does not cover:

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

General Exclusions in Chapter Three also apply.

Skilled Nursing Facility

Your Plan covers Inpatient services including:

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

Requirements

Your Plan provides benefits only if you:

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

Exclusions

Your Plan does not cover:

- cognitive re-training
- Custodial Care (see Definitions in Chapter Eight).

General Exclusions in Chapter Three also apply.

Substance Use Disorder Treatment Services

Some services require Prior Approval. See page 1 for more information regarding Prior Approval and instances where Prior Approval is not required. Your Plan covers the following Acute substance use disorder treatment services:

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

Coverage for Emergency Medical Services outside the service area will be the same as for those within the service area. If an Out-of-Network Provider bills you for a balance between the charges and what your Plan pays, please notify Blue Cross customer service team at the number on the back of your ID card. Blue Cross will defend against and resolve any request or claim by an Out-of-Network Provider of Emergency Medical Services.

Requirements

Your Plan covers substance use disorder treatment services only if you get Medically Necessary care in the least restrictive setting.

Please contact Blue Cross customer service at the number on the back of your ID card if you have questions.

Exclusions

Your Plan provides no substance use disorder treatment benefits for:

- services ordered by a court of law (unless Blue Cross deems them Medically Necessary)
- non-traditional, alternative therapies such as Rubenfeld Synergy, energy polarity therapy and somatization therapy, that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories
- services, including long-term residential programs, adventure-based activities, wilderness programs and residential programs that focus on education, socialization, delinquency
- Custodial Care (see Definitions in Chapter Eight)
- biofeedback, stress reduction classes and pastoral counseling
- psychoanalysis
- hypnotherapy.

General Exclusions in Chapter Three also apply.

Surgery

Your Plan covers surgery in both Inpatient and Outpatient settings with the following limitations and conditions:

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

Your Plan covers sterilization procedures (vasectomy or tubal ligation) even though they are not Medically Necessary. Your Plan covers only one attempt at reversal of sterilization per individual per lifetime.

See page 1 for more information regarding Prior Approval and instances where Prior Approval is not required.

General Exclusions in Chapter Three also apply.

Telemedicine Program

Your Plan covers Medically Necessary, clinically appropriate virtual consultations via your computer, tablet or cell phone, regardless of where you are located, for a variety of services, including:

- urgent care (24/7 on-demand clinical visits)
- primary care
- mental health services.

Please see your *Outline of Coverage* for details. Visit Blue Cross's website at www.bluecrossvt.org/find-doctor/telemedicine-care or call the customer service number on the back of your ID card to get started.

Limitations

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

Exclusions

Your Plan does not cover:

- Telemedicine services via email, facsimile or non-HIPAA-compliant software (such as Skype, FaceTime, etc.); or
- telemonitoring except as part of specific value-based provider arrangements.

General Exclusions in Chapter Three also apply.

Telemedicine Services

Your Plan covers the following Medically Necessary, clinically appropriate Telemedicine consultations regardless of whether you're in a health Facility, at work, at home or anywhere else:

- consultations, including second opinions
- initial or follow-up Inpatient consultations
- office or other Outpatient visits
- follow-up visits after a Skilled Nursing Facility or hospital stay
- psychology and psychiatric examinations intended to provide a diagnosis
- Prescription Drug and Biologic management
- nutritional counseling visits
- end-stage renal disease services
- medical genetic and genetic counseling services (please note genetic testing services require Prior Approval)
- neuro-cognitive testing
- intervention and behavior change counseling to quit tobacco or smoking tobacco
- intervention and behavior change counseling for substance use disorder and alcohol abuse treatment
- education and training services for managing your illness
- transitional care management services.

Please see your *Outline of Coverage* for the appropriate service or supply and its corresponding Cost-Sharing amount. All other terms and conditions related to in-person consultations apply.

Limitations

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

Your Provider must be licensed and/or certified to practice in the state where you are located during the Telemedicine service.

Exclusions

Your Plan does not cover:

- services by an Out-of-Network Provider;
- Telemedicine services via email, facsimile or non-HIPAA-compliant software (such as Skype, FaceTime, etc.); or
- telemonitoring except as part of specific value-based provider arrangements.

General Exclusions in Chapter Three also apply.

Therapy Services

Your Plan covers therapy or physical medicine services provided by:

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

Therapy services could include the following:

- radiation therapy

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

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

- for services that require constant attendance of a licensed:
  - therapist (Occupational, Physical and Speech)
  - medical doctor (M.D.)
  - Network Chiropractor (D.C.)
  - Network athletic trainer (A.T.)
  - podiatrist (D.P.M.)
  - nurse practitioner (N.P.)
  - advanced practice registered nurse (A.P.R.N.)
  - doctor of naturopathy (D.N.)
  - a doctor of osteopathy (D.O.).
- up to the specific benefit limits listed on your *Outline of Coverage* and your *Summary of Benefits and Coverage*. (This limitation does not apply to mandated treatment for Autism Spectrum Disorder as defined by Vermont law.)

Exclusions

Your Plan does not cover the following therapy services:

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

General Exclusions in Chapter Three also apply.

Note: Your Plan does not cover group physical medicine services, group exercise or Physical, Occupational, or Speech Therapy performed in a group setting.

Transplant Services

You must get Prior Approval for transplant services. See page 1 for more information regarding Prior Approval and instances where Prior Approval is not required.

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

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

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

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

Your Plan pays benefits for transplants as follows:

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

Time Period for Living Donor Benefits

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

Exclusions

Your Plan does not cover the purchase price of any organ or bone marrow that is sold rather than donated. Your Plan also does not cover voluntary transplants, such as uterine transplants as treatment of infertility.

General Exclusions in Chapter Three also apply.

Travel Expenses

Your Plan provides travel benefits up to $2500 per calendar year for certain travel expenses whenever you require abortion and/or gender affirming care and you reside in a State that bans and/or legislatively restricts access to the following:

- surgical or medication-assisted voluntary termination of pregnancy (abortion) services
- non-surgical treatments as components of gender affirming services for trans and gender diverse people or
- surgical treatments as components of gender affirming services for trans and gender diverse people.

You may use your travel benefit for certain travel expenses that include:

- travel by car (personal or rental), bus or air will be eligible with legible receipts and itineraries corresponding to the dates of service. When a rental vehicle is used, rental fee and gasoline are eligible but not mileage. When rental receipts do not clearly indicate a daily rate, the payable portion of the bill can be divided by the total number of days of the rental to arrive at a daily rate.
- mileage for daily travel (applies to personal vehicle use only) will be calculated based on the addresses of the facility and the lodging facility. Mileage is calculated as the distance between your residential address of record (e.g., not a P.O. box) to the facility selected by You to perform the service (this applies to personal vehicle use only) at the current rate per mile (see IRS medical mileage rate) for initial abortion / gender affirming care, and return care if necessary.
- daily travel, parking, and tolls may be paid with legible receipts.
- airfare is reimbursable with flight itinerary and paid ticket receipt.
- travel and lodging costs are covered when related to the abortion or gender affirming care for you and one travel companion. The cost of lodging (hotel, motel) is reimbursable with a copy of the paid invoice. Lodging will be reimbursed up to $50 per person per night (up to $100 if you travel with a companion).

Once the travel benefit is exhausted for the calendar year, no further travel benefits will be provided for the calendar year.

Most Cost-Sharing (Deductibles, Coinsurance, and Copayments) will not apply for covered transportation and lodging costs; nor will the travel benefit apply toward your Out-of-Pocket Limit. The exception is if you are enrolled in a qualified health savings account (HSA) compliant high deductible health plan. When you are enrolled in a qualified HSA compliant high deductible health plan, Cost-Sharing will apply and is applied toward your Out-of-Pocket.

To be reimbursed for covered services, you must submit the Member Claim Form, along with the following information below.

- street addresses (no P.O. box) of the following permit calculations for mileage reimbursement (applies to personal vehicle use only)
- starting location (your primary residence or acute or extended care facility if applicable)
- approved facility
- lodging facility
- legible bills and itemized statements
- legible paid receipts.

Submit your request and all supporting information to the address, email, or fax listed on the Member Claim Form.

Exclusions

Under this Travel benefit, your Plan does not cover:

- travel and lodging costs that are unrelated to the abortion or gender affirming care
- meals including food delivery services
- alcohol
- tobacco
- entertainment/souvenirs
- clothing
- travel insurance
- expenses for other persons other than the patient except for those specific expenses noted above for a travel companion
- personal care items such as toiletries
- optional rental car coverages such as roadside assistance, personal property damage/losses
- telephone calls
- taxes
- tips/gratuity
- childcare expenses

- laundry expenses
- car repair and maintenance items such as oil changes, tire or brake service or
- lost wages.

Urgent Services

Your Plan covers Urgent Services received at an urgent care facility. You may be billed for services obtained outside of the Network. If you are charged any balance between the Provider's charge and what your Plan pays, please call Blue Cross's customer service at the number on the back of your ID card.

Requirements

Your 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)

Your Plan covers one routine 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.

Your Plan does not cover the evaluation and fitting of contact lenses or eyeglasses, medical related services, 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.

Your 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

Your Plan does not cover services or supplies for:

- vision training or orthoptics and any associated supplemental testing; plano lenses
- medical or surgical treatment of the eyes
- corrective vision treatment of an Experimental Nature
- costs for services above Plan Benefit Allowed Amount
- services not indicated as a covered Plan Benefit
- vision materials (lenses, frames, etc.) for refractive purposes unless you need them to replace the lens of the eye and the lens was not replaced at the time of Surgery (unless your Group has purchased a vision materials rider)
- any eye examination or corrective eyewear required by an employer as a condition of employment.

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

VSP Claim Filing

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

To receive reimbursement when you visit a non-VSP Provider, you must pay for your services up front. Your Plan reimburses you only up to the 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 ID number to VSP. Out-of-Network claims must be submitted to VSP within six months of service. Mail the original claims reimbursement request and receipts to the address included on the form.

Vision Services (Medical)

Your Plan covers services by an optometrist or ophthalmologist only when they find or reasonably suspect a disease condition of the eye and refers you to a Provider for treatment of that condition. Your Plan covers your visit to an optometrist or ophthalmologist in the same way your Plan covers visits to Providers performing Covered eye care.

Eyeglasses, contact lenses, and refraction

Your Plan does not cover any determination of refractive state or any examination, prescription or fitting of eyeglasses or contact lenses unless the refraction, examination, prescription or fitting is for treatment of aphakia or keratoconus (see Prosthetics page 17).

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

CHAPTER THREE

General Exclusions

Your Plan pays benefits only for Covered services described under its terms. Your Plan does not cover services and supplies that are not Medically Necessary. Your Plan and any of its incorporated documents may contain specific exclusions. Your Plan does not cover service specific exclusions, even if they are Medically Necessary.

In addition to the specific exclusions listed elsewhere in your Plan, the following general exclusions apply:

(Note: If you don't agree with the Plan's decision to exclude your services, please see the Complaints and Appeals section in Chapter Four regarding your right to appeal.)

1. Services that a prior health plan must cover.
2. Services for which you would not legally have to pay if you did not have your Plan or similar coverage.
3. Services for which there is no charge.
4. Services paid directly or indirectly by a local, state or federal government agency, except as otherwise provided by law.
5. Services over the limitations or maximums set forth by your Plan.
6. Services or drugs that Blue Cross determines are Investigational, mainly for research purposes or Experimental in nature. To the extent required by law, however, your Plan covers routine costs for patients who participate in approved clinical trials.
7. Services not provided in accordance with accepted Professional medical standards in the United States.
8. Services beyond those needed to establish or restore your ability to perform Activities of Daily Living (see Definitions in Chapter Eight) or to establish or re-establish the capability to perform occupational, hobby, sport or leisure activities.
9. Acupuncture, acupressure or massage therapy; hypnotherapy (including hypnosis or hypnotic techniques), rolfing, homeopathic or naturopathic remedies. (This exclusion for naturopathic remedies does not apply to Medically Necessary services that would otherwise be Covered services when such services are performed by a naturopath and within the scope of the naturopathic Provider's license.)
10. Electrical stimulation devices used externally. (This exclusion does not apply to bone growth stimulators, transcutaneous electrical nerve stimulation [TENS] devices or neuromuscular electrical stimulators [NMES].)
11. Automatic or manual home blood pressure cuffs.
12. Bariatric Surgery, unless performed at a Blue Distinction Center.
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. Case management services not provided by Blue Cross VT.
20. Clinical ecology, environmental medicine, Inpatient confinement for environmental change or similar treatment.
21. Cognitive training or retraining and educational programs, including any program designed principally to improve academic performance, reading or writing skills.
22. Communication devices and communication augmentation devices.
23. Computer technology or accessories and other equipment, supplies or treatment intended primarily to enhance occupational, recreational or vocational activities, hobbies or academic performance.
24. Subscription, retainer, or membership fees, including concierge or "direct primary care" services.
25. Consultations between health care Providers except when they attach a written report to the patient's medical record.

26. Correction of near- or far-sighted conditions or aphakia (where the lens of the eye is missing either congenitally or accidentally or has been surgically removed, as with cataracts) by means of "laser Surgery," or refractive keratoplasty procedures such as keratomileusis, keratophakia and radial keratotomy and all related services.
27. Cosmetic procedures and supplies that are not Reconstructive.
28. Custodial Care, Rest Cures.
29. Dental services and dental-related oral Surgery, unless specifically provided by this document; dentures and procedures designed primarily to prepare the mouth for dentures (including alveolar augmentation, bone grafting, frame implants and ramus mandibular stapling).
30. Treatment of developmental delays. (This exclusion does not apply to mandated treatment of Autism Spectrum Disorder as defined by Vermont law.)
31. Any determination of refractive state or any examination, prescription or fitting of eyeglasses or contact lenses unless the refraction, examination, prescription or fitting is for treatment of aphakia or keratoconus.
32. Education, educational evaluation or therapy, therapeutic boarding schools, services that should be Covered as part of an evaluation for, or inclusion in, a Child's individualized education plan (IEP) or other educational program. (This exclusion does not apply to treatment of diabetes, such as medical nutrition therapy by approved Providers.)
33. Foot care or supplies that are Palliative or Cosmetic in nature, including supportive devices and treatment for bunions (except capsular or bone Surgery), flat-foot conditions, subluxations of the foot, corns, callouses, toenails, fallen arches, weak feet, chronic foot strain and symptomatic complaints of the feet.
34. Hearing aids or examinations for the prescription or fitting of hearing aids.
35. Tinnitus masking devices.
36. Home or automobile modifications or equipment like air conditioners, HEPA filters, humidifiers, stair glides, elevators, lifts, motorized scooters, whirlpools, furniture or "barrier-free" construction, even if prescribed by a Provider. This exclusion does not apply to manual hydraulic patient lifts, commonly known as "Hoyer" lifts.
37. Hot and cold packs.
38. Infertility services. This includes but is not limited to:
    - surgical, radiological, pathological or laboratory procedures leading to or in connection with insemination (intravaginal, intracervical, and intrauterine), 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 insemination including donor fees, cryopreservation of donor sperm and eggs.
    - all medications for treatment of infertility, including but not limited to Clomid, Clomiphene, Serophene, Bravelle, Gonal-F, Follistim AQ, Novarel, Ovidrel, Pregnyl, Profasi and Repronex when used for treatment of infertility.

    Note: This exclusion does not apply to the evaluation to determine if and why a couple is infertile.
39. 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.
40. Treatment for willfully uncooperative or intractable patients.
41. Institutional or Custodial Care for the physically or mentally handicapped.
42. Mandated treatment, including court-ordered treatment, unless such treatment is Medically Necessary, ordered by a Provider and covered under this document.
43. Non-medical charges, such as:
    - taxes;
    - postage, shipping and handling charges;
    - charges for Home Health Medical Social Work visits;
    - a penalty for failure to keep a scheduled visit; or
    - fees for copies of medical records, transcripts or completion of a claim form.
44. Food and nutritional formulas or supplements except for formulas and supplements that are considered to be "Medical Foods" as determined to be Medically Necessary. Note: This exclusion does not apply to 100% amino acid formula, which may be determined as Medically Necessary.
45. Nutritional counseling provided solely for general wellness, fitness, or lifestyle enhancement.
46. Orthodontics, including orthodontics performed as adjunct to orthognathic Surgery or in connection with accidental injury.
47. Personal hygiene items.
48. Personal service, comfort or convenience items.

49. Photography services, photographic supplies or film development supplies or services (for example, external ocular photography or photography of moles to monitor changes).
50. Physical fitness equipment, braces and devices intended primarily for use with sports or physical activities other than Activities of Daily Living (e.g., knee braces for skiing, running or hiking); weight loss or exercise programs; health club or fitness center memberships.
51. Pneumatic cervical traction devices except when the patient has a diagnosis of Temporomandibular Joint Syndrome (TMJ); gravity assisted traction devices.
52. Replacement of lost, stolen, or destroyed Prescription Drugs or Biologics received through your medical benefit.
53. Services, including modalities, that do not require the constant attendance of a Provider.
54. Services performed by a Provider that is neither licensed nor certified.
55. Specialized examinations, services or supplies required by your employer or for sports/ recreational activities (e.g. driver certifications, pilot flight physicals, etc.) or examinations required for immigration (e.g., civil surgeon examination). Note: this exclusion does not apply for sports physicals that are billed as a preventive visit and you have not had an annual preventive visit.
56. Supervised services or modalities that do not require the skill and expertise of a licensed Provider.
57. Support therapies, including pastoral counseling, assertiveness training, dream therapy, equine therapy, hippotherapy, music or art therapy, recreational therapy, stress management, wilderness programs, therapy camps, retreat centers, adventure therapy and bright light therapy. Non-medical tobacco cessation programs and other alternative approaches for tobacco cessation, such as hypnotherapy (including hypnosis or hypnotic techniques).
58. Telemedicine services via email, facsimile or non-HIPAA-compliant software, and telemonitoring.
59. Travel (other than Ambulance transport), lodging and housing (when it is not integral to a Medically Necessary level of care, even if prescribed by a Provider).
60. Treatment solely to establish or re-establish the capability to perform occupational, hobby, sport or leisure activities.
61. Treatment of obesity, except surgical treatment when determined Medically Necessary.
62. Treatment of telangiectasia such as reticular veins, spider veins, angiomata, hemangiomata and other CEAP Category 1 veins.
63. Unattended services or modalities (application of a service or modality) that do not require direct one-on-one patient contact by the Provider.
64. Vision training or orthoptics and any associated supplemental testing; plano lenses.
65. Work-hardening programs.
66. Work-related illnesses or injuries (or those which you claim to be work-related, until otherwise finally adjudicated), provided such illnesses or injuries are Covered by workers' compensation or should be so Covered.

Provider Exclusions

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

- Provider that is neither licensed nor certified.
- Provider that your Plan does not approve for the given service or that is not defined in the Definitions chapter as a Provider.
- Professional who provides services as part of his or her education or training program.
- Immediate Family Member or yourself.
- Veterans Administration Facility treating a service-connected disability.
- Out-of-Network Provider if your Plan requires use of a Network Provider as a condition for coverage under your Plan unless appropriate services are not available with a Network Provider and you have received Prior Approval for those services.
- Provider practicing outside the scope of that Provider's license or certification.
- Provider whose participation with Blue Cross has been terminated within the last three years, unless their participation has been reinstated.

CHAPTER FOUR

Claims

Remember, when you contact a Provider, you must:

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

Claim Submission

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

Network Providers will usually submit claims on your behalf if this is your primary coverage (see Chapter 5). When you use Out-of-Network Providers, you must file your own claims 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, your Plan may not provide benefits. Your claim must include all information necessary for us to administer your benefits. This includes information relating to other coverage you have.

Release of Information

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

Approval of your benefits depends on you providing sufficient information, even if your Plan pays for benefits before you do. To avoid duplicate payments, Blue Cross may inform other entities that provide benefits about your claim.

A signed *Authorization to Release Information* form from any Dependent over the age of 12 is required before discussing any claims with you.

Cooperation

You must fully cooperate with your Plan and Blue Cross to receive benefits. Blue Cross may require you to provide signed or recorded statements. You must provide all reasonably required information. Otherwise, your Plan may deny benefits.

Payment of Benefits

Your Plan pays Vermont Network Providers directly. Your Plan usually pays out-of-state Network Providers directly. Your Plan usually pays you when you use Out-of-Network Providers. Your Plan reserves the right to pay Out-of-Network Providers directly. If your Plan pays you directly, you are responsible for paying your Out-of-Network Provider.

You may not assign or transfer your benefit rights under this document to another party, including an Out-of-Network Provider, without the Plan's express written consent. Any attempt to assign by you without express written consent shall be deemed void and the assignee shall acquire no rights. Regardless of the prohibition on assignment, the Plan may, in its sole discretion, pay an Out-of-Network Provider directly for Covered services. Any payments made by the Plan will discharge its obligation to pay for Covered services. The Plan's payment to an Out-of-Network Provider, routine processing of a claim form, issuing payment at an Out-of-Network Provider rate, or denying informal or formal appeal(s) does not constitute a waiver by the Plan and the Plan shall retain a full reservation of all rights and defenses to enforce this provision

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

Payment in Error/Overpayments

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

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

How Blue Cross Evaluates Technology

Your Plan has delegated to Blue Cross the responsibilities to establish medical policies to facilitate the administration of benefits. Blue Cross's Medical Policy committee (consisting of doctors, nurses, and other Professionals) meets periodically to establish, review, update and revise medical policies. Medical policies document whether a new or existing health care technology has been scientifically validated to improve health outcomes for specific illnesses, injuries or conditions. Outcomes could include length or quality of life or functional ability.

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

- have final approval from the appropriate governmental regulatory bodies;
- be of such a nature as to be able to permit conclusions concerning its effect on health outcomes;
- be documented in peer-reviewed literature to measurably improve net health outcomes;
- be as beneficial as any established alternatives; and
- be attainable outside the Investigational setting.

Blue Cross may rely on numerous sources of information and expertise when reviewing a new technology or application.

Complaints and Appeals

When You Have a Complaint

Customer Service

You may make an inquiry to Blue Cross's customer service team at any time if you have concerns. This is usually the best first course of action. Blue Cross's customer service team can solve most problems. Contact Blue Cross's customer service team at the number printed on the back of your ID card or by email at customerservice@bcbsvt.com. Please have your ID card handy when you call. Also, call if you need help understanding the denial of coverage for a service.

What to Do if Your Issue is Not Resolved by Customer Service

You also have the right to make a formal complaint with Blue Cross's customer service or file an appeal (see below). You can do this without having contacted customer service beforehand. Complaints may be made over the telephone to Blue Cross's customer service by calling the number on the back of your ID card, or in writing via the secure Member Resource Center or by mail.

- You can make a medical complaint if you have problems with the medical care or advice that you got from your doctor. You may also make a non-medical complaint. Non-medical complaints might be about:
  - Blue Cross services
  - Blue Cross rules
  - Waiting times for visits
  - After-hours access to your doctor
  - The service at your doctor's office

Blue Cross will respond with a decision (or request further information) within 30 days of your medical complaint, and within 60 days for non-medical complaints.

If You Don't Agree with Our Decision

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

- You may file a first-level internal appeal. You may do this without making a complaint to Blue Cross's 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 Blue Cross's appeals process before taking judicial action.
- If you don't agree with Blue Cross's decision after your first-level appeal you may file a second-level internal appeal with Blue Cross. You may choose to meet with reviewers in person or by phone. Your health care provider may participate. Blue Cross will work with you to schedule a time. 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.

Reviewers

Reviewers are selected for their clinical expertise and/or their benefits knowledge. In some cases, your health care provider may call Blue Cross to discuss your case with the Provider reviewer. This usually happens prior to the first-level internal appeal. A separate reviewer conducts each level of appeal above. None of the reviewers will be the person who first denied your claim. If your first-level appeal is clinical in nature, at least one of the reviewers will be the clinical peer of the health care Provider that provided, or seeks to provide, the service that is the subject of the appeal.

Timing of Appeals

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

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

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

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

How to Request an Appeal

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

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

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

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

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

Information About Your Claim

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

After the Decision

If your appeal is urgent or concurrent, after a decision has been made, you and your health care Provider (if known) will be notified by phone right away with follow up in writing within 24 hours. In all other cases, you will be notified of the decision by mail. At any point during the appeal review process, the initial decision may be overturned. If the decision is overturned, your Plan will provide coverage or payment for your health care item or service. If your appeal is denied and the decision is not overturned, you must pay for services your Plan does not cover. You should discuss your payment arrangements with your Provider.

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

Other Resources to Help You

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

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

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

Vermont Department of Financial Regulation
(800) 964-1784 or (802) 828-3302

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

Vermont Office of the Health Care Advocate

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

CHAPTER FIVE

Other Party Liability

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

Coordination of Benefits

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

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

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

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

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

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

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

Coordination of Benefits for Children of Divorced Parents

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

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

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

In an Accident

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

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

Reimbursement

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

Medicaid and Tricare

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

Your Plan's Right to Subrogation

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

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

- If your Plan pays benefits for your health care services and then you recover expenses for those services from a third party through a suit, settlement or other means, you must reimburse your Plan before any other party. Your Plan will have a lien on your recovery from a third party up to the amount of benefits paid.
- Regardless of whether the other party admits liability and regardless of whether the funds you recover are specified for recovery as medical expenses your Plan may recover anything it paid.
- You must reimburse your Plan whether or not you have been "made whole" by the third party. Your Plan reserves the right to reduce what you owe to cover a share of attorneys' fees and other costs you incur in the process. Your Plan will be responsible for only those fees to which it agrees to pay in writing.
- Your Plan reserves the right to bring a lawsuit in your name or in its name against a third party or parties to recover benefits your Plan advanced. Your Plan may also settle its claim with a third party.
- This right of subrogation extends to any kind of auto, workers' compensation, property or liability insurance providing medical expense payments.
- You must cooperate with Blue Cross and furnish information and assistance that your Plan requires to enforce its rights.
- You must take no action interfering with your Plan's rights and interest.
- If you refuse to reimburse Blue Cross or your Plan, or fail to cooperate, either entity may take legal action against you. Your Plan or Blue Cross on behalf of your Plan may seek reimbursement from the funds you recovered from a third party, up to the amount of benefits it paid. You must also pay attorney's fees and collection expenses incurred by your Plan or Blue Cross at the direction of your Plan. Your Plan may reduce or withhold future benefits to recover what you owe.
- You agree that you will not settle your claim against a third party without first notifying Blue Cross. In some cases, your Plan will compromise the amount of its claim. Neither Blue Cross nor your Plan shall be responsible for expenses incurred by you in pursuit of your Plan's rights.

Cooperation

You must fully cooperate to protect your Plan's rights to coordination, reimbursement or subrogation. Cooperation includes:

- providing Blue Cross all information relevant to your claim or eligibility for benefits under your Plan
- providing any actions needed to assure your Plan is able to obtain a full recovery of the costs of benefits provided
- obtaining Blue Cross consent before providing any release from liability for medical expenses
- not taking any action that would prejudice Blue Cross or your Plan's rights to coordination, reimbursement or subrogation

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

CHAPTER SIX

Legal Information

Applicable Law

Your Plan and this document shall be construed in accordance with the laws of Vermont, except to the extent such laws are preempted by federal law. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Future of the Plan

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

Upon termination of Blue Cross as your contract administrator, amounts payable under the terms of your Plan prior to such termination shall be paid as determined by the Plan Organizer.

The benefits under this Plan do not vest. Your Plan Organizer reserves the right, in its sole discretion, to determine the nature and amount of benefits, if any, under your Plan, as well as the right to reduce, terminate or modify the terms or the amount of such benefits.

Limitation of Rights

This document will not be held or construed to give any person any legal or equitable right against your Plan Organizer, Blue Cross or any other person connected with your Plan, except as expressly provided in this document or as provided by applicable law, or to give any person any legal or equitable right to any assets of your Plan.

Non waiver of Rights

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

Plan Funding

The benefits are payable and other costs of the plan are financed by contributions made by enrolled employees and/or member employers to the Vermont Education Health Initiative.

Severability Clause

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

Term of Agreement

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

Third Party Beneficiaries

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

CHAPTER SEVEN

More Information About Your Plan

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

Organizations Covered by this Notice

This notice applies to the 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
- 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
- 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
- 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.

Disclosures for Plan Administrative Functions

In the event that the Plan Organizer may receive, use, and disclose PHI for Plan administration purposes, the Plan Organizer hereby agrees to:

- Maintain the privacy and security of your PHI as required by law and follow the duties and privacy practices described in this section and provide a copy upon request.
- Ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan or the Plan Organizer, as the case may be, with respect to such information.
- Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Organizer nor use or share your information other than as described in this section unless authorized by you in writing.
- Promptly notify you if a breach occurs that may have comprised the privacy or security of your information.
- Make available Protected Health Information in accordance with Federal medical privacy regulations.
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with Federal medical privacy regulations.
- Make available the information required to provide an accounting of disclosures in accordance with Federal medical privacy regulations and promptly advise you if a breach occurs that may have compromised the privacy or security of your information.
- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services, or any other officer or employee whom the authority involved has been delegated, for purposes of determining compliance by the Plan.

- If feasible, return or destroy all Protected Health Information received from the Administrator that the Plan and/or the Plan Organizer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- Ensure that the Plan Organizer and the Plan are adequately separated.

The Plan shall disclose PHI to the Plan Organizer only upon receipt of a certification by the Plan Organizer that (a) Plan documents have been amended to incorporate the above requirements and (b) the Plan Organizer agrees to comply with such provision.

The Plan may disclose to the Plan Organizer information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan.

The Plan Organizer hereby authorizes and directs the Plan through the Plan Administrator, broker, or the third party administrator or contract administrator, to disclose PHI to stop-loss carriers, excess loss carriers, insurance companies, or managing general underwriters for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage or insurance coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the HIPAA Privacy Standards.

Your rights under the Women's Health and Cancer Rights Act

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

Health plans must determine the manner of coverage in consultation with the attending Physician and the patient. Coverage for breast reconstruction and related services may be subject to Deductibles and Coinsurance amounts that are consistent with those that apply to other benefits under your Plan.

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

Newborns' and Mothers' Health Protection Act

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

Your Plan does not have standard day-limit restrictions on the length of maternity stays. Instead, each admission is reviewed for Medical Necessity. In any event, your Plan does not limit hospital stays to less than the durations required by the law. As always, if you have questions about your maternity benefits please call customer service at the phone number on the back of your ID card.

Member Rights and Responsibilities

As a member, you have the right to:

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

- **Nondiscrimination.** You have the right to receive services from us free from all forms of discrimination including on the basis of race, color, national origin, age, disability, gender identity or sex, ethnicity, sexual orientation, or HIV-status.
- **Meaningful Access.** You have the right to meaningful access to all services we provide to you regardless of any disability or if you are of limited English proficiency. Where appropriate and necessary, you are entitled to free language assistance services and auxiliary aids and services.

As a member, you have the responsibility to:

- **Choose a Primary Care Provider** (PCP) if your Plan requires a PCP.
- **Present your ID card** each time you receive services; and protect your ID card from improper use.
- **Report a lost or stolen ID card** in a timely manner by calling Blue Cross customer service at (800) 344-6690.
- **Keep your Providers informed** and understand that your Providers need up-to-date health information to treat you effectively. Talk to your Providers about your medical history, your current health status and participate in developing mutually agreed-upon treatment goals as much as possible.
- **Follow plan rules and instructions for your care** that you agreed to with your Provider. Identify yourself as a member to Providers to receive care or services and follow the policies and procedures described in your plan materials.
- **Treat your Providers with respect** by keeping your scheduled appointments and notifying your Provider ahead of time if you will be late or need to reschedule.
- **Better understand your health problems** by participating with your Provider and the plan's care management team (as appropriate) to develop a treatment plan.
- **Pay** all applicable Deductibles, Coinsurance amounts and Copayments to your health care Providers.
- **Review your Summary of Health Plan Payments** and report any discrepancies.
- **Notify your Group Benefits Manager** if 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 Manager.

CHAPTER EIGHT

Definitions

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

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

Adult Dependent Due to Disability: a Dependent who meets Blue Cross's definition of Child (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 your Plan considers reasonable for a Covered service or supply.

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

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

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

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

Calendar Year: The time period 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 Calendar Year. The Calendar Year on VEHI plans begin on January 1 and ends on December 31.

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

Child: a Participant's son, daughter or stepchild through marriage, Domestic Partnership[3] or civil union, whether biological or legally adopted (including a Child living with the adoptive parents during a period of probation); or a Child for whom the Participant is legal guardian. A Child must be under age 26 unless he or she is an Adult Dependent Due to Disability.

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

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

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.

Coinsurance: a percentage of the Allowed Amount you must pay, as shown on your *Outline of Coverage* or your *Summary of Benefits and Coverage*, after you meet your Deductible. (Refer also to Chapter One, Payment Terms.)

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

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

Copayment: (Visit Fee): a fixed dollar amount you must pay for specific services, if any, as shown on your *Outline of Coverage* and your *Summary of Benefits and Coverage*. (Refer also to Chapter One, Payment Terms.)

Cosmetic: primarily intended to improve appearance.

Cost-Sharing: costs for Covered services that you pay out of your own pocket. This term includes Deductibles, Coinsurance, and Copayments, or similar charges, but it doesn't include premiums, any balance between the Provider's charge and what your Plan pays for Out-of-Network Providers, or the cost of non-Covered services.

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

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

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

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

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

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

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

- in accomplishing Activities of Daily Living;
- in social or personal adjustment; or

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

Durable Medical Equipment (DME): equipment that requires:

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

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

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

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

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

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

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

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

Facility (Facilities): the following institutions or entities:

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

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

Gender Affirming Health Care Services: all supplies, care, and services of a medical, behavioral health, mental health, surgical, psychiatric, therapeutic, diagnostic, preventive, rehabilitative, or supportive nature, including medication, relating to the treatment of gender dysphoria and gender incongruence. Gender Affirming Health Care Services does not include conversion therapy as defined by Vermont law.

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

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

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

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

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

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

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

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

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

Investigative/Investigational:
(see Experimental)

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

Medical Foods: an amino acid modified preparation that is intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease.

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

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

- 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
- prevent deterioration of or palliate the Member's condition
- prevent the reasonably likely onset of a health problem or detect a developing problem

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

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

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

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.

Out-of-Pocket Limit: the Out-of-Pocket Limit is made up of the Deductibles and Coinsurance you pay. Copayments 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 Coinsurance for the rest of that Calendar Year. You may still be responsible for Copayments, when they apply.

Check your *Outline of Coverage* or your *Summary of Benefits and Coverage* to see all your Out-of-Pocket Limits and if you have a specific kind of limit (Aggregate or Stacked as explained in Chapter One, Payment Terms).

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

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

Participant: an individual who enrolls in your Plan.

Partnership: see Domestic Partners (Partnership).

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

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

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

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

Plan: this plan of benefits administered by Blue Cross, adopted by your employer through your Plan Organizer.

Plan Organizer: the organization that has the responsibility of overseeing operation of your Plan, Vermont Education Health Initiative.

Prescription Drugs and Biologics: products that are:

- prescribed to treat, prevent or diagnose a medical condition;
- FDA-approved (or not FDA-approved if the use meets the definition of Medical Necessity and is not considered Investigational); and
- approved for reimbursement for the specific medical condition being treated or diagnosed, or as otherwise required by law.

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

Please note that if you receive a Preventive Service and during its delivery, the Provider suspects, finds or treats a disease condition, the Provider and/or Blue Cross may not consider the service preventive.

Primary Care Provider (PCP): a health care Provider who, within that Provider's scope of practice as defined under the relevant state licensing law, provides primary care services, and who is designated as a Primary Care Provider by a managed care organization.

Prior Approval: the required approval that you must get from Blue Cross before you receive specific services noted in your Benefits Description. In most cases, Blue Cross requires that you get our Prior Approval in writing. Blue Cross may request a treatment plan or a letter of medical need from your Provider. If you do not get approval from Blue Cross before you receive certain services as noted in 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
  - lactation consultants
  - licensed practical nurses (LPNs)
  - nurse practitioners
  - registered nurses (RNs)
- nutritional counselors
- optometrists
- pharmacists
- podiatrists
- Providers (as further defined in this chapter)
- substance use disorder counselors
- therapists (Occupational, Physical and Speech

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

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

Network Provider: for most Provider types in Vermont, this includes:

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

Your Plan considers Providers outside of Vermont to be Network Providers if they are Preferred Providers with their local Blue Cross and/or Blue Shield health plans.

You may find a Network Provider by using Blue Cross's Find-a-Doctor tool at www.bluecrossvt.org/find-doctor. Select *BCBSVT Network Providers* from the drop-down menu. You may also get a directory of Network Providers from your Group Benefits Manager or from Blue Cross customer service. Providers must be in Network in order for their services to be Covered. Your Plan does not provide benefits if you do not use a Network Provider. See Choosing a Provider in Chapter One.

Out-of-Network Provider: a Provider that does not meet the definition of a Network Provider. Your Plan does not provide benefits if you use an Out-of-Network Provider and Prior Approval is not granted. See Out-of-Network Providers section in Chapter One.

Other Provider: one of the following entities:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Telemedicine: the delivery of health care services such as diagnosis, consultation or treatment through the use of live interactive audio and video over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

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

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

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

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Health plans are administered by:



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www.bluecrossvt.org

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VEHI Exclusive Provider Organization (PCP) (1/2027)

DISCLAIMERS

General Exclusions

While your health plan covers a broad array of necessary services and supplies, it doesn't cover every possible medical expense. If you would like to review the list of general exclusions before enrolling, visit **bluecrossvt.org/contracts**, click on the plan in which you are enrolling and read the chapter entitled "General Exclusions." Once you enroll, you will receive an Outline of Coverage and a link to your Certificate of Coverage. Please read both carefully as they govern your specific benefits.

How We Protect Your Privacy

The law requires us to maintain the privacy of your health information by using or disclosing it only with your authorization or as otherwise allowed by law. You may find information about our privacy practices at **bluecrossvt.org/privacypolicies**.

NOTICE: Discrimination is Against the Law

Blue Cross® and Blue Shield® of Vermont (Blue Cross VT) 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, ethnicity, sexual orientation, or HIV-status.

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

Blue Cross VT provides free language services to people who speak or sign languages other than English. We provide, for example, qualified interpreters and information written in other languages.

If you need these services, contact the Civil Rights Coordinator at **civilrightscoordinator@bcbsvt.com**.

If you believe that Blue Cross VT has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, gender identity or sex, ethnicity, sexual orientation, or HIV-Status, you can file a grievance with: Civil Rights Coordinator, P.O. Box 186, Montpelier, VT 05601-0186, call (800) 247-2583 (TTY/TDD: 711), fax (802) 229-0511, or email **civilrightscoordinator@bcbsvt.com**. You can file a grievance in person, by mail, via fax, or by email. If you need help filing a grievance, the 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 or 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
200 Independence Avenue, SW Room 509F
HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at
https://www.hhs.gov/ocr/complaints/index.html

For free language-assistance service, call (800) 247-2583 (TTY/TDD: 711).

ARABIC العربية	للحصول على خدمة المساعدة اللغوية المجانية، اتصل على الرقم (800) 247-2583 (TTY/TDD: 711). lilhusul ealaa khadmat almusaeadat allughawiat almajaaniat, atasal (800) 247-2583 (TTY/TDD: 711).
BOSNIAN BOSANSKI	Za besplatnu uslugu jezičke pomoći nazovite (800) 247-2583 (TTY/TDD: 711).
BURMESE မြန်မာဘာသာ	အခမဲ့ ဘာသာစကားအကူအညီ ဝန်ဆောင်မှုအတွက် (800) 247-2583 (TTY/TDD: 711) သို့ ဖုန်းခေါ်ပါ။
DARI دری	د وړیا ژبنی مرستې خدماتو لپاره، له (800) 247-2583 (TTY/TDD: 711) شمیرې سره اړیکه ونیسئ
FRENCH FRANÇAIS	Pour des services d'assistance linguistique gratuits, appelez le (800) 247-2583 (TTY/ TDD: 711).
KIRUNDI IKIRUNDI	Niba ukeneye ubwunganizi mu ndimi ku buntu, hamagara kuri (800) 247-2583 (TTY/TDD: 711).
NEPALI नेपाली	निःशुल्क भाषा-सहायता सेवाहरूको लागि, कल गर्नुहोस् , (800) 247-2583 (TTY/TDD: 711). Niḥśulka bhāṣā-sahāyatā sēvāharūkō lāgi, kala garnuhōs (800) 247-2583 (TTY/TDD: 711).
PASHTO پښتو	برای خدمات رایگان کمک زبانی، با شماره (800) 247-2583 (TTY/TDD: 711) تماس بگیرید
SIMPLIFIED CHINESE 简体中文	如需免费语言协助服务，请拨打 (800) 247-2583 (TTY/TDD: 711)。
SOMALI SOOMAALI	Si aad u hesho adeeg caawimo luuqadeed ah oo bilaash ah, wac (800) 247-2583 (TTY/TDD: 711).
SPANISH ESPAÑOL	Para servicios gratuitos de asistencia lingüística, llame al (800) 247-2583 (TTY/TDD: 711).
SWAHILI KISWAHILI	Kwa huduma ya usaidizi wa lugha bila malipo, piga simu kwa (800) 247-2583 (TTY/TDD: 711).
THAI ไทย	สำหรับบริการช่วยเหลือด้านภาษาฟรี โทร, (800) 247-2583 (TTY/TDD: 711). S̄å ĥrạb brikār ch̀wyh̄elūx dān phās̄'ā frī thor (800) 247-2583 (TTY/T̄DD: 711).
UKRAINIAN УКРАЇНСЬКА МОВА	Щоб отримати безкоштовні мовні послуги, телефонуйте (800) 247-2583 (TTY/TDD: 711). Shchob otrymaty bezkoshtovni movni posluhy, telefonuyte (800) 247-2583 (TTY/TDD: 711)
VIETNAMESE TIẾNG VIỆT	Đối với các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi (800) 247-2583 (TTY/TDD: 711).