HEALTH CARE BENEFITS

Vermont Freedom Plan

Certificate of Coverage

BlueCross BlueShield of Vermont

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

This is the Contract for your Health Plan.

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

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

This Contract is current until we update it. We sometimes replace just one part of your Contract. We may only change this Contract in writing and with the approval of the Vermont Department of Financial Regulation (DFR).

If you are missing part of your Contract, please call customer service to request another copy. If the benefits described in your Contract differ from descriptions in our other materials, your Contract language prevails.

How to Use This Document

- Read Chapter One, Guidelines for Coverage. Information there applies to all services. Pay special attention to the section on our Prior Approval Program.
- Find the service you need in Chapter Two, Covered Services. You may use the Index or Table of Contents to find it. Read the section thoroughly.
- Check Chapter Three, General Exclusions, to see if the service you need is on this list.
- Please remember that to know the full terms of your coverage, you should read your entire Contract.
- To find out what you must pay for care, check your *Outline of Coverage* or your *Summary of Benefits and Coverage*.
- Some terms in your Certificate have special meanings. We capitalize these terms in the text. We define them in Chapter Nine of this Certificate. We define the terms "We," "Us," "You" and "Your," but we do not capitalize them in the text.
- If you need materials translated into a different language or would like to access an interpreter via the telephone, please call the customer service number on the back of your ID card.
- If you need translation services such as telecommunications devices for the deaf (TDD) or telephone typewriter teletypewriter (TTY), please call 711.

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

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

We sell Health Plans to individuals who live in Vermont. We sell Health Plans to employer Groups located in the state of Vermont. Our plans are issued, renewed and delivered in Vermont without respect to where any covered Dependent or employee resides. You have a Vermont Freedom Plan. We contract with a network of doctors, hospitals and other health care Facilities and Professionals. These Providers, called Preferred Providers, agree to special pricing arrangements. You may receive some services from a Non-Preferred Provider without these special pricing arrangements. Please read Chapter One, Guidelines for Coverage, carefully to find out when you may receive care outside the network.

Charles P. Smith

Chair of the Board

Beth Roberts

President & CEO

Rebecca C. Heintz

Vice President, General Counsel & Secretary

TABLE OF CONTENTS

CHAPTER ONE

Guidelines for Coverage 5
- General Guidelines ... 5
- Prior Approval Program ... 5
- Case Management Program ... 6
- Choosing a Preferred Provider ... 6
- Preferred Providers ... 7
- Primary Care Providers ... 7
- Non-Preferred Providers ... 7
- Continuity of Care ... 8
- Out-of-Area Providers ... 8
- BlueCard® Program ... 8
- Blue Cross Blue Shield Global® Core Program ... 9
- How We Choose Providers ... 10
- Access to Care ... 10
- After-hours and Emergency Care ... 10
- How We Determine Your Benefits ... 11
- Payment Terms ... 11

CHAPTER TWO

Covered Services 13
- Preventive Services ... 13
- Office Visits ... 13
- Ambulance ... 13
- Autism Spectrum Disorder ... 14
- Bariatric Surgery ... 14
- Clinical Trials (Approved) ... 14
- Chiropractic Services ... 14
- Contraceptive Services ... 15
- Cosmetic and Reconstructive Procedures ... 15
- Dental Services ... 15
- Diabetes Services ... 16
- Diagnostic Tests ... 16
- Emergency Care ... 16
- Gender Affirming Services ... 16
- Hearing Aid Services ... 16
- Home Care ... 17
- Hospice Care ... 18
- Hospital Care ... 18
- Independent Clinical Laboratories ... 18
- Medical Equipment and Supplies ... 19
- Mental Health Care ... 20
- Nutritional Counseling ... 20
- Outpatient Hospital Care ... 21
- Outpatient Medical Services ... 21
- Pregnancy Care ... 21
- Rehabilitation/Habilitation ... 22
- Skilled Nursing Facility ... 22
- Substance Use Disorder Treatment Services ... 22
- Surgery ... 23
- Telemedicine Program ... 23
- Telemedicine Services ... 23
- Therapy Services ... 24
- Transplant Services ... 24
- Vision Services (Medical) ... 25

CHAPTER THREE

General Exclusions 26
- Provider Exclusions ... 29

CHAPTER FOUR

Claims 30
- Claim Submission ... 30
- Release of Information ... 30
- Cooperation ... 30
- Payment of Benefits ... 30
- Payment in Error/Overpayments ... 30
- How We Evaluate Technology ... 30
- Complaints and Appeals ... 31

CHAPTER FIVE

Other Party Liability 33
- Coordination of Benefits ... 33
- Subrogation ... 34
- Cooperation ... 34

CHAPTER SIX

Membership 35
- Adding Dependents ... 35
- Removing Dependents ... 36
- Cancellation of Coverage ... 36
- Benefits after Termination of Group Coverage ... 36
- Active Military Service ... 36
- Fraud, Misrepresentation or Concealment of a Material Fact ... 36
- Contract Reinstatement ... 37
- Voidance and Modification ... 37
- Rules About Coverage for Domestic Partners ... 37
- Right to Continuation of Coverage ... 38
- Conversion Rights ... 38

CHAPTER SEVEN

General Contract Provisions 39
- Applicable Law ... 39
- Severability Clause ... 39
- Non-waiver of Our Rights ... 39
- Term of Contract ... 39
- Subscription Rate ... 39
- Subscriber Address ... 39
- Third Party Beneficiaries ... 39

CHAPTER EIGHT

More Information About Your Contract. 40
- Our Commitment to Protecting Your Privacy ... 40
- Your rights under the Women's Health and Cancer Rights Act ... 40
- Our Pledge to You ... 41
- Member Rights and Responsibilities ... 41

CHAPTER NINE

Definitions 42

CHAPTER ONE

Guidelines for Coverage

This Certificate describes benefits for the Blue Cross and Blue Shield of Vermont (Blue Cross) Vermont Freedom Plan (VFP). This Preferred Provider Organization (PPO) plan provides better benefits when you use Preferred Network Providers. If you use Providers who are not in our Preferred Network (Non-Preferred Providers), you pay higher Cost-Sharing for your care, except as otherwise provided by law.

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

General Guidelines

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

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

Prior Approval Program

We require Prior Approval for certain services and drugs even when you use Preferred Providers except for any admission, item, service, treatment, or procedure ordered by a Provider credentialed and enrolled with us 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.

We do not require Prior Approval for Emergency Medical Services.

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

Our Prior Approval list can change. To get the most up-to-date list, visit our website at **www.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 Preferred Provider must provide supporting clinical documentation to Blue Cross. When receiving care from a Non-Preferred Provider, it is your responsibility to get Prior Approval. Forms are available on our website at **www.bluecrossvt.org/members/member-forms**. You may also get them by calling our customer service team at the phone number located on the back of your ID card.

Any Provider may help you fill out the form and give you other information you need to submit your request. The medical staff at 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 printed on our Prior Approval list except for any admission, item, service, treatment, or procedure ordered by a Provider credentialed and enrolled with us 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 is 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 Plan 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 disorder;
- 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-state Inpatient care, partial hospitalization care, and Residential Treatment Centers for mental health and substance use disorder;
- 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);
- certain surgical procedures and related services (examples include disc arthroplasty, lumbar spinal fusion, Sacroiliac joint pain treatment, Temporomandibular joint manipulation (TMJ) , and varicose veins);
- surgery and related services;
- 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 we approve benefits for care provided by Non-Preferred Providers and/or treatment Facilities for Inpatient and Outpatient care, we may require you to participate in Case Management prior to receiving ongoing care and services. To find out more information about the program, visit our website at **www.bluecrossvt.org/health-community/your-health-and-wellness/help-managing-your-health** or call (800) 922-8778.

Choosing a Preferred Provider

For many services, you may use any Provider. For some services, you must use Preferred Providers. You may have higher Cost-Sharing when using Non-Preferred Providers.

If you want a list of our Preferred Providers or want 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 may also call our customer service team at the number on the back of your ID card. We 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.

Preferred Providers

Preferred Providers will:

- secure Prior Approval for you (if the Provider is located in the Blue Cross Network);
- bill us directly for your services, so you don't have to submit a claim;
- not ask for payment at the time of service except they may ask for Deductible, Coinsurance or 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 Preferred Facility, the individual Providers there may not be Preferred Providers. Please make every effort to check the status of all Providers prior to treatment.

If you want a list of our Preferred Providers or information about a Provider, please visit our website at **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.

Primary Care Providers

You do not need to select a Primary Care Provider (PCP) for this Plan. We encourage you to form a relationship with a Provider who will coordinate your care. Your coverage does not require you to get referrals. You must get Prior Approval for certain services (see page 5) except for any admission, item, service, treatment, or procedure ordered by a Provider credentialed and enrolled with us 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 does not include Emergency Medical Services.

Non-Preferred Providers

If you believe you need to use a Non-Preferred Provider because there is not a Preferred Provider with appropriate training and experience to provide the Medically Necessary services needed to meet your particular health care needs, please call customer service at the number on the back of your ID card to assist in locating a Preferred Provider. If we determine there is not a Preferred Provider available to provide the Medically Necessary services needed to meet your particular health care needs, the Cost-Sharing will be the same as if the service was obtained by a Preferred Provider and you will not pay the balance between the Provider's charge and the Allowed Amount.

We also cover Ambulance services and Emergency Medical Services you receive from a Non-Preferred Provider when you have an Emergency Medical Condition (see Definitions) at the same Cost-Sharing.

If you use a Non-Preferred Provider for reasons other than when there is not a Preferred Provider who can provide the Medically Necessary services, we pay the Allowed Amount and you pay any balance between the Provider's charge and what we pay. You must also pay any applicable Cost-Sharing amounts (Deductibles, Coinsurance and Copayments). See your *Outline of Coverage* or your *Summary of Benefits and Coverage*. If you use one of the following Provider types that is not a Preferred Provider, we will not cover your care and you must pay the full cost:

- athletic trainers;
- cardiac rehabilitation Providers;
- certified nurse midwives and licensed Professional midwives;
- Chiropractors;
- home infusion therapy Providers;
- independent clinical laboratories
- lactation consultants;
- nutritional counseling Providers (including registered dieticians, licensed nutritionists, certified diabetic educators, medical doctors, naturopaths, doctors of osteopathy and nurse practitioners);
- pharmacies (if you have prescription drug coverage);
- Physical Rehabilitation Facilities;

- routine vision care Providers (if your coverage includes routine vision benefits); and
- Skilled Nursing Facilities.

Non-Preferred Providers at Preferred Facilities

If you receive Medically Necessary, Covered services from a Non-Preferred Provider at a Preferred facility without you consenting to waive your rights, we will cover your care as if you had been treated by a Preferred 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.

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 we provide 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. 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 our website at **www.bluecrossvt.org/members/member-forms** to complete the Continuity of Care enrollment form or contact our 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 we pay. 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 Preferred Providers with their local Blue Health Plan. See

the BlueCard® Program section below.

BlueCard® Program

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

Typically, when accessing care outside of the service area, you will obtain care from health care Providers that have a contractual agreement with the local

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

Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from health care Providers that have contracts with Blue Cross and Blue Shield plans (e.g., Participating or Preferred Providers).

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

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

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

Special Case: Value-Based Programs

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

Out-of-Area Services with Non-Contracting Providers

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

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

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

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

Blue Cross Blue Shield Global® Core Program

If you are outside the United States, the Commonwealth of Puerto Rico, or the U.S. Virgin Islands, (which we will call the "BlueCard Service Area"), you may be able to take advantage of the Blue Cross Blue Shield Global® Core Program when accessing Covered services. The Blue Cross Blue Shield Global® Core Program is unlike the BlueCard Program in certain ways. For instance, although the Blue Cross Blue Shield Global® Core Program helps you get care through a network of Inpatient, Outpatient and Professional Providers, the network is not hosted by Blue plans. When you receive care from Providers outside the BlueCard Service Area, you will typically have to pay the Providers and submit the claims yourself to obtain reimbursement for these services. If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard Service Area, please call the Blue Cross Blue Shield Global® Core Service Center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical Professional, can arrange a Physician appointment or hospitalization, if necessary.

Inpatient Services

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

Outpatient Services

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

Submitting a Blue Cross Blue Shield Global® Core Claim

When you pay for Covered services outside the BlueCard Service Area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global® Core International claim form and send the claim form with the Provider's itemized bill(s) to the Blue Cross

Blue Shield Global® Core Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from 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 We Choose Providers

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

Please understand that our Preferred Providers are not employees of Blue Cross; they just contract with us.

Access to Care

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

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

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

- a Preferred 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 Preferred Provider within a 30-minute drive; and
- a Preferred 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 Preferred Providers for less common specialty care within a 90-minute drive. This includes kidney transplantation, major trauma treatment, neonatal intensive care and tertiary-level cardiac care.

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

After-hours and Emergency Care

Emergency Medical Services

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

Emergencies might include:

- broken bones;
- heart attack;
- poisoning.

You will receive care right away in an emergency.

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

If you receive Medically Necessary, Covered Emergency Medical Services from a Non-Preferred Provider, we will cover your emergency care as if you had been treated by a Preferred Provider. You must pay any Cost-Sharing amounts required under your Contract as if you received those services from a Preferred Provider. These may include Deductibles, Coinsurance or Copayments. If a Non-Preferred 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.

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 23.

How We Determine Your Benefits

When we receive your claim, we determine:

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

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

- benefits paid by Medicare;
- Deductibles (explained below);
- 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*. We may limit benefits to the Plan Year maximums, which are also shown on these documents.

Payment Terms

Allowed Amount

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

Notes:

- Preferred 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 we approve services with a Non-Preferred Provider for circumstances outside of the situations noted in the Non-Preferred Providers section on page 7, we pay the Allowed Amount and you must pay any balance between the Provider's charge and what we pay.

Cost-Sharing

Cost-Sharing are the costs for Covered services that you pay out of your own pocket. This includes Deductibles, Copayments, and Coinsurance, or similar charges, but it doesn't include premiums, any balance between the Provider's charge and what we pay for Out-of-Network Providers, or the cost of non-Covered services. All information about your Deductible amounts, type of Deductible, 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 Plan Year before we make payment on certain services. We apply your Deductible to your Out-of-Pocket Limit for each Plan Year. You may have more than one Deductible. Deductibles can apply to certain services or certain Provider types.

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

Aggregate Deductible

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

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

Stacked Deductible

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

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

Copayment

You must pay Copayments to Providers 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. We apply Copayments toward your Out-of-Pocket-Limit for each Plan Year.

Coinsurance

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

Out-of-Pocket Limit

We apply your Deductible, your Copayments and your Co-insurance toward your Out-of-Pocket Limit. After you meet your Out-of-Pocket Limit, you pay no Coinsurance or Copayments for the rest of that Plan Year for Covered services.

When your family meets the family Out-of-Pocket Limit, all family members are considered to have met their individual Out-of-Pocket Limits. You may have separate Out-of-Pocket Limits for certain services (and if you have a Prescription Drug rider, you may have separate Out-of-Pocket Limits 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 or family plan, and you do not have an individual Out-of-Pocket Limit, your family members' Covered expenses must reach the family Out-of-Pocket Limit before we pay 100 percent of the Allowed Amount for eligible services. When your family's expenses reach this amount, we will begin to pay 100 percent of the Allowed Amount for the rest of the Plan Year for Covered services.

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

Stacked Out-of-Pocket Limit

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

Plan Year Benefit Maximums

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

Self-Pay Allowed by HIPAA

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

Third Party Premium Payments

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

Blue Cross only accepts premium and Cost-Sharing payments made by Members or on behalf of Members by the following:

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

CHAPTER TWO

Covered Services

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

Preventive Services

We provide benefits for Preventive Services. We encourage you to get Preventive Services that are appropriate for you. Examples of preventive care include colonoscopies for people age 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 15.

We pay for some Preventive Services with no 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; and
- The Health Resources and Services Administration's (HRSA) women's preventive services guidelines.

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

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

Please note that if your Provider finds or treats a condition while performing Preventive Services, Cost-Sharing may apply.

Office Visits

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

- examination, diagnosis and treatment of an injury or illness;
- injections;
- Diagnostic Services, such as X-rays
- nutritional counseling (see page 20);
- Surgery; and
- therapy services (see page 24).

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

Exclusions

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

Notes:

- We describe office visits for mental health services, substance use disorder treatment services, and chiropractic services elsewhere in this Chapter. Please see those sections for benefits.
- See page 5 for more information regarding Prior Approval and instances where Prior Approval is not required. Visit our 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

We cover Ambulance services as long as your condition meets our 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 a Non-Preferred Provider bills you for the balance between the charges and what we pay, please notify us by calling our customer service team at the number on the back of your ID card.

We cover transportation of the sick and injured:

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

Limitations

- You must get Prior Approval for non-emergency transport including transport by land, air, or water.

- We cover transportation only to the closest Facility that can provide services appropriate for the treatment of your condition.
- We do not cover Ambulance services when the patient can be safely transported by any other means. This applies whether or not transportation is available by any other means.
- We do not cover Ambulance transportation when it is solely for the convenience of the Provider, family or member.

Autism Spectrum Disorder

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

General Exclusions in Chapter Three also apply.

Bariatric Surgery

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

Clinical Trials (Approved)

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

General Exclusions in Chapter Three also apply.

Chiropractic Services

We cover services by Preferred Chiropractors who are:

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

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

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

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

If you use more than 12 chiropractic visits in one Plan Year, you must get Prior Approval from us for any visits after the 12th or your claim will be denied. See page 5 for more information regarding Prior Approval and instances where Prior Approval is not required.

Exclusions

We provide no chiropractic benefits for:

- 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), 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 do not require one-on-one patient contact by the Provider; or
- any other procedure not listed as a Covered chiropractic service.

General Exclusions in Chapter Three also apply.

Contraceptive Services

We cover outpatient contraceptive services as per HRSA guidelines for all FDA approved contraceptive methods including office visits and consultations. 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. We pay 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 *Outline of Coverage* or your *Summary of Benefits and Coverage* for Cost-Sharing details.

You can find the list of Covered Preventive Services on our 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

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

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

You must get Prior Approval for these services.

Dental Services

In the event of an emergency, you must contact us as soon as possible afterward for approval of continued treatment. We cover 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 covers a reasonable course of treatment defined as not exceeding five years from the beginning of treatment, except as otherwise required by law).
- Surgery related to head and neck cancer where sound natural teeth may be affected primarily or as a result of the chemotherapy or radiation treatment of that cancer.
- Treatment 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.
- Diagnostics 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 5 for more information regarding Prior Approval and instances where Prior Approval is not required.

Exclusions

Unless expressly required by law, we do not cover:

- Surgical removal of teeth, including removal of wisdom teeth;
- gingivectomy;

[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.

- 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); or
- charges related to non-Covered dental procedures or anesthesia (for example, Facility charges, except when Medically Necessary as noted above).

General Exclusions in Chapter Three also apply.

Diabetes Services

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

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

Diagnostic Tests

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

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

We also cover 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; and
- 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 5 for more information regarding Prior Approval and instances where Prior Approval is not required.

General Exclusions in Chapter Three also apply.

Emergency Care

We cover services you receive in the emergency room of a General Hospital. Coverage for Emergency Medical Services outside of the service area will be the same as for those within the service area. If a Non-Preferred Provider bills you for a balance between the charges and what we pay, please notify us by calling our customer service team at the number on the back of your ID card. We will defend against and resolve any request or claim by a Non-Preferred Provider of Emergency Medical Services.

Requirements

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

Gender Affirming Services

We cover Gender Affirming Health Care Services that are Medically Necessary and clinically appropriate for the individual's diagnosis or condition.

You must get Prior Approval for gender affirming services. See page 5 for more information regarding Prior Approval and instances where Prior Approval is not required.

Hearing Aid Services

We cover a Medically Necessary hearing aid for each ear and the associated hearing aid Professional services when the hearing aid or aids are prescribed, fitted, and

dispensed by a hearing care Professional within the hearing benefit network. We also cover hearing aid batteries when prescribed by a hearing care Professional.

Hearing aid Professional services we cover include:

- evaluation for a hearing aid;
- fitting of a hearing aid;
- programming of a hearing aid;
- hearing aid repairs;
- follow-up adjustments, servicing, maintenance of a hearing aid;
- ear mold impressions; and
- auditory rehabilitation and training.

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

Requirements

We only provide benefits when the hearing aid(s) are prescribed, fitted, and dispensed by a hearing care Professional within the hearing benefit network which includes an audiologist or hearing aid dispenser acting within the scope of their license, a physician or physician assistant or advance practice registered nurse acting within the scope of their license.

To locate a hearing care Professional within the hearing benefit network, visit Blue Cross's website at **www.bluecrossvt.org/find-doctor**.

Limitations

We limit coverage to one hearing aid, per ear, every three years unless a hearing care Professional determines a new hearing aid for one or both ears is Medically Necessary.

Notes:

- If you choose to purchase a hearing aid that exceeds the Plan's Allowed Amount, you will pay any difference between the Provider's charge and the Allowed Amount.
- If your Provider determines you need a Medically Necessary hearing aid that exceeds the Plan's Allowed Amount, you or your Provider may appeal. Please see Chapter Four, Complaints and Appeals, regarding your right to Appeal.

Exclusions

We provide no benefits for:

- over-the-counter hearing aids; or
- hearing aids from a hearing care Professional outside of the hearing benefit network.

General Exclusions in Chapter Three also apply.

Home Care

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

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

We also cover:

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

Private Duty Nursing

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

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

Requirements

We cover home care services only when your Provider:

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

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

Limitations

We cover home infusion therapy only if:

- your Provider prescribes a home infusion therapy regimen; or

- you use services from a Preferred home infusion therapy Provider.

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

Exclusions

We provide no home care benefits for:

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

General Exclusions in Chapter Three also apply.

Hospice Care

We cover the following services by a Hospice Provider:

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

Requirements

We only provide benefits if:

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

General Exclusions in Chapter Three also apply.

Hospital Care

Inpatient Hospital Services

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

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

We cover either the day of admission or the day of discharge, but not both. Certain Inpatient services require Prior Approval. See page 5 for more information regarding Prior Approval and instances where Prior Approval is not required.

Inpatient Medical Services

We cover services by a Physician or Professional Provider who sees you when you are an Inpatient in a hospital or Preferred 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; or
- other specialty care when you need it.

Notes:

You must get Prior Approval for Reconstructive procedures.

We limit Surgery benefits as follows:

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

Independent Clinical Laboratories

You must use 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 5 for more information regarding Prior Approval and instances where Prior Approval is not required. Visit our website at **www.bluecrossvt.org/members/member-forms** or call our customer service team 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 5 for more information regarding Prior Approval and instances where Prior Approval is not required or visit **www.bluecrossvt.org/members/member-forms**.

We cover Durable Medical Equipment you purchase from a Preferred:

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

We cover the rental or purchase of Durable Medical Equipment (DME) if they have been ordered or prescribed by a Provider. We reserve 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. Please see your *Outline of Coverage* or your *Summary of Benefits and Coverage* for Cost-Sharing details.

Replacement of lost, stolen or destroyed Durable Medical Equipment

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

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

We do not cover:

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

Supplies

We cover medical supplies such as needles, 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.

Orthotics

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

Prosthetics

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

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

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

Limitations

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

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

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

We cover dental prostheses (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

We provide no benefits for:

- treatment for hair loss due to androgenic alopecia, alopecia barbae, postpartum alopecia, traction alopecia, and/or natural or premature aging;
- Continuous Glucose Monitoring (CGM) purchased through a DME supplier (These supplies may be eligible through your pharmacy benefit.);
- 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;
- patient-actuated end-range motion stretching devices, and programmable or variable motion resistance devices;
- items or equipment that do not meet the definition of Durable Medical Equipment;
- any treatment, Durable Medical Equipment, supplies or accessories intended principally for participation in sports or recreational activities or for personal comfort or convenience; and
- repair or replacement of dental appliances or dental prosthetics (including dentures) except as listed above.

General Exclusions in Chapter Three also apply.

Note: To be sure your item meets our definition of Durable Medical Equipment, you may call our customer service team at the number listed 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 5 for more information regarding Prior Approval and instances where Prior Approval is not required.

Outpatient

We cover Outpatient mental health services including:

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

Inpatient

We cover Inpatient mental health services including:

- hospitalization; and
- Residential Treatment Programs.

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

Coverage for Emergency Medical Services outside the service area will be the same as for those within the service area. If a Non-Preferred Provider bills you for a balance between the charges and what we pay, please notify us. Call our customer service team at the number on the back of your ID card. We will defend against and resolve any request or claim by a Non-Preferred Provider of Emergency Medical Services.

Exclusions

We provide no mental health benefits for:

- services ordered by a court of law (unless we deem them Medically Necessary);
- 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; and
- Custodial Care (see Definitions);
- biofeedback, stress reduction classes and pastoral counseling;
- psychoanalysis; and
- hypnotherapy.

General Exclusions in Chapter Three also apply.

Nutritional Counseling

We cover nutritional counseling with no limit on the number of Outpatient visits.

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

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

General Exclusions in Chapter Three also apply.

Outpatient Hospital Care

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

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

You must get Prior Approval for certain radiology procedures (including CT, MRI, MRA, MRS, PET scans, and echocardiograms) and polysomnography (sleep studies). See page 5 for more information regarding Prior Approval and instances where Prior Approval is not required.

For more information about Therapy Services, see page 24.

Outpatient Medical Services

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

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

Limitations

We cover 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). We also cover the following care by a Provider or other Professional during a person's pregnancy:

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

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

We cover newborns under this Contract for up to 60 days after birth. Your newborn will be subject to their own Cost-Sharing for Covered services beginning on their date of birth, whether or not you add your newborn to coverage permanently. If you are an individual policy, your Cost-Sharing will be based on a family plan during those 60 days. (See Chapter Six for information on how to continue coverage for your newborn past this period.)

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

Better Beginnings® Maternity Wellness Program

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

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

You get the most out of the Better Beginnings program when you contact us in the first three months of your pregnancy. To get any benefits from Better Beginnings, you must actively participate. If you have questions, please call 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: We may provide benefits through the Better Beginnings program for services that we do not generally cover. (We explain these services in the packet you receive when you join Better Beginnings.) The fact that we provide special benefits in one instance does not obligate us to do so again.

Rehabilitation/Habilitation

Rehabilitation or Habilitation services may require Prior Approval. See page 5 for more information regarding Prior Approval and instances where Prior Approval is not required.

We cover:

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

You must use a Preferred 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

We do not cover:

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

General Exclusions in Chapter Three also apply.

Skilled Nursing Facility

We cover Inpatient services including:

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

Requirements

We provide benefits only if you:

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

Exclusions

We do not cover Skilled Nursing Facility care for:

- Cognitive re-training; or
- Custodial Care

Substance Use Disorder Treatment Services

Some services require Prior Approval. See page 5 for more information regarding Prior Approval and instances where Prior Approval is not required.

We cover 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); and
- Inpatient Rehabilitation.

Coverage for Emergency Medical Services outside the service area will be the same as for those within the service area. If a Non-Preferred Provider bills you for a balance between the charges and what we pay, please notify us. Call our customer service team at the number on the back of your ID card. We will defend against and resolve any request or claim by a Non-Preferred Provider of Emergency Medical Services.

Requirements

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

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

Exclusions

We provide no substance use disorder treatment benefits for:

- services ordered by a court of law (unless we deem them Medically Necessary);
- non-traditional, alternative therapies such as Rubenfeld Synergy, energy polarity therapy and somatization therapy, that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories;
- services, including long-term residential programs, adventure-based activities, wilderness programs and residential programs that focus on education, socialization, delinquency;

- Custodial Care (see Definitions);
- biofeedback, stress reduction classes and pastoral counseling;
- psychoanalysis; and
- hypnotherapy.

General Exclusions in Chapter Three also apply.

Surgery

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

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

See page 5 for more information regarding Prior Approval and instances where Prior Approval is not required.

General Exclusions in Chapter Three also apply.

Telemedicine Program

We cover 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; and
- mental health services.

Please see your *Outline of Coverage* for details. Visit our 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

We do not cover:

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

General Exclusions in Chapter Three also apply.

Telemedicine Services

We cover the following Medically Necessary, clinically appropriate Telemedicine consultations 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 (applies only if have Prescription Drug Coverage);
- nutritional counseling visits;
- end-stage renal disease services;
- medical genetic and genetic counseling services (please note genetic testing services requires Prior Approval);
- neuro-cognitive testing;
- intervention and behavior change counseling to quit tobacco or smoking tobacco;
- intervention and behavior change counseling for substance use disorder and alcohol abuse treatment;
- education and training services for managing your illness; and
- transitional care management services.

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

Limitations

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

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

Exclusions

We do not cover:

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

General Exclusions in Chapter Three also apply.

Therapy Services

We cover therapy or physical medicine services provided by:

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

Therapy services could include the following:

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

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

- for services that require constant attendance of a licensed:
  - therapist (Occupational, Physical and Speech);
  - medical doctor (M.D.);
  - Preferred Chiropractor (D.C.);
  - Preferred 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.); or
  - doctor of osteopathy (D.O.).
- up to the specific benefit limits listed on your *Outline of Coverage* and your *Summary of Benefits and Coverage* (this limitation does not apply to mandated treatment for Autism Spectrum Disorder as defined by Vermont law).

Exclusions

We do not cover the following therapy services:

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

General Exclusions in Chapter Three also apply.

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

Transplant Services

You must get Prior Approval for transplant services. See page 5 for more information regarding Prior Approval and instances where Prior Approval is not required

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

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

We pay benefits for the following services related to transplants:

- search for a donor;
- surgical removal of an organ;
- storage and transportation costs for the organ, partial organ or bone marrow; and

- costs directly related to the solid organ or bone marrow donation, including costs resulting from complications of the donor's Surgery.

We pay benefits for transplants as follows:

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

Time Period for Living Donor Benefits

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

Exclusions

We do not cover the purchase price of any organ or bone marrow that is sold rather than donated. We also do not cover voluntary transplants, such as uterine transplants as treatment of infertility. General Exclusions in Chapter Three also apply.

Vision Services (Medical)

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

Eyeglasses, contact lenses, and refraction

We don't 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 19).

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

CHAPTER THREE

General Exclusions

We pay benefits only for Covered services described in your Contract. We do not cover services and supplies that are not Medically Necessary. This Certificate and any of your riders or endorsements may contain specific exclusions. We do not cover service specific exclusions, even if they are Medically Necessary.

In addition to the specific exclusions listed elsewhere in this Contract, the following general exclusions apply:

(Note: If you don't agree with our 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 as extended benefits.
2. Services for which you would not legally have to pay if you did not have your Contract or similar coverage.
3. Services for which there is no charge.
4. Services paid directly or indirectly by a local, state or federal government agency, except as otherwise provided by law.
5. Services you require because you participated in a felony, riot, or insurrection.
6. Services over the limitations or maximums set forth in your Contract.
7. Services or drugs that we determine are Investigational, mainly for research purposes or Experimental in nature. To the extent required by law, however, we cover routine costs for patients who participate in approved clinical trials.
8. Services not provided in accordance with accepted Professional medical standards in the United States.
9. Services beyond those needed to establish or restore your ability to perform Activities of Daily Living (see Definitions) or to establish or re-establish the capability to perform occupational, hobby, sport or leisure activities.
10. Acupuncture, acupressure or massage therapy; hypnotherapy (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).
11. Electrical stimulation devices used externally. (This exclusion does not apply to bone growth stimulators, transcutaneous electrical nerve stimulation [TENS] devices or neuromuscular electrical stimulators [NMES].)
12. Automatic or manual home blood pressure cuffs.
13. Bariatric Surgery, unless performed at a Blue Distinction Center.
14. Biofeedback or other forms of self-care or self-help training.
15. Immunizations purchased in bulk, such as those provided to a group of people, and billed collectively rather than individually.
16. Fluoride treatments performed in school.
17. Whole blood, blood components, costs associated with the storage of blood, testing of blood the patient donates for his or her own use (even if the blood is used), transfusion services for blood and blood components the patient donates for his or her own use in the absence of a Covered surgical procedure. (This exclusion does not apply to blood derivatives and transfusion services for whole blood, blood components and blood derivatives.)
18. Care for which there is no therapeutic benefit or likelihood of improvement.
19. Care, the duration of which is based upon a predetermined length of time rather than the condition of the patient, the results of treatment or the individual's medical progress.
20. Case management services not provided by Blue Cross VT.
21. Clinical ecology, environmental medicine, Inpatient confinement for environmental change or similar treatment.
22. Cognitive training or retraining and educational programs, including any program designed principally to improve academic performance, reading or writing skills.
23. Communication devices and communication augmentation devices.
24. Computer technology or accessories and other equipment, supplies or treatment intended primarily to enhance occupational, recreational or vocational activities, hobbies or academic performance.
25. Subscription, retainer, or membership fees including concierge or "direct primary care" services.
26. Consultations between health care Providers except when they attach a written report to the patient's medical record.

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

    Note: This exclusion does not apply to panniculectomy when the panniculectomy is considered Medically Necessary as an adjunct to other procedures such as ventral herniorrhaphy, provided that the medical necessity criteria for panniculectomy have been met. This exclusion also does not apply to lipectomy performed as part of the treatment of lipedema.
30. Custodial Care, Rest Cures.
31. Dental services and dental-related oral Surgery, unless specifically provided by your Contract; dentures and procedures designed primarily to prepare the mouth for dentures (including alveolar augmentation, bone grafting, frame implants and ramus mandibular stapling).
32. Treatment of developmental delays. This exclusion does not apply to mandated treatment of Autism Spectrum Disorder as defined by Vermont law.
33. Drugs and pharmaceuticals, except as required by law (unless you have a Prescription Drug rider).
34. 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.
35. Education, educational evaluation or therapy, therapeutic boarding schools, services that should be Covered as part of an evaluation for, or inclusion in, a Child's individualized education plan (IEP) or other educational program. (This exclusion does not apply to treatment of diabetes, such as medical nutrition therapy by approved participating Providers.)
36. 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.
37. 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.
38. Hot and cold packs.
39. Illnesses or injuries that are:
    - a result of an act of war (declared or undeclared); or
    - sustained in active military service.
40. Infertility services. This includes, but is not limited to:
    - medications for treatment of infertility such as Clomid, Clomiphene, Serophene, Bravelle, Gonal-F, Follistim AQ, Novarel, Ovidrel, Pregnyl, Profasi and Repronex when used for treatment of infertility; and
    - surgical, radiological, pathological or laboratory procedures leading to or in connection with (for example):
        - Minsemination (intravaginal, intracervical, and intrauterine);
        - Min vitro fertilization, embryo transplantation and gamete intrafallopian transfer (GIFT);
        - Mzygote intrafallopian transfer (ZIFT); and
        - Many 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.

    Note: This exclusion does not apply to the evaluation to determine if and why a couple is infertile.
41. 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.

42. Treatment for willfully uncooperative or intractable patients.
43. Institutional or Custodial Care for the physically or mentally handicapped.
44. Listening devices like large-audience assisted listening devices designed for auditoriums, or stand-alone listening devices that can function with a hearing aid; tinnitus masking devices.
45. Mandated treatment, including court-ordered treatment, unless such treatment is Medically Necessary, ordered by a Provider and covered under your Contract.
46. 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.
47. 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.
48. Nutritional counseling provided solely for general wellness, fitness, or lifestyle enhancement.
49. Orthodontics, including orthodontics performed as adjunct to orthognathic Surgery or in connection with accidental injury.
50. Personal hygiene items.
51. Personal service, comfort or convenience items.
52. Photography services, photographic supplies or film development supplies or services (for example, external ocular photography or photography of moles to monitor changes).
53. 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.
54. Pneumatic cervical traction devices except when the patient has a diagnosis of Temporomandibular Joint Syndrome (TMJ); gravity assisted traction devices.
55. Replacement of lost, stolen, or destroyed Prescription Drugs or Biologics received through your medical benefit.
56. Services, including modalities, that do not require the constant attendance of a Provider.
57. Services performed by a Provider that is neither licensed nor certified.
58. 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.
59. Sterilization reversal (vasectomy reversal, vasovasostomy, vasovasorrhaphy, tubal ligation reversal, tubotubal anastomosis).
60. Supervised services or modalities that do not require the skill and expertise of a licensed Provider.
61. 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).
62. Telemedicine services via email, facsimile or non-HIPAA-compliant software, and telemonitoring.
63. 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).
64. Treatment solely to establish or re-establish the capability to perform occupational, hobby, sport or leisure activities.
65. Treatment of obesity, except surgical treatment when determined Medically Necessary.
66. Treatment of telangiectasia such as reticular veins, spider veins, angiomata, hemangiomata and other CEAP Category 1 veins.
67. Vision training or orthoptics and any associated supplemental testing; plano lenses (less than a +/- .50 diopter power); or two pairs of glasses in lieu of bifocals.
68. Work-hardening programs and work-related illnesses or injuries (or those which you claim to be work-related, until otherwise finally adjudicated), provided such illnesses or injuries are covered by workers' compensation or should be so covered. (This provision does not require an individual, such as a sole proprietor or an owner/ partner to maintain worker's compensation if they are not legally required to be covered.)

Provider Exclusions

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

- Provider that is neither licensed nor certified.
- Provider that we do not approve for the given service or that is not defined in our Definitions chapter as a Provider.
- Professional who provides services as part of his or her education or training program.
- Immediate Family Member or yourself.
- Veterans Administration Facility treating a service-connected disability.
- Non-Preferred Provider if we require use of a Preferred Provider as a condition for coverage under your Contract unless appropriate services are not available with a Preferred 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 with us; and
- give information about all other health coverage you have.

Claim Submission

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

Preferred Providers must submit claims on your behalf for Covered services if this is your primary coverage. When you use Non-Preferred Providers, you must file your own claims. You can find a Member Claim Form at **www.bluecrossvt.org/members/member-forms** or request one by calling our customer service team at the number on the back of your ID card.

Release of Information

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

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

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

Cooperation

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

Payment of Benefits

We pay Vermont Preferred Providers directly. We usually pay out-of-state Preferred Providers directly. We usually pay you when you use Non-Preferred Providers. We reserve the right to pay Non-Preferred Providers directly.

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

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

Payment in Error/Overpayments

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

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

How We Evaluate Technology

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

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

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

- be attainable outside the Investigational settings.

Complaints and Appeals

When You Have a Complaint

Customer Service

You may make an inquiry to our customer service team at any time if you have concerns. This is usually the best, first course of action. Our customer service team can solve most problems. Contact our customer service team at the number listed 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 our decision to deny a service or coverage.

If You Don't Agree with Our Decision

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

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

Reviewers

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

Timing of Appeals

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

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

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

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

How to Request an Appeal

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

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

PO Box 186
Montpelier, VT 05601-0186

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

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

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

Information About Your Claim

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

After Our Decision

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

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

Other Resources to Help You

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

Employee Benefits Security Administration
(866) 444-EBSA (3272) (for Group coverage only.)

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

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

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

Vermont Office of the Health Care Advocate

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

CHAPTER FIVE

Other Party Liability

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

Coordination of Benefits

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

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

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

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

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

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

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

Coordination of Benefits for Children of Divorced Parents

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

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

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

In an Accident

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

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

Reimbursement

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

Medicaid and Tricare

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

Subrogation

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

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

Cooperation

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

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

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

CHAPTER SIX

Membership

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

You may add or remove Dependents from your membership under the conditions noted in this chapter. To do this, contact your Group Benefits Manager. If you do not have coverage through your employer, please call customer service at the number on the back of your ID card. You can also visit our secure Web portal, the Blue Cross Member Resource Center at **www.bluecrossvt.org/member-logins**, for information about your Plan and enrollment.

In most circumstances, you must cover either all or none of your Dependents who are eligible under your Contract, unless otherwise ordered by a court of law.

Adding Dependents

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

Marriage/Civil Union

If we receive your request within 31 days after the date of marriage/civil union, your new type of membership begins the first day of the month following the date of marriage/civil union. If we receive your request more than 32 days after the date of your marriage/civil union, your new membership begins the first day of the month after we receive your request.

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

Birth or Adoption

We cover your Child for 60 days after:

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

We must receive your request for a membership change to continue benefits for the Child past 61 days. If we receive your request within the 60 days:

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

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

Dependent's Loss of Coverage

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

Court-ordered Dependents

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

Qualified Medical Child Support Orders (QMCSO)

The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) mandates that group health plans provide benefits according to qualified medical child support order requirements. Contact your plan administrator to obtain, without charge, a copy of the QMCSO procedures.

Adult Dependents Due to Disability

To continue coverage for an Adult Dependent Due to Disability over age 26, we require proof of the continuing existence of a qualifying disabling condition. We must receive the following:

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

Our medical director must review this information and deem the Adult Dependent incapacitated as defined by law before we will provide coverage.

We must receive the information within 60 days of the date the individual would otherwise lose coverage to avoid interrupting coverage. If we receive the above information more than 60 days after the date the individual would no longer be an eligible Dependent, coverage will begin the first day of the month after we receive the information.

Removing Dependents

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

- a Dependent dies;
- the subscriber and Spouse/Party to a civil union divorce;
- a couple legally separates;
- a Child turns 26; or
- the Adult Dependent Due to Disability is no longer incapacitated.

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

Cancellation of Coverage

Cancellation of Coverage by You, by the Group or by Us

You or your Group may cancel this Contract without cause at the end of any calendar month by giving 15 days prior written notice. Blue Cross may cancel this Contract in accordance with state and federal law.

Upon Contract cancellation, we refund your Group the amount of any unearned prepaid subscription rates we hold. Such payment constitutes a full and final discharge of all our obligations under this Contract, unless otherwise required by law. We will continue to provide benefits for all Covered services received before the date of cancellation.

Default in Subscription Payment

We allow at least a one month grace period for payment.

If we do not receive your payment on or before the end of the grace period.

- We will mail you a cancellation notice.
- This Contract ends after midnight on the last day of the grace period after we send you a cancellation notice.

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

Benefits after Termination of Group Coverage

If you are entitled to benefits for a continuous total disability existing on the date your Group terminates coverage, we provide benefits for Covered services received in connection with your total disability until the earliest of:

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

We will consider you to have a total disability if, because of an illness or injury, you are unable to engage in any employment or occupation for which you are or have become qualified by reason of education, training, or experience and you are not engaged in any employment or occupation for wage or profit. If Blue Cross continues to provide coverage, we are entitled to collect premium payments for the duration of the extension of benefits period.

A minor Dependent is considered to have a total disability only if, because of an illness or injury, he or she is unable to engage in activities that are normal for a person of the same age, gender and ability.

If your group coverage at termination covers your Dependents, any extension under this section applies only to the individual who has a continuous total disability at the time of termination.

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

Active Military Service

Upon receipt of written request, Blue Cross will suspend coverage for active service military members. We will repay any subscription rates paid by someone actively serving in the military according to the proportion owed.

Fraud, Misrepresentation or Concealment of a Material Fact

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

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

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

Contract Reinstatement

By law, we may reinstate a cancelled Contract solely at our discretion and only on such terms and conditions as we decide.

Voidance and Modification

Unless your application or an exact copy of it is included or attached to your Contract, no representation you make on your application for a Contract will:

- make this Contract void; or
- be used in any legal proceeding under your Contract.

Only a Blue Cross and Blue Shield of Vermont officer can bind us legally by changing or waiving any provisions of your Contract.

Rules About Coverage for Domestic Partners

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

Enrollment Eligibility

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

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

To enroll an eligible Domestic Partner, both the subscriber (employee) and the Domestic Partner must complete and sign a *Statement of Domestic Partnership*. You may obtain these forms from your Group Benefits Manager. A notary public must witness the signature of this document. You need to provide the following documentation in support of the *Statement of Domestic Partnership*:

- proof of common residence; and
- proof of financial interdependence, e.g., joint bank accounts or credit cards, executed powers of attorney, listing of your Domestic Partner as a beneficiary on your insurance policy and/or designated signatures on safety deposit boxes.

Effective Date of Coverage

The effective date of coverage of an eligible Domestic Partner and any initially eligible Dependents of the Domestic Partner will be as follows:

When we replace your Group's prior carrier, if the Group already had Domestic Partnership coverage and a partner qualified for coverage under the Group's previous Domestic Partnership policy, coverage may begin on the Group's effective date. If your Group is adding Domestic Partnership coverage for the first time, and a partner qualifies for coverage under the new Domestic Partnership policy, coverage may begin on the Group's effective date if we receive a *Statement of Domestic Partnership* with the subscriber's application.

When an existing Group obtains Domestic Partnership Coverage for the first time, an eligible Domestic Partner's coverage may begin the first of the month after we receive a *Statement of Domestic Partnership* and an application. We must receive this request within 30 days of when your Group obtains coverage for Domestic Partners.

When an employee is first hired, an eligible Domestic Partner's coverage may begin on the subscriber's effective date if we receive a *Statement of Domestic Partnership* with the subscriber's application.

In all other cases, an eligible Domestic Partner's coverage may begin:

- on an open enrollment date if we receive a *Statement of Domestic Partnership* and an application form before the open enrollment date; or
- the first of the month following the open enrollment date, if the Plan receives the *Statement of Domestic Partnership* and application during the month in which the open enrollment date occurs.

Other effective date provisions in your Certificate apply.

Continuation of Group Coverage for Domestic Partners

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

Termination of Domestic Partnership

When two parties no longer meet requirements for Domestic Partnership status, the subscriber must complete and file a *Termination of Domestic Partnership* form within 30 days of the change in status. Forms are available from your Group Benefits Manager.

The subscriber must mail a copy of the termination notice to the Domestic Partner within 14 days of completing the notice. Termination will be effective on the first day of the month following our receipt of the notice.

If a subscriber cancels coverage for a Domestic Partner, he or she may not include another Domestic Partner on the membership until nine months from the date of cancellation.

Right to Continuation of Coverage

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

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

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

You must pay the entire cost of your coverage.

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

Continuation rights do not apply if:

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

Continuation of insurance ends when:

- 18 months pass from the date you would have lost coverage, or longer if you are entitled to protection under federal law;
- you fail to make timely payment of the required contribution;
- you become entitled to Medicare or become covered under any other Group plan that has no preexisting condition exclusion provision; or
- your employer stops offering any Group plan (if your group replaces this coverage with a similar plan, you may continue coverage under that plan).

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

Conversion Rights

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

CHAPTER SEVEN

General Contract Provisions

Applicable Law

This Contract is intended for sale and delivery in, and is subject to the laws of, the State of Vermont and the United States. We uphold its provision only to the extent allowable by law. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Severability Clause

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

Non-waiver of Our Rights

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

Term of Contract

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

Subscription Rate

We have different rates for single and multi-person memberships. Your rate or rating formula is on file with and approved by the Green Mountain Care Board.

Subscription Rate Payments

The subscription rate must be paid in advance directly to us. We allow at least a one month grace period for payment.

Changes in the Subscription Rate

We may change rates only if we receive approval from the Green Mountain Care Board. We will notify your Group of any rate change in accordance with state law.

Subscriber Address

You must notify us of any change of address. Call customer service at the number listed on the back of your ID card, or mail your change of address to:

Blue Cross and Blue Shield of Vermont
PO Box 186
Montpelier, VT 05601-0186

You may also change your address by visiting our Member Resource Center on our website at **www.bluecrossvt.org**.

We send all notices to the subscriber's address on file. This represents our full responsibility to notify the subscriber and member, regardless of whether they receive the notice.

Third Party Beneficiaries

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

CHAPTER EIGHT

More Information About Your Contract

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

Our Commitment to Protecting Your Privacy

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

Federal and state laws require us to maintain the privacy of your protected health information (PHI) and to provide this notice to you of our legal duties and privacy practices. We make a complete copy of our Notice of Privacy Practices available on our website, **www.bluecrossvt.org/privacy-policy**. You may ask for a paper copy of our Notice of Privacy Practices at any time by calling our customer service team at the number on the back of your ID card.

PHI is information about you, including demographic data, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health, the provision of health care to you or the payment for that care. Federal law requires us to maintain the privacy of your PHI by using or disclosing it only with your authorization or as otherwise allowed by law. We may share your PHI as needed for treatment, payment and health care operations. You have the right to gain access to your health information and to information about our privacy practices. If you have any questions or want additional information about the privacy of your information please contact us at:

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

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

Do you know your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and Surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy, including lymphedema. Health Plans must determine the manner of coverage in consultation with the attending Physician and the patient. Coverage for breast reconstruction and related services may be subject to Deductibles and Coinsurance amounts that are consistent with those that apply to other benefits under the plan.

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

Newborns' and Mothers' Health Protection Act

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

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

Our Pledge to You

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

Member Rights and Responsibilities

As a member, you have the right to:

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

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

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

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

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

Nondiscrimination. You have the right to receive services from us free from all forms of discrimination including discrimination 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.

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.

Notify us if there's a change in your family size, address, phone number, PCP or any other change in your membership.

CHAPTER NINE

Definitions

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

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

Adult Dependent Due to Disability: a Dependent who meets our definition of Child, but who is age 26 and older and who:

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

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

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

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

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

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

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

Certificate/Certificate of Coverage: this document.

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

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

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

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.)

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

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.)

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

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 we pay for Out-of-Network Providers, or the cost of non-Covered services.

Covered: describes a service or supply for which you are eligible for benefits under your Contract.

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

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

Deductible: the amount you must pay toward the cost of specific services each Plan Year before we pay certain benefits. Check your *Outline of Coverage* or your *Summary of Benefits and Coverage* for your Deductible amounts and to see if you have a specific kind of Deductible (Aggregate or Stacked as explained in Chapter One, Payment Terms.)

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

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

- imaging (radiology, X-rays, ultrasound and nuclear);
- studies of the nature and cause of disease (laboratory and pathology tests);
- medical procedures (ECG and EEG);
- allergy testing (percutaneous, intracutaneous, patch and RAST testing);
- mammograms; and
- hearing tests performed by a hearing care professional (see also General Exclusions).

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

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

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

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

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

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

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

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

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

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

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

Emergency Medical Services includes those services needed to stabilize the patient, as well as post-stabilization services furnished as part of an out-patient observation, or an in-patient or out-patient 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: the organization that has agreed to forward subscription rates due under your Contract.

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

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

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

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

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

Hearing Aid: any small, wearable electronic instrument or device designed and intended for the ear for the purpose of aiding or compensating for impaired human hearing and any related parts, attachments, or accessories, including ear molds and associated remote microphones that pair with hearing aids to improve word comprehension in difficult listening situations in live or telecommunications settings.

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. We compute the length of an Inpatient stay by counting either the day of admission or the day of discharge, but not both.

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

Investigative/Investigational: (see Experimental)

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

Medical 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; and
- peer-reviewed abstracts accepted for presentation at major medical association meetings.

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

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

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

Member: an individual who enrolls in the Health Plan.

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

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

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

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

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

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

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

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

Partnership: see Domestic Partners (Partnership).

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

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

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

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

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

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

Prescription Drugs and Biologics: products that are:

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

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

Professional: one of the following practitioners:

- athletic trainers
- audiologists
- Chiropractors (as further defined in this chapter)
- hearing care Professional
  - audiologist
  - hearing aid dispenser acting within the scope of their license
  - Physician acting within the scope of their license
  - Physician assistant acting within the scope of their license
  - advanced practice registered nurse acting within the scope of their license
- 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 us;
- licensed and/or certified where required; and
- acting within the scope of that license and/or certification.

Preferred Provider: any Provider that has a Preferred Provider agreement with us; or any Provider located out of state that has a similar agreement with another Blue Cross and Blue Shield Plan (see also Non-Preferred Provider below). This includes:

- Pharmacies who make an agreement with our Pharmacy Benefit Manager; and
- Vision Providers who make an agreement with our vision service partner.

For some types of service, we do not provide benefits if you do not use a Preferred Provider. See choosing a Preferred Provider in Chapter One, Guidelines of Coverage. You may find a Preferred Provider by using our Find-a-Doctor tool on our website at **www.bluecrossvt.org/find-doctor**. Select BCBSVT Network Providers from the drop-down menu.

Non-Preferred Provider: a Provider that does not meet the definition of a Preferred Provider. For some types of service, we do not provide benefits if you use a Non-Preferred Provider. They are listed 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; and
- Surgery for initial reconstruction of breasts after mastectomy.

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

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

availability and 24 hour onsite nursing services. Care includes treatment with a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs. Residential care also includes training in the basic skills of living as determined necessary for each patient.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Index

A

Access to Care 10

Activities of Daily Living
- Definitions 42

Acupuncture
- General Exclusions 26

Acute Care
- Definitions 42

Adding Dependents 35

Adult Dependent Due to Disability
- Definitions 42

After-hours and Emergency Care 10

Allowed Amount 11
- Definitions 42

Ambulance
- Definitions 42
- Prior Approval 6

Applicable Law 39

Autism Spectrum Disorder 14
- Definitions 42

B

Bariatric Surgery 14

Better Beginnings® Maternity Wellness Program 21

Biofeedback
- General Exclusions 26

BlueCard® Program
- BlueCard Service Area 42

Blue Cross Blue Shield Global® Core Program 9

Blue Distinction Centers
- Definitions 42

C

Case Management Program 6

Certificate
- Definitions 42

Child
- Definitions 42

Chiropractic Services 14
- Definitions 42
- Exclusions 14
- Prior Approval 6
- Therapy Services 24

Choosing a Preferred Provider 6

Chronic Care
- Definitions 42

Claims 30
- Claim Submission 30
- Complaints and Appeals 31
- Cooperation 30
- Payment in Error/Overpayments 30
- Payment of Benefits 30
- Release of Information 30

Claim Submission 30

Clinical Trials 14
- Definitions 42

Coinsurance 11
- Definitions 42

Communication devices
- General Exclusions 26

Complaints and Appeals 31
- Request an Appeal 31

Continuation of Coverage 38

Continuity of Care 8

Contraceptive Services 15

Contract
- Definitions 42

Cooperation 30

Coordination of Benefits 33
- For Children of Divorced Parents 33

Copayment 11
- Definitions 42

Cosmetic 15
- Definitions 43
- General Exclusions 27
- Prior Approval 6

Cosmetic and Reconstructive Procedures 15

Cost-Sharing 11
- Coinsurance 11
- Copayment 11
- Deductible 11
- Definitions 43
- Out-of-Pocket Limit 12

Covered Services 13
- Covered 43
- Office Visits 13
- Preventive Services 13

Custodial Care
- Definitions 43
- General Exclusions 27

D

Deductible 11
- Aggregate Deductible 11
- Definitions 43
- Stacked Deductible 11

Definitions 42

Dental Services 15
- General Exclusions 27
- Prior Approval 6

Dependent
- Definitions 43

Diabetes Services 16

Diagnostic Services 16
- Definitions 43

Domestic Partners 37
- Definitions 43
- Rules About Coverage 37

Domiciliary Care
- Definitions 43

E

Educational evaluation
- General Exclusions 27

Electrical stimulation devices
- General Exclusions 26
- Prior Approval 6

Emergency Care 16
- After-hours 10

Emergency Medical Condition
- Definitions 44

Experimental or Investigational Services
- Definitions 44

F

Facility (Facilities)
- Definitions 44

Foot care
- General Exclusions 27

Fraud, Misrepresentation or Concealment of a Material Fact 36

G

Gender Affirming Services 16
- Definitions 44

General Contract Provisions 39

General Exclusions 26

General Guidelines 5

Group
- Definitions 44

Group Benefits Manager
- Definitions 44

Guidelines for Coverage 5

H

Habilitative/Rehabilitative
- Definitions 44

Health Plan
- Definitions 45

Hearing Aid Services 16
- Definitions
  - Hearing aid 45
  - Hearing care Professional 47
- General Exclusions

Listening devices 28
Home Care 17
Private Duty Nursing 17
Home Health Agency/Visiting Nurse Association
Definitions 45
Hospice Care 18
Definitions 45
Hospital Care 18
Definitions
General Hospital 44
Inpatient Hospital Services 18
Inpatient Medical Services 18
Outpatient Hospital Care 21
How We Choose Providers 10
How We Determine Your Benefits 11

I

Immediate Family Member
Definitions 45
Immunizations
General Exclusions 26
In an Accident 33
Independent Clinical Laboratories 18
Infertility Services
General Exclusions 27
Inpatient
Definitions 45
Hospital Services 18
Medical Services 18
Mental Health Care 20
Services under BCBS Global® Core Program 9
Intensive Outpatient Programs
Definitions 45
Investigative
Definitions 45

L

Listening devices
General Exclusions 28

M

Medicaid and Tricare 33
Medical Care
Definitions 45
Medical Equipment and Supplies 20
Definitions 43
Orthotics 19
Prior Approval 6
Prosthetics 19
Replacement 19
Supplies 19
Medical Foods
Definitions 45
Medically Necessary Care
Definitions 45
Medical or Scientific Evidence
Definitions 45
Member
Definitions 46
Member Rights and Responsibilities 41
Membership 35
Active Military Service 36
Adding Dependents 35
Cancellation of Coverage 36
Domestic Partners 37
Removing Dependents 36
Mental Health Care 20

N

Network Pharmacy
Definitions 46
Non-medical charges
General Exclusions 28
Non-Preferred Providers 7
Definitions 47
Nonprescription treatment of obesity
General Exclusions 28
Non waiver of Our Rights 39
Notice of Privacy Practices 40
Nutritional Counseling 20
Nutritional formulas
General Exclusions 28

O

Occupational Therapy 24
Definitions 46
Office Visits 13
Off-label Use of a Drug
Definitions 46
Orthodontics
General Exclusions 28
Other Party Liability 33
Coordination of Benefits 33
For Children of Divorced Parents 33
In an Accident 33
Medicaid and Tricare 33
Reimbursement 33
Subrogation 34
Other Provider
Definitions 46
Other Resources to Help You 32
Outline of Coverage
Definitions 46
Out-of-Area Providers 8
Out-of-Area Services with Non-Contracting Providers 9
Out-of-Pocket Limit 12
Aggregate Out-of-Pocket Limit 12
Definitions 46
Stacked Out-of-Pocket Limit 12
Outpatient
Definitions 46
Hospital Care 21
Medical Services 21
Mental Health Care 20
Services under BCBS Global® Core Program 9

P

Palliative
Definitions 46
Party to a Civil Union
Definitions 46
Payment in Error/Overpayments 30
Payment Terms 11
Allowed Amount 11
Coinsurance 11
Copayment 11
Cost-Sharing 11
Deductible 11
Out-of-Pocket Limit 12
Physical Rehabilitation Facility
Definitions 46
Physical Therapy 24
Definitions 46
Physician
Definitions 46
Plan Year
Definitions 46
Plan Year Benefit Maximums 12
Policy
Definitions 46
Preferred Providers 7
Definitions 47
Pregnancy Care
Better Beginnings Maternity Wellness Program 21
Prescription Drugs and Biologics
Definitions 46
Prior Approval Program 6
Preventive Services 13
Definitions 46
Primary Care Providers 7
Definitions 46
Prior Approval Program 5
Definitions 46
Prior Approval List 5
Request Prior Approval 5

Private Duty Nursing 17

Professional
Definitions 47

Provider
Definitions 47

Provider Exclusions 29

Psychiatric Hospital
Definitions 47

R

Reconstructive 15
Definitions 47
Prior Approval 6

Rehabilitation/Habilitation 22
Definitions 44
Prior Approval 6

Reimbursement 33

Release of Information 30

Residential Treatment Center
Definitions 47

Residential Treatment Program
Definitions 47

Respite Care
Definitions 48

Rest Cure
Definitions 48

S

Self-Pay Allowed by HIPAA 12

Services covered by a prior health plan
General Exclusions 26

Skilled Nursing Facility 22
Definitions 48

Speech Therapy 24
Definitions 48

Spouse
Definitions 48

Sterilization reversal
General Exclusions 28

Subrogation 34

Subscriber Address 39

Subscription Rate 39

Substance Use Disorder
Treatment Services 22

Supportive Care
Definitions 48

Support Therapies
General Exclusions 28

Surgery 23
Definitions 48
General Exclusions 27
Prior Approval 6

T

Telemedicine
Definitions 48
Program 23
Services 23

Therapy Services 24

Third Party Premium Payments 12

Transplant Services 24
Prior Approval 6

U

Urgent Services 48
Definitions 48

V

Vision Services (Medical) 25

W

We, Us, Our
Definitions 48

Work-related Illnesses
General Exclusions 28

Y

You, Your
Definitions 48

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Vermont Freedom Plan Certificate of Coverage (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).

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